Metro North **GP Alignment Program**

MATERNITY WORKSHOP

Saturday 22nd October 2022

First Trimester Case Studies

This is a joint initiative between Metro North Hospital and Health Service and Brisbane North PHN

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government

Red group – first trimester

- Jessica - healthy 24 year old
- LNMP 4 weeks ago & uHCG is positive
- This is her first pregnancy, she has no private health insurance & she wants to know what comes next
- She has a 15 min appointment
- Outline your approach

NHMRC Iodine recommendation

- NHMRC recommends **all women** who are **pregnant, breastfeeding or considering pregnancy,** take an **iodine** supplement of **150 micrograms (µg) each day**
- Women with pre-existing thyroid conditions should seek advice from medical practitioner prior to taking a supplement
- Women who are thyrotoxic, have Graves disease or multinodular goitre should not take supplemental iodine

https://www.nhmrc.gov.au/about-us/publications/iodine-supplementation-pregnant-and-breastfeeding-women

Iodine supplementation

- Iodine and folic acid fortification of bread mandatory since 2009 but not high enough levels for pregnancy – supplementation recommended
- **Most pregnancy and breastfeeding multivitamins contain iodine**
- Iodised salt recommended for women of child bearing age

https://www.foodstandards.gov.au/

Queensland Government
Queensland Health

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Nutrition Education Materials Online (NEMO)

Health Professionals

Maternal Health

Search by keyword

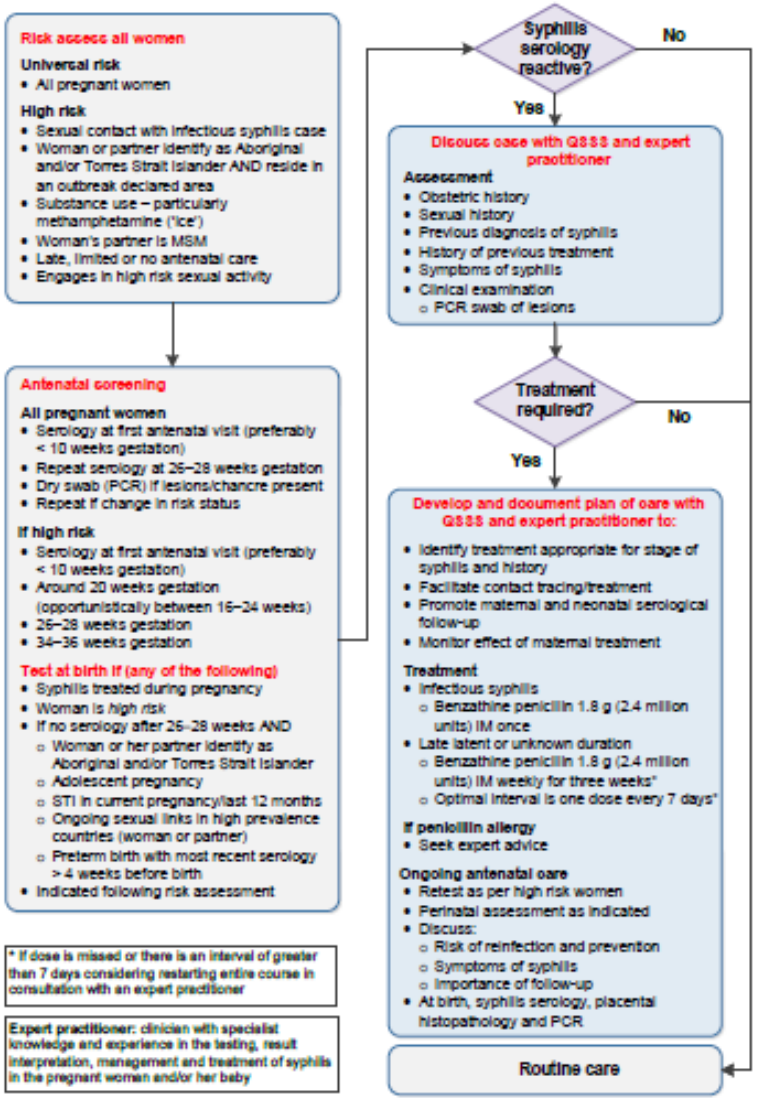
Title	Author	Description
Clinician resources		
Gestational Diabetes Mellitus eLearning Series	Queensland Health	
NHMRC Pregnancy Care Guidelines 2019	Department pf Health	
Evidenced-Based Demand Management Toolkit		
Patient education resources		
Diabetes in Pregnancy – Dietitian form	Queensland Health	
Folate	Food Standards Australia & New Zealand	
Food safety (including listeria)	Food Standards Australia & New Zealand	
Gestational Diabetes Presentation	NEMO Maternal Health Group	
Mercury	Food Standards Australia & New Zealand	

https://www.health.qld.gov.au/nutrition/clinicians

Specific STI testing

- National guidelines recommend testing *all* women under the age of 30 for **Chlamydia** as part of antenatal screen
- Queensland guidelines recommend repeating **Syphilis** serology at
  - K26-28 in all women
  - K20, K26-28, K34-36 weeks if high risk

Flow Chart: Antenatal care



IM: intramuscular injection, MSM: Men who have sex with men, PCR: Polymerase Chain Reaction QSSS: Queensland Syphilis Surveillance Service, STI: sexually transmitted infection, <: less than ≤ less than or equal to

Queensland Clinical Guidelines https://www.health.qld.gov.au/qcg/

Antenatal Syphilis Kit (ASK)

For antenatal healthcare providers

Are you screening your pregnant patient for syphilis?

1,037 positive syphilis notifications in QLD in 2021

In 2021, 29 cases were pregnant women

69% of infectious syphilis cases were in non-First Nations people, and **21%** in First Nations people

There was a **9% increase** of cases in women of reproductive age

ASK.

It matters to your patient & their baby

Enquire now to access our fully funded online toolkit

For more info

P 07 3250 0242
E ask@true.org.au
W bit.ly/askaboutsyphilis

This course is endorsed by Queensland Health and accredited by the Australian College of Midwives for 4.5 CPD hours, the Australian College of Nurses for 4.5 CPD hours and the RACGP for 9 CPD points.

true relationships & reproductive health

Queensland Government

For more information on ASK visit bit.ly/askaboutsyphilis

V1-20220327

Clinical education on syphilis in pregnancy

TRUE RELATIONSHIPS AND REPRODUCTIVE HEALTH PRESENTS:

Antenatal Sexual health Kit (ASK)

Education for antenatal service providers

The **Antenatal Sexual health Kit** provides education about syphilis, the Queensland Syphilis in Pregnancy Guideline, sexual health assessments and partner notification.

- 30min webinar
- Online training modules
- Podcast series
- Online forum
- Online resource hub

The course is free and available to all healthcare providers including GPs, GP registrars, nurse practitioners, general practice nurses, registered nurses, registered midwives and Aboriginal and Torres Strait Islander health practitioners.

ASK.

It matters to your patient & their baby

Enquire now to access our fully funded online toolkit

For more info

P 07 3250 0242

E ask@true.org.au

W bit.ly/askaboutsyphilis

true relationships & reproductive health

Queensland Government

For more information on ASK visit **bit.ly/askaboutsyphilis**

V1-20200227

Clinic. Education. Counselling.

fb.me/TrueClinics fb.me/TrueEducate

Queensland dTpa vaccination program for pregnant women

- Vaccination during pregnancy reduces the risk of pertussis in young infants by 90%
- Direct passive protection by transplacental transfer of pertussis antibodies from mother to fetus during pregnancy

https://immunisationhandbook.health.gov.au/

Queensland dTpa vaccination program for pregnant women

- Recommended as a single dose in **each** pregnancy (optimal time 20 - 32 weeks)
- Funded by Queensland Health

https://immunisationhandbook.health.gov.au/

dTpa recommendations for adult household contacts and carers

Adult household contacts and carers of infants <6 months of age are recommended to receive dTpa vaccine at least 2 weeks before they have close contact with the infant if their last dose was more than 10 years ago

https://immunisationhandbook.health.gov.au/

Influenza

- Pregnant women are strongly recommended to receive influenza vaccine each pregnancy
- Can be given during any stage of pregnancy

https://immunisationhandbook.health.gov.au/

COVID-19

RANZCOG and ATAGI recommend

- Pregnant women be routinely offered mRNA COVID-19 vaccination (Pfizer or Moderna) at any stage of pregnancy, breast feeding or planning a pregnancy
- Can be given at the same time as Influenza vaccine

COVID-19 vaccines | Australian Government Department of Health and Aged Care

COVID-19

Pregnant women should have a booster dose, 6 months after your last vaccine dose or COVID-19 infection, whichever is more recent.

COVID-19 vaccines | Australian Government Department of Health and Aged Care

Vaccination in pregnant women

- In Australia, vaccination is predominantly undertaken in General Practices (Australian Immunisation Handbook 2018)
- Women who receive a recommendation from their health care provider are more likely to receive the vaccine
- Some Metro North Health Antenatal Clinics and Hospitals provide Influenza and dTpa vaccinations

Pregnancy Health Record

Immunisation

Anti D Prophylaxis (Rh D negative women only)	☐ Not required ☐ 28 weeks If *no*, reason: Batch number: ☐ 34–36 weeks If *no*, reason: Batch number:	Print name: Designation: / Signature: Print name: Designation: / Signature:	
dTpa (diphtheria, tetanus and whooping cough) vaccine	☐ Yes ☐ No Date given: / / Gestation: weeks Batch number:	Print name: Designation: / Signature:	
Influenza vaccine	☐ Yes ☐ No Date given: / / Gestation: weeks Batch number:	Print name: Designation: / Signature:	
Other (specify)	Date given: / / Gestation: weeks Batch number:	Print name: Designation: / Signature:	

https://clinicalexcellence.qld.gov.au/sites/default/files/docs/clinical-pathways/pregnancy-health-record.pdf

Blue group - first trimester

- Kylie – a healthy 32 year old aboriginal woman is pleased as her period is overdue and her home pregnancy test is positive
- She has been stable on 100 mcg thyroxine daily for several years & is taking no other medication
- She has a 15 min appointment
- Outline your approach

Working together to support Aboriginal and Torres Strait Islander Families

- Ngarrama Maternity Services
- Ngarrama Family Service
- Women's Business Maternity and Gynaecology Service
- Brisbane North PHN Aboriginal and Torres Strait Islander health and wellbeing

Aboriginal and Torres Strait Islander health and wellbeing

We're committed to improving the health outcomes of Aboriginal and Torres Strait Islander people in the North Brisbane and Moreton Bay region.

Through working with community and for community, we aim to close the gap in life expectancy, improve the mortality rates for children, and improve access to culturally appropriate and high-quality healthcare.

Pre-gestational hypothyroidism - management in pregnancy

- **increase total weekly dose by 30%** once pregnancy confirmed
- monitor **TFT every 4 weeks during first trimester and every 6 - 8 weeks thereafter**
- **target TSH 0.5 – 2.5 mIU/L**
- postpartum - return to pre-pregnancy dose

https://metronorth.health.qld.gov.au/wp-content/uploads/2017/10/thyroid-disorders-pregnancy.pdf

Pre-gestational hyperthyroidism - management in pregnancy

- **refer to Endocrinology service pre-conception or as early as possible in pregnancy**

https://metronorth.health.qld.gov.au/wp-content/uploads/2017/10/thyroid-disorders-pregnancy.pdf

Thyroid Tips

- Routine TSH in pregnancy is **not** recommended

- Check TSH if
  - current or previous treatment for or symptoms of thyroid dysfunction &/or goitre
  - known positive antithyroid antibodies
  - > 30yo
  - BMI > 40
  - FHx thyroid disease
  - T1 DM, coeliac disease, Addison's disease, pernicious anaemia
  - history of miscarriage, infertility or pre-term delivery
  - Recent use amiodarone, lithium, IV contrast for CT scan

Subclinical hypothyroidism diagnosed in pregnancy

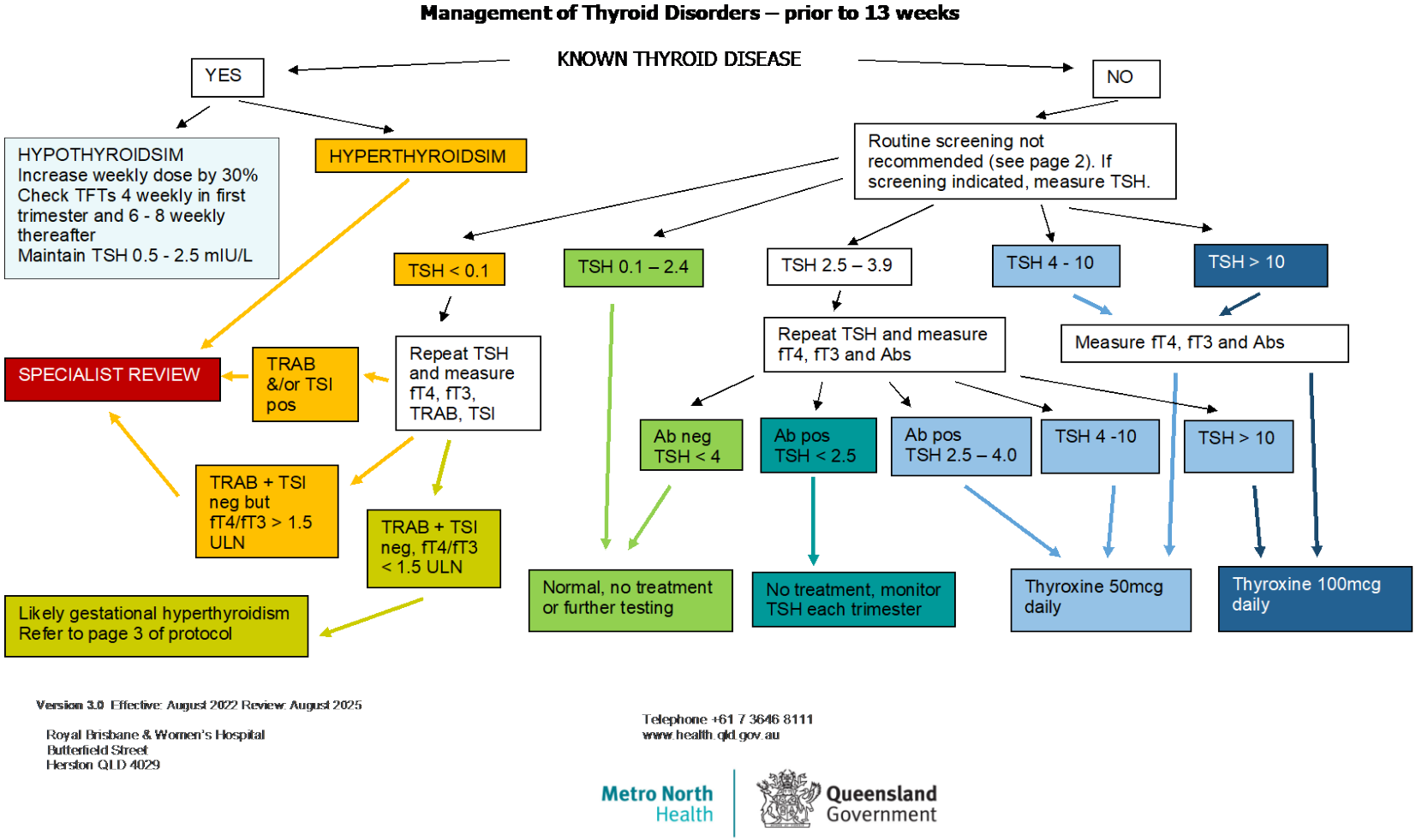
- TSH 2.5 - 4.0, repeat TSH, measure fT4, fT3 & anti-thyroid antibody titres
- 4.0 - 10, measure anti-thyroid antibody titres and commence thyroxine 50mcg daily
- If TSH > 10.0, measure anti-thyroid antibody titres and commence thyroxine 100mcg daily

https://metronorth.health.qld.gov.au/wp-content/uploads/2017/10/thyroid-disorders-pregnancy.pdf

