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VA/DoD Clinical Practice Guideline for the Management of Pregnancy (2023)

About the Guideline

- The Department of Veterans Affairs (VA) and the Department of Defense (DoD) Evidence-Based Practice Work Group was chartered and established in 2004.
- This clinical practice guideline is intended to give healthcare providers a framework to evaluate, treat, and manage the individual needs and preferences of pregnant patients, thereby leading to improved clinical outcomes.
- In 2018, the VA and DoD published a guideline for the management of pregnancy, which was based on evidence reviewed through May 2017.
- The system-wide goal of developing evidence-based guidelines is to improve patients' health and well-being by guiding health care practitioners in best practices.

Key Clinical Considerations

Become familiar with the recommendations and best-practice statements provided in this guideline, especially if you work in an acute care setting.

Routine Care

- A group model of prenatal care is suggested, instead of individual provider appointments.
- All healthy pregnant patients who have no known contraindications are encouraged to participate in regular, mild-to-moderate exercise sessions, three or more times per week.
- If the pregnancy is uncomplicated, a woman can and should continue a standard work schedule throughout the pregnancy.
- For patients with singleton pregnancies choosing aneuploidy (extra or missing chromosomes) screening, noninvasive prenatal testing is recommended.
- For patients with twin pregnancies choosing aneuploidy screening, noninvasive prenatal testing is suggested.
- Assessing all patients for risk factors that may impact the initiation and continuation of lactation is suggested. Risk factors may include depression, obesity, inappropriate weight gain, and gestational diabetes.
- To improve the probability of initiating and continuing lactation, individual or group lactation education is suggested for all pregnant and postpartum patients. Education may be delivered via in-person, telemedicine, or multimedia modalities.
- For the prevention of urinary incontinence in late pregnancy and up to six months postpartum, early prenatal evaluation of pelvic floor muscle function and pelvic floor muscle exercise instruction is suggested for all patients.

- For patients who report urinary incontinence in the postpartum period, a referral to pelvic health rehabilitation is suggested.
- Consider offering telemedicine as a complement to routine perinatal care.
- Inadequate data was available to offer a recommendation for or against specific interventions that would reduce disparities in perinatal care access as they related to maternal and childbirth outcomes.

Nutrition

- At least 400 mcg of folic acid should be taken daily, beginning one month before conception, and continuing throughout the pregnancy.
- Folic acid should be continued throughout breastfeeding.

Mental Health Screening

- Screening for the use of unauthorized prescription medications, alcohol, tobacco and nicotine products, cannabis, and illicit drugs should be performed, because such substances may result in adverse outcomes. Additional evaluation and treatments are recommended if a woman screens positive for any of these substances.
- Screening for depression should occur periodically during pregnancy and in the postpartum period utilizing a standardized tool (e.g., the Edinburgh Postnatal Depression Scale or the nine-item Patient Health Questionnaire).
- Patients with posttraumatic stress disorder (PTSD) should be screened for active PTSD and offered PTSD treatment.
- Screening should be performed regarding intimate partner violence.

Mental Health Treatment

- For pregnant patients at risk for perinatal depression, offering individual or group interpersonal psychotherapy or cognitive behavioral therapy is recommended.
- For treating depression during pregnancy or postpartum, interpersonal psychotherapy is recommended.
- For treating depression during pregnancy or postpartum, cognitive behavioral therapy is suggested.
- Peer support is suggested to improve depressive symptoms for patients with perinatal depression or for those at risk for perinatal depression.
- For depressive symptoms in perinatal patients, exercise, mindfulness, yoga, or any combination is suggested.
- Psychotherapies, such as interpersonal psychotherapy or cognitive behavioral therapy, or yoga (or both) are suggested for anxiety symptoms during and after pregnancy.

Education

- Education on breastfeeding and assessments, in addition to support for breastfeeding, should be provided for all pregnant patients and their families, and should begin with the first appointment and continue throughout the pregnancy and postpartum period.

- Education should include the use of open-ended questions and should be tailored to the needs of the pregnant woman and the resources available in the community.

