

High Risk- Pregnancy Related Complications

R.Thomas



Pregnancy Complications #1

- ❖ Bleeding during pregnancy
- ❖ Hyperemesis gravidarum
- ❖ Gestational hypertension
- ❖ HELLP syndrome
- ❖ Gestational diabetes

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Pregnancy Complications #2

- ❖ Blood incompatibility
- ❖ Amniotic fluid imbalances
- ❖ Multiple gestation
- ❖ Premature rupture of membranes

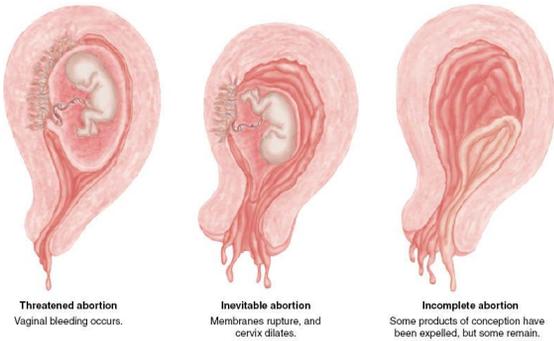
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Bleeding Conditions of Early Pregnancy

- ▶ Abortion
 - Spontaneous
 - Threatened
 - Inevitable
 - Incomplete
 - Complete
 - Missed
 - Recurrent

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Spontaneous Abortion

- ❖ Cause unknown and highly variable
 - First trimester commonly due to fetal genetic abnormalities
 - Second trimester more likely related to maternal conditions
- ❖ Nursing assessment
 - Vaginal bleeding
 - Cramping or contractions
 - Vital signs, pain level
 - Client's understanding

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Spontaneous Abortion: Nursing Management

- ❖ Continued monitoring: vaginal bleeding, pad count, passage of products of conception, pain level, preparation for procedures, medications (see Drug Guide 19.1)
- ❖ Support: physical and emotional; stress that woman is not the cause of the loss; verbalization of feelings, grief support, referral to community support group

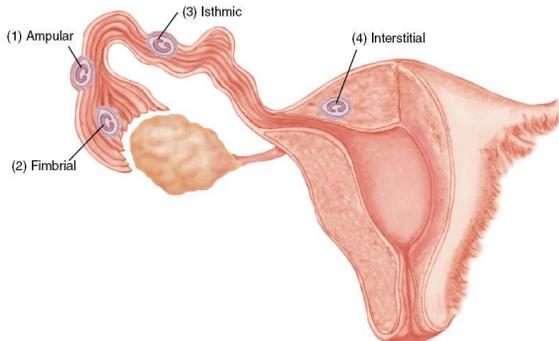
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Ectopic Pregnancy

- ▶ Etiologies
- ▶ S/S
 - Hallmark sign: abdominal pain with spotting within 6 to 8 weeks after missed menses
 - Lab and Diagnostics– TV US, hCG, additional lab
- ▶ Management
 - Medical: drug therapy (methotrexate, prostaglandins, misoprostol, and actinomycin)
 - Salpingostomy
 - Salpingectomy
 - Grief counseling





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Ectopic Pregnancy

- ❖ Nursing management
 - Preparation for treatment
 - Analgesics for pain
 - Medications for medical treatment
 - Teaching about signs and symptoms of rupture
 - Surgery
 - Emotional support
 - Education

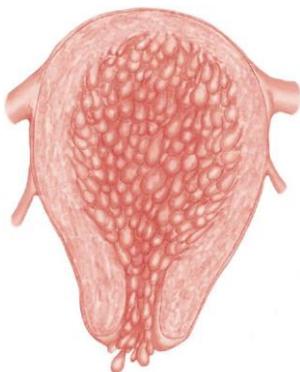
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Gestational Trophoblastic Disease

- ▶ Pathophysiology
- ▶ Incidence
- ▶ Types
 - Benign Neoplasm
 - Hydatiform Mole
 - GT Neoplasm
 - Invasive Mole
 - Choriocarcinoma





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Hydatiform Mole

- ▶ Most common form of GTD
- ▶ Risk factors
- ▶ Types
 - Partial
 - Complete
- ▶ Diagnosis
- ▶ S/S
- ▶ Management