Subclinical hyperthyroidism diagnosed in pregnancy

- Prior to 20 weeks
  - TSH < 0.1, repeat TSH, measure fT4, fT3, TRAb, &/or TSH receptor stimulating immunoglobulin (TSI)
- From 20 weeks - term
  - TSH < 0.4, repeat TSH, measure fT4, fT3, TRAb, &/or TSH receptor stimulating immunoglobulin (TSI)
- Refer all patients with positive TRAb and/or TSI

https://metronorth.health.qld.gov.au/wp-content/uploads/2017/10/thyroid-disorders-pregnancy.pdf



https://metronorth.health.qld.gov.au/wp-content/uploads/2017/10/thyroid-disorders-pregnancy.pdf

Vitamin D

- Routine Vitamin D testing not recommended
- 400 IU Vitamin D daily as part of a pregnancy multivitamin

https://ranzcog.edu.au/resources/statements-and-guidelines-directory/

https://www.mja.com.au/journal/2012/196/11/vitamin-d-and-health-adults-australia-and-new-zealand-position-statement

Vitamin D deficiency

25-hydroxyvitamin D, quantification in serum, for the investigation of a patient who:
(a) has signs or symptoms of osteoporosis or osteomalacia; or
(b) has increased alkaline phosphatase and otherwise normal liver function tests; or
(c) has hyperparathyroidism, hypo- or hypercalcaemia, or hypophosphataemia; or
(d) is suffering from malabsorption (for example, because the patient has cystic fibrosis, short bowel syndrome, inflammatory bowel disease or untreated coeliac disease, or has had bariatric surgery); or
(e) **has deeply pigmented skin, or chronic and severe lack of sun exposure for cultural, medical, occupational or residential reasons;** or
(f) is taking medication known to decrease 25OH-D levels (for example, anticonvulsants); or
(g) has chronic renal failure or is a renal transplant recipient; or
(h) is less than 16 years of age and has signs or symptoms of rickets; or
(i) is an infant whose mother has established vitamin D deficiency; or
(j) is an exclusively breastfed baby and has at least one other risk factor mentioned in a paragraph in this item; or
(k) has a sibling who is less than 16 years of age and has vitamin D deficiency

http://www.mbsonline.gov.au/

Vitamin D deficiency

- > 50 nmol/L - 400 IU vitamin D (cholecalciferol) daily as part of pregnancy multivitamin

- 30 - 49 nmol/L - 1000 IU daily

- < 30 nmol/L - 3000 – 5000 IU daily for 6 -12 weeks then check vitamin D; continue 1000 – 2000 IU daily maintenance dose

https://www.mja.com.au/journal/2012/196/11/vitamin-d-and-health-adults-australia-and-new-zealand-position-statement

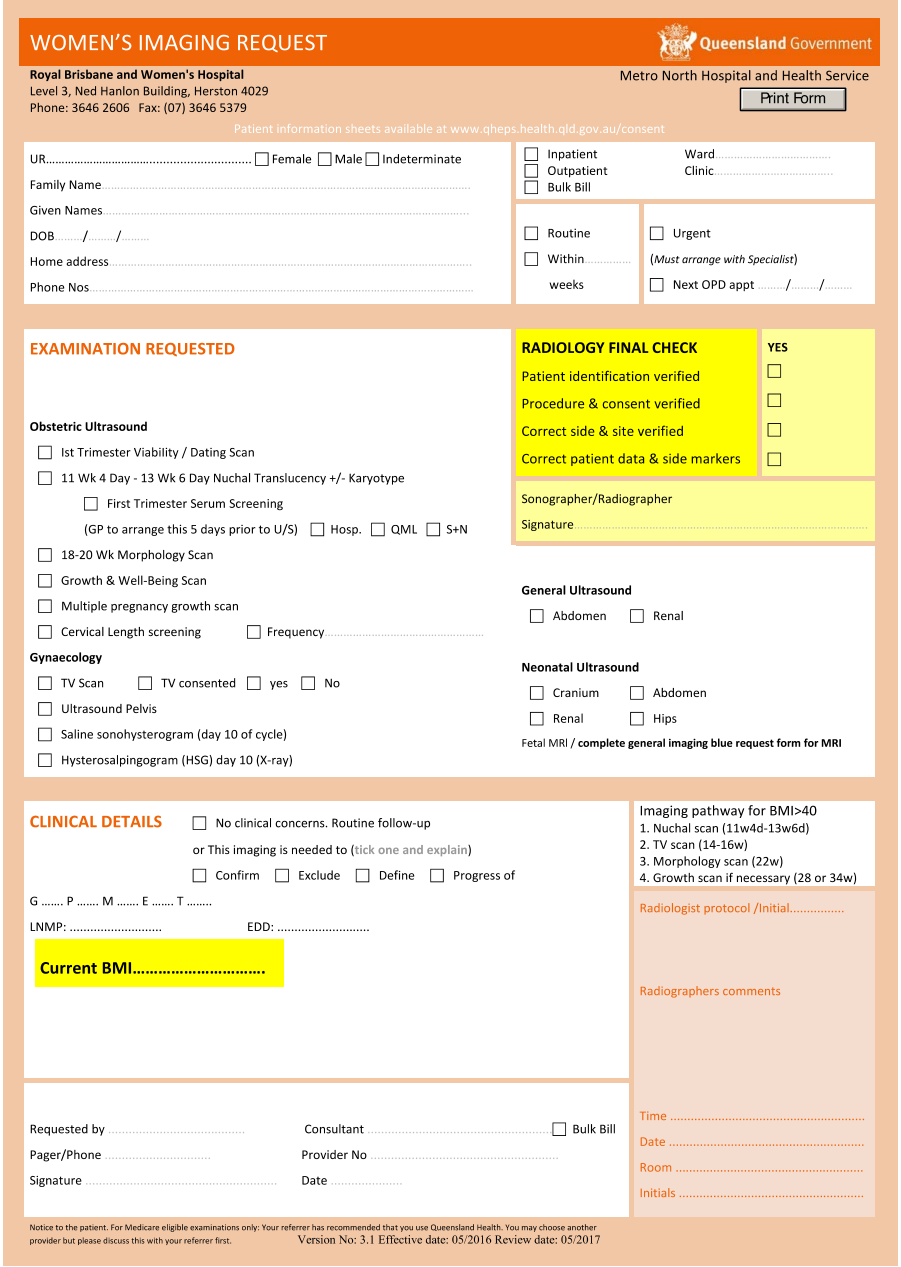
Green group – first trimester

- Amanda – a healthy 40 year old presents with a positive pregnancy test. Her first child, now 23 years old was born at term weighing 4500g
- Her BMI is 24, blood tests (FBC, E/LFT, TFT, Iron studies) from 2 years ago were normal and her family is healthy
- She requests an USS “just to be sure” as she knows her risk of miscarriage is high and she wants to see the baby’s heart beat ASAP
- She has a 30 min appointment
- Outline your approach

Women > 35yo

Risks include

- GDM
- Preeclampsia
- VTE
- Miscarriage
- Multiple pregnancy
- Chromosomal abnormality
- Preterm birth
- Low birth weight
- Caesarean birth



WOMEN'S IMAGING REQUEST

Queensland Government

Royal Brisbane and Women's Hospital
Level 3, Ned Hanlon Building, Herston 4029
Phone: 3646 2606 Fax: (07) 3646 5379

Metro North Hospital and Health Service

Print Form

Patient information sheets available at www.qheps.health.qld.gov.au/consent

UR..... ☐ Female ☐ Male ☐ Indeterminate

Family Name.....

Given Names.....

DOB...../...../.....

Home address.....

Phone Nos.....

☐ Inpatient ☐ Outpatient ☐ Bulk Bill

Ward.....
Clinic.....

☐ Routine
☐ Within..... weeks

☐ Urgent
(*Must arrange with Specialist*)
☐ Next OPD appt...../...../.....

EXAMINATION REQUESTED

Obstetric Ultrasound

☐ Ist Trimester Viability / Dating Scan
☐ 11 Wk 4 Day - 13 Wk 6 Day Nuchal Translucency +/- Karyotype
☐ First Trimester Serum Screening
(GP to arrange this 5 days prior to U/S) ☐ Hosp. ☐ QML ☐ S+N
☐ 18-20 Wk Morphology Scan
☐ Growth & Well-Being Scan
☐ Multiple pregnancy growth scan
☐ Cervical Length screening ☐ Frequency.....

Gynaecology

☐ TV Scan ☐ TV consented ☐ yes ☐ No
☐ Ultrasound Pelvis
☐ Saline sonohysterogram (day 10 of cycle)
☐ Hysterosalpingogram (HSG) day 10 (X-ray)

RADIOLOGY FINAL CHECK	YES
Patient identification verified	☐
Procedure & consent verified	☐
Correct side & site verified	☐
Correct patient data & side markers	☐

Sonographer/Radiographer
Signature.....

General Ultrasound

☐ Abdomen ☐ Renal

Neonatal Ultrasound

☐ Cranium ☐ Abdomen
☐ Renal ☐ Hips

Fetal MRI / **complete general imaging blue request form for MRI**

CLINICAL DETAILS

☐ No clinical concerns. Routine follow-up
or This imaging is needed to (tick one and explain)
☐ Confirm ☐ Exclude ☐ Define ☐ Progress of

G ..... P ..... M ..... E ..... T .....

LNMP: ..... EDD: .....

Current BMI.....

Imaging pathway for BMI>40
1. Nuchal scan (11w4d-13w6d)
2. TV scan (14-16w)
3. Morphology scan (22w)
4. Growth scan if necessary (28 or 34w)

Radiologist protocol /Initial.....

Radiographers comments

Requested by ..... Consultant ..... ☐ Bulk Bill
Pager/Phone ..... Provider No .....
Signature ..... Date .....

Time .....
Date .....
Room .....
Initials .....

Notice to the patient. For Medicare eligible examinations only: Your referrer has recommended that you use Queensland Health. You may choose another provider but please discuss this with your referrer first.

Version No: 3.1 Effective date: 05/2016 Review date: 05/2017

https://metronorth.health.qld.gov.au/rbwh/wp-content/uploads/sites/2/2017/06/womens-imaging-request-form.pdf

Metro North Hospital and Health Service

Royal Brisbane and Women's Hospital

Maternal Fetal Medicine (MFM)

Referral Guidelines for Antenatal Ultrasound and MFM Consultation

Queensland Government

https://metronorth.health.qld.gov.au/wp-content/uploads/2020/06/mfm-guidelines-antenatal-ultrasound-refer.pdf

Print Reset Form

Queensland Government

Royal Brisbane & Women's Hospital

MATERNAL FETAL MEDICINE (MFM) REFERRAL FOR IMAGING AND CONSULT

To: Dr Renuka Sekar MBBS DGO FRANZCOG CMFM
Director Maternal Fetal Medicine CAPC

Metro North Health Service District
Centre for Advanced Prenatal Care
Level 6, Ned Hanlon Building
Butterfield Street Herston Qld 4029

(Affix RBWH patient identification label here or write details below)

RBWH URN:
Family name:
Given names:
Date of birth: Sex: ☐ M ☐ F ☐ I
Address:
Phone: Mobile:
Medicare No: Ref No:
Expiry Date: **Ineligible Patient:** ☐ Yes ☐ No

Fax Referrals to: **1300 364 952**

If urgent also call Doctor or Midwife on **(07) 3646 0840**

INCOMPLETE REFERRALS WILL BE DECLINED

REFERRAL DOCTOR DETAILS

Request date:
Referring Doctor name:
Referring Doctor provider number:
Referring Doctor contact number:
Obstetric Consultant name:
Address / Department:
Referring Doctor signature:

MANDATORY - CLINICAL DETAILS

EDC: by ☐ LMNP ☐ Scan

G: P: M: O:

Current BMI (mandatory):

Please upload images to PACS and attached all previous ultrasound reports and blood results

Full antenatal blood screen at:

☐ QML ☐ S&N ☐ NIPT ☐ CFTs ☐ Other:

Obstetric / Medical history:

A/N Serology:

Infectious Status (MRSA/VRE):

Allergies:

Medications:

EXAMINATION REQUIRED (tick below)

☐ Nuchal translucency +/- karyotype (11+3 wks – 13+6wks)
☐ 18 – 20 week morphology ultrasound
☐ Tertiary ultrasound

