



Complete Summary

GUIDELINE TITLE

DoD/VA clinical practice guideline for management of uncomplicated pregnancy.

BIBLIOGRAPHIC SOURCE(S)

Veterans Health Administration, Department of Defense. DoD/VA clinical practice guideline for the management of uncomplicated pregnancy. Washington (DC): Department of Veteran Affairs; 2002 Oct. Various p. [533 references]

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
CONTRAINDICATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT
CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY

SCOPE

DISEASE/CONDITION(S)

- Uncomplicated pregnancy (Evaluation; Screening; Risk Assessment/Prognosis; Management)
- Complications of pregnancy (Screening; Prevention)

GUIDELINE CATEGORY

Evaluation
Management
Prevention
Risk Assessment
Screening

CLINICAL SPECIALTY

Family Practice
Obstetrics and Gynecology

INTENDED USERS

Advanced Practice Nurses
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To provide a scientific evidence-base for practice interventions and evaluations
- To enhance patient education so that pregnant women and their providers will each be aware of the specific expectations for every visit, thus promoting a partnership with a common goal of a healthy infant and mother
- To improve patient and provider satisfaction with antenatal care from initial encounter in the clinic through parturition by providing an overview of screening and monitoring options as well as discussion about general clinical approaches to uncomplicated pregnancy
- To change the traditional interval-based visit template to a system with specific gestational age visits, each having a specific well-defined goal and objectives

TARGET POPULATION

Pregnant female patients eligible for care in the Department of Defense/Veterans Administration (DoD/VA) health care delivery system

INTERVENTIONS AND PRACTICES CONSIDERED

Interventions at All Visits

1. Screening for hypertensive disorders of pregnancy
2. Breastfeeding education
3. Exercise during pregnancy
4. Influenza vaccine (season-related)
5. Referral to a specialist if client no longer meets criteria for uncomplicated pregnancy

Interventions at First Visit (6-8 Weeks)

1. Self-questionnaire of prenatal risk factors
2. Selected history taking
3. Selected physical examination (thyroid disorders, hypertension, sexually transmitted disease, body mass index [BMI], vital signs, domestic violence, blood pressure, cardiac abnormality, vaginal bleeding, pelvic exam, dating criteria)
4. Screening for tobacco use – offer cessation
5. Screening for alcohol use – offer cessation
6. Screening for drug abuse – offer treatment
7. Screening for domestic abuse
8. Screening for Rh Status

9. Screening for rubella
10. Screening for varicella
11. Screening for hepatitis B
12. Screening for syphilis rapid plasma regain (RPR)
13. Screening for asymptomatic bacteriuria (ASB)
14. Screening for human immunodeficiency virus (HIV) – Counsel
15. Immunization – tetanus diphtheria (Td) booster (first trimester)
16. Immunization – hepatitis B (first trimester)
17. Laboratory testing as indicated (Glucola for gestational diabetes mellitus [GDM], cervical smear, complete blood count [CBC], ABO Rh blood typing, rapid plasma reagent [RPR], rubella test, hepatitis B surface antigen test, gonorrhea and Chlamydia test, urinalysis and culture, antibody screen

Interventions at First Visit with Provider (10-12 Weeks)

1. Assessing inappropriate weight gain
2. Auscultation fetal heart tones
3. Screening fundal height
4. Screening for gonorrhea
5. Screening for chlamydia
6. Screening for cervical cancer
7. Counseling for cystic fibrosis screening

Interventions (Weeks 16-27)

1. Maternal serum analyte screening
2. Routine ultrasound
3. Counseling for family planning
4. Educate regarding preterm labor

Interventions (Weeks 28-36)

1. Assess for preterm labor
2. Daily fetal movement counts
3. Screening for gestational diabetes
4. Iron supplementation
5. Anti-D prophylaxis for Rh-Negative pregnant women
6. Screening for Group B Streptococcus (GBS)
7. Assessment of fetal presentation

Interventions (Weeks 38-41)

1. Weekly cervical check (stripping)
2. Post-dates antenatal fetal testing

Guideline Developer Recommendation against the Following Interventions During Pregnancy

1. Screening with fetal fibronectin
2. Cervical examination
3. Antenatal pelvimetry

4. Routine urine dipstick test
5. Routine edema evaluation
6. Screening for cytomegalovirus (CMV)
7. Screening for parvovirus
8. Screening for toxoplasmosis
9. Screening for bacterial vaginosis
10. Vitamin supplementation
11. Immunization – measles, mumps, rubella (MMR)
12. Immunization – Varicella
13. Ultrasound (US) evaluation of cervical length at week 24
14. Repeat screening for anemia, syphilis, and isoimmunization
15. Screening for hypothyroidism

MAJOR OUTCOMES CONSIDERED

- Maternal, fetal, and neonatal outcomes (morbidity, mortality, complications of pregnancy)
- Patient and provider satisfaction
- Identification of high-risk pregnancies

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The Institute for Clinical Systems Improvement (ICSI) - Health Care Guideline: Routine Prenatal Care (2000) was identified by the Working Group as an appropriate seed guideline. It served as the starting point for the development of questions and key terms.

Fifty-six researchable questions and associated key terms were developed by the Working Group after orientation to the seed guideline and to goals that had been identified by the Working Group. The questions specified:

- Population - characteristics of the target population
- Intervention - diagnostic, screening, therapy, and assessment
- Control - the type of control used for comparison
- Outcome - the outcome measure for this intervention (morbidity, mortality, patient satisfaction, and cost)

A systematic search of the literature was conducted. It focused on the best available evidence to address each key question, and ensured maximum coverage of studies at the top of the hierarchy of study types: evidence-based guidelines, meta-analyses, and systematic reviews (Cochrane, EBM, and EPC reports). The Institute for Clinical Systems Improvement (ICSI) Guideline evidence was carefully reviewed. The Working Group agreed that ICSI, Cochrane, or other

meta-analyses addressed 32 of the questions. Three questions were not researched because legal mandates preclude debate.

At this point, the focus shifted to the 21 remaining questions that required further study. The search continued using well-known and widely available databases that were appropriate for the clinical subject. Limits on language (English), time (1990 through June 2001) and type of research (randomized controlled trials [RCT]) were applied. The search included MEDLINE and additional specialty databases, depending on the topic.

The search strategy did not cast a wide net. Once definitive clinical studies that provided valid relevant answers to the question were identified, the search stopped. It was extended to studies/reports of lower quality (observational studies) only if there were no high quality studies.

The results of the search were organized and reported using reference manager software. At this point, additional exclusion criteria were applied. Typical exclusions were studies with physiological endpoints, or studies of populations that were not comparable to the population of interest (e.g., studies of practices in Third World counties).

Evidence Appraisal Reports for each of the 21 unanswered questions were prepared by the Center for Evidence-based Practice at the State University of New York, Upstate Medical University, Department of Family Medicine (these reports are available by request). Each report covered:

- Summary of findings
- Methodology
- Search terms
- Resources searched
- Articles critically appraised
- Findings

The Working Group suggested some additional references. Copies of specific articles were provided to participants on an as-needed basis. This document includes references through June 2001.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Practicing clinicians thoroughly evaluated the evidence-based recommendations. The clinical experts and research team evaluated the evidence according to criteria proposed by the U.S. Preventive Services Task Force (USPSTF) (2001).

The experts themselves, after an orientation and tutorial on the evidence grading process, formulated Quality of Evidence ratings, a rating of Overall Quality, a rating of the Net Effect of the Intervention, and an overall Recommendation.

Quality of Evidence (QE)

I: Evidence obtained from at least one properly randomized controlled trial

II-1: Evidence obtained from well-designed controlled trials without randomization

II-2: Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group

II-3: Evidence obtained from multiple time series studies with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.

III: Opinions of respected authorities, based on clinical experience; descriptive studies and case reports; or reports of expert committees

Overall Quality

Good: High grade evidence (I or II-1) directly linked to health outcome

Fair: High grade evidence (I or II-1) linked to intermediate outcome or Moderate grade evidence (II-2 or II-3) directly linked to health outcome

Poor: Level III evidence or no linkage of evidence to health outcome

Net Effect of Intervention

Substantial:

- More than a small relative impact on a frequent condition with a substantial burden of suffering, or
- A large impact on an infrequent condition with a significant impact on the individual patient level

Moderate:

- A small relative impact on a frequent condition with a substantial burden of suffering, or
- A moderate impact on an infrequent condition with a significant impact on the individual patient level

Small:

- A negligible relative impact on a frequent condition with a substantial burden of suffering, or
- A small impact on an infrequent condition with a significant impact on the individual patient level

Zero or Negative:

- Negative impact on patients, or

- No relative impact on either a frequent condition with a substantial burden of suffering, or
- An infrequent condition with a significant impact on the individual patient level

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Guideline for the Management of Uncomplicated Pregnancy is the product of many months of diligent effort and consensus building among knowledgeable individuals from the Veterans Administration (VA), Department of Defense (DoD), academia, and guideline facilitators from the private sector. An experienced moderator facilitated the multidisciplinary Working Group that included obstetricians, midwives, internists, family practitioners, physician´s assistants, nurses, and pharmacists, as well as consultants in the field of guideline and algorithm development.

