December 10, 2013

Memorandum

To: Family Physicians, General Internists, Obstetricians/Gynecologists, Nurse Practitioners, Nurse Midwives

From: Grant Greenberg MD, MA, MHSA, Guidelines Clinical Lead
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Subject: UMHS Clinical Care Guideline: Prenatal Care

What’s New!

- Standard criteria for estimating due date. Standard UMHS criteria are detailed on page 13.
- Progesterone therapy. Offer to patients with history of prior spontaneous preterm birth.
- Cervical length screening. Perform for all patients at the time of the fetal anatomical survey for all patients.
- Diabetes testing/screening. Protocols for diagnosis have been modified
  - High risk patients – diabetes. At the 1st prenatal visit test women with signs/symptoms of diabetes or history of gestational diabetes. Use fasting plasma glucose and A1c. (See Page 8 for details.)
  - All patients – gestational diabetes. At 24-28 weeks screen all patients without a diagnosis of diabetes for gestational diabetes. Use a 50 g Glucose Challenge Test. A result ≥ 135 mg/dl is considered abnormal. (See Page 9 for details.)
- Tdap vaccination. Offer Tdap vaccination to all pregnant women. Performing this vaccination at 27-36 weeks optimizes passive immunization of newborns for pertussis.
- STD testing. In addition to testing all women for sexually transmissible infections including HIV, in patients at risk for STDs during pregnancy testing should be repeated in the third trimester.

Key Aspects.

- Prenatal care summary. Table 1 summarizes main aspects of prenatal care (history & examination, testing & treatment, and education & planning) from preconception through delivery based on gestational age.
  - Initial visits. For average risk women: an intake at 6-8 weeks, with a follow-up office visit with a provider at 10-12 weeks.
  - Subsequent visits. Every 4-6 weeks until 34 weeks, then every 2 weeks until 37 weeks, then weekly.
- Assess risk factors for adverse pregnancy outcome. Counsel, test or refer as indicated.
  - Fetal surveillance. Common indications and protocols for antepartum fetal surveillance are presented in Table 2.
  - Referral. Selected indications for referral are summarized in Table 3.
- Elective birth only ≥ 39 weeks. Elective birth before 39 weeks’ gestation is contraindicated.

Patient education material.

Available via the Patient Education Clearinghouse