

STANDARDS, LIMITS AND CONDITIONS FOR PRESCRIBING, ORDERING AND ADMINISTERING DRUGS¹

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¹ Formerly *Guidelines for Prescribing, Ordering and Administering Drugs*

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2.1 DRUGS WHICH MAY BE INDEPENDENTLY PRESCRIBED, ORDERED AND ADMINISTERED BY A MIDWIFE WITH SPECIALIZED CERTIFICATION OR WHICH MAY BE ADMINISTERED AFTER CONSULTING WITH AND ON THE ORDER OF A MEDICAL PRACTITIONER.....76

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Controlled Substances for use in prodromal and active labour and for use in the early postpartum period can be found in the *CMBC Standards, Limits and Conditions for Prescribing, Ordering and Administering Controlled Substances*.

For antibiotic treatment of Sexually Transmitted Infections, please refer to the *Standards, Limits and Conditions for Prescribing, Ordering and Administering Drugs for Sexually Transmitted Infections*.

For Hormonal Contraceptives, please refer to the *Standards, Limits and Conditions for Prescribing, Ordering and Administering Hormonal Contraceptives*.

Cross Reference to the *Standards, Limits and Conditions for Prescribing, Ordering and Administering Drugs*

This cross reference to CMBC's *Standards, Limits and Conditions for Prescribing, Ordering and Administering Drugs* is an inclusive list, organised by purpose or clinical indication. Midwives may not independently prescribe, order or administer any other drugs or substances unless, on the advice of the College's Multidisciplinary Standards of Practice Committee, these standards are amended consistent with the Schedule A and B of the Midwives Regulation or the government amends the Schedules to the Midwives Regulation.

The clinical indications are listed in alphabetical order followed by the category of drug treatment, then by name of drug options.

Anaphylactic Reactions

Histamine Antagonists

Diphenhydramine Hydrochloride (Benadryl®)
Sympathomimetic
Epinephrine hydrochloride
Epinephrine hydrochloride (EpiPen®)

Breast Milk Production

Galactagogue

Domperidone (Motilium®)

Candidiasis – Nipple; Oral Thrush; Vaginal

Anti-fungals – Nipple treatment

APNO (All Purpose Nipple Ointment) - mupirocin, betamethasone, miconazole
Miconazole (Monistat®) derm cream
Triamcinolone - neomycin sulfate - nystatin – gramicidin (Kenacomb®)

Anti-fungals – Oral thrush treatment

Nystatin (Nilstat®, Mycostatin®)

Anti-fungals – Vaginal treatment

Clotrimazole (Canesten®)
Miconazole (Monistat®)

Episiotomy and Repair

Local Anaesthesia

Bupivacaine Hydrochloride (Marcaine®) – amide type anaesthetic
Lidocaine Hydrochloride (Xylocaine®) – amide type anaesthetic
Chloroprocaine (Nesacaine®) – ester type anaesthetic

Group B Streptococcus

Antibiotics

Ampicillin
Cefazolin,
Clindamycin
Penicillin G
Vancomycin

Hemorrhoids

Corticosteroids

Hydrocortisone compound

Herpes Simplex Virus

Anti-virals

Acyclovir
Valacyclovir hydrochloride

Hydration

Intravenous Fluids

Normal saline (0.9% NaCl)
Ringer's lactate
5% dextrose in water (D5W)

Hypertonic Uterine Contractions

Nitrates

Nitroglycerin

Hypovolemia

Intravenous Fluids

Normal saline (0.9% NaCl)

Induction/Augmentation of Labour (specialized practice certification required for prescribing)

Dinoprostone Insert/Prostaglandin E2 (Cervidil®)
Misoprostol
Oxytocin

Influenza

Anti-virals

Oseltamivir (Tamiflu®)

Zanamivir (Relenza®)

Vaccines

Flu and Seasonal Influenza Vaccine

Labour Pain Management

Inhalants

Nitrous Oxide pre-mixed 50/50 with Oxygen (Entonox® or Nitronox®)

Mastitis

Antibiotics

Cephalexin (Keflex®)

Clindamycin

Cloxacillin

Narcotic-Induced Depression

Narcotic Antagonist

Naloxone Hydrochloride (Narcan®)

Nausea and Vomiting

Anti-Nausea/Anti-Emetic

Dimenhydrinate (Gravol®)

Doxylamine succinate-pyridoxine hydrochloride (Diclectin®)

Metoclopramide (Maxeran®, Apo-Metoclop®)

Ranitidine (Zantac®, Apo-Ranitidine®, Novo-Ranidine®, Nu-Ranit®)

Ophthalmia Neonatorum Prophylaxis

Erythromycin Ophthalmic Ointment

Perineal Laceration/Repair

Local Anaesthesia

Bupivacaine Hydrochloride (Marcaine®) – amide type anaesthetic

Lidocaine Hydrochloride (Xylocaine®) – amide type anaesthetic

Chloroprocaine (Nesacaine®) – ester type anaesthetic

Postpartum Hemorrhage

Uterotonic agents

Carboprost tromethamine (Hemabate®)

Ergonovine maleate

Misoprostol (Cytotec®)
Oxytocin

Postpartum Pain Management

Non-steroidal anti-inflammatories

Diclofenac (Voltaren®)
Naproxen (Anaprox®, Naprelan®, Naprosyn®)

Analgesics

Acetaminophen with Tramadol (Apo-Tramadol/Acet®, Tramacet®)

Urinary Tract Infection

Antibiotics

Amoxicillin (Amoxil®, Polymox®, Trimox®)
Cefixime (Suprax®)
Cephalexin (Keflex®)
Nitrofurantoin (Apo-Nitrofurantoin®, Macrobid®, Macrochantin®, Novo-Furantoin®)

Vaccine Prophylaxis

Immune globulins

Hepatitis B immune globulin (HyperHep®, BayHep®, Infanrix hexa®)
Rho (D) immune globulin (Human) (WinRho®)
Measles/Mumps/Rubella (MMR)

Vitamin and mineral prophylaxis and therapy

Phytonadione (Vitamin K1)
Folic Acid

PREGNANCY DRUG RISK CATEGORIES

<u>Category</u>	<u>Definitions</u>²	<u>Clinical Application</u>
Category A	Controlled studies in clients fail to demonstrate a risk to the fetus in the first trimester (and there is no evidence of a risk in later trimesters),	For all practical purposes, there are no Category A drugs.

² Canadian Pharmacists Association. (2010). *Compendium of Pharmaceuticals and Specialties (CPS)*. Ottawa, ON: CPA.

and the possibility of fetal harm appears remote.

Category B

Either animal-reproduction studies have not demonstrated a fetal risk but there are no controlled studies in pregnant clients or animal-reproduction studies have shown an adverse effect (other than a decrease in fertility) that was not confirmed in controlled studies in clients in the first trimester (and there is no evidence of a risk in later trimesters).

Category B drugs include prenatal vitamins, acetaminophen and several other medications used routinely and safely during pregnancy. If there is a clinical need for a Category B drug, it is considered safe to use it.

Category C

Either studies in animals have revealed adverse effects on the fetus (teratogenic or embryocidal or other) and there are no controlled studies in clients or studies in clients and animals are not available. Drugs should be given only if the potential benefit justifies the potential risk to the fetus.

Category C drugs have not been shown to be harmful to fetuses (if they had been, they wouldn't be Category C drugs). However, there are some reasons to be more concerned about these drugs than Category B drugs. If the pregnant patient will benefit from a Category C drug, it is generally used, although most obstetricians would prefer a Category B drug if it will give equivalently good results.

Category D

There is positive evidence of human fetal risk, but the benefits from use in pregnant clients may be acceptable despite the risk (e.g., if the drug is needed in a life-threatening situation or for a serious disease for which safer drugs cannot be used or are ineffective.)

Category D drugs have some significant risks. They should be used during pregnancy only when the alternatives are worse.

Category X

Studies in animals or human beings have demonstrated fetal abnormalities or there is evidence of fetal risk based on human experience or both, and the risk of the use of the drug in pregnant clients clearly outweighs any possible benefit. The drug is

Category X drugs should not be used during pregnancy.

contraindicated in clients who are or may become pregnant.

PREGNANCY DRUG RISK DEFINITIONS OF RECOMMENDATIONS³

COMPATIBLE

The human pregnancy experience, either for the drug itself or drugs in the same class or with similar mechanisms of action, is adequate to demonstrate that the embryo-fetal risk is very low or nonexistent. Animal reproduction data are not relevant.

NO (LIMITED) HUMAN DATA – PROBABLY COMPATIBLE

There may or may not be human pregnancy experience, but the characteristics of the drug suggest that it does not represent a significant risk to the embryo-fetus. For example, other drugs in the same class or with similar mechanisms are compatible or the drug does not obtain significant systemic concentrations. Animal reproduction data are not relevant.

COMPATIBLE – MATERNAL BENEFIT – EMBRYO – FETAL RISK

There may or may not be human pregnancy experience, but the potential maternal benefit far outweighs the known or unknown embryo-fetal risk. Animal reproduction data are not relevant.

HUMAN DATA SUGGEST LOW RISK

There is limited human pregnancy experience, either for the drug itself or drugs in the same class or with similar mechanisms of action, including the 1st trimester, suggesting that the drug does not represent a significant risk of developmental toxicity (growth restriction, structural anomalies, functional/behavioral deficits, or death) at any time in pregnancy. The limited human pregnancy data outweigh any animal reproduction data.

NO (LIMITED) HUMAN DATA – ANIMAL DATA SUGGEST LOW RISK

Either there is no human pregnancy experience or the few pregnancy exposures have not been associated with developmental toxicity (growth restriction, structural anomalies, functional/behavioral deficits, or death). The drug does not cause developmental toxicity (at doses that did not cause maternal toxicity) in all animal species studied at doses ≤ 10 times the human dose based on body surface area or area under the plasma concentration vs. time curve; a measure of the systemic exposure of a drug (AUC).

NO (LIMITED) HUMAN DATA – ANIMAL DATA SUGGEST MODERATE RISK

Either there is no human pregnancy experience or the few pregnancy exposures have not been associated with developmental toxicity (growth restriction, structural anomalies, functional/behavioral deficits, or death). The drug causes developmental toxicity (at doses that did not cause maternal toxicity) in one animal species at doses ≤ 10 times the human dose based on body surface area or AUC.

NO (LIMITED) HUMAN DATA – ANIMAL DATA SUGGEST RISK

Either there is no human pregnancy experience or the few pregnancy exposures have not been associated with developmental toxicity (growth restriction, structural anomalies, functional/behavioral deficits, or death). The drug causes developmental toxicity (at doses that did not cause maternal toxicity) in two animal species at doses ≤ 10 times the human dose based on body surface area or AUC.

³ Briggs, Gerald G., Freeman, Roger K. (2015) *Drugs in Pregnancy and Lactation* Tenth Edition.

NO (LIMITED) HUMAN DATA – ANIMAL DATA SUGGEST HIGH RISK

Either there is no human pregnancy experience or the few pregnancy exposures have not been associated with developmental toxicity (growth restriction, structural anomalies, functional/behavioral deficits, or death). The drug causes developmental toxicity (at doses that did not cause maternal toxicity) in three or more animal species at doses ≤ 10 times the human dose based on body surface area or AUC.

CONTRAINDICATED – 1ST TRIMESTER

Human exposures in the 1st trimester, either to the drug itself or to drugs in the same class or with similar mechanisms of action, have been associated with developmental toxicity (growth restriction, structural anomalies, functional/behavioral deficits, or death). The drug should not be used in the 1st trimester.

CONTRAINDICATED – 2ND AND 3RD TRIMESTERS

Human exposures in the 2nd and 3rd trimesters, either to the drug itself or to drugs in the same class or with similar mechanisms of action, have been associated with developmental toxicity (growth restriction, structural anomalies, functional/behavioral deficits, or death). The drug should not be used in the 2nd and 3rd trimesters.

CONTRAINDICATED

Human exposures at any time in pregnancy, either to the drug itself or to drugs in the same class or with similar mechanisms of action, have been associated with developmental toxicity (growth restriction, structural anomalies, functional/behavioral deficits, or death). Animal reproduction data, if available, confirm the risk. The drug should not be used in pregnancy.

NO (LIMITED) HUMAN DATA – NO RELEVANT ANIMAL DATA

There is no human pregnancy data or relevant data in animals, or the human pregnancy experience, that may or may not include the 1st trimester, is limited. The risk in pregnancy cannot be assessed.

HUMAN DATA SUGGEST RISK IN 1ST TRIMESTER

Evidence (for the drug or similar drugs) suggests that there may be an embryo-fetal risk for developmental toxicity (growth restriction, structural anomalies, functional/behavioral deficits, or death) in the 1st trimester but not in the 2nd and 3rd trimesters. The human pregnancy data outweigh any animal reproduction data.

HUMAN DATA SUGGEST RISK IN 1ST AND 3RD TRIMESTERS

Evidence (for the drug or similar drugs) suggests that there may be an embryo-fetal risk for developmental toxicity (growth restriction, structural anomalies, functional/behavioral deficits, or death) in the 1st and 3rd trimesters but not in the 2nd trimester. The human pregnancy data outweigh any animal reproduction data.

HUMAN DATA SUGGEST RISK IN 2ND AND 3RD TRIMESTERS

Evidence (for the drug or similar drugs) suggests that there may be a fetal risk for developmental toxicity (growth restriction, structural anomalies, functional/behavioral deficits, or death) in the 2nd and 3rd trimesters but not in the 1st trimester. The human pregnancy data outweigh any animal reproduction data.

HUMAN DATA SUGGEST RISK IN 3RD TRIMESTER

Evidence (for the drug or similar drugs) suggests that there may be a fetal risk for developmental toxicity (growth restriction, structural anomalies, functional/behavioral deficits, or death) in the 3rd trimester, or close to delivery but not in the 1st or 2nd trimesters. The human pregnancy data outweigh any animal reproduction data.

HUMAN (AND ANIMAL) DATA SUGGEST RISK

The human data for the drug or drugs in the same class or with the same mechanism of action, and animal reproduction data if available, suggest there may be a risk for developmental toxicity (growth restriction, structural anomalies, functional/behavioral deficits or death) throughout pregnancy. Usually, pregnancy exposure should be avoided, but the risk may be acceptable if the maternal condition requires the drug.

LACTATION DRUG RISK CATEGORIES⁴

L1 Compatible:

Drug which has been taken by a large number of breastfeeding mothers without any observed increase in adverse effects in the infant. Controlled studies in breastfeeding clients fail to demonstrate a risk to the infant and the possibility of harm to the breastfeeding infant is remote; or the product is not orally bioavailable in an infant.

L2 Probably Compatible:

Drug which has been studied in a limited number of breastfeeding clients without an increase in adverse effects in the infant. And/or, the evidence of a demonstrated risk which is likely to follow use of this medication in a breastfeeding client is remote.

L3 Probably Compatible:

There are no controlled studies in breastfeeding clients, however the risk of untoward effects to a breastfed infant is possible, or controlled studies show only minimal non-threatening adverse effects. Drugs should be given only if the potential benefit justifies the potential risk to the infant. (New medications that have absolutely no published data are automatically categorized in this category, regardless of how safe they may be.)

L4 Possibly Hazardous:

There is positive evidence of risk to a breastfed infant or to breastmilk production, but the benefits of use in breastfeeding mothers may be acceptable despite the risk to the infant (e.g. if the drug is needed in a life-threatening situation or for a serious disease for which safer drugs cannot be used or are ineffective).

L5 Hazardous:

Studies in breastfeeding mothers have demonstrated that there is significant and documented risk to the infant based on human experience, or it is a medication that has a high risk of causing significant damage to an infant. The risk of using the drug in breastfeeding clients clearly outweighs any possible benefit from breastfeeding. The drug is contraindicated in clients who are breastfeeding an infant.

BREASTFEEDING DRUG RISK DEFINITIONS OF RECOMMENDATIONS⁵

COMPATIBLE

⁴ Hale, T. W., Rowe, Hilary E., (2014). *Medications in Mother's Milk (16th edition)*. Plano, TX: Hale Publishing.

⁵ Briggs, Gerald G., Freeman, Roger K. (2015) *Drugs in Pregnancy and Lactation* Tenth Edition.

Either the drug is not excreted in clinically significant amounts into human breast milk or its use during lactation does not, or is not expected to, cause toxicity in a nursing infant.

HOLD BREASTFEEDING

The drug may or may not be excreted into human breast milk, but the maternal benefit of therapy far outweighs the benefits of breast milk to an infant. Breastfeeding should be held until maternal therapy is completed and the drug has been eliminated (or reaches a low concentration) from her system.

NO (LIMITED) HUMAN DATA – PROBABLY COMPATIBLE

Either there is no human data or the human data are limited. The available data suggest that the drug does not represent a significant risk to a nursing infant.

NO (LIMITED) HUMAN DATA – POTENTIAL TOXICITY

Either there is no human data or the human data are limited. The characteristics of the drug suggest that it could represent a clinically significant risk to a nursing infant. Breastfeeding is not recommended.

HUMAN DATA SUGGEST POTENTIAL TOXICITY

Human data suggest a risk to a nursing infant. The drug is best avoided during breastfeeding. Depending on the drug short-term use by the mother may be possible, but the infant should be closely monitored for potential adverse effects.

NO (LIMITED) HUMAN DATA – POTENTIAL TOXICITY (MOTHER)

Either there is no human data or the human data are limited. The characteristics of the drug suggest that breastfeeding could represent a clinically significant risk to the mother such as further loss of essential vitamins or nutrients. Breastfeeding is not recommended.

CONTRAINDICATED

There may or may not be human experience, but the combined data suggest that the drug may cause severe toxicity in a nursing infant, or breastfeeding is contraindicated because of the maternal condition for which the drug is indicated. Clients should not breastfeed if they are taking the drug or have the condition.

STANDARDS, LIMITS and CONDITIONS for PRESCRIBING, ORDERING and ADMINISTERING DRUGS⁶

1.1 Drugs which may be independently prescribed, ordered and administered by a midwife.

The following standards, limits and conditions apply to the schedule of drugs and substances which midwives are able to independently prescribe, order and administer in the community, hospital or other sites of midwifery practice. This list is inclusive. Midwives may not independently prescribe, order or administer any other drugs or substances unless, on the advice of the College's Multidisciplinary Standards of Practice Committee, these standards are amended consistent with the Schedule A and B of the Midwives Regulation or the government amends the Schedules to the Midwives Regulation.

These *Standards* provide indications, routes of administration and upper dosage limits where appropriate, for drugs which may be prescribed, ordered or administered by midwives. Following these *Standards* is mandatory for all registered midwives.

Management decisions on clinical data should be based on local dosage and administration where these differ from those provided in this standard.

Antibiotics

Choice of antibiotic^{7,8} – It is important to review the sensitivity patterns of bacteria in your local area or health authority.

Antibiotic treatment of sexually transmitted infections requires specialized certification, please refer to the *Standards, Limits and Conditions for Prescribing, Ordering and Administering Drugs for Sexually Transmitted Infections*.

A) Antibiotics for Urinary Tract Infection

**Amoxicillin (Amoxil[®], Polymox[®], Trimox[®]),
Cephalexin (Keflex[®]),
Nitrofurantoin (Apo-Nitrofurantoin[®], Macrobid[®], Macrochantin[®], Novo-Furantoin[®]) and
Cefixime (Suprax[®])**

Urinary tract infection is the most common bacterial infection during pregnancy. Due to predisposing factors such as urinary stasis and vesicoureteral reflux, there are greater risks of upper UTIs during pregnancy. Untreated upper UTIs are associated with low birth weight, prematurity, premature labour, hypertension and/or preeclampsia, anemia, and amnionitis. Asymptomatic bacteriuria found on a midstream urine culture is a risk factor for an upper UTI. Timely treatment reduces the risk of symptomatic infection with its associated risks. A follow-up culture for test of cure should be obtained at one week after completion of treatment; up to 30 percent will fail to clear asymptomatic bacteriuria. If a repeat urine culture is positive or if symptoms remain, physician referral is required.

⁶ Formerly *Guidelines for Prescribing, Ordering and Administering Drugs*

⁷ Drug Information Lexicomp. (n.d.). *Cephalexin, nitrofurantoin, cefixime*. Retrieved from www.uptodate.com

⁸ Vancouver Island Health Authority. (2012). *Infection prevention and control manual*. Retrieved from www.viha.ca

Amoxicillin (Amoxil®, Polymox®, Trimox®)

Penicillin antibiotics act as a broad spectrum bactericidal against many gram-positive and gram-negative microorganisms. This is achieved through the inhibition of biosynthesis of cell wall mucopeptide.

Indications and Clinical Use:

For treatment of uncomplicated asymptomatic or symptomatic urinary tract infections (UTIs) in pregnancy and the postpartum caused by *Enterococcus faecalis*, *Escherichia coli*, or *Proteus mirabilis*.

Contraindications:

Documented hypersensitivity or allergy to amoxicillin or to any other penicillin antibiotic.

Warnings and Precautions:

Reduces efficacy of oral contraceptives; adjust dose in renal impairment; may enhance chance of candidiasis. Prolonged use may result in fungal or bacterial superinfection, including *C. difficile*-associated diarrhea (CDAD) and pseudomembranous colitis; CDAD has been observed >2 months post-antibiotic treatment.

Use with caution in asthmatic patients.

Breastfed infants may develop slightly looser stools than normal. Modification of bowel flora and allergic sensitization of the infant may occur⁹.

Pregnancy:

Human Data Suggest Risk in 1st and 3rd Trimesters

Lactation:

Category L1 - Compatible

Adverse Reactions:

Upset stomach, diarrhea, vomiting, vaginal infection and mild skin rash. The following should be reported to a medical practitioner immediately: severe skin rash, itching, hives, difficulty breathing or swallowing, wheezing, unusual bleeding or bruising, sore throat, painful mouth or throat sores, jaundice and diarrhea.