Serial scans as requested (tick reason)

☐ Multiple pregnancy
☐ Rh disease / alloimmunisation
☐ Fetal growth and wellbeing ultrasound
☐ Cervical length measurement:
☐ Other:

Details:

MFM PROCEDURES

☐ **CVS - 11–14 weeks**
☐ **Amniocentesis from 16 weeks**
☐ **Fetal echocardiography and consultation**
☐ **Discussed with patient**

COUNSELLING

☐ **Preconception counselling**
☐ **Termination of Pregnancy options counselling**

All genetic counselling should be referred to Genetic Health Queensland

OFFICE USE ONLY (MFM Staff)

Date received: Actioned:
Triaged by:
Comments:
Appointment date: Time:
Accession No.:
Doctor:
☐ Appointment confirmed with patient

Report: ☐ **Sent with patient** ☐ **Faxed to referring doctor**

MATERNAL FETAL MEDICINE REFERRAL FOR IMAGING AND CONSULT

DO NOT WRITE IN THIS BINDING MARGIN
Do not reproduce by photocopying
All clinical form creation and amendments must be conducted through Health Information Services

MR C 6130
v9.00 - 05/2020
Locally Printed
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Page 1 of 1

https://metronorth.health.qld.gov.au/wp-content/uploads/2017/10/mr-c-6130.pdf

Orange group – first trimester

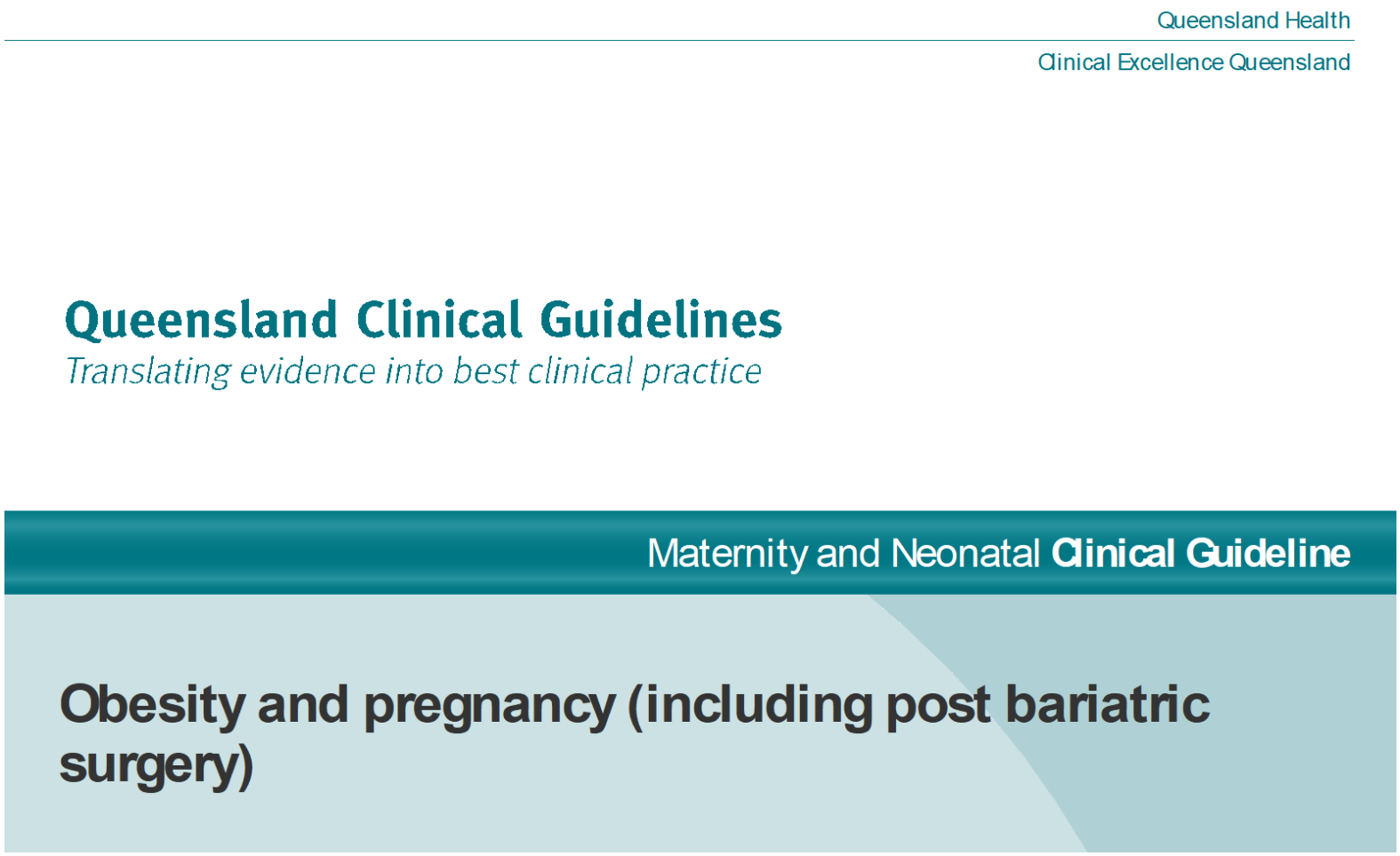
- Nicole – a healthy 37 year old has a positive home pregnancy test
- Home pregnancy test performed 3/52 earlier was negative
- Nicole is unsure when she fell pregnant as her periods are irregular and her LNMP was 7 weeks ago
- Her pre-pregnancy weight is 108kg height 165cm BMI 40
- Nicole has been taking folic Acid 0.5 mg daily and wants to know what to do next
- She has a positive family history of VTE
- 15 min appointment booked
- Outline your approach

Women > 35 yo

Risks include

- GDM
- Preeclampsia
- VTE
- Miscarriage
- Multiple pregnancy
- Chromosomal abnormality
- Preterm birth
- Low birth weight
- Caesarean birth

Obesity guidelines



Queensland Clinical Guidelines https://www.health.qld.gov.au/qcg

Risks of high pre-pregnancy BMI

Maternal Risks

- Maternal death or severe morbidity
- Miscarriage
- Thromboembolic disease
- Gestational diabetes mellitus
- Hypertension & pre-eclampsia
- Pre-term birth
- Induction of labour
- Instrumental delivery
- Caesarean section
- Anaesthetic risks
- Wound infection
- Post partum haemorrhage
- Breast feeding challenges
- Depression & anxiety
- Eating disorders

Fetal/Baby Risks

- Congenital malformations
- Difficulties with fetal surveillance
- Stillbirth
- Macrosomia/LGA
- Shoulder dystocia
- Pre-term birth
- Jaundice, hypoglycaemia
- NICU admission
- Respiratory distress syndrome
- Neonatal and infant death
- Less breastfeeding
- Childhood obesity, metabolic syndrome, generational obesity
- Neurodevelopmental differences

Resource considerations

- Facility design
- Staff training
- Large BP cuffs, calibrated bariatric scales
- Bariatric beds, theatre trolleys, wheelchairs etc
- USS
- Fetal monitoring
- Intravenous access

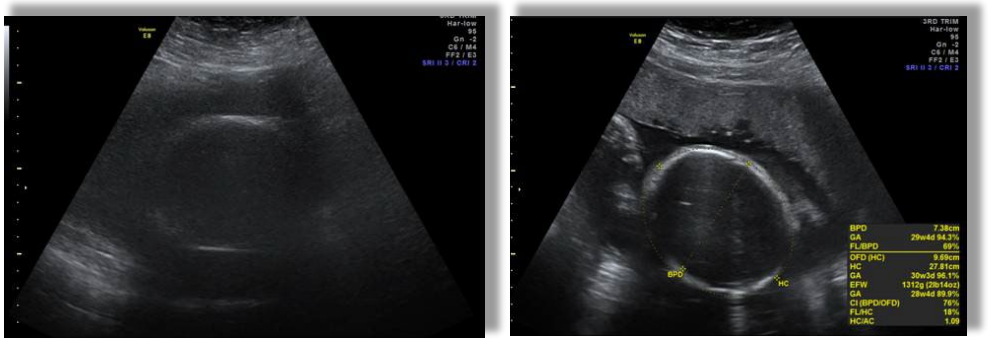


Image source: Donna Traves Sonographer, RBWH

Obesity in pregnancy

- It is recommended that all women are weighed at each visit
- Advise women of their target weight gain based on **pre-pregnancy BMI** (Refer to page a6 PHR)
- Refer all women with BMI ≥ 25 to a dietician

Target Weight Gains

*Calculations assume a 0.5–2kg weight gain in the first trimester for single babies.
Refer to dietitian if multiple pregnancies, as different goals required. Dietary and physical activity requirements discussed (refer to page b2).
Refer to Queensland Clinical Guideline: *Obesity in pregnancy* for further information.

Pre-pregnancy BMI (kg/m^2)	Rate of gain 2nd and 3rd trimester (kg/week)*	Recommended total gain range (kg)
Less than 18.5	0.45	12.5 to 18
18.5 to 24.9	0.45	11.5 to 16
25.0 to 29.9	0.28	7 to 11.5
≥30.0	0.22	5 to 9

https://clinicalexcellence.qld.gov.au/sites/default/files/docs/clinical-pathways/pregnancy-health-record.pdf

RBWH Maternity Dietitian Referral

Required

- Date of referral
- Patient information:
  - Full name, date of birth, contact details, postal address or contact address (if not the same as usual residence)
  - Allergies (drug/ topical preparation)
  - Aboriginal and Torres Strait Islander status (if applicable)
- Referring practitioner:
  - Full name, address and contact details
  - Provider number and signature
- Patient referral information:
  - Detailed reason for referral (including the problem to be assessed, degree of loss of function, pain experienced etc.)
  - Relevant information about patient's condition such as previous medical/ surgical treatment (include systemic and topical medications prescribed for the condition) and any associated medical conditions which may affect the condition or its treatment (e.g. Diabetes)
  - Relevant investigations (pathology, radiology, histology etc), preferably results from within last 4 weeks
  - Current medications and doses, prescribed and over the counter (Note any recent changes in drug therapy)

Desirable

- Relevant psychological and social issues impacted by condition (if applicable)
- Smoking & alcohol history (if applicable)
- South Sea Islander status (if applicable)
- Medicare Number (if applicable)
- Interpreter requirements (if applicable)
- Patient status – DVA, Work cover, Motor Vehicle Insurance, ineligible (if applicable)

If sufficient information is not provided you and your patient will be notified in writing that we are unable to clinically categorise and place the patient on an appropriate wait list until this information is received. Once a completed referral has been accepted and categorised you will receive advice that your patient has been placed on the waiting list. Please maintain clinical supervision of your patient's condition prior to the initial consultation with the specialist. Please notify Central Patient Intake (CPI) of any significant change in their condition.

Resources

Criteria for Referral to Early Pregnancy Assessment Unit (PDF)

Early Pregnancy Assessment Unit Referral & Admission Flowchart (PDF)

Maternity and gynaecology resources

Maternity Referral Form (PDF)

MFM Referral for Imaging and Consult (RBWH) (PDF)

RBWH Women's Imaging Request Form (PDF)

RBWH Maternity Dietitian Referral Form (PDF)

MFM Guidelines for Antenatal and Ultrasound Referral (PDF)

Specialists list

Standardised Fetal Growth Chart Referral Pathway (PDF)

Perinatal Wellbeing Team Referral (PDF)

General referral criteria

eReferral template

Referral requirements

A referral may be rejected without the following information.

– Essential referral information

https://metronorth.health.qld.gov.au/specialist_service/refer-your-patient/antenatal-and-maternity

Personal Healthy Lifestyle Phone Coaching

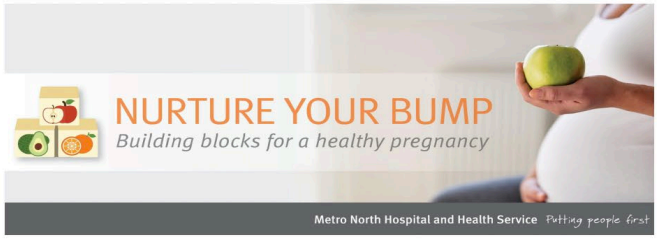
Is this program for you?

- Did you start pregnancy above a healthy weight (BMI above 25kgm/^{2})? or have you gained weight more quickly than recommended?
- Are you looking for some extra support, motivation and a personalised pregnancy health plan to get you on track?

If you answered **YES**, our program is for **YOU**!

Living Well during Pregnancy is a free healthy lifestyle telephone coaching program, exclusively for Royal mums-to-be, to help you achieve your healthiest pregnancy possible!

Register or refer now



Pregnancy Workshop

Pregnant & wondering...

- Which cheese is safe to eat?
- Can I eat fish?
- Should I be taking a multivitamin?
- What heartburn & morning sickness remedies actually work?
- Is it safe to exercise in pregnancy?

We are here to answer all your questions, register for our 2-hour workshop today!

Register or refer now

Maternity Outpatients Department
Location: Ground floor, Ned Hanlon Building, Royal Brisbane and Women's Hospital
Phone: (07) 3646 7182
Fax: (07) 3646 5482
Email: LivingWellDuringPregnancy@health.qld.gov.au

Resources

Printable flyer for mums: Personal telephone health coaching Living Well during Pregnancy (PDF)

Printable flyer for mums: Pregnancy Workshop Nurture Your Bump (PDF)

Printable referral form: RBWH Maternity Dietitian (PDF)

Pregnancy Weight Gain Charts

Select the correct chart based on pre-pregnancy BMI:

- BMI less than 25kg/m2 (Healthy weight) (PDF)
- BMI more than 25kg/m2 (Above healthy weight) (PDF)

If pregnant with twins or triplets:

- BMI less than 25kg/m^2 (Healthy weight) (PDF)
- BMI more than 25kg/m^2 (Above healthy weight) (PDF)

Refer your RBWH patient to see a dietitian

For support with:

- Hyperemesis
- Previous weight loss surgery
- Low pre-pregnancy body weight (BMI<18.5kg/m2)
- Low gestional weight gain

Refer your patient > (PDF)

https://metronorth.health.qld.gov.au/rbwh/healthcare-services/maternity-services/living-well-pregnancy

HEALTHY PREGNANCY HEALTHY BABY
Healthy pregnancy weight gain training

CPD Recognised by Australian College of Midwives 1.5 CPD hour

Healthy pregnancy weight gain is an important part of any healthy pregnancy to optimise pregnancy and future health outcomes for mothers and their offspring. Monitoring weight during pregnancy, coupled with a conversation between a woman and her health professional about progress, healthy eating and physical activity is a recommended part of routine care for all women.

