South Western Sydney

Antenatal Shared Care Guidelines

March 2020
Aim
The antenatal Shared Care Program aims to provide a high standard of antenatal care for women who have a low risk pregnancy. The women are cared for by the Antenatal Services at one of the six district hospitals in conjunction with their General Practitioner.

The GP Antenatal Shared Care Program is coordinated jointly with South Western Sydney Local Health District (SWSLHD) and South Western Sydney Primary Health Network (SWSPHN).

Objectives
- To provide choice, continuity of care and greater accessibility for women by seeing their General Practitioner during pregnancy
- To enable registered General Practitioners (GPs) to provide a high standard of antenatal care to women who are considered suitable for Antenatal Shared Care
- To provide GPs with a recommended ‘Best Practice’ standard of antenatal care
- To reduce demands on the hospital outpatient services

Eligibility
- Listed on the database of South Western Sydney PHN practicing GP/registrars
- Fulfil the requirements for SWSPHN GP affiliation
- Agree to follow local protocols and procedures and participate in any necessary feedback or quality improvement activity
- GP registrars must have an ANSC recognised GP in their practice to be eligible to be an ANSC provider for advice, support and supervision

Recognition
GPs wishing to practice Antenatal Shared Care in south western Sydney need to be recognised with the program. Recognition for ANSC requires:
- Satisfying the current requirements of SWSLHD for appointment as a recognised General Practitioner
- Attendance at a SWSPHN/SWSLHD Antenatal Shared Care Program orientation course
- Maintain 12 points of CPD activity related to antenatal care each triennium.
  - All ANSC GPs will be audited at the end of the triennium
  - SWSPHN commits to providing at least 8 points of antenatal CPD activities each year. SWSPHN will record the names of the GPs attending the activities they run.
  - GPs attending antenatal CPD activities outside of SWSPHN must self-record and provide some form of evidence to the SWSPHN ANSC Coordinator
- Ensure South Western Sydney PHN are notified of any changes in practice details
- New accreditation certificates will be issued at the start of each year to ANSC practitioners that continue to meet all requirements

Quality Assurance
Quality assurance activities will be conducted periodically by SWSPHN in conjunction with SWSLHD
Suitability for shared care

Women suitable for ANSC are women who:

- Have been assessed as having a low-risk pregnancy (has no identified risks or only category A risks as defined in the National Midwifery Guidelines for Consultation and Referral)
- Do not require multi-disciplinary care or extensive care coordination

Women with specific pre-existing medical conditions, pregnancy complications, or psychosocial needs (defined as Category B or C risks) require a higher level of multi-disciplinary care coordination than shared care typically provides and are classed as unsuitable for ANSC.

The list of clinical presentations identified as unsuitable for shared care include:

- Pre-existing or poorly controlled gestational diabetes
- Clinical or sub-clinical thyroid Disease
- Hypertension / Cardiovascular Disease
- Significant Anaemia or other Haemoglobinopathy
- Epilepsy
- Renal Disease
- Current drug Addiction or treatment
- Child protection concerns &/or FACS involvement
- HIV positive
- Coagulation disorders
- History/current pregnancy related thrombosis
- Rh or other blood group incompatibility
- Cervical insufficiency (cervical cerclage)
- Connective tissue autoimmune disease
- Endocrine disorder requiring treatment
- Previous stillbirth, neonatal death
- Rhesus allo Immunisation or other abnormal serology
- Multiple Pregnancy
- Risk of preterm birth/rupture of membranes <32 weeks
- Uterine Abnormalities
- BMI ≤18 or ≥35
- Placenta accrete
- Autoimmune disorders
- Poorly controlled medical conditions
- Recurrent miscarriage (≥3 consecutive pregnancy or mid-trimester losses)
- Foetus with known congenital abnormality (structural/chromosomal)

If a GP believes that a women with one of the above presentations is still suitable for ANSC, a case discussion with the hospital can be requested and a determination made on a case by case basis.
Antenatal care record

