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Extreme premature delivery 22-26 week's gestation

Patient Information

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The WWL Way

Introduction

Babies born very prematurely may not survive or may have long-term problems. These problems are set out in more detail below. The chances of survival depend on many factors including stage of the pregnancy, birth weight, inherited abnormalities, condition at birth and presence or absence of infection. The potential risks in your individual situation will be explained.

This leaflet is written for parents who are at risk of having a very premature baby (delivering between 22 and 26 weeks of pregnancy). You will need to make some important choices about your care before and during labour if this occurs.

This leaflet contains important information to help you decide what would be best for you, your baby and your family. We are happy to go through this leaflet with you to clarify any points and answer your questions. The obstetricians and neonatologist (doctor that cares for sick new born babies) will discuss with you what it may mean for your baby if he or she delivers soon.

You may be offered a visit to the neonatal unit, which is where your baby is likely to receive specialist care, if delivered early.

Gestation and survival of extreme premature babies

Babies born early may not survive, may survive and be healthy or may survive but have long term problems and disabilities. The chance of survival increases with each additional week of pregnancy and the risk of disabilities reduces.

Outcomes at different gestations

Babies born extremely prematurely have very immature organs. They are at increased risk of problems in later childhood even if they survive the neonatal period. These are some of the potential problems:

- Damage to their brain, such as cerebral parenchymal cysts (small “holes” in the brain) and hydrocephalus (too much fluid in the brain). These changes can cause cerebral palsy and/or learning difficulties.
- Damage to their eyes (retinopathy), which may affect their vision.
- Hearing problems.
- Damage to the lungs (chronic lung disease) causing breathing problems.
- Problems with feeding and long term growth.

The biggest studies to look at the short term outcomes after extreme preterm birth in England were the Epicure (1995) and Epicure 2 (2006). Below survival data is from Epicure 2 (2006).

22+0 – 22+6 weeks

If the gestational age is certain and less than 23+0 it is considered in the best interests of the baby, and standard practice, for resuscitation **not** to be carried out as survival remains extremely rare (3/478 babies survived to discharge in the Epicure study; only 1 without major morbidity). This group of babies may attempt to gasp and move when born which is expected. They should be kept comfortable, treated with respect, dignity and love.

23+0 – 23+6 weeks

(19% of babies born alive survive, 23% of these have no major long lasting disabilities)

This group of babies have a poor survival rate and high risk of disabilities therefore a decision not to start resuscitation may be appropriate in the best interests of the baby. However, if the parents wish their baby to be resuscitated or where there is no time for discussion with the parents, the baby doctors will provide full resuscitation.

24+0 – 24+6 weeks

(40% of babies born alive survive, 29% of these have no major long lasting disabilities)

Babies are generally offered full treatment and support (resuscitation) unless the parents and doctors consider that the baby will be born severely compromised. If the baby is assessed by the **baby doctors** to be more immature than expected, deciding not to start resuscitation may be considered in the best interest of the baby.

25+0 – 25+6 weeks

(66% of babies born alive survive, 38% of these have no major long lasting disabilities)

It is appropriate to provide full active treatment and support to these babies at birth.

26+0 weeks and 26+6 weeks

(77% of babies born alive survive)

Full resuscitation (active treatment to support baby's life) is generally the standard approach.

Uncertain Gestation

If the gestation is uncertain, or for babies thought to be between 22 and 23 weeks where the parents are adamant that they want every reasonable attempt to keep baby alive, management is generally discussed with the **baby doctors who will attend the delivery**. This does not automatically mean resuscitation; the final decision lies with the baby doctors present at delivery after careful assessment of the baby. Resuscitation may be appropriate if baby is born vigorous and of an apparently good birth weight. If the baby is not vigorous (no regular breathing or sustained movement) there is no need to seek other signs of life (pulsating cord, pulse, heart beat).

Less than 22+0 weeks

This group of babies do not survive. They may attempt to gasp and move when born. They should be kept comfortable and treated with respect, dignity and love.

Mode of delivery (the way your baby is born)

In extremely preterm babies there is no clear evidence that the baby's health is improved by caesarean section over vaginal birth. The operation is more difficult when the baby is very small and the pregnancy very early and it is unlikely to improve the outlook for the baby.

At gestations less than 26 weeks, the most important predictor of survival is gestation, not the way baby is born. Baby may survive but with multiple long-term problems that affect very premature babies (problems with breathing, vision, hearing, brain development, cerebral palsy, childhood hospital admissions, behavioural problems, delayed milestones).

Compared to vaginal birth, a caesarean is associated with increased risks to the mother's health and future pregnancies (bleeding, infection, thromboembolism (blood clots) increased risk of adherent placenta (placenta attached to the scar), uterine rupture and caesarean delivery in a future pregnancy).

Usually a caesarean delivery is not appropriate before 26 weeks of pregnancy unless the mother is very unwell and urgent delivery is required for her health (e.g. very high blood pressure) rather than awaiting induction of labour and vaginal birth. This is because these babies have a high risk of dying or suffering from major disability.

Rarely, a caesarean may be considered after 25 weeks of pregnancy in specific situations, such as baby lying across the womb instead of in the head down position (baby lying in bottom down position with feet presenting first) because of the associated risks to baby. However, any potential benefits are still unclear and many obstetricians and parents would not want to consider a caesarean until after at least 26 weeks.

Between 25 and 26 weeks some parents may wish the baby to be delivered by caesarean section if there was evidence of the baby becoming unwell during labour, but some might choose to allow the labour to progress, with the understanding that some babies will not survive labour.

Your baby's heart rate monitoring

Continuous electronic foetal heart rate monitoring (CTG) is usually advised after 26 weeks of pregnancy. This form of monitoring may occasionally be used at 25 weeks following careful discussion with the parents if a plan has been agreed to consider a Caesarean in labour if the baby shows signs of distress. Otherwise, intermittent heart rate monitoring may be offered.

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Comments, Compliments or Complaints

The Patient Relations/Patient Advice and Liaison Service (PALS) Department provides confidential on the spot advice, information and support to patients, relatives, friends and carers.

Contact Us

Tel: 01942 822376 (Monday to Friday 9am to 4pm)

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Ask 3 Questions

Become more involved in decisions about your healthcare. You may be asked to make choices about your treatment. To begin with, try to make sure you get the answers to three key questions:

1. What are my options?
2. What are the pros and cons of each option for me?
3. How do I get support to help me make a decision that is right for me?

How We Use Your Information

For details on how we collect, use and store the information we hold about you, please take a look at our “how we use your information” leaflet which can be found on the Trust website: www.wwl.nhs.uk/patient_information/Leaflets/default.aspx

This leaflet is also available in audio, large print, Braille and other languages upon request. For more information call 01942 773105.

CALL 111
when it's less urgent than 999