Special Recommendations in High-Risk Prenatal Care

PART ONE

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2025 COLORADO PERINATAL SUBSTANCE USE DISORDER INTEGRATION CONFERENCE, AVON, CO

Hosted by: Practice Innovation Program
UNIVERSITY OF COLORADO
ANSCHUTZ MEDICAL CAMPUS

INTEGRATED CARE
FOR WOMEN AND BABIES

Disclosures

None

Disclaimers

Not ALL of the following recommendations have formal references or society recommendations.

There is still a significant amount of prenatal care that is based on historical delivery and/or local standard of care.

For High-Risk Pregnancy that standard is typically set by local Maternal Fetal Medicine (MFM) recommendations.

Objectives

- Briefly review evidence-based, routine prenatal care updates
- Work through recommended additions to care based on common pre-existing medical conditions such as:
  - Diabetes
  - Chronic HTN
  - Obesity and s/p Bariatric Surgery
  - Thyroid Disease

Routine Prenatal Care

	PNC				Fu Labs	Antental Testing			Delivery Plan	RISK Factors
	Labs	*US Plan*	*Medication*	*Referral*		*Start*	*Frequ*	*Type*		
Routine	Prenatal Panal (CBC, Bld Type, Rh, Antibody screen, rubella, RPR, Hep B), Varicella, HIV, GC/CL, *A1C*, **Hep C**, Urine (cx, *UDM*). Pap if indicated.	Dating . Anatomic (18-22 wks)	PNV	N/A	1 hr GTT at 24-28 wks	41 wk . (39 wk if first US ≥ 22 wks)	twice weekly	mBPP (NST+AFI)	Recommend IOL at 41 wks, test if 41-42 weeks, refer to MFM by 42 wks if pt refuses IOL	for late term: stillbirth, macrosomia, CPD

Routine Prenatal Care

Labs

- CBC
- Blood Type, Rh, & Antibody
- Rubella
- RPR vs TPA
- Hep B
- HIV
- Urine Cx
- Gc/Ct

Often Missed "NEW" Additions

- Hep C
- Varicella
- A1C

What is not here?

- Urine Toxicology
- TSH
- Pap

Routine Prenatal Care

Ultrasounds
- Dating
- Screening Anatomic

Screenings
- Mental Health
  - PHQ9, GAD7, CIDI
- Substance Use
  - 5Ps
- IPV *USPSTF B*
  - *E-HITS*

Other Labs

GTT

RPP at 28 wks & Delivery*

ACOG PA 2024

Antenatal Testing if PostDates

2x/wk mBPP at 41 wk

*(*39 wks if first US >22 wks)*

Referral

MFM by 42 wks if IOL refused

A little more information . . .

Rh status is NOT antibody status!

- No longer indicated for 1st trimester bleeding *Dec 2024 ACOG CPU*

TPA is the preferred initial screen for Syphilis.

- If +, an RPR w/ quant is performed and TPPA

Hepatitis - *Sept 2023 CPG*

- HBsAg universal *(SR, MQ)*
- Triple Panel screening (HBsAg, anti-HBs, and total anti-HBc) *(SR, LQ)*
  - If > 18 y/o and don't have the above documented as -
  - Anyone who hasn't completed the vaccine series
  - Those w/ ongoing risks of infection regardless of testing hx or vaccination status
- HepC virus antibodies *(SR, LQ)*

Varicella

A1C - Risk-based (*USPSTF)*

- Obesity
- hx of gDM or DM
- family hx of gDM or DM
- Ethnicity (Hispanic, Native American, South or East Asian, African American, Pacific Islander)

