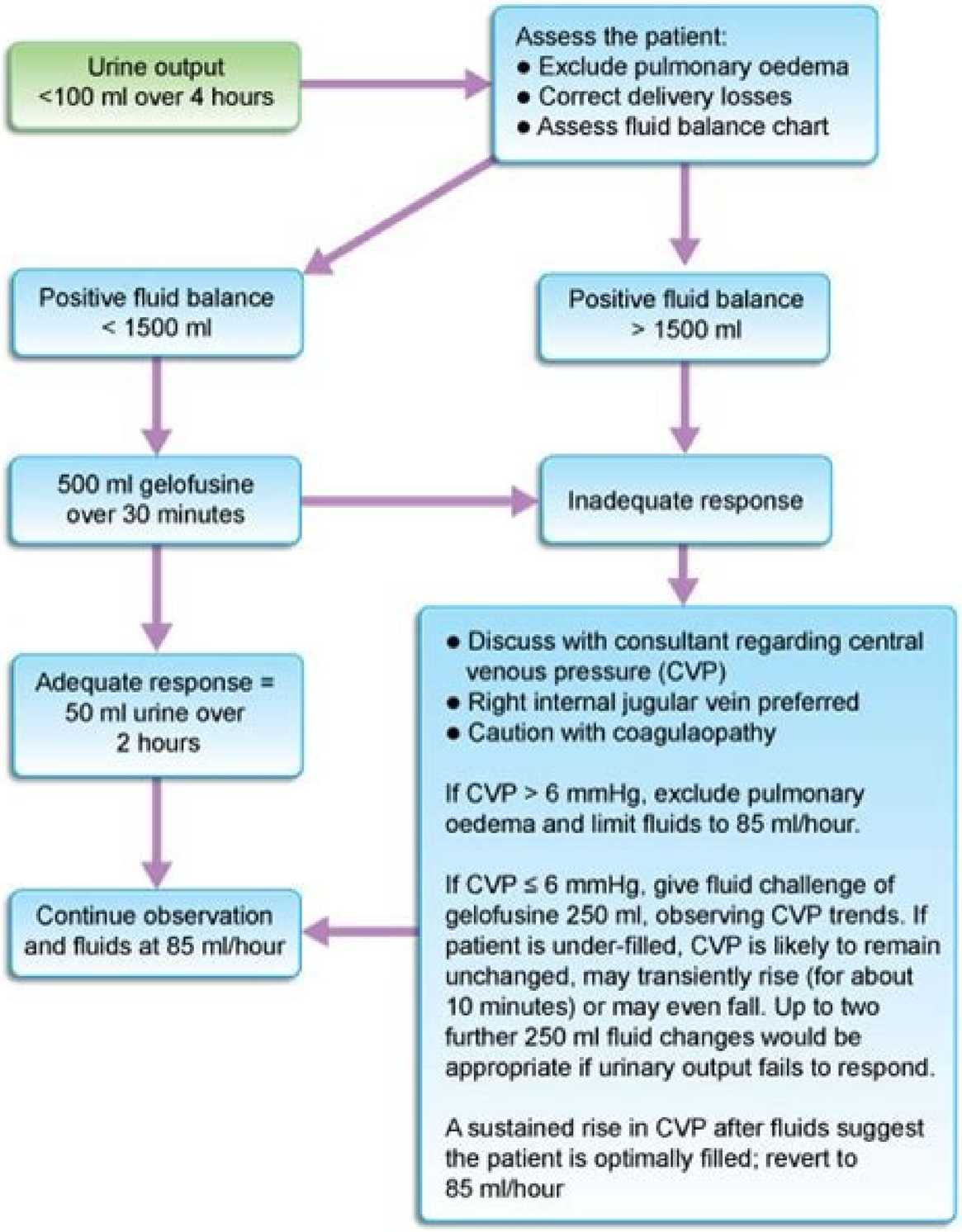
Rcog green top guidelines anti d



BRAND NAME	GENERIC NAME	TYPE	MANUFACTUER
Betadine 5%	povidone-iodine solution	topical	Alcon
Indications: Prepping of the periocular region—lids, brow, and cheek—and irrigation of the ocular surface—cornea, conjunctiva, and palpebral fornices; the unapproved use for adenoviral conjunctivitis.			
