HROB Stickers

**11/19/2024**

**2 VESSEL UMBILICAL CORD**

See Guideline for **Management of isolated soft ultrasound markers for aneuploidy in the second trimester**

**ADRENO-GENITAL SYNDROME, previous child and same FOB**

 At 10 weeks, draw MaternaT 21 to determine fetal sex.

 When results of MaternaT 21 are complete, send Perinatology referral for a plan of management.

 DO NOT start high dose dexamethasone.

**ADVANCE MATERNAL AGE, age 35-39**

 Recommend MaternaT 21 at 10-12 weeks before the patient’s appointment in Anchorage at 20 weeks

Offer 2nd trimester MSAFP screen

 Recommend referral to Perinatology for DAFUS and Genetic Counseling.

**ADVANCE MATERNAL AGE, age 40 plus**

 Recommend MaternaT 21 at 10-12 weeks before the patient’s appointment in Anchorage at 20 weeks

Offer 2nd trimester MSAFP screen

 Recommend referral to Perinatology for DAFUS and Genetic Counseling.

 NST-AFI weekly starting at 36 weeks

 Recommend delivery by EDD

**ALLERGY TO PENICILLIN**

If GBS positive, GBS culture will automatically reflex in lab for sensitivity to clindamycin and erythromycin.

**AMNIOTIC BAND/**

Refer to Perinatology

**ANEMIA, Hg <11**

 Follow Anemia in pregnancy guideline

**ASYMPTOMATIC BACTURIA**

 Test of cure (TOC) at next appointment

 Urine culture every visit

 Treat any level of bacteriuria

**cardiac anomalies in fetus, current pregnancy**

If suspected anomaly found during screening ultrasound in Bethel, contact ~~HROB and~~ Perinatologist for a plan of care.

 Document plan of care in patient note and problem list

 Return to HROB meeting after the ANMC visit to discuss and plan for subsequent care.

**Chronic Hepatitis B Virus (HBV) Infection**

HbsAg positive

 Draw Liver Enzymes, HBV DNA

 If HBV DNA detected with a specific titer over 10IU, refer to Hepatology for possible anti-viral therapy.

 If HBV DNA not detected or detected <10IU, do not sent referral.

 **ALL neonates born to mother with a positive HBsAg WILL receive HBIG and HBV vaccine at birth with parental consent.**

**CHRONIC HYPERTENSION**

 Consult HROB or OB/GYN on call at 1st prenatal visit or at diagnosis

 Baseline testing: Urine protein/creatinine ratio, comprehensive metabolic panel.

 Consider EKG/Echocardiogram if longstanding hypertension or multiple medications. HROB meeting will decide if these are necessary.

Consider Stopping medication and rechecking blood pressure in 1 week.

Change Medication to labetalol or metoprolol if possible, if on amlodipine, ok to continue

 Aspirin 162mg daily from 12 weeks until delivery

 Ultrasound for growth weeks 24, 28, 32, 36

 Start antenatal testing at 34 weeks, BPP weekly

 Repeat labs for suspected superimposed Preeclampsia, if found, contact HROB or OB/GYN for plan of care. Discuss at every prenatal visit with HROB or OB/GYN.

 Consult obstetrician at 37 weeks for delivery plan

**CONGENITAL ADRENAL HYPERPLASIA, previous child**

At 10 weeks, draw MaternaT 21 to determine fetal sex.

 When results of MaternaT 21 are complete, send MFM referral for a plan of management.

 DO NOT start high dose dexamethasone.

**DIABETES, PRE-PREGNANCY**

 Aspirin 162mg daily from 12 weeks until delivery

Consult Obstetrician for medication

 Recommend insulin starting with NPH.

 Baseline testing: Protein/creatinine ratio, comprehensive metabolic panel, TSH.

 Consider EKG/Echocardiogram if longstanding disease, severe/brittle disease or co-morbid conditions. HROB meeting will decide if these are necessary.