The Antenatal Record, also known as the ‘yellow card’, is the official hospital record (and sometimes the only one available at the time the woman is admitted). The Yellow card will be issued to the woman by her GP or at her initial visit to the Antenatal Clinic. When completing, please consider:

• Documentation on the ‘yellow card’ following each encounter is mandatory
• The record should be written legibly, completed in a uniform manner using only standard and widely accepted abbreviations and signed
• GP’s should stamp their details on the bottom right-hand corner of the yellow card so that their contact details are easily accessible
• Women should be encouraged to carry the antenatal record with her at all times
• Should the woman forget her card at a visit, the relevant details should be copied onto a letterhead and given to her to keep with the card
• Pathology tests and ultrasound results are to be recorded on the yellow antenatal record. First visit tests are entered on the front page, but for subsequent tests leave a space for the results to be added later or use the space provided at the bottom of the reverse side of the sheet
• The results of any investigations performed by the GP should be recorded. If the results are not available at the time the woman is given her record, write down the name of the service used and the date ordered. It is recommended that a copy of pathology results and ultrasound reports are forwarded to the Antenatal Clinic as soon as possible (by post, fax or give to woman)

GPs using practice software

For GPs using practice software, it is acceptable to print out your clinical notes and any pathology/ultrasound results received and staple them to the Antenatal Record.

In mid-late 2020, the antenatal clinics will be moving to an electronic system and their clinical notes will be attached to the card in the same fashion.

Sample Antenatal ‘Yellow Card’ Record
Determination of estimated date of confinement

To determine the EDC:

1. If the last menstrual period (LMP) is certain and the menstrual cycle is regular, add 7 days and 9 months or 280 days to the first day. If the cycle length is greater than or less than 28 days then add or subtract the difference respectively. For example, for a 35 day cycle add 14 days and 9 months or 287 days.

2. If the LMP is unknown or uncertain, use an ultrasound scan (USS) to determine the EDC.
   - The earlier the USS, the more accurate in terms of dating however the foetal heart beat needs to be seen. In choosing between multiple scans always use the earliest USS, and a transvaginal ultrasound if available.
   - Only change menstrually determined dates if:
     - The USS at less than 12 weeks gestation is more than 6 days different.
     - The USS at 12 to 20 weeks is more than 10 days different.
     - Dates should not be changed by a third trimester ultrasound scan.

To assist GPs in determining the estimated date of confinement, dating wheels are provided to all ANSC practitioners. If you require a replacement, contact the SWSPHN ANSC Coordinator to arrange delivery.
### Criteria for referral back to LHD care

#### Immediate referral to hospital for assessment

- Rupture of membranes or antepartum haemorrhage (send immediately to the Birthing Unit for assessment)
- Intractable vomiting with dehydration and ketosis
- Threatened preterm birth
- Undiagnosed severe abdominal pain
- Decreased foetal movements ≥ 26 weeks
- Suspicion of foetal death in-utero
- Unusual headaches or visual disturbances
- Abdominal trauma (e.g. fall, motor vehicle accident)
- Seizures or “faints” in which seizure activity may have occurred
- Significant dyspnoea on mild-moderate exertion, orthopnoea or nocturnal dyspnoea
- Symptoms or signs suggestive of deep vein thrombosis
- Pyelonephritis
- Symptoms or signs of pre-eclampsia

Complete the following:

Phone the ANC or on-call Obstetrics Registrar for women <20 weeks gestation to discuss:
- whether the situation requires urgent A&E assessment or an earlier antenatal clinic appointment
- whether the complications arising may not need hospital assessment

Phone the Birthing Unit for women ≥20 weeks gestation to discuss with a midwife or obstetrics registrar:
- whether the situation requires urgent Birth Unit assessment or an earlier antenatal clinic appointment
- whether the complications arising may not need hospital assessment

Women referred back to the Hospital require further assessment within the antenatal clinic and an appropriate appointment should be arranged.

Please note that for women in these urgent categories, vaginal speculum examinations would not be appropriate in the GP rooms.

