Roles on L&D (daytime)

- HO1 and off service residents: manage ROB service, see patients in OBT, vaginal deliveries, post partum tubal ligations
- HO2: manage inpatient GYN service, ER/floor consults assist in care of OBT patients, CS deliveries, assist in labor management
- HO3: supervise ROB list, CNM consults, manage laboring patients, see patients in OBT
- HO4: supervise MFM list, consults, L&D and OBT patients

Roles on L&D (Float)

- HO1 and off service residents: manage ROB service, see patients in OBT, vaginal deliveries
- HO2: manage inpatient GYN service, MFM service and Urogyn service, ER/floor consults, assist in care of OBT patients, CS deliveries, assist in labor management
- HO3: supervise ROB list, CNM consults, manage laboring patients, see patients in OBT
- HO4: supervise GYN oncology list, supervise consults, L&D and OBT patients

**Roles will change as vacations/sick leave occur and in the second half of the academic year while on Float

Regular Obstetrics Service (ROB)

The schedule on ROB is as follows:

0530-0600: postpartum pre-rounds
0700: Board Sign Out on L&D
- Formal postpartum rounds with GYN ward attending following GYN and Board sign out
0815: Mother Baby Multidisciplinary rounds
1800 board sign out on L&D
*On Sundays board sign out/end of shift is at 1900
*The Daytime HO1 should get sign-out from the Float HO1 around the start time of pre-rounds

During the week all post-partum patients need to be seen by an intern with a progress note done and forwarded to the GYN ward attending before 7a.m. board sign out.

******WEEKEND ROUNDING: On weekends plan to arrive at 6:30 to get sign out from the night HO1. You will then do your pre-rounding and write notes in preparation for rounding with the L&D attending at 900 AM.**

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Postpartum Rounds

Review the following for all patients
- concerns with pain control
- concerns with lochia

- breast feeding/pumping vs formula feeding
- post partum birth control
- concerns with bowel and/or bladder function
- tolerance of PO
- presyncopal symptoms
- remove CS bandage after 48h
- **if pt has any of the following: tell your senior resident, see the patient, and get repeat vitals**

*** heavy vaginal bleeding, large volume blood loss with fundal pressure, fever, tachycardia, chest pain, dyspnea, new oxygen requirement, concern for DVT, syncopal episode, difficult to rouse or seizure like activity***

<u>Postpartum patients with gHTN</u>

DX: systolic BP ≥ 140 or diastolic BP ≥ 90 on two separate occasions separated by at least 4 hours after 20 WGA with proteinuria < 300mg in 24 hours or P:C < 0.3

- monitor for signs/symptoms of preeclampsia
- consider in house observation for 72h postpartum vs early BP check within 1 wk of discharge
- send home with (pre)eclampsia return precautions

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<u>Postpartum patients with cHTN</u>

DX: systolic BP ≥ 140 or diastolic BP ≥ 90 prior to 20 WGA without development of severe features

- continue home dose antihypertensives (if applicable) in post partum period
- monitor for signs/symptoms of preeclampsia
- consider in house observation for 72h postpartum vs early BP check within 1 wk of discharge
- send home with (pre)eclampsia return precautions

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<u>Postpartum patients with PreE Without Severe Features</u>

DX: systolic BP ≥ 140 or diastolic BP ≥ 90 on two separate occasions separated by at least 4 hours after 20 WGA with proteinuria ≥300mg in 24h or P:C ≥0.3.

- monitor for signs/symptoms of severe preeclampsia
- rescue severe range BP with PO labetalol or nifedipine
- check reflexes
- daily PIH labs until stable and WNL
- consider oral, scheduled antihypertensive if pt has >2 systolic BP >150 or diastolic BP >100.
- consider in house observation for 72h postpartum vs early BP check within 1 wk of discharge

- send home with (pre)eclampsia return precautions

Postpartum patients with PreE with Severe Features or Superimposed PreE with Severe Features

DX: systolic BP ≥ 160 or diastolic BP ≥ 110 on two separate occasions separated by at least 4 hours after 20 WGA or systolic BP ≥ 140 or diastolic BP ≥ 90 on two separate occasions separated by at least 4 hours after 20 WGA with severe features (HA, vision change, persistent epigastric or RUQ pain, lab changes etc) with proteinuria ≥300mg in 24h or P:C ≥0.3.

