Premature labour is the main cause of neonatal morbidity and mortality in developed countries and represents a major perinatology and socio-economic problem.
Currently we speak about preterm parturition syndrome, that can be induced by various factors, from which inflammation is considered as the most important, mainly of infectious etiology.
Combination of anamnesis, ultrasound cervicometry and cervicovaginal fetal fibronectin test is presently considered as the most reliable in diagnostics of premature labour. These examinations have a high negative predictive value. The primary objective of tocolysis is to delay delivery in order to save time for induction of lung maturity and transfer in utero to specialized centres. Oxytocin antagonists are currently considered as ideal tocolytics. Administration of antibiotics at spontaneous premature labour with intact membranes and without any signs of infection is not recommended.
In case of premature rupture of membranes, infection may represent its cause or possible secondary complication as well. That is why antibiotics should always be administered in this case, ideally erythromycin. Further management depends paricularly on gestational age of the fetus. Efficacious primary prevention of premature labour is not possible so far. The means of secondary prevention depend especially on our ability to identify high-risk pregnancies. Benefit of antibiotics in prevention was not evidenced, by contrast there has been a renaissance in progesteron use. The last section contains statistics concerning iatrogenic prematurity due to planned caesarean deliveries performed before 39 completed weeks of pregnancy. The hypothesis was verified, that there is a high incidence of iatrogenic prematurity. In spite of the current recommendation, 63,4% of caesarean deliveries were performed before 39 completed weeks of pregnancy. This iatrogenic prematurity was associated with higher neonatal morbidity, particularly respiratory complications.