Therapeutic amnioreduction – L&D nursing guidelines

Purpose: percutaneous draining of large quantities of amniotic fluid

Pt status:

Pt is outpatient, please chart complete triage assessment, full set of vitals (including pain), FHR tracing as appropriate for gestation. Also, upon discharge, please put in nursing note regarding education given and no further questions. There is no need to chart full admission assessment, education, or care plan.

Indications:

Severe polyhydramnios with maternal symptom due to the excess amniotic fluid

Staff:

Patient's nursing staff provider

Faculty MFM; physician for sonography/assistant

Equipment list (review with provider what equipment they will need you to obtain):

GE US machine from triage – usually procedure is done in Triage 1

Amnioreduction equipment:

Paracentesis tray

20-gauge spinal needle (6.00

inch) arterial line tubing x 2

(sterile) three-way stopcock x 1

20-gauge syringe x 2

wall suction canister x 2; wall suction extension tubing

10 cc syringe x 3 if amniotic fluid is needed for analysis

Staff:

Patient's nursing staff provider

Faculty MFM; physician for sonography/assistant

Procedure:

Pre-op abx:

not indicated

Anesthesia/analgesia:

local lidocaine (in paracentesis tray)

IV narcotic +/- anxiolytic reasonable

50 mcg fentanyl IV + 1 mg Ativan IV 2-3 min prior to starting procedure

Prep/positioning:

Supine position with left lateral tilt (bovie pad not needed)

US machine present

Mayo stand for paracentesis tray (opened in sterile fashion)

Procedure briefly: MFM will perform US to confirm fetal position and obtain AFV/MVP.

Specimen:

Usually no specimen

May have amniotic fluid for karyotype, array, save cells, PCR for infectious studies (review with MFM for needed lab evaluation)

Post procedure – recovery – discharge:

Meds: may give Indocin 50 mg po prior to discharge and then 25 mg po q 8 hours x 24-48 hours

If plan is for cesarean/delivery for abnormal fetal monitoring, place on fetal monitor post procedure. Review with MFM regarding fetal monitoring needed for individual case (prolonged monitoring vs reactive NST.)

Discharge in consultation with MFM when tolerating PO, void without comps, appropriate pain symptoms.

Will need follow up in US unit in 5-7 days for antenatal testing and AFV

These algorithms are designed to assist the primary care provider in the clinical management of a variety of problems that occur during pregnancy. They should not be interpreted as a standard of care, but instead represent guidelines for management. Variation in practices should take into account such factors as characteristics of the individual patient, health resources, and regional experience with diagnostic and therapeutic modalities.

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