And now . . . the fun stuff

DIABETES

	PNC				Fu Labs	Antental Testing			Delivery Plan	RISK Factors
	Labs	*US Plan*	*Medication*	*Referral*		*Start*	*Frequ*	*Type*		
hx gestDM	A1C on intake screens for pregestational diabetes	routine	routine	N/A	Routine 1 hr	Routine	Routine	Routine	Routine	70% w/ gDM have DMII w/i 20 years, latino --> 60% develop w/i 5 yr
A1 gDM (diet controlled)	n/a	n/a	n/a	N/A	check 2hr GTT at 4-12 wks PP	Routine (unless other risk factor then treat like A2)			Routine	Increased congenital malformations (2-6x), cns malform 10x inc., 5x inc in heart malf; fetal macrosomia, fetal hypoglycemia, fetal RDS
A2 gDM (well controlled)	n/a	n/a	metformin vs insulin	N/A		32 wk 32 wk	q 4 wk weekly	growth US NST	39w0d - 39w6d	
A2 gDM (poorly controlled)	n/a	n/a	insulin vs metformin	MFM ENDO		32 wk 32 wk	q 4 wk 2x/wk	growth US NST	37w0d - 38w6d *(per MFM)*	
preexist PRE-DM		n/a	metformin?	nutrition	early 1 hr	-	-	-	routine	
preexist Type 2 - controlled (A1C ≤ 7)	CMP, 24 hr urine	Dating . Anatomic *(per MFM)*	ASA* *Cont metformin if already on & controlled*	MFM Endo Optho q trm	repeat CMP, 24 hr urine and prot/cr ratio q 1-3 months	28 wk . 32 wk	q4 wk . 2x/wk	growth US . NST	39w0d - 39w6d	
preexist Type 2 - Uncontrolled (A1C > 7)	CMP, 24 hr urine, prot:cr	Dating Anatomic @ MFM (+ fetal echo)	ASA* . *intensify insulin therapy*	MFM Endo Optho q trm **TRANFER CARE**		28 wk . 28 wk	q 4 week . 2x/wk	growth US @ MFM NST	per MFM	
Type 1	CMP, 24 hr urine, prot/cr ratio, TSH	Dating . Anatomic @ MFM (+ fetal echo)	ASA*	MFM Endo Optho q trm ***Transfer based on control***		28 wk . 28 wk	q 4 week . 2x/wk	growth US @ MFM NST	per MFM	

A little more information . . .

Pre-existing PREDIABETES

- No existing ACOG guidelines
- Standard early Intervention
  - Metformin if you would start it in absence of pregnancy
  - Diet, weight gain recommendations, exercise
  - Nutrition referral
- May 2024 - American Journal of Perinatology
  - "Even in patients with multiple risk factors, early screening for GDM does not improve outcomes."

Early Glucose Tolerance Testing Reminders

- 50g (1 hr) at the time of diagnosis
- If NORMAL - repeat at 24-28 weeks
- If Elevated → 100g (3 hr)
  - If Normal → Repeat ONLY the 3 HR at 24-28 wk

Post Partum

- 75g (2hr) GTT at 4-12 wks due to high incidence of Type 2 DM

Hyperglycemia

- Hyperglycemia can be teratogenic, especially prior to 10 wks gestation
- Hospitalization is indicated for IMMEDIATE glycemic control w/ insulin drip if A1C > 9
  - Detailed anatomic US by MFM w/ fetal echo

"Control"

- A1C goal < 7
- Fasting (<95), 1 hr PP (<140) OR 2 hr PP (120), HS (<110)
  - Looking for 90+% to be in range each wk
  - Rapid advancement of medical management due to potential impact on fetal growth daily

Aspirin

ACOG CO update 2023

Recommended if high risk for preeclampsia (or multiple moderate risk factors)

HIGH
- ★ Hx of preE
- ★ multigestation
- ★ cHTN
- ★ DM
- ★ CKD
- ★ AI

MODERATE
- ★ Nulliparity
- ★ Obesity
- ★ Fam Hx preE
- ★ AMA
- ★ hx of LBW/SGA, adverse preg, >10 year interval
- ★ Sociodemographic characteristics

81mg PO daily starting at 12-28 wks (< 16 wk optimal)

NOT indicated for solely: stillbirth, FGR, PTB, EPL

keeping it going

HYPERTENSION

ACOG PBs 2019/2020

	PNC				Fu Labs	Antental Testing			Delivery Plan	RISK Factors
	Labs	*US Plan*	*Medication*	*Referral*		*Start*	*Frequ*	*Type*		
HTN							*continue ASA until delivery*			
Chronic	CMP, prot:cr, 24 hr urine protein	Dating Anatomic by MFM	ASA*	MFM	Check BP 1-2 wks PP . yearly post partum BP, lipids, FBG, & BMI	32 wk . 28-32 wk	twice weekly . monthly	mBPP . growth US	38w0d	superimp preE (14-28%) -->plac abruption, FGR, PTD.
hx preE or HELLP	CMP, prot:cr, 24 urine protein	Routine	ASA*	MFM if + hx in ≥ 2 pregs					Routine	21% chance of having in sub preg. -Increased risk for: PTL, FGR, abruption, fetal demise
pre E w/o SF & gHTN	N/A	N/A				32 wk @ dx @ dx	2x/wk weekly 2x/wk	mBPP Plt/LFT/ur pro office BP's	37w0d	*OP management ok b/w 32 and 37 wks if BP < 155/105*

A little more information . . .

