1. What is the duration and dose of NSAID exposure after which monitoring of fetal cardiac function is warranted? What should this monitoring entail? Does this recommendation for monitoring apply to exposures in all trimesters?

Currently no consensus exists as to duration and dose of NSAID exposure after which monitoring of the fetal cardiac function is warranted. The practitioner should consider a form of monitoring based on the medical condition that lead to NSAIDs exposure. For example, aspirin and likely ibuprofen is associated with an increased risk of vascular disruptions, particularly gastroschisis, and small intestine atresias. Ductal constriction occurs with a frequency that increases with advancing gestation, but adverse cardiovascular outcomes are exceedingly rare. It is unclear whether routine monitoring of the cardiovascular system is warranted prior to 32 weeks of gestation. Aspirin is recommended in patients with antiphospholipid syndrome. In this scenario, a second-trimester ultrasound (to exclude gastroschisis or small bowel atresia) is recommended. This should be followed by serial evaluations of fetal growth scans and monitoring of the amniotic fluid during the second and third trimester. Ibuprofen is as effective as indomethacin in closing the ductus, but may have less effect on renal function. Discontinuation of the ibuprofen or indomethacin treatment is recommended if fetal hydrops or
oligohydramnios is identified during a routine second- or third-trimester ultrasound evaluation. The impact of NSAIDs on the amniotic fluid volume is not necessarily predictable. Several studies reported that ductal constriction, oligohydramnios, and neonatal morbidity were not associated with duration of therapy, gestational age at the beginning or end of therapy, time between dosing and delivery, or dose regimen. Given the above and the association of various maternal diseases with their chronic use, we recommend serial evaluation of the fetal growth and monitoring of the amniotic fluid in all fetuses exposed chronically to NSAIDs independent of gestational age or dose of medication.

2. Does use of tetracycline during breastfeeding in the neonatal period carry the same risk of teeth discoloration that is associated with its use in the second and third trimesters?

The use of tetracycline during tooth development (pregnancy, infancy, and childhood to age 8 years) may cause permanent discoloration of the teeth. Clinical experience suggests that maternal oral ingestion is compatible with breastfeeding.

3. Should the 1-hour oral glucose tolerance test be delayed if a patient has recently received antenatal corticosteroid therapy for threatened preterm birth?

Limited data suggest that betamethasone worsens the results of the 1-hour glucose screening test in non-gestational diabetic patients but this effect is transient. Several investigators recommend that the 1-hour glucose screening test should be postponed for 1 week.
4. Should patients on chronic glucocorticoid therapy during pregnancy receive supplemental perioperative glucocorticoids at the time of either vaginal or cesarean delivery?

In general, women who received greater than 20 mg of prednisone per day for more than 3 weeks in the 6 months prior to surgery should be assumed to have suppression of the adrenal function. Some recommend that patients on chronic glucocorticoids undergoing surgery receive their usual daily dose of glucocorticoid perioperatively. However, others recommend an increased dose of steroids perioperatively. Recent studies have questioned both the need for and current dosage regimens of supplemental perioperative glucocorticoids. Patients who have a Cushingoid body habitus or exhibit signs or symptoms of adrenal insufficiency perioperatively should be approached cautiously and most probably should receive supplemental perioperative glucocorticoids.