Gestational Trophoblastic Neoplasm

- ▶ Invasive Mole
- ▶ Choriocarcinoma



Impact & Implications for GTD

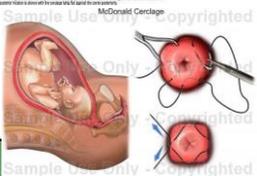
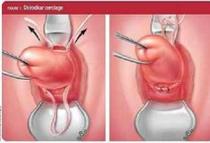
- ▶ Impact on Patient
- ▶ Implications for Nurses



Cervical Insufficiency/ Incompetent Cervix (Dysfunctional)

- ▶ Etiologies
- ▶ Dx
- ▶ Treatment
 - Bedrest
 - Pelvic rest
 - No heavy lifting
 - Cervical cerclage
 - Shiroakar
 - McDonald's

Cerclage



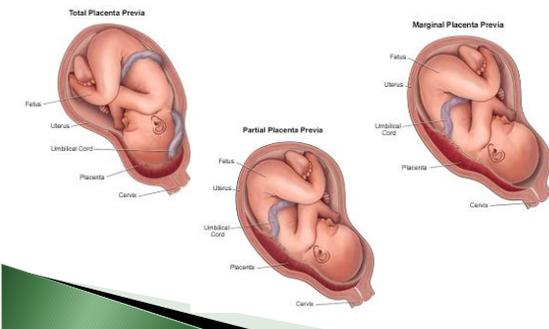
Cervical Insufficiency #2

- ❖ Nursing assessment
 - Risk factors
 - Pink-tinged vaginal discharge or pelvic pressure
 - Cervical shortening via transvaginal ultrasound
- ❖ Nursing management
 - Continuing surveillance; close monitoring for preterm labor
 - Emotional support
 - Education

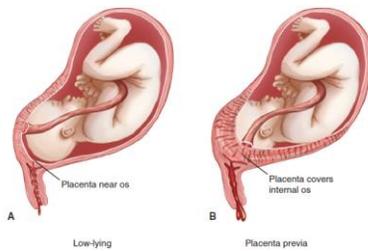
Placenta Previa

- ▶ Incidence
- ▶ Predisposing factors
 - Previous C/S
 - Induced abortions
 - Multiparity
 - Advanced maternal age
- ▶ Degrees
 - Complete
 - Parital
 - Marginal (Low Lying)
- ▶ S/S
- ▶ Dx
- ▶ Treatment/ Management

Placenta Previa



Placenta Previa #2



Placenta Previa #3

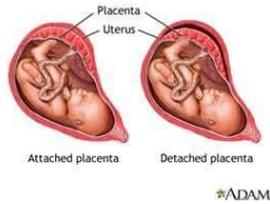
- ❖ Nursing management
 - Monitoring of maternal–fetal status
 - Vaginal bleeding; pad count
 - Avoidance of vaginal exams
 - FHR
 - Support and education: fetal movement counts, effects of prolonged bed rest (if necessary); signs and symptoms to report
 - Preparation for possible cesarean birth (see Nursing Care Plan 19.1)

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Abruptio Placentae

- ▶ Incidence
- ▶ Complete abruptio
- ▶ Partial Abruptio
- ▶ Associated factors
- ▶ S/S
- ▶ Dx
- ▶ Treatment/ Management





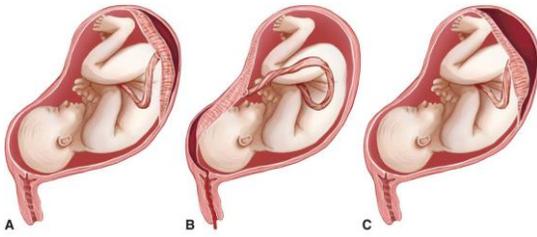
Placental Abruption #2

- ❖ Nursing assessment (see Comparison Chart 19.1)
 - Risk factors
 - Bleeding (dark red)
 - Pain (knife-like), uterine tenderness, contractions
 - Fetal movement and activity (decreased)
 - Fetal heart rate
 - Laboratory and diagnostic testing: CBC, fibrinogen levels, PT/aPTT, type and cross-match, nonstress test, biophysical profile