 Optometry referral

 Recommend 1st Trimester screening for aneuploidy, using MaternaT 21

 Refer to Perinatology for DAFUS, Fetal Echo and consultation

 Transfer of Care to Anchorage depends on patient adherence to plan of care and glucose control. Could be any time from 30 weeks to 35 weeks.

**DILATED FETAL RENAL PELVIS (UTD)**

 See Guideline for **Management of isolated soft ultrasound markers for aneuploidy in the second trimester**

**ELEVATED MSAFP**

Verify information sent to LabCorp for calculating results

Obtain ultrasound for dating if not already done.

Resubmit for recalculation if necessary

If AFP MOM <3.0, repeat AFP. If MOM still >2.5, or initial result is >3.0, refer to Perinatology for DAFUS and genetic counseling.

 In third trimester, watch for: IUGR, preeclampsia, preterm labor, vaginal bleeding. Consult HROB or OB/GYN if these occur.

 Ultrasound at 32 weeks or as directed by the Perinatologist

**FETAL GROWTH RESTRICTION, Suspected**

Obtain an ultrasound for fetal Growth

 If US shows EFW<10%,

Obtain cord Doppler

Send images to Perinatologist

Follow recommended plan of care from Perinatologist

 If ultrasound shows EFW>10%, contact HROB or OB/GYN for plan of management.

**GENITAL HERPES**

 Inspection of vulva and vagina at 36 weeks and in labor

 Encourage valacyclovir 500mg BID for prophylaxis at Be in Bethel visit or 4 weeks before planned delivery

**Gestational Diabetes**

Goal: Fasting <95, 2 hour postprandial <120 or 1 hour postprandial <140

 Close monitoring until controlled (weekly visits or contact).

Weekly discussion at HROB rounds

Growth US at 36 weeks

 If poor control (>25% of values above goal)

consider medical therapy (insulin(preferred) or oral medication)

stay in Bethel after 32 weeks

 If the patient is not providing data through finger stick glucose monitoring, offer Continuous glucose monitor.

 If the patient is not providing any data from any method of testing, transfer to Anchorage at 35 weeks or sooner.

**GESTATIONAL DIABETES, POOR CONTROL**

Consult HROB or OB/GYN at every visit for patients in poor control (>25% of values above goal) to update the plan of care.

Transfer to Anchorage at 32 weeks

**GESTATIONAL DIABETES, ON MEDICATION**

Insulin is preferred medication. Only use oral medication if the patient refuses insulin.

Goal: Fasting <95, 2 hour postprandial <120 or 1 hour postprandial <140

 Close monitoring (weekly visits or contact).

Weekly discussion at HROB rounds

Adjust medication weekly until goal achieved.

Weekly BPP after 32 weeks. (stay in Bethel)

Transfer to Anchorage at 32-35 weeks depending on patient participation with the plan of care and glucose control.

**GESTATIONAL HYPERTENSION/PREECLAMPSIA in current pregnancy**

Prenatal visits twice a week

 Weekly Labs CBC, CMP, protein/Creatinine ratio. 24-hour urine as recommended by HROB or OB/GYN physician.

 NST 2x/week, AFI weekly

 US OB follow-up for growth every 3 weeks

 If Growth restriction suspected, contact HROB or OB/GYN for a plan.

 Consult with HROB or OB/GYN at EVERY VISIT

 Refer to North Wing Physician for delivery at 38 weeks

**Gestational pruritus**

 Do not start Ursodiol

 Repeat Bile Acids and LFT every 1-2 weeks.

**GESTATIONAL PRURITUS WITH LAB ABNORMALITIES OR SEVERE PRURITUS**

Lab abnormalities: Cholic acid > 3.0, elevated AST, ALT, bilirubin or alkaline phosphatase > 300.

Severe itching is excoriations, scratching during appointment, itching that alters sleep

Start ursodiol 600mg po BID. Treat as Cholestasis.

NST weekly after 32 weeks.

Induce at 39 weeks.

