

Protocol ID: QH-20170928

**Verify the safety and effectiveness of the cerclage  
pessary in the prevention and treatment of high-risk  
preterm pregnancy**

Version:3.0 (June 12, 2018)

## **1. General information**

Sponsor: QH Medical Technology Ltd.

Investigators and Clinical Research Organizations:

Primary investigator: Juntao Liu<sup>1</sup>

Other investigators: Jinsong Gao<sup>1</sup>, Yan Jiang<sup>3</sup>, Xiaowei Liu<sup>3</sup>, Luming Sun<sup>4</sup>, Yuan Wei<sup>2</sup>, Pengbo Yuan<sup>2</sup>, Yangyu Zhao<sup>2</sup>, Gang Zou<sup>4</sup>.

1:Peking Union Medical College Hospital; 2:Peking University Third Hospital; 3:Beijing Obstetrics and Gynecology Hospital, Capital Medical University; 4:Shanghai First Maternity and Infant Hospital

(In no particular order, listed in the alphabetical order of the last name)

## **2. Rationale**

### **2.1. Justification of the relevance of the trial.**

Preterm birth complicates 13% of all pregnancies worldwide and is the most important cause of neonatal morbidity and mortality.<sup>1</sup> Although disability-free survival rates have increased over the years as a result of improved facilities and treatments, preterm birth is still accountable for 75% of all perinatal deaths and >50% of morbidities.<sup>2,3</sup> Women with a history of a preterm delivery have a distinctly increased risk to deliver preterm in a subsequent pregnancy. This risk ranges from 11,1% with one previous preterm delivery up to 28% for two previous preterm deliveries.<sup>4</sup> This also applies to women with a history of a second trimester fetal-loss after 20 weeks of gestation who show an increased risk of 12% for preterm birth in a subsequent pregnancy.<sup>5</sup> Yet another independent risk factor for PTB is a previous cervical surgery; after a single surgical conisation the risk of PTB increases almost 5 fold and after two even 10-fold.<sup>6</sup> One treatment option for prevention of preterm birth is a cervical pessary. A cervical pessary is a silicone ring with a smaller diameter to be fitted around the cervix and a larger diameter to fix the device against the pelvic floor. This effectively rotates the cervix toward the posterior vaginal wall and corrects the cervical angle.<sup>7</sup> A prospective-randomised trial by Goya et. al<sup>7</sup> proved a significant reduction of the preterm delivery rate in singleton pregnancies with cervical shortening ( $\leq 25$  mm, 18-22 weeks of gestation) after placement of a pessary compared to expectant management. In a cohort analysis by Alfirevic et al.<sup>8</sup> of asymptomatic women with a singleton pregnancy and a history of preterm birth and a short sonographic cervix the placement of a cervical pessary proved to be as effective as cerclage or treatment with 200 mg vaginal progesterone in reducing the preterm birth rate. A pilot study investigating the effect of pessary treatment in asymptomatic women with a singleton pregnancy and a history of at least one cold knife conisation and a short sonographic cervix suggest a beneficial effect on the prolongation of the pregnancy.<sup>6</sup> In the one Cochrane review<sup>9</sup> available concerning pessary therapy the authors detail a significant decrease in the incidence of spontaneous preterm birth in women with a short cervix when compared with expectant management: PTB less than 37 weeks'

gestation (22% versus 59 %; RR 0.36, 95% CI 0.27 to 0.49) and PTB less than 34 weeks' gestation (6% and 27% resp. RR 0.24; 95% CI 0.13 to 0.43). However, the need for further trials in different settings and with different risk factors is obvious. This study aims to investigate the effect of a prophylactic treatment with a cervical pessary in women at high risk of PTB due to a history of at least one previous preterm delivery and/or a history of late abortion.

