DIAGNOSIS AND MANAGEMENT OF CERVICAL INSUFFICIENCY

DEFINITION AND INTRODUCTION

Cervical insufficiency is defined as the inability of the uterine cervix to retain a pregnancy in the second trimester, in the absence of uterine contractions. (1)

A history of cervical insufficiency has been applied to women with one or more second trimester pregnancy losses/preterm births (before 34 weeks) who fulfil this definition. It must be noted that a short cervical length on transvaginal scan in the second trimester is a risk factor for preterm birth but is not sufficient to diagnose cervical insufficiency.

Prematurity is the leading cause of perinatal death and disability. Evidence suggests that the incidence of preterm labour and birth is continuing to rise worldwide. Currently 6% of babies in New Zealand are born preterm. Despite efforts and interventions aimed at reducing the incidence globally the results have been largely disappointing. (2)

It can be difficult to distinguish between women who have a short cervix and those that have true cervical insufficiency. Structural cervical weakness is the likely cause of many recurrent second trimester miscarriages but may only account for a minor proportion of all second-trimester losses/births. The majority of these cases are probably caused by other disorders, such as decidual inflammation/infection, placental bleeding, or uterine overdistension. These other disorders can initiate biochemical changes within the cervix that lead to premature shortening and often a single (i.e. nonrecurrent) second trimester loss/birth.

RISK FACTORS

Refer to the Obstetric clinic is guided by Section 88 Referral Guideline.

CERVICAL RISK FACTORS: (SEE APPENDIX A)

- **Collagen abnormalities** — genetic disorders affecting collagen (eg. Ehlers Danlos syndrome) have been associated with an increased risk of preterm birth (4)

- **Uterine anomalies** — increase the risk of second trimester preterm birth, eg. Septate uterus, bicornuate uterus and even arcuate uterus (5).

- **Biologic variation** — although a short cervix is predictive of preterm birth, it is not diagnostic of cervical insufficiency and many women who have a congenitally short cervix deliver at term (6)
PAST OBSTETRIC HISTORY: (SEE APPENDIX B)

- Recurrent mid-trimester pregnancy losses
- Previous preterm pre-labour rupture of membranes at less than 32 weeks
- Prior pregnancy with a cervical length measurement of less than 25 mm prior to 27 weeks of gestation

ACQUIRED FACTORS (MORE COMMON)

- **Cervical trauma** — which can also result from labour and delivery (eg. spontaneous, forceps or vacuum, caesarean section) may weaken the cervix, and contribute to cervical insufficiency.

- **Mechanical dilation** — eg. dilation and curettage [D&C], dilation and evacuation [D&E], pregnancy termination, hysteroscopy. In women with a short cervical length and no prior preterm birth, prior cervical mechanical dilatation is one of the most common associated risk factors.

- **Treatment of cervical intraepithelial neoplasia:**
  A cone biopsy has been shown to be a risk factor for preterm delivery. In addition, a LLETZ (Loop excision procedure), particularly repeat ones have also been shown to increase the risk. The evidence for a single isolated LLETZ increasing risk of cervical insufficiency is more tenuous and relates to the size of the excised tissue.

CLINICAL FINDINGS

- Women may have no symptoms or can present with mild symptoms, eg. painless vaginal spotting, increased vaginal discharge, premenstrual-like cramping or backache or pelvic pressure.
- Women may present with these symptoms from as early as 14 to 20 weeks of gestation.
- On physical examination, the cervix may be soft and closed with minimal effacement (occurs early in the course of cervical insufficiency).
- Transcervical ultrasound cervical length is typically short (less than or equal to 25mm) and debris may be seen in the amniotic fluid. If serial ultrasound examinations have been performed, a decrease in cervical length overtime will be noted.

DIAGNOSIS

This is based on either a classic past obstetric history alone or on a combination with transvaginal ultrasound (TVU) measurement of cervical length. Diagnosing those women with advanced cervical dilatation and/or effacement by physical examination alone is sufficient.

