MANAGEMENT OF CHORIOAMNIONITIS

I. Diagnosis:

- Temp of 37.8°C (100°F) and 2 or more of the following:
  - Maternal tachycardia (>100 bpm)
  - Fetal tachycardia (>160 bpm)
  - Uterine tenderness
  - Foul odor of amniotic fluid
  - Maternal leukocytosis (>15K cells/mm³)

→ Temp + maternal tachycardia + fetal tachycardia → >90% sensitivity for chorioamnionitis¹²

II. Treatment/Management

- Ampicillin 2g IV q6h given first (fastest to cross placenta), then Gentamicin 1.5 mg/kg IV q8h. If proceeding with Cesarean Section, add Clindamycin 900 mg IV for anaerobic coverage.³
  - Rapid intrapartum treatment with Ampicillin/Gentamicin at time of diagnosis is crucial and significantly decreases neonatal/maternal morbidity/mortality.³ ⁴
  - Coverage: Gram+ (GBS), Gram– (Ecoli), Atypicals (Ureaplasma, Mycoplasma, Gardnerella), Anaerobes (Bacteroides)
  - Duration of chorioamnionitis, that is sufficiently treatment, is not related to adverse maternal/neonatal outcome. Cesarean Section increases morbidity in women with documented chorioamnionitis (increased number of blood transfusions, uterine atony, ICU admissions.) Cesarean section intervention should be a decision similar to that made for patients without chorioamnionitis. (There is data supporting increased rates of CSection with women who have chorioamnionitis due to higher rates of labor dystocia)⁵

III. Postpartum Management

- Randomized data supports not treating postpartum (vaginal and cesarean).⁶ ⁷
  - Clinical judgment is appropriate for continuation of antibiotics.
  - Randomized studies state that there is no difference in rates of infection for women who were treated 24 hours postpartum vs women given one additional dose of antibiotic after the procedure.

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