Preventive Health Guideline: Perinatal Care

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Preventive Health Guidelines for Perinatal Care

Preconception Counseling and Interventions

During preventive health care visits in women who could become pregnant, there are core topics in preconception care that should be addressed.

1. Assessments as a basis for counseling:
    - Maternal and paternal family history, genetic history and medical history
    - Gynecologic, obstetric history and physical exam
    - Current medications, prescription and nonprescription
    - Substance use including alcohol, tobacco, recreational and illicit drugs
    - Exposure to violence and intimate partner violence
    - Nutritional status
    - Exposure to environmental and occupational teratogens
    - Socioeconomic, educational and cultural context
    - Reproductive life plan

   Review immunization status.
    - Since live virus vaccines pose a theoretical risk for the fetus, women at risk or susceptible to measles, mumps, rubella and varicella should complete vaccination series at least one month before pregnancy.
    - Inactivated flu vaccine can and should be given early in the flu season for both pregnant and non-pregnant women.
    - Tdap vaccine use is recommended during every pregnancy and preferably given in the third trimester, between 27 weeks and 36 weeks.

2. Screening or diagnostic studies may be offered as appropriate:
    - Sexually transmitted infections: Chlamydia and gonorrhea have been strongly associated with ectopic pregnancy, infertility and chronic pelvic pain.
    - Screen for chlamydial infection annually for all sexually active women aged 25 years or younger.
    - Provide targeting screening for gonorrhea in women at increased risk of infection
    - Consider preconception HIV testing to allow for informed decisions regarding treatment and timing of pregnancy.
    - Preconception genetic screening: All patients should be offered carrier testing for cystic fibrosis, spinal muscular atrophy, complete blood count and screening for hemoglobinopathies, and thrombophilias
    - Woman of the Ashkenazi Jewish, French-Canadian and Cajun population should be offered screening for Tay-Sachs disease and those with family history.
    - Depression screening using a validated depression screening tool (attached)
        - PHQ-9
        - Edinburgh Postnatal Depression Scale (EPDS)

   Chronic Medical Conditions
    - Diabetes – achieve A1c at or below 6.0 mg/dL to decrease risk of spontaneous abortion, birth defects and macrosomia
    - Thyroid disease – treat hypothyroidism or hyperthyroidism to decrease risk of miscarriage and preterm delivery
    - Maternal PKU – Adhere to low-phenylalanine diet before conception and during

pregnancy to decrease risk of having children with cognitive deficiencies and other birth defects
    - Address asthma, hemoglobinopathies, inherited thrombophilias, obesity, history of bariatric surgery, hypertension

3. Counseling on the following should be offered:
    - Substance use and abuse
        - Women who smoke cigarettes or use any other form of tobacco should be identified and encouraged and supported in an effort to quit.
        - Women who are trying to become pregnant should be counseled to refrain from all alcohol use.
        - Address the abuse of prescription and nonprescription recreational drug use. Refer to appropriate resources and follow up to access adherence to recommendations.
    - Medication use
        - In general, recommend use of lowest effective dose of only necessary medications
        - Known teratogenic medications: warfarin, anti-seizure drugs, ACE inhibitors and isotretinoin
    - Nutrition, physical activity
        - Well-balanced diet
        - Avoid dieting for quick weight loss, skipping meals; assess for eating disorders
        - Additional risk factors for nutrition problems: adolescence, tobacco and substance use, history of pica in a previous pregnancy, high parity, mental illness
        - Folic acid supplementation, 0.4mg daily to help reduce major brain and spinal cord birth defects starting at least one month before conception
        - Near-normal BMI before attempting conception
        - Exercise at least 20-30 minutes on most days of the week

Antepartum Care

Prenatal care should begin in the first trimester.

1. The frequency of follow-up visits is determined by the individual needs of the ~~woman~~ mother and an assessment of risks. The frequency and regularity of scheduled prenatal visits should be sufficient to enable practitioners to accomplish the following:
    - Assess the well-being of the mother and her fetus
    - Provide ongoing, timely and relevant prenatal education
    - Complete recommended health screening studies and review results
    - Detect medical and psychosocial complications and institute indicated intervention
    - Provide reassurance and support

    General guideline for an uncomplicated pregnancy is examination every 4 weeks for the first 28 weeks, every 2 weeks until 36 weeks of gestation and weekly thereafter.

