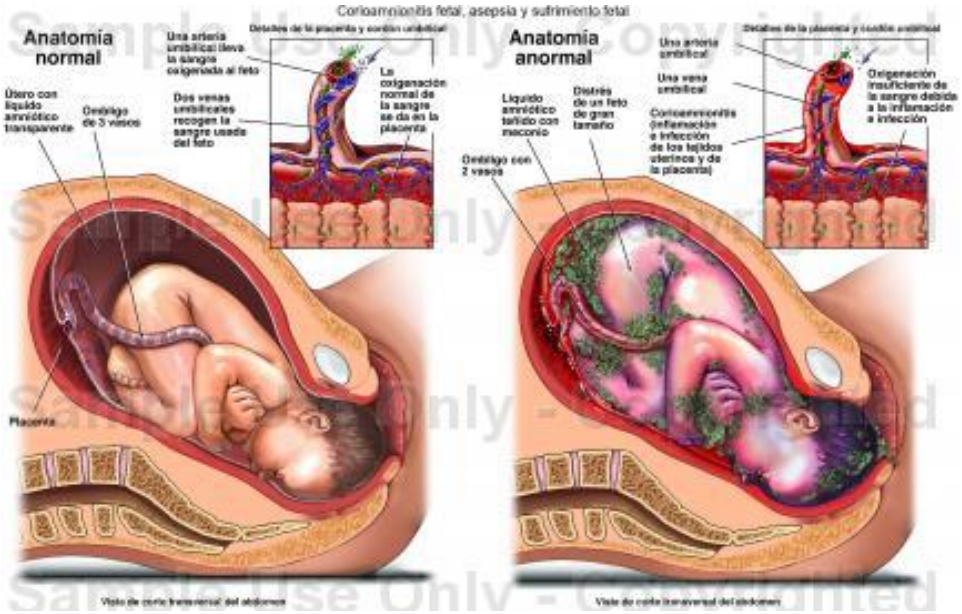
Corioamnionitis

Guías de Perinatología 2015
¿Es tiempo de renovar?

Neonatología
Hospital Barros Luco Trudeau

Dra. Helga Vera
Medicina Materno Fetal

Corioamnionitis criterios de Gibbs



a) Tº ax >/= 38ºC

b) 2 o + criterios:

- i. Aumento de la sensibilidad uterina a la palpación
- ii. Secreción purulenta, turbia o de mal olor por el OCE
- iii. FC materna > 100 lpm
- iv. LCF > 160 lpm
- v. GB > 15.000 leucocitos/mm3

Parto Prematuro
Uso de Antibióticos

Guías Minsal 2015

• No está indicado el uso de antibióticos en el síntoma de parto prematuro con membranas íntegras. Recomendación A.

- No prolonga la gestación
- Hay tendencia al aumento de mortalidad NN Evidencia 1

  Romero 1993, King 2008 Cochrane, Hutzal, 2008.

• AMCT : persistencia /reaparición de DU pese a tocolisis y cérvix <15 mm. Recomendación C. (evidencia 3)

Vaisbuch, 2010

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RPM. 24-34-semanas

Guías Minsal 2015

1. El uso de **antibióticos** aumenta el período de latencia al parto. Recomendación A.
2. El uso de **corticoides** en embarazos de pretérmino disminuye el riesgo de muerte NN, distress respiratorio,hemorragia intracerebral y ECN. Recomendación A.
3. Los tocolíticos no sirven para prolongar la latencia al parto.

Antibioticoterapia.

Guías Minsal 2015

Objetivo ATB

1. Aumentan período de latencia
2. Prevenir la infección decidual ascendente
3. Reducir la morbilidad asociada a la edad gestacional
4. Reducir la patología infecciosa del neonato. (7)

Cochrane, demostró reducción de la corioamnionitis clínica, prolongación del embarazo por al menos 48 horas (hasta 7 días) y la reducción de las morbilidades neonatales (infección, distress respiratorio, hemorragia intraventricular).

Ampicilina 2 gr/ 6 h +Eritromicina 250 mg IV /6 h, luego 5 días de esquema oral (amoxicilina 500 mg /8 h VO + Eritromicina 500 mg / 6 h VO).

