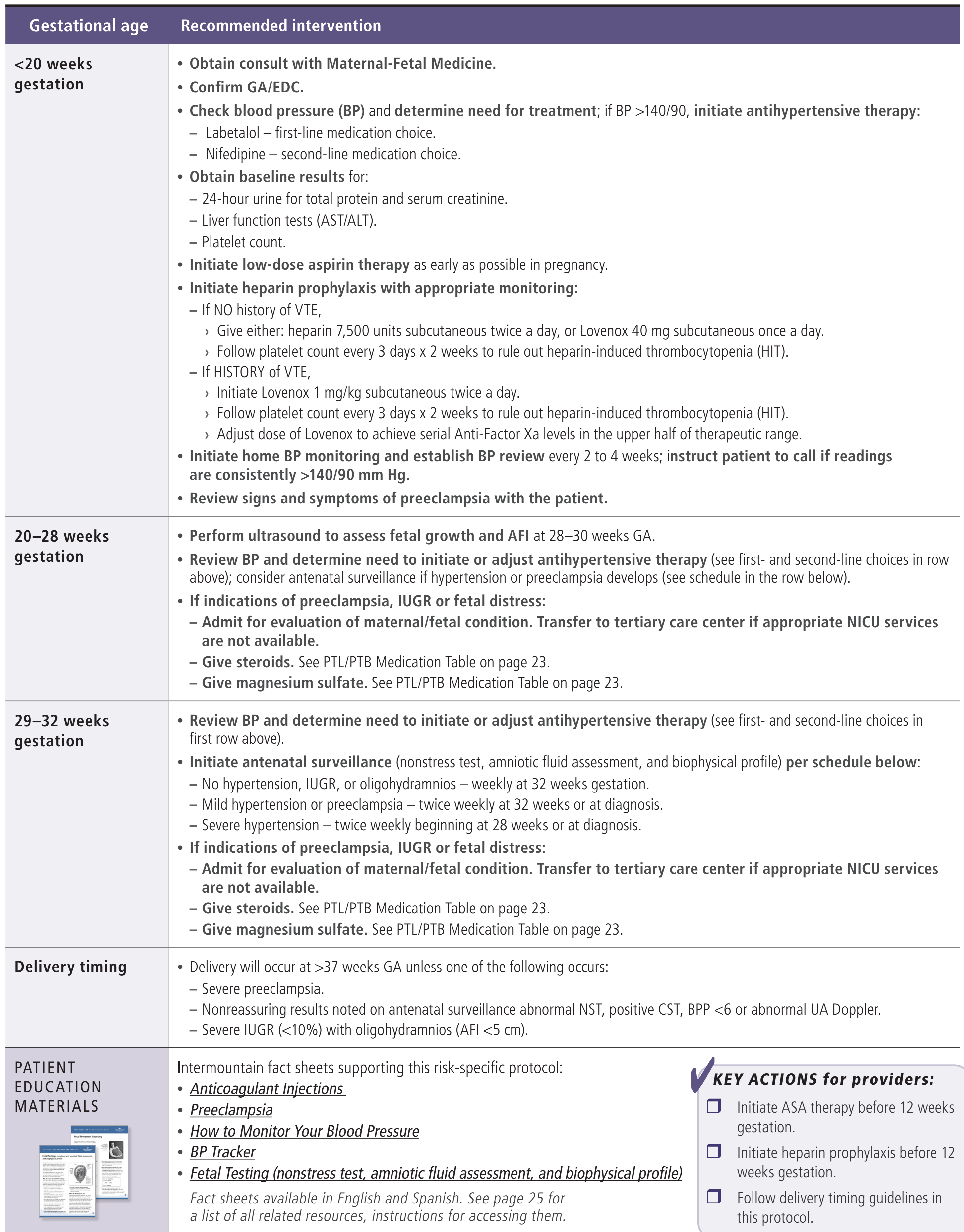
▶ **Click here** to view the complete care process model, ***Prevention and Management of Preterm Birth (Spontaneous and Indicated)***

CARE PROTOCOL: Antiphospholipid Antibody Syndrome (APS)



Gestational age	Recommended intervention
<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.

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