- monitor for signs/symptoms of deterioration/HELLP
- check reflexes while on magnesium and UOP (should be >30cc/hr at least)
- daily PIH labs until stable and WNL

*** PIH labs = CBC, AST, ALT, Cr, LDH, AlkPhos, +/- Uric Acid**

*** Post partum P:C ratios are less reliable in setting of lochia; consider in & out cath if needed**

- 24h IV magnesium sulfate (usually 2g/h) for 24h after delivery; foley stays in until mag discontinued
- rescue severe range BP ≥160/110 with oral antihypertensive (labetalol or nifedipine); if ≥2 rescues in 24h, consider starting scheduled antihypertensive and titrate up as needed
- **if pt has any of the following: tell your senior resident, see the patient, get repeat vitals and consider repeat PIH labs if not recently done**

*** persistent HA, epigastric/RUQ pain, vision change, decreased urine output, dyspnea, chest pain, tachycardia, new oxygen requirement, concern for DVT, syncopal episode, difficult to rouse or seizure like activity***

- consider in house observation for 72h post partum or until 24h without severe range BP vs early BP check within 1 wk of discharge
- send home with (pre)eclampsia return precautions

Antihypertensives in Pregnancy

1. **Labetalol**
   --Brand name: Normodyne, Trandate
   --MOA: Nonselective B-blocker and selective alpha-1 Blocker
   --Starting Oral Dose: 100 mg BID or TID
   --Max Oral Dose: 2400 mg/day
   --Starting IV Dose: 10mg. Double dose q10-min PRN until the desired blood pressure response is obtained.
   --Do not exceed 300 mg in 24 hours.
2. **Nifedipine**
   --Brand name: Procardia,
   --MOA: Calcium channel blocker
   --Starting Oral Dose: Initial 10 mg x 8 hours
   --Max Oral Dose: 120 mg (Procardia XL) once daily
3. **Hydralazine**
   --Brand name: Hydra-Zide BiDil

--MOA: Direct vasodilation of arterioles (with little effect on veins)
--Starting Oral Dose: 10 mg 4 times/day for first 2-4 days then increase by 10-25 mg/dose every 2-5 days
--Max Oral Dose: 300 mg per day. Note: Addition of another antihypertensive agent is preferable to increasing dosage beyond 100 mg because of poor patient tolerance.
--I.M., I.V.: 5 mg/dose. If no response after 20 mins, a bolus of 10 mg may be given. If no response after 20 mins, 20mg more may be given. The dose that proved effective will be repeated at 2-6 hour intervals.

4. **Methyldopa**
--Brand name: Aldoril
--MOA: Alpha-2 adronergic agonist, DOPA decarboxylase inhibitor
--Starting Oral Dose: 250 mg 2-3 times/day; increase every 2 days as needed
--Max Oral Dose: 3g/day

Postpartum patients with GDM

GDMA1 (diet controlled) & GDMA2 (medication controlled)
- Regular diet.
- will need 1 fasting CBG post partum; if <150, no further work up in house
- if fasting CBG >150, repeat the next day and ensure it is fasting; if sill elevated, consult senior resident
- order 2 hour GTT to be done at 6 wks postpartum
- send home with information about repeat GTT/GDM

Postpartum patients with T2DM

In general, can half dose of hypoglycemics (oral agents and/or insulin – basal and nutritional) post partum.
- ADA diet
- check fasting and 2h post prandial CBG
- consider use of insulin sliding scale for post prandial coverage and transition to scheduled dose prior to discharge if needed; goal <200
- Breastfeeding mothers will require more calories
- insulin, glyburide, metformin, glipizide are okay during breastfeeding
- **if pt has any of the following: tell your senior resident, see the patient, and get repeat vitals**

*** hypoglycemia <60, persistently elevated post prandial CBG >200, symptoms of infection, dyspnea, chest pain, tachycardia, new oxygen requirement, concern for DVT, syncopal episode, difficult to rouse or seizure like activity***

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OB/MFM protocols can be found at
http://unmobgyn.pbworks.com/w/page/83785075/FrontPage

ROB Hand off Report

__yo G_P_ s/p (LT)CS or SVD @ __ wks, on date/time
EBL, lac, Hct, any delivery complications
Gender/weight/apgars/
neonatal location (ICN3, NBICU, MBU)
Rh/Rubella/Breast or Bottle/PPBCM
PNC:
//