Pre Pregnancy Eval
- End organ evolvement (level C)
- Secondary (11-14%)
- Optimize comorbidities
- Optimize control

Medication Review
- AVOID ACE inhibitors and ARBs
- fetogenic (renal dysgenesis, calvarial hypoplasia, FGR)

Superimposed preE on cHTN
- Occurs in 20-50% of patients
  - 5x higher than baseline population
- Difficult to diagnose
  - sudden increase in baseline or proteinuria
  - preE labs

Eval for Heart Disease
- Poor control > 4 yrs, > 30 y/o
- EKG +/- Echo

"Control"
- No benefit to tight control
- Initiate at 160/110* (level B)
- Labetalol and Nifedipine are 1st line (level B)

Delivery
- cHTN 38 wks+ if not on medication (37 wks+ if on meds) *level A*
- at 37 wks if superimposed or preE/gHTN w/o severe features l*evel A*
- 34 wks + if superimposed preE w/ severe features *level B*

Box 1. Risks of Chronic Hypertension in Pregnancy

Maternal	Fetal and Neonatal
• Death	• Stillbirth or perinatal death
• Stroke	• Growth restriction
• Pulmonary edema	• Preterm birth
• Renal insufficiency and failure	• Congenital anomalies (eg, heart defects, hypospadias, esophageal atresia)
• Myocardial infarction	
• Preeclampsia	
• Placental abruption	
• Cesarean delivery	
• Postpartum hemorrhage	
• Gestational diabetes	

Aspirin for everyone!

another doozy

Obesity

ACOG PB June 2021/2025

	PNC				Fu Labs	Antental Testing			Delivery Plan	RISK Factors
	Labs	*US Plan*	*Medication*	*Referral*		*Start*	*Frequ*	*Type*		
Obesity										
pregravid BMI 30-35	CMP, prot:creat	routine	consider ASA if > 2 moderate risk factors for preE	routine		26 wk	q 6 wk	growth US	Routine	DM, gDM, preE, medically indicated PT delivery, twin, post date gestation, OSA, labor dystocia, CSX, macrosomia, congen abnml, stillbirth, VTE, PP infection
pgBMI 35 - 40		Anatomic?		MFM for imaging based on shape		26 wk . 36 wk	q 4 wk . weekly	growth US . BPP	Consider PP pharmacologic DVT prophylaxis based on risk; use Lovenox Post CSX	
pgBMI 40-45		Detailed Anatomic + fetal echo @MFM		MFM for imaging and consult		26 wk . 34 wk	q 4 wk . weekly	growth US . BPP		
BMI > 45		Detailed Anatomic + fetal echo @MFM		**TRANSFER CARE**		26 wk . 34 wk	q 4 wk . weekly	growth US (@ MFM) . BPP		
s/p Bariatric Surgery	CBC, CMP, PTH, Iron, ferritin, folate, Vit A, Vit B12, Vit D	MFM *(if surgery within the past 12-24 months)*	PNV . Calcium citrate 1200 mg . Ferrous Sulfate 325 mg QOD	Nutrition referral . Bariatric surgery if any concerns	CBC, BMP, iron, ferritin, folate Ca, & Vit D q trimester	28 wk	q 4 wk	growth US *(if surg was w/i last 12-24m)*	Routine	N/V, electrolyte derrangement, dumping syndrome, FGR (if surgery within 12-24 months, cesarean

A little more information . . .

- Level A
  - PreGravid BMI should guide care
  - SubQ drain should not be used routinely after csx
  - Diet and Excercise better than exercise alone
- Level B
  - Encourage wt loss pre-pregnancy*
  - Allowing longer 1st stage is reasonable to reduce csx
  - Thromboprophylaxis
- Level C
  - US limitations
  - early glucose screen
  - Weekly antenatal testing
    - by 37 wks if pgBMI 35.0-39.9
    - at 34 wks if pgBMI > 40
- So what about growth Ultrasounds?
  - 2022 AJOG - lower rates of FGR/SGA in obesity
  - 2024 AJP - Consider delaying until 32 wks, limited utility
  - But . . .

last one (for this session)

