

TRIAGE OF PREGNANT PATIENTS IN EMERGENCY DEPARTMENT (WITHOUT OBSTETRIC COVERAGE)

Pregnant patient presents to emergency department

Obtain patient's EDD (due date)
to determine gestational age (GA)

AND

Symptoms that could be pregnancy-related?
(headache, visual changes, shortness of breath, abdominal
pain, cramping, contractions, abdominal trauma, vaginal
bleeding/discharge, decreased fetal movements)

GA < 20 weeks
with/without possible
Pregnancy-related symptoms

Usual ED care

GA ≥ 20 weeks
WITH possible
Pregnancy-related symptoms

GA ≥ 20 weeks
Without possible
Pregnancy-related symptoms

Usual ED care

*Clinical
guidelines
translate best
evidence into
best practice. If
concurrent
conditions
and/or special
circumstances
exist, patient
care can, **and**
should be,
individualized.
Please consider
this guidance as
only suggestions
for clinical care,
not mandates.*

Prompt evaluation should include:

OB history (G_?P_?)

Vital signs

Fetal heart rate via handheld Doppler or US

Pelvic exam for cervical dilation

*Digital exam is acceptable in absence of vaginal bleeding, rupture
of membranes, known vasa previa, or known placenta previa*

+/- Labs (including CBC and CMP if hypertension)

+/- POCUS for fetal presentation

**Ideally within
15 minutes of
patient's arrival**

Call appropriate transfer center for higher level of obstetric/neonatal care

Call should NOT be delayed for labs, US

OneCall for MaineHealth Maine Medical Center: (207) 662-6632
for transfer to MMC Portland or consultation with Maternal-Fetal Medicine

**Northern Light Integrated Transfer Center for
Eastern Maine Medical Center:** (207) 973-9000
for transfer to Northern Light EMMC or consultation with OB/GYN

**may be suitable for transfer to local hospital with OB coverage at later GA*

POSTPARTUM patients:

If within **6 weeks** of delivery with: fever/chills, breast pain, chest pain, SOB, abdominal pain, heavy
vaginal bleeding, BP ≥160/110 mmHg, dehiscence or infection of perineal laceration or cesarean incision

Call appropriate transfer center above for OB/GYN consultation and/or transfer (if indicated)

For treatment of hypertension, refer to Hypertensive Disorders in Pregnancy guideline available at: <https://www.mainehealth.org/health-care-professionals/clinical-guidelines-protocols/obstetrical-perinatal-guidelines>

POTENTIAL ANTEPARTUM MEDICATIONS

Only administer if advised to do so by MFM or OB/GYN

- FOR fetal lung maturity:** Betamethasone 12 mg IM for single dose (**preferred**)
OR Dexamethasone 6 mg IM for single dose
- FOR tocolysis of contractions:** Indomethacin 50 mg PO for single dose (**only if < 32w0d**)
OR Nifedipine 20 mg PO for single dose
- FOR Group B strep (GBS):** Penicillin G 5 million units IV **OR** Ampicillin 2 grams IV for single dose
IF low-risk penicillin allergy (e.g., isolated rash without urticaria)
Cefazolin 2 g IV x 1 dose
IF high-risk penicillin allergy (e.g., urticaria, anaphylaxis)
Clindamycin 900 mg IV x 1 dose
- FOR neuroprotection:** Magnesium sulfate 4 gm bolus, followed by 1 gm/hour
for GA < 32w0d to
↓risk of cerebral palsy
Bolus: 4 gm in 100 mL NS, infuse once (over 15-20 minutes)
Maintenance: 20 gm in 500 mL NS, infuse at rate of 25 mL/hr
- FOR seizure prophylaxis:** Magnesium sulfate 4 gm bolus, followed by 2 gm/hour
for preeclampsia/eclampsia
Bolus: 4 gm in 100 mL NS, infuse once (over 15-20 minutes)
Maintenance: 20 gm in 500 mL NS, infuse at rate of 50 mL/hr
- Calcium gluconate 10% (1 gm)
if magnesium toxicity occurs
- Alternative: Magnesium sulfate 10 gm, intramuscular
Administer 5 gm in each buttock. Mix with 1 mL 2% xylocaine.

Potential POSTPARTUM Medications

Recommend discussion with OB/GYN prior to administration

- FOR postpartum hemorrhage:** *May include one or more of the following options:*
Methergine 0.2 mg IM for single dose (**avoid with hypertension**)

Carboprost 250 mcg IM for single dose (**avoid with asthma**)

Misoprostol 800 mcg per rectum for single dose

Tranexamic acid (TXA) 1 gm IV for single dose
- FOR seizure prophylaxis:** Magnesium sulfate 4 gm bolus, followed by 2 gm/hour
for preeclampsia/eclampsia
Bolus: 4 gm in 100 mL NS, infuse once (over 15-20 minutes)
Maintenance: 2 gm in 500 mL NS, infuse at rate of 50 mL/hr
- Calcium gluconate 10% (1 gm)
available for magnesium toxicity
- Alternative: Magnesium sulfate 10 gm, intramuscular
Administer 5 gm in each buttock. Mix with 1 mL 2% xylocaine.