Dosage and Administration:

Asymptomatic bacteriuria (ASB):

Amoxicillin (Amoxil®, Polymox®, Trimox®): 500 mg orally every 8 hours (tid) for 3 days

Acute cystitis:

Amoxicillin (Amoxil®, Polymox®, Trimox®): 250-500 mg orally every 8 hours (tid) for 10 days

May be taken with food

Onset of Action:

Oral: Rapid; food does not interfere with absorption.

⁹ Drug Information Lexicomp. (n.d.). *Amoxicillin drug information*. Retrieved from www.uptodate.com

Half-Life:

1-1.4 hours

Cephalexin (Keflex®)

A first generation cephalosporin antibiotic. It interferes with the bacteria's cell wall formation by weakening the cell wall, causing it to rupture and killing bacteria.

Indications and Clinical Use:

For the treatment of asymptomatic or symptomatic urinary tract infection. It does not cover methicillin-resistant Staph Aureus (MRSA), which may account for about 21% of the staph aureus cultured¹⁰. It is also used to treat other bacterial infections such as pneumonia and bone, ear and skin that are not included in the *Midwives Regulation - Schedule A and B*.

Cephalexin provides good coverage for 1) streptococcus & staphylococcus; and modest coverage for 2) Escherichia coli, Klebsiella and Proteus (EKP) gram negative bacteria implicated in urinary tract infections.

Contraindications:

Documented anaphylaxis to any penicillin antibiotic.

Warnings and Precautions:

Prolonged use may result in fungal or bacterial superinfection, including *C. difficile*-associated diarrhea (CDAD) and pseudomembranous colitis; CDAD has been observed >2 months post-antibiotic treatment. Use with caution in patients with renal impairment; modify dosage in severe impairment.

Breastfed infants may develop slightly looser stools than normal.

Pregnancy:

Compatible – generally accepted that cephalosporins are safe to use during pregnancy

Lactation:

Category L1 – Compatible – generally considered to be compatible with breast-feeding

Adverse Reactions:

Upset stomach, diarrhea, vomiting, vaginal infection and mild skin rash. The following should be reported to a medical practitioner immediately: severe skin rash, itching, hives, difficulty breathing or swallowing, wheezing, unusual bleeding or bruising, sore throat, painful mouth or throat sores, jaundice and diarrhea.

Dosage and Administration:

Asymptomatic Bacteriuria:

Cephalexin (Keflex®): 250 mg orally every 6 hours (qid) for 3 days

Cystitis:

Cephalexin (Keflex®): 250 mg orally every 6 hours (qid) for 7-14 days or
500 mg orally every 12 hours (bid) for 7-14 days

¹⁰ Vancouver Island Health Authority (VIHA) 2011

May be taken with or without food. Taking with food may minimize gastrointestinal distress. Taking an active probiotic concurrently may help minimize changes to GI flora.

Onset of Action:

Rapid absorption, peak in about 1 hour.

Half-Life:

Adults: 0.5-1.2 hours; prolonged with renal impairment

Elimination:

Urine (80% to 100% as unchanged drug) within 8 hours

Maximum milk concentration occurs at 4 hours after a single oral dose and gradually disappears by 8 hours after administration.

Nitrofurantoin (Apo-Nitrofurantoin[®]; Macrobid[®]; Macrochantin[®]; Novo-Furantoin[®])

Inhibits bacterial enzyme systems thus interferes with metabolism and cell wall synthesis.

Indications and Clinical Use:

For the prevention and treatment of urinary tract infections caused by susceptible gram-negative and some gram-positive organisms; *E. coli*, *S. aureus*, *Enterococcus*, *Klebsiella*, and *Enterobacter*. *Pseudomonas*, *Serratia*, and most species of *Proteus* are generally resistant to nitrofurantoin.

Contraindications:

Contraindicated, at term (37-42 weeks)^{11, 12}, during labour, or when onset of labour is imminent as it may cause hemolytic anemia in infants, most often in the Mediterranean population.

Warnings and Precautions:

Caution is advised with G6PD deficiency or anemia. Although rare, severe hepatic reactions have been associated with nitrofurantoin (onset may be insidious); discontinue immediately if hepatitis occurs. Has been associated with peripheral neuropathy (rare); risk may be increased by renal impairment, diabetes, vitamin B deficiency, or electrolyte imbalance.

Pregnancy:

Human Data Suggest Risk in 3rd Trimester

Lactation:

Category L2 - Limited Human Data – Probably Compatible
Use with caution in newborns at risk for hyperbilirubinemia.

Adverse Reactions:

Nausea, vomiting, diarrhea, drowsiness and dizziness, peripheral neuropathy (reversible) and respiratory symptoms (drug-induced pneumonitis).

Dosage and Administration:

¹¹ Cimolai, N., Cimolai, T. (2007, June 19). Nitrofurantoin and pregnancy. *CMAJ*, 176(13), 1860-1861.

¹² Hooton, T. M. (2012). *Acute uncomplicated cystitis and pyelonephritis in women*. Retrieved from www.uptodate.com

Sustained release (commonly Macrobid®): 100 mg orally with food every 12 hours (bid) for 5 to 7 days, or
Regular release – 50-100 mg orally with food every 6 hours (qid) for 3 days if UTI is asymptomatic and 7 days if symptomatic.

Take with meals to improve absorption and decrease adverse effects.

Onset of Action:

Metabolized according to sustained or regular release. Slower absorption in sustained release.

Peak antibacterial concentrations: approximately 30 minutes.

Half-Life:

20-60 minutes

Cefixime

(Suprax®) An oral antibiotic of the cephalosporin class, related to penicillin. This drug has an extended spectrum of activity including about 95% coverage of E. Coli, which is the most common organism causing UTI in pregnancy.

Indications and Clinical Use:

Used for the treatment of urinary tract infection in pregnancy (UTI). This drug should be considered as a second line for treatment of UTI in pregnancy due to concerns of developing resistance.

Contraindications:

Allergy to cephalosporin group of antibiotics

Warnings and Precautions:

Chance of cross-reactivity is low (around 3%) if the patient is penicillin sensitive, however do not use it for highly allergic (eg. anaphylactic) patients. Use with caution in patients with colitis.

Alteration of GI flora may occur, as with all antibiotics, see *Probiotic Use with Antibiotics*.

Pregnancy:

Compatible

Lactation:

Category L2 - Limited Data – Probably Compatible

Adverse Reactions:

Diarrhea, gas, loose stools, nausea and stomach upset.

Dosage and Administration:

The dose is 400 mg daily for 7 days.
Administer with food if GI upset occurs.

Onset of Action:

Time to peak, serum: 2-6 hours; delayed with food.

Half-Life:
3-4 hours.

B) Antibiotics for Group B Strep Prophylaxis

Choice of antibiotic¹³ - It is important to review the sensitivity patterns of bacteria in your local area or health authority.

Ampicillin, Penicillin G, Cefazolin, Clindamycin, and Vancomycin

For treating asymptomatic Group B Strep, the midwife may order these antibiotics following the Perinatal Services of BC (PSBC) or other appropriate hospital protocol. All of these antibiotics have similar activity against GBS and all cross the placenta. Ampicillin, having a broader spectrum of anti-microbial activity than Penicillin, may be more likely to lead to selection or resistant organisms than would widespread use of Penicillin.

Group B streptococcus (GBS) bacteria is a gram-positive coccus commonly found in the gastrointestinal tract. It is estimated that between 10 and 30% are colonized with the Group B streptococcus at any given time including at the time of birth. The GBS bacteria can migrate out of the digestive tract and into the vaginal canal and into the urethra and colonize the bladder. GBS bacteriuria occurs in 2% to 4% of all pregnancies and is associated with urinary tract disease (see Antibiotics for Urinary Tract Infection above), endometritis, wound infection and an increased risk of neonatal disease. Heavy colonization of GBS has been associated with preterm labour and preterm premature rupture of membranes. GBS can potentially cause devastating complications for the newborn infant such as sepsis, pneumonia, meningitis and death.

The antibiotic regimen of choice for intrapartum chemoprophylaxis is intravenous Penicillin G or Ampicillin. Penicillin G is generally considered preferable to Ampicillin. If allergic to Penicillin, intravenous Cefazolin may be administered if low risk for anaphylaxis, or intravenous Clindamycin if high risk for anaphylaxis **and** the GBS is confirmed to be sensitive to Clindamycin, or intravenous Vancomycin if at high risk for anaphylaxis and the GBS is not sensitive to Clindamycin. If Vancomycin is being considered, an antenatal referral for penicillin skin testing to confirm the penicillin allergy is recommended. The incidence of anaphylactic reaction to Penicillin ranges from .04 to .004 (4 in 10,000 to 4 in 100,000).

Ampicillin

A broad spectrum anti-microbial synthetic Penicillin inhibiting bacterial cell wall synthesis. It is an antibacterial agent with a broad spectrum of bactericidal activity against Penicillin-susceptible Gram-positive organisms and other common Gram-negative pathogens.

Indications and Clinical Use:

Intravenous Ampicillin for intrapartum chemoprophylaxis against GBS infection.

Contraindications:

Hypersensitivity to Ampicillin or any other component of the formulation or to other penicillins.

¹³ Drug Information Lexicomp. (n.d.). *Ampicillin, Penicillin G, Cefazolin, Clindamycin, Vancomycin drug information*. Retrieved from www.uptodate.com

Warnings and Precautions:

*Clostridium difficile associated diarrhea (CDAD) has been reported and can occur over two months after the use of many antibacterial agents, including Ampicillin. CDAD ranges in severity from mild diarrhea to fatal colitis. Treatment with antibacterial agents alters the normal flora of the colon which in turn leads to the overgrowth of *C. difficile*.

Use with caution in asthmatic and renal impaired patients.

Breastfed infants may develop slightly looser stools than normal.

Pregnancy Category:

Human Data Suggest Risk in 1st Trimester

Lactation Category:

Category L1 - Compatible

Adverse Reactions:

Fever, rash, nausea and vomiting, penicillin encephalopathy and seizure.

Dosage and Administration:

IV: 2 g initial dose followed by 1 g every 4 hours until delivery.
Administer over 10-15 minutes (1-2 g).

Onset of Action:

Peak serum concentrations occur immediately once administration is complete.

Half-life:

0.7-1.5 hours in adults. Serum concentrations may still be detectable within 6 hours of administration.

Penicillin G

Inhibits mucopeptide synthesis of bacterial cell wall. Penicillin G is a bactericidal against penicillin-susceptible microorganisms.

Indications and Clinical Use:

Intravenous Penicillin G is the **antibiotic of choice** for intrapartum chemophylaxis.

Contraindications:

History of a hypersensitivity reaction to any penicillin.

Warnings and Precautions:

Administer drug with caution to cephalosporin-sensitive patients due to possible cross-reactivity.

Use with caution in patients with histories of significant allergies and/or asthma.

Use with caution in patients with renal impairment and in patients with a history of seizure disorder.

Breastfed infants may develop slightly looser stools than normal.

Pregnancy:

Compatible

Lactation:

Category L1 - Compatible

Adverse Reactions:

Anxiety, confusion, dizziness, tremors, nausea, vomiting and diaphoresis.

Dosage and Administration:

IV: 5 million units followed by 2.5 – 3.0 million units every 4 hours until delivery.

Onset of Action:

IV: Peak serum concentrations occur immediately once administration is complete and within 1 hour.

Half-Life:

30-50 minutes

Elimination:

Urine (58% to 85% as unchanged drug)

Cefazolin

First generation cephalosporin antibiotic. Cefazolin inhibits bacterial cell wall synthesis by binding to one or more of the penicillin-binding proteins, thus inhibiting cell wall biosynthesis.

Indications and Clinical Use:

If allergic to Penicillin, and at low risk for anaphylaxis, intravenous Cefazolin may be administered.

Contraindications:

Hypersensitivity to cefazolin sodium, any component of the formulation, or other cephalosporins

Warnings and Precautions:

Use with caution in patients with a history of penicillin allergy.
Use with caution in patients with renal impairment.
Use with caution in patients with a history of seizure disorder.
Breastfed infants may develop slightly looser stools than normal.

Pregnancy:

Compatible

Lactation:

Category L1 - Compatible

Adverse Reactions:

Fever, seizure, rash, pruritus, Stevens-Johnson syndrome, diarrhea, nausea, vomiting, abdominal cramps, colitis and oral candidiasis

Dosage and Administration:

IV: 2 g followed by 1 g every 8 hours until delivery.

Onset of Action:

IV: Peak serum concentrations occur immediately once administration is complete and within 0.5-2 hours.

Half-Life:

90-150 minutes

Elimination:

Urine (80% to 100% as unchanged drug)

Clindamycin

Clindamycin is a lincosamide, a type of antibiotic that works by inhibiting bacterial protein synthesis.

Indications and Clinical Use:

Used as a second choice treatment for GBS if penicillin allergic. Intravenous Clindamycin is recommended if at high risk for anaphylaxis **and** the GBS is confirmed to be sensitive to Clindamycin.

Contraindications:

Known hypersensitivity or allergy.

Warnings and Precautions:

Prolonged use may result in fungal or bacterial superinfection, including *C. difficile*-associated diarrhea (CDAD) and pseudomembranous colitis. With any diarrhea after taking Clindamycin, maternal stool should be tested for *C. difficile*. A positive test for *C. difficile* is a reason for physician consult. CDAD has been observed >2 months post-antibiotic treatment.

Pregnancy:

Compatible

Lactation

Category L2 - Limited Data – Probably Compatible

Clindamycin has the potential to cause adverse effects on the breastfed infant's gastrointestinal flora. If oral or intravenous clindamycin is required during breastfeeding, it is not a reason to discontinue breastfeeding, but an alternate drug may be preferred. Monitor the infant for possible effects on the gastrointestinal flora, such as diarrhea, candidiasis (thrush, diaper rash) or rarely, blood in the stool indicating possible antibiotic-associated colitis.

Adverse Reactions:

Upset stomach, diarrhea, vomiting, vaginal infection and mild skin rash.

The following side effects should be reported to a medical practitioner immediately: severe skin rash, itching, hives, difficulty breathing or swallowing, wheezing, unusual bleeding or bruising, sore throat, painful mouth or throat sores, jaundice and diarrhea (in particular with Clindamycin).

Dosage and Administration:

IV: 900 mg every 8 hours until delivery.

Onset of Action:

Absorption is rapid; widely distributed into most body tissues and fluids, including gallbladder, liver, kidneys, bone, sputum, bile, and pleural and synovial fluids.

Half-Life:

2-3 hours

Vancomycin

A glycopeptide anti-infective antibiotic. Inhibits bacterial cell wall synthesis by blocking glycopeptide polymerization which alters cell-membrane permeability.

Indications and Clinical Use:

Intravenous Vancomycin is recommended if at high risk for anaphylaxis and the GBS is not sensitive to Clindamycin.

Contraindications:

Hypersensitivity to Vancomycin or any component of the formulation. Avoid in patients with previous hearing loss.

Warnings and Precautions:

Use with caution in patients with renal impairment.

Rapid IV administration may result in erythema, flushing, hypotension, urticaria, and/or pruritus.

Pregnancy:

Compatible

Lactation:

Category L1 - Limited Human Data – Probably Compatible

Small amounts of Vancomycin are excreted in human milk. When given intravenously, the small amount that distributes to the milk would not be expected to cause systemic toxicity due to the lack of GI absorption. Effects could include modification of bowel flora.

Adverse Reactions:

Anaphylaxis, hypotension, pruritus, rash, Stevens-Johnson syndrome, urticaria, vasculitis, nausea, chills, drug fever, hypotension and flushing of the face, neck, upper chest, and extremities.

Dosage and Administration:

IV: 1 g every 12 hours until delivery.

Onset of Action:

IV: Immediately after completion of infusion

Half-Life:

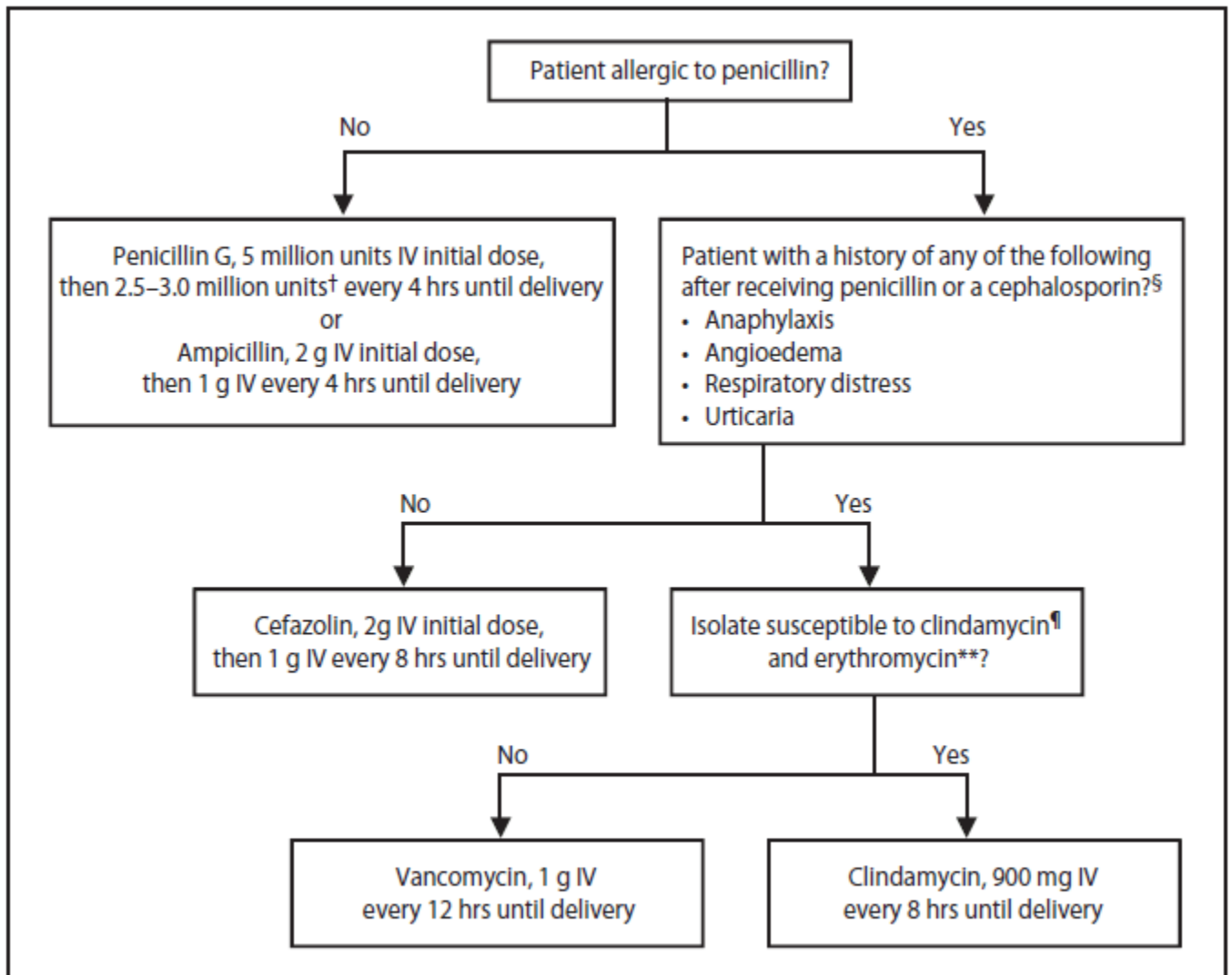
5-11 hours.

Elimination:

Urine (80% to 90% as unchanged drug)

Recommended regimens for intrapartum antibiotic prophylaxis for prevention of early-onset group B streptococcal (GBS) disease*

SOGC 2014 summary excerpt



C) Antibiotics for Mastitis

Choice of antibiotic¹⁴- It is important to review the sensitivity patterns of bacteria in your local area or health authority.

Cephalexin (Keflex®), Cloxacillin and Clindamycin

For treatment of symptoms consistent with mastitis for more than 24 hours. If the symptoms are worsening (increased pain, spreading of the redness, enlargement of the hardened area) for less than 24 hours, it is reasonable to start the antibiotics sooner. Whether mastitis is resolving with or without antibiotic treatment, symptoms should progressively resolve and should have disappeared over 2 to 5 days. Fever will usually be gone within 24 hours, the pain within 24 to 48 hours, and the breast hardness within the next few days. The redness may remain for a week or longer.

Breastfeeding should continue through the treatment of mastitis, even when on antibiotics as these are considered safe in breastfeeding. **Continuation of breastfeeding is considered safe and is encouraged.**

Cephalexin or Cloxacillin – both about equally effective.
Cloxacillin may be used if there is no allergy to penicillin.
Cephalexin may be used if there is a rash-only reaction to penicillin as the chance of cross-reaction is only about 3%.
Cloxacillin and cephalexin should be avoided if there is a serious allergy to penicillin (anaphylaxis; hives; throat edema; bronchoconstriction; serum sickness; hemolytic anemia; exfoliative dermatitis; organ dysfunction).

Clindamycin may be used if there is a serious penicillin allergy as above, or as a second choice if the infection is unresponsive to either cephalexin or cloxacillin.

The overall rate of susceptibility of Staph aureus to these three antibiotics is about the same, around 80%, however clindamycin is effective in about 75% of the methicillin-resistant bacteria (MRSA). Check local resistance patterns.

Cephalexin (Keflex®)

Cephalexin is a first generation cephalosporin antibiotic. It interferes with the bacteria's cell wall formation by weakening the cell wall, causing it to rupture and killing bacteria.

Indications and Clinical Use:

For the treatment of mastitis as well as treatment of asymptomatic or symptomatic urinary tract infection. Used to treat the gram positive cocci (staphylococcus aureus) that commonly cause mastitis. It does not cover methicillin-resistant Staph Aureus (MRSA), which may account for about 21% of the staph aureus cultured¹⁵. It is also used to treat other bacterial infections such as pneumonia and bone, ear and skin that are not included in the *Midwives Regulation - Schedule A and B*.

