

University of South Florida  
Department of Obstetrics and Gynecology  
Divisions of Midwifery and Specialist in General  
Obstetrics and Gynecology  
Office Handbook- Beta Version 5/2021

This document is not intended to be the only acceptable way of practice but offers a common protocols and practices to allow standardization within a large group.

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Clinic Manager: Jen Rios, RN  
Nurse Supervisor: Jessica Major

1. Office Staff

## 2.a Confirmation of pregnancy and Initial prenatal visit documentation and coding (9/14/21)

### Pregnancy Conformation Visit

Recommend note .STCCONFIRMPREG

Establish dates based on LMP or order/preform dating US

Ectopic and bleeding precautions

Give safe medications in pregnancy- .stcsafemedspreg

PNV, nausea medications PRN

Add problems to problem list (except supervision of normal/high risk pregnancy)

-whenever possible use O code (anemia in pregnancy, not iron deficiency anemia)

Referrals as needed

Review practice specifics

Do not create a pregnancy episode

Pap+ GC/CT as needed

Blood type, if not on file

Decide follow-up based on planned viability and genetic screening

- gestational sac only- repeat scan in 14 days

- yolk sac- repeat scan in 11 days

- viable pregnancy- schedule follow up at 10+ weeks for NIPT and 12 weeks for NT

Primary Dx Z32.01 pregnancy test positive

Bill E/M code (ie 99213)

If bedside ultrasound:

Document in a separate note

Use Dot phrase .STCUSOBREPORT

CPT 76817 if Transvaginal

CPT 76815 if Transabdominal

### Initial Prenatal (ideally 10-14 weeks)

Recommend note .STCNEWOB

Create pregnancy episode

Add problem supervision of normal/high risk pregnancy

Discuss CF/SMA/SS screening

Genetic screening

Update pap/Physical exam if not already done

Initial labs

Pregnancy Check list (.stcpnc)

If getting NIPT- bedside US if not done previously or referral for early anatomy

Primary Dx supervision of normal (or high) risk pregnancy

- If the pt has any problems they are considered high risk (asthma, anemia, etc.)

Medicaid CPT 99800206, 99800207 or 0500f

If commercial insurance use E/M code

If bedside ultrasound:

Document in a separate note

Use Dot phrase .STCUSOBREPORT

CPT 76817 if Transvaginal

CPT 76815 if Transabdominal

Both of these are billable visits and pt will pay copay. Other routine prenatal visits will not have a co-pay.

## 2.b Problem List (5/13/21)

All problem list should have supervision of normal or high risk pregnancy

- If any other problems on the list, then it is a high risk pregnancy
- Use dot phrase .stfpnc

All other problems should be listed, if possible, using an O code

- Example: Anemia in pregnancy (O99.019) not iron deficiency anemia (D50.9)

Use STC dot phrases when available in the plan

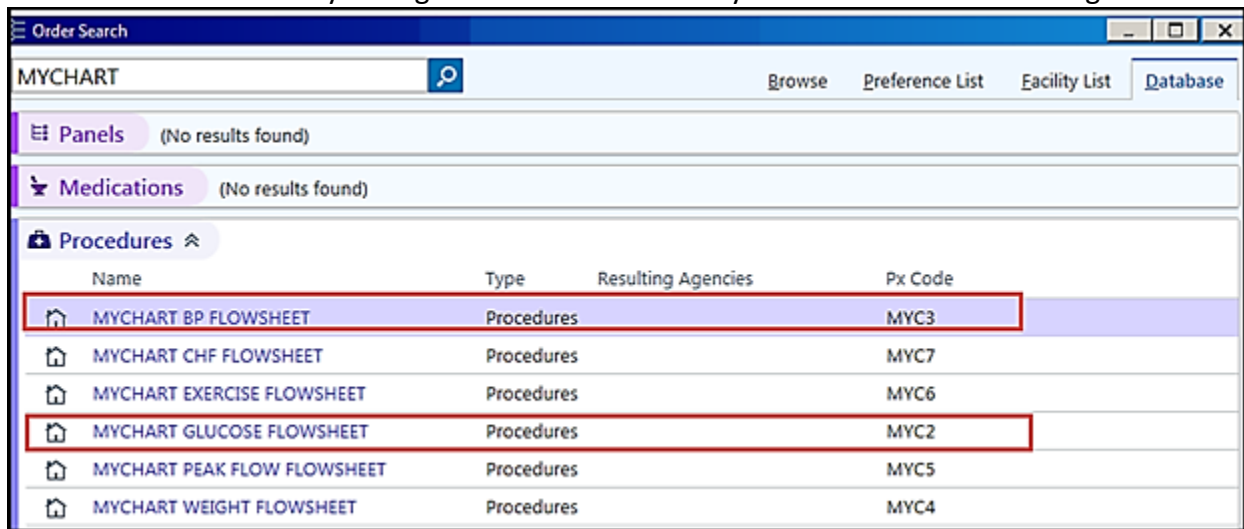
- STCAMA
- STCANTIPHOSAB
- STCASTHMA
- STCCARIDIAC
- STCCHTN
- STCDIDITWIN
- STCDM
- STCGastricBypass
- STCGHTNPREE
- STCHEPC
- STCHIV
- STCHYPOTHYRIOD
- STCISOIMMUNE
- STCIUGR
- STCMONODI
- STCobesity
- STCPretermbirth
- STCReccurentpregloss
- STCSickleCellDisease
- STCSickleCellTrait
- STCseizure

## 2.c Telehealth information (5/13/21)

1. English
  - a. Virtual care info sheet - .virtualcareinfosheet
  - b. BP cuff - .virtualBPcuff
  - c. Kick counts .virtualkickcounts
  - d. Doppler instructions .virtualdopper
2. Spanish
  - a. Virtual care info sheet - .virtualcareinfosheetSPAN
  - b. BP cuff - .virtualBPcuffSPAN
  - c. Kick counts .virtualkickcountsSPAN
  - d. Doppler instructions .virtualdopperSPAN

### Glucose and BP logs

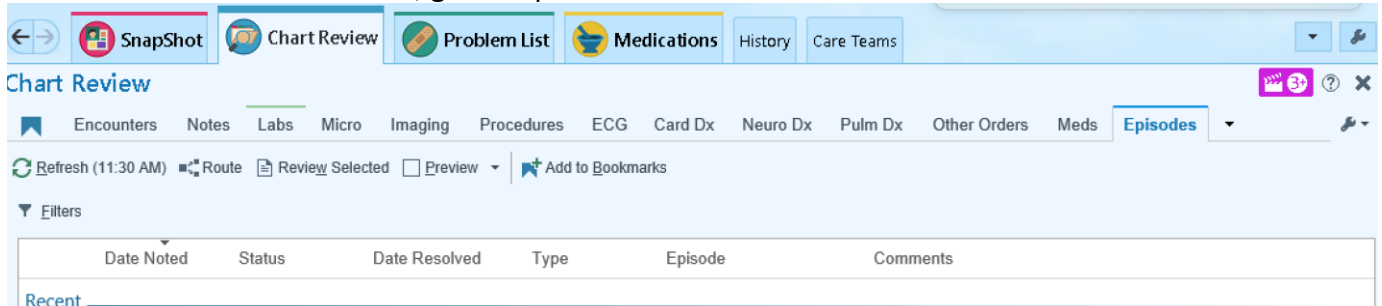
Under orders choose “mychart glucose flowsheet” or mychart BP flowsheet” and sign order



| Name                        | Type       | Resulting Agencies | Px Code |
|-----------------------------|------------|--------------------|---------|
| MYCHART BP FLOWSHEET        | Procedures |                    | MYC3    |
| MYCHART CHF FLOWSHEET       | Procedures |                    | MYC7    |
| MYCHART EXERCISE FLOWSHEET  | Procedures |                    | MYC6    |
| MYCHART GLUCOSE FLOWSHEET   | Procedures |                    | MYC2    |
| MYCHART PEAK FLOW FLOWSHEET | Procedures |                    | MYC5    |
| MYCHART WEIGHT FLOWSHEET    | Procedures |                    | MYC4    |

Pt will be able to log on to Mychart and under “track my health” and log the values

To review under “chart review”, go to “episodes”



| Date Noted | Status | Date Resolved | Type | Episode | Comments |
|------------|--------|---------------|------|---------|----------|
| Recent     |        |               |      |         |          |

They will show up in your box weekly if you were the ordering provider. As long as pt has an upcoming appointment and there is nothing severe, then you are not responsible to manage the BP/glucose.

To end tracking when it is in your box, go to “manage this list”. Then there is a button to end tracking.

Otherwise you can go to “episodes of care” under the epic tab and manage it that way.

## 2.d Nausea and Vomiting in Pregnancy Protocol (5/13/21)

### Purpose:

Allow treatment of nausea and vomiting in early pregnancy without a provider visit.

### Eligibility criteria:

1. Established patient at USF OB/GYN seen in last 2 years
2. Positive pregnancy test at home or in the office
3. Complaint of nausea and or vomiting that has started since being pregnant

### Exclusion criteria:

1. Needs to go to the ER if
  - i. If fever, chills, back pain or infectious symptoms
  - ii. Unable to tolerate fluid intake for >24 hours
  - iii. Unable to urinate

### Procedure:

1. Nurse phone triage
  - a. If patient meets criteria:
    - i. Try supportive measures:
      1. Eating frequently in small amounts
      2. Eating high-carbohydrate, low-fat foods
      3. Eating protein-predominant meals
      4. Eating a bland, dry diet
      5. Drinking small amounts of cold, clear, carbonated or sour liquids
      6. Drinking between meals rather than with meals
      7. Lying down as needed; getting plenty of rest
      8. Changing position slowly, especially when rising
      9. Going outside for fresh air as needed
      10. Avoiding offensive foods and smells
      11. Not brushing teeth after eating
      12. Switch to folic acid 400mcg per day instead of prenatal vitamin
      13. Ginger capsules 250mg 3-4 times a day
      14. P6 wrist acupressure with wrist bands
    - ii. Instructed to try OTC medications first
      1. B6 + Unisom regiments- Unisom may make you sleepy
      2. B6 25mg + Unisom 12.5mg 3-4 times a day
    - or
    3. B6 25mg 3-4 times a day with Unisom 25mg nightly
  - iii. If patient fails the above:
    1. Prescription for Compazine 5-10mg orally 3-4 times a day

- a. Some people will experience agitation or very, very rarely stiff neck muscles. If this starts stop medication immediately.

or

- 2. Prescription for Phenergan 12.5-25mg orally or rectally every 4-6 hours

- a. Some people will be drowsy, rarely people get agitation

- iv. If patient continues to have vomiting should be seen by a provider in the office for a problem visit. This does not replace the initial intake visit if it has not occurred yet.

## 2. Documentation

- a. STCNVPREGNANCY- Pt is \*\*\* weeks pregnant and complaining of nausea and vomiting. Denies fever, chills, back pain and infectious symptoms. Reviewed supportive measures. Reviewed OTC medications. Prescription for \*\*\* sent to the pharmacy.

### 2.e First trimester screen vs. NIPT (5/13/21)

Based on current ACOG Guidelines, all patients should be offered NIPT regardless of risk factors. This does not guarantee insurance coverage for the test.

They may have the NIPT done through Quest or Labcorp, but we cannot tell them the cost and it can be >\$2000. Even if their insurance says that it is covered, that does not mean that they will not have significant out-of-pocket cost depending on their deductible and lab plan. If patient elects for this use orders:

- Quest- QNATAL Advanced
- Labcorp- Maternity 21

To avoid this problem, we offer testing through Myriad. We will collect the blood in the office. They will be told the cost of the test prior to the test being run. If that cost is too high, they can choose to cancel it as long as they respond to the email/calls. Generally, out-of-pocket expense should not exceed \$350. If patient elects for this order:

- Myriad Prequel Prenatal Screen

If they choose to have NIPT, we will offer an early anatomy ultrasound at 10-14 weeks.

- Order OB ultrasound- viability/dating

Though a FTS may be covered by their insurance, again it does not mean it is free. They may still have out-of-pocket cost depending on their deductible and lab plan. If patient elects for this order:

- First trimester screen w/HCG and nuchal translucency
- OB ultrasound – nuchal translucency/genetic counseling

## 2.f CF/SMA/SS screening (5/13/21)

Based on current ACOG Guidelines, all patients should be screened for CF/SMA/SS and Fragile X regardless of ethnicity. This does not guarantee insurance coverage for the tests.

Any patient may elect to see the genetic counselor to go over their specific risks and have the appropriate tests ordered. If they decline, the provider may order the agreed upon tests. There is a form in all new patient packets that should be filled out about their choices (see below).

They may have the carrier screening done through Quest or Labcorp, but we cannot tell them the cost and it can be >\$2000. Even if their insurance says that it is covered, that does not mean that they will not have significant out-of-pocket cost depending on their deductible and lab plan.

To avoid this problem, we offer testing through Myriad. We will collect the blood in the office. They will be told the cost of the test prior to the test being run. If that cost is too high, they can choose to cancel it as long as they respond to the email/calls. Generally, out- of- pocket expense should not exceed \$350. If patient elects for this order:

- Myriad Foresight Carrier Screen

## GENETIC CARRIER SCREENING (Nov2020)

Genetic carrier screening is an optional blood test that checks to see if a person is a **carrier** of genetic conditions which could cause serious health problems in their children. Most individuals who are carriers do not have any health problems or symptoms and don't have any family history.

For most conditions tested both biological parents need to be carriers of the same condition to have a risk to pass it on to a child. However, there are conditions for which only the mother needs to be a carrier for the child to be at risk. Those who are found to be carriers may be referred for Genetic Counseling to discuss additional tests available prior to, or during pregnancy, as well as how best to plan and prepare for birth. A normal/negative carrier screen reduces, but does not eliminate the chance for children to have the conditions tested. Genetic carrier screening does not rule out all genetic conditions or birth defects.

Screening for below conditions is offered as they are the most common:

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                           |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Cystic Fibrosis (CF)</b>                                        | CF is a condition which causes the mucus in the body to be thick and sticky. It most often causes lung infections and lung damage, making it hard to breathe. It can also cause problems in other organs, like the pancreas. The symptoms of CF can be more or less severe. Although symptoms of CF can be treated, there is no cure and people with severe forms of CF may have shorter life expectancy. |
| <b>Spinal Muscular Atrophy (SMA)</b>                               | SMA is a condition that causes muscle weakness which can affect muscles that are important in speaking, walking, breathing, and swallowing. The symptoms of SMA can be more or less severe. Although symptoms of SMA can be treated, there is no cure and children with the severe type of SMA may pass away in early childhood.                                                                          |
| <b>Sickle Cell Disease &amp; Thalassemias (Hemoglobinopathies)</b> | Hemoglobinopathies most often cause anemia (lack of oxygen) but, depending on the condition, can cause other problems such as pain and organ damage. The symptoms of hemoglobinopathies may be more or less severe. Although there has been significant progress in treating hemoglobinopathies, there is no cure.                                                                                        |
| <b>Fragile X syndrome</b>                                          | Fragile X is the most common cause of developmental and intellectual disabilities, which is typically more severe in m. There is no cure for Fragile X. It is typically passed only from the mother.                                                                                                                                                                                                      |

If you are of a specific ethnicity, such as for example Ashkenazi Jewish, or you have a family history of a genetic condition, please inform your healthcare provider as you may benefit from meeting with a **Genetic Counselor** to discuss screening for additional diseases than those listed above.

Insurance coverage can vary based on your benefit plan and other factors. Genetic carrier screening is often covered for insured patients of reproductive age, but may be subject to copays or deductibles.

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PLEASE MAKE A SELECTION BELOW:

- ☐ **ACCEPT:** I have received information from my healthcare provider regarding genetic carrier screening and hereby accept this screening.
- ☐ **DECLINE:** I have received information from my healthcare provider regarding genetic carrier screening and hereby decline to undergo this screening despite being advised of the benefits of these options.
- ☐ **GENETIC COUNSELING:** I have received information from my healthcare provider regarding carrier screening and desire to be referred for Genetic Counseling prior to proceeding with additional screening.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_

2.g Covid Vaccine Letter (5/13/21)

Dot phrase: .stccovidvaccineletter

To Whom it May Concern,

@NAME@ is a patient of our practice. She is currently pregnant. @NAME@ has expressed interest in the COVID19 vaccine. She has been provided information regarding the COVID-19 vaccine, including:

- limits of data regarding safety in pregnancy
- potential for unreported side effects
- risks of COVID-19 in pregnancy including higher rates of intubation and ICU admission and pregnancy complications

She has also been given the opportunity to discuss these issues with a provider for any further questions. In accordance with guidelines from the Society of Maternal Fetal Medicine, Centers for Disease Control, and American College of Obstetricians and Gynecologists, we believe that it is reasonable to offer this pregnant individuals this vaccine. @NAME@ demonstrates a thorough understanding of the risks and benefits of obtaining the COVID-19 vaccine and I support her decision to obtain this vaccine during her pregnancy.

Feel free to contact our office if there are any additional questions or concerns.

Sincerely,

@MEWITHCRED@

@TD@

Response to request for exemption:

We have recently received requests for letters for exemptions to COVID 19 vaccine mandates. Based on current available data from experts in the fields of obstetrics, gynecology, fertility, immunology, public health, and infectious disease, it is our medical opinion that in most conditions the benefits of the vaccine outweigh the risks. This includes common conditions such as pregnancy, desiring to be pregnant and various gynecologic issues such as endometriosis.

Pregnant women who get COVID- 19 are more likely to become very sick and need care in the hospital. Beyond this, they are three times more likely to get admitted to the ICU and 2-3 times more likely to need life support. The vaccine can help to prevent this. Multiple studies including thousands of patients have shown that there are no increased complications in pregnancy or at delivery from the vaccine. There has been no increase in problems in children of women who received the vaccine while pregnant.

For those who desire to be pregnant, studies have shown that there is no change in a women's ability to get pregnant after receiving the vaccine. There is also no increased risk of miscarriage. This includes women who are undergoing fertility treatments. The American Society of Reproductive Medicine is the leading national organization for infertility therapy and

recommends “Everyone, including pregnancy women and those seeking to become pregnant, should get a COVID-19 vaccine.”

The studies on menstrual issues after vaccination are few. The UK national registries show that some women will have an abnormal cycle for one cycle after vaccination but there is no effect on pregnancy or miscarriage rates. This is thought to be due to the temporary rise in immune response and can also be seen in people with severe illnesses. One in 5 women who are infected with COVID-19 will have an abnormal cycle. At least one study has shown that women with endometriosis may be more likely to get severe COVID symptoms if they are infected. Based on what we know, we recommend vaccination for all women including those with menstrual disorders.