Mercer,Jama 1997; Mercer , Semin Perin 2003 ; Gómez 2007

Guías Minsal 2015

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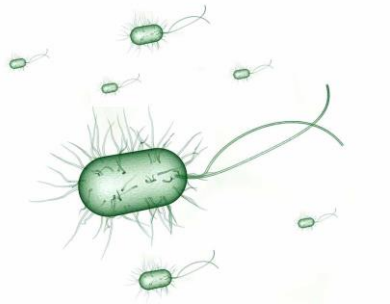
MINI REVIEW
published: 14 March 2017
doi: 10.3389/fphar.2017.00097

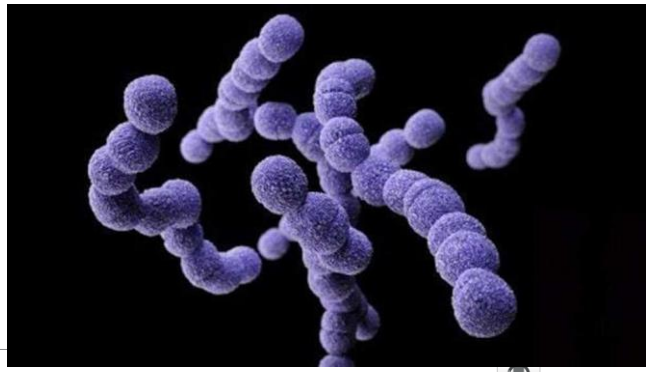
Check for updates

Antibiotic Therapy for Chorioamnionitis to Reduce the Global Burden of Associated Disease

Clark T. Johnson[1]*, *Rebecca R. Adami*[2] and *Azadeh Farzin*[3,4]

- Ureaplasma (47%)
- Mycoplasma (30%)
- Gardnerella vaginalis (25%),
- Bacteriodes (30%)
- Group B Streptococcus (15%)
- Gram negative rods
  - Escherichia Coli (8%)





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Antibiotic Therapy for Chorioamnionitis to Reduce the Global Burden of Associated Disease

Clark T. Johnson[1], Rebecca R. Adami[2] and Azadeh Farzin[3,4]*

TABLE 1 | A selected list of antibiotics and routes of administration, as included in the WHO guide of essential medications (WHO, 2016), with pregnancy category, half-life, and indication of placental passage efficacy.

Antibiotic class	Antibiotic	Pregnancy category	Route	Half-life (hours)	Placental transfer
Penicillins	Benzyl PCN	B	Injection	0.5	Incomplete
	Benzathine PCN G	B	Injection	30–50	Incomplete
	PCN V	B	Oral	0.5	Incomplete
	Procaine PCN G	B	Injection	20–40	Incomplete
Aminopenicillins	Ampicillin	B	Injection	1	Complete
	Amoxicillin	B	Oral	1.3	Complete
Penicillins: (Pellicinase Resistant)	Cloxacillin	B	Oral, Injection	0.5	Incomplete
Cephalosporins	Cefazolin	B	Injection	2	Complete
	Cephalexin	B	Oral	1	Complete
Cephalosporins:	Ceftriaxone	B	Injection	8	Complete
3rd Generation	Cefotaxime	B	Injection	1	Complete
	Ceftazidime	B	Injection	2	Complete
Vancomycin	Vancomycin*	C	Injection	4–6	Incomplete

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B-Lacatmase Inhibitors	Amoxicillin/Clavulanate	B	Oral	1.0	Complete
Carbapenams	Imipenam+Cilastin	B	Injection	1–2	Incomplete
Aminoglycosides	Gentamicin	C	Injection	2–4	Incomplete
Macrolides	Erythromycin	B	Oral, Injection	1–1.5	incomplete
	Azithromycin	B	Oral	12	Incomplete
	Clarithromycin	C	Oral	5–7	Complete
Chloramphenicol	Chloramphenicol	C	Oral, Injection	1.2	Complete
Lincosamide	Clindamycin*	B	Oral, Injection	2–3	Complete
Fluoroquinolones	Ciprofloxacin	C	Oral, IV	3.7	Incomplete
Nitroimidazole	Metronidazole		Oral, injection, suppository	9	Complete
Nitroheterocylic	Nitrofurantoin	B	Oral	0.33	Incomplete
	Spectinomycin	B	Injection	2	Incomplete
Anti-Folate Agents	Trimethoprim/Sulfa	C	Oral, Injection	12	Incomplete
	Trimethoprim	C	Oral	12	Incomplete
Tetracycline	Doxycycline	D	Oral	12–16	Complete