This Healthy Pregnancy Healthy Baby, pregnancy weight gain training is designed to prepare health professionals to engage in respectful conversations about weight and lifestyle and equip them to deliver best practice care consistent with current evidence.

The content has been developed in consultation with a reference group of Queensland health professionals. The suite of online professional development resources is broken down into **7 short modules** with a total completion time of **90 minutes**. Each module will take around 10-15 minutes to complete including a knowledge check. The training is flexible, allowing learners to do one module and come back later to complete others. A certificate is available on completion of the post–training questionnaire.

This training package is suitable for any member of the multidisciplinary team caring for pregnant women including, midwives, obstetricians, physicians, general practitioners, practice nurses, dietitians, physiotherapists, and other allied health practitioners.

https://metronorth.health.qld.gov.au/health-professionals/healthy-pregnancy-healthy-baby

Modules

Introduction

Module 1 — **Weight - evidence and practice**

Module 2 — **Achieving a healthy weight gain**

Module 3 — **Having the conversation**

Module 4 — **Pregnancy weight gain charts**

Module 5 — **Brief intervention advice**

Module 6 — **Managing deviations**

Module 7 — **Special considerations**

Assessment

First visit to GP

- Women with a BMI > 30
  - Include BMI in referral
  - Routine antenatal bloods plus ELFTs, OGTT or HbA1c, urine protein/creatinine ratio, ferritin, B12, folate, vitamin D, Mg
  - 2.5 - 5 mg folic acid daily
  - First trimester OGTT/HbA1c – if negative, repeat OGTT at 24 – 28/40
  - Early dating USS – confirm gestational age
  - Aneuploidy screening – CFTS, NIPT
  - Detailed anomaly scan & growth and well-being scan
  - Assess risk factors for pre-eclampsia, VTE, OSA
  - Advise on healthy gestational weight gain

Surveillance for co-morbidities

Table 16. Antenatal surveillance

Aspect	Consideration	
GDM	• If early screening is normal, repeat at 24–28 weeks gestation • Refer to Queensland Clinical Guideline: *Gestational diabetes mellitus*[105]	
Hypertension	• Document the appropriately sized blood pressure cuff • If pre-existing hypertension, consider cardiac evaluation (e.g. electrocardiogram), especially if smoking • Refer to Queensland Clinical Guideline: *Hypertension and pregnancy*[114]	
Pre-eclampsia	• Assess for clinical risk factors and consider prophylaxis (e.g. aspirin) • Refer to Queensland Clinical Guideline: *Hypertension and pregnancy*[114]	
Venous thromboembolism (VTE):	• BMI greater than 30 kg/m^2 is a risk factor for VTE • Refer to Queensland Clinical Guideline *Venous thromboembolism prophylaxis in pregnancy and the puerperium*[115]	
Obstructive Sleep Apnoea (OSA)	• OSA in women experiencing obesity (compared to women experiencing obesity without OSA) results in[99]: ○ Higher rates of medical and surgical complications ○ Longer hospital stays ○ Higher rates of admission to ICU • Greater sensitivity to adverse effects of opioids (e.g. respiratory depression)[81] • If frequent snoring reported, offer screening[87] • The Australian Sleep Association recommend screening by using the STOP Questionnaire ○ If the answer is yes to two or more of the following questions, refer to a physician/sleep specialist	
	S	Do you **s**nore loudly (louder than talking or loud enough to be heard through closed doors)?
	T	Do you often feel **t**ired, fatigued or sleepy during daytime?
	O	Has anyone **o**bserved you stop breathing during your sleep?
	P	Do you have or are you being treated for high blood **p**ressure?
Depression and anxiety	• If concerns are identified, perform additional psychosocial assessment, and/or refer as required[44] • Recommend thorough routine and baseline investigations (e.g. to exclude hypothyroidism)	
Eating disorders	• Increased risk of adverse maternal and neonatal outcomes[116] • Maintain awareness of history or symptoms suggestive of an eating disorder[25,100] (e.g. binge or purge eating, laxative overuse) • Refer to perinatal mental health/mental health services as required	

Pregnancy weight gain chart for BMI 25kg/m² or over

(Affix patient identification label here)

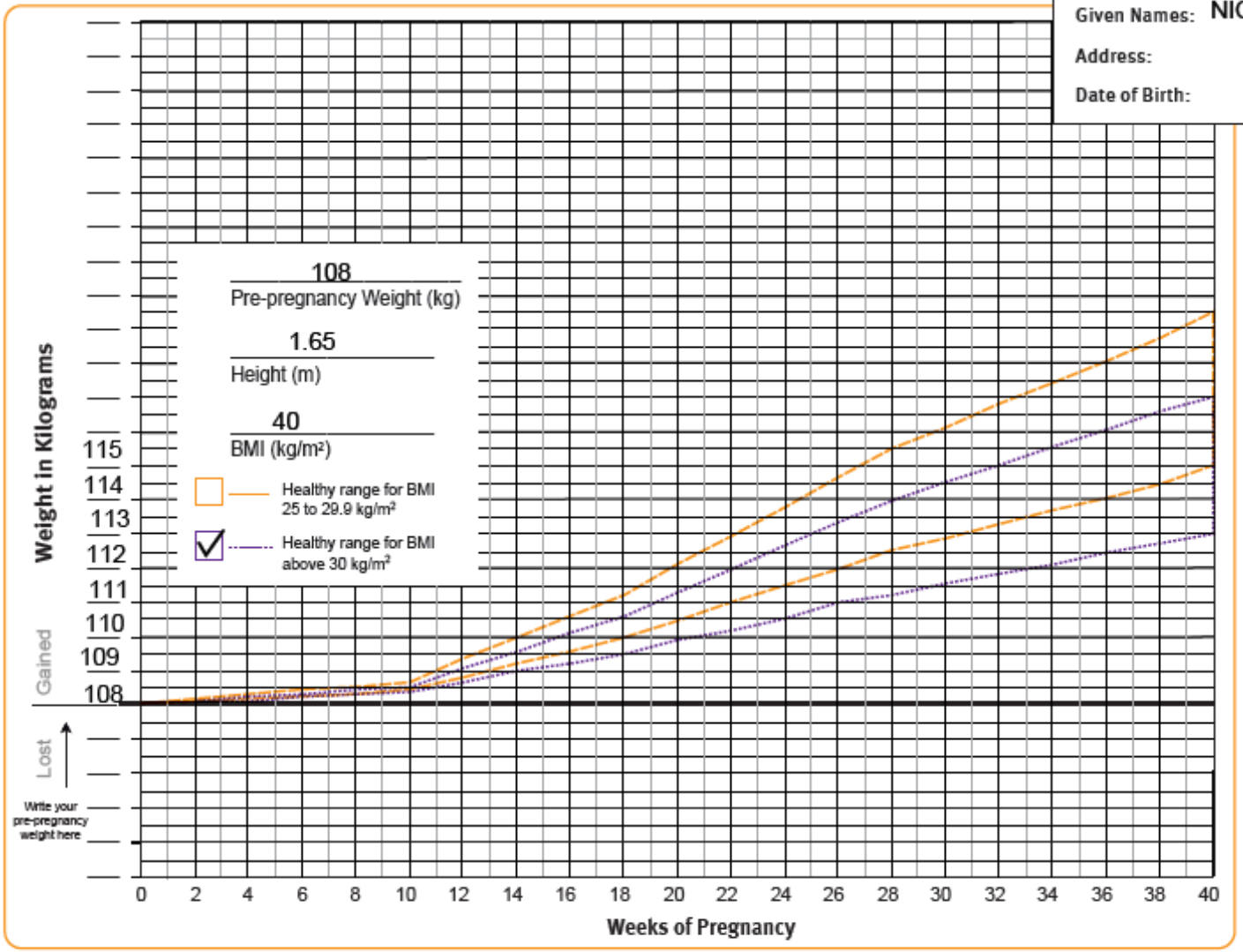
URN:

Family Name:

Given Names: NICOLE

Address:

Date of Birth: Sex: ☐M ☐F ☐I



Congratulations on your pregnancy!

Healthy pregnancy weight gain is important for your health and the health of your baby as you can see on the other side of this page. . Almost all women can gain a healthy amount by eating well, being active and monitoring their weight. Bring this pregnancy weight gain chart to your antenatal appointments and ask your maternity health care provider to plot your weight and discuss your progress towards your weight gain goals for this pregnancy.

The amount of weight you should gain depends on your weight (and body mass index – BMI) before you became pregnant. Choose the weight gain range that matches your pre-pregnancy BMI (see below to calculate your BMI).

Pre-pregnancy BMI 25 to 29.9 kg/m²	Pre-pregnancy BMI Above 30 kg/m²
Gain 7 to 11.5 kg	Gain 5 to 9 kg

How to use this tracker:

1. Write down height and weight before pregnancy in the two spaces provided.
2. Calculate your pre-pregnancy BMI using the following equation: $\frac{\text{weight (in kg)}}{\text{height x height (in meters)}}$

   Alternatively, you can do so using this online calculator: http://www.gethealthyqld.com.au/healthier-you/tools-and-calculators/bmi-calculator/
3. Starting from pre-pregnancy weight, add 1kg to each space along the left hand line on the graph.
4. Weigh yourself each appointment and every week or two between appointments and place a mark on the line where your weight and weeks gestation cross.
5. Connect the dots to track your weight gain throughout pregnancy.

Acknowledgement to Royal Brisbane and Women's Hospital Nutrition and Dietetics Department, adapted from Institute of Medicine weight gain recommendations for pregnancy.

Version 4 | Effective Dec 2017 | Review Nov 2021

Queensland Government

First visit to GP

- Consider low dose aspirin 100mg/day, if obese and additional risk factors for preeclampsia
- Antenatal thromboprophylaxis if obese and additional risk factors for VTE
- Queensland Clinical Guidelines

  - *Venous thromboembolism (VTE) prophylaxis in pregnancy and the puerperium*

  - *Hypertension and pregnancy*

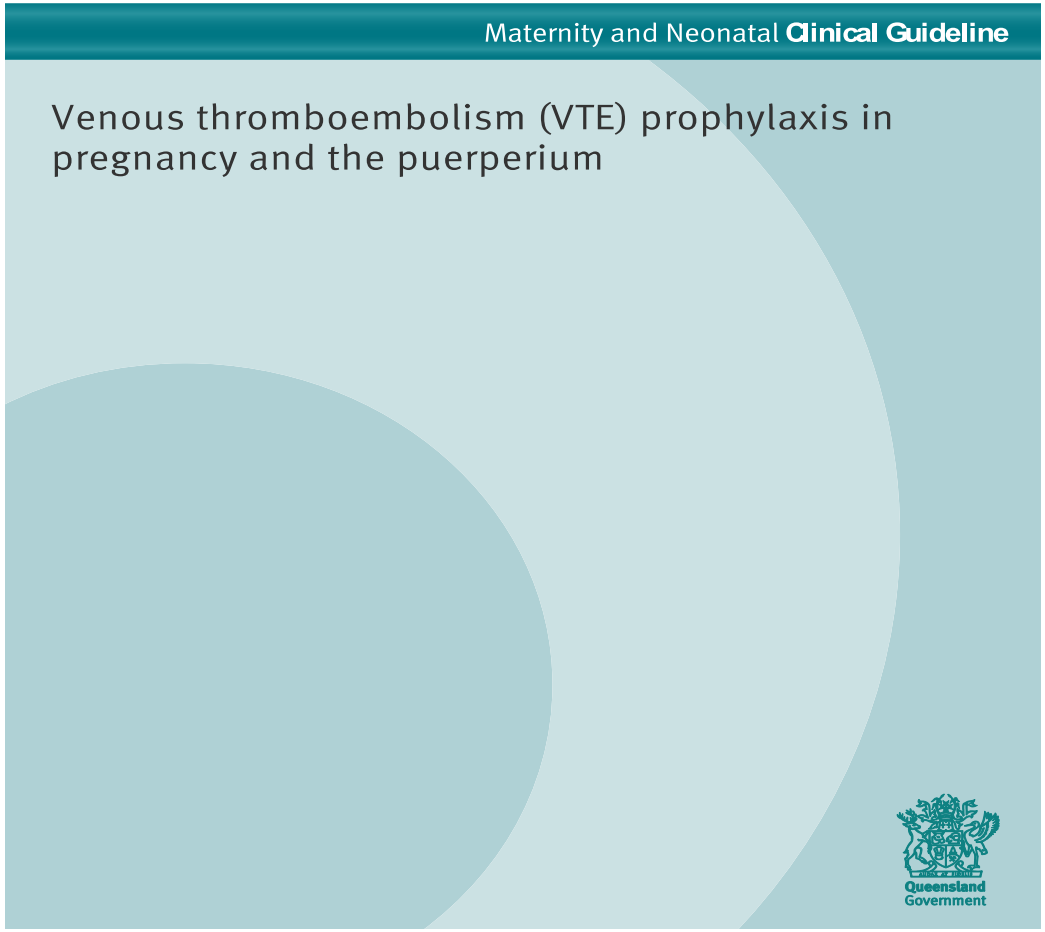
Queensland Clinical Guidelines https://www.health.qld.gov.au/qcg/

Venous thromboembolism (VTE)

- Leading cause of direct maternal death in Australia 2006 – 2016
- Assess for VTE risk at every antenatal and postnatal visit
- Thromboprophylaxis according to risk