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Placental Abruption #3



Partial abruption, concealed hemorrhage

Partial abruption, apparent hemorrhage

Complete abruption, concealed hemorrhage

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Placental Abruption #4

❖ Nursing management

- Tissue perfusion: left lateral position, strict bed rest, oxygen therapy, vital signs, fundal height, continuous fetal monitoring
- Support and education: empathy, understanding, explanations, possible loss of fetus, reduction of recurrence

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Placental Abnormalities

- ▶ Placenta accreta
- ▶ Placenta increta
- ▶ Placenta Precreta



Pica

- ▶ Etiology
- ▶ S/S
 - Iron deficiency anemia
 - Zinc deficiency
 - Parasites
 - Toxins
 - Microorganisms
- ▶ Treatment/ Management
 - Nutritional counseling

Hypertensive Disorders of Pregnancy

- ▶ Chronic hypertension
- ▶ Gestational hypertension
- ▶ Preeclampsia
- ▶ Eclampsia
- ▶ Chronic hypertension with superimposed preeclampsia

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Chronic Hypertension

- ▶ Diagnosis
 - Evidence suggests that hypertension preceded the pregnancy
 - When a woman is hypertensive before 20 weeks of gestation
- ▶ Effects
- ▶ Therapeutic management

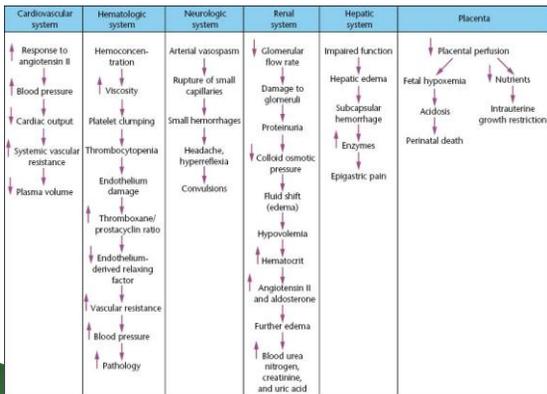
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Gestational HTN

- ▶ Risk factors
 - Primipara
 - Pregestational DM
 - Multiple gestations
 - Family hx of preeclampsia
 - Maternal age >35
- ▶ Treatment/ Management
 - Prevent complications
 - Prevent seizures
 - Safe delivery

Preeclampsia

- ▶ Etiology & S/S
 - Vasospasms
 - Vasoconstriction
 - ↓renal perfusion→proteinuria
 - ↓circulation to liver→↑liver enzymes
 - ↓cerebral circulation→cerebral hemorrhage
 - ↓placental circulation→infarctions, abruptio, IUGR
- ▶ Characterized
 - Mild or severe
- ▶ Dx
- ▶ Treatment/ Management



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Magnesium Sulfate

- ▶ Action
- ▶ Use
- ▶ Route/ Dosage
- ▶ Adverse Rxn
- ▶ Magnesium toxicity
- ▶ Nursing Interventions



Eclampsia

- ▶ Seizures

- ▶ Nursing Interventions/Management



Gestational Hypertension: Management #1

- ❖ Mild preeclampsia management
 - Bed rest, daily BP monitoring, and fetal movement counts
 - Hospitalization; IV magnesium sulfate during labor
- ❖ Severe preeclampsia management
 - Hospitalization; oxytocin and magnesium sulfate; preparation for birth
- ❖ Eclampsia management
 - Seizure management, magnesium sulfate, antihypertensive agents; birth once seizures controlled

Gestational Hypertension: Management #2

- ❖ Nursing assessment: risk factors, BP, nutritional intake, weight, edema; urine for protein; other laboratory tests if indicated
- ❖ Nursing management
 - Home management for mild preeclampsia
 - Hospitalization for severe preeclampsia; quiet environment, sedatives, seizure precautions, antihypertensives DTR testing, assessing for magnesium toxicity and labor



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HELLP Syndrome

- H- hemolysis of RBC's
- E- elevated
- L- liver enzymes
- L- low
- P-platelets
- ▶ Incidence
- ▶ S/S
- ▶ Dx
 - CBC, liver enzymes (LFT's)
- ▶ Treatment/ Management

