Comments Please 20051-5-010

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YOUR REFERENCE - GL 91

IN YOUR REPLY PLEASE QUOTE

Address reply to officer whose official title appears below signature.

D R A F T D I S C U S S I O N D O C U M E N T

25.07.91

GUIDELINES FOR OBSTETRIC CARE

AUCKLAND AREA HEALTH BOARD

NERAL

The individual responsible for a patient's care must be clearly recorded in the notes at all times.
An antenatal record should be held by the patient, carried by her to all visits to care givers, and brought with her at the onset of labour.
Identification of non-obstetric risk factors requires that all pregnant women should have at least one formal history and examination by a medical practitioner with obstetric training and a Board contract.
Once referred, the specialist will

1. discuss with the primary care provider when necessary,
2. decide on the appropriate level of subsequent care,
3. provide a clear management plan,
4. clearly indicate the need for additional specialist consultation for those patients referred to the primary care provider, and
5. document the above in writing.

Referral in all situations should be as early as possible to encourage early risk identification and allow formal planning of subsequent care.
Antenatal inpatients should be under the care of a public hospital specialist.
The below list comprises those situations where a consultation by an obstetric specialist is required.

C. Consultation in Labour

Non cephalic presentation
Fetal heart rate abnormalities
Thick meconium liquor
Prolonged rupture of membranes >24 hours
Failure to progress (>4 hours at any dilatation, >1 hour in second stage)

D. Consultation in Postnatal Period

Placenta undelivered after 30 minutes
Third degree tear
Primary PPH not responding to initial therapy
Secondary PPH
Puerperal psychosis
Neonatal death

E. Paediatric Consultation

All newborn infants should be examined within 12 hours of birth by a medical officer.

Immaturity (<36 weeks gestation)
Low birthweight (<2500g birthweight)
Birth asphyxia (severe depression, eg 5 min Apgars <6, sustained hypotonia
Apnoea or respiratory distress, persistent or recurrent cyanosis, grunting or tachypnoea
Meconium exposure
Jaundice - early onset jaundice (first 36 hours)(>120)
- bilirubin >280 anytime (term baby)
- prolonged jaundice (>3 weeks)
Bile-stained or persistent vomiting
Abdominal mass or distension
Persistent fresh blood in stools
Suspicion of oesophageal atresia or tracheoesophageal fistula
No passage of meconium by 36 hours
Definite feeding problems
Convulsions
Irritability
Lethargy

Prepared by mixed professional group 25 July 1991

Midwife Bronwyn Cox

General Practitioners Lee Nixon
Tony Hay

Obstetricians Lesley McCowan
Neil Buddicom
Neil Pattison

A. Consultation in Early Pregnancy (Booking)

Age >39 or <18 years *

Weight < 50 kg

Obesity (when fetal assessment is difficult)

Short stature <148 cm

Medical disease
- hypertension
- previous pulmonary emboli or thrombosis
- autoimmune disease
- thyroid disease
- heart disease
- renal disease
- diabetes
- epilepsy (on treatment)
- unstable or severe asthma
- neoplasia
- major psychiatric disorder
- haemorrhagic disorder
- multiple sclerosis
- significant respiratory impairment

Substance abuse

Previous
- caesarean section
- uterine, major cervical or vaginal surgery
- perinatal or intermediate fetal death
- growth retarded babe (<10th percentile)
- difficult labour or delivery, eg shoulder dystocia
- severe proteinuric pre-eclampsia
- premature delivery (<35 weeks)
- PPH requiring transfusion
- baby requiring active resuscitation or child with brain damage
- puerperal psychiatric disorder

Recurrent miscarriage (3 or more)

2 or more terminations of pregnancy

No antenatal care prior to 34 weeks *

B. Consultation during Pregnancy

Recurrent bleeding prior to 28 weeks (2 or more episodes)

Fetal abnormality

Gestation 42 weeks and beyond

Hypertension (>95mmHg diastolic) without proteinuria at any time

Hypertension with proteinuria

Antepartum haemorrhage

Polyhydramnios

Oligohydramnios

Anaemia (< 80g/l)

Unstable lie or malpresentation after 36 weeks

Multiple pregnancy

Intrauterine growth retardation (or suspected)

Suspected disproportion/large baby

Abnormal glucose tolerance test

Rhesus antibodies

Assessment for induction

Preterm labour <36 weeks

Fetal death

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