Queensland Clinical Guidelines https://www.health.qld.gov.au/qcg/

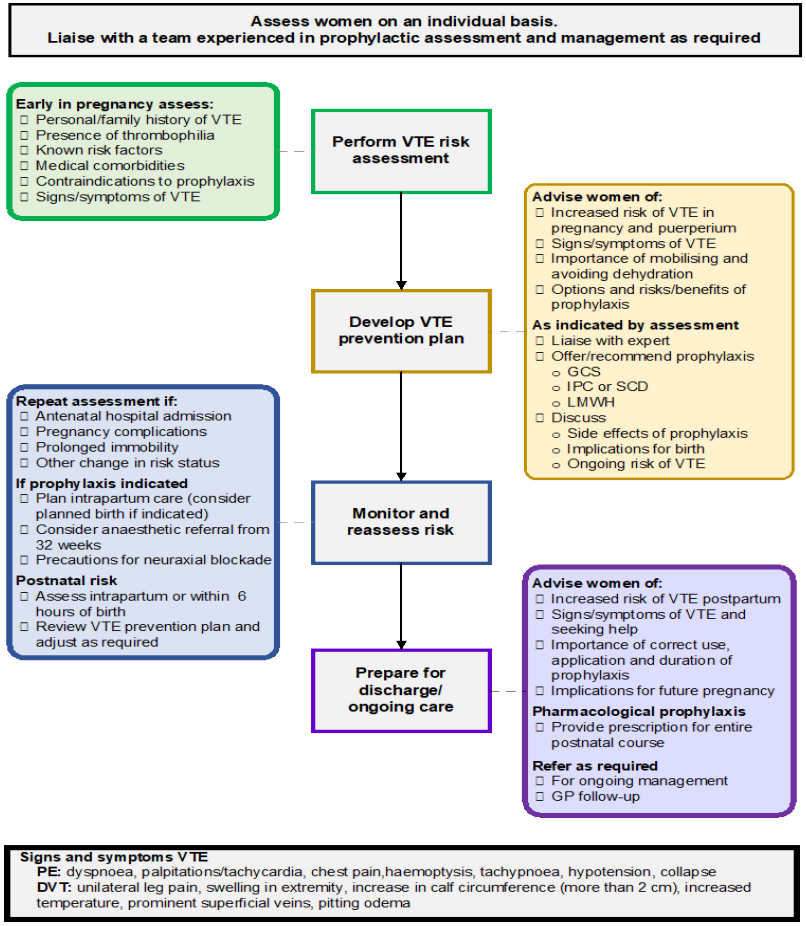
Queensland Clinical Guidelines
Translating evidence into best clinical practice



Queensland Clinical Guidelines https://www.health.qld.gov.au/qcg/

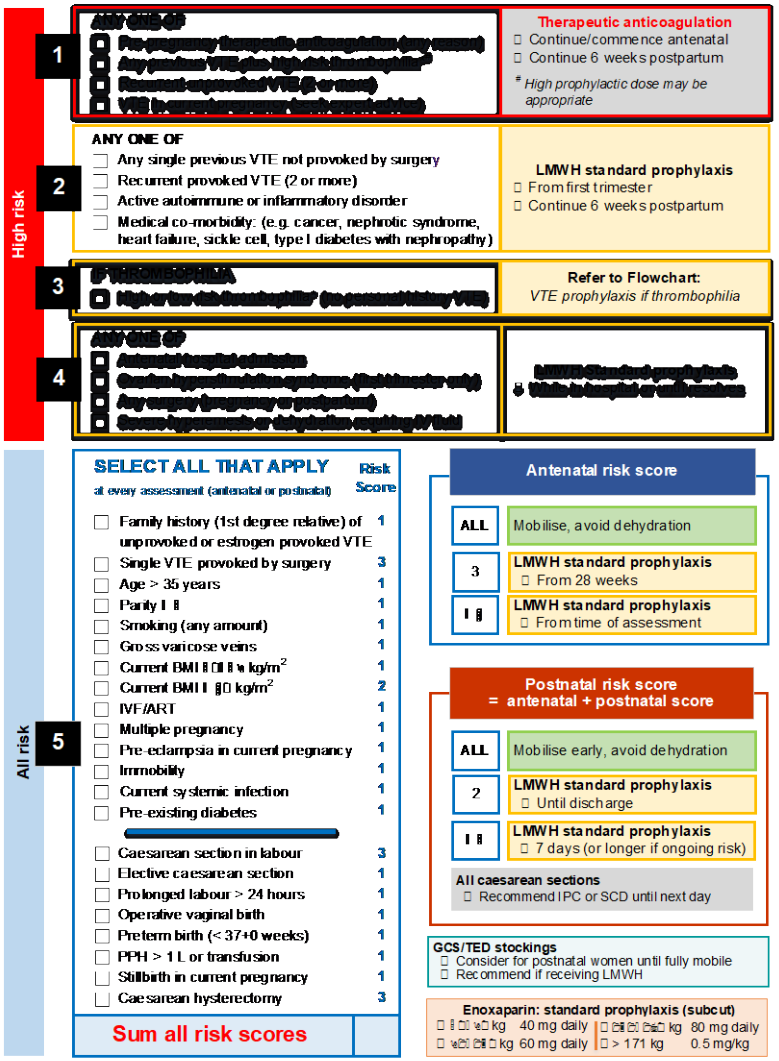
VTE assessment

Flow Chart: VTE assessment for pregnant and postpartum women



DVT: deep vein thrombosis, **GCS:** graduated compression stockings, **GP:** general practitioner, **IPC:** intermittent pneumatic compressions, **LMWH:** low molecular weight heparin, **PE:** pulmonary embolism, **SCD:** sequential compression device, **VTE:** venous thromboembolism,

Flowchart: Antenatal and postnatal thromboprophylaxis according to risk

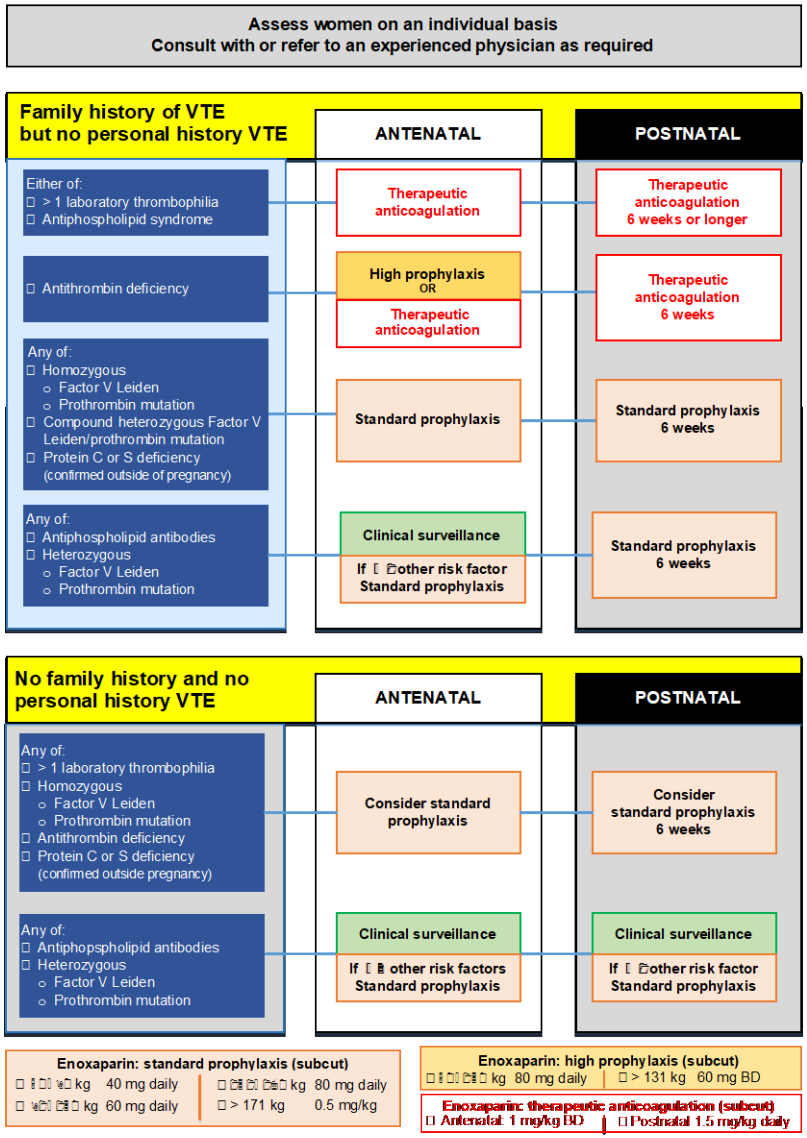


***High risk thrombophilia:** > 1 laboratory thrombophilia, APS, antithrombin deficiency, protein C deficiency, protein S deficiency, homozygous FVL, homozygous prothrombin mutation, compound heterozygous FVL/prothrombin mutation
Low risk thrombophilia: heterozygous FVL, heterozygous prothrombin mutation, antiphospholipid antibodies

APS: antiphospholipid syndrome, **ART:** artificial reproductive technology, **BMI:** body mass index, **FVL:** factor V Leiden, **GCS:** graduated compression stockings, **IPC:** intermittent pneumatic compressions, **IVF:** in-vitro fertilisation, **LMWH:** low molecular weight heparin, **PE:** pulmonary embolism, **PPH:** Primary postpartum haemorrhage, **SCD:** sequential compression device, **SLE:** systemic lupus erythematosus, **TEDS:** thromboembolic deterrent stockings **VTE:** venous thromboembolism, ≥: greater than or equal to, **>:** greater than

Flowchart: F20.9-2-V2-R25

Flowchart: Thromboprophylaxis if thrombophilia



Flowchart: F20.9-3-V1-R25

Pink group – first trimester

- Kate – a 34 year old G3 P2 has an unplanned pregnancy
- It is 6 weeks since her LNMP and she presents with PV bleeding
- She is a blood donor and upon asking, she informs you that her blood group is A Rh negative
- She has a 15 min appointment
- Outline your approach

First trimester bleed

- Is the woman haemodynamically stable?
- What is her blood group?
- Where is the fetus?
- Is the fetus viable?

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Translating evidence into best clinical practice

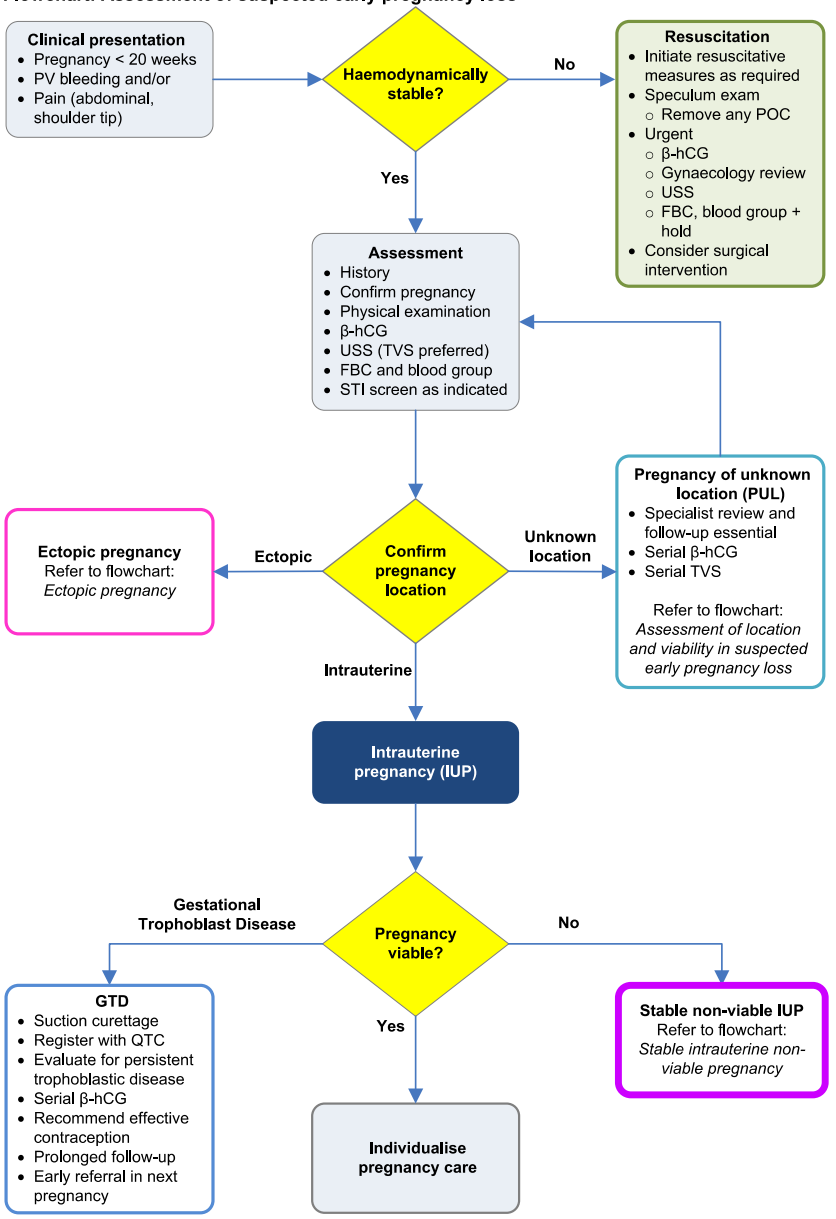
Maternity and Neonatal **Clinical Guideline**

Early pregnancy loss

Queensland Government

https://www.health.qld.gov.au/qcg/

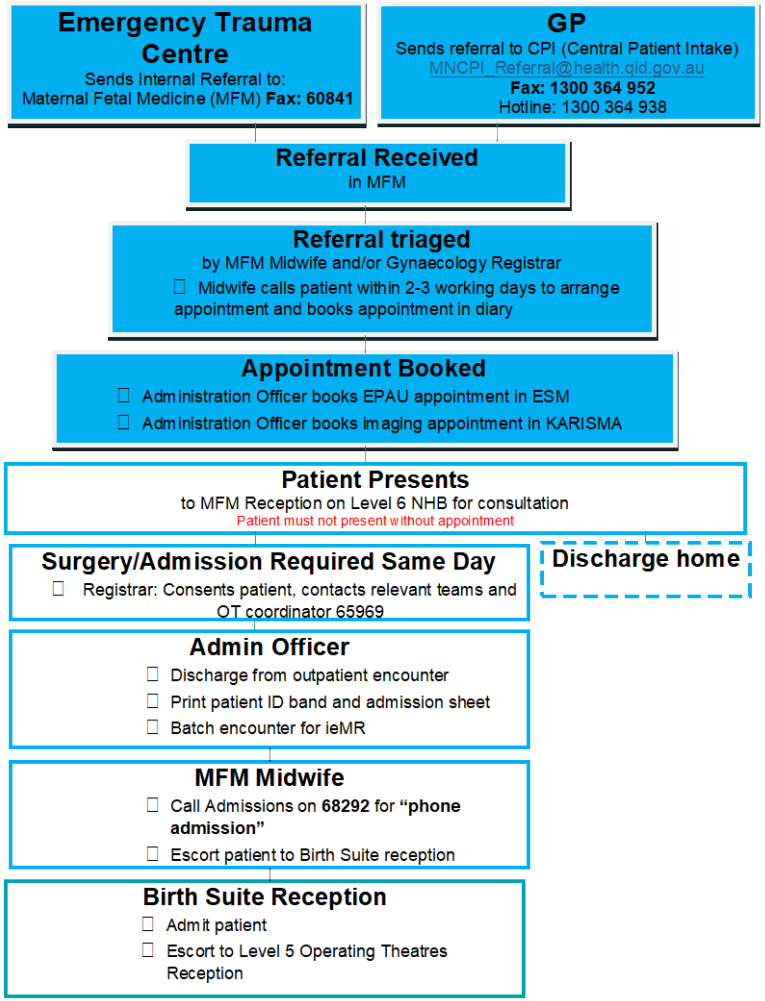
Flowchart: Assessment of suspected early pregnancy loss



β-hCG: human chorionic gonadotropin, **FBC:** full blood count, **GP:** General practitioner, **GTD:** gestational trophoblast disease, **IUP:** intrauterine pregnancy, **POC:** products of conception, **PUL:** pregnancy of unknown location, **PV:** per vaginam, **QTC:** Queensland Trophoblast Centre, **STI:** sexually transmitted infection, **TVS:** transvaginal scan, **USS:** ultrasound scan, **>:** greater than

Early Pregnancy Assessment Unit (EPAU)

Referral & Admission Flowchart, see inclusion criteria for referral.