#### Routine referral back to the antenatal clinic

The GP is encouraged to refer back to the first available Antenatal Clinic if any of the following problems/conditions arise:

- Multiple pregnancy
- Gestational Diabetes
- Uterine growth is unusually small or large. Symphysial-fundal height discrepancy ≥3cm requires escalation (arrange urgent ultrasound)
- Increased uterine activity is noted or reported (i.e. preterm labour)
- Placenta praevia detected
- Foetal abnormality is suspected/detected
- Generalised pruritus (arrange LFTs, UEC, FBC, fasting bile salts, uric acid)
- Hb <95g/l
- Platelets ≤150
- Rhesus allo immunisation
- Malpresentation after 36 weeks
- Necessity for support services such as social worker or drug & alcohol services
- Any other problem which represents a significant departure from a normal Antenatal course and which will require attention before the next scheduled ANC visit

Complete the following:

Call the relevant ANC or contact the CMC GP liaison to alert them of the need for the woman to be seen earlier so an appointment can be arranged (see ‘Contact for Clinical Advice Section’ for phone and fax numbers)

All relevant documents should be sent with the woman or faxed through to the appropriate ANC.
<table>
<thead>
<tr>
<th>Weeks</th>
<th>Investigations</th>
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<tbody>
<tr>
<td>6-10</td>
<td>Blood tests:</td>
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<tr>
<td></td>
<td>• Blood Group and Antibody Screen, FBC, VDRL Screen, Rubella titre, Varicella IgG</td>
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<td>• Hep B surface antigen, Hep C &amp; HIV</td>
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<td></td>
<td>• Thalassaemia Screening (HbEPG and ferritin)</td>
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<td></td>
<td>• TSH (all women) and TFTs (if indicated)</td>
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<td></td>
<td>• Fasting BGL (patients with GDM risk factors)</td>
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<td></td>
<td>• EUC/LFTs (for obese women or known or suspected renal or liver disease)</td>
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<td></td>
<td>• Vitamin D (if risk factors)</td>
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<td></td>
<td>• Toxoplasma, cytomegalovirus and herpes serology (if risk factors present)</td>
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<td></td>
<td>Urine tests:</td>
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<td></td>
<td>• MCS for asymptomatic UTI and proteinuria</td>
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<td></td>
<td>• PCR for chlamydia and gonorrhoea (for women ≤25 years or with risk factors)</td>
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<td>Other:</td>
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<td>• Cervical smear if due</td>
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<td></td>
<td>• Dating scan or serum beta hCG</td>
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<td></td>
<td>Discuss/offer aneuploidy screening options:</td>
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<tr>
<td></td>
<td>• 10+ weeks: Non-Invasive Prenatal Testing (NIPT) - not if multiple pregnancy, not Medicare funded, first trimester scan still recommended for morphology</td>
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<td>• 11 – 13 (+6) weeks: Nuchal Translucency Scan + First Trimester Screen (β-hCG, PAPP A)</td>
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<tr>
<td>13-20</td>
<td>75 gm OGTT for women with risk factors and fasting BGL result between 5.1 mmol/L and 6.0 mmol/L - see policy</td>
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<tr>
<td>18-20</td>
<td>Morphology Ultrasound &amp; cervical length</td>
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<tr>
<td>28</td>
<td>Antibody Screen – Rh negative women</td>
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<tr>
<td></td>
<td>FBC</td>
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<td></td>
<td>Diabetes Screening - 75g oral GTT</td>
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<td></td>
<td>Vitamin D (if previously low)</td>
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<td>Boostrix</td>
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<tr>
<td>36</td>
<td>Antibody Screen (if required)</td>
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<td>FBC</td>
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<td></td>
<td>LVS for GBS</td>
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<tr>
<td>Postnatal</td>
<td>Pap smear (if due)</td>
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<td></td>
<td>Investigations (if required)</td>
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<tr>
<td></td>
<td>75gm OGTT after 6 weeks (if GDM during pregnancy)</td>
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<table>
<thead>
<tr>
<th>Weeks</th>
<th>Education Topic</th>
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<tbody>
<tr>
<td>6-20</td>
<td>• Options for care, birth and routine antenatal schedule</td>
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<tr>
<td></td>
<td>• Medication Safety</td>
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<td>• Smoking and/or drug and alcohol cessation</td>
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<td>• Diet, nutrition, listeria and exercise</td>
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<td></td>
<td>• Genetics and genetic testing</td>
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<td></td>
<td>• Influenza and other viral illnesses e.g. varicella, pertussis</td>
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<td></td>
<td>• Dental Care</td>
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<td>• Benefits of breastfeeding, previous experiences and knowledge +/- breast assessment and referral to lactation services</td>
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<td>&lt;24</td>
<td>• Foetal movement discussions at all appointments</td>
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<td></td>
<td>• Issues from previous labours, births and experiences</td>
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<td></td>
<td>• Revisit alcohol, smoking, drugs, diet and nutrition (as above)</td>
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<td></td>
<td>• Minor disorders of pregnancy</td>
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<tr>
<td>24-32</td>
<td>• Foetal movement discussions at all appointments (as above)</td>
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<tr>
<td></td>
<td>• Pelvic floor exercises &amp; perineal massage</td>
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<tr>
<td></td>
<td>• Changing relationships, emotions, sexuality</td>
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<tr>
<td>&gt;32</td>
<td>• Foetal movement discussions at all appointments including indications for foetal monitoring</td>
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<tr>
<td></td>
<td>• Infant safety - SIDS and car</td>
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<td></td>
<td>• Newborn Vaccines and tests (including, Hep B, vitamin K, and newborn bloodspot tests)</td>
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<td>• 3rd stage management</td>
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<td>• Postnatal Contraception/sexuality</td>
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<td>• Signs of labour, purpose &amp; strategies to manage intensity and reasons to present to hospital</td>
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<td>• Post-dates management</td>
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<td>• Importance of reading to baby and toddler</td>
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The page numbers listed below reference sections of the NSW Kids and Families Having a Baby Book.
**Additional Comments**

