



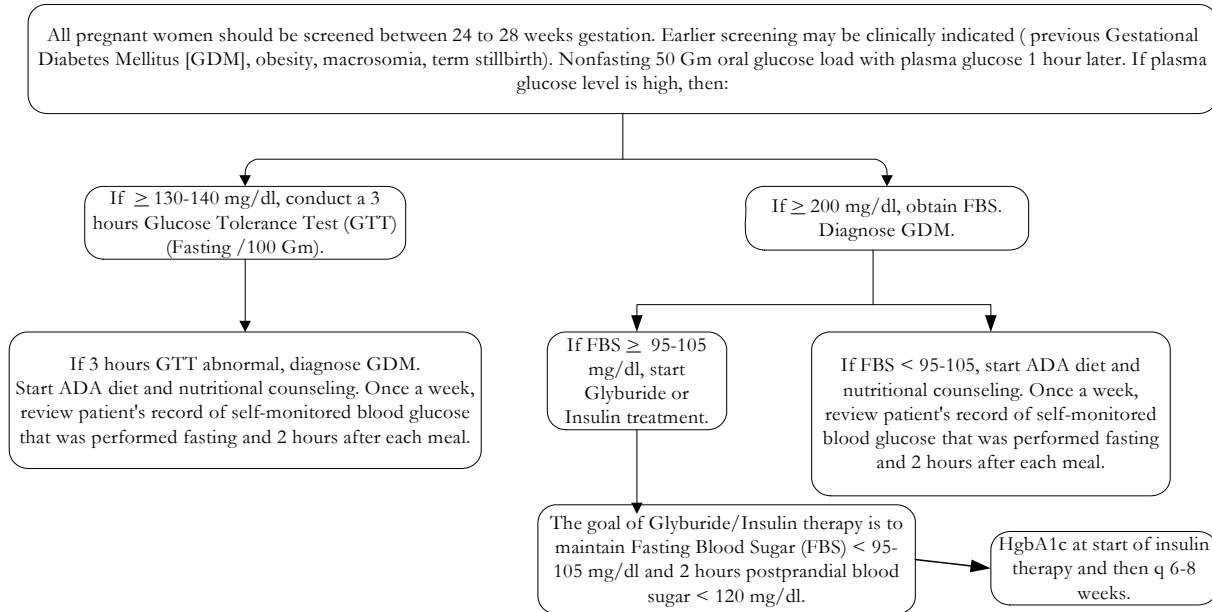
## Obstetrical Clinical Recommendations\*

### High-Risk Pregnancy - Preterm Delivery, Gestational Diabetes, and Pregnancy-Induced Hypertension

- A course of antenatal corticosteroids is recommended between 24 and 34 weeks gestation for patients who are at risk for Preterm Delivery (PTD). Corticosteroid therapy administered to the mother prior to birth is effective in reducing respiratory distress syndrome, intracranial hemorrhage and mortality in the preterm newborn.
- Pregnant women at risk for PTD should be screened for bacterial vaginosis during the first or early second trimester. According to the Centers for Disease Control and Prevention (CDC 2006 Guidelines) appropriate antibiotic therapy may decrease the risk of preterm birth. (ACOG Practice Bulletin May 2006, pg.4)
- Risk of PTD increases with each additional prior spontaneous PTD. Sonographic measurement of cervical length and fetal Fibronectin (fFN) help define risk for current and recurrent PTD. Current evidence supports the use of 17-P injections begun in the second trimester and continued weekly until 36 weeks for singleton pregnancies with a history of PTD. ( "The Delivery Probability Profile: A new tool to predict PTD?" By James Kurtzman, MD Contemporary OB/GYN, January 2008)
- Universal screening of all pregnant women for Group B Strep should be performed at 35 to 37 weeks gestation (CDC Guidelines, 2006).
- AMERIGROUP'S MFM Advisory Panel highly recommends acute tocolysis for preterm labor and strongly encourages maintenance to prevent PTD. Preterm birth is the leading cause of neonatal morbidity and mortality. (Obstetrics and gynecology (Volume 113, NO.3 March 2009) "Tocolytic Therapy *A Meta-Analysis and Decision Analysis*"

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Updated 7/18/07 & Reviewed 7/08

## Gestational Diabetes Mellitus



- Diet controlled (A1): Fetal evaluation per clinical indications. Deliver by 40 weeks (or sooner if clinically indicated).
- Insulin controlled (A2): Weekly Biophysical profile (BPP): one or two times weekly starting at 32 weeks (or sooner if clinically indicated). Sonogram every three to four weeks for fetal growth. Deliver at 38 to 39 weeks, if fetus mature (or sooner if clinically indicated).

