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The HTA Forum

PhilHealth Your Partner in Health

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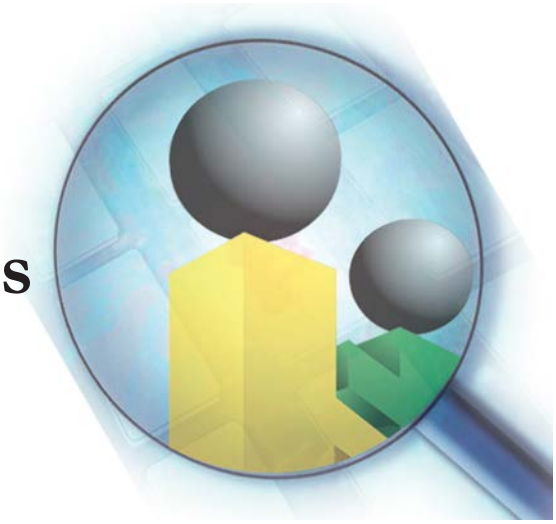

Performance Report on PhilHealth Use of CPGs for Quality Assurance and Accreditation

Although PhilHealth is not in the business of developing clinical practice guidelines (CPGs), it has played a critical role in promoting the development and utilization of CPGs by the medical specialty societies. At present, PhilHealth has identified the following clinical practice guidelines that can serve as basis for quality assurance and accreditation: community-acquired pneumonia (CAP) in adults and in children, asthma in adults and in children, urinary tract infection in adults and in children, hypertension, acute bronchitis, acute gastroenteritis, dyspepsia, dengue hemorrhagic fever, cataract, diabetes mellitus, normal spontaneous delivery, chronic cough in children, first simple febrile seizure, cholecystitis, and acute appendicitis.

PhilHealth initiatives in CPG implementation, spearheaded by the HTA Committee, fall into three main categories.

Educational interventions

PhilHealth has provided logistical support to the development of the cataract guideline by the Philippine Academy of Ophthalmology (PAO) and to the Philippine Society of Microbiology and Infectious Disease (PSMID) guideline working groups. As a result of this support, the cataract guideline has been included in the National Guideline Clearinghouse in the US. PSMID produced its CPGs on urinary tract infection (UTI), community-acquired pneumonia in adults and tuberculosis in adults.

PhilHealth has also conducted oral presentations to promote guidelines during several PMA regional conferences. The CPGs that were presented were the Philippine Heart Association guideline on hypertension, the PSMID guideline on UTI and CAP. Copies of the guidelines were distributed by PhilHealth to the participants.

PhilHealth has also published the HTA Forum to promote evidence—based medicine. Health technology assessments, which are systematic evidence-based evaluations of the safety, effectiveness, and efficiency of medicines and procedures, have been regular features of the Forum. These assessments have been used by PhilHealth to select drugs and procedures for insurance coverage. By publishing them, PhilHealth intends to help improve the quality of health care provided to its members and to provide guidance to doctors, hospitals and patients about the reimbursability of specific drugs,

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tests and procedures. This can potentially minimize the number of denied claims.

Accreditation

PhilHealth policies have consistently supported guideline use. The PhilHealth BenchBook, released in 2005 and set for implementation in 2007, requires guideline utilization. Standard 2.4.1 requires that "clinical pathways derived from clinical practice guidelines and other types of clinical evidence should be developed or implemented for the top 10 cases of admissions and/or consultations." In addition, standard 7.2 requires that "resources for developing or adopting clinical practice guidelines are provided" by the hospital.

The PhilHealth BenchBook is consistent with the principles of evidence-based health care set forth by the National Health Insurance Act. For example, the Act requires that health care providers participate in and conduct health technology assessments in the selection and implementation of health interventions in order to promote quality and cost-effectiveness. In turn, the BenchBook requires that "new processes of care are designed collaboratively based on scientific evidence, clinical standards, cultural values and patient preferences (standard 7.2)". Currently, preparation for implementation of the BenchBook consists of two main strategies.

PhilHealth systems accrediting and surveying hospitals are undergoing enhancements and capacity building. On the other hand, hospitals and health care providers have been familiarizing and capacitating themselves to comply with the new BenchBook accreditation standards.

