Preventive Prenatal High-Risk Guideline

Population at Risk	Definition of Population	Interventions
High Risk Sexual Behavior	1. Personal history of a prior sexually transmitted infection 2. Age <25 years 3. New sex partner in past 60 days 4. More than one sex partner or sex partner with multiple concurrent sex partners 5. Sex partner diagnosed with a sexually transmitted infection 6. No or inconsistent condom use outside a mutually monogamous sexual partnership 7. Trading sex for money or drugs 8. Sexual contact with sex workers 9. Meeting anonymous partners on the internet 10. Unmarried status 11. Lower socioeconomic status or high school education or less 12. Admission to correctional facility or juvenile detention center 13. Use of illicit drugs 14. Living in a community with a high prevalence of sexually transmitted infections	Chlamydia & Gonorrhea (1st visit) should be done for all patients, not just high risk If positive, treat and then perform test of cure 3-4 week after treatment. Repeat in 3rd trimester if at continued risk or if + screen first trimester *HIV screen (may opt out with consent) should be done for all patients, not just high risk Repeat *HIV in 3rd trimester if at increased risk Test all women for hepatitis B surface antigen (HBsAg) regardless of previous vaccination status RPR/VDRL at first prenatal visit, at 28-32 weeks, and at delivery.
Hepatitis B and Hepatitis C risk factors	Risk Factors: 1. Household contact with persons with known hepatitis B 2. Sexual contacts with persons with known Hepatitis C 3. Drug use (particularly IVDU) 4. HIV infection	Hepatitis C screening for all women at first prenatal visit Repeat 3rd trimester if risk factors exist Test all women for hepatitis B surface antigen (HBsAg) regardless of previous vaccination status If HBsAg is negative, however high risk for HBV infection test for hepatitis B surface antibody (anti-HBs) and hepatitis B core antibody (anti-HBc). If anti-HBs and anti-HBc are negative, offer vacinnation

Population at Risk	Definition of Population	Interventions
Blood transfusion 1978-1985		*HIV screen, Hep C, HbsAg (1st visit)
Unsensitized D-negative women		Screen for blood type and antibodies at first prenatal visit D-negative women who screen positive for anti-D antibodies should not receive anti-D immune globulin D-negative women with a negative anti-D antibody screen and who are carrying a fetus that is, or may be, D-positive are candidates for anti-D immune globulin at: ●28 weeks of gestation ●After delivery of a D-positive newborn ●After an antepartum event associated with an increased risk of fetomaternal bleeding (bleeding, accident, trauma or abuse) D (Rh) antibody testing at 24-28wk or with any bleeding, accident, trauma or abuse May administer anti-D immuneglobulin (Rhogham) prior to test results being known D (Rh) evaluation immediately postpartum and administer Rhogam if infant is Rh + (within 72 hours of deliver)

Population at Risk	Definition of Population	Interventions
Women at increased risk of gestation diabetes or undiagnosed Type 2 diabetes	Per ACOG PB #190, Interim Update, February 2018 ACOG recommends considering early testing for women with BMI > 25 (or >23 in Asian patients) and one or more of the following risk factors. • Physical inactivity • First degree relative with diabetes • High risk race (African American, Latino, Native American, Asian American, Pacific Islander) • Have prevoiusly given birth to an infant weighing 4,000 g or more • Previous GDM • Hypertension (140/90 or on therapy for HTN) • HDL cholesterol level < 35 mg/dl or trigliceride level > 250 gm/dl. • Women with PCOS • A1c > or equal to 5.7%, impaired GTT or impaired fasting glucose on previous testing • Other clinical conditions associated with insulin resistance (prepregnancy BMI > 40, acanthosisis nigracans) • History of cardiovascular disease.	Check Hgb A1C at first prenatal visit or 50g one hour GTT in the first prenatal visit. Formal three hour GTT if screening one hour GTT is abnormal Repeat 50g one hour GTT in the third trimester if first one was normal Formal three hour GTT if repeat one hour GTT is abnormal

***Virginia State Law Governing HIV Testing:**

§ 32.1-37.2. Consent for testing for human immunodeficiency virus; condition on disclosure of test results; counseling required; exceptions.