## **2.2. Description of the study population.**

Women with a singleton pregnancy at 12 – 18 weeks of gestation and a history of at least one previous preterm delivery before 34+0 weeks and/or a history of late abortion attending the reference hospital and who do not fulfil the exclusion criteria the study will be proposed. The patients will be informed of the intended therapeutic effect and possible side effects. If they agree and after obtaining their informed consent, they will be randomised according to either usual management with rescue cerclage placement only when (and as soon as possible) a cervical shortening below 25 mm occurs (=control group) or cervical pessary placement (= pessary group). Pessaries or cerclage shall be placed up to 37+0 weeks of gestation. Serial cervical length measurements shall be conducted every 4 weeks in order to diagnose cervical shortening as soon as possible in the control group.

## **2.3. Name and description of the device under investigation.**

The Arabin cervical pessary, which is CE-certified for preventing SPB (CE 0482 / EN ISO 13485: 2003 annex III of the council directive 93/42 EEC).  
See annex I.

## **2.4. Statement that testing will be performed according to protocol, GCP and applicable legal requirements.**

The Clinical Trial will be conducted following the protocol, the GCP, and all legal requirements.

## **3. Objective**

This study aims to investigate the benefit of a prophylactic cervical pessary treatment in women at high risk of PTB due to a history of at least one previous preterm delivery before 34+0 weeks and/or a history of late abortion.

## **4. Design**

## 4.1. Specific description of primary and secondary variables.

### 4.1.1. Primary outcome:

- Child's birth and survival

### 4.1.2. Secondary outcomes:

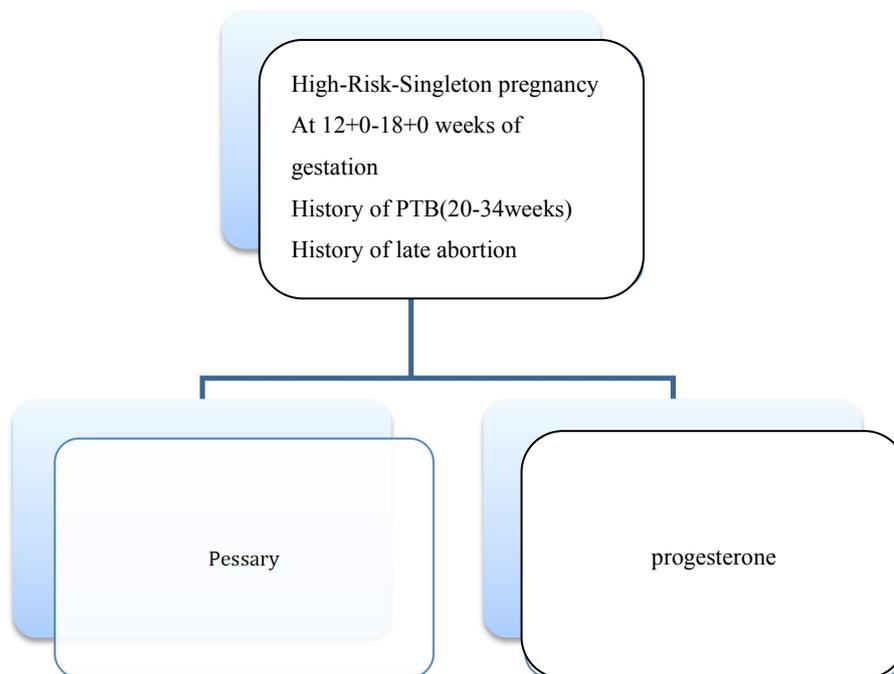
- Offspring
  - Time to birth
    - Preterm birth before 37 weeks: rate of delivery before 36+6 weeks
    - Preterm birth before 34 weeks: rate of delivery before 33+6 weeks
    - Preterm birth before 32 weeks: rate of delivery before 31+6 weeks
    - Preterm birth before 30 weeks: rate of delivery before 29+6 weeks—
    - Preterm birth before 28 weeks: rate of delivery before 27+6 weeks—
  - Birth weight: median weight (g) of the newborns at birth
  - Fetal or neonatal death: rate of intrauterine demise or neonatal death during the first 24 hours
  - Neonatal morbidity: rate of major adverse neonatal outcomes before discharge from the hospital
    - Intraventricular Haemorrhage (IVH): grades III-IV
    - Retinopathy of prematurity
    - Respiratory Distress Syndrome (RDS): grades II-IV,
    - Need for ventilation > 72 h
    - Necrotising enterocolitis
    - Proven or suspected sepsis, antibiotics (>5 days)
    - Need (Duration in days) for neonatal special care (NICU)
  - Harm from intervention
- Mother:
  - Maternal death
  - Significant maternal adverse events (rate):
    - Heavy bleeding: bleeding that requires a medical intervention
    - Cervical tear: cervical rupture due to the pessary placement
    - Uterine rupture: rupture of the uterus due to contractions or surgery
  - Physical or psychological intolerance to pessary: discomfort or pain due to the pessary that makes daily life uncomfortable (number of cases)
  - Rupture of membranes before 32 weeks: rate of—rupture of amniotic membranes before 31+6 weeks
  - Infection/inflammation
  - Hospitalisation for threatened preterm labour before 32 weeks: requirement of hospitalisation due to preterm contractions that need medical treatment to try to stop them before 31+6 weeks (rate)

