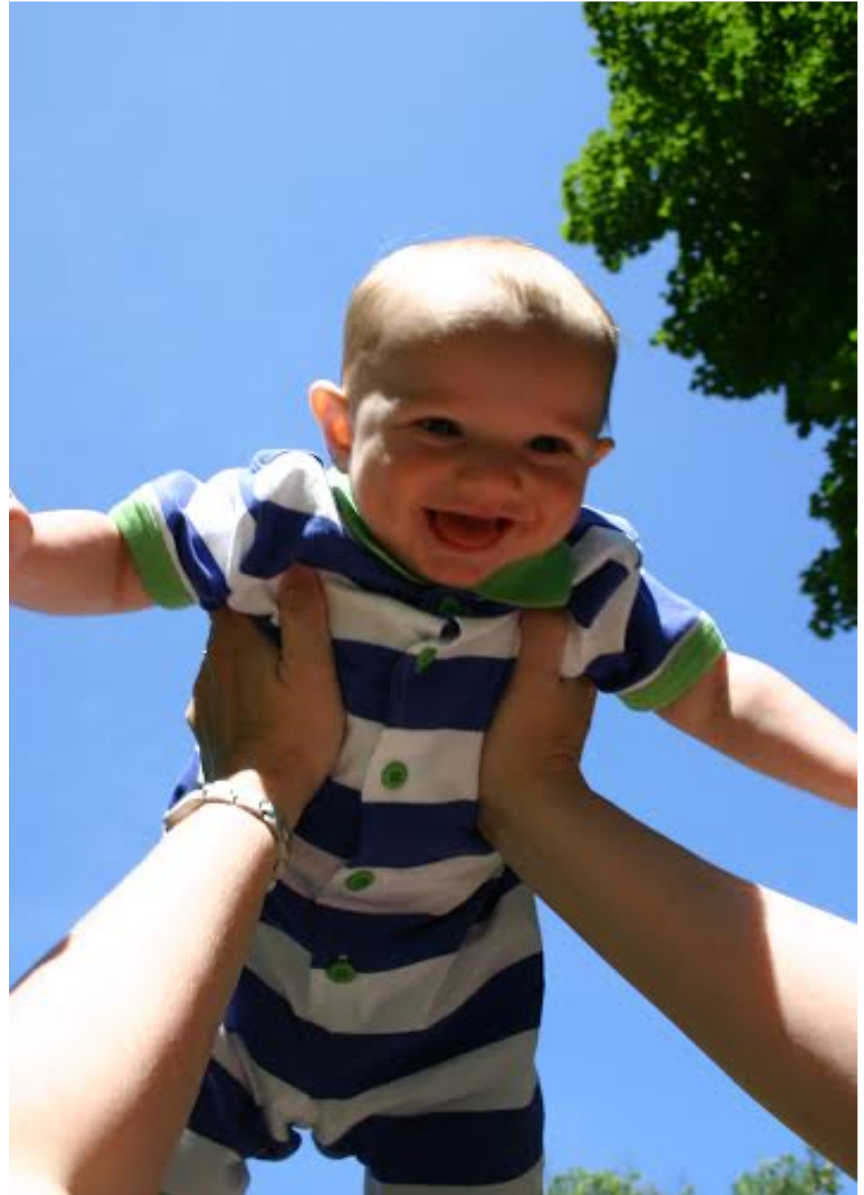
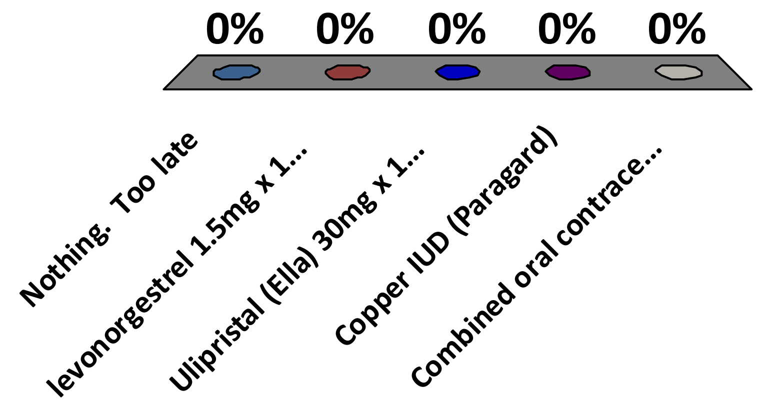
OB Review

QUESTIONS YOU COULD SEE ON THE BOARDS



1. 18 year old college student presents to the student health center. She is worried because she was with her boyfriend 4 nights ago and the condom broke. What would be the most effective option, if any, for emergency contraception?

