12/19/2024njm

ANTENATAL TESTING FLOWSHEET

INDICATION	START	NST[1]	AFI/MVP	Doppler[2]	BPP[3]	Ripen / Deliv
AMA (≥ 40 yo) [9]	36 wks	1x/wk	1x/wk			39 - 40 wks
AMA (≥ 40 yo) - Expectant Mgt [10]	40 wks	2x/wk	1x/wk			40 - 42 wks
BMI ≥ 40 kg/m2		no testing needed				41-42 wks
CHTN: - controlled, no meds		no testing needed				39 -39 6/7 wks
CHTN: -controlled on meds	36 wks	1x/wk	1x/wk			39 -39 6/7 wks
CHTN: - difficult control	32 wks	2x/wk	1x/wk			≥ 37 wks
DM / GDMA2 - adequate control [8]	32 wks	2x/wk	1x/wk			39 -39 6/7 wks
DM / GDMA2 - inadequate control [8]	32 wks	2x/wk	1x/wk			≥ 38 wks
FGR[7] (≥3 to <10 %)	at diagnosis	See footnote #13 below				38-39 wks
FGR[7] (<3 %, Abn Doppler)	at diagnosis	See footnote #13 below				≤ 37 wks
GDMA1 diet only		no testing needed				40-41 wks
GDMA1: - Limited documentation: Suboptimal lab profile.[11]	32 wks	2x/wk	1x/wk			39 -39 6/7 wks
Discordant Twins	at diagnosis	2x/wk	MVP[4]	FGR: 1x/wk	FGR: 1x/wk	37-38 wks
Gastroschisis	32 wks	2x/wk	1x/wk	(if FGR)1x /wk		36-37 wks
Gest HTN	At Dx p 32 wk	1x/wk	1x/wk			37-38 wks
HIV+		no testing needed				≥ 38 wks
IHCP: TBA ≥ 10 <40	32 wks	1x/wk	1x/wk	1x/wk		38 -38 6/7 wks
IHCP: TBA ≥ 40 <100	32 wks	1x/wk	1x/wk	1x/wk		37-37 6/7 wks
IHCP: TBA ≥ 100	32 wks	2x/wk	1x/wk	1x/wk		36-36 6/7 wks

H/O IUFD -IUFD ≥ 32 wks	2 wks pre-IUFD	2x/wk	1x/wk	39 -39 6/7 wks
-IUFD ≥ 32 wks (Inadequate documentation: Consider MFM)	32 wks	2 wks	1x/wk	39 -39 6/7 wks
-IUFD < 32 wks (Explainable medical etiology (HTN, DM, etc…): Maximize medical mgt)		no testing needed		39 -39 6/7 wks
-IUFD < 32 wks (Unexplainable medical or recurrent etiology: Consult MFM		no testing needed		39 -39 6/7 wks
Oligohydramnios [5,7]	32 wks	2x/wk	repeat 24 hrs	36-37 6/7
Polyhydramnios [6,7]	at diagnosis	1x/wk	1x/wk	as indicated
Post Dates	41 wks	2x/wk	1x/wk	41-42 wks
Preeclampsia - without severe features	at diagnosis	2x/wk	1x/wk	≥ 37 wks
Severe Pruritus - on Ursodiol	32 wks	1x/wk		39 -39 6/7 wks
Severe Pruritus - other labs [12]	32 wks	1x/wk		39 -39 6/7 wks
Severe Pruritus - not on Ursodiol		no testing needed		39 -39 6/7 wks
Suboptimally dated	39 wks	2x/wk	1x/wk	41-42 wks
MC/DA Twins	prn	2x/wk	MVP	37-38 wks
DC/DA Twins	prn	1x/wk	MVP	38-39 wks

Other (hyperthyroid, Down syndrome, etc.): individualize

Footnotes

1 False negative rate of NST = 2.4/1000

2 Dopplers only of proven benefit in FGR

3 False negative rate of BPP = 0.4/1000

4 MVP = maximum vertical pocket of AF should be ≥2 cm

5 Oligohydramnios (no vertical pocket ≥2cm), AFI, if reported, <5.0

6 Moderate and severe polyhydramnios (any vertical pocket ≥12 cm, or AFI ≥ 30)

7 Refer to MFM if <32 wks or have any questions

8 Adequate control (≥70% in range for GDM with normal FBS(s), or ≥90% for Pre-existing DM, then kick counts 32-36 wks)

9 GUS at 32 wks and 36 wks

10 If chooses expectant mgt p 40 wks 1.) encourage delivery at 41 wks 2.) obtain GUS, if not performed within 3 wks

11 Limited documentation: Suboptimal lab profile
-If HgbA1c ≥ 6.0
or
If any two of the following office-based results is:
-Abdominal Circumference > 95th percentile
< 70 percent of either serum or office fingersticks are in range.
-Mild polyhydramnios: DVP of ≥ 8 cm < 12 cm, or an AFI of ≥ 24 cm < 30 cm

12 Cholic acid ≥ 3 umol/L, Total Bilirubin ≥ 1.0 mg/dL, AST 2x normal limit, ALT 2x normal limit, Alk. Phosphatase ≥ 300 U/L

13 Fetal Growth Restriction (From Figure 1 in Fetal Growth Restriction guideline)
For FGR 3rd% - 9th%:
-Fetal heart rate monitoring once per week
-Doppler q 1 – 2 weeks, then if normal, q 2 – 4 weeks
-Fetal growth q 3 – 4 weeks
-Delivery at 38 – 39 weeks
For FGR < 3rd%:
-Fetal heart rate monitoring once per week
-Doppler q week
-Fetal growth every 2 weeks (although we will likely perform growth at 3 – 4 weeks)
-Delivery at 37 weeks or less

NB: Our Dept. default is not to perform cervical ripening or cesarean delivery prior to 39 wks EGA without medical / obstetric criteria like those noted above. Please see our other Dept. guidelines for other indicated deliveries prior to 39 weeks.