Screening and Diagnostic Testing

- Prenatal screening for aneuploidy and the most common clinically significant genetic disorders should be offered to all pregnant patients.
- If aneuploidy screening is desired, cell-free fetal DNA screening should be considered; however, screening test selection should be individualized. The patient's age, baseline aneuploidy risk, and test performance for a given condition should all be taken into consideration.
- Risk-factor screening should include the following:
    - Preeclampsia
    - Diabetes mellitus
    - Spontaneous preterm birth
    - Intimate partner violence
- It is recommended that a two-step process for gestational diabetes screening (a 1-hour oral glucose challenge test followed by a 3-hour oral glucose tolerance test) be completed for all pregnant patients at 24 to 28 weeks' gestation.
- Infectious disease screening should be performed, and conditions treated (as appropriate), per Centers for Disease Control and Prevention (CDC) recommendations, and may include the following:
    - Gonorrhea
    - Chlamydia
    - Syphilis
    - Human immunodeficiency virus (HIV)
    - Hepatitis B and C
    - Rubella
    - Varicella
    - Human papillomavirus (HPV)
    - Herpes simplex virus (HSV)
    - Asymptomatic bacteriuria
    - Tuberculosis
    - Group B streptococcus (GBS)
- An immunization assessment should be performed for all pregnant and breastfeeding patients.

Imaging

- A first-trimester ultrasound is recommended to confirm or establish the gestational age and estimated birth date, to identify multiple pregnancies, and to confirm the presence of cardiac activity.
- If a woman presents after the first trimester, an ultrasound before 22 weeks' gestation to assess anatomy and confirm gestational age is encouraged.

Preparing for Delivery

- A scheduled delivery is recommended for all patients who have not delivered by 41 weeks and 0/7 days.
- If a woman is not scheduled for delivery at 41 weeks and 0/7 days, antepartum fetal testing should be performed.

Preterm Delivery

- For patients between 24 0/7 weeks' gestation and 34 6/7 weeks' gestation with signs and symptoms of preterm labor, consider fetal fibronectin testing as part of the evaluation plan.
- For patients with a singleton pregnancy with a short cervix and a history of spontaneous preterm birth, or both, vaginal progesterone or cerclage is suggested.
- Due to insufficient evidence, no recommendation can be made regarding the use of aspirin to reduce recurrent spontaneous preterm birth.

Hypertensive Disorders

- For patients at risk for developing preeclampsia, initiate aspirin therapy (100 to 150 mg) at or before 16 weeks' gestation.
- Counseling on the benefits of the Dietary Approaches to Stop Hypertension (DASH) diet is suggested for patients with cardiometabolic disorders, such as gestational diabetes, hypertension, and obesity.
- Due to insufficient evidence, no recommendation can be made regarding the self-monitoring of blood pressure during pregnancy and postpartum.

Postpartum Care

- Documentation of reproductive history is recommended if a woman has a past or current history of gestational diabetes mellitus, hypertension, or preeclampsia.
    - Education should be provided to patients who are at higher risk for these conditions, such as those with cardiovascular disease and/or diabetes.
- If a woman has a history of acute pulmonary edema, which is often associated with other conditions such as preeclampsia or magnesium sulfate toxicity, they are encouraged to have a follow-up visit in primary care.

Referral

- Evaluation and counseling by a qualified obstetric provider are encouraged if there is an unexplained elevation of maternal serum alpha-fetoprotein, due to an increased risk for adverse perinatal outcomes.
- It is not recommended to use the fetal fibronectin test in asymptomatic patients for preterm delivery screening; however, using this test is recommended as a part of the evaluation strategy in patients between 24 and 34 6/7 weeks' gestation with signs and symptoms of preterm labor.

Special Considerations

High Risk for Preeclampsia

- A low dose of aspirin (e.g., 100 to 150 mg daily), beginning at or before 16 weeks' gestation, is recommended for patients at risk for preeclampsia.

High Risk for Preterm Delivery

- Antenatal progesterone therapy may be used, when appropriate, for patients at high risk for recurrent preterm delivery.
- Consultation with an advanced prenatal care provider (e.g., an obstetrician or maternal-fetal medicine specialist) is recommended.
- Progesterone is usually started early in the second trimester and continued until approximately 36 weeks' gestation.

Over 44 Years of Age

- A planned delivery is suggested at 38 weeks for individuals over the age of 44 years to reduce the risk of stillbirth.

History of Bariatric Surgery

- Evaluation for nutritional deficiencies and the need for nutritional supplementation where indicated (e.g., vitamin B12, folate, iron, calcium) is suggested for individuals who have undergone bariatric surgery.
- Due to insufficient evidence, no recommendation can be made regarding routine supplementation of vitamins A, D, E, or K for pregnant patients with a history of bariatric surgery.
- Pregnant individuals with a history of gastric bypass surgery should be evaluated by a bariatric surgeon.

Reference

Department of Veterans Affairs and the Department of Defense. (2023). *VA/DoD clinical practice guideline for the management of pregnancy: Version 4.0*, 1–193. https://www.healthquality.va.gov/guidelines/WH/up/VA-DoD-CPG-Pregnancy-Full-CPG_508.pdf