Adapted in part from Grayson et al. (2010), Roberts et al. (2008), and WHO (2016).
PCN, Penicillin.
**Indicates WHO complementary medication, to be considered for specific clinical circumstances.*

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Obstet Gynecol. Author manuscript; available in PMC 2017 Mar 1.
Published in final edited form as:
Obstet Gynecol. 2016 Mar; 127(3): 426–436.
doi: 10.1097/AOG.0000000000001246

PMCID: PMC4764452
NIHMSID: NIHMS738406
PMID: 26855098

Evaluation and Management of Women and Newborns With a Maternal Diagnosis of Chorioamnionitis: Summary of a Workshop

Rosemary D. Higgins, MD,[1] George Saade, MD,[2] Richard A. Polin, MD,[3] William A. Grobman,[4] Irina A. Buhimschi, MD,[5] Kristi Watterberg, MD,[6] Robert M. Silver, MD,[7] Tonse NK Raju, MD,[1] and the Chorioamnionitis Workshop participants*

Obstet… …nuscript; available in PMC 2017 Mar 1.
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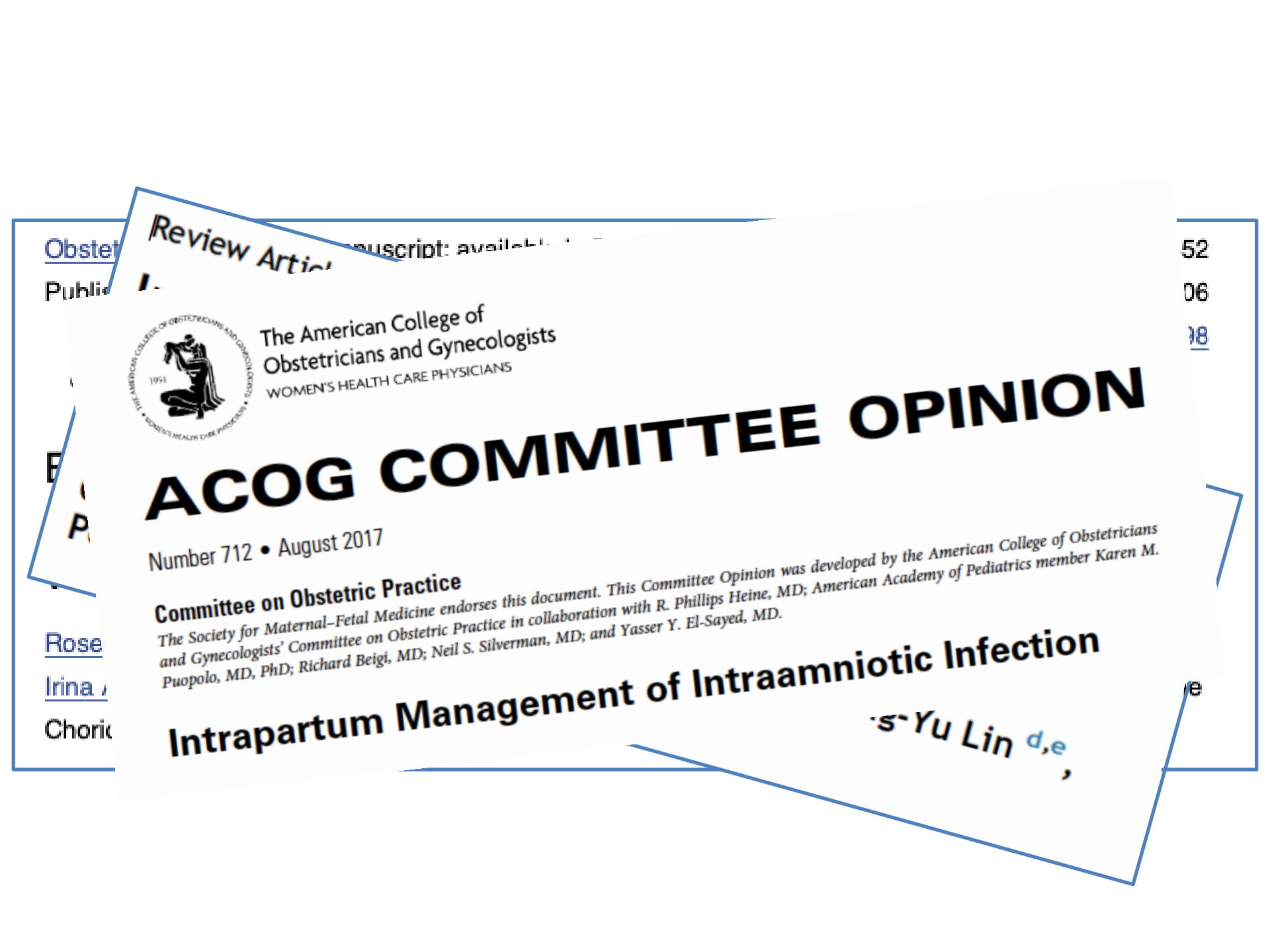
Review Article