- Mean hospital stay duration: number of days of admittance at the hospital
- Use of tocolytic treatment: Type of tocolytic, days of treatment, dose

#### 4.2. Description of the trial design.

Open Multicentre Randomized Controlled Trial, in parallel groups, based on treatment with progesterone comparing the placement of a prophylactic cervical pessary with usual management in singleton pregnancies at high-risk of PTB due to a history of at least one previous preterm delivery and/or a history of late abortion.

#### 4.3. Flowchart.



#### 4.4. Description of the medical device and the treatment regimen.

The cervical pessary is a vaginal device (silicone ring) that is used to treat pregnant women for preventing spontaneous preterm birth. This device can be easily placed around the uterine cervix without pain (see annex I).

Women with a singleton pregnancy at 12+0 – 18+0 weeks of gestation and a history of at least one previous preterm delivery before 34+0 weeks and/or a history of late abortion attending the reference hospital for a preventive examination will be informed of the ongoing trial. The patient will be advised of the intended therapeutic effect and possible side effects. If they agree and after obtaining their informed consent, they will be randomised according to either progesterone (=control group) or cervical pessary placement up to 37+0 weeks (= pessary group).

If the pregnant woman is assigned to the pessary group and after having excluded a vaginal infection the pessary will be inserted directly. This procedure does not need anaesthesia and it does not need to be done in a surgery room. After the insertion of the pessary the correct fit of the pessary is verified by transvaginal ultrasound and in case it does not fit perfectly, it can easily be adjusted.

In the control-group, the pregnant women be treated with progesterone. Utrogestan is one of the normal drugs in China to prevent spontaneous preterm birth, the Utrogestan used in this study is from Laboratories Besins International. For the enrollment, pregnant women in the control group were treated by 200 mg QN, it is used for 34 gestational weeks.

The pessary will be removed at 37+0 weeks of gestation, or before if any unexpected event occurs (see 4.6). After insertion of the pessary the obstetrical management during the remainder of the pregnancy will be usual management.

Further surveillance of the pregnancy will not be influenced by the participation on the study.

#### **4.6. Completion and interruption criteria of the study or the subjects.**

The pessary will be removed at 37+0 weeks of pregnancy. The indications to remove them before this time will be: active bleeding stronger than period bleeding, persistent contractions after tocolysis and premature rupture of the membranes after 34+0 weeks.

After removing the pessary, the obstetrical management will be done as usual and will not be influenced by the study.