The Working Group participated in two face-to-face sessions to reach a consensus about the guideline recommendations and to prepare a draft document. The draft was revised by the experts through numerous conference calls and individual contributions to the document. The guideline presents evidence-based recommendations that have been thoroughly evaluated by practicing clinicians.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The following rating scheme is from the U.S. Preventive Services Task Force (USPSTF) (2001).

Grade of Recommendation

- A: A strong recommendation that the intervention is always indicated and acceptable
- B: A recommendation that the intervention may be useful/effective
- C: A recommendation that the intervention be considered
- D: A recommendation that a procedure may be considered not useful/effective, or may be harmful
- I: Insufficient evidence to recommend for or against; clinical judgment should be used

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The final draft of the guideline is distributed for review by an at large audience across the Veterans Administration (VA) and Department of Defense (DoD). Patient Care Services and the Network-appointed Guideline Champions solicit feedback from a broader group of end users. Members of related QUERI groups are also asked to comment. Network designated staff will be asked to use the guideline in the direct care setting and provide feedback to the Network Guideline Champions. This portion of the field test is intended to provide feedback regarding the format and usability. At this time, the peer review of the guideline is also being completed by at least three VA /DoD staff, including primary care clinicians, who have been trained and previously assigned to perform the independent review. Within 3 weeks, the rating tool containing the reviewer's comments and recommendation will be forwarded to the Office of Quality and Performance and the Vice Chairperson of the NCPG Council. The Vice Chairperson of the NCPG Council will forward a summary of the recommendations from the peer reviewers to the National Champions. Final editing incorporates feedback as appropriate. The National Senior Champions along with the Evidence Chaperone and the NCGPC Representative will integrate comments and suggestions into the final document as appropriate. Discussion of serious controversies regarding interpretation of the evidence will be included in the introduction to the guideline and may be the subject of discussion at the time of review with the Council. Provider tools will also be finalized and submitted to Employee Education System for final formatting. Prior to delivery to the NCPG Council, the champions group will re-convene by conference call to approve the final draft and tools.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The recommendations for the management of uncomplicated pregnancy in the primary care setting are organized into 3 major algorithms. The algorithms, the objectives, annotations, and recommendations that accompany them, and the evidence supporting the recommendations are presented below. The quality of evidence (I, II-1, II-2, II-3, III), overall quality (good, fair, poor), net effect of intervention (substantial, moderate, small, zero or negative), strength of recommendation grading (A-D, I) are defined at the end of the "Major Recommendations" field.

Note: A list of abbreviations is provided at the end of the "Major Recommendations" field.

Algorithm: Management of Uncomplicated Pregnancy

A. Confirmed Pregnancy

Confirmation of pregnancy is established by a confirmed positive urine or serum pregnancy test.

B. First Visit with Nurse: 6 To 8 Weeks

Complete Self-Questionnaire
Assess For Risk Factors

Annotation

After confirmation of the pregnancy, the goal of the first prenatal contact is to exchange information and identify existing risk factors that may impact the pregnancy. This initial contact may be accomplished in a group setting or during a one-on-one visit. Table 1 in the original guideline document contains a checklist of the data collected during the first visit with the nurse and/or health care provider (Family Practitioner, Certified Nurse-Midwife or Obstetrician/Gynecologist [OB/GYN]). These data are required to assess the appropriateness of using the Uncomplicated Pregnancy Guideline follow-up. In addition, all active duty pregnant women are required to have an occupational health screening per AR40-501 exception to policy.

C. Are There Any Contraindications To Continue With The Uncomplicated Pregnancy Guideline?

Annotation

Indications for Referral to Physician on First Visit

Past OB/GYN History:

- Prior preterm delivery (<37 weeks)
- Intrauterine fetal demise (IUFD) – 10 weeks after cardiac activity
- Prior cervical/uterine surgery
- Prior preterm labor requiring admission (e.g., early cervical change)
- Fetal anatomic abnormality (e.g., open neural tube defects in prior child or first degree relative)
- Past complicated pregnancy

Medical History:

- Pre-existing diabetes
- Gestational diabetes
- HIV
- Chronic hypertension
- Systemic disease that requires ongoing care (e.g., severe asthma, lupus, and inflammatory bowel disease)
- Current mental illness requiring medical therapy
- Cancer

- Seizure disorders
- Hematologic disorders
- Recurrent urinary tract infections/stones

Psycho-Social:

- Substance use disorders
- Eating disorders
- Postpartum depression

Conditions in Current Pregnancy:

- Relative body mass index (BMI) <16.5
- Age (<16 or >40 years at delivery)
- Vaginal bleeding

D. Are There Absolute Contraindications To Continue With The Uncomplicated Pregnancy Guideline?

Annotation

Absolute Contraindications to the Uncomplicated Pregnancy Guideline:

Pregnant women identified as having any of the following conditions should exit the Uncomplicated Pregnancy Guideline.

- Pre-existing diabetes
- Gestational diabetes mellitus (GDM)
- Fetal anomaly or abnormal presentation (≥ 36 weeks)
- Multiple gestation
- Placenta previa
- Chronic hypertension
- Systemic disease that requires ongoing care (e.g., severe asthma, lupus, and inflammatory bowel disease)
- Drug abuse
- Human immunodeficiency virus (HIV) (or abnormal screen)

Relative Contraindications to the Uncomplicated Pregnancy Guideline:

Pregnant women identified as having one or more of the following conditions should be evaluated by a healthcare provider (experienced in obstetrics) to determine the risk of continuing with the Uncomplicated Pregnancy Guideline.

- Age (<16 or >40 years at delivery)
- Past complicated pregnancy
- Prior preterm delivery (<37 weeks)
- Prior preterm labor requiring admission (e.g., early cervical change)
- Intrauterine fetal demise (IUFD) – 10 weeks after cardiac activity was first noted
- Prior cervical/uterine surgery

- Fetal anatomic abnormality (e.g., open neural tube defects in prior child or first degree relative)
- Abnormal fetal growth
- Preterm labor requiring admission (i.e., regular uterine contractions and cervical change)
- Abnormal amniotic fluid
- Second or third trimester bleeding
- Relative BMI <16.5
- Hematologic disorders
- Severe anemia (<24 percent hematocrit)
- Cancer
- Seizure disorders
- Recurrent urinary tract infection/stones
- Substance use disorders (alcohol/tobacco)
- Eating disorders
- Surgery
- Abnormal screen – antibody, hepatitis, syphilis, and Papanicolaou (PAP)
- Abnormal maternal serum analyte test (e.g., triple screen)
- Current mental illness requiring medical therapy

E. Visit With Provider - Weeks 10-12

Annotation

See Prenatal Care Interventions and Interventions Summary Table in the original guideline document.

F. Routine Visits - Weeks 16-27

Annotation

Visits during this period should include the following:

- Auscultation of fetal heart tones - if negative, elevate care
- Screening fundal height
- Screening for hypertensive disorders
- Assessing inappropriate weight gain
- Educate about symptoms of preterm labor (week 20)
- Review for development of contraindications – exit the Uncomplicated Pregnancy Guideline if absolute contraindications are identified

For specific interventions see Prenatal Care Interventions – Weeks 16-27.

G. Routine Visits - Weeks 28-41

Annotation

Visits during this period should include the following:

- Auscultation of fetal heart tones - if negative, elevate care

- Screening fundal height
- Screening for hypertensive disorders
- Assessing inappropriate weight gain
- Assess for symptoms of preterm labor (week 28)
- Assessment of fetal kick counts
- Review for development of contraindications - exit the Uncomplicated Pregnancy Guideline if absolute contraindications are identified

For specific interventions see Prenatal Care Interventions – Weeks 28-41.

H. Postpartum Visit

Annotation

The postpartum visit provides the opportunity for providers to interact with the new mother and her infant through interview, exam, and testing. The timing and the content of the postpartum visit have often been topics for debate. Recent literature helps the provider to answer these questions based on the evidence.

- The maternal postpartum visit should occur approximately 8 weeks after delivery. Eight weeks is the optimal time to decrease the rate of false positive cervical smears, though consideration of the mother's schedule should also be taken into account. (Rarick & Tchabo, 1994) (Quality of the Evidence [QE]: I; Overall Quality: Good; Recommendation [R]: B)
- Tests that should be performed at this visit include the cervical smear, pelvic exam, and breast exam. (Londo et al., 1994; Weiss, Senf, & Udall, 1989) (QE: II; Overall Quality: Fair; R: B)
- Topics addressed at this exam should include contraception, postpartum depression, feeding method, sexual activity, weight, exercise and the woman's assessment of her adaptation to motherhood. (QE: III; Overall Quality: Poor; R: C)

Prenatal Care Interventions

To see a prenatal care intervention summary table, refer to the original guideline document.

Interventions at All Visits

I-1 Screening for Hypertensive Disorders of Pregnancy -- Weeks: All

The Working Group's Recommendations for Women in Low Risk Pregnancy:

1. Recommend measuring blood pressure of all pregnant women at each prenatal visit, following the guidelines of the National High Blood Pressure Education Program and the Veterans Administration/Department of Defense (VA/DoD) Clinical Practice Guidelines for Hypertension. (National Institutes of Health (NIH) Working Group on High Blood Pressure in Pregnancy, 2000;

- United States Preventive Services Task Force (USPSTF), Guide to Clinical Preventive Services, 1996) (QE: III; Overall Quality: Good; R: B)
2. Women diagnosed with hypertension during pregnancy should exit the Uncomplicated Pregnancy Guideline. (NIH Working Group on High Blood Pressure in Pregnancy, 2000; Cunningham & Lindheimer, 1992) (QE: III; Overall Quality: Good; R: B)
 3. Korotkoff 5 sound (disappearance of sound) will be used to determine the diastolic pressure.