ROB HO1 Coverage

- The L&D HO1 is responsible for the postpartum service
- Each resident can see up to 5 postpartum patients; if there are an excess of patients on the ROB service at any given time after the OB and off-service interns have each seen 5 patients, additional rounding support can be provided by the Float HO1 or the L&D HO3. It will be the prerogative of the L&D HO1 to distribute patients and to alert the Float HO1 or L&D HO3 of the need for rounding help
- When the L&D HO1 is on vacation, ROB rounds will be covered by off-service residents and supervised by L&D HO3

Postpartum Inpatient Provider Progress Note

S: Ask all pts: Breast-feeding? (encourage). If you have questions or concerns about breast-feeding, consult with patient's nurse first. Pain? - Will have cramping pp that & with breast-feeding. Lochia? - Will have up to 6wks pp but < period. Ambulating/eating/urinating/defecating (or passing gas) birth control?
O: Vitals, HCT, CV, LNGS, ABD (fundal ht @ what cm below umbilicus, must feel it, must be firm). Examine c/s incision or any laceration. Include the Perinatal Lab template for GBS, Hepatitis, etc.
A: __YO G_P_ S/P NSVD/C/S for (reason)/forceps or vacuum delivery w/__ degree lac
P: Postpartum milestones, management of comorbid conditions, neonatal/lactation needs, need for rhogam/MMR/Tdap, PPBCM, follow up plans

Postpartum Orders

In PCO, select power orders and on home screen, refer to folder titled "Obstetrics"

- SVD:

- OB Postpartum Orders
- select q8h VS, choose PRN or scheduled tylenol or ibuprofen, add AM CBC PRN

- CS:

- OB Post C/S Orders + OB Post C/S Pain Medication Orders
- choose when foley removed, schedule Tylenol & ibuprofen (+24h if received duramorph) with PRN opiates at least initially

- $3^{rd}/4^{th}$ degree lac:

- Post delivery order set as above + scheduled Colace, miralax, and PRN opiates
- add Hurricaine spray, TID Sitz baths, and give Rx for tucks PRN
● GDM:
- Post delivery order set as above + AM CBG
● T2DM:
- Post delivery order set as above + fasting CBG + 2hr post prandial CBG + half of antenatal medications
- for insulin, use Insulin SQ Eating Adult and modify as needed
● gHTN, cHTN, PreE without SF:
- Post delivery order set as above + q4h VS
● PreE with SF
- Post delivery order set as above + q4h VS
- OB Pre-eclampsia or Hypertension and modify lab orders
● PPTL
- OB Postpartum Tubal Ligation (PPTL)

* Don't forget to do home med reconciliation*

Discharge Planning

- In Power Chart Office (PCO), complete "Depart"
  - fill out "Discharge OB General Custom" and add any additional patient education information needed
  - Prescribe discharge Rx and write discharge order
- D/C orders are written in the a.m. for all patients who are expected to leave that day.
- There is no one available to D/C a baby after hours. If there is <u>any</u> possibility of a mom going home late, let PEDS know during the day or put in discharge order "pending peds" in comment
- Attend multidisciplinary peds rounds daily at 0815 to communicate with pediatric service and nursing
- In general, uncomplicated patients s/p SVD can be discharged after 2 midnights in the hospital after delivery. Ah the earliest, NSVD patients can go home the 24h after delivery unless delivery was after 2000.
  - discharge with Colace, PNV, Ibuprofen and Tylenol
- C-section patients usually stay two to three days but in absence of other complications, can stay up to 4 midnights in the hospital after delivery
  - discharge with Colace, PNV, Ibuprofen, oxycodone and Tylenol; will be seen in 2wks for incision check
- PP tubal can leave when tolerating meal on same day as surgery as long as 24h s/p NSVD
  - discharge with Colace, PNV, Ibuprofen, opiates and Tylenol; will be seen in 2wks for incision check

- Add ferrous sulfate 325mg BID to TID if discharge Hct ≤ 30
- Add PPBCM if applicable; see below
- You DO NOT need to request 2 or 6 wk postpartum follow up visits; the appt center will do it automatically
- To send medications to the discharge pharmacy, they need to be sent THE DAY BEFORE anticipated discharge

Appointments

- To request a WHC or Eubank appointment, send a power chart message to: APPT.OBGYN-IMSG with the patient details
- To request a CRH appointment, fill out an ad hoc for the referral and send a message in power chart to: OBGYN-CRH-MSG

Birth Control

- cOCPs/ring/patch: Ask pt if she smokes or h/o HTN, history of blood clots, liver problems, migraines, smoker > 35 yr old; don't initiate until 6 weeks postpartum. Consult MEC for eligibility

Suggestions: Sprintec (pills) /nuva ring/xulane (patch)
Common SE: nausea, breakthrough bleeding

- POPs: consult MEC for eligibility, ok to start immediately after delivery

Suggestions: Micronor
Common SE: irregular menses, HA, nausea.