**Antenatal Colposcopy**
Women with Cervical Intra-epithelial Neoplasia (CIN) diagnosed on the antenatal smear or just prior to the pregnancy should be referred for Colposcopy - this can be done through the hospital gynaecology clinic or alternative facilities according to woman’s choice.

**Influenza Vaccine**
Recommended for all women planning a pregnancy and for those women who are pregnant in the influenza season regardless of gestation.

**Iodine**
NHMRC recommends supplementation of 150 μg/day to ensure that all women who are pregnant, breastfeeding or considering pregnancy have adequate iodine status.

**Iron & Folic Acid**
- Folic Acid 500mcg should be recommended for all women from pre-conception up to 12 weeks.
- A dose of 5mg Folic Acid is recommended for:
  - Women taking antiepileptic drugs
  - ≥ 30 BMI
  - Type 1 or Type 2 diabetes
  - Previous history of spina bifida
- The dose may also alter if she is known to have elevated homocysteine levels.
- Commence iron supplementation for those with a Hb of <10.5 and investigate as appropriate.

**NIPT, & NT Plus**
Non-Invasive Prenatal Testing estimates cell free foetal DNA within maternal circulation, is highly sensitive for Trisomy 21 (>99%) and has a low false positive rate (<2%) (sensitivity and specificity are slightly less for the other major autosomal and sex chromosomal aneuploidies). Currently a consensus of management has not been agreed upon however if the NIPT test is performed then the NT plus scan may be offered in a modified version- an ultrasound (at 12+ weeks) and PAPP-A NT Plus scan at 11 – 13(+6) weeks; please check that U/S provider is fully accredited to perform NT Plus scans. Screening of a low risk population for the later development of pre-eclampsia is currently undergoing evaluation.

**Pertussis Vaccine**
Boostrix recommended from 28 weeks for every pregnancy. If Boostrix was given inadvertently in the first trimester, it is not given again in the third trimester and instead is given in the postnatal period.

