# CARE PROTOCOL: Antiphospholipid Antibody Syndrome (APS)

<table>
<thead>
<tr>
<th>Gestational age</th>
<th>Recommended intervention</th>
</tr>
</thead>
</table>
| **<20 weeks gestation** | • Obtain consult with Maternal-Fetal Medicine.  
• Confirm GA/EDC.  
• Check blood pressure (BP) and determine need for treatment; if BP >140/90, initiate antihypertensive therapy:  
  – Labetalol – first-line medication choice.  
  – Nifedipine – second-line medication choice.  
• Obtain baseline results for:  
  – 24-hour urine for total protein and serum creatinine.  
  – Liver function tests (AST/ALT).  
  – Platelet count.  
• Initiate low-dose aspirin therapy as early as possible in pregnancy.  
• Initiate heparin prophylaxis with appropriate monitoring:  
  – If NO history of VTE,  
    › Give either: heparin 7,500 units subcutaneous twice a day, or Lovenox 40 mg subcutaneous once a day.  
    › Follow platelet count every 3 days x 2 weeks to rule out heparin-induced thrombocytopenia (HIT).  
  – If HISTORY of VTE,  
    › Initiate Lovenox 1 mg/kg subcutaneous twice a day.  
    › Follow platelet count every 3 days x 2 weeks to rule out heparin-induced thrombocytopenia (HIT).  
    › Adjust dose of Lovenox to achieve serial Anti-Factor Xa levels in the upper half of therapeutic range.  
• Initiate home BP monitoring and establish BP review every 2 to 4 weeks; instruct patient to call if readings are consistently >140/90 mm Hg.  
• Review signs and symptoms of preeclampsia with the patient. |
| **20–28 weeks gestation** | • Perform ultrasound to assess fetal growth and AFI at 28–30 weeks GA.  
• Review BP and determine need to initiate or adjust antihypertensive therapy (see first- and second-line choices in row above); consider antenatal surveillance if hypertension or preeclampsia develops (see schedule in the row below).  
• If indications of preeclampsia, IUGR or fetal distress:  
  – Admit for evaluation of maternal/fetal condition. Transfer to tertiary care center if appropriate NICU services are not available.  
  – Give steroids. See PTL/PTB Medication Table on page 23.  
  – Give magnesium sulfate. See PTL/PTB Medication Table on page 23. |
| **29–32 weeks gestation** | • Review BP and determine need to initiate or adjust antihypertensive therapy (see first- and second-line choices in first row above).  
• Initiate antenatal surveillance (nonstress test, amniotic fluid assessment, and biophysical profile) per schedule below:  
  – No hypertension, IUGR, or oligohydramnios – weekly at 32 weeks gestation.  
  – Mild hypertension or preeclampsia – twice weekly at 32 weeks or at diagnosis.  
  – Severe hypertension – twice weekly beginning at 28 weeks or at diagnosis.  
• If indications of preeclampsia, IUGR or fetal distress:  
  – Admit for evaluation of maternal/fetal condition. Transfer to tertiary care center if appropriate NICU services are not available.  
  – Give steroids. See PTL/PTB Medication Table on page 23.  
  – Give magnesium sulfate. See PTL/PTB Medication Table on page 23. |
| **Delivery timing** | • Delivery will occur at >37 weeks GA unless one of the following occurs:  
  – Severe preeclampsia.  
  – Nonreassuring results noted on antenatal surveillance abnormal NST, positive CST, BPP <6 or abnormal UA Doppler.  
  – Severe IUGR (<10%) with oligohydramnios (AFI <5 cm). |

**PATIENT EDUCATION MATERIALS**

Intermountain fact sheets supporting this risk-specific protocol:

- **Anticoagulant Injections**
- **Preeclampsia**
- **How to Monitor Your Blood Pressure**
- **BP Tracker**
- **Fetal Testing (nonstress test, amniotic fluid assessment, and biophysical profile)**

Fact sheets available in English and Spanish. See page 25 for a list of all related resources, instructions for accessing them.

**KEY ACTIONS for providers:**

- Initiate ASA therapy before 12 weeks gestation.
- Initiate heparin prophylaxis before 12 weeks gestation.
- Follow delivery timing guidelines in this protocol.