Advisory Board on Midwifery

Virginia Board of Medicine

June 16, 2023

10:00 a.m.

Advisory Board on Midwifery

Board of Medicine

Friday, June 16, 2023 @ 10:00 a.m.

9960 Mayland Drive, Suite 201

Henrico, VA

PERIMETER CENTER CONFERENCE CENTER
EMERGENCY EVACUATION OF BOARD AND TRAINING ROOMS
(Script to be read at the beginning of each meeting.)

PLEASE LISTEN TO THE FOLLOWING INSTRUCTIONS ABOUT EXITING THESE PREMISES IN THE EVENT OF AN EMERGENCY.

Training Room 2

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When the alarms sound, leave the room immediately. Follow any instructions given by Security staff

Exit the room using one of the doors at the back of the room. (**Point**) Upon exiting the doors, turn **LEFT.** Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

ADVISORY BOARD ON MIDWIFERY
Minutes
September 23, 2022

The Advisory Board on Midwifery met on Friday, September 23, 2022 at 10:00 a.m. at the Department of Health Professions, Perimeter Center; 9960 Mayland Drive, Henrico, Virginia, 23233.

MEMBERS PRESENT: Rebecca Banks, LM - Vice-Chair
Ildiko Baugus, LM

MEMBERS ABSENT: Ami Keatts, M.D.
Erin Hammer, LM

STAFF PRESENT: William L. Harp, MD - Executive Director
Michael Sobowale, LLM - Deputy Director for Licensure
Colanthia Opher, -Deputy Director for Administration
Erin Barrett, JD - DHP Senior Policy Analyst
Beulah Baptist Archer - Licensing Specialist

GUESTS PRESENT: Adrienne Ross
Misty Ward, LM

Call to Order

Rebecca Banks called the meeting to order at 10:11 a.m.

Emergency Egress Procedures

Dr. Harp announced the emergency egress instructions.

Roll Call

The roll was called; no quorum was declared.

Approval of Minutes

The minutes were not approved as no quorum was present.

Adoption of Agenda

The agenda was not adopted as no quorum was present.

Public Comment

No public comment was received at the outset of the meeting. Public comment was reopened for Misty Ward later in the meeting. Ms. Ward inquired whether the Advisory Board had a mechanism to remove members who do not attend meetings. Dr. Harp explained that the Governor appoints and has the authority to remove Advisory Board members. Ms. Ward indicated she may be in touch with the Governor.

New Business

1. **Periodic Review of Regulations Governing the Practice of Licensed Midwives**

Mrs. Barrett discussed the mandatory four-year review of Chapter 130 to determine whether this regulation should be repealed, amended or retained in its current form, without impacting public safety. The review of this regulation will be guided by the principles in Executive Order 14 (as amended July 16, 2018). There were a number of comments received during the public comment period. She said only those that referenced a section of the regulations were meaningful to the process. She pointed out that authorization for midwives to possess and administer medications would be a matter for the General Assembly.

Ms. Barrett then presented her recommendations to amend or delete current language provisions in 18VAC85-130-30(10), 18VAC85-130-100(G), 18VAC85-130-110, 18VAC85-130-130, 18VAC85-130-140, and 18VAC85-130-150. Some of these provisions are in the law, and it is unnecessary to repeat them in regulation. These suggested revisions were discussed thoroughly with the members of the Advisory Board in attendance. Although a quorum was not available to make the suggested revisions a recommendation from the Advisory Board, Ms. Barrett said she will present them to the Board of Medicine with a recommendation for adoption.

2. **Review of Bylaws for Advisory Boards**

Erin Barrett presented the uniform Bylaws for all Advisory Boards that the full Board approved at its June meeting. Since the Bylaws are slated to become effective on September 29, 2022, this was for information only.

3. **Discuss Process for Additions to High Risk Pregnancy Disclosures Guidance Document**

Rebecca Banks stated that Guidance Document 85-10 on Disclosures in High-Risk Pregnancy Conditions needed to be updated. Dr. Harp provided general guidance on the process for updating guidance documents. Ms. Banks and Ms. Baugus indicated they would forward a few items that they believed required revision and any additions as well. Historically, updates to this document have been addressed by an ad hoc committee consisting of equal numbers of Advisory Board members and Board of Medicine members. The committee would be appointed by the Board of Medicine

President. Further detail about the process will be sought from Ms. Barrett, DHP Senior Policy Analyst.

4. **Approval of 2023 Calendar**

The 2023 meeting was not approved as no quorum was present.

5. **Election of Officers**

Officers were not elected as no quorum was present.

Announcements

License statistics

Beulah Baptist Archer provided the license count for licensed midwifery, as follows:

Current active midwives in Virginia	79
Current active out of state	29
Current inactive out of state	1
Total	109

Next Scheduled Meeting

The next scheduled meeting is February 10, 2023 @ 10:00 a.m.

Adjournment

With no other business to conduct, Rebecca Banks adjourned the meeting at 11:23 a.m.

William L. Harp, MD Executive Director

Board of Medicine
Advisory Board on Midwifery
Current Regulatory Actions
As of May 31, 2023

In the Governor's Office

None.

In the Secretary's Office

VAC	Stage	Subject Matter	Date submitted*	Time in office	Notes
18VAC85-130	Fast-track	Implementation of changes following 2022 periodic review of Chapter	5/30/2023	1 day	Periodic review changes voted on at October Board meeting

* Date submitted to current location

At DPB or OAG

None.

Recently effective/awaiting publication

None.

Ad Hoc Committee Meeting

Review and Revision of Midwifery Guidance Document 85-10

May 18, 2023

Call to Order: Dr. Ransone called the meeting to order at 10:09 am.

Members Present:
Karen Ransone, MD – Chair
David Archer, MD
Becky Banks, LM [Joined Remotely]
Ildiko Baugus, LM
Ami Keatts, MD
Erin Hammer, LM

Staff Present:
William L. Harp, MD – Executive Director
Michael Sobowale, LL.M. – Deputy Director for Licensing
Colanthia M. Opher – Deputy Director for Admnistration
Roslyn Nickens, Licensing Supervisor
Erin Barrett, Director of Legislative and Regulatory Affairs
Matthew Novak, DHP Policy Analyst

Guests Present: Nicole Lawter, Lobbyist

Charge of the Committee

Dr. Harp noted that 5 of the 6 members were present in the room which constituted an in-person quorum. He said that the statute on electronic meetings allowed a member with good reason approved by the Chair to participate remotely if a quorum was present. A temporary medical condition has prevented a member of the Committee from being physically present for the meeting, so she will be participating virtually.

Dr. Harp went on to say that at the September 2022 meeting of the Advisory Board on Midwifery, it was determined that Guidance Document 85-10 on high-risk pregnancy disclosures for midwives should be reviewed and revised as appropriate. The thought was that updated research, advancements

in practice, and new technology should be incorporated into the document. He pointed out that some of the agenda packet was without numbers, so when members speak about their proposed amendments, they reference the section of 85-10 so all could be on the same page.