Our group has reviewed the data. We stand with the CDC, ACOG, ASRM and SMFM in recommending the Covid-19 vaccine to all our patients, including our pregnant patients regardless of trimester, those planning to get pregnancy, and those with menstrual disorders. Currently the risk of Covid-19 in our community is high and we take the responsibility of protecting our patients very seriously. If you would like to consult with a doctor on the issue, we would be happy to set up an appointment with us.

Sincerely,

USF Obstetrics and Gynecology Physicians and Midwives

Additional resources and references:

<https://www.acog.org/womens-health/faqs/coronavirus-covid-19-pregnancy-and-breastfeeding>

<https://www.acog.org/womens-health/experts-and-stories/the-latest/how-do-we-know-the-covid-19-vaccines-are-safe-and-effective-one-expert-explains>

<https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/pregnancy.html>

<https://www.smfm.org/covidfamily>

<https://www.gov.uk/government/publications/coronavirus-covid-19-vaccine-adverse-reactions/coronavirus-vaccine-summary-of-yellow-card-reporting>

[https://www.reproductivefacts.org/news-and-publications/covid-19-resources-for-patients/?\\_ga=2.125875657.571807550.1635961864-902859321.1635961864](https://www.reproductivefacts.org/news-and-publications/covid-19-resources-for-patients/?_ga=2.125875657.571807550.1635961864-902859321.1635961864)

Wainstock T, Yoles I, Sergienko R, Sheiner E. Prenatal maternal COVID-19 vaccination and pregnancy outcomes. *Vaccine*. 2021 Oct 1;39(41):6037-6040. doi: 10.1016/j.vaccine.2021.09.012. Epub 2021 Sep 7. PMID: 34531079; PMCID: PMC8421099.

Male V. Menstrual changes after covid-19 vaccination. BMJ. 2021 Sep 15;374:n2211. doi: 10.1136/bmj.n2211. PMID: 34526310.

Moazzami B, Chaichian S, Samie S, Zolbin MM, Jesmi F, Akhlaghdoust M, Pishkuhi MA, Mirshafiei ZS, Khalilzadeh F, Safari D. Does endometriosis increase susceptibility to COVID-19 infections? A case-control study in women of reproductive age. BMC Womens Health. 2021 Mar 22;21(1):119. doi: 10.1186/s12905-021-01270-z. PMID: 33752656; PMCID: PMC7983080.

Li K, Chen G, Hou H, Liao Q, Chen J, Bai H, Lee S, Wang C, Li H, Cheng L, Ai J. Analysis of sex hormones and menstruation in COVID-19 women of child-bearing age. Reprod Biomed Online. 2021 Jan;42(1):260-267. doi: 10.1016/j.rbmo.2020.09.020. Epub 2020 Sep 29. PMID: 33288478; PMCID: PMC7522626.

#### 2.h Anatomy scan (5/13/21)

Anatomy scans can be from 18-22 weeks.

For obese patients, 20-22 weeks is preferred.

All anatomy ultrasounds are level 2. If AFP has not previously be done, there may be little benefit of doing it after the ultrasound as long as spine/cranium views are adequate and normal.

## 2.i Prenatal care education options

### i. Online Resources- Dot phrase .onlinepregnancyresources

#### Online Pregnancy Resources

Sign up for a Prenatal Virtual Support Group with a USF Midwife:  
[tiny.cc/USFsupportgroup](http://tiny.cc/USFsupportgroup)

Trusted Resources to Learn About COVID-19 and Pregnancy:

<https://mothertobaby.org/fact-sheets/covid-19/>

<https://floridahealthcovid19.gov/>

<https://www.cdc.gov/coronavirus/2019-ncov/index.html>

Resources for Prenatal Education Questions:

<https://familydoctor.org/family-health/pregnancy-and-childbirth/>

<https://www.marchofdimes.org/pregnancy/prenatal-care.aspx>

<https://www.lamaze.org/Parents>

Tour of Labor and Delivery Online:

<http://www.virtually-anywhere.net/tours/ugh/womens/vtour/index.html>

Online Birthing Classes:

<https://www.tgh.org/event/labor-birth-preparation-e-class>

<https://evidencebasedbirth.com/evidence-based-birth-childbirth-class-virtual-experience/>

<https://www.lamaze.org/lamaze-classes-online>

Virtual Prenatal Groups:

March of Dimes through 9/2020

<http://www.cvent.com/events/supportive-pregnancy-virtual-groups-/event-summary-973b69bfc5dc46ff93a407f4417fb609.aspx>

Postpartum Birth Control Options:

[www.bedsider.org](http://www.bedsider.org)

Breastfeeding and Postpartum Questions:

[www.newmomhealth.com](http://www.newmomhealth.com)

<https://www.lamaze.org>

laleche league <https://www.llli.org>

Postpartum Depression

<https://www.theseventhmomproject.org>

SAMSHA HelpLine 1 (800) 662-HELP

<https://www.nimh.nih.gov/health/publications/perinatal-depression/index.shtml>

Virtual Doula, Lactation and Childbirth Education

<https://www.buddhabellybirth.com>

Email: [hello@buddhabellybirth.com](mailto:hello@buddhabellybirth.com)

Phone (727) 489-4750

<https://www.OneLoveDoula.com>

Email: Onelovedoulaservice@gmail.com

Phone: (813)704-0156

Growth with doulas & dads is a free on call doula service for women living in Hillsborough County only

Phone: (813) 712-6300

ii. Tampa General Hospital Classes

<https://www.tgh.org/WomensHealth/childbirth-education>

WOMEN'S CENTER TOUR

LABOR & BIRTH PREPARATION - FIVE-WEEK SERIES

HYBRID E-CLASS: LABOR & BIRTH PREPARATION

BREASTFEEDING BASICS

BASIC NEWBORN CARE

CAR SEAT CHECK

READY, SET, GRANDPARENT!

BOOT CAMP FOR NEW DADS

BOOT CAMP FOR NEW MOMS

BECOMING A BIG BROTHER OR A BIG SISTER

INFANT AND CHILD CPR AND SAFETY

DOGS & STORKS

iii. Doulas

Dot phrase .Doulas

Doula Services

[Www.tampabaybirthnetwork.org](http://Www.tampabaybirthnetwork.org)

This is a website that includes a directory of birth professionals including doulas.

Some private doulas that we often work with include:

Website: [Buddhabellybirth.com](http://Buddhabellybirth.com)

Email: [hello@buddhabellybirth.com](mailto:hello@buddhabellybirth.com)

Phone (727) 489-4750

Website: [OneLoveDoula.com](http://OneLoveDoula.com)

Email: [Onelovedoulaservice@gmail.com](mailto:Onelovedoulaservice@gmail.com)

Phone: (813)704-0156

Growth with doulas & dads is a free on call doula service for women living in Hillsborough County only

Phone: (813) 712-6300

## 2.j New Gestational Diabetes Handout (11/2020)

Task the OB Nurse/MA pool to place orders for glucometers, mychart glucose log and diabetic educator appointment. The below statement should be sent to pt for counseling by provider or nurse. Dot phrase .STCNEWGDMPT.

### New Gestational Diabetes Handout

You have been diagnosed with gestational diabetes. This is a condition that affects many women in pregnancy. It is caused by interactions between the placenta and your body that leads to elevated sugar levels in your blood. Unless you were diagnosed in the first half of your pregnancy, this will likely go away after delivery.

During the pregnancy it is important to control your sugars as poor control can lead to poor pregnancy comes for both you and your baby. This can be done with diet, exercise and sometimes medications are necessary. We will provide you with a glucose meter and directions for how to use it. You will learn to check your sugars 4 times a day. The goal is that your fasting sugar should be under 95 and one hour after your meals it should be 140 or less. We will send you to see the diabetic educator to learn about your diet. In the meantime, you should avoid sugary drinks and cut down on carbohydrates such as rice, bread and cereal. You should have moderate activity such as walking for 30 minutes 5 times a week.

If despite your best efforts at changes to your diet and exercise, your blood sugars remain elevated, you may need to be started on medications such as insulin or metformin. If you have to be started on medications, it means you are at higher risk for complications and we will need to do additional screenings such as weekly ultrasounds starting at 32 weeks and delivery at 39 weeks.

If not controlled, gestational diabetes can lead to rapid growth of the baby and problems with the delivery. Short term, it can increase the chances the baby has trouble breathing after delivery, has to be treated for low sugars sometimes requiring an IV, or will need to be treated for jaundice. It can also increase the baby's risk of obesity, diabetes and metabolic syndrome long term. If the baby is measuring too big, we may recommend a cesarean section to prevent shoulder dystocia. A shoulder dystocia is when the baby is too big to fit through your pelvis and gets stuck. This can lead to serious complications including permanent nerve damage and even death.

After delivery, women with gestational diabetes are still at higher risk for diabetes. As many as half of women will go on to have diabetes outside of pregnancy in their lifetime. Obesity increases this risk. At 6 weeks after delivery we should do a 2 hour fasting test to make sure that the diabetes is gone. If not, then you should follow up with your primary doctor for treatment. If the diabetes is gone, then you should be tested every 3 years to see if it comes back.



## 2. k Diabetes clinic

Guidelines for patients referred/to be seen in Diabetes Clinic:

- any MFM consults for patients with diabetes as the major medical issue
- follow up visits for treatment management as needed
- preconception counseling for type 1 and type 2 diabetes
- if pt has GDM, and generalist has started insulin

The generalists will direct patients to send in blood sugar logs (preferably mychart) on Sunday, Monday so that Dr. Lanouette can review them all Monday/Tuesday. Patients seen by Lanouette or MFM will have logs reviewed by Dr. Lanouette. Patients not seen by MFM will have generalists review blood sugar logs, unless concerning issue day-of and generalist speaks with MFM of the day. If pt has GDM, on insulin, Lanouette sees patient and if well-controlled can remain in generalist unless other qualifying conditions for HRG clinic, following up in diabetes clinic as requested by generalist or Dr. Lanouette. Dr. Lanouette and Clair, MFM nurse have patient lists for these patients they see and are working closely to ensure blood sugar logs are diligently reviewed. Dr. Lanouette will message the patient once the log has been reviewed with any follow-up questions, and Clair helps case manage for patients who haven't sent in logs, etc.

## 2.1 High Risk Generalist Clinic at STC

Purpose: to provide guidance for the appropriate use of the High Risk (HR) Generalist Clinic at STC

Process:

-Schedule managed by MFM staff in order to keep templates closed to general public

### Routes to get to HR generalist clinic:

1. Request (by generalist or CNM) → gatekeeper approval → patient scheduled  
Send brief message (with primary diagnosis) attached to patient chart in Epic to the MFM nursing pool of Paige.  
If approved, the MFM staff will call the patient to schedule her appointment.  
If not approved, message will be returned with explanation.
2. MFM consult → MFM recommendation of follow up care (Generalist, HR generalist, or Fellow clinic) → gatekeeper approval → patient scheduled
3. If condition of patient changes → MFM follow up and re-evaluate for an updated plan (plan may be/include a change in location of care)

### *Conditions that qualify for High Risk Generalist Clinic*

#### Maternal disease

Thyroid disease Graves

Seizure disorder on meds

Uncontrolled Asthma

DM Type 2 diabetes requiring insulin- **not sole diagnosis into clinic, seen in Diabetes clinic first if primary request/diagnosis**

CHTN on multiple meds

HIV stable on meds

Proteinuria/mild- moderate renal disease

Controlled Lupus

Controlled sickle cell

Uncommon conditions if mild: Von Willebrand disease, Multiple sclerosis, Myasthenia gravis

#### Uterine issues

Large Fibroids

Prior uterine rupture

Cervical insufficiency **with cerclage**

Venous thromboembolism on anticoagulants

Preeclampsia

#### Fetal

Twin gestations (Mono-di)

Alloimmunization- not requiring transfusion

IUGR with abnormal Dopplers or comorbid conditions

Fetal malformations

Not life-limiting (such as isolated VSD, gastroschisis)  
Requiring serial ultrasounds

Placenta:

Previa- s/p bleed  
Chronic abruption

2. m    Breast pump dot phrase

Order breast pump under supplies. In comments put the dot phrase

Dot phrase- .stcbreastpump

E0603-Double Electric Breast Pump and any included supplies

Dx:Z39.1

Duration: 1-9999

@EDD@

## 2.n. Ordering PP LARC

Liletta is our preferred progestin IUD due to cost. Pt can request Mirenas/skylas or paraguards. We have not had good success with coverage for Kylenea. We have not had any difficulty with coverage for Liletta for AUB/menorrhagia.

To order any LARC:

At the end of the visit CC the chart to the USF GYN MA/Nuse pool.

Use dot phrase .STCIUDAUTH

@NAME@

@MRN@

@ED@

IUD / LARC Authorization Form

Dx: \*\*\*

IUD or LARC Type: \*\*\*

US Guided: {YES/NO:26064}

## 2. o. GBS and 3rd trimester GC/CT screen

GBS testing should be done at 36 0/7 to 37 6/7 weeks. Self-collection is an acceptable option. Instructions are in the bathrooms. Pt should be screened regardless of mode of delivery unless they are already supposed to have antibiotics (hx of GBS sepsis, GBS bacteria, etc).

3<sup>rd</sup> trimester GC/CT testing is recommended by the AAP if:

- 24 years or younger,
- having new or multiple sex partners
- having a sex partner with concurrent partners
- having a sex partner with a sexually transmitted infection
- living in an area in which the prevalence of Chlamydia trachomatis or Neisseria gonorrhoeae is high

## 2.p Laboratory Thresholds

### Anemia:

1<sup>st</sup> trimester- if Hg < 11.5

- consider Hemoglobinopathy work up if not previously done
- consider iron therapy if history of heavy periods or recent pregnancy

2/3<sup>rd</sup> trimester- Hg <10

- consider iron therapy if previously normal Hg
- repeat CBC in 2-4 weeks for response +/- iron levels
- if unable to tolerate oral iron or no response to iron, consider iron levels and iron infusion

### GCT

Over 130 should be referred for 3 hour glucose tolerance test. Task OB nurse pool to schedule.

2. q. Anesthesia referrals

CC chart to surgery scheduling pool requesting anesthesia consult and reason

2.r. Interdepartmental referrals

Place referral order and tell pt to call department if no response in 1 week.

If urgent, notify OB nurse to assist with follow up.

2. s. Scheduling Inductions and cesarean sections

CC chart to surgery scheduling pool with dot phrase .scheduleIOLCS

Place "orders for admission" and sign and hold

- If c-section use: "Cesarean section pre-op orders" set

- If Induction use:

- "Labor and Delivery Admission Orders" and "cervical ripening/induction" order sets

- Give handout on Inductions. Dot phrase .STCINDUCTIONINSTRUCTIONS

## 2. t. Elective inductions

We offer elective inductions but follow ACOG recommendations that there is not enough information to recommend them universally at this point. If choosing elective induction patient must be accept of all agents including Pitocin and ideally offered an outpatient foley balloon. Make sure to give handout on elective inductions.

### Elective induction cheat sheet

- At 38 weeks
  - Must have cervical exam at this visit
  - Give handout on elective inductions
    - STCELECTIVEPT
  - Give handout on inductions in general
    - STCINDUCTIONINSTRUCTIONS
  - Document in chart
    - STCELECTIVEINDUCTION
  - Place request to pool
    - STCSCHEDULEELECTIVEIOL
    - Request 1 day later if balloon to be placed (ie. 39w1d for 39 week induction)
  - Place admission and induction orders including agent

## 2. u. Outpatient Foley Balloons

Will be scheduled the day before their hospital induction

- They are scheduled at certain times so they can have a pre and post NST.
- This cannot be before their recommended delivery time (i.e. No 36w6d for 37 weeks). The balloon counts as starting their induction.
- Patient instructions: STCFOLEYPTINSTRUCTION
- Consent form: STCFOLEYCONSENT
- Procedure note: STCCERVICALFOLEYNOTE
  - Must be finished the day of the procedure
- Billing: 59200 Insertion of a cervical dilator
- Instruct patient to only come to the hospital for the usual obstetrical indications regardless of the status of the balloon

## **Outpatient Cervical Ripening Protocol (1/2021)**

### **Purpose:**

Approximately 22% of pregnancies in the United states will end with an induction of labor. This increases the time spent in labor and delivery as well as cost. Outpatient foley balloons are a safe and effective way to reduce time spent in labor and delivery and improve bishop score on

presentation. The purpose of this protocol is to outline the procedure for outpatient foley balloon placement for elective or medical inductions who have a Bishop score of less than 6.

**Inclusion criteria:**

- Nulliparous or multiparous patients with no prior uterine surgeries with Bishop score less than 6

AND

- Indication for delivery
  - Desires elective induction and greater than 39 weeks
  - Postdates pregnancy
  - Fetal demise
  - Gestational Hypertension
  - Chronic Hypertension (no meds or stable on medications)
  - Diabetes Mellitus (well controlled, not requiring insulin)

There may be other medical indications not listed here. If there is a question of appropriateness, the indication will need to be reviewed by Medical Director or designee.

**Exclusion criteria**

- Abnormal Fetal Lie or non-Cephalic lie
- Abruptio Placenta
- Active Genital Herpes
- Category II or III Fetal Heart Tracing
- Chorioamnionitis
- Complete Placenta Previa
- Inadequate Pelvis or Pelvic Abnormality
- Invasive Cervical Cancer
- Known Vasa Previa
- **Latex allergy**
- Multiple Gestation
- Previous Uterine Incision (including low transverse cesarean)
- Polyhydramnios
- Ruptured Membranes
- Pre-eclampsia or uncontrolled blood pressure
- Umbilical Cord Prolapse
- Any Contraindication to Induction of Labor or vaginal birth

**Supplies:**

- Foley catheter 16-26 gauge with a 30cc balloon
- Sterile saline 100cc
- Speculum
- Ring forceps
- 30-60 cc syringe and needle
- Foley plug

**Procedure:**

1. Provider will review indication of delivery and place a surgery scheduling request to the pool.
2. Procedure will be explained to patient and given handout on induction of labor (STCINDUCTIONINSTRUCTIONS). If elective induction, provider will also give elective induction of labor handout (STCELECTIVEPT).
3. Once induction is confirmed by Tampa General L&D, pt will be scheduled for foley balloon placement.
4. Nurse/MA will obtain vital signs and perform NST. I
  - a. f not reactive and reassuring, provider will discuss alternatives with patient.
5. Prior to balloon placement provider will confirm:
  - a. Patient's identifying information
  - b. Date desired for induction
  - c. EDC
  - d. Gestational age
  - e. Indication for induction
  - f. Bishop Score
  - g. Allergies including Latex
6. Obtain Consent Form for patient (Appendix A or STCFOLEYCONSENT)
7. Provider will place Foley balloon through cervix with 40-60ml of normal saline
8. Nurse will perform 30 min NST or until reactive. Notify provider of suspected rupture of membranes, fever, abnormal bleeding, non-reassuring FHT or tachysystole. Strip will be reviewed with provider prior to patient discharge.
9. Post procedure instructions will be given to pt (Appendix B or STCFOLEYPTINSTRUCTIONS).
10. Provider will document procedure (STCFOLEYNOTE). For billing purposes the CPT code for the procedure is 59200 "Insertion of cervical dilator"

## Appendix A

### Patient Label

Cephalic presentation: YES

Provider Initials \_\_\_\_\_

Membranes intact: YES

Provider Initials

\_\_\_\_\_

Cervical exam today      \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Bishop Score Today      \_\_\_\_\_

### **Informed Consent for Cervical Ripening with Foley Balloon**

Your Provider \_\_\_\_\_ has recommended that you have cervical ripening with the Foley balloon prior to your induction. This procedure is expected to improve your chances of a vaginal delivery by improving the dilation, effacement and consistency of your cervix.