- Depoprovera: 150 mg IM q12 wks. (Consider not giving if infant preterm or other reason for NBICU admit until 4 weeks PP due to unsupported concerns of negative impact on breast milk.)

Common SE: Weight gain, menstrual irregularity

- IUD: If placed post placentally, need 2wk string check appt; eligible if pt has Medicaid or has grant device. If pt has commercial insurance, need appt at 6wks with PNC provider for placement. If pt is self-pay, consider referral to CRH for discounted device
- Nexplanon: May be placed prior to discharge if pt has Medicaid. If pt has commercial insurance, need appt at 6wks with PNC provider for placement. If pt is self-pay, consider referral to CRH for discounted device
  - for placement, will need 10cc 1% lidocaine, syringe, draw needle, 22G injection needle, betadine swabs, Nexplanon, krilex, alcohol, bandaid

ALL DISCHARGES SUMMARIES SHOULD BE WRITTEN WITHIN 48 HOURS OF DISCHARGE AND FORWARDED TO WARD ATTENDING

Sample Discharge Summary

There are a million variations on this. This one is a bit longer because of the GDMA1. Some

people go into more on the delivery. Essentially, you want to provide information relevant to those providing care in the future, especially immediate follow-up care.

Your Name:
Patient name:
Patient DOB:
Patient MRN:
Date of Admission:
Date of Discharge:
Attending Physician (on the day of discharge):
Diagnosis on Admission:

1. 32y.o. G3P2002 with an IUP at 37.3 weeks in active labor
2. GDMA1
3. Rubella non-immune

Hospital Course:
This is a 32 y.o. G3 now P3003 admitted at 37.3 weeks gestation in active labor. Her labor was augmented and she progressed to complete to deliver a live baby girl on 9/10/2007 at 1446. Baby girl weighed 3590 grams and had apgars of 8 and 9. A 1st degree laceration was noted and did not require repair. The patient's EBL for the delivery was 350 cc.

The mother's post-partum care has been uncomplicated. She has been meeting all of her post-partum milestones and was ready to be discharged home on post-partum day #1. The patient is breast feeding and will use oral contraceptives. The patient was noted to be Rubella non-immune and received a Rubella immunization prior to discharge. The patient's admit HCT was 37 and her post-partum HCT was 34. The patient's post-partum CBG was 87. On discharge, the patient is afebrile, her vital signs are stable, her lochia is appropriate, and her fundus is firm and at the umbilicus. She is discharged to home in stable condition.
Discharge Diagnosis:

1. s/p term SVD
2. s/p 1st degree perineal laceration not requiring repair
3. GDMA1
4. s/p Rubella immunization
5. If anemic (HCT<35), please note the cause i.e. expected acute blood loss post-partum.

Discharge Medications:

1. Ibuprofen 600 mg po q6 hours prn as needed for pain. Dispense: 30. Refills: none.
2. Sprintec 1 tab po qday for 28 days. Starting at ~4 weeks post-partum. Dispense: 1 month supply. Refills: 11.
3. Prenatal Vitamins 1 tab po qday for 30 days. Dispense 30 days. Refills: 3.

(Can also dictate "Please import from PCO")
Discharge Instructions:

1. Diet: Diabetic
2. Activity: as tolerated
3. Follow-up: at M&FP West Mesa in 4-6 weeks for routine post-partum check.

4. GDMA1: Patient to do 2 hour GTT at follow-up visit.
5. Contraception: Oral contraceptives starting at 4 weeks post-partum.
6. Routine precautions for bleeding, infection, post-partum depression, and other concerns given.
7. Support for breastfeeding and resources within lactation clinic for help.