Disseminated Intravascular Coagulation (DIC)/ Consumption Coagulopathy

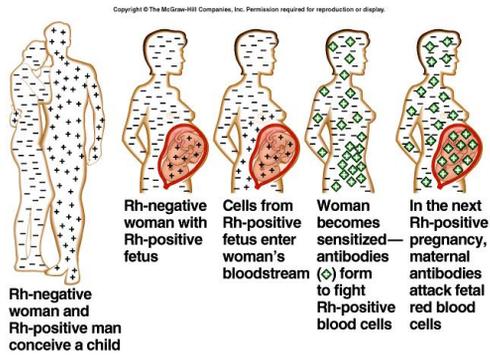
- ▶ Etiology
- ▶ Predisposing factors
- ▶ S/S
- ▶ Dx
- ▶ Treatment/ Management
 - Treat underlying cause
 - Replace clotting factors
 - Cryoprecipitate
 - FFP
 - PRBC'S
 - Whole blood
 - Observe
- ▶ Prognosis

Blood Incompatibility

- ❖ ABO incompatibility: type O mothers and fetuses with type A or B blood (less severe than Rh incompatibility)
- ❖ Rh incompatibility: exposure of Rh-negative mother to Rh-positive fetal blood; sensitization; antibody production; risk increases with each subsequent pregnancy and fetus with Rh-positive blood
- ❖ Nursing assessment: maternal blood type and Rh status
- ❖ Nursing management: RhoGAM at 28 weeks

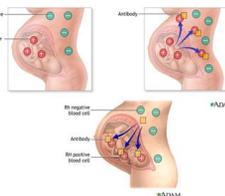
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Rh Incompatibility

- ▶ Pathophysiology
- ▶ Fetal/Neonatal Implications
 - Kernicterus → encephalopathy
 - Erythroblastosis fetalis
 - Hydrops fetalis
- ▶ Treatment/ Management
 - RhoGAM
 - (Rh D immune globulin)
 - Prenatal care
 - Rh factor
 - Indirect Coombs' test
 - Amniocentesis
 - Ultrasound
 - Intrauterine blood transfusion



Oligohydramnios

- ❖ Amniotic fluid <500 mL
- ❖ Therapeutic management: serial monitoring; amnioinfusion and birth for fetal compromise
- ❖ Nursing assessment: risk factors, fluid leaking from vagina
- ❖ Nursing management: continuous fetal surveillance; assistance with amnioinfusion, comfort measures, position changes

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Multiple Gestation

- ❖ Therapeutic management: serial ultrasounds, close monitoring during labor, operative delivery (common)
- ❖ Nursing assessment: uterus larger than expected for EDB; ultrasound confirmation
- ❖ Nursing management: education and support antepartally; labor management with perinatal team on standby; postpartum assessment for possible hemorrhage

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Risk of Multiple Pregnancy

- ▶ Maternal Risks
 - ↑ workload
 - Anemia
 - Hydramnios
 - Hyperemesis
 - Abnormal fetal positions
 - Uterine atony
- ▶ Fetal Risks
 - Congenital anomalies
 - SGA
 - Preterm birth
 - Abruptio

Care of Multiple Gestation

- ▶ Antepartum
- ▶ Intrapartum
- ▶ Postpartum



Premature Rupture of Membranes

- ❖ PROM—women beyond 37 weeks' gestation
- ❖ PPRM—women less than 37 weeks' gestation
- ❖ Treatment: dependent on gestational age; no unsterile digital cervical exams until woman is in active labor; expectant management if fetal lungs immature
- ❖ Nursing assessment: risk factors, signs and symptoms of labor, electronic FHR monitoring, amniotic fluid characteristics (see Box 19.3); nitrazine test, fern test, ultrasound

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Premature Rupture of Membranes

- ❖ Nursing management
 - Infection prevention
 - Identification of uterine contractions
 - Education and support
 - Discharge home (PPROM) if no labor within 48 hours (see Teaching Guidelines 19.3)

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Diabetes Mellitus: Classifications

- ❖ Typical classification
 - Type 1
 - Type 2
 - Impaired fasting glucose and impaired glucose tolerance
 - Gestational diabetes
- ❖ Classification during pregnancy
 - Pregestational diabetes
 - Gestational (see Table 20.1)

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Diabetes Mellitus: Pathophysiology and Pregnancy

