6.3 Outcome data on neonatal survival should be interpreted with care and the knowledge that peri-natal management has a role to play in these outcomes.

6.4 Pregnant patients at greater than or equal to 23 0/7 and up to 32 0/7 weeks gestation should be transferred to a tertiary centre with Level III NICU, despite the perceived intentions for neonatal management. The decision to transfer should be patient-specific and factor in gestational age, estimated fetal weight, and parental preferences.

6.5 The survival of infants born before or at 22 6/7 completed weeks of gestation remains uncommon. A non-interventional approach is recommended.

6.6 All extremely preterm infants who are not resuscitated, or for whom resuscitation is not successful, shall receive compassionate palliative care.

6.7 Community practitioners should be educated about the management options for extreme prematurity and should have the option to call specialist practitioners for advice in managing these cases.

6.8 Practitioners shall be aware of their local referral pathway systems for peri-natal complications, and should remain alert to new research in this area.

6.9 Infants born between greater than or equal to 23 0/7 weeks and 24 6/7 weeks of gestation with a birth weight of 500 to 599 grams (threshold of viability) present the greatest uncertainty surrounding infant survival and outcome.

a) The line between patient autonomy and medical futility is blurred.

b) If the birth weight is less than 500 grams, resuscitation should only be performed after most careful consideration.

c) A consistent obstetric and neonatal approach is important, as consistency has been shown to improve neonatal outcome. Disagreement between Obstetricians and Neonatologists may result in lack of appropriate treatment and interventions, including: medications, fetal health surveillance, and caesarean section versus vaginal delivery.

7. Counselling for Recurrence of Preterm Birth in a Subsequent Pregnancy

7.1 First trimester ultrasound should be performed in all pregnancies, especially when risk factors for preterm birth are present.

7.2 Ultrasound measured estimated fetal weight, with a good understanding of its limitations, may help in decision-making around pregnancy monitoring and obstetric interventions.

7.3 Serial transvaginal ultrasound CL measurements with specified gestational age directed surveillance may be used in patients at increased risk for preterm birth based on the expert MFM Specialist recommendations.