This case was discussed with Dr. (Attending) who agrees with the assessment and plan.
Your Name:
Date of Dictation:

OB T&T (Testing And Triage) Basics
2-2460

- Anyone pregnant > 20 wks is to be seen in T&T
- Anyone who has established prenatal care with us can be seen in T&T
- Patients with a positive pregnancy test in ED and/or triage and vaginal bleeding may be transferred to T&T
- Anyone w/in 6 wks postpartum can be seen in T&T
- Any patient with trauma or unstable is to be evaluated and cleared by ED prior to transfer to T&T.
- Be sure to fill out the MSE form.
- Write name and pager on board, if not already there.
- Can present to HO2 or HO3 for work up of ddx or assistance with exams prior to staffing with attending
- All patients should be staffed with attending prior to discharge

Guidelines for Evaluation
The purpose of these guidelines is to optimize patient care and throughput in the Testing and Triage area while fulfilling the educational goals of the department for medical students and OB-GYN and off-service residents. All learners and staff should strive to create a positive environment for learning that balances optimal patient care with education.

- All "high risk" patients must initially be seen and evaluated by an HO2 or above from July-December.
- From January-June, an OBYGN HO1 may evaluate high-risk patients. All patients must be staffed with attending prior to discharge; if there are questions on differential or work up, discuss patient with HO2 or above
- Medical students and OB/off-service interns may observe the initial evaluation and may complete the encounter (e.g., admission H&P) at the direction of a resident.

High risk is defined as:
- EGA 23 to 37 weeks
- Maternal transport
- Severe bleeding and/or pain
- Suspected severe pre-eclampsia

- Other severe maternal disease
- First/second trimester bleeding being seen for the first time
- Patients being treated with methotrexate

Uncomplicated term patients (> 37 weeks) may be evaluated initially by a HO1 (of any service). All patients seen by an off-service HO1 need to be presented to an OB-GYN HO2 or above prior to discharge

Off-service interns may not perform any procedures without supervision by an OB/GYN resident/attending, including ultrasound examinations.

Medical students are encouraged to participate in all aspects of patient care. The following guidelines apply to medical students in Triage:

- Students may participate in the first contact with a patient in Triage only when accompanied by a resident or attending physician.
- Students may perform procedures (e.g., SROM exam, ultrasound) only when accompanied by a resident or attending physician.
- After the initial contact, students may independently take a history and do the physical exam, except for the pelvic exam, as instructed by the resident or attending physician.
- Pelvic exams must be directly supervised by a resident or attending. The resident or attending must then confirm the key portions of the H&P and document appropriately.