- ❖ Fetal demands
- ❖ Role of placental hormones
- ❖ Changes in insulin resistance
- ❖ Effects on mother
- ❖ Effects on fetus (see Table 20.2)

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Effects of Preexisting Diabetes Mellitus on Pregnancy

- | | |
|-------------------|----------------------------|
| ▶ Hydramnios | ▶ Dystocia |
| ▶ Gestational HTN | ▶ Cesarean Deliveries |
| ▶ Ketoacidosis | ▶ Postpartum Hemorrhage |
| ▶ Preterm labor | ▶ Spontaneous abortions |
| ▶ Cord Prolapse | ▶ preeclampsia |
| ▶ Stillbirths | ▶ ↑ risk for pp hemorrhage |
| ▶ Hypoglycemia | |
| ▶ UTI | |
| ▶ Chronic Monilia | |

Fetal–Neonatal Risks of Maternal Diabetes Mellitus

- Congenital Anomalies
- Macrosomia
- Birth trauma
- Preterm birth
- Perinatal death
- Fetal asphyxia
- Respiratory Distress Syndrome (RDS)
- Polycythemia
- IUGR
- Hyperbilirubinemia
- Hypoglycemia
- Hypocalcemia



Diabetes Mellitus: Therapeutic Management

- ❖ Preconception counseling
- ❖ Blood glucose level control (HbA1c <7%)
- ❖ Glycemic control
- ❖ Nutritional management
- ❖ Hypoglycemic agents
- ❖ Close maternal and fetal surveillance
- ❖ Management during labor and birth

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Diabetes Mellitus: Assessment

- ❖ Health history; physical examination; risk factors
- ❖ Screening at first prenatal visit; additional screening at 24 to 28 weeks for women considered at risk
- ❖ Maternal surveillance: urine for protein, ketones, nitrates, and leukocyte esterase; evaluation of renal function/trimester; eye exam in first trimester; HbA1c q4–6 weeks
- ❖ Fetal surveillance: ultrasound; alpha-fetoprotein levels; biophysical profile; nonstress testing; amniocentesis

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Gestational Diabetes Mellitus

- ▶ Risk Factors
- ▶ Screening/ Dx
 - 24–28 weeks
 - 1 hr glucose challenge test- if >140 then
 - 3 hr oral glucose tolerance test (gold standard)
 - FBS> 95mg/dl
 - 1 hr> 180mg/dl
 - 2 hr> 155mg/dl
 - 3hr> 140mg/dl

Fetal Surveillance (DM mother)

- ▶ US
- ▶ AFP
- ▶ Fetal echocardiogram
- ▶ Kick counts
- ▶ BPP
- ▶ NST
- ▶ Amnio
 - L/S ratio (lecithin/sphingomyelin)
 - Phosphatidylglycerol (PG) and phosphatidylinositol (PI)

Antepartum

- ▶ Diet modification
 - ADA diet
 - 3 meals with 3 snacks
- ▶ Insulin therapy
 - Regular or regular & NPH BID
- ▶ Home glucose monitoring
- ▶ HgA1C
- ▶ Kidney function
- ▶ Eye exam
- ▶ EKG
- ▶ Teach S/S of hypoglycemia/hyperglycemia

Intrapartum Management

- Glucose control
- Reglular insulin only
- Hourly I&O
- D50% available



Postpartum Management

- Monitor glucose levels
- Breastfeeding encouraged
- Weight control
- Exercise
- Monitor for hemorrhage



Congenital Heart Conditions Affecting Pregnancy

- ❖ Tetralogy of Fallot
- ❖ Atrial septal defect (ASD)
- ❖ Ventricular septal defect (VSD)
- ❖ Patent ductus arteriosus
- ❖ See Table 20.3

Acquired Heart Conditions Affecting Pregnancy

- ❖ Mitral valve prolapse
- ❖ Mitral valve stenosis
- ❖ Aortic stenosis
- ❖ Peripartum cardiomyopathy
- ❖ Myocardial infarction

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Functional Classification System

- ❖ Class I: asymptomatic; no limitation of physical activity
- ❖ Class II: symptomatic (dyspnea, chest pain) with increased activity
- ❖ Class III: symptomatic (fatigue, palpitation) with normal activity
- ❖ Class IV: symptomatic at rest or with any physical activity