Intrauterine inflammation, infection, or both (Triple I): A new concept for chorioamnionitis

Chun-Chih Peng [a,b,c], Jui-Hsing Chang [a,b,c], Hsiang-Yu Lin [d,e], Po-Jen Cheng [f,g], Bai-Horng Su [d,e,*]

Rosemary D. Higgins…
Irina A. Buhimschi, MD,[5] Kristi Wa…
Chorioamnionitis Workshop participants*

2017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The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS
ACOG COMMITTEE OPINION
Number 712 • August 2017
Committee on Obstetric Practice
The Society for Maternal–Fetal Medicine endorses this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice in collaboration with R. Phillips Heine, MD; American Academy of Pediatrics member Karen M. Puopolo, MD, PhD; Richard Beigi, MD; Neil S. Silverman, MD; and Yasser Y. El-Sayed, MD.
Intrapartum Management of Intraamniotic Infection
Yu Lin d,e

Table 1 Features of isolated maternal fever and Triple I with classification.

Terminology	Features and comments
Isolated maternal fever ("documented" fever)	Maternal oral temperature 39.0 °C or greater (102.2 °F) on any one occasion is documented fever. If the oral temperature is between 38.0 °C (100.4 °F) and 39.0 °C (102.0 °F), repeat the measurement in 30 min; if the repeat value remains at least 38.0 °C (100.4 °F), it is documented fever

Suspected Triple I	Fever without a clear source plus any of the following: 1) baseline fetal tachycardia (greater that 160 beats per min for 10 min or longer, excluding accelerations, decelerations, and periods of marked variability) 2) maternal white blood cell count greater than 15,000 per mm^3 in the absence of corticosteroids 3) definite purulent fluid from the cervical os

Confirmed Triple I	All the above plus: 1) amniocentesis-proven infection through a positive Gram stain 2) low glucose or positive amniotic fluid culture 3) placental pathology revealing diagnostic features of infection

*Discontinue the use of the term "Chorioamnionitis." See the text for discussion.