The use of the foley balloon for the purpose of cervical ripening is a common practice among OB/Gyn providers. Overall if your Bishop score is less than 7, your chances of vaginal delivery is greater with cervical ripening. Cervical ripening success using the Foley balloon is equal to in hospital ripening with Cervidil. The advantage of outpatient placement is the ability to do this process at home. During this time you may eat a regular diet and walk rather than be confined to a hospital room. Alternatives to this procedure include inpatient induction or waiting for natural labor to occur depending on your particular health conditions during this pregnancy.

With insertion of the foley balloon into your cervix ,you may experience cramping and bleeding. There is the chance that your water may break spontaneously which may increase your chance of infection, but this is no greater than without the balloon in place.

By signing below. I acknowledge that I have received verbal and written instructions from my provider on warning signs and when to come to the hospital. I agree to keep my scheduled induction time.

In addition, by signing below you acknowledge that you agree to this procedure, that the risks, benefits, complications and alternatives have been reviewed with you to your satisfaction, and that your questions have been answered in full.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

I have reviewed the above with the patient. The benefits, risks, complications and alternatives (including but not limited to those listed above) have been discussed and her questions answered.

Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Post Procedure Instructions for Foley Balloon Placement**  
**For Cervical Ripening**

You have had a foley balloon placed in your cervix. The purpose of this procedure was to improved your dilation and make your time in Labor and Delivery shorter. If the balloon comes out of the vagina on its own, do not worry. That is a great sign of progress.

After your procedure, you may experience

- \*Bleeding, lighter than a period or spotting
- \*Cramping similar to period cramps
- \*Flushing or hot flashes
- \*Mild contractions

These are normal and expected reactions and this is what will help you become dilated and effaced. These symptoms may continue through the night.

Feel free to walk, do chores, be active.

Gravity will help your baby and the balloon do all the work.

Eat and drink anything you like that is safe in pregnancy.

**DO NOT** take any tub baths. Take only showers

**DO NOT** have any intercourse

**DO NOT** insert anything into the vagina

**KEEP** your appointment at Labor and Delivery

Please come to Labor and Delivery immediately if you experience any of the following:

**\*Vaginal BLEEDING heavier than one pad per hour**

**\*If you BREAK your water or think you may have**

**\*If your baby DOESN'T MOVE ten times in two hours**

**\*If you have CONTRACTIONS that are strong enough you can't talk through them every 5 minutes for 1 hour**

**\* If you have a FEVER 100.4 or greater**

If the catheter comes out on its own and you do not have any of the symptoms above, you may remain at home until your scheduled induction time.

**Call with any questions or concerns:**

TGH 813- 884-7000 or the USF Office 813-249-8500



2.v. Postpartum

2.v.i. Lactation

2.v.i.1. Patient handout

Lactation Help (STCLACTATION)

TGH Lactation Consultant (813) 844-7613

Baby Café- David Island

Main line: (813) 673- 4646

Many of the Doula groups also offer lactation help. This is a website that includes a directory of birth professionals including doulas:

[Www.tampabaybirthnetwork.org](http://www.tampabaybirthnetwork.org)

Some examples include:

Virtual Doula, Lactation and Childbirth Education

<https://www.buddhabellybirth.com>

Email: [hello@buddhabellybirth.com](mailto:hello@buddhabellybirth.com)

Phone (727) 489-4750

<https://www.OneLoveDoula.com>

Email: [Onelovedoulaservice@gmail.com](mailto:Onelovedoulaservice@gmail.com)

Phone: (813)704-0156

2.v.i.2. Lactational breast problems algorithm  
Lactational Breast Problems (5/2021)

All pt calling with breast problems should be referred to a lactation counselor for evaluation of latch and feed.

- TGH Lactation counselor- (813) 844-7613
- Tampa La Leche League- (813) 932-3664

All pt should be assessed for signs of depression if having difficulty with feeding

- Palpable lump
  - Flu like symptoms, fever, body aches- Tx for mastitis
    - Antibiotics
      - Dicloxacillin 500mg PO QID x 10 days
      - If mild PCN allergy: Cephalexin 500mg PO QID x 10 days
      - If severe PCN allergy: Clindamycin 300-450 mg PO QIDx10days
    - Supportive Care
      - Rest, fluids, empty the breast.
      - Nurse / pump every 2-3 hours.
      - For pain and fever, recommend: Acetaminophen 650mg q4-6 hours (maximum 3500 mg/day) or Ibuprofen 600 mg q6h. Counsel patient that symptoms should improve in 24 to 48 hours. If symptoms progress after 12 hours or persists after 24-48 hours, she should be seen in clinic by a licensed independent provider, or come to the ER if after hours or weekend for evaluation.
      - Position infant with chin or nose pointing toward blockage. Over 24 hours, after most feedings, soak breast in warm (not hot!) water. Use hand massage and pump to empty breast after feeds.
      - Wear loose Bra
  - If not resolved in improved with 24 hours or worsening at 12 hours, same day provider appointment
    - With breast US- will get number to set up
    - Consider change antibiotics to MRSA coverage (Clinda or Bactrim is >4 weeks old)
- No flu like symptoms- clogged duct
  - Supportive Care
    - Rest, fluids, empty the breast.
    - Nurse / pump every 2-3 hours.
    - For pain and fever, recommend: Acetaminophen 650mg q4-6 hours (maximum 3500 mg/day) or Ibuprofen 600 mg q6h. Counsel patient that symptoms should improve in 24 to 48 hours
    - Position infant with chin or nose pointing toward blockage. Over 24 hours, after most feedings, soak breast in warm (not hot!) water. Use hand massage and pump to empty breast after feeds.

- Wear loose Bra
  - Consider Lecithin 1200 mg TID-QID and Probiotics.
  - No improvement within 24 hours, consider tx for mastitis
  - If not resolved in 5-7 days get breast US/MMG
- Breast pain no lump/erythema
  - Ductal infection- sharp deep pains throughout the breast
    - Supportive treatment- Motrin 600q6h, warm breast after feeding, probiotics
    - If not improvement in 48 hours then provider apt:
      - Consider milk culture and treat based on culture
      - If systemic symptoms, tx treat for Mastitis
  - Myofasical/vasospasm pain- Motrin 600q6h, try change of position change for feeding, warm breast after feeding
    - If not improvement in 48 hours then provider apt:
      - Consider Procardia 30XL. Caution for HA and hypotension
- Nipple pain
  - Bleb- white head on nipple
    - Supportive care- Soak nipple before and/or after most feedings in warm (not hot!) water. Consider Epsom salt soaks.
    - No improvement in 48 hours, then provider apt
      - Consider I & D and Mupirocin 2% TID x7 days
  - Bacterial infection- Yellow crust/fissures
    - Wash nipple and sterilize bump parts
    - Supportive care- address latch, apply barrier like coconut oil or Crisco
    - Mupirocin 2% TID for up to 14 days
    - If no improvement after 2-3 days, provider apt
      - Consider culture of fissures or treat for yeast
  - Dermatitis- Red, burring nipple with no exudate
    - With plaque (well defined area), likely chemical irritant
      - Look for irritants- soaps, creams pads
      - 0.1% Triamciolone BIDx7 days
    - Without plaque- irritant vs may be yeast
      - Apply barrier ointment (Crisco, Coconut oil, Medical Grade Honey, Petrolatum) after each feed.
      - Consider covering nipple-areolar complex with gauze or nipple shells. Wear cotton bras.
      - Hydrogels should not be used with barrier ointment.
      - If using Petrolatum and ointment is still visible before the next feeding or pumping, wash off the nipples with water and gentle cleanser (Cetaphil, equivalent generic).
    - If not improved in 2-3 days, provider apt
      - Consider treat for yeast

- Clotrimazole OTC after each feed for 14 days. Wash off excess prior to next feed.
  - If not improving culture milk for yeast. Get CMP then start Diflucan 200mgx1, then 100mgx14 days.
- Baby has thrush
  - Treat mother:
    - Clotrimazole OTC after each feed for 14 days. Wash off excess prior to next feed.
    - If not improving in 48 hours, then provider apt:
      - Consider culture milk for yeast. Get CMP then start Diflucan 200mgx1, then 100mg x14 days.
  - Baby gets from peds
    - nystatin 100,000 u/mL susp, 0.5 mL swabbed over mucosal surfaces after each feeding x 14 days
- Low milk supply
  - Increased frequency of pumping/feeding
  - Make sure adequate water and nutritional intake
  - Review medications- antihistamines, estrogens and decongestants can reduce milk supply
  - Telehealth with provider to discuss Galactagogues- limited evidence
    - Reglan 10mg TID for up to 15 days

2.v.ii. Postpartum depression

2.v.ii.1. Patient handout

Post-Partum Mood Resources (STCPPMOODRESOURCES)

If you have thoughts of hurting yourself, your baby or others call 911, go to the nearest emergency room or to the Gracepoint Adult Emergency Services.

Gracepoint Emergency Walk-in  
2212 E. Henry Ave  
Tampa, FL 33610  
(813) 272- 2958

**24-hour Post-partum Support International Hotline**

1-800-944- 4PPD (4773)

[www.Postpartum.net](http://www.Postpartum.net)

**Local therapist who have expressed interest in postpartum depression/anxiety:**

Dr. Sh'nai Simmons

Community Victory Family Services

Ph:800-715-3606

Fax: 813-906-0206

[www.CommunityVictory.com](http://www.CommunityVictory.com)

Dr. Paula Nelson, LCSW, MCAP, CET

[www.drpaulanelson.com](http://www.drpaulanelson.com)

[paula@drpaulanelson.com](mailto:paula@drpaulanelson.com)

813-951-8889

April Mohnshine, LCSW

[www.aprilmohnshine.com](http://www.aprilmohnshine.com)

[admohnshine@gmail.com](mailto:admohnshine@gmail.com)

813-600-2932

Rhoda Donnelly, LCSW

[www.positivecounseling.net](http://www.positivecounseling.net)

(813) 922-8255

\*accepts Tricare

Dr. Katie Pollack

[www.indigocounselingfl.com](http://www.indigocounselingfl.com)

33596

(813) 603-8181

Robin Maier, LCSW

[www.robinleighmaier.com](http://www.robinleighmaier.com)

[robinmaierlcsw@gmail.com](mailto:robinmaierlcsw@gmail.com)

(813) 431-0797

Dr. Tracy Hampton, LMFT

33629

(813) 355-8284

**Local Psychiatrist who have expressed interest in postpartum depression/anxiety:**

**Dr. Deborah Knudson-Gonzalez**

USF Psychiatry

Appointments: 813-974-8900

Fax: 813-974-3223

Tampa Family Psychiatry

[tampafamilypsychiatry.com](http://tampafamilypsychiatry.com)

(813) 931-7022

The Neuropsychiatric Institute  
[neuropsychiatric.net](http://neuropsychiatric.net)  
(813) 636-8811

Bloomington Psychiatric Associates  
Dr. Kathleen Carroll, MD  
(813) 689-2466

Dr. Megan Toufexis, Psychiatry  
[www.drmegantoufexis.com](http://www.drmegantoufexis.com)  
813-906-7707

Additional Online Resources:

[www.marchofdimes.org/pregnancy/postpartum-depression.aspx](http://www.marchofdimes.org/pregnancy/postpartum-depression.aspx)

<https://www.acog.org/womens-health/faqs/postpartum-depression>

<https://postpartumprogress.com>

<https://www.helpguide.org/articles/depression/postpartum-depression-and-the-baby-blues.htm>

2.v.ii.2. Algorithm for treatment and provider resources

If pt is high risk for PP depression, schedule 2 week PP visit. Make sure DC paperwork says it to assist in scheduling.

Pt call in for PP depression in first 12 months after delivery

- Nurse will assess for SI/HI/ ability to care for self and baby using MCPAP ADSTO.
  - If SI/HI or severe symptoms
    - Then will be directed to Gracepoint or emergency room.
    - Will set up safety check with non-emergency line with police
  - In no SI/HI but reports moderate symptoms or severe symptoms but are able to wait for treatment
    - Will be scheduled for a provider visit within 2 business days
    - Will be given PP hot-line number
    - Will review where to go in emergency and have pt contract for safety
  - If no SI/HI and mild symptoms
    - Will be scheduled for a provider visit within 5 business days
    - Will be given PP hot-line number
    - Will review where to go in emergency and have pt contract for safety

Notes for providers

If patients call us, we will see them for at least the first visit.

Psych typically takes about 2 months to get an appointment. Knudson- Gonzalez specializes in Women's health/birth trauma but has limited appointments

Consider using Depression Screening Algorithm. Consider screening for bipolar before starting medications

If medication is appropriate, please proscribe at least 2 months' worth and schedule follow up in 2-4 weeks. Recommend using algorithm MCPAP Antidepressant Treatment Algorithm. Pregnancy/Lactation safety is below.

Consider having patients follow up with PCP PP rather than psych if mild or moderate and improved with pharmacotherapy.

# Assessment of Depression Severity and Treatment Options<sup>1</sup>

## EPDS SCORE or clinical assessment

## SIGNS AND SYMPTOMS OF DEPRESSION

\*Signs and symptoms in each column may overlap

| EPDS 0-8                                                                                                                 | EPDS 9-13                                                                                                                   | EPDS 14-18                                                                                                                                  | EPDS ≥19                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| <b>LIMITED TO NO SYMPTOMS</b>                                                                                            | <b>MILD SYMPTOMS</b>                                                                                                        | <b>MODERATE SYMPTOMS</b>                                                                                                                    | <b>SEVERE SYMPTOMS</b>                                                                                                                 |
| <ul style="list-style-type: none"> <li>Reports occasional sadness</li> </ul>                                             | <ul style="list-style-type: none"> <li>Mild apparent sadness but brightens up easily</li> </ul>                             | <ul style="list-style-type: none"> <li>Reports pervasive feelings of sadness or gloominess</li> </ul>                                       | <ul style="list-style-type: none"> <li>Reports continuous sadness and misery</li> </ul>                                                |
| <ul style="list-style-type: none"> <li>Placid - only reflecting inner tension</li> </ul>                                 | <ul style="list-style-type: none"> <li>Occasional feelings of edginess and inner tension</li> </ul>                         | <ul style="list-style-type: none"> <li>Continuous feelings of inner tension/ intermittent panic</li> </ul>                                  | <ul style="list-style-type: none"> <li>Unrelenting dread or anguish, overwhelming panic</li> </ul>                                     |
| <ul style="list-style-type: none"> <li>Sleeps as usual</li> </ul>                                                        | <ul style="list-style-type: none"> <li>Slight difficulty dropping off to sleep</li> </ul>                                   | <ul style="list-style-type: none"> <li>Sleep reduced or broken by at least two hours</li> </ul>                                             | <ul style="list-style-type: none"> <li>Less than two or three hours sleep</li> </ul>                                                   |
| <ul style="list-style-type: none"> <li>Normal or increased appetite</li> <li>No difficulties in concentrating</li> </ul> | <ul style="list-style-type: none"> <li>Slightly reduced appetite</li> <li>Occasional difficulty in concentrating</li> </ul> | <ul style="list-style-type: none"> <li>No appetite - food is tasteless</li> <li>Difficulty concentrating and sustaining thoughts</li> </ul> | <ul style="list-style-type: none"> <li>Needs persuasion to eat</li> <li>Unable to read or converse without great initiative</li> </ul> |
| <ul style="list-style-type: none"> <li>No difficulty starting everyday activities</li> </ul>                             | <ul style="list-style-type: none"> <li>Mild difficulties starting everyday activities</li> </ul>                            | <ul style="list-style-type: none"> <li>Difficulty starting simple, everyday activities</li> </ul>                                           | <ul style="list-style-type: none"> <li>Unable to do anything without help</li> </ul>                                                   |
| <ul style="list-style-type: none"> <li>Normal interest in surroundings &amp; friends</li> </ul>                          | <ul style="list-style-type: none"> <li>Reduced interest in surroundings &amp; friends</li> </ul>                            | <ul style="list-style-type: none"> <li>Loss of interest in surroundings and friends</li> </ul>                                              | <ul style="list-style-type: none"> <li>Emotionally paralyzed, inability to feel anger, grief or pleasure</li> </ul>                    |
| <ul style="list-style-type: none"> <li>No thoughts of self-reproach, inferiority</li> </ul>                              | <ul style="list-style-type: none"> <li>Mild thoughts of self-reproach, inferiority</li> </ul>                               | <ul style="list-style-type: none"> <li>Persistent self-accusations, self-reproach</li> </ul>                                                | <ul style="list-style-type: none"> <li>Delusions of ruin, remorse or unredeemable sin</li> </ul>                                       |
| <ul style="list-style-type: none"> <li>No suicidal ideation</li> </ul>                                                   | <ul style="list-style-type: none"> <li>Fleeting suicidal thoughts</li> </ul>                                                | <ul style="list-style-type: none"> <li>Suicidal thoughts are common</li> </ul>                                                              | <ul style="list-style-type: none"> <li>History of severe depression and/or active preparations for suicide</li> </ul>                  |