#### 4.10. Selection and withdrawal of subjects

##### **4.10. 1 Inclusion criteria.**

- Women with a singleton pregnancy and a history of at least one previous preterm delivery before 34+0 weeks and/or a history of late abortion
- 12+0 -18+0 weeks of gestation
- Minimal age of 18 years
- Informed consent signature

##### **4.10. 2 Exclusion criteria.**

- The previous preterm delivery is iatrogenic proterm labor
- Major fetal abnormalities (requiring surgery or leading to infant death or severe handicap)
- The pregnant woman with severe cervical erosion, cervical polyp, hemorrhage and the doctors think she could not use cerclage pessary

- The pregnant woman with uterine cervicitis
- The pregnant woman that has been confirmed premature birth
- Cerclage prior to randomisation
- Uterine malformation
- Placenta previa totalis
- Active vaginal bleeding at the moment of randomization
- Spontaneous rupture of membranes at the time of randomization
- Silicone allergy
- Painful regular uterine contractions
- The pregnant woman have the indication of operation cervical cerclage
- Current participation in an other RCT

#### **4.10. 3. Withdrawal criteria.**

If a participant may voluntarily withdraw from treatment or if it is necessary to remove the pessary due to the conditions described before, the patients will be followed as usual until delivery (intention-to-treat analysis).

Replacement of patients is not applicable in this trial.

#### **4. 10. 4. Rescue treatment criteria.**

According the current guide and expert advice, when the routine follow-up examination, the rescue cervical cerclage may be adopted when the secondary cervical shortening occurs.

#### **4.11. Treatment of Subjects**

##### **4.11.1. Treatments to be administered.**

The pessary will be inserted during a preventive examination in pregnancy in the examination room. This procedure does not need anaesthesia and it does not need to be done in a surgery room. After the insertion of the pessary the correct fit of the pessary is verified by transvaginal ultrasound and in case it does not fit perfectly, it can easily be adjusted. pregnant women in the control group were treated by 200 mg QN, it is used for 34 gestational weeks. The pessary or cerclage will be removed at 37+0 weeks of gestation, or before if any unexpected event occurs (see 4.6).

After insertion of the pessary the obstetrical management during the pregnancy will be usual management.

Further surveillance of the pregnancy will not be influenced by the participation on the study.

## **5. Assessment of Safety**

### **5.1. Procedures to record and report adverse events.**

If a serious and unexpected adverse effect occurs during treatment, it will be notified to the study Sponsor. The Department of Obstetrics and Gynecology of the Sponsor will fill the side effects document to notify it to the Ethics Committee.

The patient affected by the adverse effect will be followed more intensively during the first days and if nothing else occurs, she will return to the standard control.

### **5.2. Definitions.**

Adverse Event (AE): Any untoward medical occurrence in a patient or clinical investigation participants administered a medicinal product, which does not necessarily have to have a causal relationship with this treatment (the study medication). An AE can therefore be any unfavourable and unintended sign (including an abnormal laboratory finding), symptom or disease temporally associated with the use of the study medication/procedure, whether or not considered related to the study medication.

Adverse Reaction (AR): All untoward and unintended responses to a medicinal product related to any dose. The phrase "responses to a medicinal product" means that a causal relationship between a study medication and an AE is at least a reasonable possibility, i.e., the relationship cannot be ruled out.

All cases judged by either the reporting medically qualified professional or the sponsor as having a reasonable suspected causal relationship to the study medication / procedure qualify as adverse reactions.

Serious Adverse Event (SAE): A serious adverse event is any untoward medical occurrence that at any dose: Results in death; is life-threatening, NOTE: The term "life-threatening" in the definition of "serious" refers to an event in which the participant was at risk of death at the time of the event; it does not refer to an event which hypothetically might have caused death if it were more severe; Requires inpatient hospitalization or prolongation of existing hospitalization; Results in persistent or significant disability/incapacity, or is a congenital anomaly/birth defect.

Other important medical events: Other events that may not result in death, are not life threatening, or do not require hospitalization, may be considered a serious adverse event when, based upon appropriate medical judgment, the event may jeopardize the patient and may require medical or surgical intervention to prevent one of the outcomes listed above.

