Prenatal Safety, Teaching and Tests

Weeks	Tests	Teaching	Other
1st Prenatal	☐ Blood type (note Rh neg on problem list) ☐ ABO and Antibody screen if + will reflex with which antibodies ☐ H/H if <36 FeSO4 + colace ☐ HIV ☐ HBsAg and Hep C antibody ☐ Rubella ☐ RPR if + call OB ☐ GC/CT ☐ Pap (if needed) ☐ Dating US (accurate if <12w, then use 8% rule) ☐ Doppler if > 12wks ☐ Centering appointment and group	☐ Vaginal bleeding ☐ OTC meds ☐ Kitty liter & lizards ☐ Domestic violence ☐ Sex (OK) ☐ Start thinking about breastfeeding & pain plan ☐ Medicaid & WIC ☐ Qualify for free cell phone ☐ If age >35, risk of down syndrome & offer to refer to genetics consult, MFM consult ☐ TOLAC if appropriate, get op report for C/S	If GC/CT +, then TOC in 3-4 weeks >35 offer to refer to genetics counseling Ask about history of births and if PTL then CONSIDER cervical length and progesterone (timing of these) Baseline HELLP labs if hx of severe preeclampsia, ASA after 12 week
8-12 Q4wk	☐ >12wks Doppler ☐ Weight on BMI forms ☐ Counsyl (cFDNA)	☐ Handout for what to expect ☐ Weight gain based on BMI ☐ MVA & seatbelts ☐ Mercury & Fish	>12 wks ASA 162 mg if high risk preeclampsia (USPSTF Table below)
16	☐ MSAFP (15-22 weeks) ☐ Hep C if high risk ☐ Doppler ☐ Order 20wk Anatomical scan ☐ Weight on BMI forms	☐ Handout for what to expect ☐ Weight gain based on BMI ☐ MVA & seatbelts ☐ Mercury & Fish	
20	☐ Doppler ☐ Should have gotten 20wk scan ☐ Weight on BMI forms	☐ Handout for what to expect ☐ Fluoride & Dental Care ☐ Revisit Domestic Violence ☐ Preeclampsia	
24	24-28 wk labs: ☐ 1hr GTT ☐ U/A and UCx if hx prior ucx+ ☐ RPR ☐ H/H ☐ GC/CT ☐ Doppler and FH If Rh neg, repeat Ab screen. If Ab +, get titers. If titers are rising or >1:8 contact MFM. DO NOT give rhogam until after Ab screen drawn, it will effect results.	☐ Listeria Poisoning ☐ MVA & Seatbelts ☐ Preeclampsia ☐ Breastfeeding and childbirth classes ☐ Postpartum birth control-schedule BTL consult visit by 28 weeks	If 1hr GTT >140 then get 3hr GTT 3hr < 95/180/155/140, need 2/4 to fail. If ¼ then repeat in 4 weeks (glucose intolerance of pregnancy)
28	☐ Doppler and FH ☐ Give 300 mcg rhogam if mom is Rh neg/antibody (only after ab titer redrawn) ☐ tDap Vaccine (27-36 wks)	☐ Revisit weight gain ☐ PPBCM, sign consents for IUD or BTL (federal if Medicaid) ☐ Preeclampsia ☐ Pertussis Teaching	
30-34 Q2wk	☐ Doppler and FH ☐ Repeat STI panel (HIV, syphilis screen and GC/Chlam, trich) if prior STI	☐ Pre-e & labor precautions ☐ MVA & seatbelts ☐ Fetal movement & kick counts	
36	☐ Doppler and FH ☐ GBS (35-36wks) ☐ If Hep C + then RNA quant ☐ Bedside u/s for position of fetus	☐ Breastfeeding pitfalls ☐ Revisit pain control plan ☐ Labor & Pre-e precautions	
37	☐ Doppler and FH ☐ Scan for vertex presentation	☐ Baby safety: car seat, fire alarm, fire extinguisher in home, smokers in home, co-sleeping with baby	

		☐ Labor and pre-e precautions	
38-39	☐ Doppler and FH ☐ Scan for vertex presentation ☐ Discuss criteria for eIOL	☐ Labor and pre-e precautions ☐ Pain plan, labor support	Review criteria for elective IOL. Verify with attending, notify admitting team.
40+	☐ Urine dip ☐ Doppler	☐ **Schedule IOL for 41wk with L&D** ☐ Labor and pre-e precautions	
6wk Post-partum	☐ Edinburgh postnatal depression scale (EPDS) ☐ Breast, baby blues, bonding, birthcontrol, bottom, check on pap and whether she needs 2hr GTT for hx GDM	☐ Revisit PPBCM; if had Post placental IUD do speculum check for strings if don't see send for US	CPT code for PPV is 59430
Anytime	☐ Depression screen; Tx with Prozac or Zoloft (counsel on risk and benefit) ☐ Flu Vaccine	☐ Revisit PPBCM ☐ Revisit pain plan ☐ Discuss birth plan and cultural expectations	If mom is measuring size>dates (+/- 3cm). Repeat US. If macrosomia, repeat 3hr GTT