| EPDS 0-8                                                                                                                                                                                   | EPDS 9-13                                                                                                                                                                                  | EPDS 14-18                                                                                                                                                                                 | EPDS ≥19                                                                                                                                                                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>LIMITED TO NO SYMPTOMS</b>                                                                                                                                                              | <b>MILD SYMPTOMS</b>                                                                                                                                                                       | <b>MODERATE SYMPTOMS</b>                                                                                                                                                                   | <b>SEVERE SYMPTOMS</b>                                                                                                                                                                     |
|                                                                                                                                                                                            |                                                                                                                                                                                            | <ul style="list-style-type: none"> <li>Consider inpatient hospitalization when safety or ability to care for self is a concern</li> </ul>                                                  | <ul style="list-style-type: none"> <li>Consider inpatient hospitalization when safety or ability to care for self is a concern</li> </ul>                                                  |
|                                                                                                                                                                                            | <ul style="list-style-type: none"> <li>Consider medication</li> </ul>                                                                                                                      | <ul style="list-style-type: none"> <li>Strongly consider medication</li> </ul>                                                                                                             | <ul style="list-style-type: none"> <li>Strongly consider medication</li> </ul>                                                                                                             |
| <ul style="list-style-type: none"> <li>Therapy for mother</li> <li>Dyadic therapy for mother/baby</li> </ul>                                                                               | <ul style="list-style-type: none"> <li>Therapy for mother</li> <li>Dyadic therapy for mother/baby</li> </ul>                                                                               | <ul style="list-style-type: none"> <li>Therapy for mother</li> <li>Dyadic therapy for mother/baby</li> </ul>                                                                               | <ul style="list-style-type: none"> <li>Therapy for mother</li> <li>Dyadic therapy for mother/baby</li> </ul>                                                                               |
| <ul style="list-style-type: none"> <li>Community/social support (including support groups)</li> </ul>                                                                                      | <ul style="list-style-type: none"> <li>Community/social support (including support groups)</li> </ul>                                                                                      | <ul style="list-style-type: none"> <li>Community/social support (including support groups)</li> </ul>                                                                                      | <ul style="list-style-type: none"> <li>Community/social support (including support groups)</li> </ul>                                                                                      |
| <ul style="list-style-type: none"> <li>Consider as augmentation: Complementary/ Alternative therapies (bright light therapy, Omega-3 fatty acids, acupuncture, folate, massage)</li> </ul> | <ul style="list-style-type: none"> <li>Consider as augmentation: Complementary/ Alternative therapies (bright light therapy, Omega-3 fatty acids, acupuncture, folate, massage)</li> </ul> | <ul style="list-style-type: none"> <li>Consider as augmentation: Complementary/ Alternative therapies (bright light therapy, Omega-3 fatty acids, acupuncture, folate, massage)</li> </ul> | <ul style="list-style-type: none"> <li>Consider as augmentation: Complementary/ Alternative therapies (bright light therapy, Omega-3 fatty acids, acupuncture, folate, massage)</li> </ul> |
| <ul style="list-style-type: none"> <li>Support with dysregulated baby; crying, sleep, feeding problems</li> <li>Physical activity</li> </ul>                                               | <ul style="list-style-type: none"> <li>Support with dysregulated baby; crying, sleep, feeding problems</li> <li>Physical activity</li> </ul>                                               | <ul style="list-style-type: none"> <li>Support with dysregulated baby; crying, sleep, feeding problems</li> <li>Physical activity</li> </ul>                                               | <ul style="list-style-type: none"> <li>Support with dysregulated baby; crying, sleep, feeding problems</li> <li>Physical activity</li> </ul>                                               |
| <ul style="list-style-type: none"> <li>Self-care (sleep, hygiene, healthy diet)</li> </ul>                                                                                                 | <ul style="list-style-type: none"> <li>Self-care (sleep, hygiene, healthy diet)</li> </ul>                                                                                                 | <ul style="list-style-type: none"> <li>Self-care (sleep, hygiene, healthy diet)</li> </ul>                                                                                                 | <ul style="list-style-type: none"> <li>Self-care (sleep, hygiene, healthy diet)</li> </ul>                                                                                                 |

<sup>1</sup>Information adapted from: Montgomery SA, Asberg M: A new depression scale designed to be sensitive to change. *British Journal of Psychiatry* 134:382-389, 1979

**Limited or no symptoms of depression**

**Severe symptoms of depression**

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## Summary of Emotional Complications During Pregnancy and the Postpartum Period

|                                 | Baby Blues                                                                                                                                                                                                                                                                                                                                          | Perinatal Depression                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Perinatal Anxiety                                                                                                                                                                                          | Posttraumatic Disorder (PTSD)                                                                                                                                                                       | Obsessive-Compulsive Disorder                                                                                                                                                                            | Postpartum Psychosis                                                                                                                                                                                                                                                                                                                            |
|---------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is it?</b>              | Common and temporary experience right after childbirth when a new mother may have sudden mood swings, feeling very happy, then very sad, or cry for no apparent reason.                                                                                                                                                                             | Depressive episode that occurs during pregnancy or within a year of giving birth.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | A range of anxiety disorders, including generalized anxiety, panic, social anxiety and PTSD, experienced during pregnancy or the postpartum period.                                                        | Distressing anxiety symptoms experienced after traumatic events(s).                                                                                                                                 | Intrusive repetitive thoughts that are scary and do not make sense to mother/expectant mother. Rituals (e.g., counting, cleaning, hand washing). May occur with or without depression.                   | Very rare and serious. Sudden onset of psychotic symptoms following childbirth (increased risk with bipolar disorder). Usually involves poor insight about illness/symptoms, making it extremely dangerous.                                                                                                                                     |
| <b>When does it start?</b>      | First week after delivery. Peaks 3-5 days after delivery and usually resolves 10-12 days postpartum.                                                                                                                                                                                                                                                | Most often occurs in the first 3 months postpartum. May begin after weaning baby or when menstrual cycle resumes.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Immediately after delivery to 6 weeks postpartum. Occasionally begins after weaning baby or when menstrual cycle resumes.                                                                                  | May be present before pregnancy/birth. Can present as a result of traumatic birth. Underlying PTSD can also be worsened by traumatic birth.                                                         | 1 week to 3 months postpartum. Occasionally begins after weaning baby or when menstrual cycle resumes. May also occur in pregnancy.                                                                      | Typically presents rapidly after birth. Onset is usually between 2 – 12 weeks after delivery. Watch carefully if sleep deprived for ≥48 hours.                                                                                                                                                                                                  |
| <b>Risk factors</b>             | Life changes, lack of support and/or additional challenges (difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.                                                                                                                                          | Life changes, lack of support and/or additional challenges (difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Life changes, lack of support and/or additional challenges (difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems. | Lack of partner support, elevated depression symptoms, more physical problems since birth, less health promoting behaviors. Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems. | Family history of OCD, other anxiety disorders. Depressive symptoms. Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.                                                             | Bipolar disorder, history of psychosis, history of postpartum psychosis (80% will relapse), family history of psychotic illness, sleep deprivation, medication discontinuation for bipolar disorder (especially when done quickly). Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.                                     |
| <b>How long does it last?</b>   | A few hours to a few weeks.                                                                                                                                                                                                                                                                                                                         | 2 weeks to a year or longer. Symptom onset may be gradual.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | From weeks to months to longer.                                                                                                                                                                            | From 1 month to longer.                                                                                                                                                                             | From weeks to months to longer.                                                                                                                                                                          | Until treated.                                                                                                                                                                                                                                                                                                                                  |
| <b>How often does it occur?</b> | Occurs in up to 85% of women.                                                                                                                                                                                                                                                                                                                       | Occurs in up to 19% of women.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Generalized anxiety occurs in 6-8% in first 6 months after delivery. Panic disorder occurs in .5-3% of women 6-10 weeks postpartum. Social anxiety occurs in 0.2-7% of early postpartum women.             | Occurs in 2-15% of women. Presents after childbirth in 2-9% of women.                                                                                                                               | May occur in up to 4% of women.                                                                                                                                                                          | Occurs in 1-2 or 3 in 1,000 births.                                                                                                                                                                                                                                                                                                             |
| <b>What happens?</b>            | Women experience dysphoric mood, crying, mood lability, anxiety, sleeplessness, loss of appetite, and irritability.<br><br>Postpartum depression is independent of blues, but blues is a risk factor for postpartum depression.                                                                                                                     | Change in appetite, sleep, energy, motivation, and concentration. May experience negative thinking including guilt, hopelessness, helplessness, and worthlessness. May also experience suicidal thoughts and evolution of psychotic symptoms.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Fear and anxiety, panic attacks, shortness of breath, rapid pulse, dizziness, chest or stomach pains, fear of detachment/doom, fear of going crazy or dying. May have intrusive thoughts.                  | Change in cognition, mood, arousal associated with traumatic event(s) and avoidance of stimuli associated with traumatic event.                                                                     | Disturbing repetitive thoughts (which may include harming baby), adapting compulsive behavior to prevent baby from being harmed (secondary to obsessional thoughts about harming baby that scare women). | Mood fluctuation, confusion, marked cognitive impairment. Bizarre behavior, insomnia, visual and auditory hallucinations and unusual (e.g. tactile and olfactory) hallucinations. May have moments of lucidity. <b>May include altruistic delusions about infanticide and/or homicide and/or suicide that need to be addressed immediately.</b> |
| <b>Resources and treatment</b>  | May resolve naturally. Resources include support groups, psycho-education (see MCPAP for Moms website and materials for detailed information) and sleep hygiene (asking/accepting other help during nighttime feedings). Address infant behavioral dysregulation -crying, sleep, feeding problems- in context of perinatal emotional complications. | For depression, anxiety, PTSD and OCD, treatment options include individual therapy, dyadic therapy for mother and baby, and medication. Resources include support groups, psycho-education, and complementary and alternative therapies including exercise and yoga. Encourage self-care including healthy diet and massage. Encourage engagement in social and community supports (including support groups) (see MCPAP for Moms website and materials for detailed resources). Encourage sleep hygiene and asking/accepting help from others during nighttime feedings). Address infant behavioral dysregulation -crying, sleep, feeding problems- in context of perinatal emotional complications.<br><br>Additional complementary and alternative therapies options for depression include bright light therapy, Omega-3, fatty acids, acupuncture and folate. |                                                                                                                                                                                                            |                                                                                                                                                                                                     |                                                                                                                                                                                                          | <b>Requires immediate psychiatric help. Hospitalization usually necessary.</b> Medication is usually indicated. If history of postpartum psychosis, preventative treatment is needed in subsequent pregnancies. Encourage sleep hygiene for prevention (e.g. consistent sleep/wake times, help with feedings at night).                         |

<sup>1</sup> Adapted from Susan Hickman, Ph.D., Director of the Postpartum Mood Disorder Clinic, San Diego; Valerie D. Raskin, M.D., Assistant Professor of Clinical Psychiatry at the University of Chicago, IL, ("Parents" September 1996)

<sup>2</sup> O'Hara MW, Wisner KL. Perinatal mental illness: Definition, description and aetiology. Best Pract Res Clin Obstet Gynaecol. 2013 Oct 7; pii: S1521-6934(13)00133-8. doi: 10.1016/j.bpobgyn.2013.09.002. [Epub ahead of print]

MCPAP for Moms: Promoting maternal mental health during and after pregnancy  
 Revision 10.10.17

www.mcpapformoms.org  
 Tel: 855-Mom-MCPAP (855-666-6272)

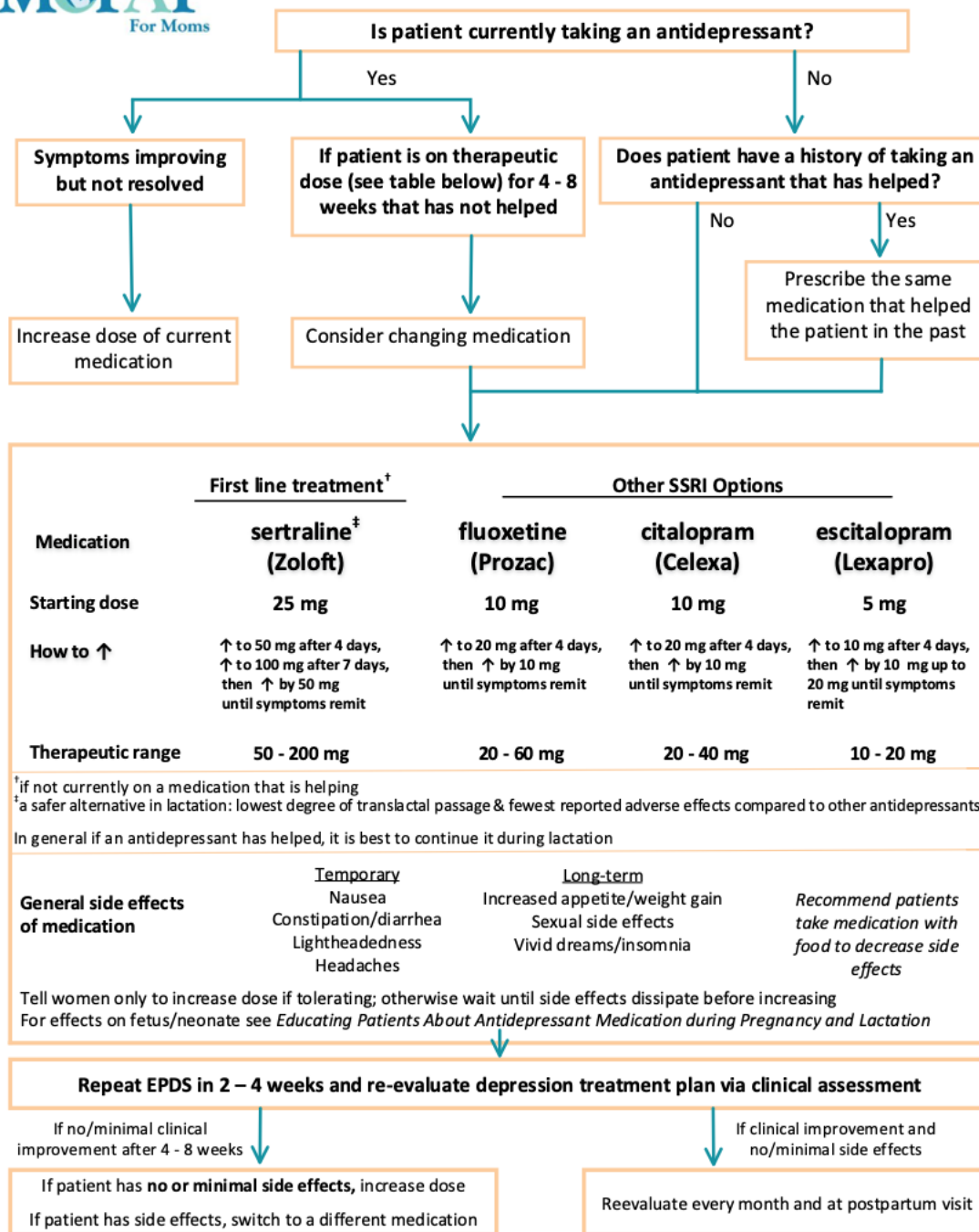
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 Funding provided by the Massachusetts Department of Mental Health

## Recommended Steps before Beginning Antidepressant Medication Algorithm

(Discussion should include yet not be limited to the below)

| <b>Counsel patient about antidepressant use:</b> <ul style="list-style-type: none"> <li>No decision regarding whether to use antidepressants during pregnancy is perfect or risk free</li> <li>SSRIs are among the best studied class of medications during pregnancy</li> <li>Both medication and non-medication options should be considered</li> <li>Encourage non-medication treatments (e.g., psychotherapy) in addition to medication treatment or as an alternative when clinically appropriate</li> </ul> |                                                                                                                                                                                                                                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Risks of antidepressant use during pregnancy                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Risks of under treatment or no treatment of depression during pregnancy                                                                                                                                                                                                            |
| <ul style="list-style-type: none"> <li>➤ Small, but inconsistent increased risk of birth defects when taken in first trimester, particularly with paroxetine</li> <li>➤ The preponderance of evidence does not suggest birth complications</li> <li>➤ Studies do not suggest long-term neurobehavioral effects on children</li> <li>➤ Possible transient neonatal symptoms</li> </ul>                                                                                                                             | <ul style="list-style-type: none"> <li>➤ Increases the risk of postpartum depression</li> <li>➤ Birth complications</li> <li>➤ Can make it harder for moms to take care of themselves and their babies</li> <li>➤ Can make it harder for moms to bond with their babies</li> </ul> |
| <ul style="list-style-type: none"> <li><i>If pregnant: In your situation, the benefits of taking an antidepressant outweigh the chance of the things we just discussed.</i></li> <li><i>If lactating: SSRIs and some other antidepressants are considered a reasonable treatment option during breastfeeding. The benefits of breastfeeding while taking antidepressants generally outweigh the risks.</i></li> </ul>                                                                                             |                                                                                                                                                                                                                                                                                    |
| <b>SEE ANTIDEPRESSANT TREATMENT ALGORITHM ON BACK FOR GUIDELINES RE: PRESCRIBING MEDICATIONS</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                    |

## Antidepressant Treatment Algorithm

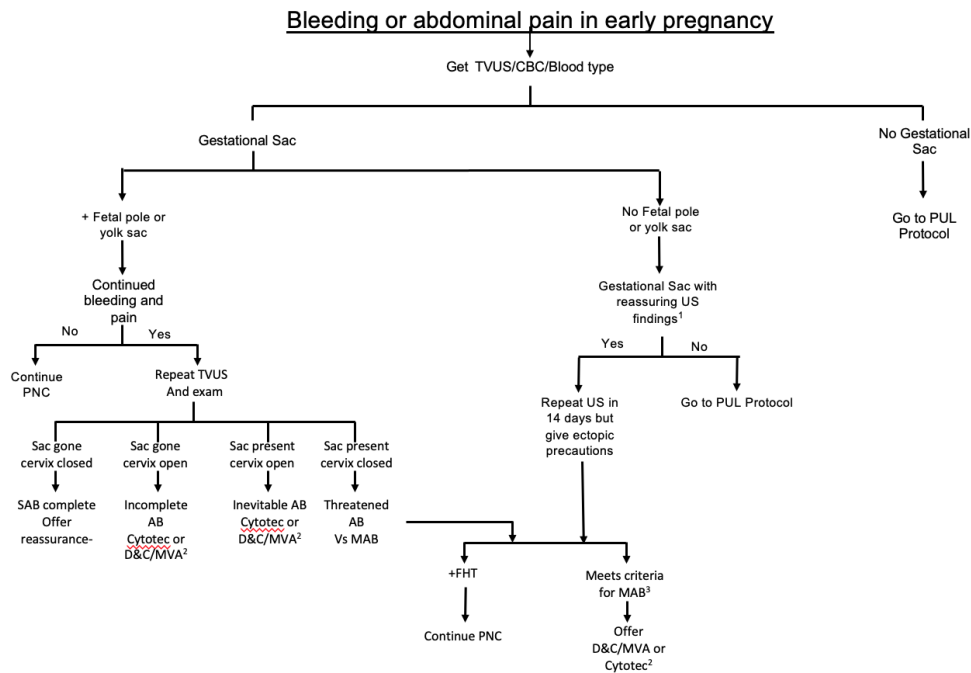


### 3. Gynecology

#### 3.a. Pregnancy of unknown location

Generally, PUL should be sent to triage for lab work, but providers may choose to manage it themselves. If provider chooses to manage the labs themselves, they are responsible for making the patient follow up. See Ectopic precautions handout. Dot phrase .STCECTOPICPRECUATIONS