To ensure no confusion or misunderstanding of the difference between the terms "serious" and "severe", which are not synonymous, the following note of clarification is provided:

The term "severe" is often used to describe the intensity (severity) of a specific event (as in mild, moderate, or severe myocardial infarction); the event itself, however, may be of relatively minor medical significance (such as severe headache). This is not the

same as "serious," which is based on patient/event outcome or action criteria usually associated with events that pose a threat to a participant's life or functioning as defined in the bullet points above. Seriousness (not severity) serves as a guide for defining regulatory reporting obligations.

Serious Adverse Reaction (SAR): An adverse event (expected or unexpected) that is both serious and, in the opinion of the reporting investigator, believed with reasonable probability to be due to one of the study treatments, based on the information provided.

Suspected Unexpected Serious Adverse Reaction: A serious adverse reaction, the nature or severity of which is not consistent with the applicable product information (e.g. Investigator's Brochure for an unapproved investigational product or summary of product characteristics for an approved product).

### **5.3. Procedures for immediate notification of serious or unexpected adverse events.**

All AEs occurring during the study /or observed by the investigator or reported by the participant, whether or not attributed to study medication, will be recorded on the CRF.

The following information will be recorded: description, date of onset and end date, severity, and assessment of relatedness to study medication, other suspect drug or device and action taken. Follow-up information should be provided as necessary.

AEs considered related to the sanitary device, as judged by a medically qualified investigator, will be followed until resolution or the event is considered stable. All related AEs that result in a participant's withdrawal from the study or are present at the end of the study, should be followed up until a satisfactory resolution occurs.

It will be left to the investigator's clinical judgment whether or not an AE is of sufficient severity to require the participant's removal from treatment. A participant may also voluntarily withdraw from treatment due to what he or she perceives as an intolerable AE. If either of these occurs, the participant must undergo an end of study assessment and be given appropriate care under medical supervision until symptoms cease or the condition becomes stable.

A medically qualified investigator will assess the relationship of AEs to the study medication.

All SAEs must be reported to the main investigator. He will perform an initial check of the report, request any additional information, and he will notify it to the Ethics Committee and CFDA. All SAE information will be recorded. It may be appropriate that some SAEs do not require immediate reporting but this must be justified. Justification might be determined, for example, by admission to hospital, or prolongation of hospitalization, where this is to be expected in the underlying disease or condition.

All adverse events (AE) life-threatening or resulting in death will be notified within 24 hours. All AE that are not life-threatening will be notified within 15 days. The rest of AE will be recorded and analyzed at the end of the study.

## **6. Efficacy assessment**

### **6.1. Specification of efficacy parameters: Primary and secondary endpoints.**

This study aims to investigate the benefit of a prophylactic cervical pessary treatment in women at high risk of PTB due to a history of at least one previous preterm delivery and/or a history of late abortion on the perinatal outcome .

### **6.2. Methods and timing to assess records and analyze the efficacy parameters.**

The pregnant women will be assessed according to usual obstetrical management in a high-risk pregnancy.

	Regular Preventive Exam 12+0-18+0 WoG	Regular Preventive Exam 34+0 WoG	Postnatal evaluation
Study procedure	study inclusion		
Informed consent signature	x		
randomisation	x		
Pessary placement	x (Pessary-Group)		
Pessary/cerclage removal		x	
progesterone	x	x	
physical exams			
Abdominal US	x	x	
Vaginal US			
BV/trichomonad/mycete			
Neonatal examination			x
Ages & Stages test (corrected age)			

## **7. Statistics**

### **7.1. Description of statistical methods.**

A descriptive analysis by preterm birth will be carried out calculating means and medians for quantitative variables and proportions for categorical variables.

Two-sided Z-tests will be used for comparing among exposure and outcomes groups per pregnancy. A multivariate logistic regression will be fitted to control for possible confounders. Relative risks and 95% confidence interval will be calculated for the outcomes.

All analysis will be carried out with SPSS® 19.0 statistical package (IBM Company SPSS Inc. Headquarters, Chicago, Illinois. USA). Statistical significance will be accepted in all cases with a  $p < 0.05$ .