Claims reimbursement

Incorporating measures of CPG compliance to claims payment is an ongoing PhilHealth initiative. Guideline recommendations that are based on Grade A evidence (See Tables indicated per guideline) have been converted into medical review criteria (MRCs) and Policy Statements.

MRCs are statements that are used to measure performance and determine compliance with standards. These performance standards are based on the recommended tests, medicines, procedures and other interventions contained in CPGs. The MRCs will be used to review claims and approve payments.

Policy Statements are based on key CPG recommendations and provide guidance to doctors, hospitals and patients as to what tests, medicines and procedures are strongly recommended to be provided if their benefits clearly outweigh the harms. There are also negative Policy Statements based on negative CPG recommendations when some tests, medicines and procedures have been found to be useless or even harmful. Policy Statements also advise the public regarding the reimbursability of tests, medicines and procedures. This issue of the HTA Forum is devoted to these Policy Statements.

In October 2000, PhilHealth adopted the Positive List of Drugs based on the Grade A recommendations of the CAP, UTI and Hypertension CPGs. The List expanded the coverage of medications eligible for reimbursement. A before and after study by Dr. Valera et. al in 2002 found that, in government hospitals, utilization of the drugs on the Positive List slightly increased after the policy took effect. In contrast, a decrease in utilization of these drugs was noted in private hospitals. Overall, the percentage of compliance with clinical practice guidelines for pneumonia and hypertension

increased after the Positive List was adopted. This increase was noted for both government and private institutions. A follow-up study using interrupted time series and segmented regression showed that prescribing patterns of PhilHealth-accredited physicians generally had conformed with the local clinical practice guideline recommendations for the management of community acquired pneumonia. In general, the implementation of the policy expanding the drug coverage for patients admitted with community acquired pneumonia did not significantly change prescribing patterns of PhilHealth-accredited physicians.

The Positive List has since expired. However, the National Health Insurance Act empowers PhilHealth to expand the list of essential drugs in the Philippine National Drug Formulary (PNDF) from time to time. This expanded list will be based on the results of the health technology assessments that PhilHealth regularly conducts.

CPG Dissemination Program

PhilHealth will be disseminating 10 CPGs this year and conducting guideline promotion activities in selected hospitals in Metro Manila and provinces. The Policy Statements of the 10 CPGs that will be disseminated are featured in this issue of the HTA Forum.

Following dissemination, PhilHealth will regularly review the claims that will be filed by the participating hospitals for adherence to the CPGs. The results of this review will be fed back to the hospitals themselves. Reports of this demonstration project will be featured in future issues of the HTA Forum.

PhilHealth Policy Statements on the Ten Commonly Claimed Illnesses

The clinical practice guidelines (CPGs) for the most common reimbursable claims in PhilHealth are featured in this issue of the HTA Forum. PhilHealth employs a 5 stage process in selecting the ten CPGs. Initially, the process involves a systematic search for CPGs published locally and abroad. Retrieved CPGs are screened for relevance to PhilHealth needs and validity of methods. To check validity, PhilHealth uses the AGREE Instrument, an international validated guideline appraisal tool, as well as an appraisal checklist developed in-house. Specific recommendations on disease assessment, laboratory tests, drug treatments and admission policies are then extracted from the screened CPGs and assessed for applicability to local settings. The technical staff of the Quality Assurance Research and Policy Development Group (QARPDG) under the supervision of the Health Technology Assessment Committee (HTAC) makes all guideline appraisals. Lastly, to be consistent with the existing National Health Insurance Act, the drugs that are mentioned in the final set of recommendations are only those that are in the 6th edition of the PNDF. All PhilHealth endorsed guidelines are in public domain, although local specialty societies that developed the selected guidelines have also been contacted.

A note on the HTA Committee

The process of selecting the CPGs is conducted by the Quality Assurance Research and Policy Development Group (QARPDG) of PhilHealth with oversight by the HTAC. The QARPDG is headed by Dr. Madeleine R. Valera and is supervised by the PhilHealth Vice President for Health Finance Policy and Services Sector, Dr. Eduardo P. Banzon.