Important: EPAU is available Monday to Friday 0900 - 12:00 in the Maternal Fetal Medicine Unit of the Ned Hanlon Building. It is not a walk-in clinic. All patients must have a written referral.

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Early pregnancy loss

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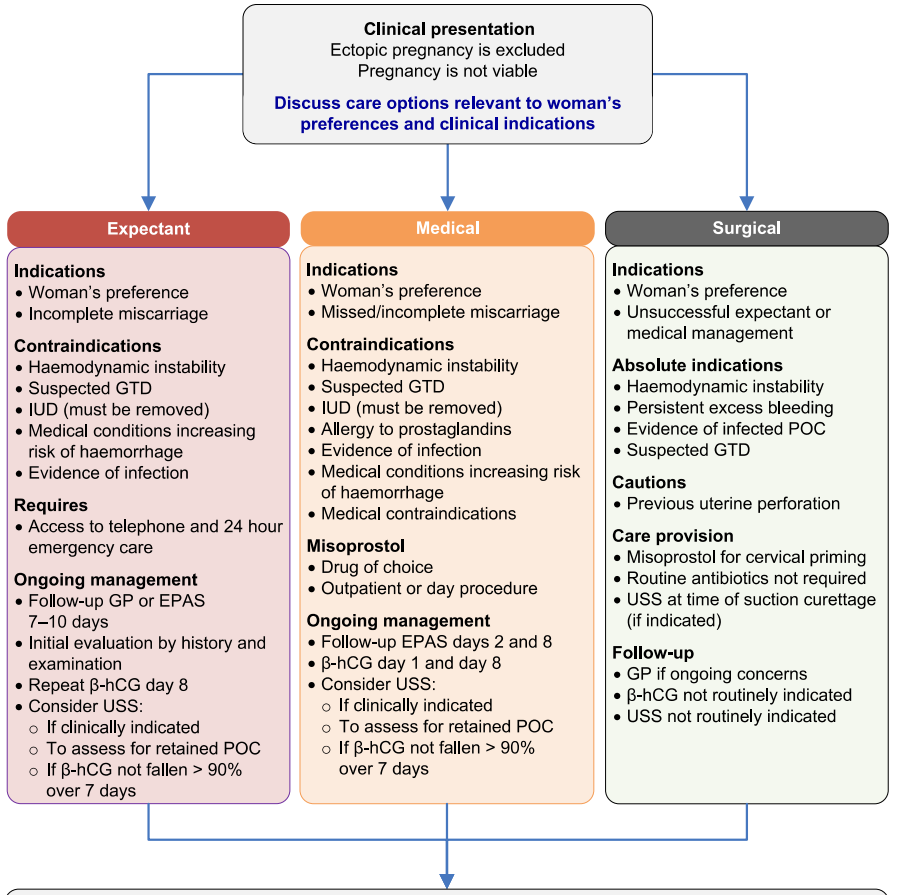
https://www.health.qld.gov.au/qcg/

Flowchart: Stable intrauterine non-viable pregnancy



β-hCG: human chorionic gonadotropin (all β-hCG measurements in International units/L (IU/L)), **EPAS:** early pregnancy assessment service, **FBC:** full blood count, **GP:** General Practitioner, **GTD:** gestational trophoblast disease, **IUD:** intrauterine device, **IUP:** Intrauterine pregnancy, **POC:** products of conception, **PUL:** pregnancy of unknown location, **PV:** per vaginam, **QTC:** Queensland Trophoblast Centre, **RhD-Ig:** RhD immunoglobulin, **TVS:** transvaginal scan, **USS:** ultrasound scan, **>:** greater than

Non-viable intrauterine pregnancy loss management

- No significant differences between expectant, medical and surgical management
- Woman's individual preferences and values as well as clinical situation determine choice of management

Non-viable intrauterine pregnancy loss management

- Expectant
  - Repeat B-hCG day 8
  - Consider USS if clinically indicated (symptomatic), to assess for retained POC, or if B-hCG not fallen >90% over 7 days
  - Refer if ongoing heavy bleeding, pain, persistent gestational sac on USS, or if infection suspected
  - Urine hCG at 3-6 weeks if no POC histopathology, failure to return to normal menstruation by 4-6 weeks, ongoing abnormal bleeding

Non-viable intrauterine pregnancy loss management

- Medical management – refer to EPAU
  - Misoprostol for incomplete miscarriage < 13 weeks
  - administered PV, oral or sublingual Day 1 and repeated Day 2 or 3
  - Mifepristone & Misoprostol combined may be more effective than misoprostol alone in missed miscarriage
  - Bleeding heavier than menses likely
  - Pain, diarrhoea, vomiting may occur
  - B-hCG Day 1 and day 8
  - Consider USS if clinically indicated (symptomatic), to assess for retained POC, or if B-hCG not fallen >90% over 7 days
  - Refer if ongoing heavy bleeding, pain, or if infection suspected
  - Urine hCG at 3-6 weeks if no POC histopathology, failure to return to normal menstruation by 4-6 weeks, ongoing abnormal bleeding

Non-viable intrauterine pregnancy loss management

- Surgical management
  - Follow up B-hCG not routinely indicated
  - Follow up USS not routinely recommended
  - Check histology
  - Rh D negative
    - 12 weeks or less 250 IU
    - > 12 weeks 625 IU

Pregnancy of unknown location (PUL)

- An Intrauterine pregnancy (IUP) is one where a yolk sac is seen – no yolk sac = a PUL

- If there is no yolk sac, especially if the B-hCG is > 800-1000 mIU/mL, be cautious

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Maternity and Neonatal **Clinical Guideline**

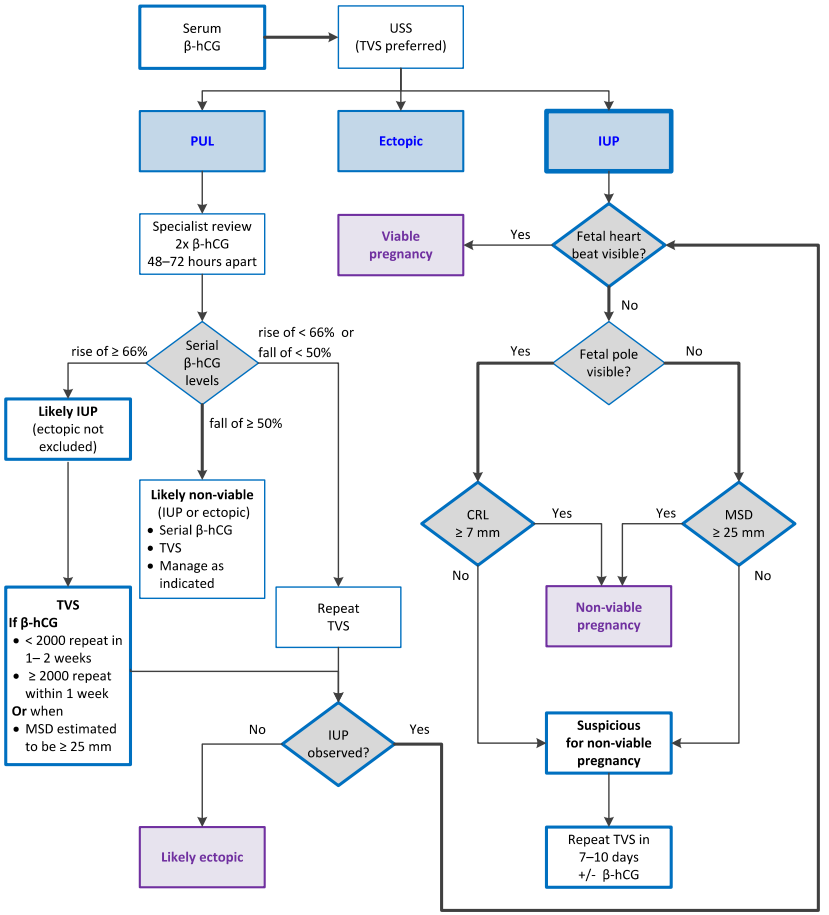
Early pregnancy loss

Queensland Government

https://www.health.qld.gov.au/qcg/

Flowchart: Assessment of location and viability in suspected early pregnancy loss

Use clinical judgement and consider the woman's individual circumstances when recommending management and the need for specialist referral



Non viable diagnostic criteria (TVS)
- MSD ≥ 25 mm and no fetus present
- Fetus with CRL ≥ 7 mm is visible, but no fetal heart movements demonstrated after observation of ≥ 30 seconds
- Absence of embryo with heartbeat ≥ 2 weeks after a scan that showed a gestational sac without a yolk sac
- Absence of embryo with heartbeat ≥ 11 days after a scan that showed a gestational sac with a yolk sac

TVS interval
- Estimate repeat TVS interval based on expected normal gestational sac growth rate of 1 mm/day

Worked example
- If MSD =12 mm, repeat TVS in 13 days or more (12 mm MSD + 13 mm growth over 13 days equals expected MSD of 25 mm)

β-hCG: human chorionic gonadotropin (all β-hCG measurements in international units/L (IU/L)), **CRL:** crown rump length, **IUP:** intrauterine pregnancy, **MSD:** mean sac diameter, **PUL:** pregnancy of unknown location, **TVS:** transvaginal scan, **USS:** ultrasound scan, **>:** greater than, **<:** less than, **≥:** greater than or equal to, **≤:** less than or equal to

Pregnancy of unknown location (PUL)

- Serial B-hCG 48 – 72 hours apart
- B-hCG usually doubles every 48hrs between 5-8 weeks gestation in a viable IUP
- TVS as clinically indicated
- B-hCG > 66 % rise – IUP more likely but ectopic can't be excluded
- B-hCG fall of 50% or greater – non-viable pregnancy more likely (IUP or ectopic)
- B-hCG < 66% rise or < 50% fall – if no IUP on repeat TVS, suspect ectopic

Ectopic pregnancy

- Triad:
  - **Amenorrhea**, 6-8 weeks post LNMP
  - **Abdominal pain**/shoulder tip/rectal
  - Irregular vaginal **bleeding**
- Risk factors include:
  - previous ectopic pregnancy
  - sterilisation
  - pregnancy associated with emergency contraception/POP/IUDs
  - tubal surgery/tubal pathology/infection/PID
  - **1/2 women diagnosed with ectopic pregnancy will have no known risk factors**

Ultrasound: Correlation with B-hCG

- IUP can usually be seen on TVS with B-hCG levels above 800 - 1000 mIU/mL
- A threshold of 1500 mIU/mL will detect 98% IUPs
- Pitfall - multiple pregnancy
- Higher thresholds will result in more missed ectopics
- IUP almost always excludes ectopic (consider heterotopic pregnancy if risk factors)

Appropriate rise in B-hCG

- B-hCG usually doubles every 48hrs between 5-8 weeks gestation in a viable IUP
- If the B-hCG is slowly rising by < 50%, it is usually a non-viable IUP or ectopic
- Consider multiple or molar pregnancy in rapidly rising levels
- Single B-hCG value
  - does not differentiate between viable and nonviable pregnancy
  - cannot be used to exclude IUP

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Maternity and Neonatal **Clinical Guideline**

Early pregnancy loss

Queensland Government

http://www.health.qld.gov.au/qcg/

Flowchart: Ectopic pregnancy

Clinical presentation (may or may not include)
- Absence of menses
- Irregular vaginal bleeding (spotting)
- Abdominal/shoulder tip pain
- Cervical motion tenderness
- Tachycardia and hypotension
- Palpable adnexal mass (50% of women)
- Absence of IUP on USS with a positive β-hCG

Discuss care options relevant to woman's preferences and clinical indications

Expectant

Indicated *only* if:
- Haemodynamically stable
- No evidence of rupture
- Low and falling serum β-hCG (<1500 IU/L at presentation)
- Minimal/no fluid in pelvis on USS
- Tubal mass < 3 cm
- Pain free
- Woman accepts need for follow-up and can access medical services

Caution if:
- Follow-up is uncertain

Ongoing management
- EPAS or equivalent
- β-hCG every 48 hours for 8 days
- If resolution occurring, then weekly β-hCG until negative
- USS if clinically indicated
- Avoid conception until sonographic resolution