I-2 Breastfeeding Education -- Weeks: All

The Working Group's Recommendations for Women in Low Risk Pregnancy:

1. Recommend offering breastfeeding education to all pregnant women at 10 to 12 weeks or the first visit with the provider. (American Academy of Pediatrics [AAP], 1997; Hill & Humenick, 1993; Hill, 1991) (QE: III, II-3; Overall Quality: Fair; R: B)
2. Recommend asking pregnant women, "What do you know about breastfeeding?" rather than, "Do you plan on breast or bottle feeding?" to provide an open opportunity for education. (Hartley & O'Connor, 1996) (QE: II-2; Overall Quality: Fair; R: B)
3. Recommend continuing education throughout pregnancy for those pregnant women who express a desire to breastfeed or for those who are still undecided on feeding method. (Berens, 2001) (QE: III; Overall Quality: Fair; R: C)
4. Recommend including family/significant others in breastfeeding education. (Berens, 2001; Humenick, Hill, & Wilhelm, 1997) (QE: III; II-1; Overall Quality: Fair; R: B)

I-3 Exercise During Pregnancy -- Weeks: All

The Working Group's Recommendations for Women In Low Risk Pregnancy:

1. Strongly recommend all healthy, pregnant women perform regular mild to moderate exercise sessions, three or more times per week. (Campbell & Mottola, 2001; Clapp, 2001; Clapp et al., 2000; Clapp, Lopez, & Harcar-Sevcik, 1999; Sternfeld et al., 1995; Sady et al., 1989) (QE: I; Overall Quality: Good; R: A)
2. Recommend individualized exercise programs for all pregnant women, based on their pre-pregnancy activity level. (Clapp, Lopez, & Harcar-Sevcik, 1999; Sternfeld et al., 1995) (QE: II-2; Overall Quality: Good; R: B)
3. Recommend against high-altitude (>10,000 feet) activities, scuba diving, and contact sports during pregnancy. (Hammer, Perkins, & Parr, 2000; Camporsei, 1996; Alderman et al., 1995) (QE: II-2; Overall Quality: Good; R: D)

I-4 Influenza Vaccine (Season-Related) -- Weeks: Any Week

The Working Group's Recommendations for Women In Low Risk Pregnancy:

1. Recommend immunizing for influenza all pregnant women who will be in the second or third trimester during the epidemic season. ("Immunization during pregnancy," 1993; Englund, Glezen, & Piedra, 1998) (QE: III; Overall Quality: Poor; R: C)

Interventions First Visit with Nurse [6-8 weeks]

I-5 Screening for Tobacco Use - Offer Cessation -- Week: 6-8

The Working Group's Recommendations for Women In Low Risk Pregnancy:

1. Strongly recommend routine screening for tobacco use in pregnancy at the initial prenatal visit. For patients who smoke, recommend assessment of smoking status at each subsequent prenatal visit. (Lumley, Oliver, & Waters, 2001; Mullen et al., 1991) (QE: I; Overall Quality: Good; R: A)
2. If the screening is positive, cessation should be strongly recommended. (Wisborg et al., 2000; Panjari et al., 1999; Dolan-Mullen, Ramirez, & Groff, 1994) (QE: I; Overall Quality: Good; R: A)
3. There is insufficient data to recommend for or against pharmacologic therapy for tobacco cessation in pregnancy.

I-6 Screening for Alcohol Use - Offer Cessation -- Week: 6-8

The Working Group's Recommendations For Women In Low Risk Pregnancy:

1. Recommend routine screening for alcohol consumption using a standardized tool (refer to the [VHA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders](#) – Appendix A-1 for screening tools). (Handmaker, Miller, & Manicke, 1999; Chang et al., 1999; Reynolds et al., 1995) (QE: I; Overall Quality: Fair; R: B)
2. If the screening is positive, cessation should be strongly recommended. (Handmaker, Miller, & Manicke, 1999; Chang et al., 1999; Reynolds et al., 1995) (QE: I; Overall Quality: Fair; R: B)
3. There is insufficient evidence regarding which cessation intervention tool is the most effective.
4. A positive screening does not exclude the pregnant women from the Uncomplicated Pregnancy Guideline.

I-7 Screening for Drug Abuse - Offer Treatment -- Weeks: 6-8

The Working Group's Recommendations for Women In Low Risk Pregnancy:

1. Recommend routine screening for illicit drug use using a self-report method. (Horrigan, Piazza, & Weinstein, 1996) (QE: II-2; Overall Quality: Fair; R: B)
2. Recommend pregnant women identified as abusing drugs be offered treatment, as per the [VHA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders](#). (Howell, Heiser, & Harrington, 1999) (QE: II-3; Overall Quality: Fair; R: B)
3. Pregnant women identified as abusing drugs are excluded from the Uncomplicated Pregnancy Guideline.

I-8 Screening for Domestic Abuse -- Weeks: 8, 24, 32

The Working Group's Recommendations for Women In Low Risk Pregnancy:

1. Recommend routine screening for domestic abuse (Gazmararian et al., 1996) (QE: II-2; Overall Quality: Fair; R: B) at weeks 8, 24, and 32, using the following three simple/direct questions. (McFarlane et al., 1992) (QE: II-2; Overall Quality: Fair; R: B):
 - Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
 - Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
 - Within the last year, has anyone forced you to have sexual activities?
2. There is insufficient evidence to recommend for or against specific interventions for identifying domestic abuse in pregnancy. (McFarlane, Soeken, & Wiist, 2000; Parker et al., 1999) (QE: III; Overall Quality: Poor; R: I)
3. If the screening is positive, follow appropriate medical/legal mandates for reporting requirements for state/branch of service.

I-9 Screening for Rh Status -- Weeks: 6-8

The Working Group's Recommendations for Women In Low Risk Pregnancy:

1. Recommend routine antibody screening for Rh status at the initial prenatal visit via indirect-antiglobulin (Coombs') testing. (Howard et al., 1998; Bowell, Allen, & Entwistle, 1986) (QE: II-2; Overall Quality: Fair; R: C)
2. Pregnant women with positive screens should be referred for consultation to assist with further management.
3. There is insufficient evidence to recommend for or against routine repeat testing at 28 weeks' gestation. (QE: III; Overall Quality: Poor; R: D)

I-10 Screening for Rubella -- Weeks: 6-8

The Working Group's Recommendations For Women In Low Risk Pregnancy:

1. Recommend all pregnant women have a serum screen for rubella status at the initial prenatal visit. (McElhaney et al., 1999) (QE: II-2; Overall Quality: Fair; R: B)
2. Recommend seronegative pregnant women be counseled to avoid exposure. (QE: III; Overall Quality: Poor; R: B)
3. Recommend seronegative pregnant women be vaccinated in the immediate postpartum period. Postpartum vaccination demonstrates >90 percent protection against clinical rubella infection and seropositivity is long lasting. Vaccinating healthy women of childbearing age provides protection for the women from adult onset rubella and for their future children from Congenital Rubella Syndrome (CRS). (Horstman et al., 1985) (QE: II-2; Overall Quality: Fair; R: B)

I-11 Screening for Varicella Weeks: 6-8

The Working Group's Recommendations for Women In Low Risk Pregnancy:

1. Recommend routine screening for varicella through history. (Smith et al., 1998) (QE: I; Overall Quality: Good; R: B)
2. If negative/unsure history, obtain a varicella titer.
3. Recommend offering vaccination postpartum, if varicella is non-immune. (Centers for Disease Control [CDC] guideline for screening for varicella) (QE: I; Overall Quality: Good; R: B)

I-12 Screening for Hepatitis B -- Weeks: 6-8

The Working Group's Recommendations For Women In Low Risk Pregnancy:

1. Recommend routine screening for hepatitis B surface antigen at the initial prenatal visit. ("Immunization during pregnancy," 1993) (QE: III; Overall Quality: Fair; R: B)
2. Consider rescreening all pregnant women with hepatitis risk factors identified during the pregnancy (e.g., intravenous [IV] drug use, exposure to hepatitis, sexually transmitted diseases [STDs], new tattoos, and blood transfusion). (Duff, 1998) (QE: III; Overall Quality: Fair; R: C)

I-13 Screening for Syphilis Rapid Plasma Reagin (RPR) -- Weeks: 6-8

The Working Group's Recommendations For Women In Low Risk Pregnancy:

1. Recommend routine screening for syphilis using serologic testing (i.e., Rapid Plasma Reagin [RPR] or Venereal Disease Research Laboratory [VDRL]) at the initial prenatal visit. (Donders et al., 1993; Dorfman & Glaser, 1990) (QE: II-3; Overall Quality: Fair; R: B)
2. Recommend confirmatory test using a more specific treponemal assay (Fluorescent treponemal antibody absorption [FTA-ABS], microhemagglutination *Treponema pallidum* [MHA-TP], hemagglutination treponemal test for syphilis [HATTS]) for pregnant women who test positive. (Hart, 1986) (QE: II-2; Overall Quality: Fair; R: B)
3. Strongly recommend therapy with penicillin G antibiotic for pregnant women who have confirmed syphilis, as recommended by other sexually transmitted disease (STD) guidelines. (QE: II-2; Overall Quality: Fair; R: A)
4. Recommend appropriate medical/legal mandates follow-up and state/service branch reporting requirements for pregnant women screening positive.