Thyroid Disease

ACOG PB 2020

	PNC				Fu Labs	Antental Testing			Delivery Plan	RISK Factors
	Labs	*US Plan*	*Medication*	*Referral*		*Start*	*Frequ*	*Type*		
Hypo	TSH . *(if decide to check TSH and NEW dx made, initiate treatment for TSH > 4)*	Routine *(unless TSH was > 10 in pregnancy then Anatomic by MFM)*	Increase levothyrozine by 20-30% of home dose at dx of pregnancy.	n/a unless uncontrolled	TSH q 4 wk post change & atleast 1x per trim. **(goal<2.5)** . TSH 6wk PP	Routine	Routine	Routine	*Reduce to original dose after delivery* . Routine	Miscarriage, neonatal neurodevelopment issues if TSH >10, PPH, postpartum depression, lower APGARS, preeclampsia, preterm birth, abruption, FGR (if untreated
HYPER	TSH, FT4	antatomic @ MFM	PTU in first trimester, methimazole in second and third	Endo MFM **TRANSFER CARE**	FT4 q2 wks until controlled, then q2-4 wks. Goal FT4 is upper limit of nml	After 20 wk	q 4 wk	growth US	Routine, if well controlled	Miscarriage, hypertensive disorder, preterm birth, abruption, low birthweight, FGR, neonoatal hypo- and hyperthyroidism

A little more information . . .

- **Level A**
  - Universal screening is NOT recommended
  - TSH is firstline
  - Hypothyroidism
    - Monitor q 4-6 wks
    - treatment goal of TSH <2.5
  - HYPERthyroidism
    - Monitor free T4 (sometimes T3), goal upper limit of normal
- **Level B**
  - Use PTU or methimazole for treatment based on trimester, etc
- **Level C**
  - Continue to test as clnically indicated (symptoms, personal or family hx, DM 1)
  - Thyroid testing NOT indicated in hyperemesis

Part 1 Conclusion

- Not everyone needs a TSH or screening with urine toxicology
- Make sure to add in Hep C, Varicella, and triple Hep B
- Strongly evaluate need for A1C and ASA (indicated more often than not)
- Glycemic control is crucial to improved outcomes in diabetes
- If nothing else - the presentation should have convinced you that preconception counseling and optimization of chronic health conditions is crucial

QUESTIONS?

Special Recommendations in High-Risk Prenatal Care

PART TWO

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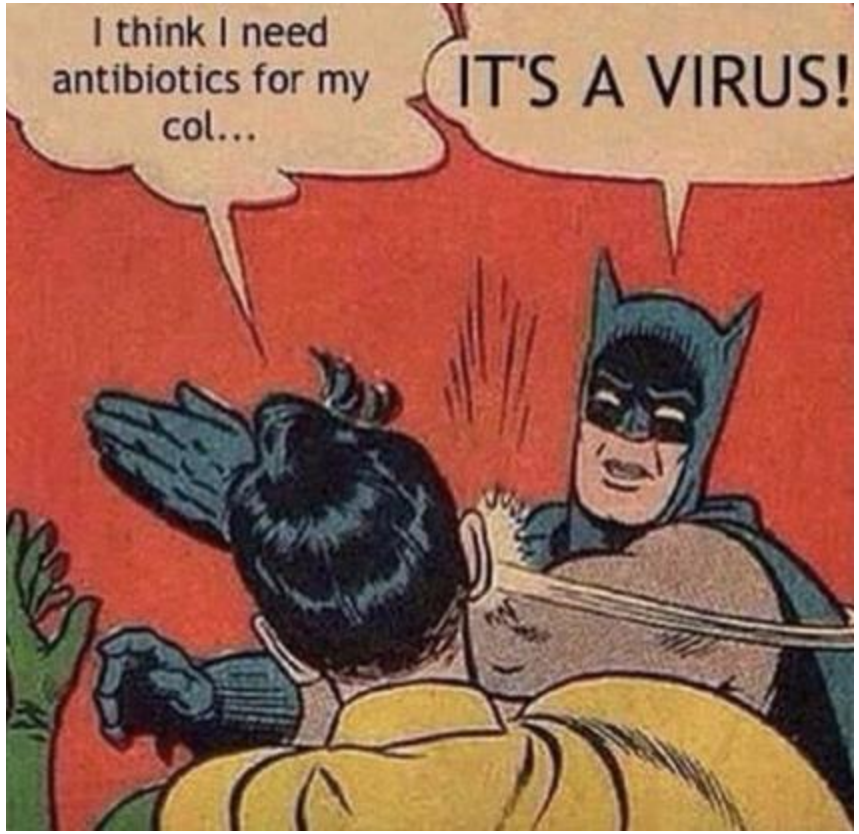
Objectives