**Prophylactic Anti-d**
Routinely given to all Rhesus negative women at 28 – 30 and 34 – 36 weeks in hospital clinics.

**Sexual Health Screen**
Screen all pregnant women for HIV. Complete sexual health screening, including discussing Chlamydia testing with <25yr old and those women ‘at risk’

**Thalassaemia Screening**
It is recommended that all pregnant women be offered haemoglobin EPG as an initial investigation together with a full blood count, ferritin and a manual film.
If this has been completed during an earlier pregnancy, there is no need to repeat the test.
If a known carrier, the father’s status needs to be ascertained and if father is a carrier refer to genetics counsellor.
**TSH and T4**

Universal screening of pregnant women for thyroid dysfunction remains controversial. The American Thyroid Association concludes that there is insufficient evidence FOR or AGAINST universal first trimester TSH screening.

It is recommended that TSH screening be completed for women with:

- Personal history of thyroid dysfunction, including:
  - Hyperthyroid or hypothyroid disease
  - Postpartum thyroiditis
  - Thyroidectomy
  - Thyroid lobectomy
  - Treatment with radioactive iodine
  - Therapeutic head or neck irradiation
  - Nuclear accident exposure
  - Goitre
  - Known presence of thyroid antibodies
- Age >30 years
- Autoimmune disease (including Type I diabetes, pernicious anaemia, coeliac disease)
- Use of amiodarone, lithium or recent iodinated radiocontrast administration
- Morbid obesity (BMI >40)
- Pregnancy complications, infertility, recurrent miscarriage, preterm birth
- Family history of thyroid disease
- Residing in an area of known moderate to severe iodine insufficiency

**Ultrasound**

- First trimester dating scan is required for those with uncertain dates
- Ultrasound should also be performed for relevant complications (e.g. vaginal bleeding)
- At 18-20 weeks foetal morphology is assessed. It is recommended that the ultrasound provider specialises in obstetrics and gynaecology
- Please note abnormalities (e.g. low placenta), date the test was performed and gestational age on the yellow card
- Dating of the pregnancy by ultrasound becomes increasingly unreliable after 20 weeks gestation
- Please fax the report and ensure the woman takes the ultrasound report and film to the Antenatal Clinic at the next visit. After review, the films will usually be returned to the woman

**Varicella**

This screening test is now part of the routine antenatal screening and should be completed for all women.

**Young Mums**

- Young Mum’s clinics are available at Bankstown, Fairfield, Liverpool and Campbelltown ANCs
- Young Mum education classes are available at Liverpool and Campbelltown Hospitals (these are free classes and run weekly)
- Young mums are able to access the Pregnancy and Parenting Support program from Catholicare
- For young mums without birthing support, Catholicare is able to assist in arranging a free doula to provide birthing support
Breastfeeding

GPs are uniquely positioned to counsel mothers about the health impact of breastfeeding.

“For infants, not being breastfed is associated with an increased incidence of infectious morbidity, as well as elevated risks of childhood obesity, type 1 and type 2 diabetes, leukaemia, and sudden infant death syndrome. For mothers, failure to breastfeed is associated with an increased incidence of premenopausal breast cancer, ovarian cancer, retained gestational gain, type 2 diabetes, myocardial infarction, and the metabolic syndrome.”


Topics to cover

Consider discussing the following breastfeeding topics over the course of the antenatal visits:

- Baby feeding goals
- The benefits of breastfeeding
- Breastfeeding tips for new mothers
- Breastfeeding after breast surgery
- Expressing and storing breastmilk
- Increasing your supply of breastmilk
- Mastitis - Causes, prevention and treatment
- Preparing artificial formula feeds, sterilising bottles and teats
- Use and care of dummies (pacifiers)
- Using nipple shields
- Weaning or suppressing lactation

For tips on how to discuss breastfeeding with pregnant women, see the Change Talk 2.0 App

Further Breastfeeding supports

Australian Breastfeeding Association Helpline:
- Phone: 1800 mum 2 mum
- Email counselling
- Interpreters available
- Information - www.breastfeeding.asn.au