I-14 Screening for Asymptomatic Bacteriuria (ASB) -- Weeks: 6-8

The Working Group's Recommendations For Women In Low Risk Pregnancy:

1. Strongly recommend screening for asymptomatic bacteriuria [ASB] at initial obstetrical visit via urine culture and sensitivity. (Smaill, "Antibiotics for asymptomatic bacteriuria," 2001; USPSTF, 1996; Romero et al., 1989) (QE: I; Overall Quality: Good; R: A)
2. There is insufficient evidence to recommend for or against repeat screening throughout the remainder of pregnancy. (QE: III; Overall Quality: Poor; R: I)

3. Strongly recommend a three to seven day course of appropriate antibiotics based on positive culture and sensitivity and woman's history of medication allergies. (Smaill, "Antibiotics for asymptomatic bacteriuria," 2001) (QE: I; Overall Quality: Good; R: A)
4. There is insufficient evidence to recommend for or against a test of cure (TOC) after completion of antibiotic therapy, except in pregnant women with ASB-Group B Strep. (QE: III; Overall Quality: Poor; R: I)

I-15 Screening for Human Immunodeficiency Virus (HIV) – Counsel -- Weeks: 6-8

The Working Group's Recommendations for Women In Low Risk Pregnancy:

1. Strongly recommend routine testing at the initial prenatal visit. (American Academy of Pediatrics/American College of Obstetricians and Gynecologists [AAP/ACOG], 1995) (QE: I; Overall Quality: Good; R: A)
2. Pregnant women who test positive for HIV should be referred for treatment and counseling.
3. Recommend retesting all high risk pregnant women during the early third trimester and offer repeat testing for patients who refused the first test. (Tookey et al., 1998; Higgins, et al., 1991) (QE: II-2; Overall Quality: Fair; R: B)
4. Pregnant women identified with HIV are excluded from the Uncomplicated Pregnancy Guideline.

I-16 Immunization – Tetanus and Diphtheria (Td) Booster (First Trimester) -- Weeks: 6-8

The Working Group's Recommendations For Women In Low Risk Pregnancy:

1. Strongly recommend routine screening for Td booster status at the initial prenatal visit. (USPSTF, 1996; "Immunization during pregnancy," 1993) (QE: II-1; Overall Quality: Good; R: A)
2. If there is no documentation of Td booster within the last ten years, Td booster should be provided. There are no contraindications other than a previous severe reaction to Td vaccination, such as anaphylaxis, generalized urticaria, or angioedema. (Institute for Clinical Systems Improvement [ICSI], 2001; Fingar & Francis., 1998; USPSTF, 1996) (QE: II-1; Overall Quality: Good; R: A)
3. If the pregnant woman is an immigrant and it is unclear that she ever received the primary vaccination series, she should be given a primary series with an initial dose, a second dose a month later and a third dose 12 months later. (ICSI, 2001; Fingar & Francis, 1998; USPSTF, 1996) (QE: II-2; Overall Quality: Fair; R: B)

I-17 Immunization - Hepatitis B (First Trimester) -- Weeks: 6-8

The Working Group's Recommendations For Women In Low Risk Pregnancy:

1. Recommend immunizing for hepatitis B all pregnant women with high-risk factors predicting positive hepatitis B during pregnancy. (CDC guideline for

Hepatitis B immunization; AAP/ACOG, 1995) (QE: II-3; Overall Quality: Fair; R: B)

Interventions First Visit with Provider [10-12 weeks]

I-18 Assessing Weight Gain (Inappropriate) -- Weeks: All

The Working Group's Recommendations For Women In Low Risk Pregnancy:

1. Recommend assessing and documenting body mass index (BMI) of all pregnant women at the initial visit. (Sebire et al., 2001) (QE: II-2; Overall Quality: Fair; R: B) (Institute of Medicine [IOM], 1990) (QE: III; Overall Quality: Fair; R: C)
2. Pregnant women found to have a BMI <20 should be referred for nutrition counseling and considered at increased risk for fetal growth restriction. (Kramer "High protein supplementation," 2000; Sebire et al., 2001) (QE: II-2; Overall Quality: Fair; R: B)
3. Recommend screening for inappropriate weight gain for all women at every visit during pregnancy. ("A WHO collaborative study," 1997) (QE: III; Overall Quality: Fair; R: C)
4. Pregnant women with inadequate weight gain at 28 weeks who are unresponsive to nutritional treatment exit the Uncomplicated Pregnancy Guideline. (Kelly et al., 1997) (QE: II-2; Overall Quality: Fair; R: B)

I-19 Auscultation Fetal Heart Tones -- Weeks: 10-12

The Working Group's Recommendations For Women In Low Risk Pregnancy:

1. Recommend assessing fetal heart tones at each prenatal visit, starting at 10 to 12 weeks. (Engstrom, 1985; Jimenez, Tyson, & Reisch, 1983) (QE: III; Overall Quality: Poor; R: C)

I-20 Screening Fundal Height -- Weeks: All

The Working Group's Recommendations for Women In Low Risk Pregnancy:

1. Recommend measuring fundal height in all pregnant women at each visit during the second and third trimesters. (Engstrom & Work, 1992; Lindhard, et al., 1990; Mathai, Jairaj, & Muthurathnam, 1987; Pearce & Campbell, 1987; Wise & Engstrom, 1985; Jimenez, Tyson, & Reisch, 1983; Calvert et al., 1982; Quaranta et al., 1981) (QE: I; Overall Quality: Good; R: B)
2. There is insufficient evidence to recommend for or against measuring fundal height after 36 weeks' gestation. (QE: III; Overall Quality: Poor; R: I)

I-21 Screening for Gonorrhea -- Weeks: 10-12

The Working Group's Recommendations For Women In Low Risk Pregnancy:

1. Recommend screening for gonorrhea in all pregnant women. (QE: II-2; Overall Quality: Fair; R: B)

2. Pregnant women with positive cultures should be treated with ceftriaxone, per CDC guidelines.
3. Pregnant women with positive screens for gonorrhea should be screened for other STDs.
4. Recommend performing a TOC during pregnancy after completing antibiotic therapy. TOC in pregnant women, unlike non-pregnant women, is recommended due to risk of complications resulting from persistent or recurrent infections.
5. Recommend counseling to decrease rate of reinfection.
6. Recommend referring partner for testing and treatment, as appropriate. Pregnant women must abstain from intercourse pending TOC.

I-22 Screening for Chlamydia -- Weeks: 10-12

The Working Group's Recommendations for Women In Low Risk Pregnancy:

1. Recommend screening all pregnant women for chlamydia trachomatis at the initial physical examination. (Hammerschlag et al., 1979) (QE: II-2; Overall Quality: Fair; R: B)
2. Pregnant women with positive cultures should be treated with azithromycin or erythromycin, per CDC guidelines. (Blackwell et al., 1993) (QE: II-2; Overall Quality: Fair; R: A)
3. Pregnant women with positive screens for chlamydia should be screened for other STDs. (Vuylsteke et al., 1993) (QE: II-2; Overall Quality: Fair; R: B)
4. Recommend performing a TOC during pregnancy after completing antibiotic therapy. TOC in pregnant women, unlike non-pregnant women, is recommended due to risk of complications resulting from persistent or recurrent infections. (QE: III; Overall Quality: Poor; R: C)
5. Recommend counseling to decrease rate of reinfection. (Vuylsteke et al., 1993) (QE: II-2; Overall Quality: Fair; R: C)
6. Recommend referring partner for testing and treatment, as appropriate. Pregnant women must abstain from intercourse pending TOC. (QE: III; Overall Quality: Poor; R: C)

I-23 Screening for Cervical Cancer -- Weeks: 10-12

The Working Group's Recommendations For Women In Low Risk Pregnancy:

1. Recommend screening all pregnant women for cervical cancer at the first prenatal visit, or as early in pregnancy as possible. (Lurain & Gallop, 1979) (QE: II-2; Overall Quality: Good; R: B)
2. Recommend performing cervical screening in pregnancy with a brush sampler and spatula. (Hoffman et al., 1991; Koonings et al., 1992) (QE: I; Overall Quality: Good; R: A)
3. Recommend women with abnormal cervical smears during pregnancy be managed based on local algorithms, which may include repeat testing, observation, or colposcopy. (LaPolla, O'Neil, & Wetrich, 1988) (QE: III; Overall Quality: Fair; R: C)

I-24 Counseling for Cystic Fibrosis (CF) Screening -- Weeks: 10-12

The Working Group's Recommendations for Women In Low Risk Pregnancy:

1. Recommend educating all pregnant women using a CF carrier-screening brochure about a possible risk of CF. (ACOG and American College of Medical Geneticists [ACMG], 2001) (QE: III; Overall Quality: Poor; R: I)
2. Recommend offering CF screening to all pregnant women who desire it. (ACOG & ACMG, 2001) (QE: III; Overall Quality: Poor; R: I)
3. Recommend referring all pregnant women with a family history of CF for genetic counseling. (ACOG & ACMG, 2001) (QE: III; Overall Quality: Poor; R: I)
4. For couples who desire screening at <18 weeks´ gestation, only one partner should be initially screened; if the screening is positive then the other partner should be screened.
5. For couples who desire screening at >18 weeks´ gestation, both partners should be screened simultaneously. This reduces the increased time frame of sequential screenings and provides couples wishing to terminate the pregnancy faster access to the screening results.