2. Each prenatal visit should include:
    - Evaluation of blood pressure
    - Evaluation of weight
    - Evaluation of uterine size for progressive growth and consistency with estimated date of delivery
    - Presence of fetal heart activity at appropriate gestational ages
    - After quickening is reported, evaluation of fetal movement, contractions, leakage of fluid or vaginal bleeding

3. Routine antepartum care
    - Lab testing early in pregnancy
        - Blood and Rh type
        - Antibody screen
        - CBC
        - VDRL/RPR
        - Urine screening and culture
        - HBsAg
        - HIV counseling/testing
        - Chlamydia, gonorrhea
        - Mantoux TB skin test or Quantiferon blood test
    - Fetal ultrasound imaging to determine gestational age, fetal number, viability and placental location
    - Estimated date of delivery (EDD) for planning, interpretation of tests, determination of fetal size, designing interventions to prevent preterm and post-term births
    - Deliveries before 39 weeks of gestation should not be done without a maternal or fetal indication. Accuracy of the gestational age, cervical status, and consideration of any potential risks to the mother or fetus are paramount in any discussion of a non-medically indicated delivery. Term gestation should be confirmed using the following criteria:
        - Ultrasound measurement at less than 20 weeks of gestation supports gestational age of 39 weeks or greater
        - Fetal heart tones have been documented as present for 30 weeks by Doppler ultrasonography
        - It has been 36 weeks since a positive serum or urine HCG test

4. Patient education
    - First visit
        - Scope of care provided in the office
        - Laboratory studies and their indications
        - Expected course of the pregnancy
        - Signs and symptoms to be reported to the physician
        - Role of members of the health care provider team
        - Anticipated schedule of visits
        - Physician or midwife schedule and labor and delivery coverage
        - Practices to promote health maintenance
        - Risk counseling, to include substance use and abuse
        - Psychosocial topics in pregnancy and the postpartum period; including depression screening using a validated tool (PHQ-9)
    - First trimester
        - Nutrition: well-balanced, varied, nutritional food plan consistent with access to food and preferences; special or individual needs require nutritionist referral. Prenatal vitamin supplementation
        - Weight gain is dependent on pre-pregnancy BMI
            - Underweight: gain 28-40 lbs
            - Normal weight: 25-35 lbs
            - Overweight: 15-25 lbs
            - Obese: 11-20 lbs
    - Second and third trimester
        - Working
        - Childbirth education classes

- Choosing a newborn care provider
- Anticipating labor
- Hospital admission and discharge
- Breastfeeding
- Neonatal interventions

Postpartum

1. The length of the medically necessary hospital stay following delivery will be determined by the physician and mother. The following minimum maternal criteria must be met for discharge:
    - Afebrile with pulse and respirations of normal rate and quality; blood pressure within normal range
    - Uterine fundus is firm; amount and color of lochia are appropriate for the duration of the recovery
    - Urinary output is adequate
    - No abnormal physical or emotional findings
    - Any surgical repair/wound has minimal edema and no evidence of infection; appears to be healing without complication
    - Able to eat and drink without difficulty, ambulate with ease, adequate pain control
    - Demonstrates readiness to care for self and newborn
    - Pertinent lab results are available including postpartum H & H
    - Instructions on postpartum activity and exercises and common discomforts and remedies have been provided
    - Instructions in self and baby care at home has been provided and mother is prepared to recognize and respond to danger signs and postpartum follow-up care symptoms
    - ABO blood group and D type are known and, if indicated, appropriate D immune globulin administered
    - Support person(s) are available for the first few days of discharge

2. Approximately 4-6 weeks after delivery there should be a postpartum review and examination. It should include:
    - Interval history including adaptation to newborn
    - Inquiry regarding breastfeeding
    - Physical examination including weight, BP, breasts and abdomen as well as a pelvic examination, episiotomy repair and uterine involution evaluation, PAP test
    - Depression screening using a validated tool
        - PHQ-9
        - Edinburgh Postnatal Depression Scale (EPDS)
        - Maternal Postpartum depression screening may also be done by the baby's provider at the 2 week check. Should the provider identify signs and symptoms of depression, approval maternal referrals will be made.(including assisting the mother with PCP selection)
    - Birth control should be reviewed or initiated
    - Preconception counseling for future pregnancies