A. Nothing. Too late
B. levonorgestrel 1.5mg x 1 dose
C. Ulipristal (Ella) 30mg x 1 dose
D. Copper IUD (Paragard)
E. Combined oral contraceptive pills

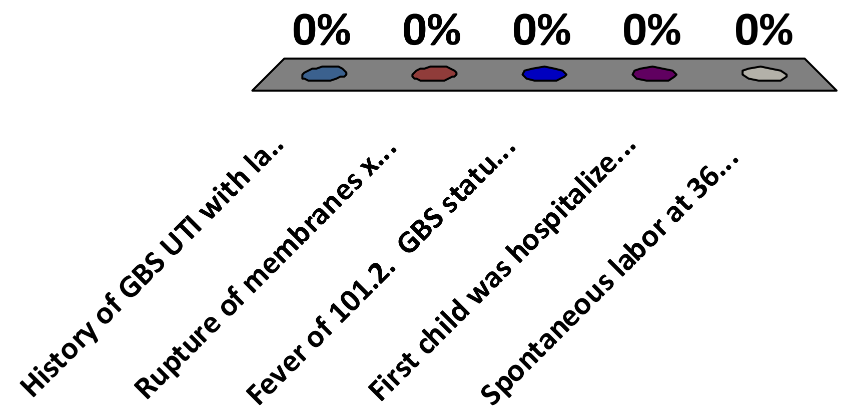


Question 1 Answers - D

- A. Not too late
- B. levonorgestrel 1.5mg = Plan B One-Step. Max efficacy w/in 72h, mod efficacy w/in 120h. Similar effectiveness to levonorgestrel 0.75mg BID
- C. ulipristal = Ella. Can be used w/in 120h of unprotected intercourse
- D. Copper IUD = Paragard. Most effective method of emergency contraception. May be used up to 7 days after unprotected intercourse.
- E. Combined oral contraceptive pills - 2 doses taken 12 hours apart.

2. Which of the following is not an indication for intrapartum antibiotic prophylaxis for Group B strep?

A. History of GBS UTI with last pregnancy
B. Rupture of membranes x 20 hours. Unknown GBS.
C. Fever of 101.2. GBS status unknown
D. First child was hospitalized in the nursery for GBS bacteremia
E. Spontaneous labor at 36 weeks EGA. Unknown GBS.

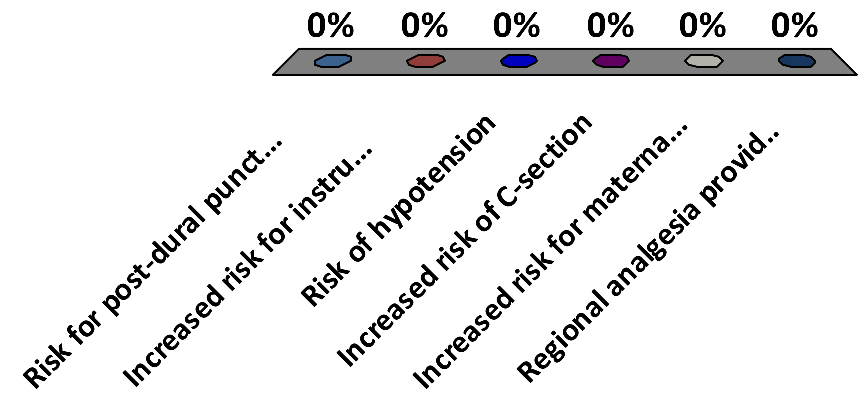


Question 2 Answers - A

- All pregnant women should be screened for GBS at 35-37 weeks by vaginal & rectal swab.
- Women who have had GBS in their urine during the current pregnancy or who have had a previously infected infant do not need to be screened.
- When GBS screening results are unavailable, treatment should be started if EGA less than 37 weeks, rupture of membranes > or = 18 hours, or temp greater than or equal to 100.4 F
- Start antibiotics at the time of labor or rupture of membranes. As long as not in labor, do not start antibiotics prior to C-section.
- Penicillin is first choice for antibiotic; ampicillin also OK first choice
- If PCN allergic and no h/o anaphylaxis, resp distress, or urticaria, can use cefazolin (Ancef)
- If PCN allergic with h/o anaphylaxis, order susceptibility testing and use clindamycin if susceptible. If not, use vancomycin

3. Which of the following associations is false regarding regional analgesia (epidural or spinal)

A. Risk for post-dural puncture headache.
B. Increased risk for instrument-assisted vaginal delivery
C. Risk of hypotension
D. Increased risk of C-section
E. Increased risk for maternal fever
F. Regional analgesia provides better pain relief than opioid analgesia