#### PUL Algorithm (2/2021)

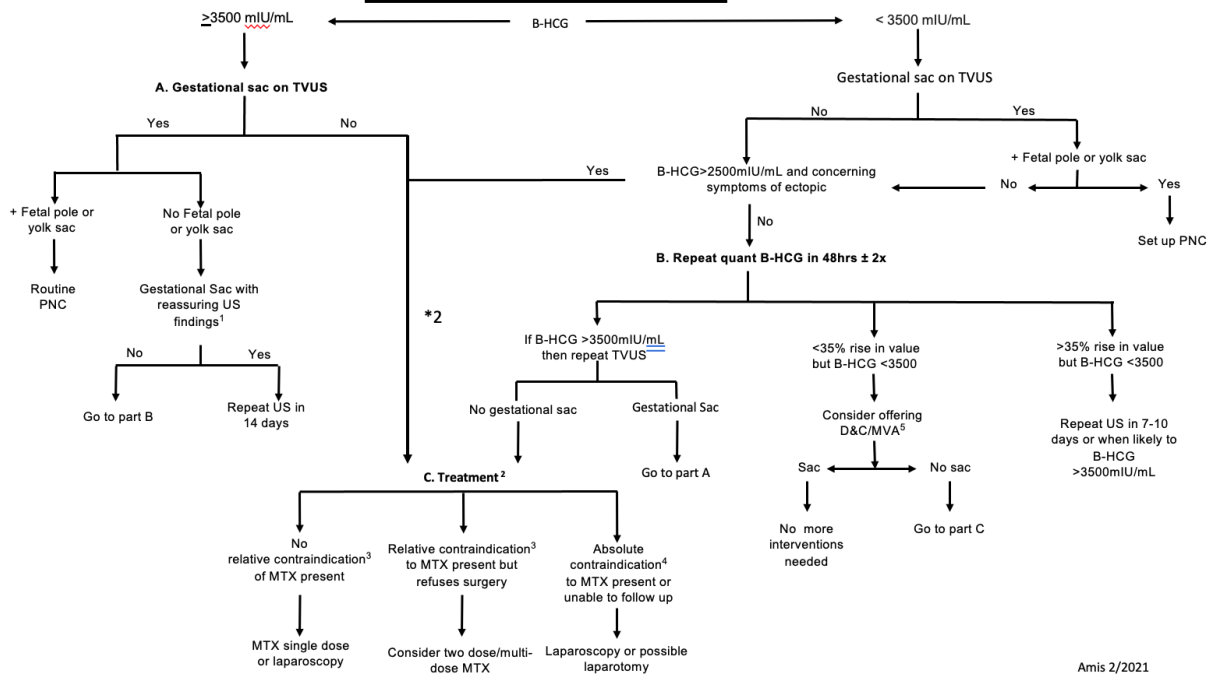


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1. Positive US findings: double decdua signs and eccentrally located gestational sac
2. B-HCG does not need to be followed. Endometrial strip thickness is not predictive of retained products, only presence or absence of sac is. Patients should be treated clinical based on vaginal bleeding and cervical exam.
3. Criteria for MAB:
  - CRL greater than 7mm with no FHT
  - Mean sac diameter of 25mm or greater with no fetal pole
  - Absence of embryo with heartbeat 2 weeks or more after a scan that showed a gestational sac without a yolk sac
  - Absence of embryo with heartbeat 11 days or more after a scan that showed a gestational sac with a yolk sac

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## Pregnancy of Unknown location



1. Positive US findings: double decidua signs and eccentrally located gestational sac
2. If high suspicion for complete AB and benign abdomen, may repeat BHCG in 24-48 hours. Complete AB is confirmed if BHCG drops >50%. If does not drop, consider proceeding with treatment.
3. Relative contraindications:
  - BHCG > 5000
  - adnexal mass greater than 4cm
  - Fetal heart beat
  - refusal to accept blood transfusion
4. Absolute contraindications:
  - Intrauterine pregnancy
  - Evidence of immunodeficiency
  - Moderate to severe anemia
  - Leukopenia or thrombocytopenia
  - Sensitivity to methotrexate
  - Active pulmonary disease including moderate to severe asthma
  - Active peptic ulcer disease,
  - Clinically important hepatic dysfunction
  - Clinically important renal dysfunction
  - Breast feeding, ruptured ectopic pregnancy
  - Hemodynamically unstable patient
  - Inability or unwillingness to follow up.
5. Cytotec may be appropriate to give given clinical suspicion but this does not rule out ectopic. Methotrexate may be appropriate but without D&C/MVA will result in excessive use of Methotrexate and Methotrexate-related side effects. Observation with falling BHCG may be appropriate but does not rule out ectopic or prevent rupture. **All of these patients must be followed to BHCG of 0.**

Amis 2/2021

## **References**

Connolly A, Ryan DH, Stuebe AM, *et al.* Reevaluation of discriminatory and threshold levels for serum  $\beta$ -hCG in early pregnancy. Obstet Gynecol. 2013 Jan;121(1):65-70.

Barnhart K, Hummel AC, Sammel MD, *et al.* Use of "2-dose" regimen of methotrexate to treat ectopic pregnancy. Fertil Steril. 2007 Feb;87(2):250-6. Epub 2006 Nov 13.

Doubilet PM, Benson CB, Bourne T, *et al.* Diagnostic Criteria for Nonviable Pregnancy Early in the First Trimester. N Engl J Med. 2013 Oct 10;369(15):1443-51.

Seeber BE, Sammel MD, Guo W, *et al.* Application of redefined human chorionic gonadotropin curves for the diagnosis of women at risk for ectopic pregnancy. Fertil Steril. 2006 Aug;86(2):454-9. Epub 2006 Jun 6

Morse CB, Sammel MD, Shaunik A, *et al.* Performance of human chorionic gonadotropin curves in women at risk for ectopic pregnancy: exceptions to the rules. Fertil Steril. 2012 Jan;97(1):101-6.e2

## **ACOG Practice Bulletins**

# 191 Tubal Ectopic Pregnancy

# 150 Early Pregnancy Loss

# **Pregnancy of Unknown Location**

## **What is a pregnancy of unknown location?**

A pregnancy of unknown location is diagnosed when someone has pain and/or bleeding, a positive pregnancy test and nothing on ultrasound. It can be an early normal pregnancy, the beginning of a miscarriage, or an ectopic pregnancy. It is important to figure out what kind of pregnancy it is because ectopic pregnancies can be life threatening if not diagnosed and treated.

## **What is an ectopic pregnancy?**

Ectopic pregnancy is when a pregnancy starts growing outside of the uterus. Most often the pregnancy is in the fallopian tube. It is rare and occurs in about 2% of all pregnancies. Usually the symptoms are cramping, pelvic pain and/or bleeding after a positive pregnancy test. Often early pregnancy loss (miscarriage) and sometimes normal pregnancies can cause the same symptoms. If an ectopic pregnancy grows too large it can tear or rupture the tube or other organs causing life-threatening internal bleeding.

## **How is an ectopic pregnancy diagnosed?**

When a woman has pain and or bleeding in the first trimester, her doctor or midwife should order some tests. Usually ectopic pregnancy is diagnosed with a combination of ultrasound and the pregnancy hormone B-HCG (often referred to as a Beta level). Often it takes more than one blood tests each 48 hours apart to make the diagnosis.

## **How is ectopic pregnancy treated?**

If an ectopic pregnancy is diagnosed, it can be treated with an injectable medicine called methotrexate or with surgery. Your doctor will discuss with you which is best for you and the risks and benefits of both. If you get the medication methotrexate, you will continue to need to get blood work afterwards for at least a couple of weeks till your B-HCG levels are zero.

## **What are some signs I need to go to the Emergency Room while finding out what kind of pregnancy I have?**

If you have new or worsening pain, you need to be seen by a doctor. If the pain is so bad you cannot walk, shoots to your shoulder, or you pass out, you should go to the nearest emergency room. Otherwise if you start having heavy vaginal bleeding using more than 1 pad/hour, you need to see the doctor. This could be a sign of a miscarriage.

**My follow up:**

My next appointment is \_\_\_\_\_

- at Labor and Delivery Triage on the 4<sup>th</sup> floor of Tampa General Hospital.
- at Genesis Women's Center at Healthpark  
5802 N. 30th Street  
Tampa, FL 33610  
(813) 236-5150
- at my own OB/GYN

Given handout .stcabnormalpregnancy

### **Abnormal pregnancy (5/2021)**

#### **What is an abnormal pregnancy?**

An abnormal pregnancy is a pregnancy that will never result in the birth of a child. This can be diagnosed by ultrasound or by bloodwork depending on how far along the pregnancy is. Given enough time, an abnormal pregnancy will become a miscarriage. On average, miscarriages happen in about 1-2 out of 10 pregnancies but is more common the older you are. It is often due to a chromosome or genetic problem with the pregnancy and there was nothing you could have done to change the outcome.

#### **How is an abnormal pregnancy diagnosed?**

An abnormal pregnancy may cause bleeding or cramping, or no signs at all. Depending on your symptoms, your provider may check a hormone level called BHCG (often referred to as a Beta level). If the numbers do not go up the way it's expected, then you may be diagnosed with an abnormal pregnancy. In other cases, an ultrasound is done showing a pregnancy sac but no embryo (baby) or a embryo without a heartbeat.

#### **How is an abnormal pregnancy treated?**

An abnormal pregnancy does not necessarily need treatment. Most will pass as a miscarriage within 8 weeks. If you do not want to wait that long or do not want to experience a miscarriage, there are options. One option is a medication called Cytotec® or misoprostol to make the miscarriage happen sooner. Your medical provider will look at your ultrasound and health history and see if this is an option for you. The other option is a surgical procedure to remove the pregnancy. This can be done awake with pain medications or asleep in the operating room. When it's done awake it called a manual vacuum aspiration or MVA. When it's done asleep it's called a dilation and curettage or D&C.

#### **What is a normal symptoms of a miscarriage?**

When the pregnancy is passing, bleeding is typically heavy, and you may soak through 2 large pads an hour for 1-2 hours. There may be pink or white tissue in the blood. If the heavy bleeding lasts for more than 2 hours or you feel dizzy, light headed or like you are going to pass out, you should go to the nearest emergency room. Afterwards, you should have lighter bleeding like a period that can last up to 2 weeks. You may also have mild cramping. If you have severe cramping or a fever, contact your doctor or go to the emergency room.

#### **What is medical management of miscarriage?**

Medical management of a miscarriage is when medication is given to help push the pregnancy out of the uterus. The process can be started with a medication called Mifepristone® that stops the pregnancy from growing. Then Cytotec® or misoprostol helps the uterus contract to push out the pregnancy. Cytotec® can also be used alone. Typically, the Cytotec® is placed in the vagina or in the cheeks and within a few hours will start to work. Most women will pass the pregnancy after 1-2 doses. Bleeding and cramping is similar to a miscarriage. Those who do not pass the pregnancy after 1-2 doses, will need a procedure like a D&C or MVA.

#### **What is a manual vacuum aspiration or MVA?**

A manual vacuum aspiration or MVA is a procedure to remove the abnormal pregnancy. Numbing medicine is given in the cervix while you are awake and may have taken other pain medications. Some people choose to take anxiety medication for this procedure; ask your doctor if you would like this. After

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the numbing medicine, a thin tube is put in the uterus with a device that looks like a large syringe attached. This is used to remove the pregnancy. The whole process takes less than 10 minutes. During the procedure you may experience cramping that will quickly get better after the procedure. Either a tissue exam or ultrasound will confirm the pregnancy is removed. Afterwards, light bleeding and cramping is expected for up to 1-2 weeks. If you have heavy bleeding, severe cramps or a fever, contact your doctor or go to the emergency room. If you do choose to take anxiety medication, you will need someone to drive you home.

**What is a dilation and curettage or D&C?**

A dilation and curettage or D&C is similar to an MVA except that it is performed in the operating room while you are asleep. During the procedure you will not feel pain or know what's going on. A thin tube is put in the uterus to remove the pregnancy. When you wake up the procedure will be complete. Afterwards light bleeding and mild cramping is expected for usually a few days but can last a week or two. If you have heavy bleeding, severe cramps or a fever, contact your doctor or go to the emergency room. You will also need someone to drive you home if you choose this procedure.

**What happens after the pregnancy has passed?**

After the pregnancy has passed, you can either start birth control or wait for your next period to try to get pregnant again. Most people who have a miscarriage will go on to have a normal pregnancy the next time. If you have more than one miscarriage in a row, talk to your doctor about what should happen next.

### 2.b.i. Scheduling D&C

Pt diagnosed with missed AB based on ultrasound criteria, has incomplete AB or retained products of conception

Review risks, benefits and alternatives with patient including expectant management, Mifi/Cytotec, D&C and MVA as appropriate.

Give them MAB handout if appropriate (STCABNORMALPREGNANCY).

Send a dot phrase .stcpreopgynDNCMAB to the surgery scheduling pool.

**For attending put “GYN attending of the week” unless you are planning to do the case.**

**CC the chart to the GYN attending to of the week.**

**If there are special concerns for the case, call the attending directly.**

Place GYN Pre op orders under Orders for Admission just like for c-sections or inductions. They will usually only need type and screen and a CBC unless there are other concerns. These can be drawn day of but make sure to tell the patient to get there early. Antibiotic is Doxycycline unless they have an allergy.

**MVA Cheat Sheet**

**Day of Dx:**

Pt diagnosed with missed AB based on ultrasound criteria, has incomplete AB or retained products of conception

Make sure pt does not meet exclusion criteria:

- A) Coagulation disorders, anticoagulant drug therapy
- B) Uterine anomalies unless procedure is scheduled under ultrasound guidance
- C) Pelvic inflammatory disease/cervicitis
- D) Extreme anxiety that would make it difficult to successfully complete the procedure while patient is awake
- E) Any medically unstable comorbidity (i.e. uncontrolled HTN, seizure disorder)
- F) Cervical stenosis
- G) BMI >50 or >350 lbs (can consider only after reviewing with attending physician)
- H) Anemia with hemoglobin less than 9 (can consider only after reviewing with attending physician)

Review risks, benefits and alternatives with patient.

Give them MAB handout if appropriate (STCABNORMALPREGNANCY).

Give them MVA Patient Instructions (STCMVAPTINSTRUCTIONS)

Send prescriptions to the pharmacy

1. Doxycycline 200 mg (preferred) or Azithromycin 1 g Po x1 dose
2. Ibuprofen 800 mg PO x1 dose or instruct OTC
3. Ativan 2-4 mg or Xanax 0.5-1 mg Po x1 if desired
  - **Cannot take till the consent is signed**
  - **Must have a driver to go home**

Notify nurses to schedule pt on appropriate schedule.

Ensure patient has a documented blood type and recent hemoglobin

**Day of:**

Explain procedures and sign consents

Have pt take medications

Do procedure and document (STCMVAPROCEDURE)

Give Rhogam if needed

Make sure they have discharge instructions

## MVA Patient Instructions

You have chosen to have a manual vacuum aspiration or MVA to treat your condition. If this is not what you want, please talk to your provider as there may be other choices.

Before your procedure you will need to pick up your prescriptions and take them a half hour before your appointment.

1. Doxycycline or Azithromycin- this is an antibiotic to prevent infection.
2. Ibuprofen or Tylenol- this will help with the cramping. You can take over the counter. You can take 4 over the counter ibuprofen or one extra strength Tylenol
3. Ativan or Xanax- this is to help relax you. If you choose to use this, **you must see the doctor and sign the consent before you take it. Please come at least a half hour before your appointment to sign the consent and allow time for the medicine to work. You also must have a ride home, as you will not be able to drive after taking this medication.**

After the procedure, light bleeding and cramping is expected for up to 1-2 weeks. For at least 1 week, use pads only. You may resume intercourse when the bleeding has stopped or after a week, whichever is longer.

You may take ibuprofen or Tylenol for pain.

Call your doctor or go to the emergency room if you have any:

- Heavy bleeding more than two pads an hour for two hours in a row
- Severe pain or cramps that does not resolve with ibuprofen or Tylenol
- A fever of 100.4 or higher
- Dizziness or passing out
- Nausea, vomiting or diarrhea for more than 24 hours post procedure
- Overwhelming sadness or depression

# **Protocol: Office MVA for Miscarriage Management**

**SUPPORTIVE DATA:** Manual vacuum aspiration (MVA) in the office is a safe, patient-centered, relatively painless, and cost-effective diagnostic and therapeutic means of evacuating the uterus during first trimester miscarriage

## **INDICATIONS:**

- A) Treatment/completion of missed or incomplete spontaneous abortion in first trimester (<12 weeks)
  - 1. Ensures POC are fully evacuated
  - 2. Controls hemorrhage
  - 3. Evacuates post-partum and post-abortal hematometra

## **RELATIVE CONTRAINDICATIONS:**

- I) Coagulation disorders, anticoagulant drug therapy
- J) Uterine anomalies
- K) Pelvic inflammatory disease/cervicitis
- L) Extreme anxiety
- M) Any medically unstable comorbidity (i.e. uncontrolled HTN, seizure disorder)
- N) Cervical stenosis
- O) BMI >50 and >350 lbs.
- P) Anemia with hemoglobin less than 9