- Prior to performing any test to determine infection with human immunodeficiency virus, a medical care provider shall inform the patient that the test is planned, provide information about the test, and advise the patient that he has the right to decline the test. If a patient declines the test, the medical care provider shall note that fact in the patient's medical file.
- Every person who has a confirmed positive test result for human immunodeficiency virus shall be afforded the opportunity for individual face-to-face disclosure of the test results and appropriate counseling. Appropriate counseling shall include, but not be limited to, the meaning of the test results, the need for additional testing, the etiology, prevention and effects of acquired immunodeficiency syndrome, the availability of appropriate health care, mental health care and social services, the need to notify any person who may have been exposed to the virus and the availability of assistance through the Department of Health in notifying such individuals.

- C. Opportunity for face-to-face disclosure of the test results and appropriate counseling shall not be required when the tests are conducted by blood collection agencies. However, all blood collection agencies shall notify the Board of Health of any positive tests.
- D. In the case of a person applying for accident and sickness or life insurance who is the subject of a test to determine infection for human immunodeficiency virus, insurers' practices including an explanation of the meaning of the test, the manner of obtaining consent, the method of disclosure of the test results and any counseling requirements shall be as set forth in the regulations of the State Corporation Commission.

§ 54.1-2403.01. Routine component of prenatal care.

- As a routine component of prenatal care, every practitioner licensed pursuant to this subtitle who renders prenatal care, including any holder of a multistate licensure privilege to practice nursing, regardless of the site of such practice, shall inform every pregnant woman who is his patient that human immunodeficiency virus (HIV) screening is recommended for all pregnant patients and that she will receive an HIV test as part of the routine panel of prenatal tests unless she declines (opt-out screening). The practitioner shall offer the pregnant woman oral or written information that includes an explanation of HIV infection, a description of interventions that can reduce HIV transmission from mother to infant, and the meaning of positive and negative test results. The confidentiality provisions of § 32.1-36.1, test result disclosure conditions, and appropriate counseling requirements of § 32.1-37.2 shall apply to any HIV testing conducted pursuant to this section. Practitioners shall counsel all pregnant women with HIV-positive test results about the dangers to the fetus and the advisability of receiving treatment in accordance with the then current Centers for Disease Control and Prevention recommendations for HIV-positive pregnant women. Any pregnant woman shall have the right to refuse testing for HIV infection and any recommended treatment. Documentation of such refusal shall be maintained in the patient's medical record.

The risk factors as listed in the reference:

HR1= Women with history of STD or new multiple sex partners. Clinicians should also consider local epidemiology. Chlamydia screen should be repeated in 3rd trimester if at continued risk.

HR2 = Women under age 25 with two or more sex partners in the last year, or whose sex partner has multiple sexual contacts; women who exchange sex for money or drugs; and women with a history or repeated episodes of gonorrhea. Clinicians should also consider local epidemiology. Gonorrhea screen should be repeated in the 3rd trimester if at continued risk.

HR3 = In areas where universal screening is not performed due to low prevalence of *HIV infection, pregnant women with the following individual risk factors should be screened; past or present injection drug use; women who exchange sex for money or drugs; injection drug-using, bisexual, or *HIV-positive sex partner currently or in the past; blood transfusion during 1978-1985; persons seeking treatment for STDs.

HR4 = Women who are initially HbsAg negative who are at high risk due to injection drug use, suspected exposure to hepatitis B during pregnancy, multiple sex partners.

HR5 = Women who exchange sex for money or drugs, women with other STDs (including *HIV), and sexual contacts or persons with active syphilis. Clinicians should also consider local epidemiology.

HR6 = Women who continue to inject drugs.

HR7 = Unsensitized D-negative women.

HR8 = Prior pregnancy affected by Down syndrome, advanced maternal age >35 yr., known carrier of chromosome rearrangement.

HR9 = Women with previous pregnancy affected by neural tube defect" that seem to reference a recommendation that is no longer there, that must have existed in a previous iteration of these guidelines.

References:

1. Up-to-Date article on Syphilis in Pregnancy. Accessed September 22, 2020
2. Up-to-Date article on Prenatal Care. Accessed September 22, 2020
3. Up-to-Date article on Prevention of RhD Alloimmunization in Pregnancy. Accessed Septemer 22, 2020
4. Up-to-Date article on Diabetes Mellitus in Preganancy: screening and diagnosis. Accessed September 22, 2020