What’s New From ACOG 2012

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Disclosures

• I was on the ACOG Executive board and the ACOG Practice Bulletin Committee for OB (2004-2012)

Objectives

• Define severe hypertension in pregnancy
• List the 2 first line drugs to use to manage acute severe hypertension
• Know the correct timing of prophylactic antibiotics for all cesarean deliveries
• Know the TDAP recommendation for pregnant women

Levels of evidence for ACOG

• A based on good and consistent scientific data
• B based on limited or inconsistent scientific data
• C based primarily on consensus and expert opinion
Influenza Vaccine in Pregnancy

- Pregnant women have excessive morbidity and mortality from flu (H1N1 data, Louie)
- Increased with co-morbidities
- CDC: all women pregnant October-May should get inactivated vaccine ANYTIME in pregnancy
- Only way to reduce flu in < 6 month old infants

Louie NEJM 2010;362:27

CO October 2010

Flu Vaccination

- No adverse effects to mother or babies of inactivated vaccine reported
- Thimerosal (mercury containing preservative in multidose vials)
  » Only adverse report is occasional skin irritation
  » No evidence that it causes any adverse effect in children

H1N1 in Pregnancy

- CA 2009 cases pregnancy, pp.(102) nonpregnant women (137)
- 38% false negative rapid tests
- Lack of rapid treatment (> 48 hrs) sig associated with more ICU adm, more deaths
  » Only 50% pregnant pts got early treatment
  » No deaths got early treatment
  » 8% pregnant women died

Louie NEJM 2010;362:27

Immunization Update

- Increase in Pertussis in US
  » Ca > 9000 cases in 2010 (1/3 of total US)
- CDC recommends TDAP in pregnancy
  » Tetanus toxoid, reduced diptheria toxoid, acellular pertussis vaccine
  » Give in pregnancy or postpartum

www.cdc.gov/vaccines

CO 521 March 2012
Emergent Antihypertensive Therapy

- **Hypertensive emergency**
  - SBP > 160 or DBP > 110
  - Lasting > 15 min
- **Untreated associated with**
  - Cerebral infarction or hemorrhage
  - Systolic hypertension likely higher risk for stroke
    - 27/28 women with stroke had systolic hypertension
    - 4/28 had diastolic hypertension

CO 514
Dec 2011
Martin OG 2005;105:246

General Therapy Recommendations

- **Have order set or guidelines**
- **Goal:** achieve BP 140-160/90-100
- **Stabilize before any surgical interventions**
- **Close maternal/fetal monitoring**

Labetalol (alpha and beta blocker)

- 20 mg IV over 2 min
- Repeat BP in 10 min if still elevated 40 mg
- Repeat in 10 min, if still elevated 80 mg
- Repeat in 10 min, if still elevated switch to hydralazine (10 mg IV over 2 min)
- Repeat in 20 min if still elevated consult
- Once BP stable repeat q 10 min for 1 hr, q 15 min for 1 hr, then q 30 min for 1 hr, then q 4 hr

Hydralazine (smooth mm relaxant)

- 5 or 10 mg IV over 10 min
- Repeat in 20 min if still high 10 mg IV
- Repeat in 20 min if still high switch to labetalol 20 mg IV
- Repeat in 10 min if still high 40 mg IV and consult
Chronic Hypertension

- Mild: 140-159/90-109
- Severe: >160/110
- Pre or early pregnancy w/u
  - Determine end organ involvement and baseline for preeclampsia assessment
  - Renal fx, EKG, echo, ophthalmologic exam
    - Cr, bun, 24-hr protein, pc ratio

Who to Treat in Pregnancy

- >150/100
  - Goal: keep BP less
  - Treatment reduces risk severe htn only
- If end organ damage treat at lower levels
  - Goal < 140/90
- “reasonable to withhold .. Therapy in mild hypertension”

Appropriate Medications

- Labetalol (200 – 2400/dy)
- Nifedipine (30-120/dy)
- Methyldopa (0.5-3.0g/dy)
- Hydralazine (50-300/dy)
- HCTZ (12.5-50/d)

