Counselling and management for anticipated extremely preterm birth

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ABSTRACT

Extremely preterm birth (birth between $22^{0/7}$ and $25^{6/7}$ weeks' gestational age [GA]) often requires parents to make complex choices about the care of their infant. Health professionals have a significant role in providing information, guidance and support. Parents facing the birth of an extremely preterm infant should have the chance to meet with both obstetrical and paediatric/neonatal care providers to receive accurate information about their infant's prognosis, provided with clarity and compassion. Decision making between parents and health professionals should be an informed and shared process, with documentation of all management decisions. Consultation with and transfer to tertiary perinatal centres are important for the care of both mother and fetus. As the survival of infants born before or at 22 completed weeks' GA remains uncommon, a noninterventional approach is recommended, whereas at 23, 24 and 25 weeks' GA, counselling about outcomes and decision making should be individualized for each infant and family, using factors which influence prognosis. All extremely preterm infants who are not resuscitated, or for whom resuscitation is not successful, must receive compassionate palliative care.

Key Words: *Antenatal counselling; Ethics; Extreme prematurity; Resuscitation*

RECOMMENDATIONS using the GRADE recommendations format:

1. Parents facing the birth of an extremely preterm infant should have the opportunity for face-to-face discussions with their obstetrical care provider and with a neonatologist or paediatrician. If the situation permits, parents should be able to meet with their health care providers on more than one occasion. (Strong Recommendation)
2. Parents must receive information that is as accurate as possible about their infant's likelihood of survival and long-term outcome, presented in a compassionate and clear manner. Offering supplementary written information is encouraged. Parental understanding of all information should be verified. (Strong Recommendation)
3. Decision making between parents and health professionals should be an informed and shared process. Decision aids may be helpful for parents. (Strong Recommendation)
4. Discussions and decisions concerning management of labour, mode of delivery and intensity of neonatal intervention must be explicitly recorded and available to all members of the health care team. (Strong Recommendation)
5. Counselling should be ongoing. If decisions about care of the infant change, these changes must be clearly documented. If pregnancy continues, parents should be provided with updated information. (Strong Recommendation)
6. Caregivers must obtain the most accurate information about GA and estimated fetal weight available. (Strong Recommendation)
7. When a pregnant woman is believed to be at least 22 weeks' GA and at risk of giving birth prematurely, her health professional should consult with a maternal-fetal medicine specialist and neonatologist. (Strong Recommendation)
8. Transfer to a tertiary level perinatal centre is recommended for all women with threatened preterm birth who are thought to be at least 23 weeks' GA and are safe to transfer. In situations where, following consultation with a tertiary centre and complete and fully informed decision making by the family, a decision has been made not to resuscitate an extremely preterm infant, care providers and the family may agree not to transfer the mother. Antenatal corticosteroids should be administered when active management is considered. (Strong Recommendation)
9. Elective Cesarean section is not recommended before 24 weeks' GA unless for maternal indications. (Strong Recommendation)
10. At 22 weeks' GA, since survival is uncommon, a noninterventional approach is recommended with focus on comfort care. (Strong Recommendation)
11. At 23, 24 or 25 weeks' GA, counselling about outcomes and decision making around whether to institute active treatment should be individualized for each infant and family. (Strong Recommendation)
12. At 23 and 24 weeks' GA, active treatment is appropriate for some infants. (Weak Recommendation)
13. Most infants of 25 weeks' GA have improved survival and neurodevelopmental outcomes and active treatment is appropriate for these infants except when there are significant additional risk factors. (Weak Recommendation)

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14. When GA or the plan of care is uncertain, all births of extremely preterm infants must be attended by individuals capable of managing the infant. (Strong Recommendation)
15. All extremely preterm infants who are not resuscitated or for whom resuscitation is not successful must receive compassionate palliative care, including warmth and pain relief. (Strong Recommendation)

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