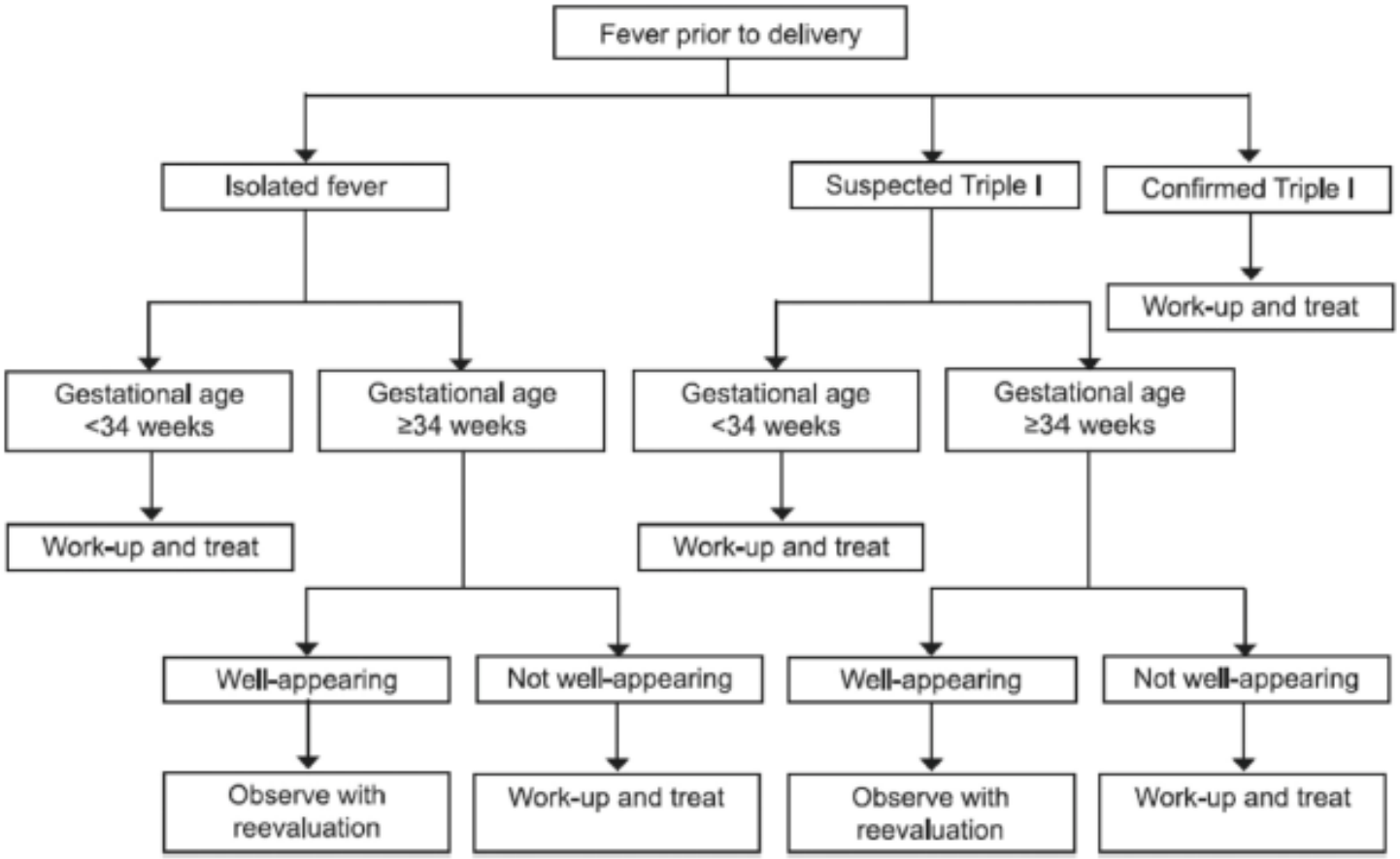

Figure 1 Proposed algorism for neonatal management.

Table 1. Recommended Antibiotic Regimens for Treatment of Intraamniotic Infection ⇦

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.

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ACOG COMMITTEE OPINION

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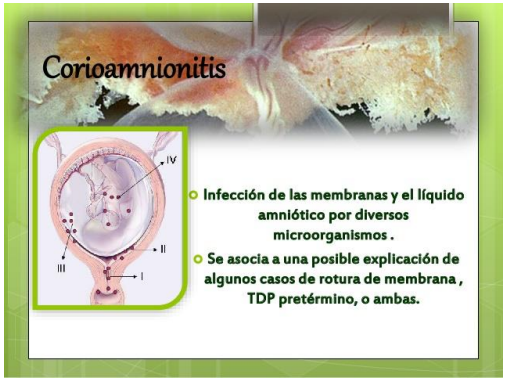
Intrapartum Management of Intraamniotic Infection



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.

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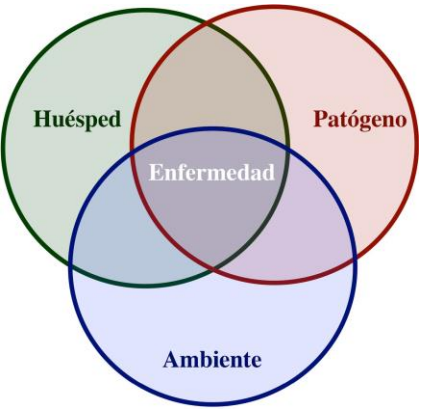
Intrapartum Management of Intraamniotic Infection

Box 1. Checklist of items to include in communication between the obstetric and neonatal teams.

- Gestational age
- Maternal tachycardia
- Fetal tachycardia
- Maternal white blood cell count greater than 15,000
- Maternal group B streptococci status
- Duration of rupture of membranes
- Duration of labor
- Purulent fluid
- Amniotic fluid evaluation
- Highest maternal temperature
- Epidural anesthesia use
- Prostaglandin use
- Antimicrobial agent(s) used
- Antipyretic used
- Spontaneous preterm birth
- Prior spontaneous preterm birth



Queda mucho por hacer

- Profilaxis adecuada de infecciones
- Marcadores antenatales de infección accesibles
- Identificación del germen causante
- Estudios de realidad local