Fetal Monitoring for Nonobstetric Surgery/Procedures

Nonobstetric surgery/procedures may become necessary during pregnancy, which requires discussion among the surgical/procedure team, Obstetrics, Anesthesia, and nursing.

ACOG guidelines include the following:
- A pregnant woman should never be denied indicated surgery, regardless of trimester.
- Elective surgery should be postponed until after delivery.
- If possible, nonurgent surgery should be performed in the second trimester.

Potential surgery/procedures that may occur during pregnancy include:
- Cholecystectomy
- Appendectomy
- Hernia/bowel surgery
- Orthopedic surgery
- Gastroenterology procedures (endoscopy, colonoscopy, MRCP, ERCP)

Important considerations for all pregnant women undergoing nonobstetric surgery include:
- Positioning with left lateral tilt if > 20 weeks, in order to reduce aortocaval compression
- May consider betamethasone course for fetal lung maturity, following MFM consult

The plan for fetal monitoring will depend on gestational age and type of surgery/procedure.

Prior to Viability (Less than 23 0/7 weeks):
- Assess fetal heart rate before and after surgery/procedure, which can be performed by nursing (doptone) or a resident (bedside ultrasound), depending on availability. The Labor & Delivery charge nurse (662-0056) should be notified to help arrange this.

After Viability (23 0/7 weeks and beyond):
- If intraoperative fetal monitoring is not technically feasible (e.g., appendectomy), an NST should be performed prior to, and immediately following the surgery/procedure.
• If intraoperative fetal monitoring is technically feasible (i.e., not abdominal surgery), the fetus should be monitored continuously throughout the surgery/procedure.
  ➢ The Labor & Delivery charge nurse should be notified at least 24 hours in advance (662-0056) of any surgery/procedure that will require fetal monitoring.
  ➢ The patient should be consented for possible emergency cesarean.
  ➢ A Labor & Delivery nurse will need to be present for continuous monitoring.
  ➢ The covering obstetrician should be aware and available, if needed.
  ➢ A cesarean delivery kit should be available at the location of the surgery/procedure, in case emergency delivery becomes necessary.
  ➢ Neonatology should be made aware, with placement of neonatal warmer and resuscitation equipment at the location of the surgery/procedure.

Reference:
ACOG Committee Opinion No. 474, Committee on Obstetric Practice: Nonobstetric Surgery During Pregnancy, February 2011.