Interventions Weeks: 16-27

I-25 Maternal Serum Analyte Screening -- Weeks: 15-20

The Working Group´s Recommendations For Women In Low Risk Pregnancy:

1. Recommend offering multiple marker maternal serum analyte screening to all pregnant women at gestational ages between 15 and 20 weeks. The ideal screening period is 15 to 18 weeks in order to maximize test accuracy and allow time for adequate follow-up counseling and testing. (ACOG & American College of Medical Geneticists [ACMG], 2001; Haddow et al., 1992) (QE: II-1; Overall Quality: Good; R: B)
2. Recommend providing pre-test patient education and counseling to ensure that women understand screening test limitations and false-positive rates, as well as the need for subsequent diagnostic tests for screen-positive women. (Nadel et al., 1990) (QE: II-2; Overall Quality: Good; R: B)
3. If the screening is positive, targeted ultrasound examinations can be used for risk modification and counseling prior to making the decision for invasive testing. (Smith-Bindman et al., 2001) (QE: II-1; Overall Quality: Good; R: B)
4. Pregnant women with persistent unexplained elevations of maternal serum alpha-fetoprotein (MSAFP) are at increased risk for adverse perinatal outcome and should exit the Uncomplicated Pregnancy Guideline. (ACOG & ACMG, 2001) (QE: II-1; Overall Quality: Good; R: B)
5. Women at high risk for fetal aneuploidy (age \geq 35 at delivery or prior first child or fetus with aneuploidy) require genetic counseling. (Haddow et al., 1994) (QE: II-1; Overall Quality: Good; R: B)

I-26 Routine Ultrasound -- Weeks: 16-20

The Working Group´s Recommendations For Women In Low Risk Pregnancy:

1. Recommend counseling and educating all pregnant women prior to scheduling sonographic study. Education will include information on potential benefits, limitations, and safety of prenatal ultrasound. Documentation of education and counseling is recommended; however, written informed consent is not

- deemed necessary. (Chervenak & McCullough, 1992) (QE: III; Overall Quality: Fair; R: B)
2. Recommend offering a complete obstetric sonographic examination between 16 and 20 weeks of gestation to all low-risk consenting pregnant women (see Appendix A-2 titled "Standard for Performance of Antepartum Obstetrical Ultrasound Examination" in the original guideline document). (Society of Obstetricians and Gynaecologists of Canada [SOGC], 1999) (QE: III; Overall Quality: Fair; R: B)
 3. Strongly recommend all complete obstetric sonographic studies be performed and interpreted by qualified healthcare providers (see Appendix A-2 titled "Standard for Performance of Antepartum Obstetrical Ultrasound Examination" in the original guideline document). (Crane et al., 1994; American Institute of Ultrasound in Medicine [AIUM], 2003) (QE: I; Overall Quality: Good; R: A)

I-27 Counseling for Family Planning -- Weeks: Start at Week 20

The Working Group's Recommendations For Women In Low Risk Pregnancy:

1. Recommend antepartum counseling and educating all pregnant women regarding family planning, to include various temporary contraceptive means and/or permanent sterilization. (Pati & Cullins, 2000) (QE: III; Overall Quality: Poor; R: C)

I-28 Educate Regarding Preterm Labor -- Week: 20

The Working Group's Recommendations for Women In Low Risk Pregnancy:

1. Pregnant women will be screened for factors that would result in a 10 percent or greater risk of preterm delivery and, if present, will be excluded from further care in the Uncomplicated Pregnancy Guideline. (Lockwood & Kuczynski, 1999; Knox et al., 1993; Holbrook, Laros, & Creasy, 1989; Ross et al., 1986) (QE: II-2; Overall Quality: Fair; R: B) Risk factors that would place a patient at a >10 percent risk of preterm delivery include the following:
 - Prior spontaneous preterm delivery (following preterm labor or preterm premature rupture of membranes)
 - History of cervical incompetence
 - Tobacco abuse and poor nutrition (i.e., BMI <18)
2. Pregnant women will be educated about the most common symptoms of preterm labor. (Katz, Goodyear, & Creasy, 1990; Morrison, 1990; Ross et al., 1986; Herron, Katz, & Creasy, 1982) (QE: II-2; Overall Quality: Good; R: A):
 - Low, dull backache
 - Four or more uterine contractions per hour. Uterine contractions may be perceived by the patient as:
 - Menstrual-like cramps
 - Sensation of the "baby rolling up in a ball"
 - Abdominal cramping (may be associated with diarrhea)
 - Increased uterine activity compared to previous patterns.
 - Increased pelvic pressure (may be associated with thigh cramps)

- Change in vaginal discharge such as change in color of mucus, leaking of clear fluid, spotting, or bleeding
 - Vaginal discharge associated with itching or fish-like odor immediately after intercourse
 - General sensation that "something feels different" (e.g., agitation, flu-like syndrome, and sensation that baby has "dropped")
3. If the pregnant woman experiences any of the above symptoms or is unsure about the presence of any of the above, she should lie down on her side with one of her hands on her lower abdomen to palpate for uterine contractions an additional hour; if symptoms persist and/or she palpates four or more uterine contractions in the hour, she should seek immediate medical care. The exception to this is the pregnant woman who notes the presence of vaginal bleeding, leaking of clear fluid from the vagina, or a vaginal discharge with a fish-like odor immediately after intercourse, all of which should prompt immediate medical attention. (QE: III; Overall Quality: Poor; R: I)
 4. Educate the pregnant woman that she is the most important link in the early diagnosis of preterm labor, and that early diagnosis and treatment of preterm labor increases the chances for successful prolongation of the pregnancy and the probability of a healthy infant. (Katz, Goodyear, & Creasy, 1990; Herron, Katz, & Creasy, 1982) (QE: II-2; Overall Quality: Good; R: B)

See Table 2 titled "Risk Factors for Preterm Delivery" in the original guideline document.

Reinforce Education of Patient about Preterm Labor Risk -- Week: 24

The Working Group's Recommendations for Women In Low Risk Pregnancy:

1. Pregnant women will be educated about the most common symptoms of preterm labor (Katz, Goodyear, & Creasy, 1990; Morrison, 1990; Ross et al., 1986; Herron, Katz, & Creasy, 1982) (QE: II-2; Overall Quality: Good; R: A):
 - Low, dull backache
 - Four or more uterine contractions per hour. Uterine contractions may be perceived by the patient as:
 - Menstrual-like cramps
 - Sensation of the "baby rolling up in a ball"
 - Abdominal cramping (may be associated with diarrhea)
 - Increased uterine activity compared to previous patterns
 - Increased pelvic pressure (may be associated with thigh cramps)
 - Change in vaginal discharge, such as change in color of mucus, leaking of clear fluid, spotting or bleeding
 - Vaginal discharge associated with itching or fish-like odor immediately after intercourse
 - General sensation that "something feels different" (e.g., agitation, flu-like syndrome, and sensation that baby has "dropped")
2. If the pregnant woman experiences any of the above symptoms or is unsure about the presence of any of the above, she should lie down on her side with one of her hands on her lower abdomen to palpate for uterine contractions for an additional hour. If symptoms persist and/or she palpates 4 or more uterine contractions in the hour, she should seek immediate medical care. The exception to this is the pregnant woman who notes the presence of vaginal

- bleeding, leaking of clear fluid from the vagina, or a vaginal discharge with a fish-like odor immediately after intercourse, all of which should prompt immediate medical attention. (Working Group Consensus) (QE: 111; Overall Quality: Poor; R: 1)
3. Reemphasize to the pregnant woman that she is the most important link in the early diagnosis of preterm labor, and that early diagnosis and treatment of preterm labor increases the chances for a healthy infant. (Katz, Goodyear, & Creasy, 1990; Herron, Katz, & Creasy, 1982) (QE: 11-2; Overall Quality: Good; R: B)
 4. Educate the pregnant woman that she can safely continue moderate exercise and activity during her pregnancy as long she does not notice any of the symptoms of preterm labor. The exception to this is that she may notice some increase in uterine cramping with moderate exercise or activity. This is of no consequence so long as the cramping ceases when she stops her activity. She should be told to limit her activity to no more than two hours per session. (See Intervention I-3 "Exercise During Pregnancy") (QE: 11-1; Overall Quality: Good; R: B)
 5. Women with uncomplicated pregnancies may continue a standard work schedule throughout their pregnancy. If their work is strenuous or they spend long periods of time on their feet, such as a nurse, they should limit their work week to 40 hours and workday to 8 hours during the last trimester (beginning at 28 weeks) or sooner if they frequently experience symptoms of preterm labor while at work. Pregnant women should attempt to limit periods of time on their feet to 3 hours. (Mozurkewich et al., 2000; Gabbe & Turner, 1997; Luke et al., 1995; Teitelman et al., 1990) (QE: 11-2; Overall Quality: Good; R: B)
 6. There is no evidence that sexual intercourse increases the probability of preterm labor in women with uncomplicated pregnancy. They may experience some uterine contractions following orgasm; however, this is a normal response and she only needs to seek medical attention if they persist at four or more per hour for at least three hours, or if vaginal bleeding or spotting is noted. (Read & Klebanoff, 1993) (QE: 11-2; Overall Quality: Good; R: A)