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Cardiac Disease

- ▶ Classifications
 - I- no limitations
 - II- slight limitations
 - III- moderate limitations
 - IV- unable to perform activity without difficulty
- ▶ Treatment/ Management
 - Antepartum
 - Intrapartum
 - Postpartum

Cardiac Disease: Intrapartum Management

- ▶ 300 to 500 mL of blood is shifted from the uterus and placenta into the central circulation.
 - Extra fluid causes a sharp rise in cardiac workload.
- ▶ Vaginal delivery is recommended for a woman with heart disease unless there are specific indications for cesarean birth.
- ▶ Minimize maternal pushing and use of the Valsalva maneuver.
- ▶ Limit prolonged labor.

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Cardiac Disease: Postpartum Management

- ▶ Although no evidence of distress during pregnancy, labor, and childbirth, women may have cardiac decompensation during the postpartum period
 - Blood from the placenta and uterus increases the workload on the heart.
- ▶ Close observation for signs of infection, hemorrhage, and thromboembolism
 - Conditions can act together to precipitate postpartum heart failure.

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Cardiac Disease: Postpartum Management (Cont.)

- ▶ Signs and symptoms of congestive heart failure include:
 - Cough (frequent, productive, hemoptysis)
 - Progressive dyspnea with exertion
 - Orthopnea
 - Pitting edema of legs and feet or generalized edema of face, hands, or sacral area
 - Heart palpitations
 - Progressive fatigue or syncope with exertion
 - Moist rales in lower lobes, indicating pulmonary edema

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Chronic Hypertension

- ❖ Hypertension before pregnancy or before 20th week of gestation or persistence >12 weeks postpartum
- ❖ Therapeutic management: preconception counseling, lifestyle changes, antihypertensive agents for severe hypertension; fetal movement monitoring; serial ultrasounds
- ❖ Nursing management: lifestyle changes (DASH diet); frequent antepartal visits; monitoring for placental abruption, preeclampsia; daily rest periods; home BP monitoring; close monitoring during labor and birth and postpartum follow-up

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Iron-Deficiency Anemia

- ❖ Usually due to inadequate dietary intake
- ❖ Therapeutic management: eliminate symptoms, correct deficiency, replenish iron stores
- ❖ Nursing assessment
 - Fatigue, weakness, malaise, anorexia, susceptibility to infection (frequent colds), pale mucous membranes, tachycardia, pallor
 - Abnormal lab results: low hemoglobin, low hematocrit, low serum iron, microcytic and hypochromic cells, and low serum ferritin

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Iron-Deficiency Anemia: Nursing Management

- ❖ Compliance with drug therapy: prenatal vitamin and iron supplement
- ❖ Dietary instruction and counseling
- ❖ Education for drug therapy (see Teaching Guidelines 20.3)

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Sickle Cell Anemia

- ❖ Defect in hemoglobin molecule (hemoglobin S)
- ❖ Therapeutic management: dependent on status; supportive therapy; blood transfusions for severe anemia, analgesics for pain, antibiotics for infection
- ❖ Nursing assessment: signs and symptoms; evidence of crisis
- ❖ Nursing management
 - Support, education, follow-up
 - Labor: rest, pain management , oxygen and IV fluids, close FHR monitoring
 - Postpartum: antiembolism stockings, family planning options

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Autoimmune Disorders

- ▶ Systemic lupus erythematosus
- ▶ Multiple sclerosis
- ▶ Rheumatoid arthritis

Infections

- ▶ CMV
- ▶ Rubella
- ▶ Herpes Simplex Virus
- ▶ Hepatitis B
- ▶ Varicella-Zoster
- ▶ Parvovirus B19
- ▶ Group B Streptococcus
- ▶ Toxoplasmosis
- ▶ HIV/ AIDS

Women Who Are HIV-Positive

- ❖ Impact of pregnancy and HIV: threats to self, fetus, and newborn
- ❖ Therapeutic management: oral antiretroviral drugs twice daily from 14 weeks until birth; IV administration during labor; oral syrup for newborn in first 6 weeks of life; decision for birthing method
- ❖ Nursing assessment: history and physical examination; HIV antibody testing; testing for STIs

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Stages of HIV Infection Outlined by the CDC

