Antenatal - Second and Third Trimester Care

Disclaimer

Routine pregnancy care in Victoria is provided by accredited antenatal care providers (public or private hospitals, private midwives, obstetricians, GP obstetricians or shared care affiliates). However, patients may require a pregnancy well-being check by their general practitioner if they:

- are in early pregnancy, prior to their first obstetric visit (up to 20 to 22 weeks for some services).
- are presenting for non-pregnancy related conditions that may have an adverse effect on fetal or maternal health, e.g. influenza, asthma, skin conditions.
- have failed to attend their routine scheduled antenatal visits.

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## Red Flags

- **Decreased fetal movements**
- Small for gestational age
- **Pre-eclampsia**
- **Cholestasis of pregnancy**

## Assessment

Initial assessment of antenatal patients is as per [Antenatal Care - First Consult](#).

1. Ensure patient has a [pregnancy booking](#) and appointments have been arranged and/or attended.

2. Ask about **symptoms of concern**.

   **Symptoms of concern**
   **Includes:**
   - **Decrease in fetal movements**
   - **Headache and/or visual changes**
   - **Abdominal pain or cramping**
   - **Vaginal bleeding, unusual discharge, and/or pain**
   - **Severe dependent oedema**
   - **Itch in absence of rash**

3. Perform a **maternal and fetal wellbeing check**.

   **Maternal and fetal wellbeing check**
   - **Maternal weight**
   - **Blood pressure**
   - **Measure symphyseal-fundal height**

   **Measure symphyseal-fundal height**
   - Measure the fundal height with a non-stretchable tape measure with the centimetres side facing down (to avoid bias).
   - Gently palpate from the lower end of the sternum down the abdomen until the fundus is reached.
   - Palpate the fundus and determine the highest point (this may not be directly in the midline). Secure the end of the tape measure at that point with fingers.
   - Measure along the longitudinal axis of the uterus from the highest point on the fundus to the symphysis pubis.
   - Record the measurement in centimetres. This should be roughly equivalent to dates (i.e. 30 cm at 30 weeks).

   - If >24 weeks, check fetal heart sounds using a fetal Doppler (if available)
   - Consider urinalysis (if [hypertension](#) or [symptoms of UTI](#))

4. Arrange routine investigation results if not already performed:
   - 20 to 22 weeks – [morphology ultrasound](#)
• 24 to 28 weeks:
  o FBE (and antibodies if Rhesus negative)
  o Blood group antibody screen
  o Oral 75 g glucose tolerance test – see Hyperglycaemia in Pregnancy
  o Consider ferritin – see Anaemia in Pregnancy

• 35 to 37 weeks:
  o Consider FBE and ferritin – see Anaemia in Pregnancy
  o Anovaginal swab for group B streptococcus (GBS) at 35 to 37 weeks – this is self-collected by the patient

5. Arrange additional investigations according to presentation:
   • if suspected cholestasis in pregnancy – bile acids/LFTs
   • if suspected UTI – MSU microscopy, culture, and sensitivity (MCS)
   • if suspected pre-eclampsia – FBE, urea, electrolytes, and creatinine (UEC), uric acid, LFT, spot urine – protein:creatinine ratio

Management

1. If patient clinically unwell or hemodynamically unstable, arrange emergency assessment, preferably in a hospital with a maternity service.

2. Refer for immediate obstetric review if:
   • patient reports a change or decrease in fetal movements.
   • unable to detect fetal heart beat after 24 weeks.
   • vaginal bleeding and/or abdominal or pelvic pain.
   • suspected cholestasis of pregnancy (itch with no rash and abnormal LFT/bile acids).

3. If patient has hypertension (sBP ≥ 140 mmHg or dBP ≥ 90mmHg) or symptoms of pre-eclampsia, refer for immediate obstetric review. See Hypertension in Pregnancy and Postpartum pathway.

Symptoms of pre-eclampsia
• Neurological symptoms – Headache, visual disturbance
• Oedema – may be present in normal pregnancy and pre-eclampsia can occur without oedema
• Epigastric pain or tenderness
• Nausea or vomiting
• Chest pain
• Shortness of breath (pulmonary oedema)
• General malaise
• Seizures (eclampsia)

4. If fundal height is more than 2 cm smaller than expected by dates, refer for urgent obstetric review to exclude intrauterine growth restriction. If possible, arrange urgent obstetric ultrasound prior to review.

5. If fundal height is more than 2 cm greater than expected dates, consider arranging obstetric ultrasound. Discuss with obstetric care provider.
6. Ensure all test results have been received, reviewed, and documented on patient’s handheld record. **Follow up on abnormal results.**

**Follow up on abnormal results**
- **Increased risk prenatal screening results** – see Prenatal Screening and Diagnosis of Fetal Anomalies.
- Abnormalities on 20 to 22 week morphology ultrasound – see Use and Interpretation of Pregnancy Ultrasound.
- Oral glucose tolerance test (OGTT) – see Hyperglycaemia in Pregnancy.
- FBE – treat any anaemia.
- Antibodies – if any abnormal antibodies detected, seek obstetric advice.
- MSU – treat UTI and asymptomatic bacteriuria in pregnancy.
- GBS positive – ensure obstetric provider aware of need for intrapartum antibiotic prophylaxis.