**GRAND MULTIPARA (5 or more deliveries)**

 Active management of 3rd Stage recommended

 Discuss Birth Control Plans at 36 weeks

 Sign Sterilization consent at 20 week visit, if considering sterilization

**GROUP B STREP BACTERIURIA in current pregnancy**

 **Any** level of GBS in the urine at any time of the pregnancy initiates this plan

**Do not** do screen with vaginal/rectal swab at 36 weeks.

Begin prophylaxis in labor per guideline.

**GROUP B STEP, PREVIOUS BABY WITH INVASIVE DISEASE**

 Screen for bacteriuria per the routine.

 **Do Not** screen with vaginal/rectal swab at 36 weeks.

Begin prophylaxis in labor per guideline.

**GROUP B STEP, PREVIOUS PREGNANCY WITH POSITIVE CULTURE AT TERM, BUT NO NEONATAL INFECTION**

No treatment is indicated

 Screen at 36 weeks per routine protocol

**HBsAg POSITIVE, NEW FINDING**

 Draw LFTs, HB core IgM, HBeAg, HBeAb, HBsAb, HB DNA PCR

 Refer to ANMC hepatology

**HIGH RISK FOR PRETERM BIRTH**

 Reason:

 HROB meeting discussion or consult OB/GYN

If recommended, start progesterone 200mg per vagina qhs 16 – 36 weeks

 Urine culture every visit

 Serial cervical length every 2 weeks from 16- 24 weeks

 If cervical length less than 30mm, see sticker for short cervix of the “Guideline Preterm Labor: Screening and Prevention”

 Treat BV if symptomatic (screening for BV is not indicated)

**HISTORY OF DEPRESSION/POST PARTUM DEPRESSION**

 Screen every visit for depression

 Contact ACT or Behavioral Health for score >9

 Consider SSRI postpartum

**HISTORY OF DOMESTIC VIOLENCE**

 Discuss at every visit.

 Monitor for signs or symptoms of abuse

 Offer counseling or referral for services.

**HISTORY OF INTRAHEPATIC CHOLESTATIS**

 Draw baseline total bile acids and liver enzymes at first visit

 Monitor for symptoms at every visit

 If severe clinical symptoms, redraw labs above and begin Ursodiol 600 mg BID.

 See guideline

**HISTORY OF IUGR OR SMALL FOR GESTATIONAL AGE (SGA) <20% FETUS**

Growth scans at 24, 28, 32 and 36 weeks

**HISTORY OF A LARGE FOR GESTATIONAL AGE (LGA) >90% FETUS OR >4000GM**

 Screen for Gestational Diabetes per protocol

 Ultrasound at 36 weeks for growth

**HISTORY OF MOLAR PREGNANCY**

Make sure first trimester US has history of Molar pregnancy as a diagnosis

 Review the US with HROB physician

 Refer patient to HROB meeting

 Send Placenta for pathology after delivery.

**HISTORY OF POSTPARTUM HEMORRHAGE**

 Second IV in labor

 Standard: T&S in labor and assessment for risk of postpartum hemorrhage

 Active Management of 3rd stage of labor

 Consider prophylactic Tranexamic Acid

 If PPH risk score is 3 prior to induction of labor, transfer care to Anchorage prior to induction. Contact OB unit to help with calculating the score if needed.

**HISTORY OF GESTATIONAL HYPERTENSION/PREECLAMPSIA with or without SEVERE FEATURES/ECLAMPSIA**

 Aspirin 162mg daily from 12 until delivery.

 Baseline labs: Protein/Creatinine ratio, CBC, CMP.

 Monitor for signs or symptoms of preeclampsia and repeat labs as needed

**HISTORY OF SEIZURE DISORDER**

 Begin Folic Acid 4mg daily ASAP

 Draw Drug level for current medication

 Consult HROB or OB/GYN for possible medication change

 DAFUS US at 18-22 weeks in Anchorage

 Monitor symptoms and drug levels as needed

 Monitor drug levels Postpartum as physiology changes

Consider adding vitamin K 10mg daily from 36 weeks to delivery

Do not give Tdap vaccine.

