6. Depression Screening

Pregnant patients should be screened for depression using validated instruments (e.g., EPDS, PHQ-9) at approximately 28 weeks. See Recommendation 21 for further details.

g. 36 Weeks

1. Group B Streptococcus Screening

Group B streptococcus is the leading cause of early-onset sepsis in newborns, the primary risk factor being maternal colonization of the genitourinary and gastrointestinal tracts. Antenatal screening is recommended for all pregnant patients between 36 0/7–37 6/7 weeks, except for patients already identified as candidates for GBS prophylaxis based on urine culture or history of a prior affected infant.(279) A single vaginal and rectal swab should be used to collect the sample for culture, and antibiotics should be initiated in labor for patients who screen positive.(280) Samples collected by a provider or patient self-collected are acceptable methods of screening.(281) GBS culture is highly predictive of colonization within 5 weeks of collection; repeat screening should be considered if more than 5 weeks have elapsed before the onset of labor.(279)

2. Fetal Presentation

Assessment of fetal presentation should take place at 36 weeks' gestation, ideally, with the use of ultrasound for confirmation.(282, 283) Cephalic presentation will be found in many patients; in the case of non-cephalic presentation, counseling and intervention are recommended. If a breech presentation is found, an external cephalic version (ECV) should be offered at 37 weeks if there is no contraindication.(284) This timing allows adequate opportunity for spontaneous cephalic version, minimizes the chance of reversion if successful, and reduces the chance of iatrogenic preterm delivery. Potential benefits of this management include improving vaginal delivery rates and reducing the morbidity associated with cesarean delivery. ECV can be offered to patients with or without a previous cesarean birth.(285)

C. Postpartum

To optimize the current and future health of recently pregnant patients and their neonates, postpartum care should be treated as an ongoing process, instead of a single encounter. The care should be tailored to the patient's individual needs.(286)

Ideally, all patients should have initial contact with their obstetric provider within 3 weeks of birth; this initial assessment can be done either in-person or via telehealth. By the end of this visit, a plan for individualized postpartum follow-up care should be determined.

Prioritizing early in-person follow-up rather than telehealth alone should be considered for individuals with a high risk of postpartum depression, high risk of cesarean wound infection or perineal wound infection (from third- or fourth-degree lacerations), lactation difficulties, or chronic conditions likely to require postpartum medication titration.