Adoption of Agenda

Upon a motion by Dr. Archer, seconded by Ildiko Baugus, the agenda for the meeting was adopted as presented.

Public Comment

There was no public comment.

Discussion of Suggested Revisions to Guidance Document 85-10

Dr. Ransone discussed how she thought the work should proceed. Ildiko Baugus stated that the list of proposed changes she submitted in disclosures #11-22 consisted of updated research in midwifery within the last 5 years.

Dr. Keatts suggested adding "difficulty breast feeding" to both maternal risks and fetal/neonatal risks in #4 – Anemia (Hematocrit Less Than 30 or Hemoglobin Less than 10 at term).

Dr. Ransone also suggested adding "difficulty breast feeding" to both maternal risks and fetal risks in #11 – Essential Chronic Hypertension. Dr. Keatts suggested adding "Stroke" as a last bullet point under Maternal Risks.

In #14, Ildiko Baugus and Becky Banks suggested striking "avoided" at the end of the first paragraph and insert "decreased based on new research."

In #25, VBAC, Dr. Ransone suggested striking "But" at the beginning of the second sentence and replacing it with "If", also striking "Because" and using parentheses (uterine rupture can be sudden and unexpected, labor outside the hospital can delay delivery and increase the risk of injury and death for both mother and baby in an emergency)

Dr. Ransome suggested striking the words, "Beta" and "rare" after meningitis from the draft proposed disclosure #38.

Dr. Archer moved to accept the changes as discussed and to amend the existing Guidance Document as suggested. Idiko Baugus seconded the motion. Motion passed.

During discussion of her submitted changes for #11-22, Ildiko Baugus highlighted the change she recommended in #14 to edit the last statement in the first paragraph to strike the phrase, "and breastfeeding is avoided" to be replaced with, "decreases your risk of transmitting to your baby through breastfeeding" with reference to the citation provided.

Becky Banks discussed her recommendations for changes in disclosures #1 through #10. She specifically highlighted her suggested edit under "Intrapartum Risk Factors" to place a new section under alcohol abuse regarding opioid use disorder during pregnancy. In the citations for disclosure #5, she provided new language to strike the second citation and replace it with the following, "Antepartum Fetal Surveillance: ACOG Practice Bulletin #229. (2021) June 1. She also presented new possible disclosures to be added to the existing Guidance Document.

Erin Barrett pointed out that because the Guidance Documents was originally created several years ago the document itself is difficult to edit with modern technology. She suggested that the entire document be restructured. She suggested removing the preamble at the top of each disclosure page, additional statements about the Guidance Document in the box at the bottom of each disclosure, and remove all the citations, footnotes and references as well as the structured consent forms. Ildiko Baugus proposed including citations, footnotes and references in the section dealing with Intrapartum Risk Factors only.

Becky Banks made a motion to leave the preamble for Intrapartum Risk Factors only and remove it from all other disclosures. Ildiko Baugus seconded. The motion carried.

Dr. Ransone moved to remove the references and citations and the additional statements about the Guidance Document in the box at the bottom of each disclosure and list all references in one list. The motion passed.

Next Steps

The next steps will be to incorporate the suggested edits into a proposed draft version of Guidance Document 85-10 and present it for discussion at the next Advisory Board on Midwifery.

Adjournment

There being no further business, the meeting adjourned at 11:05 am.

Guidance Document: 85-10

Revised: August 4, 2023
Effective Date: TBD

Virginia Board of Medicine

Disclosures by Licensed Professional Midwives for High-Risk Pregnancy Conditions

Regulations which govern licensed professional midwives require that midwives disclose to patients, when appropriate, options for consultation and referral to a physician, as well as information on health risks associated with the birth of a child outside of a hospital or birthing center. *See* 18VAC85-130-81(A). Regulations of the Board, specifically 18VAC85-130-81(B), list the risk factors and conditions that require disclosure, as well as steps the midwife must take if the risk factors or conditions are presented. 18VAC85-130-81(C) contains requirements for communication and record-keeping if risk factors or conditions are identified.

This guidance document provides evidence-based information and a format to record the disclosure of information and options for consultation and referral in the patient's record for each risk factor or condition included in 18VAC85-130-81(B). Use the table of contents links below to access forms for particular risk factors or conditions.

**** The disclosure for intrapartum risk factors should be given to a client at the first prenatal visit. ****

Table of Contents

Intrapartum Risk Factors

The Midwives Model of Care recognizes the client/patient as the primary decision-maker in all aspects of her care and respects her autonomy. This is supported within a model of well-informed, shared decision-making in order to achieve optimal clinical outcomes. Disclosure of risks is an integral part of the informed consent process, as outlined by the North American Registry of Midwives ("NARM").

> If a midwife supports a client's choices that are outside of her [plan of care], she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision-making process.

Informed Consent for Waiver of Midwife's Plan of Care, NARM.

Licensed professional midwives are trained experts in the management of low-risk pregnancy and birth outside of the hospital. Certain conditions may present increased risk to the mother and baby. The risks listed below apply to birth in any setting and are not all-inclusive. The condition or risk factor listed may require medication and treatment outside of the scope of practice of licensed professional midwives in Virginia and therefore may necessitate consultation with a physician, additional testing, and careful consideration of the appropriateness of birth in an out-of-hospital setting. Some conditions in pregnancy are optimally managed and supported by a multidisciplinary team that may include midwives, obstetricians, perinatologists, family physicians, psychologists, social workers, and spiritual advisors.

Conditions requiring on-going medical supervision or on-going use of medications.

Clients with chronic medical conditions, clients on prescribed medications, or clients under medical care for a time-limited problem that coincides with pregnancy should be advised to consult with their treating healthcare providers regarding the impact of these conditions and medications on pregnancy, as well as any impact pregnancy may have on their other diagnosed conditions. Women who choose not to disclose information regarding any existing medical conditions or existing medications may increase their risk of complications.

Current substance abuse (including alcohol and tobacco).

Obstetrical complications of cigarette smoking include:

- Growth restriction (IUGR)
- Spontaneous abortion (miscarriage)
- Sudden infant death syndrome (SIDS)

Alcohol abuse leads to:

- Nutritional deficiencies
- Fetal alcohol syndrome

In addition to increased risk of preterm labor and baby being small for gestational age, complications resulting from using other drugs are listed below:

- Heroin and cocaine consumption result in medical, nutritional, and social neglect
- Cocaine and amphetamine use causes hypertension and placental abruption
- Intravenous drug use increases the risk of contracting infectious diseases
- Maternal substance use of opioids, benzodiazepines, barbiturates, and alcohol can cause neonatal abstinence syndrome ("NAS"). NAS is a set of drug withdrawal symptoms that affect the central nervous, gastrointestinal, and respiratory systems in the newborn when separated from the placenta at birth.

Opioid use disorder.

Opioid use disorder during pregnancy may contribute to:

- Preterm birth
- Stillbirth
- Maternal mortality
- Neonatal abstinence syndrome

Documented intrauterine grown retardation (IUGR)/small for gestational age (SGA) at term.