TABLE 20.6 Stages of HIV Infection Outlined by the CDC

Stages	Description	Clinical Picture
I	Acute infection	Early stage with pervasive viral production Flu-like symptoms 2–4 weeks after exposure Signs and symptoms: weight loss, low-grade fever, fatigue, sore throat, night sweats, and myalgia Ability to spread HIV is highest during this stage because large amounts of HIV are being produced in the body, and the CD4 count drops.
II	Asymptomatic infection or clinical latency	Viral replication continues within lymphatics, but slows down Usually free of symptoms; lymphadenopathy
III	Persistent generalized lymphadenopathy	Possibly remaining in this stage for years; AIDS develops in most within 7–10 years Opportunistic infections occur
IV	End-stage disease (AIDS)	Severe immune deficiency; very vulnerable to infections High viral load and low CD4 counts Signs and symptoms: bacterial, viral, or fungal opportunistic infections, fever, wasting syndrome, fatigue, neoplasms, and cognitive changes

Centers for Disease Control and Prevention (CDC). (2019a). HIV and women. Retrieved June 16, 2020, from <https://www.cdc.gov/hiv/group/gender/women/index.html>.
Centers for Disease Control and Prevention (CDC). (2019b). HIV and pregnant women, infants, and children. Retrieved June 16, 2020, from <https://www.cdc.gov/hiv/group/gender/pregnantwomen/index.html>.

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Women Who Are HIV-Positive: Nursing Management

- ❖ Pretest and posttest counseling
- ❖ Education
- ❖ Support
 - Preparation for labor, birth, and afterward
 - Elective cesarean birth
 - Compliance with antiretroviral therapy
 - Family planning methods

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Vulnerable Populations

- ❖ Adolescents
- ❖ Pregnant women over age 35
- ❖ Obese pregnant women
- ❖ Women who are positive for HIV
- ❖ Women who abuse substances

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Pregnant Adolescent: Nursing Assessment

- ❖ Vision of self in future
- ❖ Realistic role models; emotional support
- ❖ Level of child development education
- ❖ Financial and resource management; work and educational experience
- ❖ Anger and conflict resolution skills
- ❖ Knowledge of health and nutrition for self and child
- ❖ Challenges of parenting role
- ❖ Community resources

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Pregnant Adolescent: Nursing Management

- ❖ Support
- ❖ Future planning (return to school; career or job counseling); options for pregnancy
- ❖ Frequent evaluation of physical and emotional well-being
- ❖ Stress management; self-care (see Box 20.3)
- ❖ Education (see Teaching Guidelines 20.6, Healthy People 2030 Box 20.2)

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Woman Over Age 35

- ❖ Nursing assessment
 - Preconception counseling; lifestyle changes; beginning pregnancy in optimal state of health
 - Laboratory and diagnostic testing for baseline; amniocentesis; quadruple blood test screen
- ❖ Nursing management: promotion of healthy pregnancy; education; early and regular prenatal care; dietary teaching; continued surveillance

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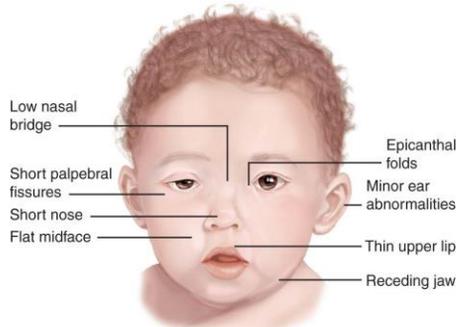
Pregnant Woman with Substance Abuse

- ❖ Impact of pregnancy: fetal vulnerability; teratogenic effect; addiction consequences
- ❖ Effect of common substances (see Table 20.6)
 - Alcohol: FAS; FASD (see Box 20.4; Figure 20.8)
 - Caffeine; nicotine
 - Cocaine
 - Marijuana
 - Opiates and narcotics: neonatal abstinence syndrome
 - Sedatives
 - Methamphetamines

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Pregnant Woman with Substance Abuse



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Pregnant Woman with Substance Abuse

- ❖ Nursing assessment: history and physical examination (see Box 20.5); urine toxicology
- ❖ Nursing management
 - Nonjudgmental approach
 - State protection agency investigation for positive newborn drug screen
 - Counseling
 - Education