Antenatal information for women regarding breastfeeding:
- Australian Breastfeeding Association run monthly breastfeeding classes
- Hospital antenatal classes
- Private antenatal classes
- Books and prenatal class DVDs are also available

Lactation Support

The SWLHD Child and Family Health Nursing Teams employ a number of lactation consultants, with drop in clinic times during the week. To refer for a lactation consultant, contact Triple I

Private lactation consultants can be found at www.lcanz.org
Antenatal Examinations

It is suggested that the antenatal visits include the following:

- History - foetal movements, etc.
- Discussion on the importance of FM and recognising and knowing appropriate follow up
- Blood Pressure
- Evidence of oedema
- Foetal Heart Rate - Doppler after 16 weeks
- Estimation of fundal height – Symphysial-Fundal Height to be measured after 20 weeks
- The foetal presentation after 26 weeks
- The engagement of the head after 36 weeks (though significance is subjective)

Symphysial-fundal height chart:

The curves represent the 10th, 50th and 90th percentiles for normal pregnancy.

Readings below the 10th percentile, between 28 and 34 weeks’ gestation are most likely to predict intra-uterine growth retardation.

Fundal height should be measured from the top of the fundus of the uterus to the top of the symphysis pubis, with the tape measure lying in contact with the skin of the abdominal wall

The measurement at the fundus should be made by palpation vertically downward

![Symphysial-fundal height chart](image)

Walk your fingers up the side of the belly.

Find the top of the uterus (it feels like a hard ball under the skin).

You can feel the top by curving your fingers into the belly.
Antenatal Complications Management

Unwanted Pregnancy

- Is it a viable intra-uterine pregnancy?
  - NO (see miscarriage or ectopic pathway based on clinical suspicion)
  - YES
    - Counsel and complete Termination of Pregnancy (TOP) referral according to gestational age

  ≤ 9/40 Medical Abortion
  7/40 - 20/40 Surgical Abortion

Termination counselling for Foetal Anomaly Liverpool Hospital FMU (02) 8738 5631

Hyperemesis Gravidarum

- Is the woman ketotic or showing signs of dehydration?
  - NO
    - Counsel and provide dietary advice
    - Consider anti-emetic medication to control symptoms
    - Assess MSU and TSH/T4 if not previously performed
  - YES Send to ED ASAP

Suspected Ectopic Pregnancy

- Is the woman stable?
  - STABLE
    - Quant. βhCG + Ultrasound to confirm
    - Ectopic pregnancy confirmed?
    - NO
      - Monitor for further complications or alternative diagnosis
    - YES
      - Send to ED ASAP
  - UNSTABLE
    - Call Ambulance ASAP

Suspected Miscarriage (Threatened/Incomplete)

- Suspected type of miscarriage?
  - Ectopic (see ectopic pathway)
  - Stable miscarriage
  - Unstable miscarriage

- Quant. βhCG + Ultrasound to confirm

  Miscarriage has occurred?
  - YES
    - Evidence of molar pregnancy?
      - YES
        - Refer to ED or EPAS ASAP
      - NO
        - Monitor for further complications or alternative diagnosis
  - NO
    - Counsell and arrange outpatient appointment with relevant clinic

Hyperemesis Gravidarum

- Is the woman ketotic or showing signs of dehydration?
  - YES
    - Refer to ED or EPAS ASAP
  - NO
    - Counsell and arrange outpatient appointment with relevant clinic

Hypertension

- Measure BP using appropriate size cuff
  - Systolic < 140
    - Diastolic < 90
      - Normal range (continue to monitor)
  - Systolic ≥ 140 and/or Diastolic ≥ 90
    - Requires review
      - < 20 weeks gestation: Urgent referral to ANC within 7 days
      - ≥ 20 weeks gestation: Refer/contact birthing unit
  - Systolic ≥ 170 and/or Diastolic ≥ 110
    - Immediate Referral
      - < 20 weeks gestation: Send to ED
      - ≥ 20 weeks gestation: Send to Birthing Unit