Complications for the growth-restricted fetus include:

- Prematurity
- Perinatal morbidity
- Stillbirth

Reviewing evidence-based information, the Board has determined that IUGR is a serious problem, regardless of why the baby is small. About 20% of stillborn babies are IUGR, and perinatal mortality for growth-restricted infants may be 6 to 10 times higher than for those of normal size. Most IUGR stillbirths occur after the 36th week of pregnancy and before labor begins.

Suspected uterine rupture.

The Board determines the following based on evidence-based information regarding uterine rupture:

- There have been no reported maternal deaths due to uterine rupture

- Overall, 14% - 33% of women will require a hysterectomy when the uterus ruptures
- Approximately 6% of uterine ruptures will result in perinatal death, which is an overall risk of intrapartum fetal death of 20 per 100,000 women undergoing trial of labor after previous cesarean section
- For term pregnancies, the reported risk of fetal death with uterine rupture is less than 3%. Although the risk is similarly low, there is insufficient evidence to quantify the neonatal morbidity directly related to uterine rupture.

Prolapsed cord or presentation.

Prolapsed cord is a term describing a cord that is passing through the cervix at the same time or in advance of the fetal presenting part. This occurs in approximately 1.4-6.2 per 1,000 pregnancies. Although uncommon, it is considered a true obstetrical emergency most often necessitating a cesarean delivery. Prolapsed cord is also associated with other complications of pregnancy and delivery. Fetal risks include:

- Hypoxia
- Stillbirth/death

Suspected complete or partial placental abruption.

Placental abruption results from a cascade of pathophysiologic processes ultimately leading to the separation of the placenta prior to delivery. Pregnancies complicated by abruption result in increased frequency of:

- Low birth weight
- Preterm delivery
- Stillbirth
- Perinatal death

Suspected placental previa.

Pregnancies complicated with placenta previa have significantly higher rates of:

- Second-trimester bleeding
- Pathological presentations
- Placental abruption
- Congenital malformations
- Perinatal mortality
- Cesarean delivery
- Apgar scores at 5 minutes lower than 7
- Placenta accreta
- Postpartum hemorrhage
- Postpartum anemia
- Delayed maternal and infant discharge from the hospital

Suspected chorioamnionitis.

Chorioamnionitis is a potentially serious complication, as described below:

- Chorioamnionitis is a major risk factor in the event of preterm birth, especially at earlier gestational ages, contributing to prematurity-associated mortality and morbidity
- Increased susceptibility of the lung for postnatal injury, which predisposes for bronchopulmonary dysplasia.
- Chorioamnionitis is associated with cystic periventricular leukomalacia, intraventricular hemorrhage and cerebral palsy in preterm infants
- Prenatal inflammation/infection has been shown a risk factor for neonatal sepsis

Preeclampsia/eclampsia.

Complications of preeclampsia include:

- Eclampsia
- HELLP (hemolysis, elevated liver enzymes, low platelets) syndrome
- Liver rupture
- Pulmonary edema
- Renal failure
- Disseminated intravascular coagulopathy (DIC)
- Hypertensive emergency
- Hypertensive encephalopathy
- Cortical blindness

Maternal complications occur in up to 70% of women with eclampsia and include:

- DIC (disseminated intravascular coagulation)
- Acute renal failure
- Hepatocellular injury
- Liver rupture
- Intracerebral hemorrhage
- Cardiopulmonary arrest
- Aspiration pneumonitis
- Acute pulmonary edema
- Postpartum hemorrhage
- Maternal death. Rates of 0-13.9% have been reported.

Fetal complications in preeclampsia are directly related to gestational age and the severity of maternal disease and include increased rates of:

- Preterm delivery
- Intrauterine growth restriction
- Placental abruption

- Perinatal death

Thick meconium stained amniotic fluid without reassuring fetal heart tones and birth is not imminent.

Meconium staining of the amniotic fluid is a common occurrence during labor. Although a large proportion of these pregnancies will have a normal neonatal outcome, its presence may be an indicator of fetal hypoxia and has been linked to the development of:

- Cerebral palsy
- Seizures
- Meconium aspiration syndrome

Abnormal auscultated fetal heart rate pattern unresponsive to treatment or inability to auscultate fetal heart tones.

Sustained abnormal fetal heart rate patterns include bradycardia (abnormally low heart rate) and decelerations in the baby's heart rate. Additionally, tachycardia (abnormally high heart rate) is abnormal, and can also be an indication for the need for further evaluation. Historically, a 30-minute rule from decision-to-incision time for emergent cesarean delivery in the setting of abnormal FHR pattern has existed; however, the scientific evidence to support this threshold is lacking.

Excessive vomiting, dehydration, or exhaustion unresponsive to treatment.

- Sufficient fluid intake during labor may prevent hemoconcentration, starvation, and activation of the thrombogenic and fibrinolytic system
- With extreme exhaustion, the chances of fetal distress and non-progressive labor are greatly increased
- Bleeding during or after the placental birth, followed by shock, are much more likely to occur when the woman and her uterus are exhausted
- Maternal exhaustion is diagnosed with a combination of ketonuria, elevated temperature, and elevated pulse. This condition is also known as ketoacidosis, in that the mother's blood becomes abnormally acidic and less able to carry oxygen. Unless this condition is reversed, fetal distress will result.

Blood pressure greater than 140/90 which persists or rises and birth is not imminent.

Women with chronic hypertension are at increased risk of:

- Superimposed preeclampsia (25% risk)
- Preterm delivery
- Fetal growth restriction or demise
- Placental abruption
- Congestive heart failure
- Acute renal failure

- Seizures
- Stroke
- Death

Maternal fever equal to or greater than 100.4°.

Fever can indicate infection. Fever in labor is associated with:

- Early neonatal and infant death
- Hypoxia
- Infection-related death. These associations were stronger among term than preterm infants
- Meconium aspiration syndrome
- Hyaline membrane disease
- Neonatal seizures
- Assisted ventilation

Labor or premature rupture of membrane (PROM) less than 37 weeks according to due date.

Premature rupture of membranes before 37 weeks' gestation (and where there is at least an hour between membrane rupture and the onset of contractions and labor) can have consequences for both the mother and the baby.

Risks to baby:

- Neurologic injury
- Infection
- Respiratory Distress
- Death
- Increased need for neonatal intensive care services

Maternal risks:

- Infection
- Prolonged Labor
- C-Section
- Death

Because the out-of-hospital birth setting does not provide for immediate access to medications, surgery, and consultation with a physician, there may be increased risks to mother and/or baby if any of these conditions present during the birth. In some communities, the lack of availability of a seamless, cooperative hospital transfer process adds additional risk during intrapartum transfer.

I understand that the intrapartum risks may not be apparent until labor, and my opportunity for referral to a physician, should I choose that, would be limited to hospital transfer and transfer of care to the physician on call at that facility.

I have received and read this document, discussed it with my midwife, and my midwife has answered my questions to my satisfaction.