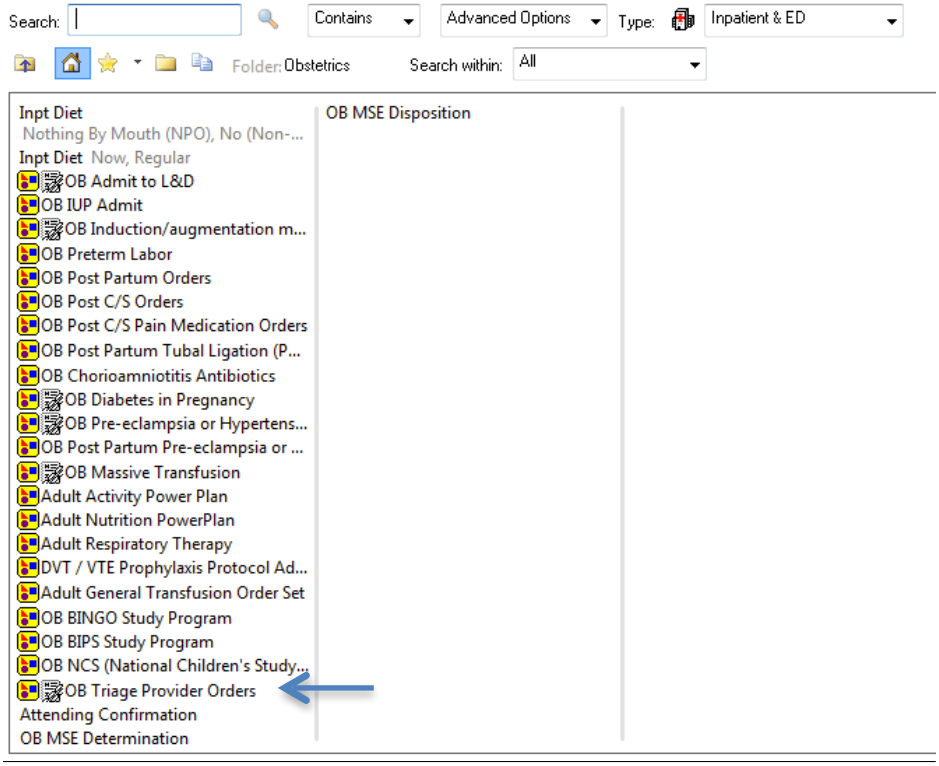
TRIAGE NOTE

- Initial statement for presentation and dictation
  ___YO G_P_@____wks GA by (LMP c/w _ wk U/S;
  Sure LMP/ no U/S; unsure LMP __wk U/S, etc)
  C/o _____
- Ask everyone: Contractions? Vag. Bleed? ROM?
  + fetal movement (+ fmvt if >20 WGA)
- If high BP or face/hand swelling
  Ask: Headache? Resolved w/Tylenol? Visual changes? (describe)
  RUQ/epigastric pain? Face or hand swelling?
- When d/c from T&T always write under "plan" Section
  - "labor precautions" (vag bleed, ROM + FMVT,)
  - "Fetal kick counts stressed" (FKC) (means ≥ 8 MVTS in 2 hours. Done once a day at time baby moves most. If < 8, then try again after eating/drinking something – counting is done once 8 MVTS felt) if ≥ 28 wks
  - Document scheduled follow-up

**** Please Note: you are responsible for following up any labs you order with the patient whether ordered on day or night shifts. ****

OB Triage Orders

- Every triage patient needs ONE "OB Triage Provider Orders" Power Plan
    - The plan must be initiated to complete the MSE (medical screening exam) determination
    - The plan has common orders separated by chief complaint; use those orders as you are able



Every triage patient will need a DISCHARGE ORDER to complete the MSE disposition unless they are admitted at which point an admission order (in a separate power plan) will suffice.

Common complaints and their work up

1.First TM VB (r/o ectopic/PUL)
[ ] NIPS (CBC, HCG, T&S)
[ ] Speculum exam
[ ] bimanual exam
[ ] rhogam if Rh neg
[ ] US (either DI or BSUS) for pregnancy location
➔ if PUL; add to beta book + ectopic precautions
➔ if SAB; counsel on options + bleeding precautions
➔ if IUP; request prenatal care/follow up + bleeding precautions
➔ if ectopic; counsel on management options as pt is eligible (MTX vs lsc)

2.Second or Third TM VB
[ ] review pt chart for risk factors (EX: drug use, cervical dysplasia, abnormal placentation,

trauma, or contraindications to SVE – previa – etc)
[ ] NST if > 24 WGA
[ ] US for LVP/AFI, placental location/abruption and fetal presentation
[ ] speculum exam for STD amp, wet mount, vaginal pathogen panel
[ ] SVE if no previa
[ ] rhogam if Rh neg; consider Kb stain
➔ Placental bleeding: (abruption, previa) admit for obs vs delivery pending fetal/maternal status
➔ Work up rectal bleeding, hematuria, or cervicitis; manage as needed + bleeding precautions

3.PPROM: LOF <34 WGA
[ ] NST
[ ] US for LVP/AFI & fetal presentation
[ ] speculum exam (no gel) for nitrazine, ferning, pooling
[ ] collect regular GBS if needed
** NO SVE until PPROM excluded **
➔ PPROM confirmed: admit to MFM for latency abx and ANCS
➔PPROM excluded: work up preterm labor, vaginal discharge urinary incontinence, etc

4.PPROM: LOF 34-37 WGA
[ ] review pt chart for risk factors (EX: cerclage, TIUP, or contraindications to SVE – previa – etc)
[ ] NST
[ ] US for LVP/AFI & fetal presentation
[ ] speculum exam (no gel) for nitrazine, ferning, pooling
[ ] collect regular GBS if needed
SVE if no previa
➔ PPROM confirmed: admit to L&D for delivery; discuss late preterm ANCS
➔PPROM excluded: work up preterm labor, vaginal discharge urinary incontinence, etc

5.SROM/PROM: LOF >37 WGA
[ ] review pt chart for risk factors (EX: cerclage, TIUP, or contraindications to SVE – previa – etc)
[ ] NST
[ ] US for LVP/AFI & fetal presentation
[ ] speculum exam (no gel) for nitrazine, ferning, pooling; false positives (urine, BV, sperm, blood, saline)
[ ] collect rapid GBS if needed
[ ] SVE if no previa
➔ ROM confirmed: admit to L&D for delivery
➔ ROM excluded: work up labor, vaginal discharge urinary incontinence, etc