¹⁴ Dixon, J.M. (2012). *Lactational Mastitis*. Retrieved from www.uptodate.com

¹⁵ Gregson, D., Henwick, S., Swaine, F.B. (2011). *Medical Microbiology Services Review Final Report*. Retrieved from www.viha.ca/NR/rdonlyres/4A984B51-2DF9-48A0-98F1-0B4613573A80/0/medical_microbiology_services_review2011.pdf

Cephalexin provides good coverage for 1) streptococcus & staphylococcus; and modest coverage for 2) Escherichia coli, Klebsiella and Proteus (EKP) gram negative bacteria implicated in urinary tract infections.

Contraindications:

Documented anaphylaxis to any penicillin antibiotic.

Warnings and Precautions:

Prolonged use may result in fungal or bacterial superinfection, including *C. difficile*-associated diarrhea (CDAD) and pseudomembranous colitis; CDAD has been observed >2 months post-antibiotic treatment.

Use with caution in patients with renal impairment; modify dosage in severe impairment. Breastfed infants may develop slightly looser stools than normal.

Pregnancy:

Compatible

Lactation:

Category L1 - Compatible

Adverse Reactions:

Upset stomach, diarrhea, vomiting, vaginal infection and mild skin rash.

The following should be reported to a medical practitioner immediately: severe skin rash, itching, hives, difficulty breathing or swallowing, wheezing, unusual bleeding or bruising, sore throat, painful mouth or throat sores, jaundice and diarrhea.

Dosage and Administration:

Mastitis:

Cephalexin (Keflex®): 500 mg orally every 6 hours (qid) for 10-14 days

Note: Dose and duration of therapy can vary depending on infecting organism, severity of infection, and clinical response of patient. Treat severe staphylococcal infections for at least 14 days.

May be taken with or without food. Taking with food may minimize gastrointestinal distress. Taking an active probiotic concurrently may help minimize changes to GI flora.

Onset of Action:

Rapid absorption, peak in about 1 hour.

Half-Life:

Adults - 0.5-1.2 hours; prolonged with renal impairment

Elimination:

Urine (80% to 100% as unchanged drug) within 8 hours

Maximum milk concentration occurs at 4 hours after a single oral dose and gradually disappears by 8 hours after administration.

Cloxacillin

Cloxacillin is a penicillin-type antibiotic and is closely related to methicillin. Interferes with bacteria cell wall formation by weakening the cell wall, causing rupture and killing bacteria.

Indications and Clinical Use:

Mastitis as a complication of lactation. It is also used in other skin and soft tissue infections which are not in the *Midwives Regulation - Schedule A and B*.

Cloxacillin is particularly effective in Staph Aureus infections, and covers about 79% of those bacteria¹⁶. The remainder (about 21%) are “methicillin resistant staph aureus” MRSA, which may be susceptible to clindamycin.

It is generally not used to treat streptococcal infections as there are other more specific choices, or UTIs as it has limited gram negative coverage.

Contraindications:

Hypersensitivity to Cloxacillin. Any other penicillin allergy.

Warnings and Precautions:

Prolonged use may result in fungal or bacterial superinfection, including *C. difficile*-associated diarrhea (CDAD) and pseudomembranous colitis; CDAD has been observed >2 months post-antibiotic treatment.

Use with caution in patients with renal impairment; modify dosage in severe impairment. Breastfed infants may develop slightly looser stools than normal.

Pregnancy:

No (Limited) Human Data – Probably Compatible

Lactation:

Category L2 – Limited Data – Probably Compatible

Adverse Reactions:

Upset stomach, diarrhea, vomiting, vaginal infection and mild skin rash.

The following side effects should be reported to a medical practitioner immediately: severe skin rash, itching, hives, difficulty breathing or swallowing, wheezing, unusual bleeding or bruising, sore throat, painful mouth or throat sores, jaundice and diarrhea.

Dosage and Administration:

Cloxacillin: 500 mg orally every 6 hours for 10-14 days.

Cloxacillin should be taken 1 hour before or 2 hours after meals with water. Serum levels are reduced by 50% with food intake.

Taking an active probiotic concurrently may help minimize changes to GI flora

Onset of Action:

Rapid onset, peak in about 1 hour.

Half-Life:

¹⁶ Gregson, D., Henwick, S., Swaine, F.B. (2011). *Medical Microbiology Services Review Final Report*. Retrieved from www.viha.ca/NR/rdonlyres/4A984B51-2DF9-48A0-98F1-0B4613573A80/0/medical_microbiology_services_review2011.pdf

Adults - 0.5-1.5 hours

Clindamycin:

Clindamycin is a lincosamide which is a type of antibiotic that works by inhibiting bacterial protein synthesis. Used as the second choice for mastitis. Clindamycin is one of the best alternatives for the gram positive cocci most often causing mastitis as it also covers methicillin-resistant Staph Aureus (MRSA) (76%)¹⁷. It is active against gram-positive aerobes and most anaerobes. The concern with clindamycin is that it may predispose to *C. difficile* diarrhea, which is why it is a second choice agent.

Indications and Clinical Use:

Second-line choice for treatment of mastitis if penicillin allergic or if sensitivities indicate resistance to cephalexin or cloxacillin. It is also used in other skin, soft tissue, and pelvic infections which are not in the *Midwives Regulation - Schedule A and B*.

Contraindications:

Known hypersensitivity

Warnings and Precautions:

Prolonged use may result in fungal or bacterial superinfection, including *C. difficile*-associated diarrhea (CDAD) and pseudomembranous colitis. With any diarrhea after taking Clindamycin, maternal stool should be tested for *C. difficile*. A positive test for *C. difficile* is a reason for physician consult. CDAD has been observed >2 months post-antibiotic treatment.

Pregnancy:

Compatible

Lactation:

Category L2 - Limited Data – Probably Compatible

Clindamycin has the potential to cause adverse effects on the breastfed infant's gastrointestinal flora. If oral or intravenous clindamycin is required during breastfeeding, it is not a reason to discontinue breastfeeding, but an alternate drug may be preferred. Monitor the infant for possible effects on the gastrointestinal flora, such as diarrhea, candidiasis (thrush, diaper rash) or rarely, blood in the stool indicating possible antibiotic-associated colitis.

Adverse Reactions:

Upset stomach, diarrhea, vomiting, vaginal infection and mild skin rash.

The following side effects should be reported to a medical practitioner immediately: severe skin rash, itching, hives, difficulty breathing or swallowing, wheezing, unusual bleeding or bruising, sore throat, painful mouth or throat sores, jaundice and diarrhea (in particular with Clindamycin).

Dosage and administration :

Clindamycin: 450 mg orally every 6 hours (qid) for 10-14 days

¹⁷ Vancouver Island Health Authority (VIHA) 2011

Clindamycin can be taken with or without food. However, since Clindamycin may cause an upset stomach, taking it with food or milk is recommended. Taking an active probiotic concurrently may help minimize changes to GI flora.

Onset of Action:

Absorption is rapid; widely distributed into most body tissues and fluids, including gallbladder, liver, kidneys, bone, sputum, bile, and pleural and synovial fluids.

Time of serum level peak is: Oral: Within 60 minutes.

Half-Life:

Adults - 2-3 hours.

Probiotic use with Antibiotics

For minimizing antibiotic-associated diarrhea the use of an oral probiotic is now considered evidence-based. The narrower the spectrum of the antibiotic, the lower the chance of disrupting the normal gastrointestinal tract flora. Some antibiotics, such as clindamycin are associated with a higher risk of diarrhea. The use of active-culture Balkan style yogurt or active probiotic culture yogurt may be helpful in reducing this risk. Recommended probiotics include lactobacillus, acidophilus and bifidus. These are available without a prescription.

D) Erythromycin Ophthalmic Ointment

Macrolide type antibiotic ointment interferes with microbial protein synthesis.

Indications and Clinical Use:

Prophylaxis of ophthalmia neonatorum. Prevention of ophthalmia neonatorum due to *Neisseria gonorrhoeae* or *Chlamydia trachomatis* or other bacteria.

Placed in the newborn's eyes within one hour of birth as required by British Columbia law (*See B.C. law re: informed refusal*).

Contraindications:

Hypersensitivity to erythromycin or any component.

Adverse Reactions:

Hypersensitivity, minor ocular irritation and redness.

Dosage and Administration:

Ointment, ophthalmic: 0.5% (1 g, 3.5 g)

Instill 1 application of 1 cm ribbon into each conjunctival sac.

Wipe each eyelid gently with sterile cotton; instill 1 cm ribbon of ointment in each lower conjunctival sac; massage eyelids gently to spread the ointment; after 1 minute, excess ointment can be wiped away with sterile gauze. Avoid contact of applicator tip with skin or eye.

Anaesthetics

Bupivacaine hydrochloride

(Marcaine®) Without epinephrine. Bupivacaine is an amide-type local anaesthetic that blocks the initiation and conduction of nerve impulses.

Indications and Clinical Use:

Used to anaesthetize the perineum and vaginal walls for repair of laceration or an emergency episiotomy.

Contraindications:

Hypersensitivity to bupivacaine, amide type local anesthetics (lidocaine, mepivacaine, ropivacaine), or any component of the formulation.

Warnings and Precautions:

Use with caution in patients with cardiovascular disease including patients with hypotension or heart block.

Use with caution in patients with hepatic impairment.

Pregnancy:

Compatible

Bupivacaine is approved for use at term in obstetrical anesthesia or analgesia.

Lactation:

Category L2 - Limited Data – Probably Compatible

Adverse Reactions:

Hypotension, bradycardia, palpitation, restlessness, anxiety, dizziness, pruritus, urticarial and anaphylaxis.

Dosage and Administration:

Usual Concentration: 0.25% (2.5 mg/mL). Maximum individual dose should not exceed 2 mg/kg of body weight and in general the maximum total dose should not exceed 175 mg or 70 mL. Usual maximum dose is 12.5 mg to 37.5 mg or 5-15 mL.

Subcutaneous administration is the route of choice – only the lowest dose needed to provide effective anaesthesia should be administered. Injections should always be made slowly and with frequent aspirations to avoid inadvertent rapid intravascular administration which can produce increased systemic absorption and toxicity.

Onset of Action:

10-15 minutes (slightly slower acting than lidocaine)

Half-Life:

2.7 hours

Time to peak, plasma: 30-45 minutes

Elimination:

Urine (6% as unchanged drug)

Lidocaine hydrochloride

(Xylocaine®) Without epinephrine. Lidocaine is an amide-type local anaesthetic. Blocks the initiation and conduction of nerve impulses.

Indications and Clinical Use:

Used to anaesthetize the perineum and vaginal walls for repair of laceration or an emergency episiotomy.

Contraindications:

Hypersensitivity to lidocaine, amide type local anaesthetics (bupivacaine, mepivacaine, ropivacaine), or any component of the formulation.

Midwives are encouraged to consult with anaesthesia antenatally, in the event that a sensitivity or allergy to anaesthetic agents is suspected.

An allergy to lidocaine is unlikely when used without epinephrine. The concern is often an adverse drug reaction to the adrenaline (epinephrine) that is found in a combined lidocaine/epinephrine product. The epinephrine is added to constrict the blood vessels to help concentrate the local anaesthetic at the site where it is needed. If epinephrine enters the circulatory system, it can cause tachycardia. In an anxious person this could trigger a panic attack.

Warnings and Precautions:

Use with caution if there is hepatic dysfunction due to an increased risk of lidocaine toxicity.

Pregnancy:

Compatible

Lactation:

Category L2 - Limited Human Data – Probably Compatible

Adverse Reactions:

Hypotension, anxiety, dizziness, nausea, vomiting, dyspnea, allergic reactions and anaphylaxis.

Dosage and Administration:

Lidocaine comes in numerous concentrations (e.g. 1%, 2%).

Usual concentration: 1% (10 mg per mL) or 2% (20 mg per mL). Maximum individual dose should not exceed 4.5 mg/kg (or 300 mg).

Subcutaneous administration is the route of choice – only the lowest dose needed to provide effective anaesthesia should be administered. Injections should always be made slowly and with frequent aspirations to avoid inadvertent rapid intravascular administration which can produce increased systemic absorption and toxicity.

Onset of Action:

5-10 minutes

Half-Life:

1.5-2 hours

Elimination:

Urine (<10% as unchanged drug, ~90% as metabolites)

Analgesics

Acetaminophen with Tramadol

(Apo-Tramadol/Acet[®], Tramacet[®]). Acetaminophen and Tramadol is an analgesic, opioid combination medication. Tramadol is more potent than codeine and most closely resembles the opiates.

Acetaminophen component: Inhibits prostaglandin synthesis in the central nervous system and peripherally blocks pain impulse; it produces antipyresis from inhibition of the hypothalamic heat-regulating center.

Tramadol component: Binds to opiate receptors in the CNS causing inhibition of ascending pain pathways, altering pain perception and response to pain; also inhibits norepinephrine and serotonin uptake, and modifies ascending pain pathways.

Indications and Clinical Use:

Combined Acetaminophen and Tramadol is used **for ≤ 72 hours** to relieve acute short-term moderate to severe pain in the postpartum period following vaginal and/or operative delivery.

Contraindications:

Hypersensitivity to acetaminophen, tramadol, opioids, or any component of the formulation; opioid-dependent patients; narcotics, centrally-acting analgesics or psychotropic drugs; hepatic dysfunction.

Tramadol is contraindicated during or within 14 days following monoamine oxidase (MAO) inhibitor therapy first generation antidepressants. The MAO inhibitor antidepressants are older antidepressants, now reserved for extremely resistant cases of depression unresponsive to new agents: Isocarboxazid (Marplan[®]), Phenelzine (Nardil[®]), Tranylcypromine (Parnate[®]), Moclobemide (generics).

Warnings and Precautions:

Acetaminophen: Do not exceed the maximum recommended dose (4000 mg = 4 g) per 24 hours. Liver toxicity has been reported following chronic abuse of acetaminophen at > 200 mg/kg/day.

Tramadol: May cause CNS depression and/or respiratory depression and may impair physical or mental abilities.

Use with caution in patients taking tranquilizers and/or antidepressants, or those with an emotional disturbance including depression; history of seizure disorder.

*CNS depressants: Use with caution and reduce dosage when administering to patients receiving other CNS depressants.

Tramadol may enhance the neuroexcitatory and/or seizure-potentiating effect of MAO Inhibitors. Consider alternatives to combined treatment with tramadol and monoamine oxidase inhibitors due to an increased risk of serotonin syndrome and seizures.

*Serotonin syndrome: Avoid, if possible, use with serotonergic agents such as triptans (migraine treatment), lithium, sibutramine, meperidine, dextromethorphan, St John's wort, any anti-depressant including: TCAs, MAO inhibitors (use with extreme caution; contraindicated in Canadian product labeling), SNRIs, and SSRIs (such as citalopram, sertraline, fluoxetine etc.) venlafaxine, trazodone; use caution with drugs which impair metabolism of tramadol (ie, CYP2D6 and 3A4 inhibitors); concomitant use may increase the risk of serotonin syndrome.

A history of anaphylactoid reactions to opioids may increase risks for similar reactions to tramadol.

Healthcare provider should be alert to problems of abuse, misuse, and diversion.

Pregnancy:

Acetaminophen – Human Data Suggest Low Risk; Compatible

Tramadol - Human Data Suggest Risk

There is a risk of congenital birth defects if exposure occurs during organogenesis.

Continuous intake leads to the potential complication of neonatal withdrawal. Long term neurobehavior effects of the neonate are unknown.

Lactation:

Acetaminophen – Category L1 - Compatible

Tramadol – Category L3 - Limited Data - Probably Compatible

Tramadol is considered suitable for short term use in lactation as about 3% of the dose enters milk. However, this medication has an active metabolite via the CYP 2D6 enzyme, thus caution is recommended. In addition, experience with this medication is limited in the neonatal/pediatric population. If this medication is given in lactation, the lowest effective dose should be given for the shortest possible period of time. The neonate should also be monitored for signs of sedation, such as not waking up to feed at regular intervals. If ongoing narcotic is required postpartum consider other alternative agents such as hydromorphone.

Adverse Reactions:

Acetaminophen – Diarrhea, gastric upset with overdose.

Tramadol - Sedation, respiratory depression, nausea, vomiting, constipation, pruritus, hives, angioedema, bronchospasm, toxic epidermal necrolysis, Stevens-Johnson syndrome have been reported.

Rare reactions including anaphylactoid fatalities have been reported following initial dosing. Adverse events were observed in animal studies. Tramadol has been shown to cross the human placenta when administered during labor. Postmarketing reports following tramadol use during pregnancy include neonatal seizures, withdrawal syndrome, fetal death, and stillbirth. Not recommended for intrapartum use.

Dosage and Administration:

Tramacet[®] is a combination medication consisting of the following:
Acetaminophen: 325 mg plus Tramadol: 37.5 mg
Usual dose: PO1- 2 tablets every 4 to 6 hours as needed for pain
Maximum dose: PO 8 tablets per 24 hours

Note: if 8 tablets are taken daily, this equals: acetaminophen 2600 mg/day. Maximum dose of acetaminophen is 4,000 mg/day, a top up with plain acetaminophen (4 x 325 mg or 2 x 500 mg) per 24 hours is considered safe.

May be administered with or without food.

Onset of Action:

Acetaminophen: < less than 1 hour

Tramadol: 60-90 minutes.

Time to peak effect: Tramadol: 2-3 hours

Half-Life:

Adult – Acetaminophen – 2 hours, Tramadol - 6-8 hours, 7-9 for the active metabolite

Neonate – Acetaminophen – 7 hours, Tramadol – 3.6 hours in children (no data in neonates)

Prescription:

Acetaminophen with tramadol may be prescribed in hospital or in the community. It does not require a duplicate prescription pad. A prescription cannot exceed three days. No refills..

Anti-fungals¹⁸

Clotrimazole

(Canesten[®]) Anti-fungal agent which binds to phospholipids in the cell membrane altering cell wall permeability.

Indications and Clinical Use:

For the treatment of susceptible fungal infections; vaginal and nipple Candidiasis.

Contraindications:

Hypersensitivity to Clotrimazole or any component of the formulation

Warnings and Precautions:

Avoid contact with eyes when using topical formulation.

Any excess cream or ointment should be removed from the nipples before nursing.

Pregnancy:

Compatible

Lactation:

Category L1 - Compatible

¹⁸ Drug Information Lexicomp. (n.d.). *Clotrimazole, miconazol, nystatin drug information*. Retrieved from www.uptodate.com

Clotrimazole has poor oral bioavailability and is unlikely to adversely affect the breastfed newborns, including topical application to the nipples¹⁹.

Adverse Reactions:

Vulvar/vaginal burning, itching, soreness and edema.

Dosage and Administration:

Intravaginal or topical.

- Canesten[®] 1% vaginal cream: 1 full applicator intravaginally for 6 consecutive days, at bedtime.
- Canesten[®] 100 mg vaginal inserts: 1 insert intravaginally for 6 consecutive days at bedtime.
- Canesten[®] 2% vaginal cream: 1 full applicator intravaginally for 3 consecutive days at bedtime.
- Canesten[®] combi-pak 3-day therapy: 1 insert intravaginally for 3 consecutive days at bedtime. The cream should be spread onto the irritated area once or twice a day as needed, for up to 7 consecutive days.
- Canesten[®] combi-pak 1-day therapy: 1 insert intravaginally for 1 day, at bedtime. The cream should be spread onto the irritated area once or twice a day as needed, for up to 7 consecutive days.
- Canesten[®] Topical Cream or Solution: Thinly apply and massage sufficient solution or cream into the affected area and surrounding skin areas twice daily, in the morning and evening. To be successful, the cream or solution should be applied regularly and in sufficient quantities. Continue treatment for 2 weeks.

The blue section of the CPS contains Information for the Patient for Canesten[®] Vaginal and Canesten[®] Topical.

Miconazole

(Monistat[®]). Anti-fungal agent which inhibits biosynthesis. This causes damage to the fungal cell wall membrane and increases permeability.

Indications and Clinical Use:

For the treatment of vulvovaginal candidiasis and other fungal skin and mucous membrane infections.

Contraindications:

Hypersensitivity to Miconazole or any component of the formulation.

Warnings and Precautions:

Avoid contact with eyes when using topical formulation.

Discontinue use if sensitivity or irritation occurs.

Any excess cream or ointment should be removed from the nipples before nursing.

Pregnancy:

Compatible

Lactation:

¹⁹ National Library of Medicine's LactMed Database. (n.d.). *Clotrimazole levels and effects while breastfeeding*. Retrieved from www.drugs.com/breastfeeding/clotrimazole.html

Category L2 - No Human Data – Probably Compatible

Miconazole has poor oral bioavailability and unlikely to adversely affect the breastfed newborns, including topical application to the nipples²⁰.

Adverse Reactions:

Allergic dermatitis, burning, maceration, irritation and itching.

Dosage and Administration:

Topical or Intravaginal.

- Monistat[®] 7 cream: 15 g applicator-full intravaginally once daily at bedtime for 7 consecutive days.
- Monistat[®] 7 vaginal suppositories: 1 (100 mg) suppository intravaginally daily at bedtime for 7 consecutive days.
- Monistat[®] derm cream: Apply a thin layer of cream topically to cover the affected area twice daily. Continue treatment for 2 weeks.
- Monistat[®] 3 vaginal ovules: 1 (400 mg) ovule intravaginally daily at bedtime for 3 consecutive days.

Nystatin

(Nilstat[®] Mycostatin[®]). Anti-fungal agent which binds to sterols in fungal cell membrane, changing the cell wall permeability.

Indications and Clinical Use:

For the treatment of Candidiasis, particularly of the mouth (thrush) and intestines of infants and children. A less potent antifungal than clotrimazole or miconazole for vaginal candida.

Contraindications:

Hypersensitivity to Nystatin or any component of the formulation

Pregnancy:

Compatible

Lactation:

Category L1 - Compatible

Adverse Reactions:

Diarrhea, stomach pain, nausea and vomiting.