<b>Outcome</b>	<b>Statistical Test</b>
Birth before 34 Weeks of Gestation	Two-sided Z-Test (RR, 95% CI)
Time to Birth	Log-rank test (HR, 95% CI)
Birthweight	Multilevel model (mean $\pm$ SD)
Fetal / Neonatal Death	Two-sided Z-Test (RR, 95% CI)
Neonatal Morbidity	Two-sided Z-Test (RR, 95% CI)
Need for Hospitalization	Two-sided Z-Test (RR, 95% CI)
Days of Hospitalization	Two-sided Z-Test (RR, 95% CI)
Maternal Adverse Events	Two-sided Z-Test (RR, 95% CI)
Pessary Intolerance	Two-sided Z-Test (RR, 95% CI)
Vaginal Infections	Two-sided Z-Test (RR, 95% CI)

the complete data set for the secondary endpoints will be available after the last women enrolled in this study has given birth, so the analysis of these outcome parameter will be done right after this event.

## **7.2. Expected number of subjects to be included.**

Group sample size of 121 in Group 1 and 121 in Group 2 achieve 80% power to detect a difference between the group proportions of 0,1240. The proportion in Group 1 (the treatment group) is assumed to be 0,8 under the null hypothesis and 0,9240 under the alternative hypothesis. The proportion in Group 2 (the control group) is 0,8000. The test statistic used is the two-sided Z test with pooled variance. The significance level alpha of the test was 5 %. To account for a drop out rate around 20%, sample size of 121 in each group, overall  $n=242$  women will be recruited.

## **7.3. Criteria for the completion of the trial.**

A non-justified case of maternal death (temporary stop until complete evaluation of the case by an external committee).

## **7.4. Selection of subjects to be included in each analysis.**

The analysis will include all the subjects that have been randomised.

## **8. Quality and Control Assurance**

Main investigator and collaborators: In order to ensure the Quality of the data they will provide instructions and training to the sites involved in the trial; review the CRF data; and detail of any other steps taken to ensure quality of research.

The main investigator will sign the study protocol and the “investigator’s commitment; he will apply for the Ethics Committee and the Director’s approval; and he will review the final report of the study.

The collaborators will assess patient’s eligibility, they will inform the patients and ask for the informed consent; and they will be responsible of the CRF and obtaining and registering all data.

Monitor: he will perform regular monitoring according to ICH GCP. Data will be evaluated for compliance with the protocol and accuracy in relation to source documents. Monitors will verify that the clinical trial is conducted and data are generated, documented and reported in compliance with the protocol, GCP and the applicable and local regulatory requirements.

Serious Breaches: A serious breach is defined as “A breach of GCP or the trial protocol which is likely to effect to a significant degree: (a) the safety or physical or mental integrity of the subjects of the trial; or (b) the scientific value of the trial”. All serious breaches will be notified to the competent Regulatory Authority according to applicable legislation.

## **9. Ethical issues**

The Sponsor, participating Centres and Investigator will ensure that this study is conducted in accordance with the Protocol, the principles of the Declaration of Helsinki (see annex III), ICH Guidelines for Good Clinical Practice and in full conformity with relevant regulations as well as applicable national laws, the German Law and in accordance with regulations and guidelines applicable to clinical trials relating to medical devices.

The protocol, informed consent form, participant information sheet and any applicable documents will be submitted to an appropriate Ethics Committee (EC) and Regulatory Authority for written approval. All substantial amendments to the original approved documents will be also sent to an appropriate Ethics Committee (EC) and Regulatory Authority for written approval. The study will not begin until the approval of the EC and Director’s consent.

## **10. Data Management and Registry File**

Patient's participation in the study will be annotated into the medical history. The main investigator will perform a list with the participant's names, ID numbers and codes. He also will have a file with all the information referring to the study. All the data will be collected in a database that will be accessed worldwide. The randomisation will be done on a computer basis. Once entering in the website, if the patient fulfils the inclusion criteria, the computer generated list will randomise the patient to "pessary" or "control" group. The excluded patients will be also collected in the database. Every participating centre will have its own randomisation list, and it will be accessible with a username and password. The trial staff will ensure that the participants' anonymity is maintained. Only a participant ID number on the CRF and in the electronic database will identify the participants. All documents will be stored securely and only accessible by trial staff and authorized personnel. The study will comply with the Data Protection Legislation that requires data to be anonymized as soon as it is mandatory to do so.