Interventions Weeks: 38-37

I-29 Assess for Preterm Labor -- Weeks: 28-34

The Working Group's Recommendations For Women In Low Risk Pregnancy:

1. All pregnant women at risk for preterm labor at week 28 will be asked if they have experienced any of the following symptoms since the previous visit:
 - Low, dull backache
 - Menstrual-like cramps or sensation the "baby is rolling up in a ball"
 - Increased pelvic pressure (may be with thigh cramps)
 - Abdominal cramping (may be associated with diarrhea)
 - Increased uterine activity compared to previous patterns (more than 4 contractions per hour)
 - Change in vaginal discharge such as change in color of mucus, leaking of clear fluid, spotting or bleeding
 - Sensation that "something feels different" (e.g., agitation, flu-like syndrome, and sensation that baby has "dropped")

Educate the pregnant woman that she is a vital link in the early detection and treatment of preterm labor. (Katz, Goodyear, & Creasy, 1990; Herron, Katz, & Creasy, 1982) (QE: II-2; Overall Quality: Good; R: B)

2. If the pregnant woman experiences any of the above symptoms or is unsure about the presence of any of the above, she should lie down on her side with one of her hands on her lower abdomen to palpate for uterine contractions for an additional hour. If symptoms persist and/or she palpates 4 or more uterine contractions in the hour, she should seek immediate medical care. The exception to this is the pregnant woman who notes the presence of vaginal bleeding, leaking of clear fluid from the vagina or a vaginal discharge with a fish-like odor immediately after intercourse, all of which should prompt immediate medical attention. (QE: III; Overall Quality: Poor; R: I)
3. If no diagnosis of preterm labor is established, continuation in the guideline is appropriate.

I-30 Daily Fetal Movement Counts -- Weeks: 28-37

The Working Group's Recommendations for Women in Low Risk Pregnancy:

1. Recommend instructing all pregnant women about the importance of assessing fetal movement on a daily basis beginning in the third trimester. (Moore & Piacquadio, 1989; Neldam, 1980) (QE: II-1; Overall Quality: Good; R: B)
2. Recommend instructing all pregnant women as to the course of action they should take if they do not perceive the minimum fetal movement counts within the time frame specific to their health care facility. (Moore & Piacquadio, 1989; Neldam, 1980; Pearson & Weaver, 1976; Sadovsky & Yaffe, 1973) (QE: II-1; Overall Quality: Good; R: B)

I-31 Screening for Gestational Diabetes -- Week: 28

The Working Group's Recommendations For Women In Low Risk Pregnancy:

1. Recommend screening all pregnant women for gestational diabetes mellitus (GDM) at 24 to 28 weeks' gestation. (Griffen et al., 2000; Danilenko-Dixon et al., 1999; Williams et al., 1999) (QE: II-2; Overall Quality: Fair; R: B)
2. Screening for GDM should be performed by randomly administering a 50 gram oral glucose tolerance test (GTT) followed by a blood draw one hour later. (ACOG & ACMG, 2001; Naylor et al., 1997) (QE: II-1, II-3; Overall Quality: Good; R: A) Generally accepted threshold values of the 1-hour screen are between 130 mg/dL and 140 mg/dL. Pregnant women who are positive require the diagnostic 3-hour GTT. (AGOG & ACMG, 2001) (QE: III; Overall Quality: Fair; R: B)
3. In the 3-hour GTT a 100 gram-glucose load is administered to a woman who has fasted overnight (minimum 8 hours). Blood draws are performed fasting and at 1, 2 and 3 hours after the oral glucose load.
4. Two acceptable sets of threshold values for the 3-hour 100 gram GTT that can be used to diagnose gestational diabetes: the National Diabetes Data Group (NDDG) criteria and the Carpenter/Coustan conversion criteria. Institutions should adopt one of these two criteria sets based upon their population demographics. There should NOT be variance within the facility itself, though

- variance may occur between facilities. Pregnant women diagnosed with gestational diabetes using these criteria will exit the Uncomplicated Pregnancy Guideline. . (ACOG & ACMG, 2001; Report from Expert Committee on the Diagnosis and Classification of Diabetes Mellitus, 2000) (QE: II-3; Overall Quality: Fair; R: B)
5. As impairment of glucose metabolism is a spectrum, pregnant women with just one abnormal value on the 3-hour GTT should exit the Uncomplicated Pregnancy Guideline (QE: III; Overall Quality: Poor; R: C) and be managed using one of the following methods:
 - Undergo a repeat 3-hour 100 gram glucose challenge test approximately one month following the initial test.
 - Have dietary management and intermittent postprandial glucose testing performed in a manner similar to women with gestational diabetes. (ACOG & ACMG, 2001; Lindsay, Graves, & Klein, 1989; Langer et al., 1987) (QE: III, II- 2; Overall Quality: Fair; R: C)
 - Pregnant women with a repeat GTT test that shows normal value may reenter the Uncomplicated Pregnancy Guideline.

I-32 Iron Supplementation -- Week: 28

The Working Group's Recommendations for Women In Low Risk Pregnancy:

1. There is insufficient evidence to recommend for or against routinely supplementing iron for all pregnant women who are not anemic. (QE: II-3; Overall Quality: Fair; R: I) Women exhibiting signs or symptoms of anemia at any time during their pregnancy should be evaluated upon presentation. (Hemminki & Rimpela, 1991) (QE: I; Overall Quality: Good; R: B)
2. Recommend supplementing with at least 50 mg elemental iron (325 mg ferrous sulfate) twice-a-day (bid) in all pregnant women diagnosed with anemia (hematocrit <30). Diagnosis of anemia may vary with smoking status and altitude. Clinical correlation with local laboratory is advised.

I-33 Anti-D Prophylaxis for Rh-Negative Pregnant Women -- Week: 28

The Working Group's Recommendations for Women In Low Risk Pregnancy:

1. Recommend administering anti-D prophylaxis to all unsensitized D-negative pregnant women. (Crowther & Keirse, 2001; Urbaniak, 1998) (QE: I; Overall Quality: Fair; R: B)
2. Recommend using either 300 micrograms of anti-D immunoglobulin at 28 weeks or 100 micrograms of anti-D-immunoglobulin at 28 and 34 weeks' gestation.

I-34 Screening for Group B Streptococcus (GBS) -- Week: 36

The Working Group's Recommendations For Women In Low Risk Pregnancy:

1. Recommend screening all pregnant women for GBS at 35 to 37 weeks' gestation, using a rectovaginal culture and selective broth media to identify colonized women. (Main & Slagle, 2000; Yancey et al., 1996) (QE: II-1; Overall Quality: Good; R: B)

2. Pregnant women with positive rectovaginal cultures should be treated with intrapartum IV chemoprophylaxis with either penicillin or ampicillin (if no contraindications)* (Smaill, "Intrapartum antibiotics," 2001; Main & Slagle, 2000; Boyer & Gotoff, 1986) (QE: I; Overall Quality: Good; R: A)
3. Pregnant women who have had a previous child with early-onset GBS infection or have GBS bacteriuria in the current pregnancy should receive intrapartum antibiotics, without screening cultures. (QE: II-1; Overall Quality: Good; R: A)
4. Pregnant woman presenting in labor <37 weeks' gestation should receive intrapartum intravenous (IV) chemoprophylaxis. (Boyer & Gotoff, 1986) (QE: II-1; Overall Quality: Good; R: A)
5. For women in labor at term with unknown culture status, administer intrapartum antibiotics (IAP) if the duration of membrane rupture ≥ 18 hours or maternal temperature ≥ 100.4 degrees F (38 degrees C). (QE: II-1; Overall Quality: Fair; R: B)
6. Prophylactic antibiotics should be administered at least two hours prior to delivery, when possible**. (Lin et al., 2001; de Cueto et al., 1998) (QE: II-2; Overall Quality: Good; R: B)
7. Women undergoing scheduled cesarean delivery prior to the onset of labor with intact membranes do not require prophylactic antibiotics, unless they have had a previous child with early-onset GBS infection. (Hager et al., 2000) (QE: III; Overall Quality: Fair; R: C)

*Management of the GBS-colonized parturient with a history of an allergic reaction to penicillin agents: Due to emerging resistance to previous second-line antimicrobial agents, clindamycin and erythromycin (10 to 15 percent resistant strains in most centers), alternative second-line agents for women with a history of allergic reactions to penicillin or ampicillin are listed below:

- Administer vancomycin 2 gm IV load, followed by 1 gm IV every 12 hours, for immediate hypersensitivity reaction (anaphylaxis, dyspnea, rapid onset of urticarial rash).
- Administer cefazolin 2 gm IV load, followed by 1 gm IV every 8 hours, for allergic reaction other than immediate hypersensitivity.