Dosage and Administration:

Oral drops: 100,000 units (1 mL) every 6-8 hours (tid – qid). Continue therapy for at least 48 hours after clinical cure to prevent relapse.

Also available in topical and vaginal formats but is less effective than other antifungals.

Onset of Action:

24 – 72 hours

²⁰ National Library of Medicine's LactMed Database. (n.d.). *Miconazole use while breastfeeding*. Retrieved from www.drugs.com/breastfeeding/miconazole.html

APNO (All Purpose Nipple Ointment) - mupirocin, betamethasone, miconazole

All Purpose Nipple Ointment (APNO) or Jack Newman's Nipple Cream[®]. The antibiotic mupirocin combats or prevents bacterial infections, including staphylococcus; the corticosteroid betamethasone reduces inflammation and the pain associated with inflammation; and the antifungal miconazole combats or prevents monilial infections and relieves associated pruritis.

The corticosteroid is absorbed through normal intact skin, with percutaneous absorption increased in the presence of skin irritation or inflammation. The antibacterial and antifungal agents are absorbed where the skin is inflamed.

Indications and Clinical Use:

Used as a topical treatment for irritation of the nipple, with or without secondary bacterial infection.

Contraindications:

It should not be used on viral or tubercular lesions, or by anyone with a systemic viral infection or a history of allergy to any of the ingredients.

Warnings and Precautions:

If burning, itching, or local irritation increases with use, treatment should be discontinued. While generally well tolerated, APNO should not be used over large areas of the skin, and is not intended for prolonged use.

If the condition has not improved within a week, physician consultation is indicated.

Pregnancy:

Category C

Topical use to small area is not associated with problems

Lactation:

Topical use of these ingredients is not associated with problems

Dosage and Administration:

This cream is compounded by a pharmacist using 15 grams mupirocin ointment (Bactroban® 2%), and 15 grams betamethasone ointment (0.1%) to which is added miconazole powder to a final concentration of 2% (clotrimazole powder may be substituted for miconazole, if miconazole is unavailable). Antifungal cream may be used if powder is unavailable. Ibuprofen powder may be added to a final concentration of 2% to manage pain. Changes to the formula may be made from time to time as new evidence emerges.

The cream should be applied sparingly to the nipples after each breastfeed and not washed or wiped off, even prior to the next feed. If Gentian violet is being used, the cream should not be applied at the same time.

Onset of Action:

Only a small amount of topically applied mupirocin is absorbed into the systemic circulation where it is rapidly metabolized.

Triamcinolone - neomycin sulfate - nystatin - gramicidin

(Kenacomb®) cream or ointment reduces inflammation, relieves pruritis and combats or prevents monilial and bacterial infections. The corticosteroid is absorbed through normal intact skin, with percutaneous absorption increased in the presence of skin irritation or inflammation. The antibacterial and antifungal agents are absorbed where the skin is inflamed.

Indications and Clinical Use:

Used as a topical treatment for candidiasis of the nipple, with or without secondary bacterial infection, as well as candidiasis-related diaper rash in the healthy newborn.

Contraindications:

It should not be used on viral or tubercular lesions, or by anyone with a systemic viral infection or a history of allergy to any of the ingredients.

Warnings and Precautions:

If burning, itching, or local irritation increases with use, treatment should be discontinued. Kenacomb® is not recommended for use in pregnancy. While generally well tolerated,

kenacomb® should not be used over large areas of the skin, particularly in the newborn, and is not intended for prolonged use to treat candidiasis of the nipple or candidiasis-related diaper rash.

If the condition has not improved within a week, physician consultation is indicated.

Pregnancy:

Triamcinolone – Human and Animal Data Suggest Risk
Neomycin – Human Data Suggest Low Risk
Nystatin - Compatible

Lactation:

Triamcinolone and Neomycin - Category L3 -No Data – Probably Compatible
Topical use to small area is not associated with problems
Nystatin – Category L1 Compatible
Gramicidin – Category L3 – No Data – Probably Compatible

Adverse Reactions:

Contact dermatitis, dryness, pruritus and secondary skin infection.

Dosage and Administration:

Each gram contains 100,000 units nystatin, 2.5 mg neomycin base (as sulphate), 0.25 mg gramicidin, and 1.0 mg triamcinolone.
Apply a thin layer to affected areas 2-3 times/day.

Anti-nauseants / Anti-emetics

Doxylamine succinate-pyridoxine hydrochloride

(Diclectin®) Doxylamine succinate competes with histamine for H₁-receptor sites which block chemoreceptor trigger zones which control the symptoms of nausea and vomiting. The pyridoxine hydrochloride component is a vitamin which has antiemetic effects.

Indications and Clinical Use:

Used orally for the control of nausea and vomiting in pregnancy.

The drug of choice remains Diclectin, the delayed-release combination of doxylamine and vitamin B6. Nausea and vomiting of pregnancy (NVP) is a common medical condition of pregnancy, affecting up to 80% of all pregnancies.

Contraindications:

Hypersensitivity to doxylamine, pyridoxine, or any component of the formulation.

Warnings and Precautions:

May cause CNS depression, which may impair physical or mental abilities.
Use with caution in patients with hypertensive disorders and thyroid dysfunction.

Pregnancy:

Compatible

Lactation:

Category L3 - No Human Data – Probably Compatible

Doxylamine may be excreted in breast milk, and can result in sedative effects in nursing infants. Approved use of doxylamine and pyridoxine is limited to the prenatal period.

Adverse Reactions:

Palpitation, tachycardia, dizziness, drowsiness, headache, constipation, diarrhea, dry mucous membranes and epigastric pain.

Dosage and Administration:

Give 10 mg of doxylamine combined with 10 mg of pyridoxine (Diclectin, delayed release) up to 4 tablets daily (ie, 2 at bedtime, 1 in the morning, and 1 in the afternoon). Adjust schedule and dose according to severity of symptoms²¹.

Half-Life:

10-12 hours

Elimination:

Urine

Dimenhydrinate

(Gravol[®]) is categorized in a class of drugs called antihistamines. Competes with histamine for H₁-receptor sites on effector cells in the respiratory tract, gastrointestinal tract and blood vessels; blocks chemoreceptor trigger zones.

Indications and Clinical Use:

To counteract the side effects of nausea and vomiting. While it is considered safe, Gravol[®] may produce some sedation and as such, may be used for therapeutic rest during prodromal or early labour, particularly where anxiety is a factor.

Contraindications:

Hypersensitivity or previous reactions to dimenhydrinate or any component of the formulation.

Warnings and Precautions:

Use with caution in patients with asthma, peptic ulcer, cardiac arrhythmias and thyroid dysfunction.

Pregnancy:

Compatible

Lactation:

Category L2- No Human Data – Probably Compatible

Adverse Reactions:

Palpitations, hypotension, confusion, nervousness, restlessness, headache, insomnia, tingling, heaviness and weakness of hands, vertigo, dizziness, blurred vision, nasal stuffiness, dryness of nose and throat, nausea, vomiting, diarrhea, constipation, dry mouth, tightness of chest and wheezing.

²¹ Einaron, A., Maltepe, C., Boskovic, R., & Koren, G. (2007, December). Treatment of nausea and vomiting in pregnancy: An updated algorithm. *Can Fam Physician*, 53(12), 2109-2111. Retrieved from www.cfp.ca

Dosage and Administration:

Usual Concentration: each mL contains 50 mg

50-100 mg PO every 4-6 hours, maximum dose 400 mg/day

25-50 mg IM, IV, every 4 hours, maximum dose 100 mg every 4 hours

25 mg IV should be administered slowly over 2 min

Dimenhydrinate in the injectable form is indicated when the oral or suppository form is impractical.

For severe nausea and vomiting in hospital setting, Gravol® may also be administered through the IV route.

Onset of Action:

20 to 30 minutes

Half-Life:

8.5 hours

Metoclopramide

(Maxeran®, Apo-Metoclop®) is a dopamine receptor antagonist which works in the chemoreceptor trigger zone of the brain thereby reducing emesis, increasing gastric emptying and intestinal muscle contractions, and increasing the tone of the lower esophageal sphincter.

Indications and Clinical Use:

Primarily indicated in adults for symptomatic short-term treatment of heartburn and reflux esophagitis, and nausea and vomiting. Metoclopramide can be administered during pregnancy and labour for the treatment of gastro esophageal reflux disease (GERD), nausea, vomiting and hyperemesis (see CMBC's *Indications for Discussion, Consult and Transfer of Care*).

Contraindications:

Hypersensitivity or known allergy to metoclopramide; when stimulation of gastro-intestinal motility may cause hemorrhage, perforation or obstruction of GIT; history of seizure disorder.

Warnings and Precautions:

Metoclopramide is also a prolactin stimulant and may increase milk production. It is not within the midwife scope to prescribe metoclopramide as a galactagogue. Problems in humans have not been documented and in the US it is the only drug available to stimulate milk production. (Domperidone is the preferred medication in Canada.)

Pregnancy:

Compatible

Lactation:

Category L2 – Significant Data - Compatible

Adverse Reactions:

Drowsiness, GI disturbances, constipation or diarrhea, hyper/hypotension, high doses in young people may cause extrapyramidal or dystonic reactions (reversed with diphenhydramine Benadryl®).

Dosage and Administration:

Oral: 10-15 mg/dose up to 4 times per day, 30 minutes before meals if for GI symptoms.

IV/IM: 10 to 15 mg IV or IM q 6-8 hour prn. Administer IV injection slowly, maximum rate 10 mg over 2 minutes; or may dilute 10 mg with 50 mL of NS and infuse slowly over 15-30 minutes.

Onset of Action:

Oral: 30-60 minutes;

Intramuscular: 10 to 15 minutes;

Intravenous: 1 to 3 minutes

Half-Life:

5 to 6 hours

Ranitidine

(Zantac[®], Apo-Ranitidine[®], Novo-Ranidine[®], Nu-Ranit[®]) belongs to a group of drugs called histamine-2 blockers. Ranitidine works by reducing the amount of acid produced in the stomach.

Indications and Clinical Use:

Ranitidine is administered for the treatment of gastro esophageal reflux disease (GERD), gastric ulcers, and hyperemesis (see CMBC's *Indications for Discussion, Consult and Transfer of Care*). Ranitidine can be administered during pregnancy or labour for the treatment of GERD.

Contraindications:

Hypersensitivity or known allergy to Ranitidine.

Warnings and Precautions:

Do not mix clindamycin in same syringe, due to physical incompatibility. Caution should be exercised when administering ranitidine to patients with hepatic dysfunction since ranitidine is metabolized in the liver. If breastfeeding and still experiencing severe GERD after one month post-delivery, consideration should be given to referral for further medical work-up.

Pregnancy:

Compatible

Lactation:

Category L2 - Limited Human Data – Probably Compatible

Ranitidine is excreted into human milk in concentrations exceeding those found in plasma. There have been no reported adverse effects in the newborn via milk. Although ranitidine is concentrated in milk, the overall dose is less than therapeutic²². Ranitidine is used therapeutically in pediatric patients including infants.

Adverse Reactions: (infrequent)

Headache, dizziness, nausea, stomach upset and diarrhea.

²² Hale, T. W. (2010). *Medications in Mother's Milk (14th edition)*. Amarillo, TX: Hale Publishing.

Dosage and Administration:

Adult Oral: 150 mg twice daily or 300 mg once daily at bedtime;

IV/IM: 50 mg, IV infused over 15-30 minutes, or give direct IV over a minimum of 5 minutes, or IM, every 8 hours. (Comes as premixed minibag of 50 mg/50 mL, or 25 mg/mL injection).

Onset of Action:

Oral: 1-3 hours to peak level; IM dose – Within 15 minutes; IV – onset 5-10 min.

Half-Life:

2-3 hours

Anti-virals

Acyclovir and Valacyclovir

Acyclovir and Valacyclovir are anti-viral agents which inhibit DNA synthesis and viral replication.

Indications and Clinical Use:

Valacyclovir or Acyclovir is recommended for the treatment of symptomatic recurrent herpes simplex virus (HSV) types 1 and 2 outbreaks. Valacyclovir has three to fivefold greater oral bioavailability than acyclovir, but is not recommended for treatment of severe or disseminated disease.

Dosing regimens differ based on the site and type of outbreak (genital vs. oral). For suspected primary infections, clients should be referred to a physician for physical examination and serological confirmation. For known recurrent oral or genital HSV infections, midwives may offer their clients treatment **when prodromal symptoms present** (tingling, pain and/or aura). **Once lesions appear**, treatment is no longer considered effective or recommended.

Clients with a history of recurrent genital HSV infections should be offered Acyclovir or Valacyclovir suppression therapy at 36 weeks gestation to decrease the risk of clinical lesions or viral shedding at the time of birth, therefore decreasing the need for a cesarean section (Money, D. et al, 2008). If an HSV lesion or prodrome is present at the time of delivery, an obstetrical consult is indicated, to assess for the need for cesarean section. When at risk of preterm birth, use of suppressive antivirals may be considered at an earlier gestational age.

Contraindications:

Hypersensitivity to acyclovir, valacyclovir, or any component of the formulation.

Warnings and Precautions:

Maintain adequate hydration and use with caution in patients with renal impairment, hepatic or electrolyte abnormalities.

Pregnancy:

Acyclovir & Valacyclovir - Compatible

Data exists for acyclovir use in all trimesters of human pregnancy; less information for valacyclovir. Combined data regarding use of acyclovir or valacyclovir (pro-drug of acyclovir)

has not shown an association of any consistent pregnancy complications or fetal/neonatal adverse effects, however long term follow-up data is needed. Potential benefits of short term use for indications reducing risk of transmission to newborn as well as treatment of genital herpes to prevent prematurity likely outweigh potential risks of therapy.

Lactation:

Acyclovir – Category L2 - Limited Data – Probably Compatible

- Relative Infant Dose is 1.09-1.53%; acyclovir therapy in neonates is common and produces few toxicities which are usually minor.
- Infant monitoring: vomiting, diarrhea

Valacyclovir – Category L1- Limited Data – Compatible

- Valacyclovir is rapidly metabolized to acyclovir in maternal plasma, resulting in an acyclovir Relative Infant Dose of 4.7%, which is considerably less than that used in therapeutic dosing of neonates.
- Infant monitoring: vomiting, diarrhea.

Adverse Reactions:

The most common side effects include nausea, vomiting, diarrhea, dehydration and headache. Less commonly, agitation, confusion, rash, anaemia and muscle pain have been reported. Rare hypersensitivity reactions include seizures and hepatitis. Thrombocytopenic purpura has been reported in immunocompromised patients.

Dosage and Administration (Genital HSV):

Symptomatic recurrent episode

Acyclovir: 400mg orally three times daily for 5 days OR 800mg orally three times daily for 2 days, initiate when first prodromal symptoms appear,

OR

Valacyclovir: 1000mg orally once daily OR 500 mg orally two times daily (bid) for three days, initiate when first prodromal symptoms appear.

May be taken with or without food.

Suppressive dosing at 36 weeks until delivery:

Acyclovir: 400 mg orally every 8 hours (tid), or 200 mg orally every 6 hours (qid), from 36 weeks gestation until birth,

OR

Valacyclovir: 500 mg orally every 12 hours (bid) from 36 weeks gestation until birth.

May be taken with or without food.

Dosage and Administration (Oral HSV):

Symptomatic recurrent episode:

Acyclovir: 400 mg orally five times a day for five days, initiate when first prodromal symptoms appear

OR:

Valacyclovir: 2 g orally every 12 hours (bid) for two doses, initiate when first prodromal symptoms appear.

May be taken with or without food.

OR

Acyclovir 5% cream: Apply topically to affected lesion(s) six times per day for 7 days, initiate when first prodromal symptoms appear

Benefit of treatment in Orolabial HSV:

- Valacyclovir: reduced duration of symptoms by 1 day
- Acyclovir: reduced duration of symptoms by ½ day
- Acyclovir topical: reduced duration of symptoms by ½ day

Pharmacokinetics: Time to peak, serum:

- Acyclovir: 1.5-2 hours
- Valacyclovir: 1-3 hours

Half-Life:

- Acyclovir: 3 hours
- Valacyclovir: (rapidly converted to acyclovir by first pass effect in liver) Acyclovir (active metabolite): 3 hours

Excretion:

Acyclovir: Urine (62% to 90% as unchanged drug and metabolite)

Valacyclovir: Urine (as acyclovir 89%)

Oseltamivir

(Tamiflu®) Neuraminidase inhibitors anti-viral agents' oseltamivir (Tamiflu®) and zanamivir (Relenza®) are moderately effective for the treatment of infections with susceptible viruses of influenza strains including H1N1²³. More safety data is available on oseltamivir than zanamivir in pregnancy. Thus oseltamivir is the treatment of choice for the prevention and treatment of influenza. Oseltamivir reduces the spread of influenza by blocking the action of the enzyme neuraminidase and prevents the spread of virus from cell to cell reducing the duration and severity of symptoms particularly when treatment is initiated early after onset of symptoms. The neuraminidase inhibitors also reduce the duration of shedding and viral titer.

Indications and Clinical Use:

²³ Public Health Agency of Canada. (n.d.). *Flu (Influenza)*. Retrieved from <http://www.phac-aspc.gc.ca/influenza>

Oseltamivir is recommended during pregnancy when influenza-like illness (ILI) develops, especially those in their second and third trimesters or within 2-4 weeks post-partum²⁴. There are significant increased risks for morbidity and mortality related to influenza infection during pregnancy. ILI is defined as the acute onset of respiratory illness with fever and cough and one or more of the following: sore throat, muscle pain, joint pain, exhaustion or prostration. Treatment is most effective if started early, within 48 hours of illness onset, however initiating treatment after 48 hours may still be worthwhile if the illness is progressive in severity. On average, oseltamivir may reduce the duration of symptoms by one and a half days²⁵.

Prompt initiation is recommended in initiation of antiviral therapy for individuals with suspected or confirmed influenza infection and any of the following:

- Illness requiring hospitalization
- Progressive, severe, or complicated illness, regardless of previous health or vaccination status
- During pregnancy and up to two weeks postpartum

Treatment should not be delayed while awaiting the results of diagnostic testing, nor should it be withheld in patients with indications for therapy who present >48 hrs after the onset of symptoms, particularly among patients requiring hospitalization. Patients with a negative rapid antigen test for influenza whom present with symptoms that are progressive in severity should be treated with antivirals since the sensitivity of these tests is generally low²⁶.

In addition, instructions to remain hydrated and manage fever with acetaminophen should be provided.

Those who are pregnant or postpartum recovering from influenza generally do not require antiviral therapy. The decision to initiate antiviral therapy should be based on the clinician's judgment and on what is known about the potential benefits of therapy for seasonal influenza versus the potential risks.

Patients with mild uncomplicated influenza infections who do not have risk factors for severe or complicated illness are not likely to benefit from antiviral therapy if it is initiated more than 48 hours after symptom onset.

Given concerning trends of increasing resistance with neuraminidase inhibitors, the risk of promoting antiviral drug resistance should be considered. Overuse of neuraminidase inhibitors will promote further development of resistance and could lead to these agents becoming ineffective²⁷.

Contraindications:

Known allergy to any antiviral component; previous severe reactions and/or allergic reactions such as difficulty breathing; tightness in the chest; wheezing; hives; confusion; hallucinations. Zanamivir is administered by oral inhalation and is contraindicated in patients with underlying asthma or other chronic respiratory conditions.

²⁴ Public Health Agency of Canada. (2009, July). *Interim guidance Ambulatory Care of influenza-like illness in the context of H1N1 influenza virus*. Retrieved from <http://www.phac-aspc.gc.ca/alert-alerte/h1n1/guidance-orientation-07-09-eng.php>

²⁵ Aoki, F., Allen, U.D., Stiver, H.G., Evans, G.A. (2010). *The use of antiviral drugs for influenza: Guidance for practitioners, 2010-11*. Retrieved from www.bccdc.ca

²⁶ Drug Information Lexicomp. (n.d.). *Oseltamivir*. Retrieved from www.uptodate.com.

²⁷ Health Link BC August 2010

Warnings and Precautions:

Information about the increased risk of complications with influenza illness during pregnancy should be provided, including H1N1 virus, and the need for a prompt assessment. This is especially important information for those who are pregnant and have young children with ILI.

Pregnancy:

Compatible – Limited reports during human pregnancy do not suggest a significant risk of developmental toxicity. Maternal benefit outweighs the unknown risk if any to the embryo or fetus.

Lactation:

Category L2 - Limited Data – Probably Compatible

Due to breastmilk's anti-infective benefits and the low dosages of antiviral passed through breastfeeding, it is recommended that breastfeeding be continued when taking antiviral medications. Oseltamivir is not usually prescribed for administration to children under one year of age.

If a significant infection including H1N1 is confirmed or strongly suspected, consultation with a physician is required, even if antiviral therapy has been commenced unless otherwise indicated by a symptom-based protocol established between the midwives and physician consultants in a given community.

In a pandemic situation, how the consultation process takes place may be guided by this specific community-based protocol that take into account the severity of the signs and symptoms and available medical resources.

Based on such protocols, the midwife should do an assessment to determine if referral for a telephone assessment by a physician, or an in-person physician assessment or an immediate referral for hospital admission is required.

If a specific infection has not been confirmed by a positive swab, advise that if another ILI develops, a second course of antiviral therapy may be recommended because immunity to infection cannot be documented.

Adverse Reactions:

Nausea, vomiting, diarrhea, bronchitis, abdominal pain, headache and dizziness.

There are no known interactions between oseltamivir and other drugs. Oseltamivir does not interact with the flu vaccine so both vaccinated and unvaccinated individuals can use oseltamivir.

Tamiflu® may increase the risk for self-injury and confusion in people who have the flu.

Any odd behaviour should be reported.

Please refer to the website below for a list of Reportable Adverse Reactions to Antiviral Drugs²⁸.