Medical

Indications
- Haemodynamically stable
- No evidence of rupture
- No signs of active bleeding
- Normal FBC, ELFT

Contraindications
- Allergy to methotrexate
- Geographic isolation
- Follow-up uncertain
- Presence of medical conditions (review on individual basis)
- Breastfeeding

Caution if:
- Baseline β-hCG > 5000 IU/L
- Ectopic > 3 cm on TVS
- Fetal heart motion present
- Blood transfusion not an option

Methotrexate
- If β-hCG ≤ 3000 IU/L, IMI
- If β-hCG > 3000 IU/L, IVI

Ongoing management
- EPAS or equivalent
- Serial β-hCG as per methotrexate protocol
- USS in one week then as clinically indicated
  - If FH present, refer to MFM
- Avoid conception for 4 months due to potential teratogenicity

Surgical

Indications
- Haemodynamically unstable
- Signs of rupture
- Any β-hCG level
- Persistent excessive bleeding
- Heterotopic pregnancy
- Contraindications to medical or expectant management

Procedure
- Laparoscopy method of choice
- Laparotomy if:
  - Haemodynamically unstable
  - Laparoscopy too difficult

Follow-up
- GP 14 days post-surgery
- If salpingo(s)tomy, weekly β-hCG until negative
- If salpingectomy, urinary β-hCG 3 weeks after surgery
- USS if clinically indicated
- Optimal conception interval unknown (0–3 months common)

If medical or expectant:
- Risk of rupture in acute phase from sexual intercourse or pelvic exam
- Consider alternative management if indicated (e.g. β-hCG not falling, at woman's request, tubal rupture or ongoing pain/bleeding)

Give written information about:
- Management option chosen
- Expected bleeding/symptoms
- Resumption of menstruation
- Contraception
- Follow-up arrangements

General care considerations
- Review histopathology of POC
- If indicated, recommend RhD-Ig
- Analgesia as required
- Communicate information to other care providers (e.g. GP)
- Early USS (5–6 weeks) in next pregnancy

Consider the woman's psychological needs and offer access to support

β-hCG: human chorionic gonadotropin, **ELFT:** electrolyte & liver function test, **EPAS:** Early Pregnancy Assessment Service, **FBC:** full blood count, **GP:** General Practitioner, **GTD:** gestational trophoblast disease, **IMI:** intramuscular injection, IU/L: international units per litre, **IUP:** intrauterine pregnancy, **IVI:** intravenous injection, **MFM:** maternal fetal medicine, **POC:** products of conception, **PUL:** pregnancy of unknown location, **PV:** per vaginam, **QTC:** Queensland Trophoblast Centre, **RhD-Ig:** RhD immunoglobulin, **TVS:** transvaginal scan, **USS:** ultrasound scan, **>:** greater than

Termination of pregnancy (ToP)

In Queensland, as of 3 December 2018:

- Women may request ToP up to a gestational limit of 22 weeks
- For women who are more than 22 weeks, a medical practitioner can perform ToP if they consider that, in all the circumstances, ToP should be performed **and**
- They have consulted with another medical practitioner who also considers that, in all the circumstances, ToP should be performed

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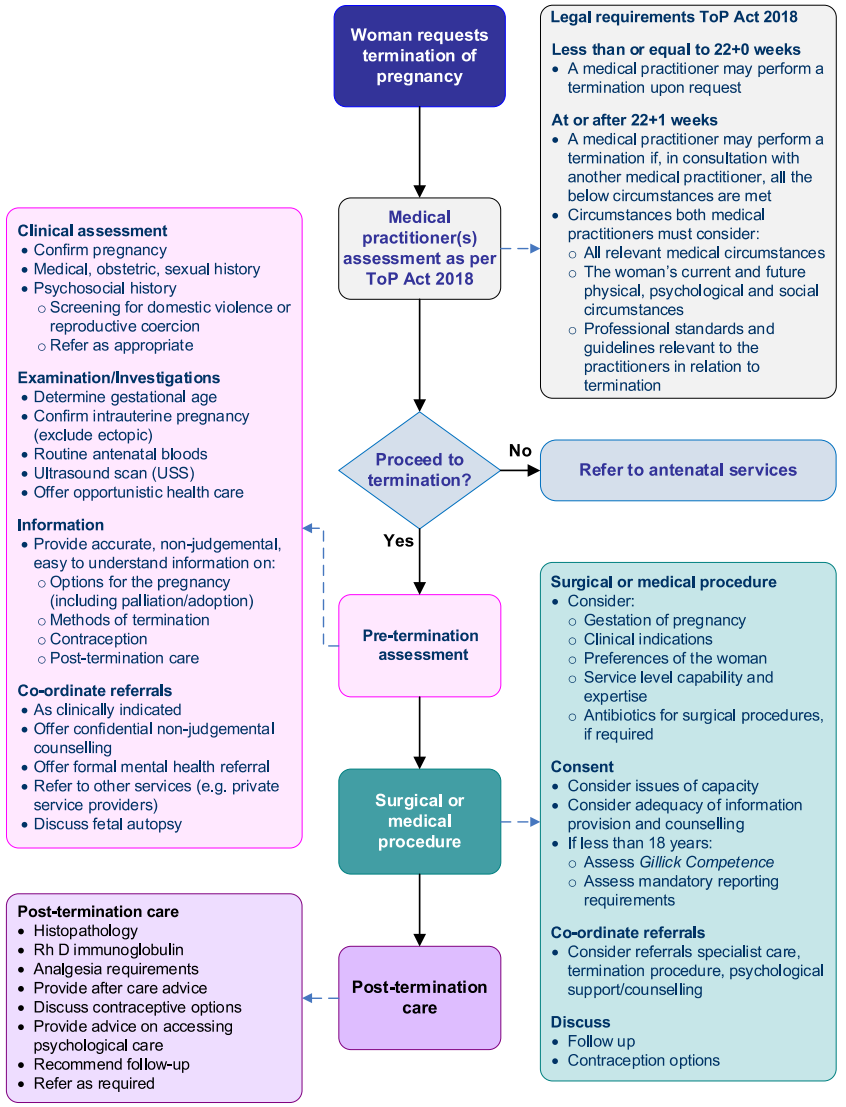
Maternity and Neonatal **Clinical Guideline**

Termination of pregnancy

Queensland Government

https://www.health.qld.gov.au/qcg/

Flow Chart: Summary of termination of pregnancy



Termination of pregnancy

Emergency department referrals

All urgent cases must be discussed with the on call Registrar to obtain appropriate prioritisation and treatment. Contact through:

- Royal Brisbane and Women's Hospital (07) 3646 8111
- The Prince Charles Hospital (07) 3139 4000
- Redcliffe Hospital (07) 3883 7777
- Caboolture Hospital (07) 5433 8888

Urgent cases accepted via phone must be accompanied with a written referral and a copy faxed immediately to the Central Patient Intake Unit: 1300 364 952.

> *From 3 December 2018 the Termination of Pregnancy Act 2018 ensures a termination of pregnancy is treated as a health issue rather than a criminal issue in Queensland. The Act supports a woman's right to health and autonomy, provides clarity for health practitioners, and brings Queensland in line with other Australian jurisdictions.*
> *Information for health practitioners can be found on the Clinical Excellence website or by contacting 13HEALTH.*
>
> *The Queensland Clinical Guideline – Termination of Pregnancy has been updated and Termination of Pregnancy Clinical Prioritisation Criteria have been developed.*

Registered medical practitioners may perform a lawful termination of pregnancy on request up to a gestational limit of 22 weeks.

For a woman who is more than 22 weeks pregnant, a termination may be performed by a medical practitioner if they consider that, in all the circumstances, the termination should be performed and they have consulted with another medical practitioner who also considers that, in all the circumstances, the termination should be performed.

Most terminations of pregnancy are performed in the private sector, sometimes supported with financial grants.

+ Other Gynaecology conditions

Send referral

Hotline: 1300 364 938

Electronic:
GP Smart Referrals (preferred)
eReferral system templates
Medical Objects ID: MQ40290004P
HealthLink EDI: qldmnhhs

Mail:
Metro North Central Patient Intake
Aspley Community Centre
776 Zillmere Road
ASPLEY QLD 4034

Health pathways

Access to Health Pathways is free for clinicians in Metro North Brisbane.

For login details email: healthpathways@brisbanenorthphn.org.au

Login to Brisbane North Health Pathways:

HealthPathways

Brisbane North

Gynaecology
Abnormal Vaginal Bleeding
Amenorrhoea
Cervical Cancer Screening
Cervical Polyps
Cervical Shock
Dysmenorrhoea
Endometrial Cancer Low Risk Follow-up
Female Genital Mutilation (FGM)
Fibroids
Hysteroscopy
Menopause
Ovarian Cancer Symptoms
Ovarian Cyst or Pelvic Mass
Prolapse
Chronic Pelvic Pain in Females
Perineal Tear Follow-up
Polycystic Ovarian Syndrome (PCOS)
Premenstrual Syndrome (PMS)
Vaginal Pessaries
Sub-fertility
Termination of Pregnancy (TOP)
Urinary Incontinence in Women
Vulvodynia
Pregnancy
Women's Health Requests
Our Health System

Home / Women's Health / Gynaecology / Termination of Pregnancy (TOP)

Termination of Pregnancy (TOP)

Red flags

- Pregnancy in a minor
- Ectopic pregnancy

Background

About termination of pregnancy (TOP)

Assessment

1. If you are not comfortable dealing with requests for TOP (e.g., conscientious objector) you must:
   - disclose your position to the patient.
   - arrange timely transfer of care to another service or medical practitioner who is not a conscientious objector and who can provide the service.
2. Take a history and check for:
   - symptoms.
   - gynaecological and obstetric history.
   - co‑morbidities which may have an impact on the pregnancy or on the method of termination e.g., heart disease, VTE, liver disease.
   - psychosocial vulnerabilities and protective factors.
3. Assess patient's emotional and mental state in a sensitive and culturally safe manner.
   - Establish patient's certainty of the decision, commitment to seeking termination, and her understanding of the implications of a TOP.
   - If there is ambivalence, assess patient for low mood, psychological distress, disturbed mental state, or indications she may be acting under duress.
   - Aim to identify:
     - need for additional support during decision making.
     - whether patient may be at increased risk of adverse mental health outcomes.
4. If the patient is a minor (aged < 18 years), assess if the sexual activity is abusive or puts the minor at risk of harm.
5. Arrange investigations.

Metro North ToP Nurse Navigator

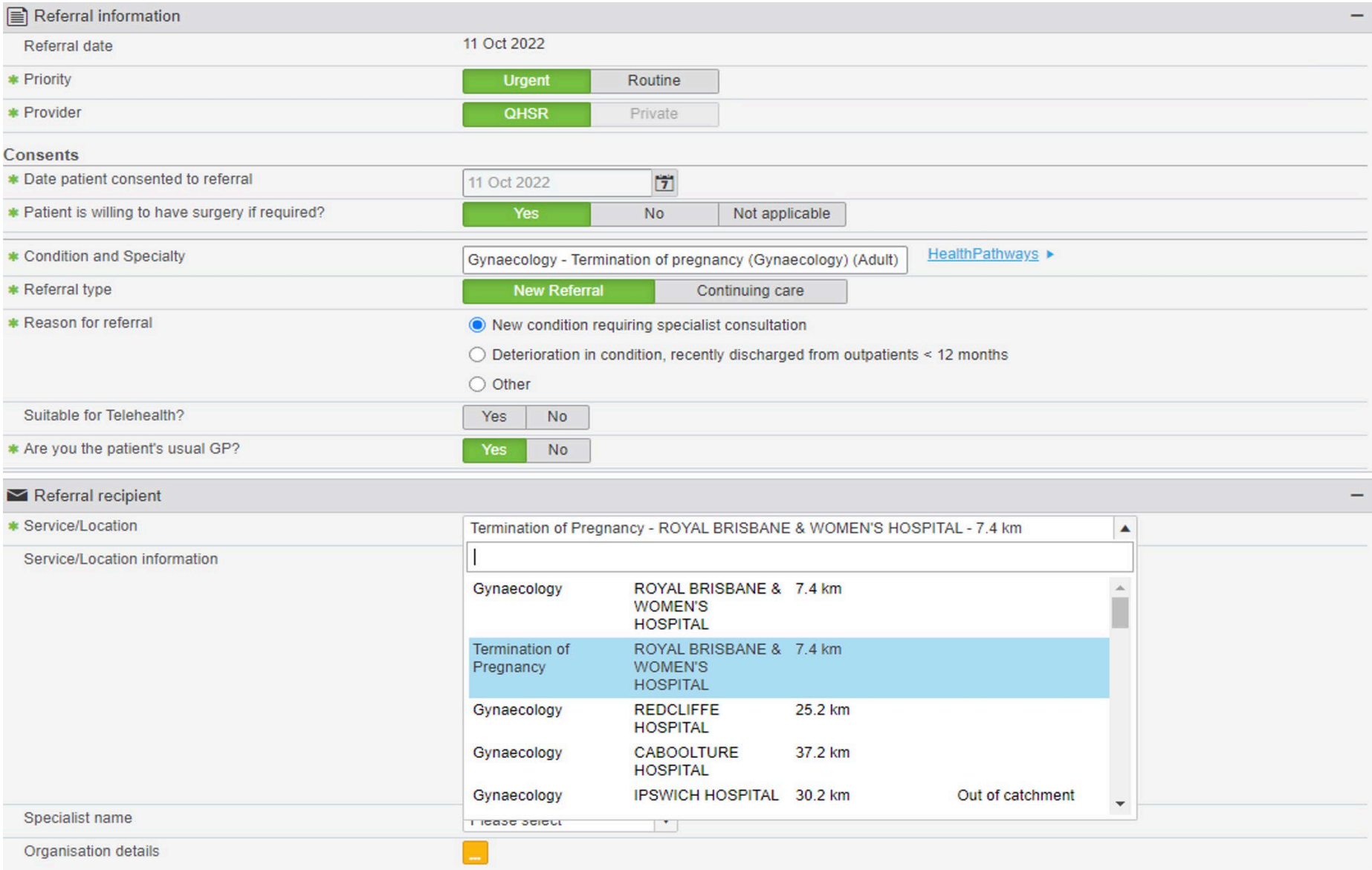
- **GP advice**
  - Monday – Friday 07:00 – 15:30
  - Phone: 0408 940 183
  - Email: http://metronorthtop@health.qld.gov.au