- Work through recommended additions to routine prenatal care based on:
  - Infections
  - Maternal Age at Delivery
  - Incarceration
  - Substance Use Disorder
  - Tobacco Use Disorder

- A look at the whole High-Risk Obstetrics Grid

starting big



Infections - pt 1

	PNC				Fu Labs	Antental Testing			Delivery Plan	RISK Factors	
	Labs	*US Plan*	*Medication*	*Referral*		*Start*	*Frequ*	*Type*			
				and/or MFM							
Infections											
HIV	CMP, TB, toxo, Trich, hep A, viral load (plasma HIV RNA) . Hep A, B, & pneumococcal vaccines	Date ***ASAP*** . Detailed anatomic @ MFM	initiate or cont ART (earlier better, triple therapy, AVOID stab/didan/riton/ covicistat) Call 1-888-448-8765	**TRANSFER CARE** to OB and/or MFM + ID consult	HIV RNA atleast monthly, CBC/CMP q 3m, CD4 counts prn	28 wk	q4 wk	growth US	routine if supressed . 38 week CSX if viral load > 1000	fetal transmission, FGR; co-infection --> FGR, PTL. . *BFing NOT rec'd in US*	
Syphillis	TPA-->RPR quant if + (TPPA if RPR -)	Dating . Anatomic (@ MFM if high titers, late tc, untrt)	PCN (1 vs 3 doses)	MFM?, HD	f/u titers at 30 wks, delivery, pp (3,6,12)	28 wk . 36 wk	q 4 wk . weekly	growth US . mBPP * (for uncont)	routine (IOL for perinatology based on fetal US)	FGR, stillbirth, congenital syphillis	acog pa april 2024
Hep B	DNA quant, CMP	routine	Tenofovir df if load > 200,000	Consider GI/Hepatology	viral load prior to treatment	28 wk	q 4 wk	growth US	routine . baby (HBV & HBIG w/i 12 hrs), BFing encouraged	pp viral flare, 90% vert transmit if not treated	acog cpg 6 sept 2023
Hep C	HCV RNA quant, CMP	routine	Defer to after pregnancy	Consider GI/Hepatology	viral load prior to treatment	28 wk	q 4 wk	growth US	routine (VD and internals not CI even w/ high load), BFing not discouraged	FGR, PTB, cholestasis, 3-10% vert ransmission if rna detect	acog cpg 6 sept 2023

A little more information . . .

- Early Universal screening for HBsAg *(SR,MQ)*
- Triple Panel (HBsAg, anti-HBs, total anti HBc) if never documented after age 18, ongoing risks, or not fully vaccinated *(SR, LQ)*
- Hep C screen w/ each pregnancy *(SR, LQ)*
- Screen and treat HepC pre pregnancy when able *(SR, MQ)*
- Use HepB DNA quant to guide therapy *(SR, LQ)* and treat > 200,000 viral load to decrease vertical transmission *(SR, MQ)*
- CSX based on obstetric indication not dx of HepB *(LQ)*
- HBIG and HepB Vaccine w/i 12 hrs when indicated *(SR, MQ)*
- Manage healthcare exposures to Hep B/C similar to if not pregnant *(SR, LQ)*
- Hep A and Hep B vaccination safe in pregnancy - use as indicated *(SR, MQ)*

Infections - pt 2

	PNC				Fu Labs	Antental Testing			Delivery Plan	RISK Factors	
	Labs	*US Plan*	*Medication*	*Referral*		*Start*	*Frequ*	*Type*			
Pyelo	routine	routine	IV then PO to total 14d . consider proph abx	Consider Uroloy	insuf evidence	routine	routine	routine	routine unless active infx	PTB, recurrent infx (septic shock, ARDs, stillbirth)	acog cc #4 aug 2023
Gc/Ct	consider Trich	routine	Abx as indicated	n/a	repeat per trimester	routine	routine	routine	routine		
Varicella	routine	Anatomic by MFM for primary infx in early pregnancy	Exp: VZIG w/i 96 hrs if VzNI . Infx: Acyclovir 800mg 5x/d	MFM	routine	28 wk	q 4 wk	growth US	routine unless otherwise indicated	FGR, fetal hydrops, heart malform	acog PB 151, june 2015
HSV	routine	routine	Acyclovir 400mg po TID at 36 wk	n/a	none	routine	routine	routine	routine (csx w/ active GENITAL lesions)	vertical transmission	acog PB 220, may 2020