Dosage and Administration:

Oseltamivir (Tamiflu®): One 75 mg capsule orally every 12 hours (bid) for 5 days or prescribe Zanamivir if nausea and vomiting.

Zanamivir (Relenza®): Two 5 mg inhalations (10 mg total) every 12 hours (bid) for 5 days. More information can be located in the appropriate product monograph. May be after meals to reduce nausea.

Dose reduction is advised for pharmacokinetic reasons when creatinine clearance of <10 ml/min is present.

Benzodiazepine Receptor Antagonists

Flumazenil

(Anexate®, Romazicon®). Flumazenil is a benzodiazepine receptor antagonist and acts as an antidote in reversing the CNS depressant effects of benzodiazepine compounds. Flumazenil has no effect on CNS depression from other causes such as opioids, alcohol, barbiturates or general anesthetics. Flumazenil, if required, should be readily available for administration.

Indications for Clinical Use:

For reversal of benzodiazepine use during procedure, or known isolated benzodiazepine overdose if not taking benzodiazepines chronically.

Contraindications:

Hypersensitivity to flumazenil or benzodiazepines or to any component of the formulation.

Warnings and Precautions:

Flumazenil may not reverse respiratory depression as well when longer acting benzodiazepines have been used. There is a need to monitor in the event that respiratory depression or sedation returns. Flumazenil may not reverse amnesia. Immediately after administration physician consultation is required.

Consult physician immediately if patient takes benzodiazepines chronically but has an acute overdose – risk of seizures may occur. The indications for flumazenil in clinical use are for benzodiazepine reversal during procedure, or known isolated benzodiazepine overdose in those who are not taking benzodiazepines chronically. The number of different types of benzodiazepines does not affect efficacy of flumazenil, however flumazenil's half-life may be shorter than the benzodiazepines used and repeated doses may be necessary.

Pregnancy:

Compatible

Although an assessment of the teratogenic risk in humans cannot be made, animal data suggests the risk is low. Human-placenta transfer to the fetus is unknown, and despite the moderate plasma protein binding capacity and inactive metabolites, the very short

²⁸ Health Canada. (2011, March 2). *Reporting adverse reactions to antiviral drugs during an influenza pandemic: Guidelines for health professionals and consumers*. Retrieved from http://www.hc-sc.gc.ca/dhp-mpps/pubs/medeff/_guide/2011-ar-ei_anti_guide-ldir/index-eng.php

elimination half-life will limit exposure. The indications for flumazenil are such that the benefit should outweigh the unknown fetal risk.

Lactation:

No Data- Probably Compatible

Flumazenil may be considered suitable for use in lactation as this medication has a very short half-life, however when administering this medication to a breastfeeding client for a benzodiazepine overdose, breastfeeding may need to be withheld due to the amount of benzodiazepine in milk and the potential risk of adverse effects (respiratory depression, sedation).

Adverse Reactions:

Headache; fatigue; tremor; weakness; diaphoresis; agitation; nausea/vomiting; seizure although rare.

Dosage and Administration:

0.1 mg/ml injectable solution

IV: 0.2 mg over 15-30 seconds

If there is no response after the initial dose, then 0.3 mg given over 15-30 sec 1 min later, if no response then again 0.5 mg IV over 15-30 sec to maximum cumulative dose of 3 mg/hr.

Onset of Action:

30-60 seconds

Half-Life:

Adult - 4-11 minutes

Neonate – unknown

Elimination:

Liver

Corticosteroids

Hydrocortisone compound

Steroid compound decreases inflammation by suppression of leukocytes and reduces capillary permeability. Examples include: Hydrocortisone rectal – Anusol HC, Hemcort HC, Hydrocortisone/pramoxine topical – Proctofoam HC, Anugesic HC.

Indications and Clinical Use:

Used as anorectal therapy for treatment of hemorrhoids in ointment or suppository form; also used in combination with topical antibiotics and anti-fungals for topical infections.

Contraindications:

Hypersensitivity to any component of the formulation.

Warnings and Precautions:

Use with caution in patients with GI disease, hepatic impairment, hypertension, osteoporosis, thyroid disease. Discontinue use if redness or irritation occurs.

Do not apply to nipples.

Pregnancy:

Compatible

The lowest effective potency should be used over the smallest possible area for the shortest possible time.

Lactation:

Category L2 - No Data – Probably Compatible

Topical use to small area is not associated with problems

Adverse Reactions:

Burning, dryness, irritation, itching, skin maceration, dermatitis and secondary skin infection.

Dosage and Administration:

Usual concentration: 0.5-2.5% cortisone

Topical: Apply thin layer of cream to affected area 2-4 times per day

Suppository: One suppository twice daily for 2 weeks for external anal itching or internal hemorrhoids or

Foam: One applicator full 1-2 times per day for 2-3 weeks for internal hemorrhoids.

Galactogogues

Domperidone

(Motilium[®]) **Domperidone** promotes the release of prolactin from the pituitary gland. It is a dopamine antagonist with anti-emetic properties.

Midwives can prescribe domperidone in the postpartum period only for the treatment of insufficient milk supply (I.M.S.). However, this treatment should not be used as the first approach to correcting IMS²⁹. A comprehensive assessment and attention to other factors that can influence milk supply and milk transfer should be completely explored as a priority prior to prescribing domperidone

Regardless of treatment plan, failure of the newborn to regain birth weight by three weeks of age is an indication for a consultation with a physician (CMBC, 2015).

Amongst lactation specialists in Canada and based on individual clinical evaluations, Domperidone has historically been prescribed in doses ranging from 30-90 mg/day to a maximum dose of 80-160 mg/day.

In 2004 the FDA and then in 2009 Health Canada issued warnings regarding the off label use of domperidone as a galactagogue. They warned that the risk of serious abnormal heart rhythms or cardiac arrest may be higher in people taking domperidone at doses greater than 30 mg a day, or in those who are more than 60 years old³⁰.

A collective of breastfeeding experts reviewed the evidence regarding FDA and Health Canada warnings on the use of domperidone to support lactation. "Of the thousands of mothers the authors of this statement have collectively treated with domperidone for the

²⁹ Newman J., Kenerman, E. (2009). *Domperidone, Getting Started*. Retrieved from http://www.nbc.ca/index.php?option=com_content&view=article&id=14:domperidone-getting-started-&catid=5:information&Itemid=17

³⁰ Health Canada. (2012, March). *Domperidone maleate – Association with serious abnormal heart rhythms and sudden death (cardiac arrest)*. Retrieved from <http://www.healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2012/14118a-eng.php>

purposes of breastfeeding support, no one is aware of a single case of maternal death from ventricular arrhythmia". In fact, Health Canada's Vigilance Program has confirmed that between 1965 and 2011, there were no cardiac related deaths reported among clients taking Domperidone (Flanders et al, 2012, p. 2).

The following is an adapted excerpt from – A Consensus Statement on the Use of Domperidone to Support Lactation (Flanders et al, 2012).

Until further research informs this debate, healthcare practitioners should consider the following recommendations when prescribing domperidone during breastfeeding:

1. *Prior to considering prescribing domperidone, ensure that there is a persistent breastfeeding problem despite an adequate trial of intensive non-pharmacologic lactation support. This would include assessment and support from a lactation consultant. ***Midwives may seek additional assessment and support from a lactation consultant however it is not necessary in order to consider prescribing domperidone.***
2. *Screen for comorbid medical conditions (including a significant personal or family history of cardiac arrhythmia), the use of QT-prolonging medications, and drugs that may affect the activity and/or metabolism of domperidone.*
3. *Adequately discuss the risks and benefits of domperidone's use as a galactagogue to ensure that patients make an informed decision.*
4. *Prescribe domperidone at the lowest effective dose and titrate up as needed based on response.*
5. *While on domperidone, ensure regular follow-up to monitor closely for efficacy, side effects and adverse reactions.*

Indications and Clinical Use:

Used to enhance breastmilk production where non-pharmacologic methods have proven ineffective and there is a previous history of inadequate milk supply.

Contraindications:

Hypersensitivity to domperidone or its excipients, with gastrointestinal obstruction, perforation, or hemorrhage, with prolactinoma, and for those with a history of breast cancer.

Warnings and Precautions:

Due to the increased risk of QTc prolongation and associated heart arrhythmias it should not be co-administered with many drugs including but not limited to: certain systemic medications, eg erythromycin-like antibiotics, ketoconazole, ventolin, antihistamines and antidepressants. For a complete list of medications please refer to www.qtdrugs.org

Domperidone should be used with caution in those with hepatic disease and with those taking anticholinergics, since these may antagonize the effect of the domperidone in the GI tract.

Pregnancy:

Category C

Lactation:

Category L1 – Limited Data - Compatible

Adverse Reactions:

Headache (1% - resolved with dose reduction), dry mouth (2%), abdominal cramps (less than 1%), rashes and urticaria and alteration of menstrual cycles.

Dosage and Administration:

Usual dose – Domperidone: 30 mg (three 10 mg tablets) PO every 8 hours (tid)³¹.

Lower dose – Domperidone: 10-20 mg (one-two 10 mg tablets) PO every 8 hours (tid)³².

Administration of domperidone is recommended approximately 30 minute before eating as bioavailability is enhanced when taken on an empty stomach.

Antacids impair bioavailability.

Domperidone must not be given intravenously.

Onset of Action:

Time to peak serum concentration: 30 minutes

Half-Life:

7 hours

Therapeutic Notes:

Milk supply is usually increased within three to four days. Although effects may be seen as soon as 24 hours, it may take 2 to 3 weeks to gain the maximum effect and most will need to continue domperidone for three to eight weeks. Therefore, the initial prescription should provide adequate coverage for a minimum of three weeks. Domperidone dosage should be gradually reduced by one tablet every 2-5 days when milk supply is adequate. Gradually reducing domperidone should continue if there is no decline in milk supply. If milk supply diminishes, return to the previous effective dose. Do not decrease the dose again for two weeks, then reassess.

Histamine Antagonists

Diphenhydramine Hydrochloride

(Benadryl®). Competes with histamine for H₁-receptor sites on effector cells in the gastrointestinal tract, blood vessels, and respiratory tract; sedative effects are also seen.

Indications and Clinical Use:

Adjunctive therapy in the treatment of anaphylactic reactions related to the administration of drugs, vaccines or sera.

Contraindications:

Hypersensitivity to diphenhydramine or any component of the formulation; acute asthma.

³¹ Newman J., Kenerman, E. (2009). *Domperidone, Getting Started*. Retrieved from http://www.nbc.ca/index.php?option=com_content&view=article&id=14:domperidone-getting-started-&catid=5:information&Itemid=17

³² Flanders, D., Lowe, A., Kramer, M., da Silva, O., Dobrich, C., Campbell-Yeo, Kenerman, E., et al. (2012). *A consensus statement on the use of domperidone to support lactation*. Retrieved from www.breastfeedinginc.ca

Warnings and Precautions:

This drug is for emergency purposes, and its use should be immediately followed by a physician consultation and if out-of-hospital, emergency transport to hospital. Further definitive treatment would be managed by a physician.

Patients should be cautioned about the possibility of CNS depression, which may impair physical or mental abilities.

Use with caution in patients with a history of asthma.

Use with caution in patients with cardiovascular disease (including hypertension and ischemic heart disease).

Use with caution in patients with thyroid dysfunction.

Pregnancy:

Compatible

Lactation:

Category L2 - Limited Human Data – Probably Compatible

Adverse Reactions:

Chest tightness, hypotension, palpitation, tachycardia, chills, confusion, convulsion, dizziness, fatigue, headache, insomnia, irritability, nervousness, restlessness, sedation, sleepiness, constipation, diarrhea, dry mucous membranes, nausea, throat tightness and vomiting.

Dosage and Administration:

Adult – 50 mg IM

Onset of Action:

Sedative effect – 1-3 hours

Half-Life:

2-10 hours

Elimination:

Urine (as unchanged drug)

Immune globulins

Hepatitis B immune globulin

See under Vaccines “Hepatitis B immune globulin and Hepatitis B vaccine”

Rh_o(D) Immune Globulin (Human) (WinRho[®] SDF)

See Protocol on Rh_o(D) sensitisation.

Indications and Clinical Use:

Should be offered to all eligible who are pregnant and Rh_o(D) negative for the purpose of preventing Rh_o(D) Isoimmunization.

Fetal erythrocytes are present >30 days after conception. Fetomaternal hemorrhage occurs in 75% of pregnancies. Maternal antibody response can be stimulated with as little as 0.1 mL of a fetomaternal transfusion (Wagle, 2011). If untreated, the incidence of Rh_o(D)

alloimmunization with pregnancy loss <12 weeks by spontaneous abortion is $\leq 2\%$; after therapeutic abortion the rate is $\leq 5\%$. The risk rises as pregnancy advances. By term, in an untreated Rh_o(D) negative pregnancy with Rh_o(D) positive fetus the alloimmunization rate is 16%. The risk of alloimmunization in those who have been appropriately treated is <0.3%.

Prophylaxis should be offered:

- At 28 weeks gestation and after the birth of a Rh_o(D) positive baby.
- As soon as possible and within 72 hours of a potential fetomaternal transfusion:
 - any bleeding associated with threatened abortion,
 - therapeutic or spontaneous abortion,
 - molar pregnancy,
 - ectopic pregnancy,
 - abruption,
 - abdominal trauma,
 - obstetrical procedures,
 - amniocentesis,
 - Chorionic Villi Sampling (CVS),
 - percutaneous umbilical blood sampling,
 - External Cephalic Version (ECV).

Criteria: only Rh_o(D) negative pregnancies where:

- the paternal/genetic donor is either Rh_o(D) positive or Rh_o(D) unknown (paternity is uncertain in 3-5% of all pregnancies)
 - the fetus is either Rh_o(D) positive or Rh_o(D) unknown, and
 - there is no sensitization to the Rh_o(D) factor.
- There has been an **informed consent process**. Some institutions require written consent.

Contraindications:

- A history of anaphylactic or severe systemic reaction to the administration of human immune globulin products.
- IgA deficiency with antibodies to IgA and a history of hypersensitivity.
- Autoimmune hemolytic anemia, with pre-existing hemolysis or at high risk for hemolysis.
- Rh_o(D)-positive.
- Rh_o(D)-negative who are Rh_o(D) immunized by standard manual Rh antibody screening tests (after due allowance for previously administered anti-D immunoglobulin).

Dosage and Administration:

- WinRho[®] SDF is available in 600 units and 1500 units and can be administered IM or IV.
- Administer WinRho[®] SDF separately from other drugs.
- Administer IV WinRho[®] SDF slowly over 3-5 minutes.
- The dose guideline is outlined in the table below.
 - The dose is dependent upon the gestational age and the quantified fetomaternal transfusion (with Kleihauer-Betke).
 - In the event of a massive fetomaternal hemorrhage, WinRho[®] SDF 90 units is recommended for each 1 mL of fetal blood in the maternal circulation.

Where the volume of fetomaternal transfusion is not available administer 1500 units (300 mcg) IM or IV as soon as possible and within 72 hours of birth.

Indication ^{33,34,35}	Rh _o (D) IG Dosage*	
	600 Units (120 mcg)	1500 Units (300 mcg)
At 28 weeks gestation		√
After spontaneous or therapeutic abortion, or termination of ectopic		√
Threatened abortion at any time ³⁶		√
Amniocentesis, cordocentesis, CVS, prior to 34 weeks ³⁷		√
Amniocentesis, ECV after 34 weeks	√	
Antepartum hemorrhage, abdominal trauma ³⁸		√
Massive fetomaternal hemorrhage	90 units/1 mL fetal blood	
Within 72 hours after birth of confirmed Rh _o (D) positive baby	√	

- Dose depends on the presence of fetal cells in the maternal circulation. A positive Rosette test is followed by a Kleihauer-Betke to quantify the fetomaternal hemorrhage and individualize the appropriate dose.
- Each antepartum hemorrhage should be treated as a separate incident with appropriate dose of anti-D immunoglobulin.
- Dosages may vary according to blood bank directives.

Pregnancy:
Compatible

Lactation:
Category L2 – Limited Data – Probably Compatible

Adverse Reactions:

- Side Effects are uncommon (<2%) Headache, chills, fever, asthenia, pallor, diarrhoea, nausea, vomiting, arthralgia, myalgia, dizziness, malaise, hyperkinesia, abdominal or back pain, hypotension, hypertension, increase LDH, somnolence, vasodilation, pruritus, rash and sweating.
- An allergic response is possible: there should be observation for at least 20 minutes after administration. *Epinephrine* and *Diphenhydramine* should be immediately available.

Warnings and Precautions:

³³ Amaryllis, A. & Smith, C. V. (2013, April). Erythrocyte alloimmunization and pregnancy. *Medscape reference: Drugs, diseases and procedures*. Retrieved from <http://emedicine.medscape.com/article/273995-overview>

³⁴ Drug Information Lexicomp. (n.d.). *Rh_o(D) immune globulin*. Retrieved from www.uptodate.com

³⁵ Each laboratory and/or institution has a protocol for the release of the product, and for determining the dose required. Contact local laboratory (transfusion services) for details.

³⁶ If WinRho[®] SDF is administered early in pregnancy, it is recommended that repeat doses be administered at 12 week intervals in order to maintain adequate levels of passively acquired anti-RH.

³⁷ For amniocentesis or chorionic villus sampling, administer WinRho[®] SDF every 12 weeks during pregnancy.

³⁸ If WinRho[®] SDF is administered between 13-18 weeks, repeat at 26-28 weeks.

- WinRho[®] SDF is made from human plasma; it may carry a risk of transmitting infectious agents, e.g., viruses and theoretically, the Creutzfeldt-Jakob disease (CJD) agent.
- Risk of transmitting an infectious agent has been reduced by screening plasma donors, testing for the presence of certain current viral infections, and including virus inactivation/removal steps in the manufacturing process.
- The product has been screened or processed to remove the risk of HIV, hepatitis A, B, and C, West Nile viruses, and human parvovirus B19.
- The risk associated with administration of this blood product is very low, however, it is possible that screening may not detect all possible pathogens and this information should be provided.
- Interference with Blood Glucose Testing: False High Blood Glucose Levels – The liquid formulation of WinRho[®] SDF contains maltose. Maltose has been shown to give falsely high blood glucose levels in certain types of blood glucose testing systems.

Live Virus Vaccines

- WinRho[®] may transiently impair the immune response to live attenuated virus vaccines such as measles, mumps, rubella, and varicella. Delay immunization with live vaccines until >3 months after administration of WinRho[®]

Inhalants

Nitrous Oxide pre-mixed 50/50 with Oxygen

(Entonox[®] or Nitronox[®]) Premixed 50/50 concentration of nitrous oxide and oxygen.

Nitrous oxide increases cerebral blood flow and intracranial pressure and decreases hepatic and renal blood flow; analgesic action is similar to morphine.

Indications and Clinical Use:

For relief of moderate pain in normal labour. Commonly used in the transition period prior to full dilation. Its analgesic effect is strong and characterized by rapid onset and offset.

Contraindications:

Nitrous oxide should not be used in patients with bowel obstruction, pneumothorax, middle ear or sinus disease.

Hypersensitivity to nitrous oxide or any component of the formulation.

Nitrous oxide should not be used without oxygen.

Warnings and Precautions:

Must be self-administered in labour during contractions.

Oxygen use: Oxygen should be briefly administered during emergence from prolonged anesthesia with nitrous oxide to prevent diffusion hypoxia.

Pregnancy:

Human and Animal Data Suggest Risk

Lactation:

Category L3 – No Data – Probably Compatible

Adverse Reactions:

Hypotension, headache, dizziness, confusion; possibly nausea and vomiting.

Personnel exposed to unscavenged nitrous oxide are at increased risk of renal and hepatic diseases and peripheral neuropathy as seen in vitamin B₁₂ deficiency. Dental personnel exposed to unscavenged nitrous oxide for more than 5 hours/week are significantly less fertile than those who are not exposed, or who are exposed to lower levels of scavenged or unscavenged nitrous oxide³⁹.

Dosage and Administration:

Face mask or mouth piece.

Self-administration should be at the beginning of a contraction.

Onset of Action:

Peak action: 30 seconds following administration.

Half-Life:

3 minutes approximately.

Oxygen

For administration by non-rebreathing mask in the course of normal labour as therapy for abnormal fetal status or in the labour or the postpartum period for maternal hemorrhage or shock. For a newborn, either free-flowing oxygen or oxygen by resuscitation bag and mask should be administered according to national neonatal resuscitation (NRP) guidelines.

Intravenous Fluids

Normal saline, Ringer's lactate, 5% dextrose in water

Intravenous access is indicated for the administration of medication and fluids (volume expansion, hydration and blood products). Prophylactic intravenous access with a saline lock can also be recommended in certain situations.

Normal Saline & Ringers Lactate

These isotonic crystalloid solutions can be used to provide volume and deliver medication and are the most likely solutions indicated for use during pregnancy, birth and postpartum.

- If an IV is established in third stage or the immediate postpartum during an out-of-hospital birth, the midwife must ensure that vital signs are normal and stable for one hour prior to removing the IV canula.
- In an out of hospital setting, initiating emergency transport to hospital should be considered early in the treatment of a postpartum hemorrhage⁴⁰. Emergency transport to hospital and consultation with a physician is required if bleeding is unresponsive to therapy.

³⁹ Drug Information Lexicomp (n.d.). *Nitrous oxide*. Retrieved from www.uptodate.com

⁴⁰ It is beyond the scope of this document to outline the complete steps in the management of a postpartum hemorrhage. Midwives are expected to initiate the appropriate steps in the management of a postpartum hemorrhage according to their Emergency Skills protocol and are reminded that hemorrhage unresponsive to therapy is an indication for transfer of care to a physician.

- Water intoxication is a potential side effect of oxytocin administration. Use electrolyte-containing solutions (i.e. normal saline or Ringer's lactate) with oxytocin reduces the risk of water intoxication.
- Intake and output records should be initiated when delivering IV fluids. Fluid overload and hyponatremia may be prevented by recording and use of balanced salt solutions.