Dosage: Instill a drop or two of a topical NSAID first, then instill four to five drops of Betadine 5%. Ask patient to close eyes and roll them around for even distribution. Then lavage out the Betadine to avoid unnecessary toxicity or discoloration with any sterile ophthalmic irrigation solution. Finish with an extra drop of an NSAID. To address secondary inflammation, prescribe Lotemax four times a day for four days.			
Denavir	penciclovir ointment	topical	Novartis
Indications: Treat the symptoms of herpes simplex virus infections—cold sores—around the lips and face.			
Dosage: Applied every two hours during waking hours for a period of four days.			
Famvir, generic	famciclovir	oral	Novartis
Indications: Slows the growth and spread of the herpes virus so that the body can fight off the infection, decrease the duration and severity of post-herpetic neuralgia, active against herpes simplex and varicella viruses			
Dosage: 500mg of three times a day for seven days for zoster and 250mg three times a day for seven days for simplex.			
Valtrex, generic	valacyclovir hydrochloride	oral	GlaxoSmithKline
Indications: Slows the growth and spread of the herpes virus so that the body can fight off the infection.			
Dosage: 1,000mg three times a day for seven days for zoster and 500mg three times a day for seven days for simplex.			
Viroptic	trifluridine 0.1% solution	topical	Monarch Pharmaceuticals
Indications: Treatment of dendritiform herpes simplex epithelial keratopathy.			
Dosage: For the first two days, every two hours during waking hours. For the next four to seven days, every two to four hours. For the next seven more days, four times a day.			
Zirgan	ganciclovir gel 0.15%	topical	Sirion Therapeutics
Indications: Treatment of eye ulcers caused by the herpes simplex virus.			
Dosage: Apply five times each day until the eye ulcer heals. Then apply the gel three times a day for seven days.			
Zovirax	acyclovir	topical	GlaxoSmithKline
Indications: Treatment of cold sores or fever blisters—blisters caused by herpes simplex virus—on the face, lips or eyes.			
Dosage: A 5% cream is applied five times a day for four days on the lips or face and a 3% ointment is applied inside the lower eyelid margin five to six times a day (usually three to four hours apart) for seven days.			
Zovirax, generic	acyclovir	oral	GlaxoSmithKline
Indications: Treatment of both herpes simplex and herpes zoster.			
Dosage: For acute disease, 800mg five times a day for seven to ten days for zoster and 400mg five times a day for simplex. For chronic suppressive treatment, 400mg twice a day or 200mg three to five times a day for up to a year.			

Rcog anti-d green top guidelines.

The Green-top Guidelines are produced following the process outlined in the handbook Developing a Green-top Guideline: Guidance for developers (PDF 2.4mb), under the direction of the RCOG Guidelines Committee. The recommendations are not intended to dictate an exclusive course of management or treatment. They must be evaluated with reference to individual patient needs, resources and limitations unique to the institution and variations in local populations. It is hoped that this process of local ownership will help to incorporate these guidelines into routine practice. Below, you can browse Green-top Guidelines by year published, or by title in the section navigator. Green-top Guidelines by year published Clinical content hub We have developed a hub of audio versions, bitesize video summaries and infographics based on our Green-top Guidelines and Scientific Impact Papers. RCOG Green-top Guidelines Birth After Previous Caesarean Birth Blood Transfusions Obstetrics Chickenpox in Pregnancy Chronic Pelvic Pain, Initial Management Endometriosis, Investigation and Management External Cephalic Version (ECV) and Reducing the Incidence of Breech Presentation Genital Herpes in Pregnancy, Management Group B Streptococcal Disease, Early Onset Late Intrauterine Fetal Death and Stillbirth Malaria in Pregnancy Diagnosis and Treatment Maternal Collapse in Pregnancy and the Puerperium Monochorionic Twin Pregnancy, Management Operative Vaginal Delivery Ovarian Cysts in