Client _____ Date _____

Midwife _____ Date _____

Guidance Document: 85-10

Revised: August 4, 2023
Effective Date: TBD

Abnormal Fetal Cardiac Rate or Rhythm

Disclosure of risks related to abnormal fetal cardiac rate or rhythm

Fetal rhythm abnormalities (fetal heart rates that are irregular, too fast or too slow):

- occur in up to 2% of pregnancies
- are usually identified by the obstetrical clinician who detects an abnormal fetal heart rate or rhythm using a Doppler or stethoscope
- majority have isolated premature atrial contractions which may spontaneously resolve
- sustained tachyarrhythmia (rapid) or bradyarrhythmia (slow) may be of clinical significance
    - may indicate severe systemic disease
    - may have the potential to compromise the fetal circulation
    - May require intensive antepartum and/or neonatal care

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Active Cancer

Maternal risks:

- maternal infection due to immune suppression
- deep vein thrombosis and pulmonary embolism during pregnancy and especially after delivery
- hemorrhage at delivery

Fetal risks:

- Intrauterine growth restriction
- Preterm birth
- Fetal health effects from exposure to maternal medications

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Acute or Chronic Thrombophlebitis

Deep vein thrombosis (DVT) and pulmonary embolism (PE) are collectively known as venous thromboembolism (VTE). VTE occurs more frequently in pregnant women, with an incidence of 0.5 to 2.0 per 1000 pregnancies, four to five times higher than in the nonpregnant population. The risk for VTE is further elevated in the postpartum period.

Risk for VTE in pregnancy in increased in women with:

- Prior history of VTE
- Advanced maternal age
- Collagen-vascular disease, especially antiphospholipid antibody syndrome
- Obesity (BMI > 30)
- Multiparity
- Hypercoaguable state
- Nephrotic syndrome
- Operative delivery
- Prolonged bed rest
- Hematologic disorders (hemoglobin SS and SC disease, polycythemia, thrombotic thrombocytopenic purpura, paroxysmal nocturnal hemoglobinuria, and some dysfibrinogenemias)
- Maternal medical conditions (diabetes, heart disease, inflammatory bowel disease)
- Smoking
- Preeclampsia

Maternal complications:

- hypoxemia
- post-phlebitic syndrome
- pulmonary infarction
- death

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Advanced Maternal Age

The "age cutoff" for advanced maternal age is not uniformly defined in literature. Generally, as birthing persons approach and pass age 40, the following risks may increase:

- Pregnancy loss, including beyond first trimester
- Fetal aneuploidy and other congenital fetal anomalies
- Health concerns which may contribute to obstetric complications such as preeclampsia, postpartum hemorrhage, and gestational diabetes
- Stillbirth
- Multiple gestation

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Anemia (Hematocrit less than 30 or hemoglobin less than 10 at term)

The World Health Organization (WHO) estimates that worldwide, 42% of pregnant women are anemic. Current knowledge indicates that iron deficiency anemia in pregnancy is a risk factor for preterm delivery and subsequent low birth weight, and possibly for inferior neonatal health. Data are inadequate to determine the extent to which maternal anemia might contribute to maternal mortality. A woman who is already anemic is unable to tolerate blood loss that a healthy woman can.

Maternal risks related to severe or untreated anemia:

- need for blood transfusion(s), resulting from a hemorrhage (significant blood loss) during delivery
- postpartum depression
- difficulty breastfeeding

Fetal/Neonatal risks related to maternal severe or untreated anemia:

- prematurity
- low-birthweight
- anemia
- developmental delays
- difficulty breastfeeding

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Any Pregnancy with Abnormal Fetal Surveillance Tests

There is no benefit in continuing a pregnancy at or post term after fetal surveillance is found to be non-reassuring. The recommendation is delivery (Price, 2014)." Abnormal stress tests at any point in pregnancy are associated with an increased risk of poor outcomes in pregnancy and during labor and delivery. Babies with diagnosed or undiagnosed anomalies are more likely to have abnormal test results requiring specialized care before or after delivery. Antepartum testing results, with regard to the overall clinical picture, should be taken seriously.

Risks to fetus:

- Stillbirth
- Asphyxia
- Fetal Acidosis
- Low Apgar scores
- Respiratory distress
- Surgical delivery
- Meconium Aspiration
- Death

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Assisted Reproductive Technologies (ART/IVF)

Assisted reproductive technologies may lead to the following increased risks:

- Multifetal gestations
- Prematurity
- Small for gestational age and perinatal mortality
- Cesarean section
- Placental issues, such as previa and abruption
- Preeclampsia
- Birth defects

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Blood Coagulation Defect

Hereditary thrombophilia, or predisposition to thrombosis, ranges from the common (Factor V Leiden heterozygosity, present in 1- 15% of pregnant women) to the rare (antithrombin deficiency occurring in 0.02%). The risk of deep vein thrombosis or pulmonary embolism (collectively known as venous thromboembolism or VTE) ranges from 0.1-7% of pregnancies. The maternal medical history determines the management during pregnancy, which can include anticoagulation with injections of heparin throughout the pregnancy and post-partum period.

The presence of one of these disorders may contribute to the risk of obstetric complications as well, including:

- IUGR
- preeclampsia
- stillbirth
- Frequent fetal surveillance is recommended in most cases, as well as timed delivery in the last week before the estimated date of delivery.

Alternatively, disorders of maternal hemostasis (such as von Willebrand disease) increase the risk of blood loss at delivery, and as hereditary disorders also increase the risk for abnormal bleeding in the newborn.

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Body Mass Index (BMI) Equal to or Greater Than 30

Obesity is defined as having a BMI of 30 or higher. The number of obese women in the United States has increased greatly during the past 25 years. Obesity has also become a major health concern for pregnant women. More than one half of pregnant women are overweight or obese.

Risks of obesity include:

- Birth defects – Babies born to obese mothers have an increased risk of having birth defects, such as heart defects and neural tube defects.
- Macrosomia – In this condition, the baby is larger than normal. This can increase the risk of the baby being injured during birth. For example, the baby's shoulder can become entrapped after the head is delivered. Macrosomia also increases the risk of cesarean birth.
- Preterm Birth – Problems associated with a mother's obesity may mean that the baby will need to be delivered early. Preterm infants have an increased risk of health problems, including breathing problems, eating problems, and developmental and learning difficulties later in life.
- Stillbirth – The risk of stillbirth increases the higher the mother's BMI.
- High Blood Pressure
- Preeclampsia – Preeclampsia is a serious illness for both the woman and her baby. Although gestational hypertension is the most common sign of preeclampsia, this condition affects all organs of the body. The kidneys and liver may fail. In rare cases, stroke can occur. The fetus is at risk of growth problems and problems with the placenta. It may require early delivery, even if the baby is not fully grown. In severe cases, the woman, baby, or both may die.
- Gestational Diabetes – High blood glucose (sugar) levels during pregnancy increase the risk of having a very large baby and a cesarean delivery. Women who have had gestational diabetes have a higher risk of having diabetes in the future, as do their children.
- Challenges in Prenatal Care – Obesity can make it more difficult for the midwife to assess fetal position and fetal growth.
- Challenges in Labor Management – Obesity can create challenges in moving the woman quickly in the event of an emergency during the birth, and can make auscultation of fetal heart tones more difficult.