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## Preeclampsia

	<b>CRITERIA</b>	<b>TREATMENT</b>
<b>Preeclampsia - Mild</b>	<ul style="list-style-type: none"> <li>Blood Pressure (BP) 140/90 mm Hg</li> <li>Proteinuria <math>\geq</math>300 mg/24 hours</li> <li>Generalized edema <math>\geq</math>5 lbs/week</li> </ul>	<p><b>&gt;37 Weeks:</b> Deliver with MgSO<sub>4</sub> protocol</p> <p><b>34-37 Weeks:</b> Use expectant management with clinical judgment regarding maternal and fetal unit stability</p> <p><b>&lt;34 Weeks:</b> Use expectant management with clinical judgment regarding steroid therapy</p>
<b>Preeclampsia - Severe</b>	<ul style="list-style-type: none"> <li>BP 160/110 mm Hg</li> <li>Proteinuria <math>\geq</math>5 Gms/24 hours</li> <li>Oliguria <math>\leq</math>500 ml/24 hours</li> <li>Platelets (PLT) &lt;150 K</li> <li>Increased Blood Urea Nitrogen (BUN), creatinine, liver enzymes</li> <li>Intrauterine Growth Restriction (IUGR)/Oligohydramnios</li> <li>End organ symptoms: headache, visual changes, epigastric or Right Upper Quadrant (RUQ) pain</li> </ul>	<p><b>&gt;34 Weeks:</b> Deliver with MgSO<sub>4</sub> protocol</p> <p><b>32-34 Weeks:</b> If fetal lungs are mature, deliver with MgSO<sub>4</sub> protocol. If fetal lungs are immature, use steroid treatment and deliver with MgSO<sub>4</sub> protocol.</p> <p><b>28-32 Weeks:</b> Hospitalize for observation. Evaluate the use of steroids. Expectant management if maternal/fetal unit stable. If the maternal/fetal unit is unstable, deliver with MgSO<sub>4</sub> protocol.</p> <p><b>&lt;28 Weeks:</b> Counsel regarding poor outcome. If the maternal/fetal unit is deteriorating, deliver with MgSO<sub>4</sub> protocol.</p>
<b>Gestational Hypertension</b>	BP without Proteinuria	
<b>HELLP</b>	Hemolysis, elevated liver enzyme, low platelets	Deliver with MgSO <sub>4</sub> protocol
<b>MgSO<sub>4</sub> Protocol</b>	Guidelines	<ul style="list-style-type: none"> <li>Administer IV during labor</li> <li>Give during initial evaluation for severe preeclampsia when the plan is to manage conservatively</li> <li>Loading dose: 4 Gm (range 2-6 Gm) over 20 minutes</li> <li>Maintenance dose: 2-4 Gm/hour</li> <li>Therapeutic serum levels: 4-8 mg/dl</li> <li>Postpartum: continue 24 hours or more until clinical indicators improve</li> </ul>

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<b>BP Control</b>	Guidelines	<ul style="list-style-type: none"> <li>• Hydralazine 5-10 mg intravenously q 20-30 minutes to a maximum of 40 mg</li> <li>• Labetalol 10-20 mg intravenously every 15 minutes to a maximum single dose of 80 mg (<b>total maximum dose 220 mg</b>)</li> </ul>
<b>Fluid Control</b>	Guidelines	<ul style="list-style-type: none"> <li>• Monitor Input and Output (I&amp;O)</li> <li>• Foley</li> <li>• Pulmonary artery catheter if hemodynamically unstable or if pulmonary edema (with Maternal Fetal Medicine [MFM] consult)</li> <li>• MFM consult is appropriate for severe and difficult cases</li> <li>• O<sub>2</sub> saturation</li> </ul>

Source: AAP/ACOG 6<sup>th</sup> edition 2007 Guidelines

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