In neonatal resuscitation Ringer's Lactate or 0.9% NaCl may be administered intravenously as a volume expander (10 mL/kg over 5 to 10 minutes) if there is evidence of acute bleeding with signs of hypovolemia as per NRP guidelines.

D5W

5% Dextrose in Water is packaged as an isotonic solution and can be indicate for hydration and provide calories, however, the glucose in the solution is quickly consumed leaving the solution hypotonic. Administration of hypotonic solutions via IV will leave the intravascular space quickly and reappear in the cells. The need for calories is not usually warranted as mild to moderate ketosis is a normal intrapartum state and hydration with 5% dextrose is associated with poorer outcomes. Use of dextrose containing solutions in the absence of saline is associated with maternal hyponatremia and hypoglycaemia in the newborn.

Narcotic antagonists

Naloxone Hydrochloride

Naloxone hydrochloride (Narcan[®]) is a narcotic antagonist used to treat opioid toxicity and overdose.

Note: The American Academy of Pediatrics (AAP) **no longer recommends** the use of naloxone hydrochloride (naloxone) for neonatal resuscitation⁴¹ at birth. There is insufficient data on the efficacy and short-term and long-term safety of naloxone to reverse respiratory depression in the neonate caused by maternal opiate exposure in labour close to the time of birth. There is also concern that naloxone is misused during resuscitation and could lead to seizures when administered to infants of opioid-dependent women. The Canadian Neonatal Resuscitation Program (NRP) Executive Committee is in agreement with this recommendation⁴². Refer to the most current NRP recommendations for first-line treatment of neonatal respiratory depression.

Indications and Clinical Use:

To reverse opioid toxicity.

Contraindications:

Previous hypersensitivity reaction to naloxone.

Warnings and Precautions:

Naloxone is not effective in reversing respiratory depression due to any other cause than opioid toxicity. Naloxone is not recommended for use during newborn resuscitation.

⁴¹ http://circ.ahajournals.org/content/122/16_suppl_2/S516#sec-61

⁴² http://www2.aap.org/nrp/docs/15535_NRP%20Guidelines%20Flyer_English_FINAL.pdf

Compatibility- Pregnancy:

Compatible

No evidence of impaired fertility or fetal harm. Naloxone crosses the placenta quickly and appears in fetal blood within 2 minutes following adult dose.

Compatibility- Lactation:

Category L3 - No Human Data – Probably Compatible

Naloxone is considered suitable for use in lactation. This medication has a very short half-life (one hour), is poorly absorbed orally and plasma levels in adults are thought to be undetectable two hours after oral doses. When administering this medication to a breastfeeding client for a narcotic overdose, breastfeeding may need to be withheld due to the amount of narcotic in milk and potential risk of adverse effects including respiratory depression and sedation.

Adverse Reactions:

Adverse reactions are typically related to reversing dependency and precipitating withdrawal and include abdominal cramps, diarrhea, nausea, vomiting, muscle weakness, dyspnea, respiratory depression, restlessness, irritability, cardiac arrest, fever, hypertension, hypotension and/or tachycardia.

Dosage and Administration:

May be administered IV or IM routes. IM route not recommended due to slow onset of action and therapeutic effect.

Adult initial dose of naloxone for reversal of respiratory depression caused by a therapeutic dose of opioids:

- **IV:** 0.04-0.4 mg, may repeat until desired response is achieved
- **IM:** 0.04-0.4 mg, may repeat until desired response is achieved

Adult initial dose of naloxone cause by opioid overdose:

- **IV:** 0.4-2 mg, may repeat until desired response is achieved
- **IM:** 0.4-2 mg, may repeat until desired response is achieved

Additional considerations:

- Consult physician following administration;
- May need to repeat doses every two to three minutes and an IV infusion may be required (midwives are unable to prescribe a naloxone IV infusion);
- Additional dose(s) may be required after reversal has occurred based on the opioids half-life.

Onset of Action:

IV: 2 minutes

IM: 2-5 minutes

Half-Life:

Adult - 0.5-1.5 hours

Excretion:

Urine as metabolites

Nitrates

Nitroglycerin

Nitroglycerin is a vasodilator which relaxes uterine smooth muscle, as well as vascular, bronchial, biliary, gastrointestinal and ureteral muscles.

Indications and Clinical Use:

For the treatment of hypertonic uterine contractions with non-reassuring fetal status as an adjunct to intrauterine resuscitation. This drug is for emergency purposes only, and its use should be immediately followed by a physician consultation and transfer of care. If used in an out-of-hospital setting, immediate emergency transport to hospital is required.

Contraindications:

Nitrates should not be administered to those with known hypersensitivity or idiosyncratic reaction to organic nitrates, severe anemia, hemorrhage, hypotension, uncorrected hypovolemia or severe liver disease. Although unlikely to be encountered in the provision of midwifery care, nitroglycerin is also contraindicated with conditions of head trauma, cerebral hemorrhage, increased intracranial pressure, restrictive cardiomyopathy, constrictive pericarditis and pericardial tamponade.

Warnings and Precautions:

To date, the evidence for safety and efficacy remains inconclusive. The use of nitroglycerin in pre-term labour is currently under evaluation. This application of nitroglycerin is NOT approved for use by registered midwives.

Pregnancy:

Human data suggest low risk-1st trimester data is limited, caution due to risk of hypotension.

Lactation:

No human data, probably compatible or limited data⁴³ - Category L4 - Possibly hazardous - There are currently no reports of nitroglycerin use in lactation, based on size of molecule it is expected to enter milk and could be a concern with prolonged use⁴⁴.

Adverse Reactions:

Include headache, which occurs in up to 50% of users at the beginning of therapy. Less than 1% of users may experience itching, wheezing, tracheobronchitis, hypotension, reflex tachycardia, palpitations or bradycardia. Syncope due to nitrate vasodilation, although rare, has been reported. Weakness, dizziness, apprehension, restlessness, nausea, vomiting, diarrhea, abdominal pain, arthralgia, muscle twitching, blurred vision, and upper and lower

⁴³ Briggs GG, Freeman RK. Drugs in Pregnancy and Lactation 10th Ed. Wolters Kluwer. Philadelphia, PA. 2015.

⁴⁴ Hale TW, Rowe HE. Medications and Mothers' Milk 16th Ed. Hale Publishing. Amarillo, TX. 2015.

respiratory infections have also been reported. Overdose symptoms are primarily related to vasodilation: flushing, headache, nausea, dizziness, hypotension and tachycardia. Methemoglobinemia is also a rare adverse effect. Most of these can be obviated by discontinuing the drug. Treatment is symptomatic and supportive. The hemodynamic effect of nitrates is brief.

Dosage and Administration:

Nitroglycerin:

Nitroglycerin 50 mcg IV given over 2 to 3 minutes; may be repeated every 90 seconds to three minutes as needed to a maximum dose of 500 mcg over 15 minutes

- **Please note, preparations come in different strengths**
- Dilute 1 mL of 5 mg/mL nitroglycerin with 100 mL of normal saline to make a concentration of 50 mcg/mL. Should NOT be mixed with other medications;
 - Administer 50 mcg per dose into lowest port on IV tubing over 1-2 minutes.
- Sublingual spray may be used however it is significantly less reliable: 0.4 mg, one to two metered doses can be administered sublingually⁴⁵. The bioavailability of this route is variable and is reported to be no more than 38%⁴⁶.
- An IV should be established, regardless of the route of administration, to prevent hypotension⁴⁷.
- Nitroglycerin binds to plastic; therefore the solution must be used within 30 minutes of preparation.

Uterine relaxation is achieved within 40-90 seconds and lasts for about 1 minute.

Onset of Action:

Sublingual spray: 1-3 minutes; IV: Immediate

Peak effect:

Sublingual spray: 4-10 minutes; IV: immediate

Half-Life:

1-4 minutes

Elimination:

Excreted by the kidneys (as inactive metabolites)

Non-steroidal anti-inflammatories

Diclofenac

(Voltaren®) is a non-steroidal anti-inflammatory (NSAID) with analgesic and antipyretic properties. While the mechanism of action is not fully understood, it is known to inhibit COX-1 and COX-2 enzymes, which results in decreased formation of prostaglandin precursors. It is commonly used post-surgically for pain relief and inflammation.

Indications and Clinical Use:

⁴⁵ Induction of labour at term: SOGC clinical practice guideline no. 296. September 2013. Retrieved from http://sogc.org/wp-content/uploads/2013/08/September2013-CPG296-ENG-Online_REV-D.pdf

⁴⁶ Chestnut, D et al. (2014). *Chestnuts Obstetric Anaesthesia Principle and Practice 5th Edition*. New York, NY: Elsevier.

⁴⁷ Lee, L., Sprague, A., Yee, J. & Ehman, W. (Eds.). (2009, January). *Fundamentals of Fetal Health Surveillance: Self-Learning Manual, 4th Edition*. Vancouver, BC: Canadian Perinatal Programs Coalition.

For pain relief during the postpartum period especially for reducing perineal pain and swelling from operative delivery and episiotomy. Acetaminophen appears to be the best option for treatment of fever during pregnancy. Ibuprofen is the least potent of NSAIDs.

Contraindications:

Should not be given during pregnancy, especially during the last three months. Diclofenac should not be given with pre-existing cardiovascular or cerebrovascular, GI or kidney disease or any bleeding disorders. Suppositories should not be given if there is a recent history of rectal or anal bleeding or inflammatory lesions. NSAIDs should not be given to those who are asthmatic or allergic to ASA.

Warnings and Precautions:

All NSAIDs cross the human placenta in pregnancy and distribute to the fetus. NSAIDs increase the risk of premature closure or constriction of the ductus arteriosus. Avoid the concurrent use of Diclofenac with other NSAIDs. It should be used with caution if under the age of 16, or when hypertensive disorders or renal disease is present.

Pregnancy:

Human Data Suggest Risk in 1st and 3rd Trimesters

Lactation:

Category L2 - No Human Data – Probably Compatible

Adverse Reactions:

Bleeding, hemorrhoid exacerbation, irritation and anal inflammation have been reported. A common side effect of NSAIDs is stomach upset. Additionally mild abdominal cramping, diarrhea, dizziness and/or headaches have been reported.

Dosage and Administration⁴⁸:

Suppository: 50 mg, 100 mg – maximum dose 100 mg/day

Oral: 50 mg – maximum dose 100 mg/day

Oral enteric coated (delayed release): 50 mg, 75 mg

Usual dose following delivery with surgical procedures is 50 mg or 100 mg per rectum, not to exceed 100 mg/day.

Diclofenac suppositories tend to be used short-term (up to three days post-surgery), whereupon oral NSAIDs are preferred.

Onset of Action:

Suppository: Suppositories tend to have a more rapid onset of action and a slower rate of absorption compared to oral enteric coated (delayed release) tablet.

Time to peak, serum: 5 hours

Suppository: ≤1 hour; approximately two-thirds of that observed with oral tablet (equivalent 50 mg dose)

Tablet, delayed release (diclofenac sodium): 2 hours

Half-Life:

⁴⁸ Health Canada – Diclofenac – update to heart and stroke related safety information and decrease in the maximum recommended daily dose for tablets and suppositories. October 6, 2014

2 hours

Elimination:

Urine (65%); feces (35%)

Naproxen

(Anaprox[®], Naprelan[®], Naprosyn[®]) is an (NSAID) with analgesic and antipyretic properties. It works by blocking the enzyme that makes prostaglandins, thereby reducing levels of prostaglandins.

Indications and Clinical Use:

Commonly used post-surgically for pain relief and inflammation.

Contraindications:

Naproxen should not be given during pregnancy. Naproxen should not be given with a known sensitivity to NSAIDs, has heart, GI or kidney disease or any bleeding disorders. Avoid the concurrent use of Naproxen with other NSAIDs.

Warnings and Precautions:

All NSAIDs cross the human placenta in pregnancy and distribute to the fetus NSAIDs increase the risk of premature closure or constriction of the ductus arteriosus. Their use is not recommended in pregnancy, especially during the last three months. Naproxen should be used with caution if under the age of 16. Suppositories should not be given if there is a recent history of rectal or anal bleeding or inflammatory lesions. Naproxen when taken with some SSRIs may cause increased bruising or bleeding.

Pregnancy:

Human Data Suggest Risk in 1st and 3rd Trimesters

Lactation:

Category L3 - Limited Human Data – Probably Compatible

Adverse Reactions:

Abdominal pain or cramping, rash, ringing in the ears, headaches, dizziness, diarrhea or constipation, and/or headaches, bleeding, hemorrhoid exacerbation, irritation and anal inflammation especially with suppository administration.

Dosage and Administration:

Suppository: 500 mg every 12 hours (bid)

Oral tablet: 250 mg, 375 mg, or 500 mg every 12 hours (bid)

Maximum daily dose of 1500 mg for three days post-surgery. The suppository form of naproxen is usually used initially, followed by oral administration.

Onset of Action:

Onset of action: Analgesic: 1 hour; Anti-inflammatory: ~2 weeks

Peak effect: Anti-inflammatory: 2-4 weeks

Time to peak, serum: 1-4 hours

Half-Life:

Normal renal function: 12-17 hours; End-stage renal disease: No change

Elimination:

Urine (95%; primarily as metabolites); feces ($\leq 3\%$)

Sympathomimetics

Epinephrine hydrochloride

Stimulates adrenergic receptors resulting in relaxation of smooth muscle, cardiac stimulation (increasing myocardial oxygen consumption), and dilation of skeletal muscle vasculature.

Indications and Clinical Use:

For the treatment of anaphylactic shock as a result of an allergic reaction following administration of a drug, vaccine or serum. Also used for neonatal resuscitation. If epinephrine is required it may be administered intravenously by umbilical vein catheter or via endotracheal tube according to NRP guidelines. This drug is for emergency purposes, and its use should be immediately followed by a physician consultation and if out-of-hospital, emergency transport to hospital.

Contraindications:

No contraindications to the use of injectable in a life-threatening situation.

Warnings and Precautions:

Use in pregnancy if the benefits outweigh the potential risk to the fetus. Use with caution in patients with cardiovascular diseases, diabetes mellitus and in patients with thyroid disease.

Pregnancy:

Human Data Suggest Risk

Lactation:

Category L2 – Limited Data – Probably Compatible

Adverse Reactions:

Angina, cardiac arrhythmia, chest pain, flushing, hypertension, pallor, palpitation, sudden death, tachycardia (parenteral), vasoconstriction, transient anxiety, apprehensiveness, cerebral hemorrhage, dizziness, headache, restlessness, dry throat, nausea and vomiting.

Dosage and Administration:

Adult: 0.3 mg (0.3 mL) IM of 1:1000 concentration.

Midwives may choose to use an auto-injector (EpiPen®) for ease of administration. Each auto-injector contains: 2 mL epinephrine injection 1:1000 and is designed to deliver a single dose of epinephrine 0.3 mg. EpiPen® contains 2 mL but delivers a single dose of 0.3 mL only, with 1.7 mL remaining in the unit after use.

Dosage and Administration:

Neonatal: ETT route – 1 mL/kg to a maximum of 3 mL of 1:10,000 concentration (do NOT chase or dilute with saline) or

IV push: 0.1 mL/kg of 1:10,000 concentration (do NOT dilute in saline) followed by 2 mL of normal saline.

Epinephrine should be administered during neonatal resuscitation when the neonate's heart rate remains less than 60 beats per minute after 30 seconds of effective IPPV with room air,

followed by 30 seconds of chest compressions with IPPV+100% oxygen. The preferred route is IV, however, an initial dose of epinephrine can be delivered by ETT while IV access is being obtained. May be repeated every 3-5 minutes as needed.

Onset of Action:

Rapid

Half-Life:

2 minutes

Elimination:

Urine (as inactive metabolites)

Uterotonic agents

Oxytocics and other uterotonics are to be administered for the management of postpartum bleeding on the registrant's own responsibility. The choice of agent and method of administration will be dependent upon the clinical scenario and availability of these medications.

In an out-of-hospital setting, initiating emergency transport to hospital should be considered early in the treatment of a postpartum hemorrhage⁴⁹.

Carboprost tromethamine

(**Hemabate**[®]) is a prostaglandin which stimulates uterine contractility. Hemostasis at the placentation site is achieved through the myometrial contractions produced.

Indications and Clinical Use:

For treatment of postpartum hemorrhage due to uterine atony that is unresponsive to conventional methods of management.

Used as a third-line agent only after oxytocin and ergonovine maleate or as a second-line agent after oxytocin when ergonovine maleate is not available or contraindicated⁵⁰.

Contraindications:

Carboprost should not be used if there is active cardiac, pulmonary or renal disease, hypersensitivity to prostaglandins or active pelvic inflammatory disease.

Warnings and Precautions:

Use with caution in patients with hypertension, hypotension, anemia, history of asthma, history of scarred uterus, diabetes mellitus or history of seizure disorders.

Must be refrigerated at 2° to 8°C. (Check specific manufacturer product monograph for most accurate storage conditions.)

Pregnancy:

Contraindicated (unless for Termination/Evacuation of Pregnancy)

⁴⁹ It is beyond the scope of this document to outline the complete steps in the management of a postpartum hemorrhage. Midwives are expected to initiate the appropriate steps in the management of a postpartum hemorrhage according to their Emergency Skills protocol and are reminded that hemorrhage unresponsive to therapy is an indication for transfer of care to a physician.

⁵⁰ Senikas, V. Leduc, D. & Lalonde, A. (2009, October). Active management of the third stage of labour: Prevention and treatment of postpartum hemorrhage. SOGC clinical practice guideline no.235. *J Obstet Gynaecol Can*, 31(10), 980-93.

Lactation:

Category L3 - No Human Data – Probably Compatible

Adverse Reactions:

Nausea, vomiting, diarrhea, chills, shivering, transient elevated temperature, transient bronchoconstriction, headache, flushing and moderate increase in blood pressure. Side effects are generally temporary and end when the therapy is discontinued.

Dosage and Administration:

250 mcg IM. This may be repeated at 15 to 90 minute intervals on the basis of response up to a cumulative dose of 2 mg.

Onset of Action:

Peak serum concentrations occur 15 to 60 minutes after injection.

Half-Life:

Less than 1 hour.

Ergonovine maleate

An alkaloid from ergot stimulates contractions and acts systemically on the upper and lower segments of the uterine smooth muscle to increase strength, duration, and frequency of uterine contractions.

Indications and Clinical Use:

Ergonovine maleate is an effective agent for the prevention and treatment of PPH. It is used as a second line medication for the treatment of postpartum uterine atony and/or for postpartum hemorrhage uncontrolled by the use of oxytocin.

Contraindications:

Ergonovine maleate is contraindicated in the presence of: hypertension, pre eclampsia, hypersensitivity to ergonovine maleate or any ingredient in the formulation, as well as for those receiving treatment for HIV which includes protease inhibitors or non-nucleoside reverse transcriptase inhibitors.

Warnings and Precautions:

Use with caution in patients with cardiovascular disease, hepatic impairment, renal impairment. Ergonovine is considered as a second choice to oxytocin due to greater risk of adverse effects and of an increased risk of retained placenta⁵¹.

Must be refrigerated (2 to 8°C). Protect from light. (Check specific manufacturer product monograph for most accurate storage conditions.)

Pregnancy:

Contraindicated

Lactation:

Category L3 – Limited Data – Probably Compatible

⁵¹ Senikas, V. Leduc, D. & Lalonde, A. (2009, October). Active management of the third stage of labour: Prevention and treatment of postpartum hemorrhage. SOGC clinical practice guideline no.235. *J Obstet Gynaecol Can*, 31(10), 980-93.

Adverse Reactions:

Hypertension, seizures, headache, hypotension, nausea and vomiting.

Dosage and Administration:

Supplied as 0.25 mg/mL. Second line medication for the treatment of postpartum uterine atony and/or for postpartum hemorrhage uncontrolled by the use of oxytocin:

0.25 mg IM or IV (slowly) once, if further doses are required, repeat every 2-4 hours.
Maximum cumulative dose of 5 doses⁵².

Onset of Action:

2-7 minutes IM

>1 minute IV

Half-Life:

0.52 hours

Misoprostol

Cytotec[®], is a synthetic prostaglandin E₁ analog and induces uterine contractions. Misoprostol is a water soluble tablet.

Indications and Clinical Use:

1) Treatment of postpartum uterine atony or postpartum hemorrhage only when injectable uterotonics are not available. Where IM oxytocin can be repeated and there is no IV treatment with oxytocin or IM ergot alkaloids available, repeating IM oxytocin is preferred to misoprostol. Misoprostol is not as effective as oxytocin or ergot in management or prevention of postpartum hemorrhage⁵³ and carries a significant risk of pyrexia and GI symptoms. Misoprostol may be used when IV oxytocin is not available after a prophylactic IM oxytocin has been administered during the third stage of labor⁵⁴, although it is not preferred.

2) Treatment of retained placenta in the absence of bleeding: Misoprostol or oxytocin can be injected into the umbilical vein. Refer to instructions provided for Injection of the Intra-Umbilical Vein for Retained Placenta.

3) Cervical ripening for induction of labour: See section 2.1: *Drugs which a midwife may administer after consulting with and on the order of a medical practitioner. As with any induction method where a physician has prescribed the inducing pharmacological agent, the midwife may continue to be involved in the care as the condition warrants. A midwife with specialized practice certification may on her own responsibility initiate induction of labour in hospital with a cervical ripening agent and/or initiate and manage an IV oxytocin induction/augmentation of labour*⁵⁵.

⁵² SOGC. (2013). Postpartum Hemorrhage. In SOGC, *Advances in labour and risk management 19th edition 2012 – 2013* (p.7). Ottawa, ON.