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Cardiac Disease

Most women tolerate the cardiovascular changes of pregnancy without difficulty. Pregnancy in a patient with significant cardiac disease is associated with significant risk. Despite occurring in only 0.2-4% of pregnancies, cardiac disease is associated with up to 30% of maternal deaths. A pregnant patient with cardiac disease will benefit from the coordinated care of a multidisciplinary team including perinatologists, cardiologists, and anesthesiologists. In particular, adults with repaired congenital heart disease may pose complex management scenarios. They may require specialized cardiac monitoring during labor and birth, and some cardiac conditions are associated with a high enough risk of labor complications that cesarean is recommended.

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Guidance Document: 85-10

Revised: August 4, 2023
Effective Date: TBD

Chronic Obstructive Pulmonary Disease or Other Pulmonary Disorders

Chronic Obstructive Pulmonary Disease (COPD) or other pulmonary disorders affect approximately 4% to 6% of adults of all ages and is one of the most common medical conditions complicating pregnancy.

Risks:

- Preterm birth
- Decreased birth weight
- Increased neonatal and maternal death

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Ectopic Pregnancy

Today, about 1 in 50 pregnancies is ectopic. An ectopic pregnancy occurs when a fertilized egg grows outside of the uterus most commonly in the tube. As the pregnancy grows, it can rupture (burst). If this occurs, it can cause major internal bleeding. This can be life threatening and needs to be treated. If there is evidence of ectopic pregnancy, medical and surgical interventions are available, and a referral should be made to an appropriate health provider. If there is a positive pregnancy test with follow-up ultrasound showing no intrauterine pregnancy, then referral should be made to an appropriate healthcare provider.

Risks:

- Fallopian tube damaged, leading to an increased likelihood of having another ectopic pregnancy in the future
- Ruptured ectopic pregnancy (when the fallopian tube splits) and severe internal bleeding, which can lead to shock
- Death

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Essential Chronic Hypertension

Elevated blood pressure, systolic >140 or diastolic >90 or both, that predates conception or is diagnosed before 20 weeks of gestation.

Maternal risks:

- Preterm delivery
- Difficulty breastfeeding
- Placental abruption
- Preeclampsia
- Eclampsia
- Seizures
- Maternal congestive heart failure
- Acute renal failure
- Stroke
- Death

Fetal/neonatal risks:

- Fetal growth restriction
- Fetal death
- Difficulty breastfeeding

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Genital Herpes or Partner with Genital Herpes

Because of its serious and potentially lethal risks to the fetus and neonate, pregnant women and their partners should be tested for HSV - Herpes Simplex Virus (HSV1 & HSV2).

In women with a previous diagnosis of genital herpes, cesarean delivery to prevent neonatal HSV infection is not indicated if there are NO genital lesions at the time of labor. To reduce cesarean deliveries performed for the indication of genital herpes, the use of oral acyclovir or valacyclovir near the end of pregnancy to suppress genital HSV recurrences has become increasingly common in obstetric practice. Several studies with small sample sizes suggest that suppressive acyclovir therapy during the last weeks of pregnancy decreases the occurrence of clinically apparent genital HSV disease at the time of delivery, with an associated decrease in cesarean delivery rates for the indication of genital HSV. However, because viral shedding still occurs (albeit with reduced frequency), the potential for neonatal infection is not avoided completely, and cases of neonatal HSV disease in newborn infants of women who were receiving antiviral suppression recently have been reported.

Genital HSV, especially in primary infections, may be dangerous to the neonate if infected during delivery, as it can cause a severe neonatal disease.

The frequency of neonatal infection ranged from 31% to 44% for primary first-episode, and 1 to 3% in recurrent.

Risks of HSV infection to the fetus include:

- intrauterine fetal demise (the death of the fetus while in the uterus)
- skin scars (cutaneous manifestations)
- ophthalmologic findings (chorioretinitis, microphtalmia)
- neurological involvement (causing brain damage)

The clinical presentation of infants with neonatal HSV infection, that is almost invariably symptomatic and frequently lethal, is a direct reflection of the site and extent of viral replication.

Risks of HSV infection to the newborn include:

- death
- neurologic (brain) damage (intracranial calcifications, microcephaly, seizures, encephalomacia)
- growth restriction
- psychomotor development impairment
- skin vesicles or scarring
- eye lesions resulting in vision loss and/or blindness (chorioretinitis, microphthalmia, cataracts)
- hearing loss and/or deafness

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Group B Strep (GBS)

The following risks are related to group B strep.

Maternal risks:

- Minimal to none

Fetal/infant risk:

- Increased in context of chorioamnionitis, GBS bacteriuria in current pregnancy, labor or birth at less than 37 weeks gestation, previous delivery with early onset of GBS sepsis, prolonged interval (18 hours or more) between rupture of membranes and delivery.
- Sepsis
- Pneumonia
- Meningitis
- Death

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History of Hemoglobinopathies

Hemoglobinopathies include sickle cell disease and its variants as well as alpha and beta thalassemia. The involvement of a multidisciplinary team including perinatologists, hematologists and anesthesiologists can allow for development of a plan to screen for and manage complications.

Maternal risks:

- cerebral vein or deep vein thrombosis
- anemia and vaso-occlusive crisis
- pneumonia
- pyelonephritis
- transfusion
- pregnancy induced hypertension
- postpartum infection, sepsis, and systemic inflammatory response syndrome
- cesarean delivery

Fetal risks:

- preterm birth and its consequences including low birth weight
- intrauterine growth restriction
- abruption placentae
- stillbirth
- genetic risk assessment is also recommended for individuals identified as carriers for hemoglobinopathy, as they may be at risk to have affected offspring.

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HIV Positive Status or AIDS

HIV transmission from mother to child during pregnancy, labor and delivery, or breastfeeding is known as perinatal transmission and is the most common route of HIV infection in children. When HIV is diagnosed before or during pregnancy, perinatal transmission can be reduced to less than 1% if appropriate medical treatment is given and the virus becomes undetectable. In such situations the risk of transmitting to the baby through breastfeeding is decreased.

Recommended medical treatment includes antiretroviral medication taken throughout pregnancy and during labor, regular monitoring of the maternal viral load, cesarean delivery for viral load > 1000 copies/mL, and initiation of antiretroviral medication for the newborn shortly after birth.

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Inappropriate Fetal Size for Gestation – Macrosomia (Large for Gestational Age)

Macrosomia (meaning big body), is arbitrarily defined as a birth weight of more than 4,000 g (8 lb, 13 oz). Also known as "large for gestational age," fetal macrosomia complicates more than 10 percent of all pregnancies in the United States.