SROM TESTS	False Pos.	False Neg.
History	12%	9%
Nitrazine	17%	9%
Ferning	1.5%	13%

6.Decreased fmvt and EGA 28+ wks
[ ] 20 min reactive NST
[ ] adequate LVP/AFI
➔ both reassuring: discharge home
➔ non-reactive NST and/or oligo: check CBG, consider vibro-acoustic stimulation or discuss prolonged monitoring with HO2 and/or attending

7.Rule-out Preterm Labor: contractions <37 WGA
[ ] review pt chart for risk factors (EX: history, TIUP, or contraindications to SVE – previa – etc)
[ ] NST
[ ] US for LVP/AFI & fetal presentation
[ ] UA/Cx if indicated
[ ] UDATR
[ ] speculum exam for STDamp, Vaginal Pathogen Pane +/- wet mount
[ ] consider ffN if <32 WGA (no gel on speculum and no recent intercourse) +/- cervical length if <28 WGA
[ ] collect regular GBS if needed
[ ] SVE if no previa (repeat in 2h if dilated)
➔ Preterm labor: (2cm and/or 80% effaced cervix or UCs w/cervical change) admit to L&D for obs, ANCS if eligible, tocolysis if eligible
➔ No change in SVE or not dilated: work up other causes of pain prior to discharge with dx of POOC (premature onset of contractions)

8.Rule-out Labor: contractions >37 WGA
[ ] review pt chart history (prior CS, TIUP, or contraindications to SVE – previa – etc)
[ ] NST
[ ] US for LVP/AFI & fetal presentation
[ ] collect rapid GBS if needed
[ ] SVE if no previa
➔ Active Labor, requesting pain control, concerning maternal or fetal factors: admit to L&D for delivery
➔ Not in labor/early latent labor: discharge walking vs home in consultation with HO2 or above or attending

9.Rule-out labor < 23 wks - No NST needed – Doppler or TOCO if have cramps/UCs and document fetal heart tones.

10.Abdominal Trauma <24 WGA
[ ] doptones
[ ] US for fluid, fetal presentation and placenta
[ ] Rh status with rhogam if bleeding
➔ if reassuring work up, discharge with return precautions and close follow up
➔Must be cleared by ER/Trauma before transfer to L&D or T&T

11.Abdominal Trauma >24 WGA
[ ] NST
[ ] US for LVP/AFI, placental location, fetal position
[ ] Rh status with rhogam if bleeding
[ ] consider coags if bleeding (PT/PTT/CBC/fibrinogen)
[ ] work up for labor if contracting
➔ All patients must be monitored for at least 4 hours, with subsequent monitoring per MFM Protocols up to 24h from incident; if <1 contraction per hr, likely ok to discharge if otherwise reassuring
➔Must be cleared by ER/Trauma before transfer to L&D or T&T

12.Methadone start
[ ] COWS; repeat q2-4h PRN
[ ] UDATR +/- chem10 and LFTs if considering subutex
[ ] EKG for QTc
If pt is in custody or past age of viability, admit for methadone titration otherwise can do as outpatient

13.Post Partum Fever: T > 38.0 x 2 at least 24 hours after delivery, or > 38.5 x 1, even in the first 24 hours
[ ] Ddx: Wind, Water, Womb, Walking, Wound, Wonder Drugs
- Atelectasis/ PNA/ Viral URI (wind)
- Mastitis/ endometritis / (womb)
- UTI (Water)
- Thrombophlebitis/ DVT (walking)
- wound infection (wound)
- misoprostol fever (wonder drug)

[ ] consider blood/urine/wound Cx pending history
➔ Antibiotics for Endometritis: gent 2.5 mg/kg load, then 1.5 mg/kg q8h + clinda: 900 mg q8h or unasyn: 3g IV load then 1.5g IV q6h

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Pregnant And Bleeding

OS OPEN:
tissue passed = incomplete ab
no tissue = inevitable ab

OS CLOSED:
threatened ab vs. complete ab

no fetal cardiac motion, os closed = missed ab
any of the above with fever and uterine tenderness = septic ab
If the os is open or if the patient is septic, she needs to have a D&C emergently.