**HISTORY OF SHOULDER DYSTOCIA**

US for growth at 36 weeks.

Transfer to ANMC at 36 weeks for delivery.

**HISTORY OF SKELETAL DYSPLASIA OR DWARFISM**

 If this occurs in any pregnancy, refer for genetic counseling.

 If counseling states there is a recurrence risk, refer to ANMC Perinatology at 1st Prenatal Visit.

 Refer all patients for DAFUS and Perinatology consultation

 Follow plan from ANMC Perinatology note

**HISTORY OF SUBSTANCE ABUSE**

 Discuss at EVERY visit

 Monitor for signs or symptoms of abuse

 Behavioral Health referral

 If opioid, refer to Suboxone clinician

 Urine drug screening frequently

**HISTORY OF STILLBIRTH**

At first prenatal, attempt to locate the post stillbirth workup in the chart and document the results in your note for HROB conference.

 Add Bile Acids and LFT to the 1st OB visit labs.

 Ultrasound for growth at 24, 28, 32 and 36 weeks.

 Visits every 2 weeks in Bethel after 28 weeks.

 Fetal Kick counts after 28 weeks

 Further planning after HROB meeting based on other diagnoses and risk factors. See ACOG Practice Bulletin 102 Management of Stillbirth

 BPP weekly after 32 weeks.

 Offer induction at 38 weeks.

**HIV disease NEW**

 **See Guideline**

Contact EIS (907-7292907 or Tiger Text role “ANMC Discharge Scheduler HIV/EIS Clinic”) ASAP for notification and/or medication start

 Get initial HIV labs based on recommendations from EIS

 Follow HIV in pregnancy Guideline

 CD4 count and viral load at 24 and 36 weeks

 Refer to Perinatology

 See guideline for decision of where to deliver

**HIV disease previously known**

 **See Guideline**

Continue HAART

 Contact EIS (907-7292907 or Tiger Text role “ANMC Discharge Scheduler HIV/EIS Clinic”) for notification and/or medication change

 CD4 count and viral load at first prenatal, 24 and 36 weeks

 Refer to Perinatology

 See guideline for decision where to deliver

**HYPERTHYROID prior to pregnancy**

Discuss with HROB or OB/GYN at first visit.

Draw TSH, Free T4 at first visit and at least each Trimester.

Redraw TSH and Free T4 4-6 weeks after a dosage change.

 Contact Perinatologist to determine need to change Methimazole, ~~change~~ to PTU for first trimester or stop all medications.

 If on PTU, continue at present dose.

 Monitor for signs and symptoms of hyperthyroid disease at every visit. (goiter, tremor, palpitations, anxiety, weight loss despite a normal or increased appetite, increased frequency of bowel movements, and shortness of breath)

**HYPERTHYROID new diagnosis**

Discuss with HROB or OB/GYN at diagnosis or if severe disease suspected.

Draw TSH, Free T4 at first visit and at least each Trimester.

Redraw TSH and Free T4 4-6 weeks after a dosage change.

 Observe carefully for signs and symptoms of Thyroid storm. (severe hypertension, goiter, tremor, palpitations, anxiety, weight loss despite a normal or increased appetite, increased frequency of bowel movements, and shortness of breath)

If tachycardic, start Atenolol 25mg daily

 Begin PTU at 50mg po TID, draw labs weekly until stable.

 Monitor for signs and symptoms of hyperthyroid disease at every visit. (goiter, tremor, palpitations, anxiety, weight loss despite a normal or increased appetite, increased frequency of bowel movements, and shortness of breath)

**HYPOTHYROID prior to pregnancy**

 Order TSH, Free T4

 Do not treat subclinical disease

 If previous thyroidectomy or ablation, increase levothyroxine dose by 25% in first trimester and measure TSH and Free T4 every 4-6 weeks until results are stable.