Contraindicated in Pregnancy

- ACE inhibitors
  - Underdeveloped calvarium, cvs abnormalities
  - Renal dysgenesis
  - Pulmonary hypoplasia
  - Iugr, demise, neonatal renal failure, iufd
- Angiotensin receptor blockers
  - Renal abnormalities, dysmorphia, iufd
Fetal Surveillance, Delivery

- No consensus on antenatal testing
  - Morbidity related to iugr, preeclampsia
- Should evaluate for fetal growth
- Delivery
  - Uncomplicated: term
  - No meds: 38 – 39 wks
  - Controlled on meds: 37 – 39 wks

Ch Hypertension Level A

- ACE inhibitors, angiotensin receptor blockers contraindicated

Ch Hypertension Level B

- Severe hypertension with acute elevation BP require medication
- Labetalol good option for first line rx
- Atenolol not recommended
- Thiazide diuretics does not need to be discontinued in pregnancy

Prophylactic Antibiotics in L+D

- Resistance risks since 1991
  - Increase in E. coli neonatal sepsis
  - Increase in amp resistance
  - Increase in GBS resistant to erythro, clinda

PB 120 June 2011
Cesarean Delivery

- All CD within 60 min of skin incision
  - Multiple studies sig decrease fever, wound infections, endometritis
- Must cover gram positive, gram negative, anaerobes
  - Cefazolin (1 gm), cefoxitin,
  - Single dose as efficacious as multiple
- Give BEFORE cord clamping

Antimicrobial Prophylaxis for Cesareans

- Previously gave after cord clamping
  - Antibiotics may mask neonatal blood cultures
  - Fetal exposure could increase colonization/infection with antibiotic resistant bugs

ACOG CO 9/2010

CO 2010

- Surgical data
  - Reduction surgical infections lowest when AB given 30 min – 120 min before skin incision
  - Want bactericidal serum levels adequate by skin incision and maintained
  - Why withhold appropriate surgical management from pregnant women?

Antibiotic Prophylaxis

- RCT ancef 1 gm IV 15-30 min pre surgery vs. post cord clamping
- Endometritis 1% vs. 5% sig
- Wound infection ns
- Total infection: 4.5 vs. 11.5% sig
- No diff in neonatal sepsis, nicu or resistant orgs
- Similar results in another 2005 study
  - Sullivan ajog 2007;196:455
Antibiotic Prophylaxis Recs

- No data that preop admin Is harmful
- RCT data that reduces endometritis
- All cesareans (not already on appropriate antibiotics) give preop prophylaxis within 60 min of start

MRSA Positive

- “…consideration may be given to adding a single dose of vancomycin to recommended antibiotic prophylaxis”

Cerclage, Manual Placenta Removal

- Insufficient evidence to recommend antibiotic prophylaxis

Cefazolin

- 1 gm IV therapeutic level maintained for 3 – 4 hours
- Covers gram pos, gram neg, anaerobes
  » Consider repeat in long cases
  » ? Need higher dose for obese women
- Clinda/gent good choice for serious pcn allergic reaction
Level A

- All CD should receive within 1 hour of skin incision
- For CD single dose, first generation cephalosporin is first line choice
- Indicated for PPROM
- Should not be used PTL (except GBS prophylaxis)

Induction of Labor Patient Safety Checklist

- New ACOG efforts
  » Has already replaced 1st one (nov 2011)
- To use for scheduling labor induction
- Has “how to use this checklist”
  » Completed by health care provider
  » Hospital should establish procedures to review appropriateness of induction
  » Hard stop should be called for questions

Pregnant/Postpartum Incarcerated Women

- 6-10% incarcerated women pregnant
- High risk for HIV, substance abuse, depression
- Correctional officers do not need to routinely be present in exam rooms
- Avoid separating mother from newborn