Risks to the mother:

- increased risk of uterine rupture after previous cesarean section or other uterine surgery;
- increased likelihood of induction at or before 40 weeks;
- increased likelihood of an operative delivery: forceps, vacuum, or cesarean section;
- trauma to vagina and/or perineum; including perineal and/or vulvar lacerations, 3rd or 4th degree episiotomy, short or long-term urinary or fecal incontinence;
- increased blood loss and/or postpartum hemorrhage,
- damage to the coccyx (tailbone)

Risks to the baby at the time of birth:

- shoulder dystocia (the baby gets stuck at the shoulders after the delivery of the head), which may result in trauma to the baby including:
    - broken clavicle (collar) bone(s);
    - brachial plexus injury, temporary or permanent nerve damage (sensory and motor) to either one or both shoulders, arms, and hands;
    - cerebral palsy;
    - hypoxia, resulting in permanent brain damage;
    - death.
- injuries related to operative delivery (forceps, vacuum, or cesarean section) including:
    - bruising and/or injury to the scalp, head and/or face;
    - temporary weakness in the facial muscles (facial palsy);
    - external eye and/or ear trauma;
    - broken clavicle (collar) bone(s);
    - brachial plexus injury (see description above);
    - cerebral palsy;
    - skull fracture;
    - bleeding within the skull;
    - seizures; lacerations (during cesarean section) to the baby's presenting part
- immature lungs and breathing problems, if the due date has been miscalculated and the infant is delivered before 39 weeks of gestation;
- need for special care in the neonatal intensive care unit (NICU)

Risks to the newborn and later childhood risks:

- higher than normal blood sugar level (impaired glucose tolerance);
- childhood obesity (research suggests that the risk of childhood obesity increases as birth weight increases);

- metabolic syndrome (a group of conditions: increased blood pressure, a high blood sugar level, excess body fat, abnormal cholesterol levels; that occur together, increasing the risk of heart disease, stroke and diabetes later in life

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Inappropriate Fetal Size for Gestation – IUGR (Small for Gestational Age)

IUGR (Intrauterine Growth Restriction) is a serious problem, regardless of why the baby is small. About 20% of stillborn babies are IUGR, and perinatal mortality for growth-restricted infants may be 6 to 10 times higher than for those of normal size. Most IUGR stillbirths occur after the 36th week of pregnancy and before labor begins.

Risks to the baby:

- low birth weight (LBW);
- difficulty handling the stresses of vaginal delivery;
- decreased oxygen levels (hypoxia);
- hypoglycemia (low blood sugar);
- low resistance to infection;
- low APGAR scores (a test given immediately after birth to evaluate the newborn's physical condition and determine need for special medical care);
- meconium aspiration (inhalation of stools passed while in the uterus), which can lead to breathing problems, lung surfactant dysfunction, chemical pneumonitis, and persistent pulmonary hypertension;
- trouble maintaining body temperature (hypothermia);
- abnormally high red blood cell count;
- admission to NICU;
- long-term growth problems;
- intrauterine fetal demise (fetal death prior to labor);
- stillbirth (fetal death during labor or birth).

Risks to the mother:

- increased stress related to fetal monitoring and surveillance (serial ultrasounds and non-stress testing);
- premature labor;
- premature birth (delivery of the fetus before 37 weeks gestation);
- induction and early delivery, before 40 weeks;
- cesarean section.

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Incomplete Spontaneous Abortion or Incomplete Miscarriage

Spontaneous abortion also known as early pregnancy loss refers to a miscarriage that happens before 20 weeks of gestation and is seen in 13% to 20% of all diagnosed pregnancies. Incomplete spontaneous abortion occurs when some tissue is retained in the uterus. Medication or a procedure may be needed to remove the tissue.

Stillbirth or intrauterine fetal demise (IUFD):

Fetal death that happens after 20 weeks of gestational age is called stillbirth and has a rate of 3.2 per 1000 births. Medical intervention is needed for delivery.

Maternal fetal risks of early or late fetal loss:

- Infection
- Hemorrhage
- Maternal coagulopathy
- Gestational trophoblastic disease
- Rh isoimmunization

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Isoimmunization to Blood Factors

Pregnant women with a negative Rh blood type (O-, A-, B-, AB-) or with other atypical antibodies have significant fetal and neonatal risk factors. Clinical manifestations of RhD haemolytic disease (HDN) range from asymptomatic mild anemia to hydrops fetalis or stillbirth associated with severe anemia and jaundice.

Use of anti-D immune globulin for prevention of D has decreased the risk of isoimmunization. Routine treatment includes prophylactic dosage at 28 weeks of gestation, after delivery of a D-positive newborn and at any significant bleeding. Testing for Rh typing should be performed with every pregnancy because revisions in lab procedures may present as a change in the Rh blood type.

Risks to the baby:

- destruction of fetal red blood cells (hemolysis);
    - mild to moderate hemolysis manifests as increased indirect bilirubin (red cell pigment)
    - severe hemolysis leads to red blood cell production by the spleen and liver
- severe anemia;
- hepatic circulatory obstruction (portal hypertension);
- placental edema, interfering with placental perfusion;
- ascites (accumulation of fluid in the abdominal cavity);
- hepatomegaly (swelling of the liver);
- increased placental thickness;
- polyhydramnios (increased amniotic fluid);
- hydrops (fetal heart failure);
- anasarca (extreme generalized edema);
- effusions (abnormal accumulation of fluid);
- intrauterine fetal demise (fetal death);
- stillbirth

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Multiple Gestation

Maternal risks:

- Anemia
- Hemorrhage
- Preeclampsia
- Gestational diabetes
- Cesarean delivery

Fetal risks:

- Twin-to-twin transfusion syndrome (TTTS) in monochorionic twins
- Vanishing twin/death of one fetus
- Congenital anomalies
- Hydramnios
- Preterm birth
- Malpresentation
- Small for gestational age
- Umbilical cord prolapse
- Neonatal intensive care unit admission

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Persistent Severe Abnormal Quantity of Amniotic Fluid (Oligohydramnios and Polyhydramnios)

Oligohydramnios (decreased amniotic fluid) may be caused by fetal anomalies (bladder outlet obstruction, renal agenesis), premature rupture of the membranes, or placental insufficiency occurring de novo or as a consequence of maternal conditions such as hypertension.

Maternal risks:

- Antepartum hospitalization
- Induction of labor
- Cesarean delivery

Fetal risks:

- Pulmonary hypoplasia (underdevelopment of the lungs)
- Limb contractures
- Abnormal fetal heart rate patterns
- Acidosis
- Neonatal intensive care unit admission
- Need for surgical intervention if anomalies present
- Stillbirth or neonatal death

Polyhydramnios (increased amniotic fluid) is most commonly idiopathic (no identifiable cause) but may be seen in maternal diabetes (especially uncontrolled or with large for gestational age fetus) and with fetal anomalies (diaphragmatic hernia, intestinal obstruction).

