

Perinatal Statements

Statement #	High Risk Statements
H1	Communication between the obstetric, neonatal, and transfusion care providers regarding alloimmunized pregnancies is recommended.
H2	Once a clinically significant antibody has been identified, paternal antigen testing is suggested to assess the risk to the fetus, if paternity is assured.
H3	For anti-K antibodies early consultation with Maternal Fetal Medicine is recommended.
H4	For patients with clinically significant antibodies to RhD, C/c, E, or K, non-invasive prenatal testing (cffDNA testing of maternal plasma) is recommended to determine if the fetus is at risk.
H5	Once a clinically significant antibody has been identified, antibody titration is recommended every four weeks until 28 weeks and every two weeks thereafter. If a critical titre is reached, referral to Maternal Fetal Medicine is recommended.
H6	Once a critical titre is reached, further monitoring of antibody titres is not routinely recommended; evaluation by Maternal Fetal Medicine with monitoring by MCA Doppler ultrasound is recommended.
H7	Maternal fetal medicine consultation is recommended for alloimmunized pregnancies with clinically significant antibodies when: <ul style="list-style-type: none"> . a critical titre is identified, and the corresponding fetal antigen is unknown or predicted positive based on cffDNA assessment. . an anti-K antibody is identified. . a previous fetus or neonate has been affected by HDFN requiring intrauterine or post-natal transfusion and the corresponding fetal antigen is unknown or predicted positive based on cffDNA assessment
H8	Monitoring of alloimmunized pregnancies with antibody titration is <i>not routinely</i> recommended in the following situations: <ul style="list-style-type: none"> . a critical titre is identified . cffDNA assessment predicts that the fetus is negative for the corresponding antigen . a previous fetus or neonate was affected by HDFN and required intrauterine or post-natal transfusion
H9	Maternal (or cord) antibody titrations are not recommended immediately pre delivery, or postpartum.
H10	RhIg is recommended for RhD negative pregnancies following any fetal intervention, invasive prenatal testing, or maternal abdominal trauma starting at 8 weeks 0 days gestation.
H11	RhIg is recommended for RhD negative pregnancies starting at 8 weeks 0 days gestation, following an ectopic pregnancy.
H12	RhIg is recommended for RhD negative pregnancies starting at 8 weeks 0 days gestation, following molar pregnancy.
H13	RhIg is recommended for RhD negative pregnancies following amniocentesis.
H14	RhIg is recommended for RhD negative pregnancies following chorionic villus sampling.

H15	<p>When RhIg may have been previously administered and there is uncertainty about whether the antibody detected is passive (due to RhIg) or immune:</p> <ul style="list-style-type: none">a. RhIg is recommended for routine antenatal dosing and for sensitizing events.b. ongoing titration of anti-D at usual intervals is recommended.c. repeat antibody assessment is suggested at six (6) months postpartum.
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