**Management of the parturient anticipated to deliver imminently following admission: As it is difficult to anticipate accurately when a woman will deliver, women identified as candidates for intrapartum antibiotics for prophylaxis (IAP) should receive prophylactic antibiotics regardless of the interval between admission and delivery as vertical transmission rates have been shown to have a clinically and statistically significant decrease within 2 hours of maternal administration. Thus, withholding of IAP from women solely on the basis of anticipated admission-delivery interval should be discouraged.

I-35 Assessment of Fetal Presentation -- Week: 36

The Working Group's Recommendations for Women in Low Risk Pregnancy:

1. Recommend screening for non-cephalic presentation for all patients at 36 weeks' gestation. (Hofmeyr & Kulier, "Cephalic version," 2001) (QE: II-2; Overall Quality: Fair; R: B)

2. There is insufficient evidence to recommend for or against Leopold's versus cervical exam as the best screening method to determine fetal presentation (Lydon-Rochelle et al., 1993; Thorp, Jenkins, & Watson, 1991) (QE: II-2; Overall Quality: Fair; R: I)
3. Recommend ultrasound for confirmation, if non-cephalic presentation is suspected. (Thorp, Jenkins, & Watson, 1991) (QE: II-2; Overall Quality: Good; R: B)
4. Recommend offering external cephalic version at 37 weeks or beyond, if non-cephalic presentation is confirmed and there are no contraindications. Exit the Uncomplicated Pregnancy Guideline. (Hofmeyr & Kulier, "Cephalic version," 2001; Hofmeyr & Kulier, "External cephalic version," 2001) (QE: I; Overall Quality: Good; R: B)

Interventions Weeks: 38-41

I-36 Weekly Cervical Check (Stripping/sweeping) -- Weeks: 38-41

The Working Group's Recommendations for Women in Low Risk Pregnancy:

1. Recommend offering routine membrane stripping to all pregnant women every visit beginning at 38 weeks. (Boulvain et al., 1999) (QE: I; Overall Quality: Good; R: A)

I-37 Post-Dates Antenatal Fetal Testing -- Week: 41

The Working Group's recommendations for women in low risk pregnancy:

1. Strongly recommend antepartum fetal testing beginning at 41 weeks. (Rosen et al. 1995; Guidetti, Divon, & Langer, 1989) (QE: I; Overall Quality: Good; R: A)
2. Testing should consist of weekly amniotic fluid index (AFI) and twice weekly non-stress testing (NST). (QE: III; Overall Quality: Fair; R: B)
3. An AFI of less than 5 or a non-reactive NST should prompt further evaluation to determine the need for delivery. These women should exit the Uncomplicated Pregnancy Guideline. (Manning et al., 1993; Rutherford et al., 1987; Chamberlain et al., 1984) (QE: II-2, III; Overall Quality: Fair; R: B)

Interventions Not Recommended in Prenatal Care

I-38 Screening with Fetal Fibronectin

The Working Group's Recommendations for Women in Low Risk Pregnancy:

1. Recommend against routine screening for preterm birth with fetal fibronectin test. (Revah, Hannah, & Sue-A-Quan, 1998; Goldenberg et al., 1996; Greenhagen et al., 1996; Hellemans, Gerris, & Verdonk, 1995; Lockwood et al., 1993; Leitech et al., 1999; Faron et al., 1998) (QE: I, II-2; Overall Quality: Good, Fair; R: D)

I-39 Cervical Examination

The Working Group's Recommendations for Women in Low Risk Pregnancy:

1. Recommend against performing cervical examination to screen for preterm birth prevention in low risk asymptomatic pregnant women. (Buekens et al., 1994) (QE: I; Overall Quality: Good; R: D)

I-40 Antenatal Pelvimetry

The Working Group's Recommendations for Women in Low Risk Pregnancy:

1. Recommend against the use of antenatal pelvimetry (clinical or radiographic) in routine prenatal care. (Pattinson, 2001) (QE: I; Overall Quality: Fair; R: D)
2. There is fair evidence that clinical pelvimetry is not effective in predicting the actual occurrence of cephalopelvic disproportion (CPD), and its performance is associated with significant increase in cesarean section rates. (Pattinson, 2001) (QE: I; Overall Quality: Fair; R: D)

I-41 Routine Urine Dipstick Test

The Working Group's Recommendations for Women in Low Risk Pregnancy:

1. Recommend against the use of urine dipstick testing for protein and glucose during prenatal visits (the appropriate screening test for gestational diabetes is the one-hour glucola). (Kuo, Koumantakis, & Gallery, 1992) (QE: II-2; Overall Quality: Fair; R: D)
2. Recommend the use of selective laboratory urinalysis for pregnant women with signs or symptoms of preeclampsia.

I-42 Routine Edema Evaluation

The Working Group's Recommendations for Women in Low Risk Pregnancy:

1. Recommend against routine evaluation for edema in pregnancy. (Young & Jewell, 2000; Kent et al., 1999) (QE: II-1; Overall Quality: Fair; R: D)

I-43 Screening for Cytomegalovirus (CMV)

The Working Group's Recommendations for Women in Low Risk Pregnancy:

1. The evidence is insufficient to recommend for or against routine screening for CMV. (QE: III; Overall Quality: Poor; R: I)
2. Recommend counseling pregnant women about methods to prevent acquisition of CMV during pregnancy.

I-44 Screening for Parvovirus

The Working Group's Recommendations for Women in Low Risk Pregnancy:

1. Recommend against routine testing for parvovirus in pregnancy. (Guidozzi, Ballot, & Rothberg, 1994) (QE: II-3; Overall Quality: Fair; R: D)

I-45 Screening for Toxoplasmosis

The Working Group's Recommendations for Women in Low Risk Pregnancy:

1. Recommend against routine testing for toxoplasmosis in pregnancy. (Wallon et al., 1999; Frenkel, 1995; Wong & Remington, 1994) (QE: I, II-3; Overall Quality: Fair; R: D)
2. Recommend counseling pregnant women about methods to prevent acquisition of toxoplasmosis during pregnancy. (QE: III; Overall Quality: Poor; R: C)

I-46 Screening for Bacterial Vaginosis

The Working Group's Recommendations for Women in Low Risk Pregnancy:

1. Recommend against routine screening for bacterial vaginosis in asymptomatic pregnant women. (Guise et al., 2001; Carey et al., 2000) (QE: I; Overall Quality: Good; R: D)

I-47 Vitamin Supplementation

The Working Group's Recommendations for Women in Low Risk Pregnancy:

1. Recommend that multivitamin supplements taken one month preconceptually should be continued through the first trimester. (Werler et al., 1999) (QE: II-3; Overall Quality: Good; R: B)
2. Strongly recommend that folate supplement taken one month preconceptually should be continued through the first trimester. (Lumley et al., 2001) (QE: I; Overall Quality: Good; R: A)
3. The evidence is insufficient to recommend for or against routine multivitamin, pyridoxine, and vitamin D supplementation beyond the first trimester. (Mahomed "Folate supplementation," 2001; Mahomed "Iron and folate supplementation," 2001; Mahomed "Iron supplementation," 2001; Mahomed & Gulmezoglu, "Pyridoxine," 2001; Mahomed & Gulmezoglu, "Vitamin D," 2001) (QE: III; Overall Quality: Fair; R: I)
4. Recommend that women who have delivered a child with an open neural tube defect (NTD) should supplement their diets with 4 mg folate for at least one month prior to conception and through the first trimester to reduce the risk of recurrence.
5. Recommend that pregnant women taking nutritional supplements for a medical condition should continue that supplementation throughout pregnancy (e.g., B-12 with pernicious anemia and folate with seizure disorders).
6. Recommend that pregnant women on restrictive diets should have nutrition consultation to customize vitamin supplementation regimen.

I-48 Immunization – Measles, Mumps, Rubella (MMR)

The Working Group's Recommendations for Women in Low Risk Pregnancy:

1. Recommend against routine measles/mumps/rubella (MMR) immunization during pregnancy. (Krogh et al., 1989) (QE: II-2; Overall Quality: Poor; R: D)

I-49 Immunization - Varicella

The Working Group's Recommendations for Women in Low Risk Pregnancy:

1. Recommend against routine varicella vaccination in pregnancy. (Smith et al., 1998) (QE: II-2; Overall Quality: Poor; R: D)
2. Recommend serological testing early in pregnancy for all pregnant women with a negative or uncertain history. (Smith et al., 1998) (QE: II-2; Overall Quality: Poor; R: B)
3. Recommend offering vaccination postpartum for pregnant women who are non-immune. (QE: III; Overall Quality: Fair; R: B)

I-50 Ultrasound (US) Evaluation of Cervical Length at Week 24

The Working Group's Recommendations for Women in Low Risk Pregnancy:

1. Recommend against routine cervical length screening at 24 weeks' gestation. (Iams, Goldsmith, & Weiss, 2001; Heath et al., 2000; Heath et al., 1998; Hibbard, Tart, & Moawad, 2000; Heath et al., 1998; Taipale & Hiilesmaa, 1998; Iams et al., 1996) (QE: II-2; Overall Quality: Fair; R: D)

I-51 Repeat Screening for Anemia, Syphilis, and Isoimmunization

The Working Group's Recommendations for Women in Low Risk Pregnancy:

1. Recommend against routine repeat screening for blood group antibodies. (Davis & Abbott, 1986) (QE: II-2; Overall Quality: Fair; R: D)
2. Recommend against routine repeat screening for anemia and syphilis. (QE: III; Overall Quality: Poor; R: D)
3. Recommend providers consider repeat testing for anemia or syphilis at 24 to 28 weeks for women who are at higher risk for these conditions. (QE: III; Overall Quality: Poor; R: C)

I-52 Screening for Hypothyroidism

The Working Group's Recommendations for Women in Low Risk Pregnancy:

1. Recommend against screening for thyroid hormone status of the mother. (Morreale de Escobar et al., 2000; Haddow et al., 1999; Pop et al., 1995) (QE: III; Overall Quality: Poor; R: D)
2. Recommend ensuring adequate iodine intake during pregnancy for pregnant women in areas of the country with questionable levels of dietary iodine. (Utiger, 1999) (QE: III; Overall Quality: Poor; R: C)

Definitions:

Quality of Evidence (QE)

I: Evidence obtained from at least one properly randomized controlled trial

II-1: Evidence obtained from well-designed controlled trials without randomization

II-2: Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group

II-3: Evidence obtained from multiple time series studies with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.