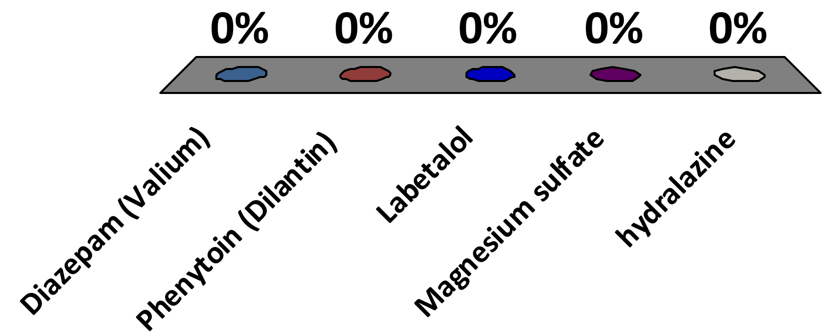


Question 3 Answers - D

- Postdural puncture headache is the most common complication of regional analgesia. A blood patch may be offered.
- There is an increased risk for an instrument-assisted vaginal delivery
- There is an increased risk for maternal hypotension, which can result in decreased placental perfusion. Occurs in 15%-33% of patients. A fluid bolus or IV vasopressor (5-10 mg ephedrine) may help.
- There is no associated increased risk for cesarean section.
- Risk for maternal fever, whether a true fever vs hyperthermia, is increased. The mechanism is not understood.
- Regional analgesia does provide better pain relief compared to opioid analgesia.
- Continuous labor support (i.e. doula) has been shown to lead to greater satisfaction with the childbirth experience and require less analgesia during labor.

4. The drug of choice for treating an eclamptic seizure is:

A. Diazepam (Valium)
B. Phenytoin (Dilantin)
C. Labetalol
D. Magnesium sulfate
E. hydralazine

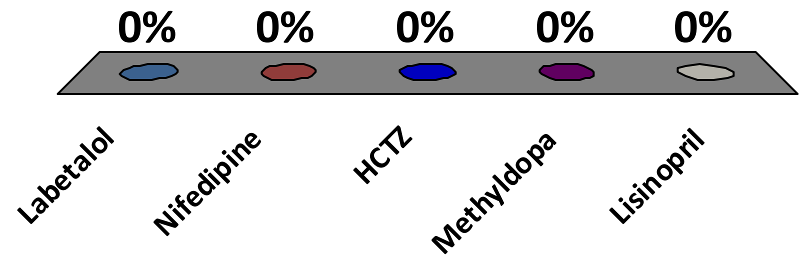


Question 4 Answers - D

- Magnesium sulfate is the drug of choice for initial and recurrent eclamptic seizures. Start with 4-6 gram loading dose followed by an infusion of 2 g/hr. May give an additional 2g bolus if seizure recurs.

5. Which of the following antihypertensive medications is contraindicated during pregnancy?

A. Labetalol
B. Nifedipine
C. HCTZ
D. Methyldopa
E. Lisinopril



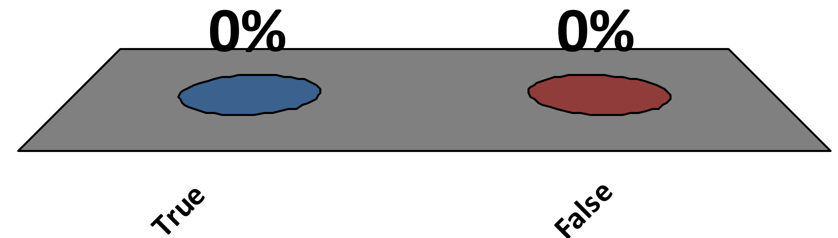
Question 5 Answers - E

- Methyldopa, labetalol, and nifedipine are most commonly used to treat HTN in pregnancy.
- Thiazide diuretics that were used prior to pregnancy **may** be continued.
- ACE inhibitors and ARBs have been associated with IUGR, Contraindicated!
- High BP (over 140/90) prior to 20 wks EGA likely reflects chronic HTN.
- Treat high BP in pregnancy if BP in consistently 150/100 or higher. Overtreating can lead to placental hypoperfusion.
- High BP (over 140/90) that develops after 20 wks EGA, with no proteinuria or other signs of preeclampsia, is gestational hypertension.
- ~50% of women with gestation HTN will develop preeclampsia

Preeclampsia is defined by BP 140/90 or higher on 2 separate readings 4 hours apart PLUS proteinuria.

A. True

B. False



Question 6 Answers - False

- Proteinuria is no longer required to have a diagnosis of preeclampsia. It is a multiorgan disease process, typically with high BP and proteinuria OR other severe feature of end organ damage. That would include severe headache, vision changes, pulmonary edema, renal failure, elevated LFTs, thrombocytopenia, etc.

- HELLP = hemolysis, elevated liver enzymes, and low platelets. High BP not necessary to meet the diagnosis.

- Seizure prophylaxis with magnesium is not required unless severe features develop. If started, stop magnesium 24-48 hours after birth.

- Deliver at 37 weeks unless severe features present. If severe, delivery is recommended.

- *The use of 80mg ASA during pregnancy has some positive effect on preventing preeclampsia.

Resources

- Bosworth, et al. An Update on Emergency Contraception. *American Family Physician* 2014; 89 (7): 545-550.
- Verani,et al. Prevention of Perinatal Group B Streptococccal Disease: Revised Guidelines from CDC, 2010
- Schrock,et al. Labor Analgesia. *American Family Physician* 2012; 85(5): 447-454.
- Leeman, Dresang, et al. Hypertensive Disorders of Pregnancy. American Family Physician 2016; 93(2):121-127.