always fun to address in “nice” terms

Age at Delivery

ACOG OCC Aug 2022

	PNC				Fu Labs	Antental Testing			Delivery Plan	RISK Factors
	Labs	*US Plan*	*Medication*	*Referral*		*Start*	*Frequ*	*Type*		
Teen	Routine	Routine	Routine	N/A	N/A	30 wk	once then prn	growth US	Routine	PTL, (LBW infants, malnutrition, PP depression, preE, IUGR).
AMA										
35-39 y/o *(at delivery)*	extra emphasis on genetic screening *(cell free DNA is first line)*	Dating . Consider Anatomic @ MFM	consider ASA if > 2 moderate risk factors for preE	prn NT US	N/A	28-32 wk . . 38 wk	once . twice weekly	growth US . . mBPP	by 40w0d	Ectopic, spon Abortion, stillbirth, chromosomal abnml, some congen abnml, placenta previa, gDM, preE, CSX, (PT birth)
≥ 40 y/o		Dating . Anatomic @ MFM		MFM by 20 wk (sooner prn NT US)	N/A	28-32 wk . . 34 wk	once . twice weekly	growth US . . mBPP	at 39w0d	

A little more information . . .

- **Level A**
  - Prenatal genetic screening and diagnostic testing options should be discussed and offered to all individuals regardless of age or risk
- **Level B**
  - Daily low dose ASA if 2 mod risks (ama already one)
  - antenatal fetal surveillance if delivery > 40 y/o 2/2 stillbirth risk
  - Deliver 39 - 39.6 for > 40 y/o
  - not an indication for csx
  - be aware of disproportionate rate of adverse outcomes in Black, American Indian, and Alaska Native pregnant individuals ages 35 and older
- Level C
  - Delivery at > 35 y/o is high risk and should be discussed - vague
  - 1st trimester US 2/2 high risk of multiples
  - Detailed anatomic US if >35 yo
  - Growth US in 3rd trimester if delivery at > 40yo