III: Opinions of respected authorities, based on clinical experience; descriptive studies and case reports; or reports of expert committees

Overall Quality

Good: High grade evidence (I or II-1) directly linked to health outcome

Fair: High grade evidence (I or II-1) linked to intermediate outcome or Moderate grade evidence (II-2 or II-3) directly linked to health outcome

Poor: Level III evidence or no linkage of evidence to health outcome

Net Effect of Intervention

Substantial:

- More than a small relative impact on a frequent condition with a substantial burden of suffering, or
- A large impact on an infrequent condition with a significant impact on the individual patient level

Moderate:

- A small relative impact on a frequent condition with a substantial burden of suffering, or
- A moderate impact on an infrequent condition with a significant impact on the individual patient level

Small:

- A negligible relative impact on a frequent condition with a substantial burden of suffering, or
- A small impact on an infrequent condition with a significant impact on the individual patient level

Zero or Negative:

- Negative impact on patients, or
- No relative impact on either a frequent condition with a substantial burden of suffering, or
- An infrequent condition with a significant impact on the individual patient level

Grade of Recommendation (R)

- A: A strong recommendation that the intervention is always indicated and acceptable
- B: A recommendation that the intervention may be useful/effective
- C: A recommendation that the intervention be considered
- D: A recommendation that a procedure may be considered not useful/effective, or may be harmful
- I: Insufficient evidence to recommend for or against; clinical judgment should be used

Abbreviations

- AAP - American Academy of Pediatrics
- ACOG - American College of Obstetricians and Gynecologists
- AFI - Amniotic Fluid Index
- AFP - Alpha-fetoprotein
- AIDS - Autoimmune Disorder
- AIUM - American Institute of Ultrasound in Medicine
- ASB - Asymptomatic Bacteriuria
- Bid - Twice a Day
- BMI - Body Mass Index
- BP - Blood Pressure
- CAGE - Alcohol Abuse/Dependency Screening Instrument
- CBC - Complete Blood Count
- CDC - Centers for Disease Control
- CF - Cystic Fibrosis
- CI - Confidence Interval
- CMV – Cytomegalovirus
- CPD - Cephalopelvic Disproportion
- CPG - Clinical Practice Guideline
- CPS - Clinical Preventive Services
- CREOG - Committee on Resident Education in Obstetrics and Gynecology
- CRS - Congenital Rubella Syndrome
- DE - Dependent Edema
- DoD - Department of Defense
- DM - Diabetes Mellitus
- DRG - Diagnosis Related Groups
- EDC - Estimated Date of Confinement
- EGA - Estimated Gestational Age
- GBS - Group B Streptococcus
- GDM - Gestational Diabetes Mellitus
- GTT - Glucose Tolerance Test
- HBIG - Hepatitis B Immune Globulin
- HCG - Human Chorionic Gonadotropin
- HIV - Human Immunodeficiency Virus
- HTN – Hypertension
- IAP - Intrapartum Antibiotics for Prophylaxis
- ICSI - Institute for Clinical Systems Improvement
- IOM - Institute of Medicine
- IPA - Intrapartum Antibiotics
- IUFD - Intrauterine Fetal Demise

IV – Intravenous
LEEP - Loop Electrosurgical Excisional Procedure
MMR - Measles/Mumps/Rubella
MOM - Multiples of the Median
MSAFP - Maternal Serum Alpha-fetoprotein
NDDG - National Diabetes Data Group
NIH - National Institute of Health
NNT - Number-Needed-To-Treat
NST - Non-Stress Testing
NTD - Neural Tube Defect
OB/GYN - Obstetrician/Gynecologist or Obstetrical/Gynecological
ONTD - Open Neural Tube Defects
Pap – Papanicolaou
PID - Pelvic Inflammatory Disease
PROM - Premature Rupture of Membranes
RCT - Randomized Controlled Trials
RPR - Rapid Plasma Reagin
RR - Relative Risks
SIDS - Sudden Infant Death Syndrome
SOGC - Society of Obstetricians and Gynaecologists of Canada
STD - Sexually Transmitted Disease
Td – Tetanus
TOC - Test of Cure
TSH - Thyroid Stimulating Hormone
US – Ultrasound
USPSTF – United States Preventive Services Task Force
VDRL - Venereal Disease Research Laboratory
VA - Veterans Administration
VHA - Veterans Health Administration

CLINICAL ALGORITHM(S)

An algorithm is provided in the original guideline document for [Management of Uncomplicated Pregnancy](#).

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

[References open in a new window](#)

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for selected recommendations (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Standardization to minimize variation in care
- Early identification and management of factors that can cause adverse perinatal outcomes
- Improved maternal, fetal, and neonatal outcomes, such as decreased morbidity, mortality, and complications of pregnancy
- Improved patient and provider satisfaction

POTENTIAL HARMS

- False-positive test results. Maternal serum analyte screening can yield high false-positive rate which may result in the need for subsequent non-invasive (targeted sonography) and invasive testing (amniocentesis)
- False-negative test results. For example, a triple screen test can give false-negative results.
- Injury from invasive tests. For example, amniocentesis can result in fetal loss.

CONTRAINDICATIONS

CONTRAINDICATIONS

Contraindications to tetanus diphtheria (Td) immunization include a previous severe reaction to Td vaccination, such as anaphylaxis, generalized urticaria or angioedema.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- Clinical practice guidelines, which are increasingly being used in health care, are seen by many as a potential solution to inefficiency and inappropriate variations in care. Guidelines should be evidenced-based as well as based upon explicit criteria to ensure consensus regarding their internal validity. However, it must be remembered that the use of guidelines must always be in the context of a health care provider's clinical judgment in the care of a particular patient. For that reason, the guidelines may be viewed as an educational tool analogous to textbooks and journals, but in a more user-friendly format.
- Modifications to the guideline will undoubtedly be necessary as a result of lessons learned and new research and practice-based evidence. The developers believe that this guideline should always be considered "a work in progress."

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Veterans Health Administration, Department of Defense. DoD/VA clinical practice guideline for the management of uncomplicated pregnancy. Washington (DC): Department of Veteran Affairs; 2002 Oct. Various p. [533 references]

ADAPTATION

The development of this guideline incorporated information from several existing evidence-based guidelines/reports, to include the following:

- Institute for Clinical Systems Improvement (ICSI) - Health Care Guideline: Routine Prenatal Care, July 2000.
- Guide to Clinical Preventive Services (CPS) Second Edition, Report of the U.S. Preventive Services Task Force, 1996.

The Working Group also acknowledged the frequent use of the American College of Obstetricians and Gynecologists (ACOG) technical bulletins and guidelines as a respected source for expert opinion.

DATE RELEASED

2002 Oct

GUIDELINE DEVELOPER(S)

Department of Defense - Federal Government Agency [U.S.]
Department of Veterans Affairs - Federal Government Agency [U.S.]
Veterans Health Administration - Federal Government Agency [U.S.]

SOURCE(S) OF FUNDING

United States Government

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Uncomplicated Pregnancy Working Group

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the [Department of Veterans Affairs Web site](#).

Print copies: Department of Veterans Affairs, Veterans Health Administration, Office of Quality and Performance (10Q) 810 Vermont Ave. NW, Washington, DC 20420.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Management of uncomplicated pregnancy. Washington (DC): National CPG Council; 2003. Various p.
- VHA/DoD clinical practice guideline for the management of uncomplicated pregnancy. Summary guideline. Washington (DC): Department of Veterans Affairs (U.S.); 2002 Sep. 27 p.
- VHA/DoD clinical practice guideline for the management of uncomplicated pregnancy. Pocket guide. Washington (DC): National CPG Council; 2002 Sep. 2 p.
- VHA/DoD clinical practice uncomplicated pregnancy. Key points. Washington (DC): National CPG Council; 2002 Sep. 2 p.

Electronic copies: Available from the [Department of Veterans Affairs Web site](#).

Print copies: Department of Veterans Affairs, Veterans Health Administration, Office of Quality and Performance (10Q) 810 Vermont Ave. NW, Washington, DC 20420.

PATIENT RESOURCES

None available

NGC STATUS

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