## **EQUIPMENT:**

- Sterile gloves, mask with face shield
- Vaginal speculum (sterile), light source
- Lubricant
- Antiseptic solution
- Container for antiseptic solution, gauze
- Manual vacuum aspirator
- Sterile cannula for aspirator (do not open until size determined by provider)
- Cervical dilator
- Tenaculum
- Ring forceps
- Sterile syringe, spinal needle, 1% Lidocaine
- Long hemostat
- Basin for emptying aspirator (may use container for antiseptic solution)
- Strainer
- Shallow clear glass/pyrex dish and backlight for examining uterine contents
- Container for pathology
- Monsel's solution/Silver nitrate available
- Misoprostol, methergine, ibuprofen
- RhoGAM if indicated

| STEPS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | KEY POINTS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>PREPARATION OF THE PATIENT:</b></p> <ul style="list-style-type: none"> <li>B) Verify patient name and date of birth</li> <li>C) Take vital signs and weight</li> <li>D) Have patient empty bladder and obtain urine sample if indicated</li> <li>E) Explain procedure to patient. Patient should have opportunity to read handouts and ask questions</li> <li>F) Assure patient has a ride home if receiving sedation</li> <li>G) Offer fluids and snacks</li> <li>H) Patient to sign consents prior to medication administration</li> <li>I) Patient to sign Rhogam refusal if indicated</li> <li>J) Administer pre-medication that patient brought to appointment ½-1 hour before procedure               <ul style="list-style-type: none"> <li>1. Doxycycline 200 mg or Azithromycin 1 g</li> <li>2. Ibuprofen 800 mg</li> <li>3. Ativan 2-4 mg or Xanax 0.5-1 mg (patient choice whether/how much to take)</li> <li>4. PRN: hydrocodone/acetaminophen 5/325 mg or oxycodone/acetaminophen 5/325 mg</li> </ul> </li> <li>K) Advise support person of where to sit and their role during procedure</li> <li>L) Prepare patient in procedure room on table with drape</li> </ul> | <p>Fever may be a reason to delay procedure, or arrange for procedure in another facility</p> <p>Ideally, patient will have appointment prior to procedure to discuss pregnancy loss and options. If planning MVA in office, Rx for medications I)1-4 given</p> <p>If patient not pre-sedated and is stable following the procedure, she should be able to drive self</p> <p>Informed consent should be obtained prior to any pre-procedure sedation</p> <p>Ascertain patient's drug sensitivity and/or history of allergy to skin prep, materials and anesthetics prior to administration of local anesthetic</p> |
| <p><b>PROCEDURE:</b></p> <ul style="list-style-type: none"> <li>A) Perform bimanual exam noting size and position of uterus and/or ultrasound</li> <li>B) Inform patient that she may experience cramping during paracervical block, dilation of the cervix and during the procedure</li> <li>C) Place speculum and perform antiseptic prep and paracervical block</li> <li>D) Dilate cervix to admit suction cannula of the appropriate size, usually equal to estimated gestational age of pregnancy</li> <li>E) With gentle traction on the tenaculum, place cannula into cervical os and move cannula</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <p>Several paracervical block recipes and techniques exist</p> <p>Use similarly sized dilator/cannula as the pregnancy measures on ultrasound or weeks gestation by LNMP/uterine sizing if no US</p>                                                                                                                                                                                                                                                                                                                                                                                                               |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
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| <p>fundus; then withdraw it slightly</p> <p>F) Prepare MVA by generating vacuum before connecting to already placed cannula</p> <p>G) Connect MVA syringe to cannula by gently pulling cannula toward you and firmly fixing within nose of MVA</p> <p>H) With gentle traction on tenaculum, adjust cannula back to optimal placement in the fundus</p> <p>I) Release the buttons on the aspirator to transfer the vacuum through the cannula into the uterus</p> <p>J) For uterine evacuation, evacuate the contents of the uterus by rotating the cannula 360 degrees several times or moving the cannula in and out until no more tissue is coming into the cannula</p> <p>K) Move lower into the body of the uterus and lower uterine segment, turning the cannula slightly with each pass to feel for the gritty texture throughout the uterine cavity</p> <p>L) For endometrial sampling, movement of the cannula gently back and forth along the anterior, posterior and lateral uterine walls should provide sufficient tissue for diagnosis</p> <p>M) Empty syringe by detaching it from cannula and emptying into a sterile basin - Repeat earlier steps until all uterine contents removed; can be 2-3 times</p> <p>N) For endometrial sampling, collect aspirated material in formalin and send specimen to pathology</p> <p>O) For uterine evacuation, inspect aspirated tissue, if not conclusive, consider re-aspiration and/or ultrasound</p> <p>P) If indicated, send products of conception to pathology in a specimen cup – doesn't require any medium</p> <p>Q) Order methergine/misoprostol as needed</p> <p>R) Order Rhogam if indicated</p> <p><b>POST PROCEDURE CARE:</b></p> <p>A) Ask the patient to remain supine for a few moments following the procedure; place chux</p> <p>B) May elevate head of table after a few minutes; assess for vasovagal reaction</p> | <p>If cannula becomes clogged, ease it back toward, but not through the external cervical os. This movement will often unclog the cannula. If it does not, cannula can be removed and tissue removed with sterile forceps or gauze. May re-use if it has not touched any non-sterile surface, otherwise employ a new sterile cannula.</p> <p>Signs that the uterus is empty include gritty sensation felt as cannula passes over the surface of the evacuated uterus, uterus contracts around or "grips" the cannula, and/or patient notes pain as uterus contracts.</p> |
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| <ul style="list-style-type: none"> <li>C) When patient feels ready, may dress and prepare for recovery</li> <li>D) During this time, offer fluids and snack, heating pad for abdomen</li> <li>E) Assess vital signs, BP every 15 minutes. Assess amount of bleeding at same intervals.</li> <li>F) Review discharge instructions, contraceptive education, warning signs, and when to call</li> <li>G) Administer Rhogam/depo if indicated</li> <li>H) Assess for painful uterine cramping</li> <li>I) Ask patient to go to restroom - if heavy bleeding is not observed and the patient is stable, may be discharged after 30 minutes if patient received sedation, 15 minutes if not</li> <li>J) Patient to have follow up appointment in 1-2 weeks scheduled</li> </ul> <p><b>DOCUMENTATION:</b></p> <ul style="list-style-type: none"> <li>A) Document procedure and patient's tolerance</li> <li>B) For uterine evacuation, document visual inspection of aspirated uterine contents</li> <li>C) Document vital signs and patients pain level before, during and after procedure</li> <li>D) Document that patient received discharge instructions and verbalized understanding, and plan for follow up care</li> </ul> <p><b>PATIENT EDUCATION:</b></p> <ul style="list-style-type: none"> <li>A) Take medication as directed, ibuprofen every 6-8 hours and narcotic as needed</li> <li>B) Pads should be used for 1 week</li> <li>C) Patient should report the following: <ul style="list-style-type: none"> <li>a. Fever with temperature higher than 100.4°F or 38°C 24 hours post procedure</li> <li>b. Severe cramping not relieved by medication, especially more than 24 hours post procedure</li> <li>c. Bleeding and soaking through more than a pad an hour</li> <li>d. Dizziness or syncope</li> <li>e. Nausea, vomiting or diarrhea for more than 24 hours post procedure</li> <li>f. Overwhelming sadness or depression</li> </ul> </li> <li>D) Give written aftercare instructions including how to get help after hours</li> </ul> | <p>For endometrial sampling, inform patient about how she will be contacted with results.</p> <p>For endometrial sampling, sexual relations may be resumed earlier, in 3 days unless bleeding is heavier.</p> <p>MVA in Office Procedure Smartphrase: STCMVAPROCEDURE</p> |
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#### References

- A) University of Washington Sample Protocols 2014
- B) IPAS Gynecological Aspiration System Instruction Manual

## Policy and Procedure Manual

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USF OBGYN Outpatient Clinics (STC, BHP, MOR, WCA)

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**SUBJECT:** Medical Management of First Trimester Spontaneous Abortion up to 11 weeks gestation with Mifepristone (Mifeprex®) and Misoprostol (Cytotec®).

**PURPOSE:** To increase chances of expulsion of a nonviable pregnancy in hopes of avoiding a surgical evacuation of uterine contents.

**DEFINITION:** None.

**POLICY:**

A. Mifepristone is a progesterone receptor antagonist. Misoprostol has prostaglandin effects. High doses will cause uterine contractions and increase chances of expulsion. Use of this combination for medical management of miscarriage maximizes the chances of expulsion of the non-viable pregnancy. This will provide an alternative to waiting for miscarriage (expectant management) and to surgical suction (MVA or D&C).

B. Patients who have the following are not considered candidates for medical treatment of miscarriage:

1. Prescribed anti-clotting medication.
2. Severe heart, liver, kidney disease, seizure history or inflammatory bowel disease.
4. Unable to return for follow-up visits or no access to backup medical care.
5. Have immune deficiency secondary to medication or medical condition. Long-standing use of corticosteroids.
6. Have a Hemoglobin less than 9.5 or Hematocrit less than 29.
7. Allergy to mifepristone or misoprostol.
8. Desires surgical management

## Medical Management of First Trimester Miscarriage with Mifepristone and Misoprostol.

### EQUIPMENT:

Provider Check List (Appendix A)

Nursing Checklist-Medical Management Miscarriage with Mifepristone/Misoprostol in the electronic medical record (EMR). Appendix B

Patient Education Materials:

Medical management of miscarriage using mifepristone/misoprostol instructions.

(Smartphrase: .stcepfmifeptinfo) Appendix C).

Signed copy of “Mifepristone Patient agreement.”

Lab results available in the EMR:

ABO RH

CBC (within the last 2 weeks)

Coagulation studies if last menstrual period (LMP) dating and ultrasound dating is greater than 3 weeks discrepant (PT/PTT/INR/fibrinogen)

Ultrasound result demonstrating non-viable pregnancy

**Table 2. Guidelines for Transvaginal Ultrasonographic Diagnosis of Pregnancy Failure in a Woman with an Intrauterine Pregnancy of Uncertain Viability.\***

| Findings Diagnostic of Pregnancy Failure                                                                   | Findings Suspicious for, but Not Diagnostic of, Pregnancy Failure†                                                                 |
|------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|
| Crown–rump length of $\geq 7$ mm and no heartbeat                                                          | Crown–rump length of $< 7$ mm and no heartbeat                                                                                     |
| Mean sac diameter of $\geq 25$ mm and no embryo                                                            | Mean sac diameter of 16–24 mm and no embryo                                                                                        |
| Absence of embryo with heartbeat $\geq 2$ wk after a scan that showed a gestational sac without a yolk sac | Absence of embryo with heartbeat 7–13 days after a scan that showed a gestational sac without a yolk sac                           |
| Absence of embryo with heartbeat $\geq 11$ days after a scan that showed a gestational sac with a yolk sac | Absence of embryo with heartbeat 7–10 days after a scan that showed a gestational sac with a yolk sac                              |
|                                                                                                            | Absence of embryo $\geq 6$ wk after last menstrual period                                                                          |
|                                                                                                            | Empty amnion (amnion seen adjacent to yolk sac, with no visible embryo)                                                            |
|                                                                                                            | Enlarged yolk sac ( $> 7$ mm)                                                                                                      |
|                                                                                                            | Small gestational sac in relation to the size of the embryo ( $< 5$ mm difference between mean sac diameter and crown–rump length) |

\* Criteria are from the Society of Radiologists in Ultrasound Multispecialty Consensus Conference on Early First Trimester Diagnosis of Miscarriage and Exclusion of a Viable Intrauterine Pregnancy, October 2012.

† When there are findings suspicious for pregnancy failure, follow-up ultrasonography at 7 to 10 days to assess the pregnancy for viability is generally appropriate.

## PROCEDURE:

1. Patient will have had ultrasound evaluation that confirmed non-viable pregnancy. Ectopic pregnancy must be excluded.
2. The provider will discuss treatment options as appropriate, including expectant management, medical management, or a surgical procedure. Medical management with Misoprostol/Mifepristone will be offered to women with **nonviable** gestations between the fifth and 11th weeks of pregnancy with confirmed non-viable pregnancy based on the Society of Radiologists in Ultrasound Guidelines for findings diagnostic of early pregnancy loss (L<sub>1</sub>). This should not be offered if having severe vaginal bleeding.
3. Document Blood work:
  1. Type and screen
  2. CBC
  3. PT/PTT/INR and fibrinogen- If LMP dating and ultrasound dating is greater than 3 weeks discrepant
  4. HCG level if unable to return for ultrasound follow up
4. If medical management is chosen, provider will complete check list and place medication orders in EMR.
  1. Mifepristone 200 mg po once. This will be administered by clinic nursing staff after Patient Agreement is signed and nursing and provider check lists are completed
    - i. Review and have the patient sign the "Patient Agreement Form", which is available at <https://www.earlyoptionpill.com/wp-content/uploads/2016/03/Patient-Agreement-Form-March2016-1.pdf>.
    - ii. A copy of this signed agreement will be given to the patient and another will be scanned into the EMR.
    - iii. List time of mifepristone administration in patient instruction sheet. (Smartphrase .EPFMIFEPTINFO).
    - iv. Signed Checklist will be scanned in to the EMR
  2. Misoprostol 200 mcg, 4 Tabs PV x1. Repeat if no bleeding after 24 hours. #4, refill one.
  3. For pain:
    - i. Ibuprofen 800 mg po q 6-8 hours prn first line for pain or cramping #30 with no refills.
    - ii. One of the following narcotic prescriptions:
      1. Hydrocodone/acetaminophen (Vicodin®) Take 1- 2 PO q 4-6 hr PRN second line for pain control. #6 with no refills. (Preferred)
      - OR
      2. Oxycodone (Roxicodone®) 5 mg Take 1-2 PO q 4 hr PRN pain. #4 with no refills. (Alternate)
  4. One of the following antinausea medications:
    - i. Oral Ondansetron ODT (Zofran®) 4-8mg PO q6 Hr PRN nausea, #10, no refills
    - ii. Oral Promethazine (Phenergan®) 25mg PO q6hours, #10, no refills

5. Instruct patient on use misoprostol. First, the patient should wash hands thoroughly and then dry them with a clean towel. 24-48 hours after administration of mifepristone, the misoprostol 800 mcg should be inserted as high into the vagina as possible. Do not insert while sitting on the toilet. Lay down for 30 minutes after placement.
6. Instruct patient to expect to have some heavy bleeding and cramping until tissue is passed. If patient has not seen any tissue or bleeding, she should administer the second 800 micrograms dose of misoprostol approximately 24 hours after the initial dose. Schedule the patient for a follow-up call to be initiated by the clinic staff one business day after the initial dose and again one business day after a second dose, if a second dose is needed.
7. All patients should be scheduled to return to the clinic in one week for an ultrasound to confirm absence of gestational sac. If patients are unable to return, they should have a repeat hcg performed at weekly intervals until negative.
8. Offer work excuse if needed.

#### **PRECAUTIONS, CONSIDERATIONS, AND OBSERVATIONS:**

1. If Rh is not known at the time of the patient's visit and she is Rh negative, she will need to have RhoGam® or MicRhoGam® arranged through her local physician's office or return to clinic within 72 hours for RhoGam® injection.
2. Plan for emergency care:  
Since approximately 10-15% of patients receiving mifepristone/misoprostol will require a surgical intervention, patients and staff must plan for this possibility at the time misoprostol is prescribed. If it will be difficult for patient to get transportation for emergency care or to find a local caregiver, she is not a suitable candidate for medical management.
4. Plan for care/support during miscarriage:  
Patients need to be expecting painful uterine cramping, heavy bleeding with large clots to begin approximately 2-4 hours after receiving misoprostol. Help them to anticipate needs (i.e., who will be with them, who could be contacted for transportation if emergency care is needed, who will care for small children). Outline in the patient handout the guidelines for when they need to contact caregiver or go to the emergency room.

## REFERENCES:

- L<sub>1</sub> American College of Obstetricians and Gynecologists. (2015) Early Pregnancy Loss. In *ACOG Practice Bulletin No 150*. 125 (5): 1258-67. Washington, DC.
- L<sub>2</sub> Schreiber CA, Creinin MD, Atrio J, Sonalkar S, Ratcliffe SJ, Barnhart KT. (2018). Mifepristone pretreatment for medical management of early pregnancy loss. *NEJM*. 378(23): 2161-2170.
- L<sub>3</sub> Zhang J, Gilles JM, Barnhart K, Creinin MD, Westhoff C, Frederick MM; National Institute of Child Health Human Development (NICHD) Management of early pregnancy failure trial. (2005). A comparison of medical management with misoprostol and surgical management for early pregnancy failure. *NEJM*. 353(8): 761-9.
- L<sub>4</sub> Trinder J, Brocklehurst P, Porter R, Read M, Vyas S, Smith L. (2006). Management of miscarriage: expectant, medical or surgical? Results of the randomized controlled trial (MIST trial). *BJOG*. 335(7552):1235-40.
- L<sub>5</sub> Kim C, Barnard S, Neilson J, Hickey M, Vazquez JC, Dou L. (2017). Medical treatments for incomplete miscarriage. *Cochrane Database of Systematic Reviews*, Issue 1. Art. No.: CD007223. DOI: 10.1002/14651858.CD007223.pub4. Retrieved 9/13/18.
- L<sub>6</sub> Neilson JP, Hickey M and Vazquez JC. (2006). Medical treatment for early fetal death (less than 24 weeks). *Cochrane Database of Systematic Reviews*, Issue 3. Art. No.:CD002253. Retrieved 9/13/18.
- L<sub>7</sub> National Abortion Federation and Consortium. NAF Fact sheet, *Fast Facts About Mifepristone*”, adapted from Planned Parenthood Federation of America Inc (PPFS) Web site: [www.plannedparenthood.org/library/facts/medabort\\_fact.html](http://www.plannedparenthood.org/library/facts/medabort_fact.html). Retrieved 1/29/16.
- L<sub>8</sub> Danco Laboratories, LLC. (2016, March). *Patient agreement form - Mifeprex® (Mifepristone)*. Retrieved from <https://www.earlyoptionpill.com/wp-content/uploads/2016/03/Patient-Agreement-Form-March2016-1.pdf>. Retrieved 10/22/18.

Date Created: 1/28/21

Approved:

Effective Date:

Date Reviewed:

Date Revised:

## APPENDIX A

### Mifepristone/Misoprostol for Early Pregnancy Loss Provider Checklist

ALL Items on this checklist must be completed prior to proceeding with medical management for early pregnancy loss.

\_\_\_ Confirm early pregnancy loss measuring  $\leq 11$  weeks. Ectopic pregnancy MUST be ruled out prior to proceeding. Please indicate below what criteria have been used to confirm pregnancy loss.

Findings diagnostic of early pregnancy loss

- Crown rump length  $>8$ mm and no heartbeat
- Mean sac diameter of  $>24$ mm and no embryo
- Absence of embryo with a heartbeat 14 days or more after a scan that showed a gestational sac without a yolk sac
- Absence of embryo  $>10$  days after a scan that showed a gestational sac with a yolk sac

If none of the above, case must be reviewed by the medical director or designee

\_\_\_ Confirm no contraindications to medical management. Contraindications include the following:

- Prescribed anticoagulation medication.
- Severe heart, liver, kidney disease, seizure history or inflammatory bowel disease.
- Unable to return for follow-up visits or no access to backup medical care.
- Have immune deficiency or immune-suppression secondary to medication or medical condition (this includes long-standing use of corticosteroids)
- Have a Hemoglobin less than 9.5 or Hematocrit less than 29.
- Allergy to mifepristone or misoprostol.

- Pregnancy measures >11 weeks gestational age
- Ultrasound concerning for molar pregnancy
- **Desires surgical management**

\_\_\_ Discussed plan for follow up:

ultrasound scheduled in the next 1-2 weeks. Follow-up ultrasound can be scheduled with Gyn or OB imaging. (PREFERRED)

or

If patient is unable to follow up by ultrasound, check serum quantitative hcg and schedule for repeat serum quantitative hcg in 72 hours after taking misoprostol, and then weekly until negative.