#### 10.1. Data ownership

Sponsor and participating Center have expressly agreed that any and all data collected and prepared in the context of the study shall be the property of the Sponsor, provided that participating Center shall remain the owner of its source data and may utilize such data as it deems appropriate without the approval, but with the reliable communication of Sponsor. Furthermore, Sponsor will always have access to the Study data, in terms of good faith and cooperation, in order to improve their own knowledge and information.

### **11. Funds and Insurance**

According to German legislation and Ethical Committee decisions, it is not necessary to enter into an insurance contract in order to cover patients while using this medical device in a clinical trial. Insofar as it has been issued with the appropriate certificate of the State Medicines Agency to the concrete use of the medical device.

Nevertheless, it will be mandatory to enter into a hedging insurance by any other participating centre of this clinical trial, in the case that it is mandatory according to the laws of their country.

No funding is provided for the study.

### **12. Publication policy**

The Sponsor takes the commitment of publishing the results of the study; despite they are good or bad.

Promoter and participating Centre agree that publications or presentations of any of the results from the study shall be in accordance with accepted scientific practice, academic standards and customs.

Authorship and other related publications questions shall be addressed in accordance with the principles of the 'Uniform Requirements for Manuscripts Submitted to Biomedical Journals' and in accordance with the requirements of the respective medical journal.

Sponsor agrees to ensure co-authorship for clinical co-investigators on any proposed multicentre publication.

Sponsor and participating Centres agree that at first they will strive to make a joint publication. After such joint publication or one year after termination of the study the following shall be agreed:

As a general principle, the parties agree that prior to submission of a publication or any other dissemination of the results, including oral presentation, the Sponsor shall have the right to prior review and comment on the content of the material to be published or presented within sixty (60) days following the receipt of the publication or any other dissemination of the results, and Participating Centre ensures that it will take Promoter's comments into due consideration.

## **References**

1. Blencowe H, Cousens S, Chou D, Oestergaard M, Say L, Moller AB, et al. Born too soon: the global epidemiology of 15 million preterm births. *Reprod Health* 2013;10(Suppl. 1): S2.
2. Ananth CV, Vintzileos AM. Epidemiology of preterm birth and its clinical subtypes. *J Matern Fetal Neonatal Med* 2006; 19:773e82.
3. Goldenberg RL, Culhane JF, Iams JD, Romero R. Epidemiology and causes of preterm birth. *Lancet* 2008;371(9606):75e84.
4. Hoffman JD, Ward K. Genetic factors in preterm delivery. *Obstet Gynecol Surv* 1999; 54: 203-10
5. Book: Oxford Desk Reference: Obstetrics and Gynecology. Ed. S. Arulkumaran, 2011

6. Kyvernitakis I, Khatib R, Stricker N, Arabin B. Is Early Treatment with a Cervical Pessary an Option in Patients with a History of Surgical Conisation and a Short Cervix? *Geburtsh Frauenheilk* 2014;74:1003-1008.
7. Goya M, Pratcorona L, Merced C, et al. Cervical pessary in pregnant women with a short cervix (PECEP): an open-label randomized controlled trial. *Lancet* 2012;379:1800-6.
8. Alfirevic Z, Owen J, Carreras Moratonas E, Sharp AN, Szychowski JM, Goya M. Vaginal progesterone, cerclage or cervical pessary for preventing preterm birth in asymptomatic singleton pregnant women with a history of preterm birth and a sonographic short cervix. *Ultrasound in Obstetrics & Gynecology*: 2013;41(2):146-51.
9. Abdel-Aleem H, Shaaban OM, Abdel-Aleem MA. Cervical pessary for preventing preterm birth. *The Cochrane database of systematic reviews*. 2013(5):CD007873.