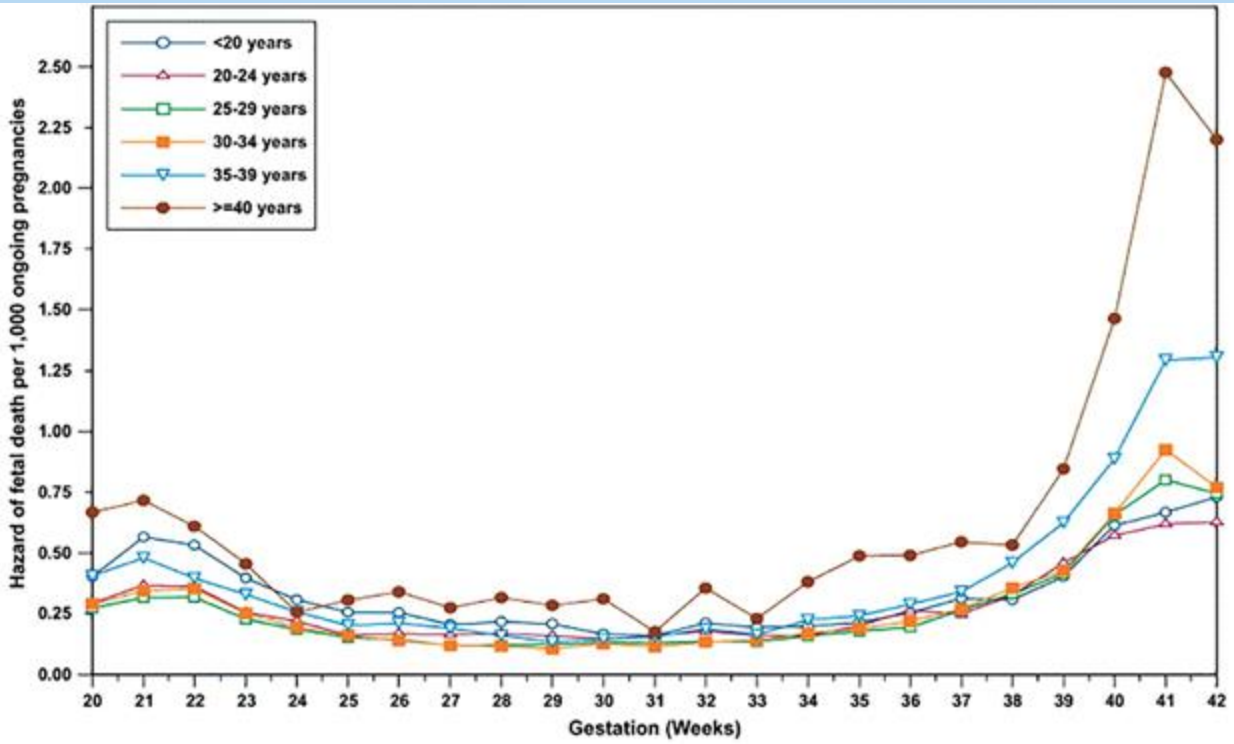


Figure 1. Risk of Fetal Death per 1,000 Ongoing Pregnancies by Week of Gestation. Reprinted from Reddy UM, Ko CW, Willinger M. Maternal age and the risk of stillbirth throughout pregnancy in the United States. Am J Obstet Gynecol 2006;195:764–70. doi: 10.1016/j.ajog.2006.06.019. Copyright 2006, with permission from Elsevier.

Table 1. Chromosomal Abnormalities in Second-Trimester Pregnancies Based on Maternal Age at Term*†

	Trisomy 21	Trisomy 18	Trisomy 13	Sex Chromosome Aneuploidy (XXX, XY, XYY, 45, X)	Microarray or Rare Chromosomal Abnormality	All Chromosomal Abnormalities
Age 20	8 per 10,000 1 in 1,250	2 per 10,000 1 in 5,000	1 per 10,000 1 in 10,000	34 per 10,000 1 in 294	37 per 10,000 1 in 270	82 per 10,000 1 in 122
Age 25	10 per 10,000 1 in 1,000	2 per 10,000 1 in 5,000	1 per 10,000 1 in 10,000	34 per 10,000 1 in 294	37 per 10,000 1 in 270	84 per 10,000 1 in 119
Age 30	14 per 10,000 1 in 714	4 per 10,000 1 in 2,500	2 per 10,000 1 in 5,000	34 per 10,000 1 in 294	37 per 10,000 1 in 270	91 per 10,000 1 in 110
Age 35	34 per 10,000 1 in 294	9 per 10,000 1 in 1,111	4 per 10,000 1 in 2,500	35 per 10,000 1 in 285	37 per 10,000 1 in 270	119 per 10,000 1 in 84
Age 40	116 per 10,000 1 in 86	30 per 10,000 1 in 333	14 per 10,000 1 in 714	51 per 10,000 1 in 196	37 per 10,000 1 in 270	248 per 10,000 1 in 40

*Not all chromosomal abnormalities increase as maternal age increases.

scraping the surface of why we are all here this weekend

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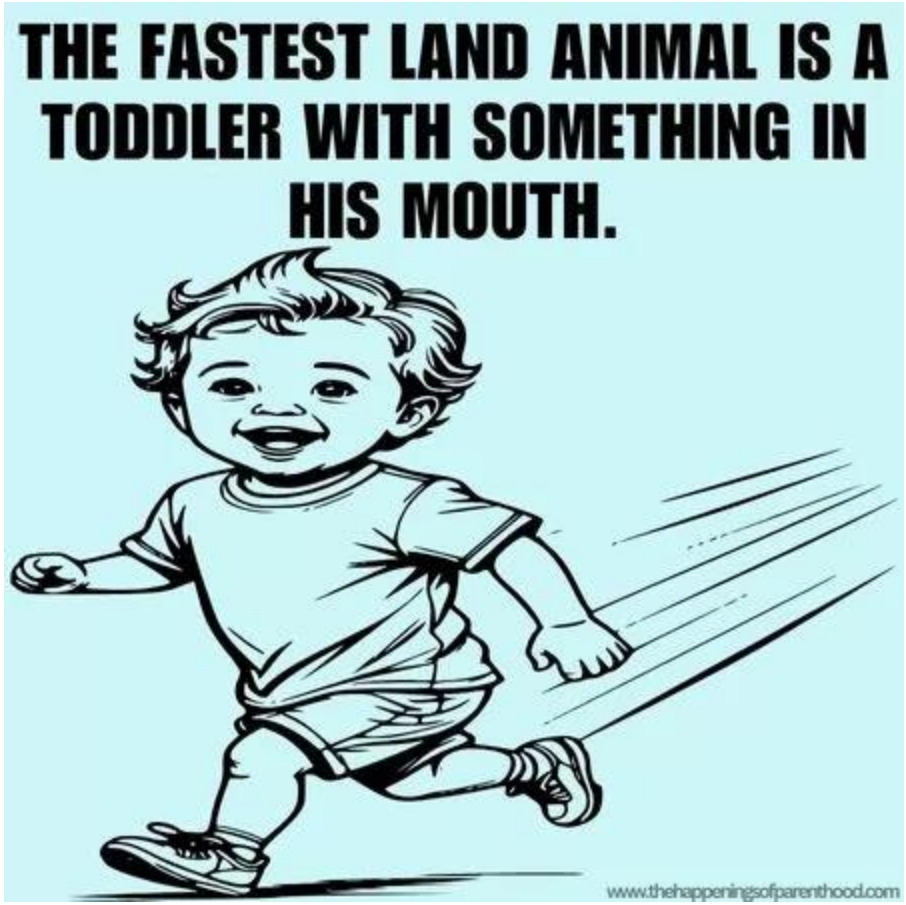
FOR WOMEN AND BABIES