Important note:
The diagnosis of cervical insufficiency is usually limited to singleton gestations because the pathogenesis of delivery at 14 to 28 weeks in multiple gestations is usually unrelated to a weakened cervix.
MANAGEMENT

The management of these women can be divided into two main groups:

1. Women for whom a conservative path will be pursued
2. Women where it is clear that surgical intervention in the form of a cerclage is indicated.
   This may be either prophylactic or therapeutic.

APPROACH TO MANAGEMENT

See pathways below.

REFERENCES

6. Vincenzo Berghella, MD. Cervical insufficiency Up to date May 2014


APPENDIX A  CONSERVATIVE MANAGEMENT

Women with cervical risk factors for cervical insufficiency but no history of previous loss.

**FIRST OBSTETRIC VISIT**
1. Urine for culture and sensitivity
2. HVS for bacterial vaginosis at first visit
Any infections should be treated

Cervical length at 16 weeks gestation

- Cervical length remains > 30 mm
  - No further scans

- Cervical length 25 mm to 30 mm
  - Commence progesterone (complete special authority)
  - Consider steroids ≥ 24/40*
  - 2-weekly TVS surveillance up until 24 weeks
  - Any further evidence consider cervical cerclage

- Cervical length <25 mm
  - 2-weekly TVS surveillance and consider cerclage if ongoing shortening

*Discuss with NICU
APPENDIX B  CONSERVATIVE MANAGEMENT

Those women with a previous 2nd trimester loss or a previous preterm delivery before 34 weeks

FIRST OBSTETRIC VISIT

Urine for culture and sensitivity
HVS for bacterial vaginosis at first visit
Consider progesterone (complete special authority)*
Any infections should be treated

Request USS for cervical length from 14 weeks at a 2-weekly interval to 24 weeks

Cervical length remains > 25 mm
Continue 2-weekly TVS surveillance until 24 weeks gestation

Evidence of shortening ≤ 25 mm

On progesterone
Commence progesterone
Consider steroids ≥ 24/40
If further shortening, consider cervical cerclage

Not on progesterone

*DDiscuss with NICU
APPENDIX C  SURGICAL MANAGEMENT

Suspected history of cervical insufficiency is:

Three or more preterm births < 34 weeks (with progressively earlier deliveries in successive pregnancies) and/or second trimester losses

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**FIRST OBSTETRIC VISIT**

1. Urine for culture and sensitivity
2. HVS for bacterial vaginosis at first visit
   Any infections should be treated

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History indicated cerclage at 12-14 weeks (after MSS-1 screening)

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2-weekly TVS surveillance until 24 weeks gestation

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If there is evidence of cervical shortening despite cerclage, consider adding progesterone*  
Consider steroids once > 23/40 weeks**

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**No trials have evaluated the efficiency of combination therapy**

*Discuss with NICU
### APPENDIX D  ACUTE PRESENTATION WITH SUSPECTED CERVICAL INSUFFICIENCY

#### ASSESSMENT
1. Take an incidental history to rule out infection or preterm labour
2. Maternal observations: temperature, pulse rate, blood pressure, respiratory rate
3. Examination: abdominal palpitations (fundal height, tenderness, uterine activity)
4. Vaginal assessment: speculum examination of cervical effacement and dilation
   - exclude – SROM, bleeding, abnormal vaginal discharge
5. Digital exam ONLY if evidence of advanced dilation and birth thought imminent
   - consult with senior registrar on-call

#### INVESTIGATIONS
1. MSU for culture and sensitivity
2. HVS and vulvo-vaginal swab for Chlamydia and Gonorrhoea
3. FBC, CRP
4. If visual signs of dilation and effacement consider a TVS for cervical length and TAS for fetal wellbeing, unless birth imminent

#### MANAGEMENT
Cervical os fully effaced AND more than 1 cm dilated

- If no contractions and no signs of infection, consider emergency cervical cerclage
  - Consider steroids depending on gestational age*
- If contracting
  - manage as threatened preterm labour

*Discuss with NICU*