⁵³ Tunçalp, Ö., Hofmeyr, G.J. & Gülmezoglu, A.M. (2012). Prostaglandins for preventing postpartum haemorrhage (Review). *Cochrane Database of Systematic Reviews, 2012*(8). CD000494. doi:10.1002/14651858.CD000494.pub4

⁵⁴ Tang J., Kapp, N., Dragoman, M. & de Souza, J.P. (2013, May). WHO recommendations for misoprostol use for obstetric and gynecologic indications. *Obstet Gynecol Int, 121*(2), 186-189. doi: <http://dx.doi.org/10.1016/j.ijgo.2012.12.009>

⁵⁵ Misoprostol use for induction of labour has not yet been included into the Framework for Midwife Certification for Induction and Augmentation of Labour in Hospital. It will come into effect when approved certification programs are in place. Please contact CMBC for more information.

Contraindications:

Misoprostol should not be used in those with a history of allergy to prostaglandins.

Warnings and Precautions:

Misoprostol should be used with caution in those with pre-existing cardiovascular disease.

Pregnancy:

Contraindicated (oral)

Human Data Suggest Low Risk (Term Cervical Ripening)

Lactation:

Category L2 – Limited Data – Probably Compatible

Adverse Reactions:

Most common (especially with oral administration): GI – diarrhea (14-40%), abdominal pain (13-20%), pyrexia and shivering (11%). Pyrexia is more common when the dose exceeds 600 mcg. Greater incidence than 1%: nausea (3.2%), flatulence (2.9%), headache (2.4%), dyspepsia (2 %), vomiting (1.3%) and constipation (1.1%).

Dosage and Administration:

1) Treatment of PPH

*Used only when no injectable uterotonic such as oxytocin or ergometrine is available.

Oral: Usual dose: 400 mcg sublingual SL^{56,57}

400 mcg-800 mcg sublingual SL can be administered⁵⁸

Rectal administration (600 mcg-800 mcg) may be used if unable to take medications orally and injectable uterotonics are not available.

* Ergonovine, 0.2 mg IM, and misoprostol, 400 mcg to 800 mcg given by the oral, sublingual, vaginal or rectal route, may be offered as alternatives in vaginal deliveries when oxytocin is not available^{59,60}.

Misoprostol is supplied as 100 and 200 mcg tablets.

Onset of Action:

Oral – 8 minutes

Sublingual – 11 minutes

Peak serum concentration – 18-34 minutes

Vaginal – 20 minutes

Rectal – 100 minutes

⁵⁶ Hofmeyr, G.J., Gülmezoglu, A.M., Novikova, N. & Lawrie, T.A. (2013). Postpartum misoprostol for preventing maternal mortality and morbidity (Review). *Cochrane Database Syst Rev*, 2013(7), CD008982. doi: 10.1002/14651858.CD008982.pub2

⁵⁷ Gizzo, S., Patrelli, T.S., Gangi, S.D., Carrozzini, M., Saccardi, C., Zambon, A., Bertocco, A., Fagherazzi, S., D'Antona, D. & Nardelli, G.B. (2013). Which uterotonic is better to prevent the postpartum hemorrhage? Latest news in terms of clinical efficacy, side effects, and contraindications: a systematic review. *Reproductive Sciences*, 20(9), 1011-9. doi: 10.1177/1933719112468951

⁵⁸ FIGO 2012 position for PPH recommends a dose of misoprostol 800 mcg SL only if oxytocin is not available.

⁵⁹ FIGO 2012 recommends a single dose of misoprostol Oral 600 mcg for active management or SL 800 mcg for pph only if oxytocin is not available.

⁶⁰ Senikas, V. Leduc, D. & Lalonde, A. (2009, October). Active management of the third stage of labour: Prevention and treatment of postpartum hemorrhage. SOGC clinical practice guideline no.235. *J Obstet Gynaecol Can*, 31(10), 980-93.

Half-Life:

20 to 40 minutes.

2) Injection of the Intra-Umbilical Vein for Retained Placenta

Misoprostol injected into the umbilical vein can be considered for retained placenta in the absence of maternal bleeding⁶¹.

The technique for injection of the intraumbilical vein is described below^{62,63}

1. Explain the procedure and obtain consent.
2. Prepare a syringe with the medication in 30 cc normal saline. Crush and dissolve 4x 200 mcg tablets misoprostol or oxytocin 20-50 IU in 30 mL normal saline. Identify the umbilical vein. Recut the cord if necessary.
3. Insert a size 10 nasogastric tube into the umbilical vein. If resistance is felt, retract the catheter by 1-2 cm and then advance further, if possible. If the catheter cannot be advanced further without force, inject the solution in this position.
4. The tube has reached the placenta when the majority of the catheter is inserted and resistance is felt. Retract by 3-4 cm to ensure that the tip is in the umbilical vein and not in a placental branch.
5. Attach the syringe to the catheter and inject the solution followed by clamping of the cord with the catheter.
6. Note the time of the injection.
7. Wait 10-30 minutes for the placenta to deliver.

3) Cervical ripening for induction of labour: See *Cervical Ripening and Induction Agents* in section 2.1: *Drugs which a midwife may administer with specialized certification or after consulting with and on the order of a medical practitioner.*

Oxytocin

Oxytocin is a hormone that stimulates uterine smooth muscle to contract by activating protein receptors which act on myofibrils. Oxytocin increases production of prostaglandin which further stimulates uterine contractions.

Indications and Clinical Use:

As a first line agent used intramuscularly or intravenously: 1) for active management to prevent postpartum hemorrhage 2) to treat postpartum hemorrhage due to uterine atony 3) for induction and augmentation of labour.

Contraindications:

Hypersensitivity to oxytocin or any component of the formulation. For induction and augmentation, any contraindication to labour including: placenta previa, vasa previa, cord presentation, fetal malpresentation such as transverse or footling breech, prior classical or inverted T cesarean section, previous uterine surgery such as myometrial incision, active genital herpes, pelvic structural deformities, cervical carcinoma, previous uterine rupture.

⁶¹ Nardin, J.M., Weeks, A. & Carroli, G. (2011). Umbilical vein injection for management of retained placenta (Review). *Cochrane Database Syst Rev*, 2011(5), CD001337. doi: 10.1002/14651858.CD001337.pub2

⁶² MORE^{OB} - Salus Global Corporation. (2014). *Postpartum Hemorrhage*. Retrieved from: <https://secure.moreob.com/en?t=/contentManager/selectCatalog&i=1317992669064&l=0&e=UTF-8&displayMode=1&ParentID=1205698412125&intro=1&startRow=0&active=no>

⁶³ Senikas, V. Leduc, D. & Lalonde, A. (2009, October). Active management of the third stage of labour: Prevention and treatment of postpartum hemorrhage. SOGC clinical practice guideline no.235. *J Obstet Gynaecol Can*, 31(10), 980-93.

Warnings and Precautions:

A midwife with specialized practice certification may, on her own responsibility, initiate induction of labour in hospital with a cervical ripening agent and/or initiate and manage an IV oxytocin induction/augmentation of labour.

Midwives without specialized practice certification may only administer oxytocin as an IV infusion for induction or augmentation of labour with a physician order.

Oxytocin is structurally and functionally related to vasopressin and its antidiuretic action can lead to water retention. For this reason electrolyte-containing solutions should be used when administering oxytocin. Water intoxication can lead to hyponatremia, confusion, convulsions, coma, congestive heart failure, and death. Fluid overload and hyponatremia with concurrent oxytocin administration may be prevented by strict intake and output recordings, use of balanced salt solutions such as Normal Saline or Lactated Ringers, and avoiding prolonged administration of an infusion of 20 to 40 units of oxytocin.

Oxytocin Vial STORAGE: Store between 15 and 30°C. DO NOT FREEZE. (Check specific manufacturer product monograph for most accurate storage conditions.)

Oxytocin Ampoule STORAGE: (Check specific manufacturer product monograph for most accurate storage conditions.)

Pregnancy:

Compatible for induction or augmentation of labour

Lactation:

Category L2 – Limited Data – Probably Compatible

Adverse Reactions:

Arrhythmias, hypertensive episodes, nausea, vomiting, uterine hypertonicity, tetanic contraction of the uterus, uterine spasm, anaphylactic reaction, subarachnoid hemorrhage, severe water intoxication with convulsions, coma, and death is associated with a slow oxytocin infusion over 24 hours.

1) **Active Management of the Third Stage of Labour:**

Dosage and Administration:

10 Units IM or;

20 Units to 40 Units added to 1000 mL normal saline or ringers lactate and administered IV at a rate of 100-150 mL/hr^{64,65} or;

5 Units IV given slowly over 1-2 minutes;

2) **Treatment of postpartum hemorrhage:**

Dosage and Administration:

10 units IM and/or;

20 to 40 Units added to 1000 mL of normal saline or ringers lactate and administered at a rate of 250 ml/hr

⁶⁴ Nordstrom L., Fogelstam K., Fridman G., Larsson A. & Rydhstroem H. (1997). Routine oxytocin in the third stage of labour: A placebo controlled randomised trial. *Br J Obstet Gynaecol*, 104(7), 781-6.

⁶⁵ Leduc D., Senikas V. & Lalonde A. (2009, October). Active management of the third stage of labour: Prevention and treatment of postpartum hemorrhage. SOGC clinical practice guideline no.235. *J Obstet Gynaecol Can*, 31(10), 980-93.

Onset of Action:

IM: 2-5 minutes

IV: 1-5 minutes

Duration of Action:

IM and IV: 30-50 minutes

Half-Life:

IM and IV: 6-15 minutes.

*Reference ranges for the onset and duration of action and half-life are varied in the literature^{66,67,68,69}.

Elimination:

Metabolised by the liver and oxytocinase and excreted by the kidneys.

- 3) **Induction and augmentation of labour: See section 2.1: *Drugs which a midwife may administer after consulting with and on the order of a medical practitioner.***

As with any induction method where a physician has prescribed the inducing or augmenting pharmacological agent, the midwife may continue to be involved in care as the condition warrants. A midwife with specialized practice certification may on her own responsibility initiate induction of labour in hospital with a cervical ripening agent and/or initiate and manage an IV oxytocin induction/ augmentation of labour⁷⁰.

Vaccines

Flu and Seasonal Influenza Vaccine

Flu and seasonal vaccines are reformulated annually because the influenza viruses change in ways that make a previous year's vaccine ineffective⁷¹. Included are standardized amounts of the Hemagglutinin (HA) protein from representative seed strains of the two human influenza A subtypes (H3N2 and H1N1) and one of the two influenza B lineages⁷².

Indications and Clinical Use:

Due to the increased severity of influenza in pregnancy, inactivated influenza vaccine is recommended during pregnancy regardless of trimester of pregnancy⁷³. Immunization during pregnancy has the advantage of potentially protecting the fetus through transplacental antibody passage or through breast milk. Among healthy pregnancies, the morbidity and mortality associated with influenza is increased during pandemics.

⁶⁶ Simpson K. R. & Crechan, P. A. (2008). *AWHONN (Association of women's health obstetric and neonatal nurses) Perinatal nursing. Edition 3*. Philadelphia, PA: Lippincott, Williams and Wilkins.

⁶⁷ Hale, T.W. (2010). *Medications and mothers' milk. Fourteenth edition*. Amarillo, TX: Hale Publishing.

⁶⁸ Embrey, M.P. (1955, February). A New Multichannel External Tocograph. *J Obstet Gynaecol Br Emp*, 62(1), 1-5.

⁶⁹ Embrey, M.P. (1961, June). Simultaneous intramuscular injection of oxytocin and ergometrine: A tocographic study. *British Medical Journal*, 1(5241), 1737-1738.

⁷⁰ PLEASE NOTE: Certification programs are not yet in place. For more information, please contact CMBC.

⁷¹ HealthLink BC. (2011). *Influenza Vaccine*. Retrieved from <http://www.healthlinkbc.ca/medications/content.asp?hwid=ue5492>

⁷² Public Health Agency of Canada. (2011, September). Statement of seasonal influenza vaccine for 2011–2012. *Canada Communicable Disease Report (CCDR)*, 37(ACS-5). Retrieved from www.publichealth.gc.ca

⁷³ Drug Information Lexicomp. (2011). *Influenza and pregnancy*. Retrieved from www.uptodate.com

If healthy and pregnancy is planned to occur during influenza season, vaccination during any trimester of pregnancy can occur to avoid morbidity associated with influenza. If delivery is expected during influenza season, immunization can occur in the third trimester to reduce the risk of infection of the newborn.

Contraindications:

Known allergy to any vaccine component; or previous severe reactions and/or allergic reactions following the administration of a flu vaccine such as difficulty breathing, tightness in the chest, tachycardia, wheezing, hives, confusion, hallucinations.

Warnings and Precautions:

Influenza vaccine is considered safe at all stages of pregnancy and during breastfeeding. Chronic conditions during pregnancy are a predisposition to high risk complications associated with influenza and these pregnancies are a priority for immunization.

*** Live vaccines administered during pregnancy may cause risk to the fetus; live, attenuated virus and live bacterial vaccines are generally contraindicated during pregnancy⁷⁴.**

Pregnancy:

Compatible - inactivated influenza vaccines can be used during all stages of pregnancy

Lactation:

Category L1 – Limited Data - Compatible

Adverse Reactions:

Possible reactions are usually mild and temporary and may include tenderness, redness, itching, bruising, and muscle ache at injection site; or headaches, fatigue, fever and myalgias.

Dosage and Administration:

Seasonal Influenza vaccine – Influenza vaccines in Canada are available as a split-virus (chemically disrupted) and an **inactivated** subunit preparation. Each 0.5 mL of vaccine dose contains 15 mcg of influenza hemagglutinin (HA) of each of the three virus strains (two type A strains and one B strain).

0.5 mL dose of the inactivated subunit preparation administered IM. The deltoid muscle is the recommended site in adults.

Hepatitis B immune globulin and Hepatitis B vaccine

(HyperHep[®], BayHep[®], Infanrix hexa[®], Engerix-B[®], Recombivax HB[®]). Hepatitis immune globulin and Hepatitis B vaccine are administered to the infants of HBsAg positive individuals, or when otherwise indicated, within 24 hours of the birth. Subsequent doses of Hepatitis B vaccine are included in Infanrix hexa[®] which is given with the normal 2, 4 and 6 month immunizations as per BC Centre for Disease Control guidelines⁷⁵. Infants requiring hepatitis B vaccination at birth will receive a total of four doses of vaccine. Whenever

⁷⁴ CDC Publications. (2012, March). *Guidelines for vaccinating pregnant women*. Retrieved from <http://www.cdc.gov/vaccines/pubs/preg-guide.htm>

⁷⁵ BC Centre for Disease Control. (n.d.). *Immunization*. Retrieved from <http://www.bccdc.ca/dis-cond/comm-manual/CDManualChap2.htm>

immune globulin or vaccines are administered, the midwife must send a record of immunization to the physician or primary care nurse practitioner to whom care is transferred at 6 weeks postpartum.

An Emergency Drug Release (EDR) number is required from the Canadian Blood Services for Hepatitis B immune globulin. The local provider of immune globulin and vaccine will obtain the number, but require advance notice and clinical information. Contact local provider of Hepatitis immune globulin and vaccine, well in advance of need, to ensure availability.

Pregnancy:
Compatible

Lactation:
Category L2 – Limited Data – Probably Compatible

Dosage and Administration:

Hepatitis B Prophylaxis for Newborns⁷⁶

1. If client is known to be HBsAG positive or at high risk (i.e. IV drug user and/or sex trade worker) for hepatitis B, but negative (possible window period) or unknown for HBsAG
Give HBIg 0.5 ml immediately after birth along with dose 1 of *hepatitis B vaccine (0.5 ml IM)
Give *hepatitis B vaccine and HBIg at the same time using separate syringes and separate sites
2. Primary caregiver or other household contact of infant has chronic hepatitis B virus infection
Give dose 1 of *hepatitis B vaccine 0.5 ml IM immediately after birth. DO NOT GIVE HBI g
3. If client is at high risk for hepatitis B other than IV drug user and sex trade worker and status is unknown or negative
Give dose 1 of *hepatitis B vaccine 0.5 ml IM immediately after birth. DO NOT GIVE HBI g
4. If other primary caregiver is at high risk for hepatitis B and their status is unknown or negative
Give dose 1 of *hepatitis B vaccine 0.5 ml IM immediately after birth. DO NOT GIVE HBI g.

*Hepatitis B vaccine:

Engerix-B 0.5 ml IM (10 mcg/0.5 ml) or Recombivax 0.5 ml IM (5 mcg/0.5 ml)

Infant's subsequent immunizations will continue on normal schedule using Infanrix-Hexa which has hepatitis vaccine included in the six components. Infant would receive a total of four hepatitis B immunizations.

⁷⁶ <http://www.healthlinkbc.ca/medications/content.asp?hwid=zb1228>

Measles / Mumps / Rubella (MMR) Vaccine

If rubella-susceptible during the antenatal period MMR vaccine should be offered in the immediate postpartum period. Those susceptible should be immunized only if they are not pregnant at vaccination time and if pregnancy is avoided for 3 months following vaccination. MMR Vaccine should not be administered to: (a) during pregnancy, since the possible effect on the fetus is not known; (b) individuals with acute febrile respiratory or other infections, or any acute illness; (c) individuals with a history of sensitivity to neomycin or polymixin; (d) individuals with blood dyscrasias, lymphomas or other generalized malignancies; (e) individuals with untreated active tuberculosis; (f) individuals undergoing treatment with immunosuppressive agents of any kind.

If rubella-susceptible and exposed to rubella during pregnancy, one should consider the possibility of providing temporary passive immunity through the administration of immune serum globulin (human). Do not give immune globulin concurrently with MMR.

Previous administration of Rh_o(D) immune globulin or blood products is not a contraindication to postpartum vaccination. Serologic testing 6 to 8 weeks post-vaccination should be carried out to ascertain that seroconversion has occurred.

Store MMR vaccine at 2 to 8 degrees C and protect vaccine from light at all times. Discard reconstituted vaccine if not used within 8 hours. Additional handling and storage requirements for the vaccine, as outlined by the supplier, must be followed.

Whenever vaccines are administered the midwife must send a record of immunization to the physician to whom care is transferred at 6 weeks postpartum. A record of immunization should also be sent to the local public health unit in communities where this is required.

Prior to administration, information must be provided on possible vaccine reactions. Epinephrine (1:1,000) should be available for immediate use in the event of an anaphylactic reaction.

Pregnancy:

Contraindicated

Lactation:

Category L3 – No Data – Probably Compatible

Dosage and Administration:

0.5 mL SC (Do **not** give IV)

TDaP Vaccine

Adacel[®] vaccine – the tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine (TDaP) protects against Tetanus, Diphtheria and Pertussis. Adacel[®] promotes active immunity against diphtheria, tetanus, and pertussis as specific antibodies are produced. Pertussis (Whooping Cough) is a respiratory illness caused by the bacterium *Bordetella pertussis*. Diphtheria is a serious infection of the nose and throat that can result in severe breathing problems, heart failure and paralysis. **Tetanus**, also called “lockjaw” can be very serious if the breathing muscles are affected.

Rates of pertussis and its attendant complications are high in infants less than 6 months of age. These infants do not have the protection of a full series of pertussis immunizations

(offered at 2, 4, 6 and 18 months). Pertussis can be very serious if it is contracted during early infancy, with mortality rates as high as 1% in infants less than 6 months of age and with 90% of pertussis deaths occurring in this age group⁷⁷. About 75% of infants with pertussis contracted it from a family member or caregiver⁷⁸. For these reasons a dose of pertussis containing vaccine is recommended during pregnancy. The vaccine provides passive protection to the infant by transfer of IgG transplacentally in the third trimester and by transfer of secretory IgA in breast milk⁷⁹. It also helps prevent transmission of pertussis to the infant after birth. In addition, to minimize the risk of transmission to the infant even further, all family members caring for the infant should be vaccinated against pertussis.

Indications and Clinical Use:

During a pertussis outbreak, the vaccine is recommended to individuals who have not received a pertussis containing vaccine within the last 5 years, or if history is unknown, and according to the following specific criteria^{80,81}:

- Administered at any stage of pregnancy, preferably during the third or late second trimester (after 20 weeks' gestation); or
- If not administered during pregnancy, Tdap should be administered immediately postpartum to ensure immunity and to reduce risk of pertussis transmission to the newborn⁸²; and
- A single dose of Tdap is recommended for anyone who has on-going close contact with those who are pregnant and children; and
- To health care professionals for whom vaccine status is unknown or who have not previously received Tdap and who have direct patient contact⁸³; and
- Adults ≥ 18 years of age who have not been immunized, including immigrants with unknown immunizations status.

Contraindications:

History of anaphylactic reaction to a previous dose of any tetanus, diphtheria, or pertussis-containing-vaccine or to any component of the formulation. History of Guillain-Barré Syndrome (GBS) within 8 weeks of receipt of a tetanus containing-vaccine.

Warnings and Precautions:

Use with caution in patients with a history of bleeding disorders, thrombocytopenia and/or patients on anticoagulant therapy. Whenever vaccines are administered the midwife must send a record of immunization to the physician to whom care is transferred at 6 weeks postpartum. A record of immunization should also be sent to the local public health unit in communities where this is required.

Information on possible vaccine reactions must be given prior to administration.

⁷⁷ Halperin, S.A., Wang, E.E., Law, B., Mills, E., Morris, R., Dery, P., et al. (1999). Epidemiological features of pertussis in hospitalized patients in Canada, 1991-1997: Report of the Immunization Monitoring Program-Active (IMPACT). *Clin Infect Dis*, 28. 1238-43.

⁷⁸ Neiderhauser, V. (2011). What's new in child and adolescent immunizations? *Nurse practitioner*, 36(10), 39-44.