 For all others, measure TSH, Free T4 each trimester.

**HYPOTHYROID new diagnosis**

 Begin levothyroxine ASAP at approximately 100mcg daily

 Check TSH Free T4 monthly until dosage stable

 Check TSH Free T4 every trimester thereafter

 Re-evaluate postpartum

**INTRAHEPATIC CHOLESTASIS (IHCP) – Severe itching and abnormal Labs**

 Start ursodiol 600 mg BID. You may increase dose up to 900mg TID for continued severe pruritus.

 Start weekly BPP at 32 weeks

 Redraw Total Bile Acids (TBA) and LFTs weekly after 32 weeks

 May return home with weekly visits

 Consult HROB meeting or obstetrician

 Correct TBA by subtracting the urodeoxycholic acid (ursodiol) from the TBA on the results.

 Severe IHCP if corrected TBA >40, must be induced at 37 weeks in Anchorage.

 If corrected TBA > 100, induce at 35-36 weeks in Anchorage.

 Mild IHCP, TBA < 40, induce at 38 weeks.

**IUGR see Fetal Growth Restriction**

**LTBI**

If prior tuberculosis diagnosis with completed treatment, diagnosis of LTBI.

No PPD or Quantiferon

 Ask about symptoms: hemoptysis, fever, night sweats, weight loss, or cough.

 If all symptoms are negative, no reactivation of TB and no treatment or diagnostic testing needed.

**MIGRAINE HEADACHES**

Discontinue triptan medication

 Low dose tricyclics OK after 1st trimester

 Tylenol.

 If above fails, refer to Neurology.

 Avoid opiates.

**OBESITY**

 If BMI >40, refer to HROB meeting for consultation.

 If BMI >40 and patient 36 weeks gestation or later, Consult HROB on call and on call CRNA on call for consultation regarding suitability for delivery in Bethel.

 For all women with BMI> 35, obtain US for growth at 28, 32 and 36 weeks and start BPP weekly at 32 weeks.

**POSITIVE ANTIBODY SCREEN**

 Confirm antibody identification.

 If antibody is Kell, Duffy (Fy), c, C, D, e or E, contact OB/GYN or discuss at HROB ASAP

 Any other antibody, contact OB/GYN for plan of management.

 Obtain Unity cell free DNA screening for T21, T18, T13, sex chromosomes and the antigen identified above. The testing kits are available at the Team Room C nursing station.

 If fetal antigen testing is negative, no further testing is needed.

 If fetal antigen testing is positive, refer to MFM for plan of care to monitor for isoimmunization.

**POSITIVE HIV SCREEN**

 Confirm HIV status with reflex testing.

 Once HIV disease confirmed, see HIV Disease, New

**PLACENTAL ABNORMALITIES**

LOW LYING: <2.5cm from internal os of the cervix

 Repeat transvaginal ultrasound monthly until resolved.

 If not resolved by 32 weeks, consult Perinatologist for further plan of management

CIRCUMVALLATE

 At risk for growth restriction. Growth US at 32 weeks to assess for growth restriction.

SUCCENTURATE LOBE

 Make sure ultrasound has screened for vasa previa

 At delivery, ensure entire placenta is removed during 3rd stage.

VELAMENTOUS CORD INSERTION

At risk for growth restriction. Growth US at 32 weeks to assess for growth restriction.

**PLACENTA PREVIA**

Placenta previa diagnosed at second trimester ultrasound

 Repeat ultrasound at 24 weeks.

 If still a previa,

 Pelvic rest: no sex, no exams

 Transfer to Anchorage until previa resolves.

 Before 24 weeks, no need to change activity unless actively bleeding

**PREDIABETES**

 Refer patient to Diabetes and prescribe supplies for finger stick testing

 Review testing results weekly at HROB rounds with diabetes team

 Screen for GDM as per routine care

**PREVIOUS CESAREAN**

 If considering repeat cesarean in Bethel, appointment with OB/GYN ASAP

Refer to HROB meeting for discussion

Repeat Cesareans done in Bethel unless there is a medical reason for the transfer.