Postmenopausal Women Vasa Praevia : Diagnosis and Management Placenta Praevia and Placenta Accreta : Diagnosis and Management Care of Women with Obesity in Pregnancy Polycystic Ovary Syndrome, Long-Term Consequences Postpartum Haemorrhage, Prevention and Management Premenstrual Syndrome, Management Recurrent Miscarriage, Investigation and Treatment of Couples Reduced Fetal Movements Shoulder Dystocia Small for Gestational Age Third- and Fourth-degree Perineal Tears, Management Thrombosis and Embolism during Pregnancy and the Puerperium, Reducing the Risk Thrombosis and Embolism during Pregnancy and the Puerperium, the Acute Management Tubal Pregnancy, Management Umbilical Cord Prolapse Clinical Recommendations on uterine artery embolisation in the management of fibroids (3rd Edition) © Copyright 2021 Wakelet Limited.All rights reserved. 1. The Use of Anti-D Immunoglobulin for Rhesus D Prophylaxis RCOG Green-top Guideline March 2011 Prepared by:- Basem Hamed 2. History • Post-delivery anti-D Ig immunoprophylaxis began in the UK in 1969. • Deaths attributed to RhD alloimmunisation fell from 46/100 000 births before 1969 to 1.6/100 000 in1990 3. Updating Guidelines on RhD immunoprophylaxis were updated in 1976, 1981, 1991 and 2002 4. Pathogenesis Of Rh Iso- immunisation ⇐ Rh Negative Women Man Rh positive (Homo/Hetero) ⇓ ⇓ ← ← Fetus → → Rh Neg Fetus No problem Rh positive Fetus→← ⇓ Rh+ve R.B.C.s enter Maternal circulation ⇐⇐Mother previously sensitized Secondary immune response ⇓ ↑? Iso-antibody (IgG) ⇓ Non sensitized Mother Primary immune response ⇓ Fetus → unaffected, 1st Baby usually escapes. Mother gets sensitised? ± ⇓ Fetus Haemolysis ⇓ ←←←← ±? 5. 1- How should the size of FMH be quantified? •A Kleihauer screening test should be performed within 2 hours of delivery to identify Rh-negative women with a large FMH who require additional anti-D Ig. •clinical circumstances are more likely to be associated with a large FMH: 1. traumatic deliveries including caesarean section 2. manual removal of the placenta 3. invasive prenatal diagnosis (amniocentesis, CVS) 4. antepartum haemorrhage 5. abdominal trauma 6. Kleihauer test Nucleated cell HbF Rh +ve MCV > 100 µ3 Empty cell HbA Rh -ve MCV 80-100 µ3 7. 2- What dose of anti-D Ig should be administered? 2 policies 1.Testing to quantify the size of FMH is recommended (UK, USA,Canada,France and Ireland). 2.A standard postnatal dose of 1000–1500 iu is used with no requirement for a routine Kleihauer test (In other European countries). 8. 2- What dose of anti-D Ig should be administered? •An intramuscular dose of 500 iu of anti-D Ig .....will neutralise an FMH of up to 4 ml. •For each 1 ml of FMH in excess of 4 ml .....a further 125 micrograms of anti-D Ig is necessary.. PREPARATIONSPREPARATIONS •250 iu •500 iu •1250 iu •1500 iu •2500 iu •5000 iu 9. 3- How should anti-D Ig be administered? TIME For successful immunoprophylaxis, anti-D Ig should be given as soon as possible after the potentially sensitising event but always within 72 hours.If it is not given before 72 hours, every effort should still be made to administer the anti- D Ig, as a dose given within 10 days may provide some protection. SITE Ideally, it should be administered into the deltoid muscle. but women who have a bleeding disorder should receive sc. or iv. 10. 3- When is anti-D Ig prophylaxis required following miscarriage, ectopic pregnancy and termination of pregnancy? Miscarriage Anti-D Ig should be given to non-sensitised RhD-negative women who have :- • Spontaneous complete or incomplete miscarriage >12W. •Surgical or Medical evacuation of the uterus, regardless of gestation. 11. 3- When is anti-D Ig prophylaxis required following miscarriage, ectopic pregnancy and termination of pregnancy? Threatened miscarriage Anti-D Ig should be given to non-sensitised RhD-negative women who have :- •>12 w. •approaching 12W, with heavy or repeated bleeding or associated abdominal pain. • >12 w e bleeding continues intermittently , anti-D Ig should be given at 6-weekly intervals. 12. 