Pelvic or Vaginal Bleeding

- Is the woman rhesus negative?
  - YES
    - Stage of pregnancy?
      - > 20 weeks
        - Send woman to Birthing Unit ASAP
      - < 20 weeks
        - Send to ED ASAP (<20 weeks) or Birthing Unit (≥ 20 weeks) for Anti-D management
  - NO
    - Send to ED ASAP (<20 weeks) or Birthing Unit (≥ 20 weeks) for Anti-D management

NO (see miscarriage or ectopic pathway based on clinical suspicion)
Gestational Diabetes Screening

Risk Factors for GDM
Any ONE of the following:

- Ethnicity: Asian, Indian subcontinent, Aboriginal, Torres Strait Islander, Pacific Islander, Maori, Middle Eastern, Non-White African
  - BMI ≥ 30 kg/m²
  - Previous GDM
- Previously Elevated Blood Glucose Level
  - Maternal Age ≥ 40 years
- Family History DM (1st degree relative with diabetes or a sister with GDM)
- Previous Macrosomia (baby with birth weight > 4500gms or > 90th centile
  - Polycystic Ovarian Syndrome
  - Medications: corticosteroids, antipsychotics
- Women who have had Bariatric Surgery (‘Gastric sleeve’ or ‘Roux-en-Y’ surgery)

YES GDM Risk Factors

Fasting Blood Glucose test
First Trimester
(Up to the end of the 12th week gestation)

≥ 6.1 mmol/L

5.1 – 6.0 mmol/L

≤ 5.0 mmol/L

75gm OGTT 13-20 weeks

Any of
- ≥ 5.1 mmol/L
- ≥ 10.0 mmol/L
- ≥ 8.5 mmol/L

< 5.1 mmol/L
< 10.0 mmol/L
< 8.5 mmol/L

Normal Antenatal Care (this includes 24-28 week 75gm OGTT)

REFER TO GDM CLINIC

NO GDM risk Factors

75gm OGTT 24-28 week’s gestation

Any of
- ≥ 5.1 mmol/L
- ≥ 10.0 mmol/L
- ≥ 8.5 mmol/L

< 5.1 mmol/L
< 10.0 mmol/L
< 8.5 mmol/L

Normal Antenatal Care
Postnatal check

Complete a postnatal check as early as required (generally between 4-6 weeks after confinement). The details of confinement are available on Midwife Discharge Data Sheet which should be routinely posted to GP’s or urgently faxed if complications have occurred.

History

• Psychological state (e.g., Postnatal Depression)
• Feeding/settling problems
• Lochia (usually stopped by 6 weeks, first period may occur at 6 weeks. Lochia is usually clear of blood by 2 weeks)
• Physical sequela of confinement. (e.g., backache/urinary symptoms etc.)
• Enquire about intercourse and any associated problems.
• Education regarding pelvic floor exercises
• Contraception (may fit diaphragm at this stage, avoid combined O.C.P. if breast feeding)

Examination

• BP (re-check again at 3/12 if high during pregnancy)
• Breasts
• Abdominal examination to check for fundal height
• P.V. (if required):
  • check episiotomy/tears, cauterise granulomas, etc.
  • check for prolapse (pelvic floor tone)
• Haemorrhoids or problematic bowel movement (discuss if relevant)
• Cervical screen (if due)
• Hb (if significant PPH or previously anaemic or symptomatic)
• Check for goitre (postnatal thyroiditis)
• For women who had Gestational diabetes- Repeat 75g OGTT at 6 weeks postpartum
• For the women who were insulin requiring gestational diabetics, ensure follow up with the hospital clinic
• Some women may be asked to attend the hospital clinic for review if they had obstetric complications

Follow up any medical problems if diagnosed during pregnancy

Offer:

• Vaccination of new parents for pertussis as per NHMRC guidelines
• 2nd MMR to mother who had low immunity and given the first MMR vaccine in hospital as per NHMRC guidelines