\_\_\_ Document blood type with Rh status and recent CBC. If none on file, they have been ordered and follow plan established

\_\_\_ If >3 week discrepancy between LMP and ultrasound measurements, then PT, PTT/INR, fibrinogen are ordered

\_\_\_ Sign “Mifepristone Patient Agreement” and ensure patient receives a copy and one copy is scanned into Epic. <https://www.earlyoptionpill.com/wp-content/uploads/2016/03/Patient-Agreement-Form-March2016-1.pdf>

\_\_\_ Order medications:

1. Mifepristone 200mg PO once. Nurse will dispense

2. Misoprostol, 200 microgram tablets, #4 with 1 refill. 4 tablets in vagina on Day 1.  
Repeat on Day 2 if no passage of clots or tissue
3. Pain control:
  - a. Ibuprofen 800 mg po q 8 hours prn first line for pain or cramping #30 with 2 refills.  
  
AND
  - b. Narcotic:
    1. Hydrocodone/acetaminophen (Vicodin®) Take 1- 2 PO q 4-6 hr PRN  
second line for pain control. #6 with no refills. (Preferred)
    - OR
    2. Oxycodone (Roxicodone®) 5 mg Take 1-2 PO q 4 hr PRN pain. #4 with  
no refills. (Alternate)
4. Anti-emetic:
  - a. Oral Ondansetron ODT (Zofran®) 4-8mg PO q6 Hr PRN nausea, #10, no refills
  - b. Oral Promethazine (Phenergan®) 25mg PO q6hours, #10, no refills

\_\_\_\_ Offer work excuse if needed

## **Appendix B**

### **Mifepristone/Misoprostol for Early Pregnancy Loss Nurse Checklist**

- ☐ Provider has completed checklist
- ☐ Patient has signed Mifepristone agreement and is present under media tab Epic
- ☐ Blood type/CBC is available
  - ☐ If Rh negative, Rhogam is given
  - ☐ If unknown, plan to return for rhogam if needed discussed
- ☐ Confirm Hg >9.5
- ☐ If LMP >3 weeks from ultrasound dates, confirm coagulation studies are normal
- ☐ Follow up call is planned next business day after misoprostol administration
- ☐ Follow up ultrasound is scheduled
  - ☐ If unable to complete ultrasound, BHCG is drawn and repeat planned in 72 hours
- ☐ Appointments are filled in on patient instruction sheet
- ☐ Reviewed patient's emergency plan including who will be with them and how to get to the hospital, etc.

## Appendix C

### MEDICAL MANAGEMENT OF MISCARRIAGE USING MIFEPRISTONE/MISOPROSTOL

#### What is an abnormal pregnancy?

An abnormal pregnancy is a pregnancy that will never result in the birth of a child. This can be diagnosed by ultrasound or by bloodwork depending on how far along the pregnancy is. Given enough time, an abnormal pregnancy will become a miscarriage. On average, miscarriages happen in about 1 in 10 pregnancies but is more common the older you are. It is usually due to a chromosome or genetic problem with the pregnancy and there was nothing you could have done to change the outcome.

#### How is an abnormal pregnancy treated?

An abnormal pregnancy does not necessarily need treatment. Most will pass as a miscarriage within 8 weeks. If you do not want to wait that long or do not want to experience a miscarriage at home, there are options. One option is a medication called misoprostol (Cytotec®) to make the miscarriage happen sooner. This works 65-85% of the time. Adding a medication called Mifepristone increases the chances that you will pass the pregnancy without other treatments. The other option is a uterine aspiration procedure that can be done awake with pain medications or asleep in the operating room. When it's done awake it called a manual vacuum aspiration or MVA. When it's done asleep in the operating room it's called a suction dilation and curettage or D&C.

### HOME CARE INSTRUCTIONS:

#### Steps:

1. You will be given mifepristone 200mg (one tablet) to take in clinic today. This medication prepares your body for the second medication. You will likely not have pain or cramping after this medication.
2. 24-48 hours after you took the mifepristone (see time and date below), you should take the second medication. First, wash your hands thoroughly with soap and then dry your hands. Second, place all 800 mcg (typically 4 tablets) of misoprostol as high into the vagina as possible with your finger. You can use an empty tampon applicator if you desire. **Do not place the medication while sitting on the toilet.** Then lie down for about 30 minutes to prevent the tablets from falling out. Tablets may not completely dissolve, but they will still be effective.  
**Place misoprostol into the vaginal on this day: \_\_\_\_\_ between \_\_\_\_:\_\_\_\_ and \_\_\_\_:\_\_\_\_.**
3. Most women will begin to have bleeding and cramping within about 2 hours of placing the misoprostol into the vagina. The bleeding and cramping should be heavier and stronger than a period; see Frequently Asked Questions for signs you might be having too much bleeding.

4. You should return for a follow-up ultrasound and visit with a provider approximately one week after medical treatment for miscarriage. Approximately 10-15% of people who use mifepristone/misoprostol for treatment of first trimester miscarriage require surgical intervention with a uterine aspiration procedure either in the clinic or operating room. If you continue to have pregnancy tissue on ultrasound, then this will be discussed and arranged.
5. Use of mifepristone/misoprostol for medical management of miscarriage will cause you to have bleeding and cramping. If you continue to have heavy bleeding seven days after the first misoprostol dose, please call our office. Bleeding that is too heavy typically will soak through a pad in less than an hour more than once. However, if you are concerned about bleeding, please contact our office. Do not place anything in the vagina for two weeks following the misoprostol (tampons, intercourse or douching).

Date for appointment and ultrasound: \_\_\_\_\_

## **FREQUENTLY ASKED QUESTIONS**

### **What is Misoprostol (Cytotec®)?**

Misoprostol is chemically similar to the substances that cause cramping with your periods (prostaglandin hormones). High doses of vaginal misoprostol cause uterine contractions.

### **How does it feel?**

You might:

- Feel strong cramps.
- Heavy bleeding or pass large clots.
- Have nausea or vomiting.
- Have diarrhea.
- Feel temporary abdominal pain.
- Have fever or chills.

Ibuprofen (800 mg every 8 hours) can reduce most of these symptoms. Acetaminophen (Tylenol®) can be used if you are allergic to ibuprofen. Sometimes we use stronger pain medications such as Hydrocodone/acetaminophen (Vicodin®) or Oxycodone/Acetaminophen (Percocet®). These are narcotic medications and while they do help with pain control, have a risk of addiction, and should only be used as directed by your doctor. You may see large blood clots or tissue at the time of the miscarriage. This heavy bleeding should last for about 2 hours and then slow down.

### **Call a doctor if you:**

- Soak more than two maxi pads an hour, for more than 2 hours in a row.
- Bleed heavily for more than 12 hours in a row.
- Pass clots larger than lemons for 2 hours or more.
- Experience vaginal discharge that smells foul or looks infected.
- Run a temperature over 100.4°F for more than 4 hours soon after using misoprostol. Call immediately if a fever starts a few days after using the misoprostol.
- Feel strong nausea or throw up for more than 4 hours.
- Are in severe pain that does not respond to painkillers.
- Have an allergic reaction to the medicine.

You may need a clinic visit. Rarely, women need surgery or hospitalization.

### **NUMBERS TO CALL:**

- USF Obstetrics and Gynecology: 813-259-8500

### **Use of medicine to assist miscarriage is not recommended if you:**

- Take anti-clotting medication or have blood clotting disorders
- Have severe heart, liver, kidney disease, seizure history or inflammatory bowel disease

- If you do not have reliable transportation available for follow-up.
- Have anemia with a hemoglobin less than 9.5.

### **Bleeding after the pregnancy has passed:**

- Bleeding may be minimal or like a period. You may bleed for a few days or off and on for a few weeks.
- Bleeding changes from bright red to pink to brown.
- Discharge should not be foul smelling.
- Small clots, no larger than a quarter, are normal.
- When you lie down blood collects in the vagina. When you stand up blood may pass in a large gush.
- Use sanitary pads for the first two weeks.
- Tampons can be used after two weeks.

### **Emotions:**

- Each person's response to miscarriage will be unique.
- Men and women often express emotions differently.
- Talking about your miscarriage is a healthy way to deal with your emotions.
- A support group or grief and loss website may be helpful.

### **Personal Care Instructions:**

#### **Sexuality:**

- No intercourse, tampons or douching for two weeks or until bleeding stops to help prevent infection. Pregnancy is possible if you have unprotected sex.
- Fatigue, physical discomfort or anxiety may make you feel that sex will never be the same. Tell your partner how you feel to avoid hurt feelings. If these symptoms persist, talk to your provider about them.

#### **Future Pregnancy:**

- We recommend waiting until you are no longer bleeding to attempt conception. Waiting until your next period can prevent confusion about if this pregnancy had completely passed.

#### **Temperature:**

- Call your doctor if your temperature is 100.4 degrees F (or 38 degrees C).

#### **Resting and Exercise:**

- Slowly resume normal activities.
- Your energy level may be low for the first week.
- Naps may be helpful.
- You may return to work as instructed by your physician.

#### **Bathing:**

- You may shower and wash hair as desired.
- Tub baths are permitted.
- Avoid submersion/swimming in pools, hot tubs, lakes or oceans for 2 weeks.

**Diet:**

- Eat a balanced diet to help your body recover.
- Drink 6-8 glasses of fluid every day.

**Will I need follow-up?**

Yes. Your health care provider needs to make sure the miscarriage is complete. You will need a return visit in one week. You will need an ultrasound at that time.

After the medication and before your follow-up exam:

- Do not drink alcoholic drinks.
- Do not take anti-coagulant (anti-clotting) drugs.

Approximately 10-15% of patients receiving mifepristone/misoprostol may need a procedure.

**When will I get my period?**

After a miscarriage, ovulation is sometimes delayed, but you should have a regular period in four to eight weeks.

3.c. Elective abortion for medical indications and second trimester loss  
For request, contact Stacy Cohen the Ryan Program Manager. Do not send to the surgery pool.  
[ryanprogram@usf.edu](mailto:ryanprogram@usf.edu) or 813 250 2130

### 3.d. Depo-Provera Consent and administration

Depo consent must be signed annually. We offer teaching for SQ and IM administration at home.

#### Depo-Provera Consent Form (11/2020)

Depo-Provera (depo medroxyprogesterone acetate, DMPA) is a progesterone related hormone used to stop ovulation. As a form of birth control, it is 99.7% effective when given on time. DMPA is given by intramuscular (IM) or subcutaneous (SC) injection and lasts for about twelve weeks. To be effective, an injection must be given every twelve weeks. DMPA can also be used to control heavy or painful periods, endometriosis, pelvic pain, and to stop ovarian cyst formation.

Potential risks and side effects from the DMPA injection include:

1. At the end of the twelve weeks after the injection, it may take from several months to a year to get pregnant. If there are problems or side effects, it may take 3-4 months before the shot wears off.
2. DMPA should not be used in the presence of serious active liver disease, known or suspected breast cancer.
3. DMPA may cause a change in periods, including bleeding more days than usual, heavier than usual, spotting between periods or no periods. These changes are common, particularly in the first six months of use. After 6 months of use, most people will have little to no bleeding.
4. If a health care provider is seen for any reason, he/she should be informed of your DMPA use.
5. Women who use DMPA may have a decrease in the amount of mineral stored in their bones. Most of the mineral comes back as soon as the Depo-Provera is stopped. You should take extra calcium supplements (1000-1200 mg/day).
6. Minor side effects may include nausea, acne, breast tenderness, weight gain (a few pounds each year), headaches, nervousness, dizziness, cramping, depression, weakness or fatigue, or decreased sex drive. These side effects may decrease over time.
7. Studies have found that women who used DMPA for contraception had no increased overall risk of cancer of the breast, ovary, uterus, cervix, or liver.
8. DMPA does not protect against HIV/AIDS or other sexually transmitted diseases.

If DMPA is started within 7 days of menstruation, no back up method needed. If DMPA is started >7 days since menstruation, condoms or Plan B are recommended for sexual intercourse for the next 7 days from the injection as well as a repeat pregnancy test. If greater than 15 weeks have passed since your last injection and you have been sexually active, you need to take a pregnancy test as you may be pregnant.

I have read and understand the above side effects, risks and complications of using DMPA injections. Alternative forms of birth control or management of my medical problems were discussed along with the risks and benefits of each. I agree to inform my doctor promptly of any side effect of this medication.

Patient name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I have requested that I can administer Depo-Provera at home. At any time, I may request to receive it from my medical provider instead. I understand all of the above risks and benefits. In addition, I understand that if I do not inject the Depo-Provera on time and correctly, there is an increased risk of contraceptive failure and pregnancy. If I am unable to inject the medication within the 11-13 week timeframe from my last injection, I will notify my medical provider for additional instructions. I agree to undergo injection training or have previously received training in how to inject the medication safely. I understand that I will have to see my provider annually or more often for refills.

\_\_\_\_\_ I have been previously trained on intramuscular and subcutaneous injections

\_\_\_\_\_ I will undergo injection training

Patient name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **Depo Provera at Home**

### **A. Supply Set-up:**

1. Depo Provera SQ 104mg prefilled syringe (check expiration)
2. Alcohol Pad
3. Band-Aid

### **B. Procedure**

Make sure you are within the window of 11-13 weeks from your last depo injection for best results. It may be given up to 15 weeks after last injection and still protect against pregnancy. If it has been more than 15 weeks, please contact your medical provider for instructions and use a back-up method such as condoms.

#### **1. Adminster Shot**

1. Wash hands
2. Remove syringe from package and shake it one minute until mixed
3. Hold needle pointing up and tap syringe to shake air bubbles to top
4. Push syringe until air bubbles are out
5. Choose injection site (in abdomen or anterior thigh), wipe with alcohol pad, and let area dry
6. Take cap off needle and hold syringe in dominant hand
7. Grab skin around injection site with non-dominant hand and insert needle all the way into skin at 45-degree angle
8. Press syringe all the way in and keep needle in place while counting to five
9. Remove needle and dispose of into a sharps container
10. Apply light pressure to prevent bleeding without massaging.

#### **2. Documentation**

- a. Document the injection date somewhere you can remember.

#### **3. Return**

- a. You will need to return annually for a well woman exam for refills. When you use your last refill please call and make an appointment

## **Depo Provera at Home**

### **C. Supply Set-up:**

4. Depo Provera 150mg (check expiration)
5. 3ml syringe
6. Needles (18g/25g)
7. Alcohol Pad
8. Band-Aid

### **D. Procedure**

Make sure you are within the window of 11-13 weeks from your last depo injection for best results. It may be given up to 15 weeks after last injection and still protect against pregnancy. If it has been more than 15 weeks, please contact your medical provider for instructions and use a back-up method such as condoms.

#### **4. Prepare Shot**

- a. Get Depo Provera 150mg IM (shake to mix well)
- b. Verify expiration date
- c. Connect 18g needle to syringe
- d. Inject 1ml air into vial and withdraw medication into syringe
- e. Change to 25g needle for injection

#### **5. Injection**

- a. Prepare site (either upper outer quadrant of hip or deltoid) with alcohol pad and let dry
- b. Insert needle and inject medication slowly, then withdraw needle
- c. Apply Band-Aid

#### **6. Documentation**

- a. Document the injection date somewhere you can remember.

#### **7. Return**

- a. You will need to return annually for a well woman exam for refills. When you use your last refill please call and make an appointment

### 3.e. Ovulation Induction

Helpful do phrases include patient instructions .STCCOMIDPTINSTRUCTIONS and .STCletrozolePTINSTRUCTIONS

#### Generalist Ovulation Induction Guideline

##### I. Introduction:

Infertility affects 12-18% of couples, but prevalence increases with age. The most common cause is anovulation. Oral medications for ovulation induction are overall well tolerated and low risk. The Generalist Division can help appropriate candidates achieve pregnancy using these methods.

##### II. Candidates:

- Patients with ovulatory dysfunction including PCOS or undiagnosed infertility
  - BMI <30 (High is at provider discretion)
  - Age <40
  - Other comorbidities otherwise well controlled

##### III. Contraindications:

- Uncontrolled diabetes (HgA1>5.5)
- Uncontrolled hypertension
- Contraindication to pregnancy

##### IV. Procedure

- Pt identified as having infertility or anovulatory cycles
- History and PE reviewed and no current contraindication to pregnancy
- GYN US for structural abnormalities
- Lab work: TSH, prolactin, FSH +/-AMH, DM testing if anovulatory
- Offer Sperm analysis/HSG (not required)
- Rx for:
  - Provera- if no periods
    - 10mg daily x10 days
  - Clomid- undiagnosed infertility
    - 50mg daily x5 starting day 5 of cycle
    - Day 12 GYN US for follicles on first cycle/new dose
    - Day 21 progesterone
    - If no ovulation may increase to 100mg
    - May use 4-6 cycles
  - Letrozole- ovulatory dysfunction
    - 2.5mg daily x5 days starting day 3 of cycle

- Day 21 progesterone
- If no ovulation may increase to 5mg
- May use 4-6 cycles
- To schedule Hysterosalpingogram (HSG)
  - Test is done between cycle days 4-12
  - Call: 813-259-0692 Option 1 on *cycle day 1*
- To schedule Semen Analysis
  - Call 813-259-0692 Option 1 to schedule
  - Patient may either collect in clinic or at home
  - *If patient collect at home, HE STILL NEED AN APPOINTMENT*
  - *If partner drops off, please bring copy of ID*

V. Other considerations:

- Recommend HSG/SA if no conception in 3 cycles
- Referral to REI if >40y/o, AMH<1, FSH >10
- Clomid- counsel risk of twins 9%, higher order 0.5%
  - Side effects 33% hot flashes, 9% abdominal pain, 2% N/V, 2% breast pain
  - Visual disturbance can be permanent
- Letrozole- Counsel risk of twins around 4%
  - Side effects 22% fatigue, 12% dizziness

### 3. f. Outpatient LEEPs

All employees should wear an N-95 at the time of a LEEP. Only high volume providers and MA have been fitted at USF due to shortages. If you are not one of the high volume providers, then you may supply your own N-95 if you wish to perform a LEEP.

## **LEEP PROCEDURE**

### **INDICATIONS:**

4. Treatment of abnormal pap smears

### **RELATIVE CONTRAINDICATIONS:**

- Q) Coagulation disorders, anticoagulant drug therapy
- R) Uterine anomalies
- S) Pelvic inflammatory disease/cervicitis
- T) Extreme anxiety
- U) Any medically unstable comorbidity (i.e. uncontrolled HTN, seizure disorder)
- V) Cervical stenosis
- W) BMI >50 and >350 lbs.