3- When is anti-D Ig prophylaxis required following miscarriage, ectopic pregnancy and termination of pregnancy? Ectopic pregnancy Anti-D Ig should be given to all non-sensitised RhD-negative women who have an ectopic pregnancy, regardless of management. 13. 3- When is anti-D Ig prophylaxis required following miscarriage, ectopic pregnancy and termination of pregnancy? Therapeutic termination of pregnancy Anti-D Ig should be given to non-sensitised RhD-negative women who have :- therapeutic termination of pregnancy, whether by surgical or medical methods, regardless of gestational age. 14. 4- Which antenatal sensitising events require anti-D Ig prophylaxis? 1.invasive prenatal diagnosis (amniocentesis, chorion villus sampling, cordocentesis, intrauterine transfusion) 2. other intrauterine procedures (e.g. insertion of shunts, embryo reduction, laser) 3. antepartum haemorrhage 4. external cephalic version of the fetus (including attempted) 5. any abdominal trauma (direct/indirect, sharp/blunt, open/closed) 6. fetal death. 15. 5- How should an RAADP programme be put into clinical practice? •In a significant proportion of cases, there is no recognised sensitising event and sensitisation is ‘silent’ secondary to occult FMH. •This occurs with increasing frequency as gestation advances, Fewer than 10% of cases occur before 28 weeks of gestation. •There are two regimens for providing RAADP: two doses of 500 iu anti-D Ig at 28 and 34 weeks of gestation, or a single dose of 1500 iu at 28 weeks of gestation. 16. 5- How should an RAADP programme be put into clinical practice? •RAADP should be offered to all non-sensitised RhD-negative women. •RAADP is a completely separate entity from the anti-D Ig required for potentially sensitising events. •There is no evidence that the efficacy of the single-dose and two-dose regimens differs, and the chosen regimen will depend on local organisational factors. •The routine 28-week antibody screening sample must be taken before administration of the first dose of anti-D. 17. 5- What are the maternal and fetal effects of RAADP? There is NO evidence to suggest that RAADP is associated with adverse events that are of consequence for the mother or baby other than the possibility of blood-borne infection. 18. 6- How should women who decline RAADP be managed? WHO? •women who object on religious grounds • women who will be sterilised after the birth • women who are certain they will have no more children In the event that RAADP is declined, antibody screening should be performed at booking and at 28 weeks of gestation to identify cases where sensitisation has occurred. Sensitisation occurring in the third trimester is unlikely to cause significant fetal problems in that pregnancy. 19. 7- Who should receive postnatal anti-D Ig prophylaxis? •At least 500 IU of anti-D Igmust be given to every non-sensitised RhD-negative woman within 72 hours following the delivery of an RhD-positive infant. •A test to detect FMH greater than 4ml must also be undertaken so that additional anti-D Ig can be given as appropriate. •If the pregnancy is non-viable and no sample can be obtained from the baby, anti-D Ig should be administered 20. 8- What is the role of non-invasive assessment of fetal blood type? cell-free fetal DNA (cffDNA) •Diagnostic accuracy of 96.5%. •In addition to ascertaining RhD status,other rarer antigens can be identified.These include K (Kell),Rh C,c and E . 21. 9- How should inadvertent transfusion of RhD-positive platelets be managed? In the event that RhD-positive platelets are transfused, prophylaxis against Rh alloimmunisation should be given. 250 iu anti-D Ig should be given following every three adult doses. 22. 10- How should inadvertent transfusion of RhD-positive blood be managed? •15 ml ..... larger anti-D Ig (2500 iu or 5000 iu). •Exchang transfusion may be necessary for large volumes of transfused blood 23. First slide heading • Point 1 • Point 2 • Point 3 • Point 4 This guideline has been archived. Please see the British Committee for Standards in Haematology (BCSH) guideline on anti-D administration in pregnancy. More recent evidence regarding routine ffDNA testing to support targeted anti-D prophylaxis has been published in BJOG.

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