Maternal risks:

- Cesarean delivery
- Post-partum hemorrhage

Fetal risks:

- malpresentation
- neonatal intensive care unit admission
- need for surgical intervention if anomalies present
- neonatal hypoglycemia
- stillbirth and neonatal death

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Platelet Count Less than 120,000

Platelet disorders in pregnancy include those that are time-limited to pregnancy (gestational thrombocytopenia, HELLP syndrome) and those that may pre-date or be newly diagnosed during the pregnancy (idiopathic thrombocytopenic purpura (ITP), thrombotic thrombocytopenic purpura (TTP)). Except for gestational thrombocytopenia, all of these platelet disorders place the mother at increased risk for blood loss and need for transfusion.

Gestational thrombocytopenia: occurs in 7-8% of pregnancies and accounts for 70-80% of cases of thrombocytopenia in pregnancy, typically diagnosed in the third trimester, rarely associated with platelet counts below 70,000, not associated with increased risks of bleeding in the mother or fetus, platelet counts return to normal after delivery.

It is important to differentiate gestational thrombocytopenia from more serious platelet disorders.

ITP: chronic disorder associated with:

- Fluctuating platelet counts that may be lower than 50,000
- Need for steroid or immune globulin treatment and platelet transfusion to avoid excess blood loss at delivery, particularly surgical delivery.

TTP: acute or chronic disorder generally associated with:

- severe thrombocytopenia of 20,000 or less
- hepatic impairment
- renal impairment
- CNS impairment
- increased risk of death for both mother and fetus

HELLP syndrome: an acute condition occurring in up to 2% of pregnancies, usually seen in the setting of preeclampsia, and characterized by:

- thrombocytopenia
- elevated liver enzymes
- hemolytic anemia
- potential for severe maternal illness including:
    - liver failure
    - hepatic subcapsular hematoma
    - excess maternal blood loss
    - seizure
    - maternal death
    - preterm birth
    - intrauterine growth restriction
    - fetal death

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Position Presentation Other Than Cephalic at Term or While in Labor

Non-cephalic presentations occur in less than 4% of all pregnancies. This would include breech, transverse lie, and compound presentations. Non-cephalic presentations are associated with congenital abnormalities of the baby, multiple pregnancies, placenta previa, and uterine abnormalities. These associations may increase risk to the mother/baby in addition to the actual risks associated with non-cephalic delivery.

C-section has become the standard mode of delivery for babies in non-cephalic positions. Physicians and midwives may not have adequate training in the vaginal delivery of non-cephalic presentations further increasing the risk of injury or death to both mother and baby. A transverse presentation is considered incompatible with vaginal delivery. Posterior, Brow, and Face presentations are associated with complicated delivery and increased maternal and/or fetal complications and may require C-section if the fetal malpresentation does not resolve.

Risks to babies:

- Low APGAR scores
- Ruptured organs (kidney, liver)
- Neck Trauma
- Genital edema
- Prematurity
- Cord Prolapse
- Respiratory distress
- Stillbirth
- Head entrapment
- Edema to face and skull
- Tracheal damage
- Increased NICU admission rates
- Shoulder/arm trauma
- Hip and leg trauma
- Intracranial hemorrhage
- Death

Maternal risks:

- C-section
- Prolonged/Dysfunctional labor
- Placenta abruption
- Increased risk of deep lacerations

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Preeclampsia/Eclampsia

Preeclampsia is a leading cause of death in pregnant women and occurs in 5% of all pregnancies. The management of preeclampsia may require medication and monitoring unavailable in an out of hospital setting.

Maternal risks:

- Hypertension leading to brain injury
- Liver Failure
- Kidney Failure
- HELLP Syndrome: an acute condition occurring in up to 2% of pregnancies, usually seen in the setting of preeclampsia and characterized by:
    - Thrombocytopenia
    - elevated liver enzymes
    - hemolytic anemia
    - potential for severe maternal illness including: liver failure, hepatic supscapular hematoma, excess maternal blood loss, seizure, maternal death, preterm birth, intrauterine growth restriction, fetal death.
- Clotting problems (DIC)
- Pulmonary edema
- Seizure (Eclampsia)
- Stroke
- Placental Abruption
- C-section
- Death

Fetal risks:

- Small for gestational age (IUGR)
- Premature birth
- Stillbirth

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Guidance Document: 85-10

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Effective Date: TBD

Pregnancy Lasting Longer Than 42 Completed Weeks with an Abnormal Stress Test

Pregnancy is considered to be post term at 42 weeks of gestation. There is limited research available to outline the risks of a pregnancy continuing beyond 42 weeks with an abnormal stress test. Current medical standard of practice is that beginning at 41 weeks, a non-stress test (NST) be combined with other indicators of fetal well-being, i.e., amniotic fluid index (AFI) or biophysical profile (BPP). There is no benefit in continuing a pregnancy at or post term after fetal surveillance is found to be non-reassuring. The recommendation is delivery.

Maternal risks:

- Oligohydramnios
- Medical induction
- C-section
- Prolonged labor
- Complicated delivery such as: Shoulder dystocia

Fetal risks:

- Large size leading to risks associated with macrosomia
- uteroplacental insufficiency
- Asphyxia
- Infection
- Neonatal acidemia
- Low Apgar
- Birth Injury
- Stillbirth
- Postmaturity/Dysmaturity syndrome
- Fetal distress
- Meconium Aspirtation
- Death

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VBAC (Vaginal Birth after Cesarean) Previous Uterine Incision or Myomectomy

Because the uterine scar for most caesarian sections is low on the uterus, women who undergo TOLAC (trial of labor after cesarean), are able to give birth vaginally 60–80% of the time. If problems arise during TOLAC, the baby may need to be born by emergency cesarean delivery (uterine rupture can be sudden and unexpected labor outside of a hospital can delay delivery and increase the risk of injury and death for both mother and baby in an emergency). Some surgery for fibroids can result in a similar risk for uterine rupture. An unknown type of prior uterine scar is a contraindication for TOLAC outside of the hospital setting so review of prior surgical records is essential part of the evaluation.

Maternal risks:

- Maternal hemorrhage
- Infection
- Thromboembolism
- Placenta accreta
- Death
- Emergency hysterectomy

Fetal risks:

- Hypoxic Ischemic Encephalopathy
- Stillbirth
- Perinatal death
- Neonatal death
- Respiratory morbidity
- Transient tachypnea
- Hyperbillirubinemia

The probability that a woman attempting TOLAC will achieve VBAC depends on her individual combination of factors.

Selected Clinical Factors Associated with Trial of Labor after Previous Cesarean Delivery Success:

Increased probability of success

- Prior vaginal birth
- Spontaneous labor

Decreased probability of success

- Recurrent indication for initial cesarean delivery (labor dystocia)
- Increased maternal age
- Maternal obesity
- Preeclampsia

- Short interpregnancy interval
- Increased neonatal birth weight

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Mental Health Issues

Clients with clinically-diagnosed and self-reported mental health issues such as:

- Depression
- Panic/anxiety
- Obsessive-compulsive traits
- Schizophrenia

should be counseled about the stresses of pregnancy and the postpartum period. Clients who are taking psychiatric medication should be made aware that some potential for birth defects may exist and are advised to discuss the risks and benefits of continuing their drugs during pregnancy with their provider.