Document patient’s choice of location and route of delivery, in note and as comment in diagnosis.

Provide trial of labor after cesarean (TOLAC) education and first prenatal visit.

Complete TOLAC consent ASAP

**Rh negative**

See Guideline.

Repeat Type and Screen with Rhogam work up at 28 weeks.

If RH negative, Give Rhogam at 28 weeks.

At delivery, follow OB guideline for Rh negative patients.

**RUBELLA NON-IMMUNE**

Repeat MMR vaccine postpartum if the patient has fewer than 3 lifetime MMR vaccines

**SHORT CERVIX ON SCREENING**

 **History of Preterm Birth**

Cervical length less than 25mm

 Consult with MFM provider to discuss cerclage

 Cervical length 26 to 29mm

 Weekly cervical length ultrasound

 Cervical length 30mm, continue every other week cervical length measurements until 24 weeks.

 **No History of Preterm Birth**

Cervical length 20mm or less

 Vaginal progesterone 200mg qhs

 Repeat cervical length in 1-2 weeks

 Cervical length 10mm or less

 Consult MFM or OBGYN for possible cerclage

**SUBOXONE TREATMENT**

 Make appointments with Dr Compton or another MAT/Women’s Health (WH) provider

 UDS as needed (does not need to be every week), Tramadol and/or gabapentin levels depending on patient’s drug use history

 Transfer to Anchorage at 36 weeks or sooner for delivery

**TWIN GESTATION (Diamniotic-Dichorionic)**

Add Folic Acid 1mg daily

Aspirin 162mg daily from 12 weeks until delivery

**18 Weeks ANMC**

 TV ultrasound for cervical length

 Early DAFUS,

 Counseling

**22 Weeks ANMC**

Full DAFUS

**24 Weeks YKHC**

 Prenatal visit

 1 hr. GST, CBC

**26 Weeks YKHC**

 Prenatal visit

 Ultrasound for fetal growth and TV ultrasound for cervical length

**28 Weeks YKHC**

Prenatal visit

**30 Weeks YKHC**

Prenatal visit

Ultrasound for fetal growth and TV ultrasound for cervical length

\*\* BE IN BETHEL due to high risk pregnancy \*\*

**31 Weeks YKHC**

 Prenatal visit

**32 Weeks YKHC**

\*\* Transfer to ANMC until delivery\*\*

**TWIN GESTATION MONOAMNIOTIC-DICHORIONIC OR MONOAMNIOTIC-MONOCHORIONIC**

Add Folic Acid 1mg daily

Aspirin 162mg daily from 12 weeks until delivery

**16 weeks –** Appointment in Anchorage to evaluate for twin-twin transfusion syndrome

 All future appointments in Anchorage

**UTERINE SHELF**

Repeat ultrasound in 4 weeks.

 These rarely are a problem

**UTI IN PREGNANCY**

 Urine Culture every visit

Prophylaxis after 2nd UTI or 1st pyelonephritis: recommend Nitrofurantoin 100mg po qhs.

**TOLAC in Bethel, Planned**

 Discuss Case at HROB meeting

 At BIB, provider will contact the HROB on call, blood bank lead, OB charge nurse.

 On admission in labor: Admitting physician will notify CRNA on call, HROB on call.

 Complete TOLAC Consent at earliest prenatal visit possible

**VITAMIN D DEFICIENCY**

 SELECT ONLY ONE SENTENCE FOR NOTE

25-OH Vitamin D > 20ng/ml Continue cholecalciferol 1000 IU daily (standard for all patients)

 25-OH Vitamin D > 12ng/ml and <20ng/ml increase cholecalciferol to 3000 IU daily

25-OH Vitamin D < 12ng/ml

If < 32 weeks, increase cholecalciferol to 3000 IU daily

If > 32 weeks give ergocalciferol 50,000 IU weekly for 12 weeks.