Additional Risk Factors

	PNC				Fu Labs	Antental Testing			Delivery Plan	RISK Factors
	Labs	*US Plan*	*Medication*	*Referral*		*Start*	*Frequ*	*Type*		
Incarceration	Trichamonas, TB? *(Pap/HPV, follow nml guidelines)* *Hep A Vac (Hep B if not prior)*	routine	routine	N/A	Repeat Syphillis, HepB, HepC, HIV, Gc/Ct, & trich screening in 3rd trimester	Routine	Routine	Routine	after 39w0d, consider social IOL	PTL, LBW. *(poor PNC, SA, low SE status, current or prior trauma, MH issues, STIs, Resp illness(flu and tdap extra important), hyperemesis increased due to poor diet)*
Tobacco Use	Routine	routine	cessation aids prn	N/A	Routine	30 wk	once then prn	growth US	Routine	Placenta previa, abruption, PROM, PTL, FGR, SIDS, birth defects, childhood obesity (3)
Substance Use	CMP Hep A Vac (Hep B if not prior)	routine	ASA MOUD	ICWB, Peer Support, BH, OTP prn	UDM?	30 wk	once then prn	growth US	after 39w0d, consider social IOL	PTL, FGR, inadequate prenatal care

A lot of OLD information

- Reproductive Health Care for Incarcerated Pregnant, Postpartum, and Nonpregnant Individuals - *CO 2021 (2024)*
- Alcohol Abuse and Other Substance Use Disorders: Ethical Issues - *CO 2015 (2021)*
- Marijuana Use During Pregnancy and Lactation - *CO 2017 (2021)*
- Tobacco and Nicotine Cessation During Pregnancy - *CO 2020 (2023)*
- Substance Abuse Reporting and Pregnancy - *CO 2011 (2022)*

A lot of OLD information

- **Opioid Use and OUD in Pregnancy - CO 2017 (2021)**
  - Screening and intervention improve outcomes
  - UNIVERSAL screening should be part of comprehensive obstetric care
  - pharmacotherapy is preferable to withdrawal
  - infants should be monitored
  - **consider modifying some elements of prenatal care**
  - prescribe opioids appropriately
  - Breastfeeding encouraged if stable on opioid agonists
  - postpartum support important
  - contraceptive counseling and access should be a routine part o SUD treatment

Part 2 Conclusion

- HIV, Syphilis, and Hep B should be screened for and can safely be treated in pregnancy to improve outcomes
- Hep C is less easily treated in pregnancy (though possible) and we should improve preconception detection and treatment when possible
- Expand our use of HepA and HepB vaccines
- There is no current consensus on additional antenatal testing for most pre-existing or primary viral infections
  - Syphilis panel later today!
- Genetic screening should be offered universally but increasingly important in individuals delivering over age of 35
- Nationally, we need more study and evidence based care in substance use disorder in pregnancy

My Soapbox

SCFM's HROB Grid

QUESTIONS?

References

- American College of Obstetrics and Gynecologist - acog.org/clinical
  - ***Special THANK YOU to Dr Michael Growney, OBGYN***
- Obstetrics Normal and Problem Pregnancies. Gabbe et al. 8th ed. 2020
- Obstetrics & Gynecology Handbook. Zheng. 3rd ed. 2020
- Southern Colorado Maternal Fetal Medicine Group