When to order NST/AFI/BPP

Condition	NST	AFI	Start at
Late Term (≥41wks)	Twice weekly	Twice weekly	41 wks
Oligohydramnios	Twice weekly	Twice weekly	At diagnosis
Pre-eclampsia	Twice weekly	Twice weekly	At diagnosis
IUGR	Twice weekly	Twice weekly	At diagnosis
Pregestational HTN requiring meds	Twice weekly	Weekly	32wks
GDMA1	Twice weekly	Weekly	40wks
GDMB or GDMA2 insulin or oral meds	Twice weekly	Weekly	32 wks
DM/GDM-poor control	Twice weekly	Weekly	30-32wks
Previous unexplained IUFD	Twice weekly	Weekly	34wks
Renal dz/SLE/antiphosphlipid antibody syndrome	Twice weekly	Weekly	32wks
AMA over 40	Weekly	Weekly	36wks

Other indications for RhoGam:

- SAB or TAB give 50 mcg (if 50mcg dose not available give 300mcg) if <13wks, give 300mcg if >13wks
- 2nd or 3rd trimester amniocentesis: give 300mcg dose
- Significant abdominal trauma without vaginal bleeding 300mcg dose
- external cephalic version 300mcg dose
- Ectopic 50mcg dose

History of HSV: start Acyclovir 400mg TID at 34-36 wks until delivery, C/S if lesions are active at time of deliver; women with >1 recurrence in a year is a reasonable candidate for prophylaxis in pregnancy as there is no evidence of harm.

Recurrent UTI

- Do not confuse leucorrhea of pregnancy with UTI, look to + nitrites& blood, then send for U/A & Cx
- Test for cure at next visit. If two UTIs then prophylaxis with cephalexin 250mg qhs or nitrofurantoin 100mg qhs

Pre-existing hypothyroid: Increase levothyroxine dose by 1/3 at first prenatal visit, and recheck TSH and free T4 every 4 weeks until TSH ≤2.5.

If h/o graves check for antibodies. Always monitor for fetal tachycardia

Pre-existing HTN:

- Goal BP is 140-150/90-100
- Baseline PIH labs: CBC, chem7, uric acid, LFT, LDH, 24hour protein, EKG, urine protein/cr ratio
- Meds: methyldopa 250mg BID max 100mg BID; labetalol 100mg TID, increase q3d until max 800mg TID but may consider a second med when reach 400mg TID; nifedipine 30mg qd of sustained release, increase q7d, max 90mg/d
- Women with a history of early onset preeclampsia <34 weeks or preeclampsia in more than one pregnancy should be started on aspirin 81mg in the late first trimester

When to offer Genetic Counseling: Age >35, h/o seizures, EtOH abuse, ACEi use, Pre-existing DM, GDMA

Table. Clinical Risk Assessment for Preeclampsia* (Taken from USPSTF, https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/low-dose-aspirin-use-for-the-prevention-of-morbidity-and-mortality-from-preeclampsia-preventive-medication)

Risk Level	Risk Factors	Recommendation
High†	History of preeclampsia, especially when accompanied by an adverse outcome Multifetal gestation Chronic hypertension Type 1 or 2 diabetes Renal disease Autoimmune disease (systemic lupus erythematous, antiphospholipid syndrome)	Recommend low-dose aspirin if the patient has ≥1 of these high-risk factors
Moderate‡	Nulliparity Obesity (body mass index >30 kg/m^2) Family history of preeclampsia (mother or sister) Sociodemographic characteristics (African American race, low socioeconomic status) Age ≥35 years Personal history factors (e.g., low birthweight or small for gestational age, previous adverse pregnancy outcome, >10-year pregnancy interval)	Consider low-dose aspirin if the patient has several of these moderate-risk factors§
Low	Previous uncomplicated full-term delivery	Do not recommend low-dose aspirin

* Includes only risk factors that can be obtained from the patient medical history. Clinical measures, such as uterine artery Doppler ultrasonography, are not included.
† Single risk factors that are consistently associated with the greatest risk for preeclampsia. The preeclampsia incidence rate would be approximately ≥8% in a pregnant woman with ≥1 of these risk factors[1, 5].
‡ A combination of multiple moderate-risk factors may be used by clinicians to identify women at high risk for preeclampsia. These risk factors are independently associated with moderate risk for preeclampsia, some more consistently than others[1].
§ Moderate-risk factors vary in their association with increased risk for preeclampsia.