



Management of Perinatal Care
Clinical Practice Guideline
Reviewed November 2014

General Principles: The MedStar Health Obstetrical Service line endorses the ACOG Perinatal Care Guidelines and ACOG Committee Opinions as a source of guidance for clinical care of women throughout the MedStar Health system.

The following is a summary of clinical actions excerpted from:

[American Academy of Pediatrics, American College of Obstetricians and Gynecologists. *Guidelines for Perinatal Care*. 7th ed. Elk Grove Village \(IL\): AAP; Washington, DC: American College of Obstetricians and Gynecologists; 2012. 580 pages. ISBN electronic: 978-1-58110-771-5 ISBN paper: 978-1-58110-734-0;](#)

Immunization recommendations are from CDC guidelines.

Preconception care is acknowledged as an important component of high quality prenatal care, but is beyond the scope of this summary document. Additional information on this topic can be found in the source document

Prenatal Care:

Quality Goals:

- Improve the timeliness of prenatal care
- Prenatal care within the first trimester or within 42 days of enrollment
- Provide education and recommended screening and intervention.
- Monitor progression of pregnancy.
- Assess the well-being of the woman and her fetus.
- Early detection and intervention of high risk factors.
- Complete 80% of expected prenatal visits. (ACOG recommends 14 visits).
- Decrease the incidence of smoking during pregnancy.
- Improve the frequency of appropriate testing during pregnancy.

Office visits

Frequency:

- Advise office visit at 8-10 weeks of pregnancy (or earlier if the patient is at risk for ectopic pregnancy)
- Every 4 weeks for first 28 weeks.
- Every 2 – 3 weeks until 36 weeks gestation.
- Every week after 36 weeks gestation.

Frequency of visits is determined by individual needs and assessed risk factors.

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First Prenatal Visit (8-10 weeks of pregnancy if first contact earlier)

Assessment at this visit should include:

- Initial history and physical.
- Family medical history.
- Genetic history.
- General exam to confirm pregnancy.
- Complete needs assessment.
- Preterm labor risk, education and prevention.
- Assess for tobacco, alcohol, drug use.
- Domestic violence screening.
- Screen for depression (current or historical) using a standardized screening tool.
- Prescriptions: prenatal vitamins and iron supplementation as necessary.

Education and counseling

- Scope of care provided in the office and anticipated schedule of visits.
- Expected course of pregnancy.
- Counseling regarding specific complications.
- Discuss routine lab studies/testing.
- Discuss genetic counseling and available prenatal diagnostic testing (invasive and non-invasive).
- Discuss high risk conditions.
- Education regarding: Labor and delivery, nutrition, exercise, working, air travel, routine dental care, tobacco use and smoke exposure, alcohol/drug consumption, over-the-counter medications, pets, etc.
- Practices to promote health maintenance such as use of safety restraints including lap and shoulder belts.
- Assess barriers to care (transportation, child care issues, work schedule).
- Encourage maternity program enrollment and prenatal classes.
- Make needed referrals for medical conditions, substance abuse and mental health problems identified in the assessment
- Encourage and provide influenza vaccination, regardless of the stage of pregnancy, during influenza season.

Routine Laboratory/diagnostic studies

- Blood type and screen.
- CBC for H&H.MCV.
- Platelet Count
- Hepatitis B surface antigen (HBsAg).
- Syphilis screening.
- Screening for gestational diabetes if at high risk (see section on gestational diabetes below).
- HIV testing unless they decline (opt-out approach). For women that decline the provider should address objections and strongly encourage HIV screening.
- Cervical Cancer Screening (if the patient is due).
- Urine C&S and urine dip for protein and glucose.

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Genetic and infectious disease testing and counseling

Genetic Screening

- It is reasonable to offer Cystic fibrosis carrier screening to all couples regardless of ethnicity. Genetic counseling is recommended for individuals with a family history of cystic fibrosis or those found to be carriers.
- Hemoglobinopathy screening should be offered to individuals of African, Southeast Asian and Mediterranean descent. Couples at risk for having a child with sickle cell disease or thalassemia should be offered genetic counseling to review prenatal testing and reproduction options.
- Patients of Ashkenazi Jewish descent should be offered prenatal carrier screening for hereditary diseases common in this group.

Infectious Disease

- All pregnant women should be screened for chlamydia during the first prenatal visit. If positive, a test of cure should be offered to the patient four weeks after completing treatment and provide counseling to decrease risk of re-infection and refer partner for testing and treatment. Those women that are less than or equal to 25 years of age or at risk for chlamydia infection should be screened again during the third trimester.
- All pregnant women at risk for sexually transmitted diseases should be screened for gonorrhea at the initial prenatal visit. Risk factors include age less than 25, a previous infection, new or multiple sex partners, inconsistent condom use, commercial sex work and drug use. If positive, a test of cure should be offered to the patient four weeks after completing treatment and provide counseling to decrease risk of reinfection and refer partner for testing and treatment. Repeat screening is recommended during the third trimester of pregnancy.
- Rescreen for HIV in the third trimester for women at high risk of acquisition
- Rescreen for syphilis in women at high risk of acquisition

Gestational Diabetes (GDM) Risk

Patients with the following risk factors should be screening for gestational diabetes at the first prenatal visit:

- Pre-pregnancy BMI = 30 kg/m.^{3,7}
- Personal history of GDM.
- Known impaired glucose metabolism

Subsequent Prenatal Visits

Every visit

- Vital signs.
- Weight (height/weight/BMI – initial visit).
- Fetal assessment from 10th week.
- Uterine size for progressive growth and consistency with EDD.
- Domestic violence screening.
- Assessment of tobacco use and smoke exposure.
- Urine dip for protein and glucose.

