Health Services
LOS ANGELES COUNTY

POLICIES AND PROCEDURES

SUBJECT: DHS THRESHOLD OF VIABILITY POLICY

POLICY NO: 311.002

PURPOSE:

To establish core definitions and obstetrical/neonatal management strategies for infants within the threshold of viability.

POLICY:

1. The gestational age of the infant shall be accurately determined. In the event that the gestational age is not known, the gestational age shall be presumed based on ultrasound estimates.

2. The presumed gestational age and the weight shall play a critical role in making decisions for antepartum management and resuscitation.

3. The mother shall be the major decision maker for the fetus/infant. If the mother is unable, paternal and/or surrogate support may make decisions assuming that they are acting in the best interest of the infant and mother.

4. A team approach shall be used during antenatal counseling of parents with infants within the threshold of viability. The team is composed of representatives from Obstetrics and Neonatology medical staff and other appropriate supporting members.

5. If the physician(s), after thorough consideration of the maternal and fetal health status and historical data, determine that there is a poor chance of fetal or neonatal survival, aggressive interventions may be withheld.

6. When resuscitation is deemed appropriate, a neonatal resuscitation team must be present during delivery.
   NOTE: As situation may change after the infant's delivery, the team's plan of care may change or be modified.

7. Newborn comfort care shall always be provided to the infant.

APPROVED BY:
REVIEW DATES:

EFFECTIVE DATE: June 1, 2012

SUPERSEDES:

8. As technology in neonatal management advances, the obstetrical/neonatal team shall inform the mother of the available resources for managing the infant during resuscitation and post-delivery. Facilities are to refer/transfer the mother to other facilities that offer more options for survival or higher level of care as appropriate.

9. Advances in neonatal science will require periodic review of facility policies regarding the threshold of viability.

Frequent monitoring and collection of facility based data on neonatal viability, survival, and success of resuscitation may be undertaken.

DEFINITIONS:

Pre-Viability: ≤ 22 6/7 weeks of gestational age
Threshold (Gray Zone) of Viability: 23 0/7 to 24 6/7 weeks gestational age
Age of Viability: ≥ 25 weeks gestational age
Non-viability or Pre-viability: A patient or infant who may be born with signs of life, but may not survive after a few minutes or few hours after birth.
Comfort Care: Provision of infant care that aims to (a) provide warmth, (b) avoid discomfort, and (c) treat the patient with dignity (example, promotion of parental-infant bonding).

PROCEDURE:

General Management Guidelines
NOTE: These are just general guidelines to be considered. Reasonable clinical judgment is required in all cases.

1. At < 22 6/7 weeks, survival rate is extremely low:
   Obstetrical Care: (a) Tocolysis if indicated, (b) Steroids not routinely offered, (c) No routine cesarean delivery for fetal indication
   Neonatal Care: No routine resuscitation offered

2. At 23 0/7 to 23 6/7 weeks gestational age,
   Obstetrical Care: (a) Tocolysis if indicated, (b) Steroids if indicated (c) Magnesium sulfate if indicated, (d) Selective use of cesarean delivery for fetal indication based on clinical decisions and in consideration of parental preference.
   Neonatal Care: (a) Selective resuscitation based on neonatal assessment and in consideration of parent's wishes. Neonatal team to be present for delivery.

3. At 24 0/7 – 24 6/7 weeks gestational age,
   Obstetrical Care: (a) Tocolysis if indicated, (b) Steroids if indicated (c) Magnesium sulfate for neuroprotection if indicated, (d) Selective use of cesarean delivery for fetal indication and/or based on clinical scenario.
   Neonatal Care: Routine resuscitation offered. Neonatal team to be present for delivery.

Monitoring The Fetus Within The Threshold Of Viability During Maternal Procedures or In The Intensive Care Unit (ICU)

NOTE: These general guidelines to be considered. Decisions should be based on reasonable clinical judgment, especially in emergent cases.

Proper monitoring, maternal or fetal, should be discussed with an Obstetrician prior to the procedure. The goal is always to protect the mother.

The likelihood of possible emergency cesarean being necessary during the maternal procedure should be considered. A plan and preparation for possible emergent delivery and neonatal resuscitation in the event a cesarean section may be required.

When a pregnant woman, with fetus within the threshold of viability, is to undergo a minor or major procedure/surgery, the fetal heart rate (FHR) should be monitored as follows:

1. At <22 6/7 weeks gestational age - an FHR should be obtained and recorded prior to and after the procedure. No monitoring required during the procedure.

2. At 23 0/7 weeks to 24 6/7 weeks gestational age – continuous or intermittent monitoring of FHR is recommended if reasonably possible.

3. At ≥25 weeks gestational age – continuous monitoring is recommended if reasonably possible and at the discretion of Obstetrician or primary physician

FHR monitoring, when required, shall be conducted in the areas where the procedure is being performed.

Required Resources
1. Portable fetal heart monitor
2. Assigned staff competent in reading and monitoring FHR (e.g., Obstetrical Nurse)
3. Obstetrical Consultation
4. A set-up for possible emergent delivery

REFERENCES:

MacDonald, H. (2002). American College of Pediatrics, Committee on Fetus and Newborn. Perinatal care at the threshold of viability. *Pediatrics,* 110: 1024-1027

Pignotti & Donzelli. (2008). Perinatal care at the threshold of viability: An international comparison of practical guidelines for the treatment of extremely preterm births. *Pediatrics*, 12: e193 – e199

Committee on Obstetric Practice. (2011). Nonobstetrics surgery during pregnancy. The American College of Obstetricians and Gynecologists, *Obsterics Gynecology,* 474: 420-421.