

Newborn Critical Care Center (NCCC) Clinical Guidelines

Joint Obstetric and Neonatology Antenatal Counseling for Anticipated “Perivable” Deliveries Prior to 25 Weeks

See also [Counseling and Management of Extremely Premature Infants 2019](#)

Background

1. Fetal gestational age, as currently estimated, is an imprecise predictor of neonatal survival, but 22 0/7 weeks of gestation is generally accepted as the lower threshold of viability.
2. Outcomes of infants delivered at 22 to 24 weeks of gestation vary significantly from center to center.
3. Because of the uncertain outcomes for infants born at 22 to 24 weeks' gestation, it is reasonable that decision-making regarding the delivery room management be individualized and family centered, taking into account known fetal and maternal conditions and risk factors as well as parental beliefs regarding the best interest of the child.
4. Attitudes and perceptions about health care and outcomes vary not only between providers and parents but also among physicians and staff. Ongoing interdisciplinary communication and written policies and procedures 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.

The Counseling Process

1. Obstetric team determines gestational age of pregnancy, based on “best obstetric estimate”, and confirms pregnancy to be 22 weeks and 0/7 days to 24 weeks and 6/7 days. Neonatal team advised of a suspected impending delivery of a 22-24 6/7 week infant
2. Pre-counseling discussion: Maternal-fetal medicine fellow or OB/MFM attending, and Neonatology fellow or attending jointly discuss assessments and the range of reasonable care strategies based on the shared assessment of the clinical setting, including likelihood of delivery, likely location of delivery, competing maternal and fetal risks and potential interventions as outlined below. The assigned primary Labor & Delivery nurse can be included to provide insight or knowledge about current patient knowledge, expectations and preferences.
 - a. The OB/MFM and Neonatology team members will jointly review possible actions (including palliative care and delivery room resuscitation) to be reviewed and discussed with the patient and family. Consideration of various components of antenatal management, such as antenatal steroids in the setting of potential for resuscitation, fetal monitoring options, magnesium sulfate for neuroprophylaxis, antibiotics, and mode of delivery will be considered individually, and will be combined as appropriate on an individual case basis.

3. After establishing clinical status, establish estimates for neonatal morbidity and mortality. 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.
4. Initial, primary counseling completed jointly with Obstetrician (Attending Staff, MFM Fellow or Chief Resident) and Neonatology (Fellow or Attending). The primary Labor & Delivery nurse should be present for counseling if possible.
 - a. 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.'
 - b. Communication needs to be sensitive to the religious, social, cultural, and ethnic diversity of the parents; in particular, for a parent with limited English proficiency, these discussions must include medical interpretation services, preferably face-to-face. Likewise, an appropriate interpreter may be needed for a parent who has limitations with hearing.
 - c. 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. A validated visual decision-aid can be used to assist counseling, but emphasis should still be placed on the possible qualitative and quantitative range of outcomes rather than quoting exact risk estimates.
 - d. Documentation of joint counseling and resultant components of a care plan in the maternal chart after the post-counseling team debriefing.
 - e. Attending/fellow-to-attending/fellow sign-out of updated plan as care continues and the plan evolves or changes
 - f. 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.
5. Post-counseling debriefing among the obstetric and neonatal team members should occur to share and confirm the care plan decisions (if any).

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 perivable gestational period to best reflect the available evidence, clinical setting and risk factors, and patient and family wishes.

References:

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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.
4. Guillen U, Suh S, Munson D, Posencheg M, Truitt E, Zupancic JAF, Gafni A, and Kirpalani H. Development and Pretesting of a Decision-Aid to Use When Counseling Parents Facing Imminent Extreme Premature Delivery. *J Pediatr* 2012; 160:382-7.