Risks associated with pregnancy and psychiatric disorders include:

- Poor maternal health
- Poor outcomes for babies including poor fetal growth and development
- Maternal psychiatric medication side effects
- Increased potential for some birth defects

Clients who are taking psychiatric medication are advised to discuss the risks and benefits of continuing their drugs during pregnancy with their mental health provider.

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Rupture of Membranes 24 Hours Before the Onset of Labor

The risk of prolonged rupture of membranes is chorioamnionitis. The risk increases with the delay between rupture of membranes and delivery.

Maternal complications:

- cesarean delivery
- endomyometritis
- wound infection
- pelvic abscess
- postpartum hemorrhage
- bacteremia, most commonly involving GBS
- Rarely:
    - septic shock
    - disseminated intravascular coagulation
    - adult respiratory distress syndrome
    - maternal death

Fetal complications:

- fetal death
- neonatal sepsis

Neonatal complications:

- perinatal death
- asphyxia
- early onset neonatal sepsis
- septic shock
- pneumonia
- intraventricular hemorrhage
- cerebral palsy

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Seizure Disorder Requiring Prescriptive Medication

Most pregnancies are uneventful in women with epilepsy, and most babies are delivered healthy with no increased risk of obstetric complications in women. When controlled, there does not appear to be an increased risk for intrauterine growth restriction, preeclampsia, preterm birth or stillbirth compared to women without seizure disorder.

Fetal risks:

- With uncontrolled seizures:
  - Intrauterine growth restriction (IUGR)
  - Preterm birth
  - Stillbirth
- Some medications are associated with an increased risk of birth defects

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Client _____ Date _____

Midwife _____ Date _____

Severe Liver Disease – Active or Chronic

Liver disease occurs in approximately 3% of pregnancies. It may be chronic or occurring coincident with pregnancy, such as viral hepatitis or drug-induced hepatotoxicity, or pregnancy specific such as HELLP syndrome, intrahepatic cholestasis of pregnancy or acute fatty liver of pregnancy.

Severe liver disease:

- Is usually acute in onset
- Can be life-threatening to the mother
- Associated with a high risk of stillbirth
- If hypertension has preceded the onset of HELLP syndrome, fetal growth restriction may also be present.

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Severe Renal Disease – Active or Chronic

Renal disease is associated with increased risks of both maternal and fetal adverse outcomes. These risks, which rise with the severity of preexisting renal disease, include:

Maternal risks:

- Hypertension
- Placental abruption
- Deterioration of renal function including permanent, end-stage renal failure

Fetal risks:

- Intrauterine growth restriction (IUGR)
- Placental abruption
- Stillbirth

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Significant 2nd or 3rd Trimester Bleeding

Significant 2nd or 3rd trimester bleeding is often associated with potentially serious conditions, including placenta previa, placental abruption, and vasa previa.

Medical management and ultrasound is indicated to rule out and/or monitor potentially serious conditions associated with significant bleeding.

Maternal risk factors:

- Cesarean section
- Hemorrhage
- Anemia
- Hypovolemic shock
- Death
- Coagulation defects (DIC)
- Damage to kidneys and brain

Fetal risk factors:

- Poor fetal growth (IUGR)
- Birth defects
- Premature birth
- Anemia
- Hypovolemic shock
- Stillbirth

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Significant Glucose Intolerance (Preexisting Diabetes, Gestational Diabetes, PCOS)

Pre-gestational diabetes mellitus (Type 1 or Type 2) affects approximately 1% of pregnancies, with an incidence rising with the incidence of type 2 diabetes in younger adults. Gestational diabetes is diagnosed in 5-7% of pregnancies.

Risk factors for GDM: occurs more commonly in women with a family history of diabetes, prior personal history of glucose intolerance including prior gestational diabetes, obesity, and maternal age over 25.

Maternal risks:

- Hypertension
- Antepartum hospitalization
- Induction of labor
- Cesarean delivery
- Uncontrolled diabetes may result in:
    - kidney damage
    - retinopathy resulting in vision loss
    - peripheral nerve damage.

Fetal risks:

- Even when controlled, pre-gestational diabetes is associated with an increased risk of miscarriage and major congenital anomalies. This risk rises with poorer control around the time of conception.
- Throughout pregnancy, diabetes is associated with increased risks of:
    - hypertensive disorders
    - large for gestational age babies
    - stillbirth
    - abnormal progression of labor
    - cesarean delivery
    - shoulder dystocia with resultant brachial plexus injury

- Due to these risks, more frequent ultrasound examinations and antepartum testing of fetal well-being may be indicated in the newborn period:
    - hypoglycemia
    - hyperbilirubinemia
    - polycythemia

Timing of delivery:

- Pre-gestational diabetes, and uncontrolled gestational diabetes: between 37 and 39 weeks, individualized
- Controlled gestational diabetes: between 39 and 41 weeks, individualized

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Uncontrolled Hyperthyroidism

Hyperthyroidism occurs in 0.2% of pregnancies; Graves' disease accounts for 95% of these cases. The signs and symptoms of hyperthyroidism include nervousness, tremors, tachycardia, frequent stools, excessive sweating, heat intolerance, weight loss, goiter, insomnia, palpitations, and hypertension.

Risks

- Premature delivery
- Severe preeclampsia
- Heart failure
- Maternal death
- Low birth weight
- Fetal death
- Abnormal thyroid function in the newborn

Thyroid storm is a medical emergency and occurs in 1% of pregnant patients with hyperthyroidism and can be triggered by infection, labor, or delivery.

Risks

- Shock
- Stupor
- Coma

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Uterine Ablation (Endometrial Ablation)

Endometrial ablation is a procedure accompanied by sterilization or the strong recommendation for continuous contraception. Pregnancy after ablation is rare and therefore there is little research, and the maternal and fetal complications are poorly defined. The general recommendation is that pregnancy is contra-indicated once endometrial ablation has been performed.

Maternal risks:

- Miscarriage
- Ectopic pregnancy
- Placenta accreta
- Manual/Surgical removal of placenta
- Hemorrhage
- Uterine rupture
- C-section
- Hysterectomy
- Death

Fetal risks:

- Prematurity
- Death
- Possible increase in anomalies
- Malpresentation

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Guidance Document: 85-10

Revised: August 4, 2023
Effective Date: TBD

Uterine Anomaly

Women with a uterine anomaly (uterine septum, unicornuate uterus, bicornuate uterus, uterine didelphys) are at risk for:

- PTB (preterm birth)
- Fetal presentation other than cephalic
- Hemorrhage
- Retained placenta
- Maternal urinary tract malformation
- Miscarriage
- Restricted fetal growth
- Cesarean delivery
- Pregnancy-associated hypertension

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Agenda Item: **Regulatory Actions Report**

Note: Dr. Harp will provide information on plan for SB1275 to the Advisory Board.

Action: None Anticipated.