⁷⁹ Gall, S.A., Myers, J. & Pichochoero, M. (2011). Maternal immunization with tetanus-diphtheria-pertussis vaccine: Effect on maternal and neonatal serum antibody levels. *Am J Obstet Gynecol*, 204(4), 334.e1-5. doi: 10.1016/j.ajog.2010.11.024

⁸⁰ Vancouver Coastal Health. (2012, April). *Pertussis Increasing in Vancouver Coastal Health Region*. Retrieved from http://www.vch.ca/media/Adacel-whooping-cough_info_Pharmacist_Mar23_2012.pdf

⁸¹ Drug Information Lexicomp (n.d.). *TdapVaccine*. Retrieved from www.uptodate.com

⁸² ACOG Women's Health Care Physicians (2012, March). *Immunization and pregnancy: Tetanus, diphtheria, and pertussis vaccination committee opinion no 521*. Retrieved from <http://www.acog.org/Resources-And-Publications/Committee-Opinions-List>

⁸³ Drug Information Lexicomp (n.d.). *Diphtheria, tetanus toxoids, and acellular pertussis vaccine*. Retrieved from www.uptodate.com

Epinephrine (1:1,000) and Diphenhydramine hydrochloride should be available for immediate use in the event of an anaphylactic reaction.

Pregnancy:
Compatible

Lactation:
Category L1 – No Data – Compatible

Adverse Events:
Assessment of available data on the safety of TDaP vaccine in pregnancy was not suggestive of higher rates of adverse events. In addition tetanus and diphtheria toxoid vaccines have been used extensively during pregnancy to combat neonatal tetanus with no evidence of teratogenicity⁸⁴.

All Adverse Events Following Immunization must be reported to the local Public Health Unit. Refer to the BCCDC for a detail overview of the definition/criteria for reporting⁸⁵. Adverse events following immunizations are generally mild; severe events resulting in permanent sequelae are extremely rare.

Minor local: redness, tenderness, swelling, pain.
Minor systemic: headache, decreased energy, generalized body-ache, nausea, diarrhea, fever, sore or swollen joints.
Severe: anaphylactic reaction.

Dosage and Administration:
IM: 0.5 mL – administered as a single injection of one dose.

Vitamin and mineral prophylaxis and therapy

Phytonadione

(Vitamin K₁). Administered orally or intramuscularly to the newborn for the prevention of hemorrhagic disease of the newborn.

Dosage and Administration:
1 mg IM within 6 hours of birth, or
2 mg orally within 6 hours of birth and repeated at 1-2 weeks and 4-6 weeks postpartum.

Folic Acid

Folic Acid taken prior to conception and during early pregnancy has a role in preventing neural tube defects. Individuals at low risk and who are planning a pregnancy benefit from a good diet of folate-rich foods and a daily multivitamin with folic acid.

Dosage - low risk:
0.4-1.0 mg orally per day.

⁸⁴ Advisory Committee on Immunization Practices. (2011). Updated recommendations for use of tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine (tdap) in pregnant women and persons who have or anticipate having close contact with an infant aged <12 months. *Morbidity and Mortality Weekly Report*, 60(41), 1424-1426.

⁸⁵ BC Centre for Disease Control (n.d.). <http://www.bccdc.ca/dis-cond/comm-manual/CDManualChap2.htm>

Individuals at high risk for neural tube defects require increased daily amounts of folic acid in the first trimester of pregnancy and ideally prior to conception. Risk factors include: Family history of neural tube defects, congenital anomaly; current health risks such as diabetes, BMI >35 kg/m², celiac disease, gluten-free diet⁸⁶, poor diet, or substance use; certain ethnic groups; currently taking a folic acid antagonist medication in early pregnancy⁸⁷.

Dosage - high risk:

5 mg orally per day, ideally beginning three months before conception and until 10 to 12 weeks post conception.

From 12 weeks post-conception and throughout pregnancy and the postpartum period (for as long as breastfeeding continues), supplementation should consist of a multivitamin with folic acid 0.4-1.0 mg.

Folic Acid greater than 1.1 mg requires a prescription

2.1 Drugs which may be independently prescribed, ordered and administered by a midwife with specialized certification or which may be administered after consulting with and on the order of a medical practitioner

Cervical Ripening/ Induction Agents⁸⁸

Midwives without specialized practice certification may only administer a cervical ripening pharmacologic agent in preparation for labour, inducing labour and/or as a continuation of cervical ripening with a physician order. As with any induction method where a physician has prescribed the inducing pharmacological agent, the midwife may continue to be involved in care as the condition warrants.

A midwife with specialized practice certification may, on her own responsibility, initiate induction of labour in hospital with a cervical ripening agent under the following conditions:

- Pregnancy **≥41 weeks gestation** with normal results from tests of fetal well-being, where indications for consultation or transfer of care to a physician are not present other than the required consultation at 42 completed weeks⁸⁹ and there is consent to labour induction.
- The reasons for initiating an induction must be compelling, convincing, consented to, and documented.

The cervical ripening is recommended if the Bishop score is ≤6.

Factor:	Score:			
	0	1	2	3

⁸⁶ Goh, I. & Koren, G. (2008, January). Folic acid in pregnancy and fetal outcomes. *J. Obs Gyn*, 28(1), 3-13.

⁸⁷ Wen, S.W., Zhou, J., Yang, Q., Fraser, W., Olantunbosun, O. & Walker, M. (2008, December). Maternal exposure to folic acid antagonists and placenta-mediated adverse pregnancy outcomes. *CMAJ*, 179(12), 1263-1268.

⁸⁸ Several cervical ripening methods can be applied to increase the success of a vaginal delivery with an unfavourable cervix which includes both mechanical and pharmacologic options. Mechanical options such as a balloon device may be applied on the registrant's own responsibility. Please refer to the *CMBC Guideline for Cervical Ripening with a Balloon Device*.

⁸⁹ While a physician consultation is required at 42 weeks, this does not preclude a midwife with this specialized certification initiating an induction on request.

Dilation (cm)	0	1-2	3-4	≥5
Effacement (%) Thickness/Length (cm)	0-30 >3	40-50 1-3	60-70 <1	≥80
Consistency	Firm	Medium	Soft	-
Position	Posterior	Mid	Anterior	-
<u>Station</u>	Spines -3 or above	Spines -2	Spines -1 or 0	Spines +1 or lower

Please refer to the *CMBC Framework for Certification for Induction and Augmentation of Labour in Hospital* in conjunction with local hospital protocols.

Dinoprostone Insert/ Prostaglandin E2 (Cervidil®)

This is a vaginal insert which contains 10 mg of dinoprostone (prostaglandin E2) in a controlled-release formulation. The vaginal insert is a thin, flat, wafer which is rectangular in shape with rounded corners contained within the pouch of an off-white knitted polyester retrieval system. The dinoprostone in the vaginal insert is released at approximately 0.3 mg/hour and, once in the plasma, is rapidly cleared and metabolized by most tissues.

Indications and Clinical Use:

For in-hospital use, Dinoprostone Insert/Prostaglandin E2 (Cervidil®) is primarily used as a method of ripening the cervix in preparation for labour or inducing labour in the presence of a medical or obstetrical indication for the induction of labour. **Prostaglandin has been recommended over the use of oxytocin for induction of labour as the preferred method of induction of labour, unless there are specific clinical reasons for not using it⁹⁰.**

Dinoprostone Insert/Prostaglandin E2 (Cervidil®) can be used in the presence of rupture of membranes (ROM); please refer to warnings and precautions below.

In the presence of ROM, the following options should be offered: expectant management or induction of labour with prostaglandin or oxytocin.

Contraindications:

Known hypersensitivity to prostaglandins, clinical suspicion or definite evidence of any condition where labour is contraindicated – including abnormal fetal status, unexplained vaginal bleeding, placenta previa, vasa previa, cord presentation, cephalopelvic disproportion, active genital herpes, pelvic structural deformities, and cervical carcinoma. It is not recommended if there is a history of previous cesarean section⁹¹ or major uterine surgery, high parity ≥6 term pregnancies, multiple pregnancy, polyhydramnios, fetal malpresentation, history of epilepsy, and should not be used simultaneously with other oxytocics.

Warnings and Precautions:

There may be an increase in chorioamnionitis with rupture of membranes and induction of labour with vaginal prostaglandin compared to when oxytocin only is used, but less than with expectant management.

⁹⁰ NICE Guideline 70 – Induction of Labour 2008 London: RCOG Press, 2008

⁹¹ Prostaglandins should not be used if there is a history of a previous cesarean section due to the increased risk of uterine rupture.

Pregnancy:

First 28 weeks of pregnancy – Contraindicated unless for termination/evacuation of
Pregnancy near or at term - Compatible

Lactation:

Category L3 - No Data – Probably Compatible (will be well-metabolized before lactogenesis)

Adverse Reactions:

Hypotension, syncope, tachycardia, dizziness, hyperthermia, nausea, vomiting, diarrhea, tachysystole, hypertonus, hyperstimulation, abnormal fetal heart tones.

Dosage and Administration:

Dinoprostone (Cervidil®) 10 mg vaginal insert digitally placed transversely deep in the posterior fornix of the vagina ensuring there is no visible string exposed outside the vagina.

Onset of Action:

Time to peak: 0.5-1 hour

Half-Life:

2.5-5 minutes

- Dinoprostone Insert/Prostaglandin E2 (Cervidil®) should be removed after 12-24 hrs or at the onset of active labour.
- If cervical ripeness is not achieved in 12-24 hrs and Dinoprostone Insert/Prostaglandin E2 (Cervidil®) has been removed, it may be repeated as needed.
- Oxytocin infusion may be started 30 minutes after Dinoprostone Insert/Prostaglandin E2 (Cervidil®) has been removed if cervix is favourable. Please see section: *Induction and Augmentation of Labour – Oxytocin*.
- Dinoprostone Insert/Prostaglandin E2 (Cervidil®) must be removed: a) when active labour is established b) in the presence of excessive uterine activity such as in hyperstimulation or hypertonus c) in the presence of an abnormal fetal heart rate pattern.

If fetal heart assessment is atypical:

- Follow FH Surveillance/Intrapartum Electronic Fetal Monitoring guidelines.
- Consult with a physician to seek guidance regarding management plan.

If fetal heart assessment is abnormal:

- Remove the Dinoprostone Insert/Prostaglandin E2 (Cervidil®), institute immediate intrauterine fetal resuscitation, prepare for expedited birth and immediately consult with a physician.

If Dinoprostone Insert/Prostaglandin E2 (Cervidil®) has been removed for tachysystole or hypertonus (more than 5 contractions in 10 minutes over 30 minutes or one contraction lasting more than 2 minutes):

- Immediately consult with a physician.
- A tocolytic such as nitroglycerin may be administered.

For tachysystole or hypertonus (six or more contractions in 10 minutes averaged over 30 minutes and/or the presence of moderate/strong contraction(s) lasting more than 90 seconds and/or less than 30 seconds of adequate resting tone between contractions) and if fetal heart is abnormal:

- Immediately consult with a physician. A tocolytic such as nitroglycerin may be administered.

****Administration of nitroglycerin should be accomplished while simultaneously arranging an emergency consult with a physician.***

(See section on Nitrates for administration)

Misoprostol

Cytotec®, is a synthetic prostaglandin E₁ analog and induces uterine contractions. Misoprostol is a water soluble tablet.

Indications and Clinical Use:

Misoprostol can be considered a safe and effective agent for labour induction with intact membranes and on an inpatient basis⁹².

Contraindications:

Misoprostol should not be used if there is a history of previous cesarean section⁹³.

Warnings and Precautions:

Misoprostol should be used with caution in those with pre-existing cardiovascular disease. Oxytocin should be started no earlier than 4 hours after the last dose of misoprostol.

Pregnancy:

Contraindicated (oral)

Human Data Suggest Low Risk (Term Cervical Ripening)

Lactation:

Category L2 - Limited Data – Probably Compatible

Adverse Reactions:

Most common (especially with oral administration): GI – diarrhea (14 – 40%), abdominal pain (13 – 20%), pyrexia and shivering (11%). Pyrexia is more common when the dose exceeds 600 mcg. Greater incidence than 1%: nausea (3.2%), flatulence (2.9%), headache (2.4%), dyspepsia (2 %), vomiting (1.3%) and constipation (1.1%). Serious adverse events with the use of misoprostol are similar to those of other prostaglandins, and include uterine tachysystole with its potential fetal and maternal effects and meconium staining of liquor⁹⁴.

Dosage and Administration^{95,96}

⁹² Misoprostal use for induction of labour has not yet been included into the Framework for Midwife Certification for Induction and Augmentation of Labour in Hospital. It will come into effect when approved certification programs are in place. Please contact CMBC for more information.

⁹³ Prostaglandins should not be used if there is a history of a previous cesarean section due to the increased risk of uterine rupture.

⁹⁴ SOGC Clinical Practice Guideline Induction of Labour No. 296, September 2013.

⁹⁵ SOGC Clinical Practice Guideline Induction of Labour No. 296, September 2013.

⁹⁶ Tang J, et al, WHO recommendations for misoprostol use for obstetric and gynecologic indications, International Journal

- Give 25 mcg orally with a drink of water (ensure that it is swallowed quickly to avoid sublingual absorption). Repeat every 2 hours as long as contractions are absent or non-painful or;
- Give 25 mcg vaginally. Repeat every 6 hours as long as contractions are absent or non-painful.

Oxytocin induction or augmentation can only be used 4 hours after the last dose.

Onset of Action:

Oral – 8 minutes

Sublingual – 11 minutes

Vaginal – 20 minutes

Rectal – 100 minutes

*Dose recommendation is variable; the lower dose has been chosen for safety purposes because of the increasing sensitivity of uterine receptors to misoprostol with increasing gestational age.

Half-Life:

20 to 40 minutes.

If fetal heart assessment is atypical:

- Follow FH Surveillance/Intrapartum Electronic Fetal Monitoring guidelines.
- Consult with a physician to seek guidance regarding management plan.

If fetal heart assessment is abnormal:

- Institute immediate intrauterine fetal resuscitation, prepare for expedited birth and immediately consult with a physician.

For tachysystole or hypertonus (six or more contractions in 10 minutes averaged over 30 minutes and/or the presence of mod/strong contraction(s) lasting more than 90 seconds and/or less than 30 seconds of adequate resting tone between contractions) and if fetal heart is abnormal:

- Immediately consult with a physician.
- A tocolytic such as nitroglycerin may be administered.

****Administration of nitroglycerin should be accomplished while simultaneously arranging an emergency consult with a physician.***

(See section on Nitrates for administration)

Induction and Augmentation of Labour

Midwives without specialized practice certification may only administer oxytocin as an IV infusion for induction or augmentation of labour with a physician order. As with any induction method where a physician has prescribed the inducing pharmacological agent, the midwife may continue to be involved in care as the condition warrants. A midwife with specialized practice certification may, on her own responsibility, initiate and manage an IV oxytocin induction/augmentation of labour in hospital under the following conditions

of Gynecology and Obstetrics (2013), <http://dx.doi.org/10.1016/j.ijgo.2012.12.009>.

- a) Pregnancy of 37 or more completed weeks with pre-labour rupture of membranes where active labour has not become established within a reasonable period of time, assessment of the fetal heart is normal, and no indications for consultation or transfer of care to a physician are present⁹⁷;
- b) Pregnancy of 37 or more completed weeks with non-progressive labour⁹⁸ with contractions that are of inadequate power⁹⁹, where amniotomy has not been effective in augmenting the labour¹⁰⁰ or is not appropriate, an assessment of the fetal heart is normal and no indications for consultation or transfer of care to a physician are present¹⁰¹;
- c) With a post-dates pregnancy, with normal results from tests of fetal well-being, where indications for consultation or transfer of care to a physician are not present other than the required consultation at 42 completed weeks¹⁰², and there is choice and consent to have labour induced.
 - The reasons for induction or augment of labour must be compelling, convincing, consented to, and documented.
 - The cervix should be favorable, ideally a Bishop Score of >6 before amniotomy and prior to oxytocin induction¹⁰³. See Bishop Score chart below.

The cervix is considered *unfavorable* if the Bishop score is ≤ 6 and *favorable* if the Bishop score is >6 .

Factor:	Score:			
	0	1	2	3
Dilation (cm)	0	1-2	3-4	≥ 5
Effacement (%) Thickness/Length (cm)	0-30 >3	40-50 1-3	60-70 <1	≥ 80
Consistency	Firm	Medium	Soft	-
Position	Posterior	Mid	Anterior	-
<u>Station</u>	Spines -3 or above	Spines -2	Spines -1 or 0	Spines +1 or lower

Please refer to the *CMBC Framework for Certification for Induction and Augmentation of Labour in Hospital* in conjunction with local hospital protocols.

Oxytocin

Oxytocin is a hormone that simulates uterine smooth muscle to contract by activating protein receptors which act on myofibrils. Oxytocin increases production of prostaglandin which further stimulates uterine contractions.

⁹⁷ PLEASE NOTE: Certification programs are not yet in place. For more information, please contact CMBC. Pre-labour rupture of membranes is not an indication for consultation for a midwife with this specialized certification.

⁹⁸ Lack of progress is defined by the Society of Obstetricians and Gynecologists of Canada as less than 0.5 cm per hour change in dilation over four hours after the onset of active labour or an arrest of dilation over two hours.

⁹⁹ Adequate contractions have been defined as at least three contractions in ten minutes lasting at least forty seconds.

¹⁰⁰ Performing an amniotomy is an entry-level competency.

¹⁰¹ Non-progressive labour is not an indication for consultation for a midwife with this specialized certification.

¹⁰² While a physician consultation is required at 42 weeks, this does not preclude a midwife with this specialized certification initiating an induction on request.

¹⁰³ MoreOB. Induction of Labour

Contraindications:

Hypersensitivity to oxytocin or any component of the formulation. For induction and augmentation, any contraindication to labour including: placenta previa, vasa previa, cord presentation, fetal malpresentation such as transverse or footling breech, prior classical or inverted T cesarean section, previous uterine surgery such as myometrial incision, active genital herpes, pelvic structural deformities, cervical carcinoma, previous uterine rupture.

Warnings and Precautions:

Oxytocin is structurally and functionally related to vasopressin and its antidiuretic action can lead to water retention. For this reason electrolyte-containing solutions should be used when administering oxytocin. Water intoxication can lead to hyponatremia, confusion, convulsions, coma, congestive heart failure, and death. Fluid overload and hyponatremia with concurrent oxytocin administration may be prevented by strict intake and output recordings and use of balanced salt solutions such as normal saline or lactated Ringer's.

Pregnancy:

Compatible for induction or augmentation of labour

Lactation:

Category L2 – Limited Data – Probably Compatible

Adverse Reactions:

Arrhythmias, hypertensive episodes, nausea, vomiting, uterine hypertonicity, tetanic contraction of the uterus, uterine spasm, anaphylactic reaction, subarachnoid hemorrhage, severe water intoxication with convulsions, coma, and death is associated with a slow oxytocin infusion over 24 hours.

Dosage and Administration:

30 international units (IU) of oxytocin in 500 mL of normal saline or 500 mL of Dextrose 5% normal saline in a secondary IV line via infusion pump to give 60 milliunits/mL.

Conversion Note: 1 mL/hr = 1 milliunit/minute (mU/min)

Low-dose oxytocin – Increase by 1-2 mU/min

Indication:

All augmentations in 2nd stage

Parous augmentation

Grand multiparous induction

VBAC augmentation/induction¹⁰⁴ (increase by 1 mU/min)

High-dose oxytocin – Increase by 2-4 mU/min

Indication:

Parous induction

Nulliparous augmentation/induction in 1st stage

Initiate oxytocin infusion at 1-2 mU/min

Increase oxytocin at 30-minute intervals until regular uterine activity is established

Usual dose for labour = 8-12 mU/min

¹⁰⁴ A midwife may not administer prostaglandin or initiate an IV oxytocin induction/augmentation of labour if there is a history of previous cesarean section or uterine surgery without a physician consultation and order.

Maximum dosage:

30-36 mU/min or 20 mU/min for VBAC

If tachysystole (more than 5 contractions in 10 minutes over 30 minutes or one contraction lasting more than 2 minutes):

- Decrease oxytocin dose to achieve the desired uterine activity.
- If fetal heart pattern is normal and uterine activity is normal, resume titration of oxytocin infusion.
- Discontinue oxytocin if tachysystole persists greater than 30 minutes and is unresponsive to decreasing dose. Notify physician immediately.

If fetal heart assessment is atypical:

- Follow FH Surveillance/Intrapartum Electronic Fetal Monitoring guidelines.
- Notify physician to seek guidance regarding dose and management plan.

If fetal heart assessment is abnormal:

- Discontinue oxytocin.
- Request physician attendance to seek guidance regarding dose and management plan.

Onset of Action:

IM: 2-5 minutes

IV: 1-5 minutes

Half-Life:

IM and IV: 6-15 minutes.

*Reference ranges for the onset and duration of action and half-life are varied in the literature^{105,106,107,108}

Elimination:

Excreted by the kidneys.

Controlled Substances for use in prodromal and active labour and for use in the early postpartum period can be found in the *CMBC Standards, Limits and Conditions for Prescribing, Ordering and Administering Controlled Substances*.

¹⁰⁵ Simpson K. R., Crechan, P. A. (2008). *AWHONN (Association of Women's Health Obstetric and Neonatal Nurses) Perinatal Nursing*. Edition 3. Philadelphia, PA: Lippincott, Williams and Wilkins

¹⁰⁶ Hale, T.W. (2010), *Medications and Mothers' Milk*. Fourteenth Edition. Amarillo, TX: Hale Publishing

¹⁰⁷ M.P. EMBREYB, .Sc., M.D., F.R.C.S., M.R.C.O.G.(1955). *A New Multichannel External Tocograph*. The Journal of Obstetrics and Gynaecology of the British Empire, Nuffield Department of Obstetrics and Gynaecology University of Oxford: VOL. LXII, No. 1 February 1955.

¹⁰⁸ M. P. EMBREYB, .Sc., M.D., F.R.C.S., M.R.C.O.G. (1961). *Preliminary Communications*. British Medical Journal, Nuffield Department of Obstetrics and Gynaecology, University of Oxford: June 17, 1961.

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