Newborn Critical Care Center (NCCC) Clinical Guidelines

Joint Obstetric and Neonatology Antenatal Counseling for Anticipated "Periviable" Deliveries Prior to 25 Weeks

See also Counseling and Management of Extremely Premature Infants 2024

Background

1. Estimated fetal gestational age (GA) is an imprecise predictor of neonatal survival. 22 0/7 weeks GA is generally accepted as the lower threshold of viability.[1,2]
2. Outcomes of infants delivered at 22 to 24 weeks GA vary significantly across centers.[2]
3. Because of the uncertain outcomes for infants born at 22 to 24 weeks GA, it is recommended that decisions regarding the delivery room management be individualized and family centered, taking into account known fetal and maternal risk factors as well as parental beliefs regarding the best interest of the child.[3]
4. Attitudes and perceptions about health care and outcomes may vary between providers, parents, and individual staff. Ongoing interdisciplinary communication and written policies can promote consistent, timely, and effective counseling.
5. Optimal decision-making regarding the delivery room management can be promoted through joint discussions between the parents and both the obstetric and neonatal care providers whenever possible.

Pre-counseling steps:

1. Obstetric team determines gestational age of pregnancy, based on "best obstetric estimate", confirms pregnancy to be 22 weeks and 0/7 days to 24 weeks and 6/7 days, and notifies neonatal team of suspected impending delivery.
2. Maternal-fetal medicine fellow or OB/MFM attending and Neonatology fellow or attending jointly discuss assessments (including likelihood of delivery, likely location of delivery, competing maternal and fetal risks) and the range of reasonable care strategies (Appendix). The assigned primary Labor & Delivery nurse can be included to provide insight or knowledge about current patient knowledge, expectations, and preferences.

Counseling:

1. Initial counseling should be completed jointly with Obstetrician (Attending/MFM Fellow/Chief Resident), Neonatology (Fellow/Attending), and primary L&D nurse when possible.
2. The primary goal of antenatal counseling is to provide parents with information that will aid their decision-making. This counseling should include not only expected outcomes for the infant but also a discussion of available options (eg, comfort care versus intervention). Health-care providers should avoid statements such as 'doing everything,' 'the parents want nothing done' or 'there is nothing we can do.'
3. Communication needs to be sensitive to the religious, social, cultural, and ethnic diversity of the parents; in particular, for parents with limited English proficiency, these discussions must include medical interpretation services, preferably face-to-face. Likewise, an appropriate interpreter may be needed for parents with hearing limitation.

4. The value of providing statistical information during counseling is unclear, and there is evidence that this information is often misunderstood. It is critically important that parents hear the potential range of outcomes rather than specific numeric estimates. The NICHD Extremely Preterm Birth Outcome Data Estimator could be consulted to identify ranges of possible outcomes but current general or institutional neonatal morbidity and mortality estimates should be incorporated when possible.

Post-counseling steps:

1. Debriefing among the obstetric and neonatal team members should occur to share and confirm the care plan decisions (if any).
2. Documentation of joint counseling and resultant components of a care plan in the maternal chart after the post-counseling team debriefing.
3. Attending/fellow-to-attending/fellow sign-out of updated plan as care continues and the plan evolves.
4. Planned serial counseling, and if indicated care plan adjustment, on at least a weekly basis or with significant clinical changes since outcome estimates will change over time.

Summary

1. Care at 22 0/7 – 24 6/7 weeks requires a multidisciplinary team with senior-level physician/provider insight and direct involvement to assist patients and families with decision-making regarding periviability care plans.
2. Plans may be customized for patients in whom possible delivery is anticipated during this periviable gestational period to best reflect the available evidence, clinical setting and risk factors, and patient and family wishes.

Appendix. Potential Discussion Points

Maternal	Neonatal
Cerclage placement Tocolytic therapy to reach steroid maturity Antenatal corticosteroids Magnesium for neuroprotection Antibiotic prophylaxis Cesarean delivery Fetal monitoring	Palliative care Delivery room resuscitation Resuscitation limitations Re-evaluation of goals in NICU

References:

1. American College of Obstetricians and Gynecologists; Society for Maternal-Fetal Medicine. Obstetric Care consensus No. 6: Periviable Birth. Obstet Gynecol. 2017 Oct;130(4):e187-e199. doi: 10.1097/AOG.0000000000002352. PMID: 28937572.
2. Raju TNK, Mercer BM, Burchfield DJ and Joseph GF. Periviable birth: executive summary of a Joint Workshop by the Eunice Kennedy Shriver National Institute of Child Health and Human Development, Society for Maternal-Fetal Medicine, American Academy of Pediatrics, and American College of Obstetricians and Gynecologists. J Perinatol 2014; 34:333–342.
3. Chervenak FA, McCullough LB & Levene MI. An ethically justified, clinically comprehensive approach to peri-viability: Gynaecological, obstetric, perinatal and neonatal dimensions, J Obstet Gynaecol 2007; 27(1): 3-7.