7. Offer vaccinations if not already given:
- influenza vaccine – at any stage of pregnancy
- pertussis vaccine – ideally between 20 and 32 weeks, see Australian Immunisation Handbook.

8. If rhesus negative, confirm anti-D has been administered at 28 and 34 weeks.

9. Confirm women are taking low dose aspirin for prevention of pre-eclampsia in patients at moderate or high risk of pre-eclampsia.

**Risk of pre-eclampsia**
- **High risk:**
  - History of pre-eclampsia, especially if early onset (before 34 weeks)
  - Systemic lupus erythematosus or antiphospholipid syndrome
  - Chronic kidney disease
  - Hypertension
  - Type 1 or type 2 diabetes
- **Moderate risk if > 1 of:**
  - Aged ≥ 40 years
  - BMI of ≥ 35 at first visit
  - Family history of pre-eclampsia in first-degree relative
  - First pregnancy
  - Multiple pregnancy
  - > 10 years since previous pregnancy

Some specialist obstetric imaging groups and genetic services offer screening for early onset pre-eclampsia, a condition that effects 0.3% of women and requires delivery before 34 weeks. This can be performed at the same time as combined first trimester screening and is estimated to detect up to 8 out of 10 pregnancies at risk of early pre-eclampsia.

**Prevention of early pre-eclampsia**
- Commence low dose aspirin 150 mg at night from 12 weeks and before 16 weeks of pregnancy, unless contraindicated (e.g., allergy, active peptic ulcer disease, or gastrointestinal bleeding).
- If risk is recognised after 16 weeks, aspirin can be commenced, however current evidence suggests this may be less effective compared to commencement prior to 16 weeks.
• Aspirin should be ceased at 36 weeks.
• Recommend adequate dietary calcium intake. Calcium supplement can be considered if dietary calcium does not meet RDI of 1000 mg per day.

10. Discuss interventions available for cessation of smoking in pregnancy.

Smoking in pregnancy
• Smoking in pregnancy increases risks of miscarriage, premature birth, low birth-weight babies and perinatal health problems.
• Smoking in pregnancy is more common in women who:
  o are socioeconomically disadvantaged.
  o experience mental health conditions.
  o have a substance use disorder.
  o have fewer social supports.

• Successful smoking cessation counselling needs to consider these factors.

Offer support and advice:
• Offer cessation interventions to pregnant women who smoke as soon as possible in the pregnancy, throughout the pregnancy, and beyond.
• Offer intense support and proactive telephone counselling, e.g. QuitCoach.
• Offer self-help material to supplement advice and support.

Self-help material
Quitline:
  o Pregnancy and Smoking (brochure)
  o Smoking and pregnancy

• If these interventions are not successful, consider nicotine replacement therapy after clearly explaining the risks involved.
• Inform pregnant women and new mothers of the dangers of passive smoking to newborn babies and young children.
• Recommend phone app Quit for You – Quit for Two. See Clinical Resources (below).
• Higher dose of NRT is needed in women who are pregnant or on oral contraceptive pills (OCP).

11. Discuss going to sleep on the side (not back) after 28 weeks. See Stillbirth Centre of Research Excellence – Sleep on Your Side When Baby’s Inside.

12. If relevant, advise patient of online resources for perinatal mental health support, e.g. Centre of Perinatal Excellence (COPE), Gidget Foundation, PANDA.

13. If 40+ weeks, ensure post-date visits are arranged with obstetric care provider.

14. For any other concerns, including abnormal results, seek obstetric advice.
Referral

- If patient clinically unwell or hemodynamically unstable, arrange emergency assessment.
- Refer for immediate obstetric review if:
  - decrease in fetal movements.
  - unable to detect fetal heart beat after 24 weeks.
  - vaginal bleeding and/or abdominal or pelvic pain.
  - suspected pre-eclampsia.
  - suspected cholestasis.

- Refer for urgent obstetric review if:
  - abnormal antibodies detected.
  - fundal height more than 2 cm less or greater than dates
  - for any other concerns.

Information

For health professionals

Further information

- Monash Health – Maternity: Guidelines and Procedures
- Stillbirth Centre of Excellence – Safer Baby Bundle
- RANZCOG – Maternal Group B Streptococcus in Pregnancy: Screening and Management
- The Royal Women’s Hospital, Mercy Public Hospitals, Western Health – Guidelines for Shared Care Affiliates 2015 [under review]

For patients

Safer Baby – Working Together to Stop Stillbirth

References


2. RACGP. Supporting smoking cessation: a guide for health professionals. [place unknown]: RACGP; 2014.

Disclaimer

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