Specific Visit: 11 – 14 weeks

- Pelvic exam, if fetal heart tones (FHT) not heard with amplification.
- Breastfeeding has well documented short- and long-term medical and neurodevelopmental advantages for infants. As such, breastfeeding should be strongly encouraged during prenatal care as the best choice for

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feeding. Patients should be offered breastfeeding educational material and classes during pregnancy and provided resources for assistance after delivery.

- Review laboratory data. Offer iron supplementation for patients with anemia.
- Offer screening tests for aneuploidy. All pregnant women, regardless of age, should be counseled about non-invasive and invasive prenatal diagnostic testing for aneuploidy with a discussion of the risks and benefits of each. Women found to have increased risk for aneuploidy with non-invasive screening should be offered genetic counseling and the option of chorionic villus sampling (CVS) or second trimester amniocentesis
- If previous low transverse cesarean delivery, discuss the risks, benefits, and alternatives to a trial of labor after cesarean as well as the risks and benefits of repeat cesarean delivery.

Specific Visit: 15-20 weeks

- Offer anatomic survey ultrasound to be completed at 18-20 weeks.
- Offer screening test for aneuploidy with a serum Multiple Marker Screen if the patient did not have first trimester screening (invasive or non-invasive) for aneuploidy. This also incorporates neural tube defect (NTD) screening. Screening and invasive diagnostic testing for aneuploidy should be available to all women who present for prenatal care before 20 weeks of gestation regardless of maternal age. Offer genetic counseling and the option of second trimester amniocentesis to women found to have increased risk for aneuploidy with screening.
- Offer neural tube defect screening (MSAFP) to women who elect first trimester screening or invasive testing for aneuploidy.
- Review signs and symptoms of pre-term labor (PTL).
- Review results of MSAFP/Multiple Marker screen and ultrasound if not already done.

Specific Visit: 24 – 28 weeks

- Screening for gestational diabetes.
- Select baby's medical provider.
- Discuss normal fetal movement
- Discuss prenatal classes
- Discuss post-partum contraception. If applicable, patient should sign Medicaid consent for sterilization at this gestational age.

Specific Visit: 27-36 weeks

- Tdap should be administered during each pregnancy, irrespective of patient's prior history of receiving. Optimal timing is between 27 and 36 weeks gestation to maximize maternal antibody response and passive antibody transfer levels in the newborn. Discuss with the patient that other adults who will be around her newborn, such as husbands, grandparents, older siblings, and babysitters, should also be vaccinated.

Specific Visit: 28 weeks

- Repeat type and screen if Rh negative, H&H.
- Administer Rh-immune globulin if Rh (-) and indirect Coombs (-).
- Confirm and document name of baby's medical provider.
- Discuss cord blood banking to allow a pregnant woman to make an informed decision on whether to participate in a public or private umbilical cord blood banking program. (Per PA House Bill 874).

Specific Visit: 32 – 34 weeks

- Repeat testing for women at risk for sexually transmitted disease, including RPR, HIV, gonorrhea and chlamydia.
- Discuss Group B Strep screening and management protocol.

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Specific Visit: 36 weeks

- Determine fetal position.
- Group B Strep screen. Screening not needed if treatment in labor is indicated based on other risk factors such as group B strep bacteria during any trimester of the current pregnancy or previous infant with invasive GBS disease.
- Discuss the risks and benefits of HSV prophylaxis in women with a history of genital herpes.
- Labor education: latent phase of labor, rupture of membranes (ROM), active labor management, analgesia in labor.
- Counsel regarding labor induction indicating that in the absence of medical indications, labor should not be induced prior to 39 weeks gestation. Such early-term deliveries (37-38 6/7 weeks gestation) are associated with higher morbidity and mortality rates when compared to neonates and infants delivered between 39 weeks and 40 weeks of gestation.

Specific Visit: 8 weeks

- Review labor education; discuss again contraception, with an emphasis on the benefits of long-acting reversible contraception such as IUDs and implants.

Specific Visit: > 41 weeks

- Baseline non-stress test (NST) or contraction stress test (CST), ultrasonography (US), biophysical profile (BPP) or a combination of these tests.
- Discuss labor induction > 41 weeks.

Postpartum Care

Postpartum vaccine

- Women (including women who are breastfeeding) who have not received a dose of Tdap previously should receive Tdap immediately after delivery and before discharge from the hospital. If Tdap cannot be administered before discharge, it should be administered as soon as feasible. Additionally, other family members and direct care caregivers should receive Tdap as recommended.

Postpartum visit

- On or between 21 days and 56 days after delivery
- Pelvic exam and /or weight, BP, breast, and abdomen exam.
- Screen for postpartum depression. Refer for intervention if indicated.
- Screen for domestic violence.
- Discuss sexual activity and contraception with an emphasis on the benefits of long-acting reversible contraception.
- Review nutrition and exercise.
- Discuss method of feeding (breast or bottle).
- Women with GDM should be screened for diabetes 6-12 weeks postpartum and should be followed up with subsequent screening for the development of diabetes or pre-diabetes.

References

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Center for Disease Control, 2014, Adult immunization schedule. Retrieved from <http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule-easy-read.pdf>

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