Restraints

- “any physical restraint or mechanical devise to control movement of prisoner’s body..”
- 2007: US Marshals Service policy: “restraints should not be used when a pregnant prisoner is in labor, delivery or in immediate postdelivery recuperation.”
- 2008: FB Prisons stopped routinely shackling pregnant women
- State, local prisons do not have to comply
  » 36 states still fail to limit restraints in pregnancy
ACOG Recommendations

- OB GYNs should support efforts to improve health care incarcerated pregnant women
  - Advocate restriction of shackling
  - Work to provide services to pregnant incarcerated women

Disclosure/Discussion Adverse Events

- Patients expect/want timely and full disclosure
  - Acknowledge responsibility, expressions of sympathy, discussion of what is being done to reduce recurrence
- Patients more likely to sue if perceive lack of honest disclosure, suspicion of cover up
- Disclosure assoc with improved recovery, less likely to sue, reduced

Disclosure

- Joint commission requires accredited hospitals to inform pts of adverse events
  - Who
  - What
  - When
  - Where
  - How

Who

- Attending, at least 2 members health care team; additional
- What: after investigation, only factual
- When: timely even if do not have all information yet
- Where: quiet, confidential space
- How: include empathy, respect dignity, appropriate regret
Intimate Partner Violence

- Most prevalent among reproductive age women
- Physical abuse, psychological abuse, sexual violence, reproductive coercion
- > 1/3 US women experienced rape, physical violence, stalking by intimate partner
- In 2007 IPV caused 2340 deaths
- 324,000 US pregnant women abused per yr
- 250,000 hospital visits/yr from IPV

ACOG Recommendations

- IPV screening should be done first prenatal visit, q trimester, postpartum
- Screen in private, safe setting
- Offer framing statement that it is standard part of visit
- Establish relationships with community resources
- Have materials available
- Have staff training

Resources

- ACOG has sample screening questions
- Reporting of abuse to children is mandatory
- Most states do not mandate reporting IPV
Other Resources

- National Domestic Violence Hotline
  » 800-799-SAFE
- National coalition against domestic violence
  » www.ncadv.org

Management of Preterm Labor

• Level A recommendations
  » Single course corticosteroids rec 24 – 34 wks at risk for preterm delivery
  » Magnesium sulfate for neuroprotection before 32 wks; should have guidelines
  » First line tocolytics: beta agonist, calcium channel blockers, NSAIDs for 48 hrs to allow administration steroids

PTL Level A Recommendations

• Maintenance therapy with tocolytics ineffective, not recommended
• Antibiotics should not be used to prolong gestation or improve neonatal outcome in PTL, intact membranes

PB 127 June 2012

PTL Level B Recommendations

• Single course repeat steroids should be considered for women whose prior course was at least 7 days ago and are < 34 wks
• Bed rest, hydration not effective for prevention PTB and should not be recommended
• Positive predictive value of postive ffn is poor and should not be used exclusively to direct management
Management GDM

• Use 1 hr 50 gm load, 3 hr 100 gm f/u
• Not recommending IADPSG 2 hr 75 gm test
  » 17.8% would have GDM
  » Insufficient data for efficacy of treatment
  » Large increase in cost
  » “no evidence exists using these criteria would lead to clinically sig improvements in maternal or neonatal outcomes and would lead to increased cost”

PB 129 aug 2012

Oral Hypoglycemics

• Glyburide
  » Sulfonylurea increases insulin secretion and sensitivity
• Metformin
  » Biguanide inhibits hepatic gluconeogenesis and glucose absorption
• Both can be considered in women with GDM

Level A Recs GDM

» Women with GDM should be treated with diet and medication when necessary
» When pharmacologic treatment necessary insulin or oral medications equivalent in efficacy so either can be first line

Proposed Performance Measures PB

• PTL: proportion of women with PTL < 34 wks who receive steroids
• Chronic hypertension: documentation of discussion of risks, baseline proteinuria, plan for evaluation of fetal growth
• Prophylactic antibiotics: none
• GDM: percentage of women with GDM who received postpartum screening