### **Equipment**

1. LEEP Machine
2. Colposcopy Machine
3. Light

### **Instruments**

1. Long Pick ups
2. Tenaculum
3. LEEP Speculum
4. LEEP Side Wall Retractor
5. ECC
6. Needle Holder
7. Scissors

### **Supplies**

1. Grounding Pad
2. Electrode (handheld or footpedal)
3. Attachments: 1.0, 1.5, 2.0
4. Cautery Ball
5. LEEP Tubing
6. Biopsy Container (3)
7. 10cc Syringe
8. 18g Needle

9. Spinal Needle
10. Lidocaine with Epi (Check exp)
11. Silk suture
12. Monsels/Silver Nitrate
13. Acetic Acid/Lugols
14. Several Large Q-Tips
15. UPT

## **LEEP Procedure**

### **PRIOR TO PROCEDURE**

1. Plug in machine to wall (NEVER bed)
2. Connect Grounding Pad to machine
3. Connect Tubing to Filter
4. Connect Electrode to machine (verify hand or foot with provider)
5. Connect tubing to speculum (do not open speculum all the way  
MUST remain Sterile)
6. Draw up 10ml Lidocaine with 18g and switch to spinal (keep needle)

### **PREPARATION OF THE PATIENT:**

- M) Verify patient name and date of birth
- N) Take vital signs and weight
- O) Have patient empty bladder and obtain urine sample for pregnancy test and document results
- P) Explain procedure to patient. Patient should have opportunity to read handouts and ask questions
- Q) Assure patient has a ride home if receiving sedation
- R) Patient to sign consents prior to medication administration
- S) Prepare patient in procedure room on table with drape
- T) Have pt remove all metal jewelry
- U) Place ground pad on thigh (never on bone)

### **PROCEDURE**

1. Turn on machine
2. Place speculum
3. Preform colposcopy and identify lesions
4. Preform cervical block with lidocaine
5. Connect electrode size of provider preference
6. Set Machine to cut or blend per provider (setting usually 50)
7. Preform Leep and cauterize base

8. Perform ECC
9. Apply Moncel's
- 10.**Get biopsy and label with suture (silk) if needed
- 11.**Place label on sheet, filter must be changed after 10 uses or 1 year

**POST PROCEDURE CARE:**

- C) Ask the patient to remain supine for a few moments following the procedure; place chux
- D) May elevate head of table after a few minutes; assess for vasovagal reaction
- K) When patient feels ready, may dress and prepare for recovery. Offer sanitary pad.
- L) Review discharge instructions, warning signs, and when to call
- M) Assess for painful uterine cramping and bleeding
- N) Patient to have follow up appointment in 4-6 weeks scheduled

**DOCUMENTATION:**

- E) Document procedure and patient's tolerance
- F) Document that patient received discharge instructions and verbalized understanding, and plan for follow up care

**PATIENT EDUCATION:**

- E) Take medication as directed, ibuprofen or acetaminophen every 6-8 hours
- F) Pads should be used for 1 week
- G) Patient should report the following:
  - a. Fever with temperature higher than 100.4°F or 38°C 24 hours post procedure
  - b. Severe cramping not relieved by medication, especially more than 24 hours post procedure
  - c. Bleeding and soaking through more than a pad an hour
- H) Give written aftercare instructions including how to get help after hours

# **Loop Electrosurgical Excision Procedure (LEEP): Before Your Procedure**

## **What is LEEP?**

A loop electrosurgical excision procedure (LEEP) removes tissue from the cervix. You may have this done if you've had a Pap test that shows tissue that isn't normal.

During LEEP, your doctor will put a tool called a speculum into your vagina. It gently spreads apart the sides of your vagina. This lets your doctor see the cervix and inside the vagina. A special fluid is sometimes put on your cervix to make certain areas easier to see.

You may get a shot of medicine to numb the cervix. You may feel a cramp when you have the shot..

Your doctor will put a device with a fine wire loop into your vagina. The doctor uses the heated wire to cut out tissue.

You may have mild cramps for several hours after LEEP. A dark brown discharge during the first week is normal. You may have some spotting for about 3 weeks.

LEEP is done in a doctor's office or a hospital. It takes only a few minutes. You can go home after the procedure.

You should be able to go back to your normal routine in 1 to 3 days. How long it takes you to recover will depend on how much was done.

## **How do you prepare for the procedure?**

- ❖ Do not douche, use tampons, have sexual intercourse, or use vaginal medicines for 24 hours before the test.
- ❖ Do not have unprotected sex for 2 weeks prior to your procedure
- ❖ Tell your doctor if:
  - You are having your menstrual period.
  - You are or might be pregnant. A urine test will be done to see if you are pregnant.
- ❖ If you take aspirin or some other blood thinner, ask your doctor if you should stop taking it before your procedure. Make sure that you understand exactly what your doctor wants you to do. These medicines increase the risk of bleeding.
- ❖ Tell your doctor ALL the medicines, vitamins, supplements, and herbal remedies you take. Some may increase the risk of problems during your procedure. Your doctor will tell you if you should stop taking any of them before the procedure and how soon to do it.

## **What happens on the day of the procedure?**

- ❖ You may eat or drink as you normally do.

- ❖ Take a bath or shower before you come in for your procedure. Do not apply lotions, perfumes, deodorants, or nail polish.
- ❖ You may want to take a pain reliever, such as ibuprofen (Advil or Motrin), 30 to 60 minutes before you have the procedure. This can help reduce any cramping pain.
- ❖ Take off all jewelry and piercings.

## **When should you call your doctor?**

- ❖ You have questions or concerns.
- ❖ You don't understand how to prepare for your procedure.
- ❖ You become ill before the procedure (such as fever, flu, or a cold).
- ❖ You need to reschedule or have changed your mind about having the procedure.

# **Loop Electrosurgical Excision Procedure (LEEP): What to Expect at Home**

## **Your Recovery**

LEEP removes tissue from the cervix. Your procedure removed abnormal tissue from your cervix.

You may have mild cramping for several hours after the procedure. A dark brown vaginal discharge during the first week is normal. You can use a sanitary pad for the bleeding.

You may also have some spotting for up to 3 weeks. How long it takes to recover will depend on how much was done during the procedure. Some medications put on your cervix can cause yellow or coffee ground colored discharge.

This care sheet gives you a general idea about how long it will take for you to recover. But each person recovers at a different pace. Follow the steps below to feel better as quickly as possible.

## **How can you care for yourself at home?**

### **Activity**

- ❖ You should be able to go back to your normal activities in 1 day.

### **Medicines**

- ❖ If you take aspirin or some other blood thinner, ask your doctor if and when to start taking it again. Make sure that you understand exactly what your doctor wants you to do.

- ❖ Take an over-the-counter pain medicine, such as acetaminophen (Tylenol), ibuprofen (Advil, Motrin), or naproxen (Aleve). Read and follow all instructions on the label.
- ❖ Do not take two or more pain medicines at the same time unless the doctor told you to.

### **Exercise**

- ❖ Do not exercise for 1 to 3 days after the procedure.

### **Other instructions**

- ❖ Use a sanitary pad if you have bleeding.
- ❖ Do not have sexual intercourse or use tampons for 3 weeks. Do not douche. This will allow your cervix to heal.
- ❖ You can take a shower anytime after the procedure. Ask your doctor when it is okay to take a bath.
- ❖ Be sure to have regular follow-up Pap tests. Your doctor can tell you how often you need to have Pap tests.

## **When should you call for help?**

**Call your doctor now** or seek immediate medical care if:

- ❖ You have pain that does not get better after you take pain medicine.
- ❖ You cannot pass stools or gas.
- ❖ You have signs of infection, such as:
  - Increased pain or foul smelling discharge.
  - A fever.
- ❖ You have bright red vaginal bleeding that soaks one or more pads in an hour, or you have large clots.

### 3. g. Outpatient Post- Procedure Instructions

### 3. h. Scheduling Operating Room cases

To schedule a case in the OR, CC the chart to the scheduling pool with the dot phrase .stcpreopgyn. Place “orders for admission” including any labs for PAT using the GYN pre-op order set. Make sure that you are scheduled for the OR on day requested.

3. i. Medication renewals

USF Health Physicians Group, Department of OB/GYN

Effective Date:

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Hormone Replacement Therapy

Purpose:

To renew hormone replacement therapy until the patient can be seen for her annual at the next available appointment date.

Scope:

Providers, Registered Nurses, Licensed Practical Nurses, Medical Assistants

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POLICY

I. Policy Statement

This policy is to accommodate established patients of the practice in renewing their hormone replacement therapy until the next available appointment is made.

II. Procedure

When the patient calls to have their hormone replacement therapy renewed:

A. Look in the patient's chart to see when she was last seen by our provider.

B. Read the providers notes as to when the patient was instructed to be seen again and if the hormone replacement therapy was ordered for one year.

1. We cannot renew if the notes reflect that the patient needs a follow up prior to one year. Must contact the provider to get an ok.
2. We cannot change a prescription if the patient would like a new hormone replacement therapy option.
3. If patient cancels appointment more than once and is calling for additional renewals, address with the provider prior to additional refills.

C. Questions that must be asked and charted before refill can be given:

1. Have you been told you have had a stroke, possible stroke or transient ischemic event (TIA) since last seen?
2. Have you been diagnosed with any new heart conditions including a heart attack since last seen?

3. Have you had a DVT (blood clot) in the past or since your last visit?
4. Have you been diagnosed with cancer since your last visit?

If the answer to any of these questions is YES, consult with a provider prior to refilling hormone replacement therapy prescription.

### III. APPROVED HORMONE REPLACEMENT RENEWAL

- A. Patient was seen by our provider within 2 years.
- B. Patient was given one year prescription.
- C. Patient has none of the conditions listed in Section C (above).

### IV. Document

#### a. STCHRTREFILL

- i. Pt requests refill of prescription HRT. Denies any new contraindications to HRT since last visit. Refill sent until annual exam.

## BIRTH CONTROL

### Purpose:

To renew birth control until the patient can be seen for her annual at the next available appointment date.

### Scope:

Providers, Registered Nurses, Licensed Practical Nurses, Medical Assistants

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## POLICY

### V. Policy Statement

This policy is to accommodate established patients of the practice in renewing their birth control until the next available appointment is made.

### VI. Procedure

When the patient calls to have their birth control renewed:

D. Look in the patients chart to see when she was last seen by our provider.

E. Read the providers notes as to when the patient was instructed to be seen again and if the birth control was ordered for one year.

1. We cannot renew if the notes reflect that the patient needs a follow up prior to one year. Must contact the provider to get an ok.
2. We cannot change a prescription if the patient would like a new birth control option.
3. If patient cancels appointment more than once and is calling for additional renewals, address with the provider prior to additional refills.

F. Questions that must be asked and charted before refill can be given:

1. Have you been told you have high blood pressure in the past year?
2. Do you get migraines with an aura? ( Do you see spots of flashing lights, tingling in the arm or face, difficulty speaking, tunnel vision prior to a migraine headache?)
3. Have you had a DVT (blood clot) in the past or since your last visit?

4. Are you a smoker over the age of 35? If so when did you start smoking?

If the answer to any of these questions is YES, consult with a provider prior to refilling birth control prescription.

## VII. APPROVED BIRTH CONTROL RENEWAL

- D. Patient was seen by our provider within 2 years.
- E. Patient was given one year prescription.
- F. Patient has none of the conditions listed in Section C (above).

## VIII. Document

### a. STCBCREFILL

- i. Pt requests refill of prescription of birth control. Denies any new contraindications to birth control since last visit. Refill sent until annual exam.

### 3. j. Vaginal discharge complaints

#### Vaginal Complaints

##### Purpose:

Allow treatment common vaginal complaints without needing appointments.

##### Eligibility criteria:

4. Established patient at USF OB/GYN seen in last 2 years
5. Age 18- 55
6. Complaint of vaginal discharge, itching or irritation
7. Not currently pregnant

##### Exclusion criteria:

2. Needs appointment if
  - i. If symptoms for more than 2 weeks
  - ii. Has been treated more than 2 time in the last year
  - iii. If fever, chills, abdominal or back pain
  - iv. New sexual partner
  - v. Does not clearly fit symptoms of yeast or BV

##### Procedure:

3. Nurse phone triage
  - a. Review is symptoms meet one of the following.
  - b. Documents
    - i. STCVDNURSECALL- pt reports \*\*\*. Denies fever, chills, abdominal pain and new sexual partners. Treatment recommended: \*\*\*
  - c. Yeast
    - i. 1 or more of the following symptoms:
      1. Itching
      2. No odor
      3. Thick white discharge or no discharge
      4. Recent antibiotic prescription
    - ii. Treatment:
      1. Diflucan 150mg PO x1 or terconazole 0.4% 1 applicator PV qhs x7 days
  - d. Bacterial vaginosis (BV)
    - i. 1 or more of the following symptoms:
      1. Thin grey to green discharge
      2. Foul odor
      3. Mild irritation
    - ii. Treatment:
      1. Flagyl 500mg BIDx7 days or Metrogel 1 applicator qhs x5 days

3.k. STI testing nursing visits  
**Sexually Transmitted Infections (STIs) Testing**

Most sexually transmitted infections (STIs), also known as sexually transmitted diseases (STDs) do not have symptoms, at least not at the beginning. We encourage you to get tested when you have a new partner. Getting tested allows us to treat you and prevent further spread of the infection. **If you are having any symptoms like fever, abnormal discharge, or pelvic pain**, then you should see a provider to talk about any additional testing or treatment that may be needed.

Typical STIs:

- Gonorrhea and Chlamydia- urine test
- Human immunodeficiency virus (HIV)- blood test
- Hepatitis C- Blood test
- Syphilis- Blood test

Hepatitis B

You can also be tested for Hepatitis B. Most people born in the United States who are 35 and younger have been vaccinated as well as many health care workers. If you were vaccinated against Hepatitis B, you most likely do not need to be tested for it. If you are unsure about your vaccination status and would like to be tested please check below.

- I would like to be tested for Hepatitis B- blood test

Herpes

You can also be tested for Herpes. This is a Herpes Virus Antibody test for Type 1 and Type 2 Herpes. If you do not have any symptoms, then this test is unlikely to be helpful. The test cannot tell the difference between a cold sore and a genital sore because either Type can occur in either location. The tests cannot tell if you were only exposed or if you are going to have outbreaks in the future. **If you have symptoms such as a sore or burning pain**, tell the nurse, medical assistant or circle this spot on the form. We will make you a confidential appointment to see a provider to look at the area and test that area for the virus itself. If you have read this and still would like Herpes blood work check below.

- I would like blood work for Herpes - Blood test HSV ½ IGG

I have read the above information and would like to proceed with the STI testing as marked above. I have been offered and decline a visit with a provider.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Amis 5/13/2021

3. I. Expedited partner therapy  
Expedited Partner Therapy

Purpose:

Allow treatment of partners of patients who have been diagnosed with Gonorrhea or Chlamydia if they are unable or unlikely to seek treatment themselves.

Eligibility criteria:

8. Patient diagnosed with Gonorrhea or Chlamydia or Trichomonas and
9. Has had a sexual relationship with the partner prior to the diagnosis and
10. The partner/s are unable or unlikely to seek treatment themselves.

Exclusion criteria:

1. Patient is unable or unwilling to supply partner's name and date of birth

Procedure:

4. Patient is told of new diagnosis
5. Nurse asks if has current partner and if they are likely to seek treatment
6. If unlikely or unable to seek treatment, offer expedited partner therapy
7. If patient desires expedited partner therapy, then they will be asked for partners full name and date of birth and pharmacy
8. Prescription will be called in stating to pharmacy that this is for expedited partner therapy.
9. Instructed to not have intercourse for 2 weeks after both partners are treated.

Treatment

1. Chlamydia
  - a. Azithromycin 1000mg PO x 1 dose
  - or
  - b. Doxycycline 100mg PO BID x7 days
2. Gonorrhea
  - a. Cefixime 800mg PO x1
    - i. Add Doxycycline 100mg BIDx7 days if Chlamydia not excluded
    - ii. Ceftriaxone is the preferred treatment, but we cannot administer it if not our patient.
3. Trichomonas
  - a. Metronidazole 2g once

Documentation

STCEXPARTNERTX- Results reviewed with patient. Treatment sent to the pharmacy. Pt offered expedited partner therapy in accordance with current Florida laws. Prescription for \*(name), DOB \*(name) sent to pharmacy and pharmacy notified of expedited partner therapy. Pt instructed no intercourse for 2 weeks after treatment.

## 4. Acute Care Clinic

### 5. Tasking

It is expected that you will answer results within 3 business days

If you are out of town/vacation then please assign your box to someone else.

For normal results that can be sent via mychart, unclick the routing box.

The screenshot shows a medical results interface. On the left, there is a sidebar with patient information: Order: 252374999, kt appt: 06/18/2021, Dx: Endometrial. The main area has a header with 'Save as QuickAction' and 'Relax Order'. Below this is a 'Results (1 of 1)' section with filters: All, None, Abnormal, Unreviewed. A checkbox is checked next to 'SURGICAL PATHOLOGY [252374999]'. Below this is a 'Result Note' section with a 'Route' checkbox circled in red. There is also a 'MyChart Comment' section with a note: 'All selected results have been released'. The interface includes various icons for editing and viewing, and a 'Copy from Pt Comm' button.

### Inbox Messaging

No message necessary:

Pt calls that pertain to last visit and instructions are in last note

Pt calls with complaint/refill with protocol already established.

Normal priority messages:

New question or update by pt.

High priority messages:

Only for problems that need answers within 24 hours or less. This should be followed up with a text or call to the provider. If provider unavailable within 2 hours, on vacation, postcall or CME or it is the end of business day, then nurse will bring it to a clinic provider.

Examples:

1. Postop complications
2. Heavy vaginal bleeding
3. Anything that might require hospital admission



## 6. Preferred referrals

### **Departmental Referrals:**

USF UroGYN- place referral and staff will call within 1 week

USF GynOnc- place referral and give pt number (813) 844 8757

REI- Shady Grove 1-888-761-1967

### **Outside Referrals:**

#### Primary Care

USF Med/Peds- All doctors (813) 259-8700

USF Family Medicine (Morsaini)- (813) 974-2201

#### Adolescent Medicine-

USF Peds- Amy Weiss

#### Breast Surgery-

TGH- Abigail Beard and Charles Cox (813) 844-7585

Private- John Cox (813) 978 8315

#### General surgery-

USF Michael Albrink (813) 259-0929

#### Colorectal surgery-

USF Jaime Sanchez and George Marcet (813) 844- 4545

#### Gastroenterology -

USF Dr. Soojong Chae (813) 974-2201

#### Rheumatology

USF John Carter and Joanne Valeriano-Marcet (813) 974-4115

#### Endocrinology-

#### Osteoporosis-

#### Plastic surgery-

USF- David Smith or Lauren Kuykendall (813) 259-0929

#### Bariatric surgery

TGH Bariatrics- Christopher DuCoin and Ashley Mooney (813) 844-7473

#### Pelvic Floor PT

See UroGYN list

TGMG (813) 660- 6940