Clinical Pathways Program

Guideline: CHORIOAMNIONITIS, INPATIENT

Updated: December 1, 2021

Clinical guideline summary

PATIENT POPULATION AND DIAGNOSIS: Obstetric inpatients

The diagnosis of chorioamnionitis is made once the following conditions are met:

1. Maternal temperature of 39° C (102.2° F) or greater.
2. Maternal temperature of 38.0° to 38.9° C (100.4° to 102° F) with one additional risk factor.
    - Maternal leukocytosis
    - Purulence cervical drainage
    - Fetal tachycardia

NOTE- Isolated maternal fever is defined as any maternal temperature between 38° C and 38.9° C with no additional risk factors present.

APPLICABLE TO: All Spectrum Health Inpatient Locations

BRIEF DESCRIPTION: An intra amniotic infection with resultant inflammation of any combination of the amniotic fluid, placenta, fetus, fetal membranes, or decidual. Failure to diagnosis chorioamnionitis and treat appropriately increases the risk for complications such as increase in acute neonatal morbidity, neonatal pneumonia, meningitis, sepsis, and death. Untreated chorioamnionitis also has long-term consequences such as bronchopulmonary dysplasia and cerebral palsy.

OVERSIGHT TEAM LEADER(S): Dr. David Columbo

OWNING EXPERT IMPROVEMENT TEAM (EIT): OB EIT

MANAGING CLINICAL PRACTICE COUNCIL (CPC): Women's Health

CPC APPROVAL DATE: 1/18/2022

OTHER TEAM(S) IMPACTED: None

IMPLEMENTATION DATE: 1/18/2022

LAST REVISED: 12/1/2021

FOR MORE INFORMATION, CONTACT: David Columbo

Clinical pathways clinical approach

TREATMENT AND MANAGEMENT:

Definition: An intra amniotic infection with resultant inflammation of any combination of the amniotic fluid, placenta, fetus, fetal membranes, or decidual. Failure to diagnosis chorioamnionitis and treat appropriately increases the risk for complications such as increase in acute neonatal morbidity, neonatal pneumonia, meningitis, sepsis, and death. Untreated chorioamnionitis also has long-term consequences such as bronchopulmonary dysplasia and cerebral palsy.

Diagnosis: The diagnosis of chorioamnionitis is made once the following conditions are met:

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NOTE- Isolated maternal fever is defined as any maternal temperature between 38° C and 38.9° C with no additional risk factors present.

Treatment: Administration of intrapartum antibiotics is recommended whenever an intra amniotic infection is suspected or confirmed. Antibiotics should be considered in the setting of isolated maternal fever unless a source other than intra amniotic infection is identified in documented.

Post-delivery recommendations: Intrapartum antibiotics for suspected or confirmed intra amniotic infection should not be continued automatically postpartum. Extension of anti-microbial therapy should be based on risk factors for postpartum endometritis. In general, women who deliver vaginally are less likely to have endometritis and may not require postpartum antibiotics. Women who undergo a cesarean section should have 1 additional dose of antibiotic therapy after delivery.

Source of recommendations: ACOG committee opinion: Intrapartum management of Intraamniotic infection. Number 712. August 2017.

Recommended antibiotic regimens are as follows:

Primary Regimen	
Recommended Antibiotics	**Dosage**
• Ampicillin *and* • Gentamicin	2 g IV every 6 hours 2 mg/kg IV load followed by 1.5 mg/kg every 8 hours *or* 5 mg/kg IV every 24 hours
Recommended Antibiotics (Mild Penicillin Allergy)	**Dosage**
• Cefazolin *and* • Gentamicin	2 g IV every 8 hours 2 mg/kg IV load followed by 1.5 mg/kg every 8 hours *or* 5 mg/kg IV every 24 hours
Recommended Antibiotics (Severe Penicillin Allergy)	**Dosage**
• Clindamycin *or* • Vancomycin* *and* • Gentamicin	900 mg IV every 8 hours 1 g IV every 12 hours 2 mg/kg IV load followed by 1.5 mg/kg every 8 hours *or* 5 mg/kg IV every 24 hours
Postcesarean delivery: One additional dose of the chosen regimen is indicated. Add clindamycin 900 mg IV or metronidazole 500 mg IV for at least one additional dose. *Postvaginal delivery*: No additional doses required; but if given, clindamycin is not indicated.	
Alternative Regimens	
• Ampicillin–sulbactam	3 g IV every 6 hrs
• Piperacillin–tazobactam	3.375 g IV every 6 hrs or 4.5 g IV every 8 hrs
• Cefotetan	2 g IV every 12 hrs
• Cefoxitin	2 g IV every 8 hrs
• Ertapenem	1 g IV every 24 hrs
Postcesarean delivery: One additional dose of the chosen regimen is indicated. Additional clindamycin is not required. *Postvaginal delivery*: No additional doses required, but if given, clindamycin is not indicated.	

Abbreviation: IV, intravenous.

*Vancomycin should be used if the woman is colonized with group B streptococci resistant to either clindamycin or erythromycin (unless clindamycin-inducible resistance testing is available and is negative) or if the woman is colonized with group B streptococci and antibiotic sensitivities are not available.