Metro North ToP Nurse Navigator

Referrals for RBWH, Redcliffe and Caboolture triaged by MN ToP Nurse Navigator

- GPSR (preferred)
  - mark urgent
  - *Condition and Specialty* Gynecology - Termination of pregnancy (Gynecology) (Adult)
  - *Service/Location* - Termination of Pregnancy - ROYAL BRISBANE & WOMEN'S HOSPITAL (for ToP referrals to RBWH, Redcliffe & Caboolture)
- eReferral
  - mark urgent and clearly state for ToP
  - Gynaecology RBWH, Redcliffe, Caboolture
- Include
  - ultrasound confirming viable intrauterine pregnancy including fetal heart rate
  - pathology including blood group and STI screen

Metro North ToP Nurse Navigator



Rh D negative women

- Pregnant women who are Rh D negative fall into two categories: those with and those without Anti-D antibodies

- **Women with Rh D (or any other) antibodies are not suitable for shared care**

Summary of guidance on the use and timing of Rh D immunoglobulin for sensitising event immunoprophylaxis

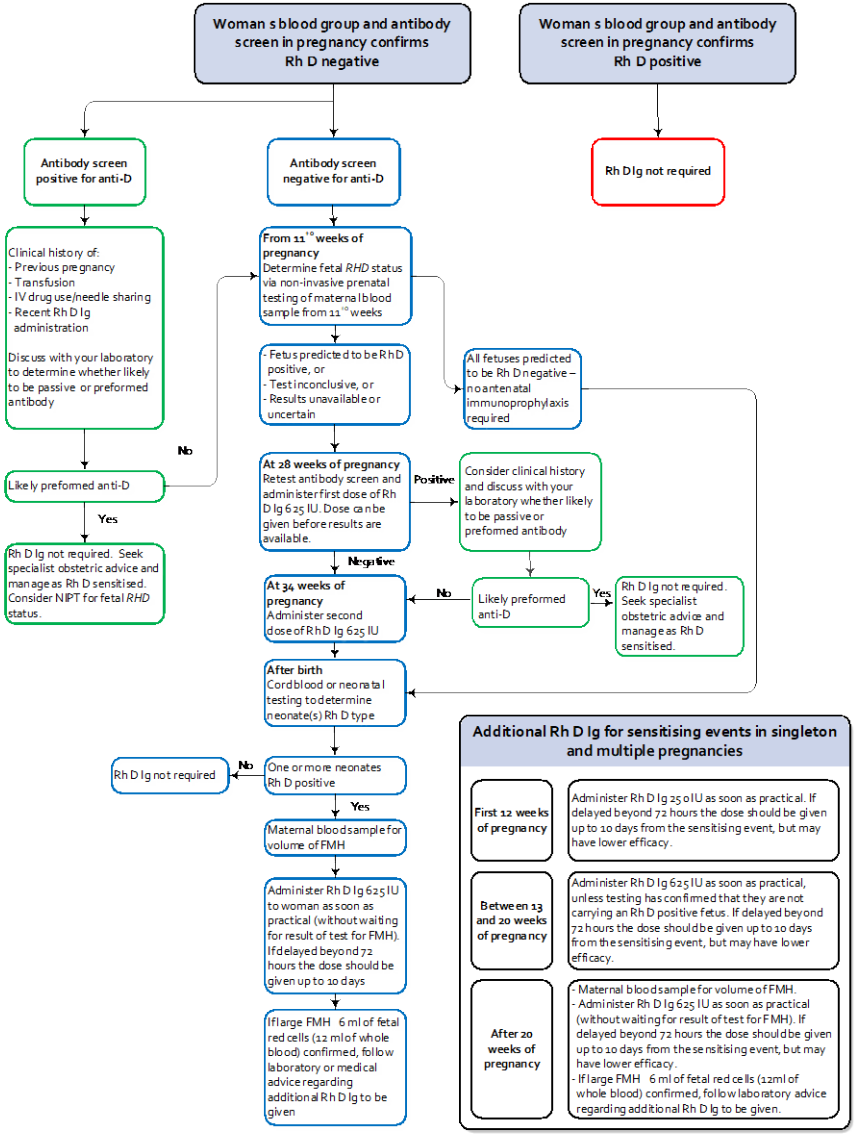
Clinical indication		Rh D immunoglobulin dose and timing	Target group	Relevant section of Guideline
Sensitising event immunoprophylaxis				
Sensitising event immunoprophylaxis in the first 12 weeks of pregnancy	• Miscarriage • Termination of pregnancy (medical after 10 weeks gestation or surgical) • Ectopic pregnancy • Molar pregnancy • Chorionic villus sampling	250 IU As soon as practical within 72 hours. If delayed beyond 72 hours, the dose should be given up to 10 days from the sensitising event, but may have lower efficacy For ongoing uterine bleeding alone, a repeat dose of Rh D immunoglobulin (250 IU if before 12 weeks and 625 IU if after) may be appropriate after an interval of 6 weeks	All Rh D negative women with no preformed anti-D antibodies	3.2.1
Sensitising event immunoprophylaxis after 12^{+6} weeks of pregnancy	• Genetic studies (chorionic villus sampling, amniocentesis and cordocentesis) • Abdominal trauma considered sufficient to cause fetomaternal haemorrhage, even if FMH testing is negative • Each occasion of revealed or concealed antepartum haemorrhage. Where the woman suffers unexplained uterine pain the possibility of concealed antepartum haemorrhage (and the need for immunoprophylaxis) should be considered • External cephalic version (successful or attempted) • Miscarriage or termination of pregnancy	625 IU As soon as practical within 72 hours. If delayed beyond 72 hours, the dose should be given up to 10 days from the sensitising event, but may have lower efficacy For ongoing uterine bleeding alone, a repeat dose may be appropriate at 6 weekly intervals	All Rh D negative women with no preformed anti-D antibodies (unless NIPT for fetal *RHD* has predicted the fetus to be Rh D negative)	3.5.1
Sensitising event immunoprophylaxis *(cont.)*				
Large FMH ≥6 mL of fetal red cells (equivalent to 12 mL of whole blood)	• Antepartum • Postpartum	625 IU as soon as possible Follow laboratory or specialist obstetric advice for additional doses of IM Rh D immunoglobulin or IV Rh D immunoglobulin, and for follow-up testing	All Rh D negative women with no preformed anti-D antibodies (unless NIPT for fetal *RHD* has predicted the fetus to be Rh D negative)	3.5.1

FMH: fetomaternal haemorrhage; IM: intramuscular; IU: international units; IV: intravenous; NIPT: non-invasive prenatal testing

anti-D - refers to circulating antibodies; *RHD* - refers to genotype; Rh D immunoglobulin - refers to the product; Rh D positive/negative - refers to blood type

Summary of clinical guidance

Care pathway for the prophylactic use of Rh D immunoglobulin in pregnancy care



FMH, fetomaternal haemorrhage; Ig, immunoglobulin; IU, international units; IV, intravenous.

anti-D - refers to circulating antibodies; *RHD* - refers to genotype; Rh D positive/negative - refers to blood type.

This care pathway is a snapshot of the clinical guidance contained within the guideline, which is based on clinical evidence and expert consensus. Policy relating to universal access to NIPT for fetal *RHD* is outside the scope of this guideline. The pathway is designed to be adapted to meet the needs and operations of individual organisations.

Adapted from NSW Health (2015)

Anti-D administration

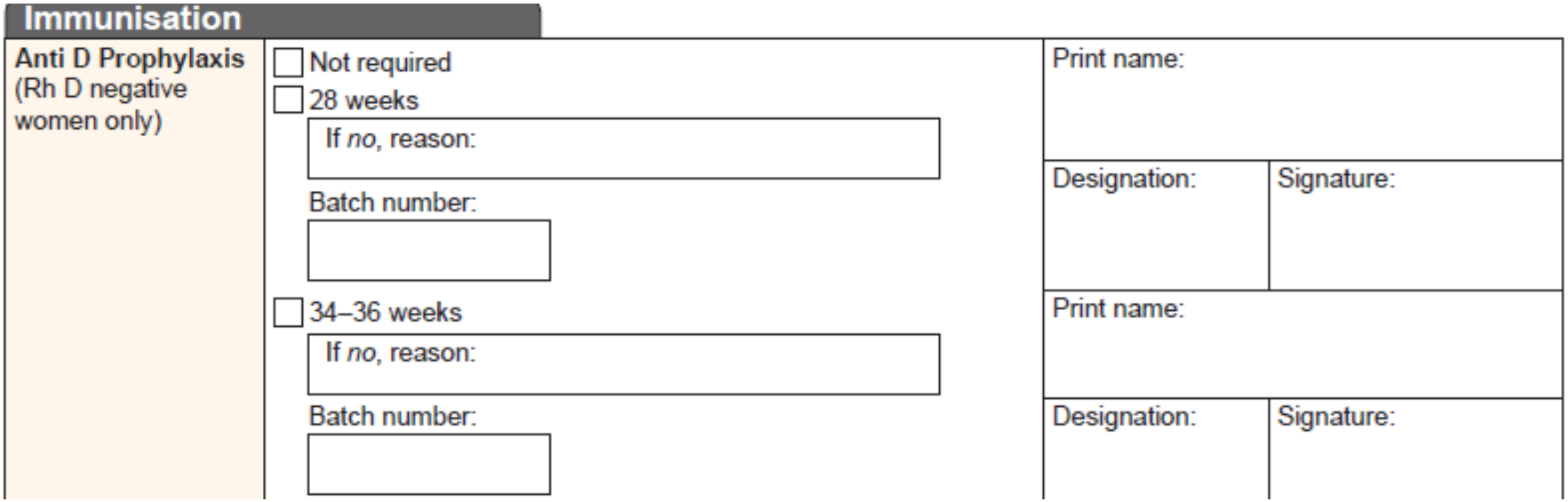
- Routine prophylaxis at 28 and 34/40

  625 IU (125µg)

- Sensitising events – within 72 hours
  - T1 250 IU (50µg)
  - T2/T3 625 IU (125µg)

- Postnatal if Rh D positive baby – quantify fetomaternal haemorrhage to guide dose – give within 72 hours

Routine Anti-D prophylaxis



Immunisation

Anti D Prophylaxis (Rh D negative women only)	☐ Not required ☐ 28 weeks If *no*, reason: Batch number: ☐ 34–36 weeks If *no*, reason: Batch number:	Print name: Designation: / Signature: Print name: Designation: / Signature:	

https://clinicalexcellence.qld.gov.au/sites/default/files/docs/clinical-pathways/pregnancy-health-record.pdf

Anti-D can be ordered from Red Cross or QML Blood Bank. **Please record the routine administration at 28 and 34-36 weeks on page a4 of the Pregnancy Health Record (PHR).** 625 IU (125 µg) is recommended for ALL Rh negative women unless they are antibody positive.

Anti-D prophylaxis for sensitising events

Any situation in which there is a risk of fetomaternal haemorrhage

- Miscarriage
- ToP (mToP after 10/40 or sToP)
- Ectopic pregnancy
- Molar pregnancy
- CVS, amniocentesis or other invasive fetal intervention
- External cephalic version
- Abdominal trauma
- Antepartum haemorrhage

Anti-D administration

- Order via QML blood bank
  - https://www.qml.com.au/
  - download and complete Anti-D request form
  - email completed form to http://QML_BriBBLab@qml.com.au
  - Anti D delivered the next business day
  - Enquiries 07 3146 5122

Request for Anti-D Immunoglobulin Injection

Please email completed form to QML Pathology Blood Bank on QML_BriBBLab@qml.com.au.
For further information, please call QML Pathology Blood Bank on (07) 3146 5122.

Date: _____

Name of person requesting: _____

Contact Phone No.: _____

Delivery Address: _____

Requesting Doctor: _____

Patient Details

Patient Name: _____

Date of Birth: _____

☐ Mini Dose Anti-D 250 IU
Quantity: _____

☐ Standard Dose Anti-D 625 IU
Quantity: _____

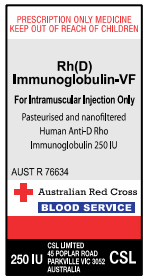
Stock

☐ Mini Dose Anti-D 250 IU
Quantity: _____

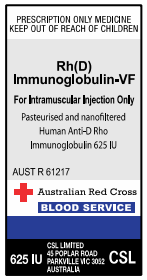
☐ Standard Dose Anti-D 625 IU
Quantity: _____

Email completed form to:
QML_BriBBLab@qml.com.au

Orders will be processed once daily and dispatched the following business day.



Mini-Dose Anti-D 250 IU



Standard Dose Anti-D 625 IU

Office Use Only

Packaged by: _____

Date: _____ Time: _____

qml.com.au

Specialist Diagnostic Services Pty Ltd (ABN 84 007 190 043) t/a QML Pathology PUB/MR/606, v5 (May21)

QML Pathology
Specialists in Private Pathology since the 1920s

Anti-D administration

- If you do not have a QML service, Anti-D can be ordered via Red Cross
  - register to order Anti-D
  - https://www.lifeblood.com.au/contact - health-professionals
  - phone 07 3838 9010

Anti-D administration

- If you *don't* have access to anti–D, please contact and refer the woman to:
  - Hospital ED for early pregnancy bleeding
  - Maternity Assessment Unit for routine prophylaxis
- If bleeding or this is 28/40 injection, send with copy of recent blood group and antibody result
- Blood group & antibody test not required for 34/40 injection if done at 28/40

Changes to Anti D use

- Insufficient evidence to support use of Rh D immunoglobulin in bleeding prior to 12 weeks gestation in an ongoing pregnancy unless bleeding is repeated, heavy or associated with abdominal pain or significant pelvic trauma
- If pregnancy requires curettage or spontaneous miscarriage occurs, 250 IU (50µg) Rh D immunoglobulin should be given
- If miscarriage or termination after 12 weeks gestation, 625 IU (125 µg) Rh D immunoglobulin should be offered

https://www.blood.gov.au/anti-d-0
https://ranzcog.edu.au/resources/statements-and-guidelines-directory/