Complete abs are tricky -- give bleeding precautions and follow hCGs. If the hCG drops normally over the first two days, have her follow-up in one to two weeks. If not a normal drop, do a D&C and check for villi or you could miss an ectopic. In general, these patients should be added to the beta book and follow-up in the Center for Reproductive Health.

Missed abs, even with bleeding, are not an emergency unless HCT is dropping or os is open. . These patients can be seen same-day or next-day at CRH. Call 925-4455 to schedule. **DO NOT** schedule for weekends or night-time, when the OR is staffed for emergencies only. Surgery in the Main OR at UNM is more expensive than at OSIS is more expensive than CRH. A manual vacuum aspiration (MVA) may be performed in Triage or ER only for incomplete ABs requiring urgent evacuation.

OTHER USEFUL INFO:

- A gestational sac should be seen on vag transducer ultrasound by hCG 1500-2000, and on abdominal ultrasound by hCG 6000.
- In a normal pregnancy, hCG should show $\geq$ 66% rise in 48 hours up to 10,000 (after that it doubles more slowly but you can see IUP on U/S).
- DO NOT FORGET TO CHECK RH ON ALL PREGNANT BLEEDING PATIENTS!
- Septic ab is rare -- ask about instrumentation.
- Threatened ab in a woman in whom FHTs have never been heard or seen -- 50% loss rate. In a woman in whom FHTs have been seen or heard at some point, loss rate is only 5%. But... check the os before you check for FHTs because if it is open, you may need to do a D&C.
- 1/3 of ectopics will show a NORMAL rise in hCG
- After any procedure short of salpingectomy should follow hCGs to 0 (as can recur in tube)
- Consider pt for methotrexate (see protocol)
- Put pt in the beta book and have pt follow-up in your PCC clinic or at the CRH.

H&P for admission to L&D or MFM

HPI: CC, onset, duration, aggravating/alleviating factors, associated sx

- Prenatal care: location, WGA at initiation, provider, pre-pregnancy weight, first TM BP
- Dating: LMP, final EDD, review of every US
- Problems this pregnancy: EX: UTI, fetal anomalies, maternal co-morbidities

PMH, PSH, OBHx (years, complications, outcomes of each pregnancy), GYNHx (menarche, regular or irregular menses, STD hx, pap smear hx, fibroids endometriosis, contraceptive hx)
Review and update home meds and allergies
Family hx, social hx

Physical Exam: VS, CV, Pulm, Abd and Pelvic exam +/- SVE and US (transabdominal vs transvaginal) as appropriate

Labs: =labperinatalmat

UNM RAPID GROUP B STREP TESTING GUIDELINES

Indications

1. Women who will be admitted to UNM Labor and Delivery at ≥ 37 weeks in labor and/or SROM without GBS test result from > 35 weeks gestational age. Perform Rapid GBS even if delivery is imminent.
2. Women admitted in preterm labor or PPROM (< 37 weeks) without known GBS status, should have routine GBS swab and prophylactic antibiotics for GBS or PPROM antibiotics NOT rapid GBS.

Labor and Delivery Management

Defer starting intrapartum antibiotics for GBS prophylaxis if rapid GBS pending until GBS known. Give first dose of antibiotic as soon as possible if delivery within 6 hours appears likely. Discontinue antibiotics if rapid GBS negative.

Approved 3/07 UH MCH Committee and Medical Directors of Labor and Delivery and Mother Baby Unit with subsequent revisions based on 2010 CDC GBS Guidelines.

Diagnostic OB Ultrasound Exam

1.Always perform a "general survey" to assess fetal position, placenta location and presence of heart motion.
2. Assess AFI/LVP
3. Comprehensive exam should be performed with supervision until competencies have been completed. This will not happen until the end of the diagnostic ultrasound rotations have occurred. For competencies and details of exam, see U/S Section.
4. U/S transducers must be cleaned per protocol and US exam must be documented in OBT encounter note

5. O

WHAT YOU SEE WHEN?

MA	Approximate Sac size	Yolk Sac Seen	CRL Measurable?	EHM/ FHM Seen?	Amniotic Membrane Seen?
5 wks	1 cm	NO	NO	NO	NO
6 wks	1.5 cm	YES	NO	YES	NO
7 wks	2 cm	YES	YES	YES	NO
8 wks	3 cm	YES	YES	YES	YES
9-11 wks	4-5 cm	YES	YES	YES	YES
12 wks	6 cm	NO	YES	YES	YES

Table describing general expectations of sonographic findings from week 5–12 MA.