The HTAC was set up in 1998 to conduct health technology assessments and advise PhilHealth in the selection of health technologies for insurance coverage. Since then, the HTAC has also conducted training workshops for PhilHealth on CPG appraisal and implementation using PhilHealth accreditation and claims reimbursement to enhance provider adherence to CPGs. All PhilHealth activities that aim to promote the adoption and utilization of CPGs are planned, implemented and evaluated with the technical assistance of the HTAC.

PEDIATRIC COMMUNITY ACQUIRED PNEUMONIA (PCAP)

Clinical Diagnosis

In a coughing child, look for the following signs:

TABLE 1

AGE	SIGNS
3 months to 5 years	Tachypnea and/or chest indrawing (Grade B) [2]
5 to 12 years	Fever, tachypnea, crackles (Grade D) [2]
Beyond 12 years	Fever, tachypnea, tachycardia and at least one abnormal chest findings of diminished breath sounds, rhonchi, crackles or wheezes (Grade D) [2]

Hospital Admission

Classify patients by risk of dying (see Table 2). PCAP C and D patients may be hospitalized. [Grade D][2] PCAP A and B patients can be managed on an outpatient basis. **[Grade D]**[2]

TABLE 2. RISK CLASSIFICATION FOR PNEUMONIA-RELATED MORTALITY [LEVEL 5] (PPS, 2004)

VARIABLES	PCAP A Minimal risk	PCAP B Low risk	PCAP C Moderate risk	PCAP D High risk
1. Co-morbid illness	None	Present	Present	Present
2. Compliant caregiver	Yes	Yes	No	No
3. Ability to follow-up	Possible	Possible	Not possible	Not possible
4. Presence of dehydration	None	Mild	Moderate	Severe
5. Ability to feed	Able	Able	Unable	Unable
6. Age	>11 mo	>11 mo	<11 mo	<11 mo
7. Respiratory rate 2-12 months 1-5 years > 5 years	 ≤50/min ≤40/min ≤30/min	 >50/min >40/min >30/min	 >60/min >50/min >35/min	 >70/min >50/min >35/min
8. Signs of respiratory failure a. retraction b. head bobbing c. cyanosis d. grunting e. apnea f. sensorium	 None None None None None None	 None None None None None None	 Intercostal/ subcostal Present Present None None Irritable	 Supraclavicular/ intercostal/subcostal Present Present Present Present Lethargic/stuporous/ comatose
9. Complications [effusion, pneumothorax]	None	None	Present	Present
ACTION PLAN	OPD Follow-up at end of treatment	OPD Follow-up after 3 days	Admit to regular ward	Admit to critical care unit Refer to specialist

Diagnostic Tests

Chest x-ray [Grade B, Level 2b][2] and white blood cell count [Grade C, Level 4][2] may be requested for hospitalized patients.

When indicated, culture and sensitivity of blood, pleural fluid, tracheal aspirate, and blood gas and/or pulse oximetry may be requested for hospitalized patients. **[Grade D, Level 5]**[2]

No routine ESR or CRP. **[Grade A, Level 1b]**[2] No routine examinations for non-hospitalized patients. **[Grade D]**[2]

Treatment

For PCAP A or B patients without previous antibiotic, give oral amoxicillin (40-50 mg/kg/day in 3 divided doses for an average of 7 days). **[Grade D]**[2] Alternative drugs include cotrimoxazole, chloramphenicol, erythromycin or formulary macrolides.

For PCAP C patients, give penicillin G (100,000 units/kg/day in 4 divided doses) or **ampicillin** (100 mg/kg/day in 4 divided doses). **[Grade D]**[2] Alternative drugs include chloramphenicol, cefuroxime and ampicillin-sulbactam.

No cough preparations needed.

Monitoring Response to Initial Therapy

Look for symptom resolution. **[Grade D, Level 5]**[2]

No follow-up labs needed. [Grade D, Level 5][2]

Streamlining Antibiotic Therapy

In selected patients, switch to oral therapy when signs of infection are resolving after 2-3 days. **[Grade D, Level 5]**[2] These are patients who show symptom resolution, ability to feed and absence of complications.

Supportive Care/Ancillary Treatment

Among inpatients, oxygen and hydration may be given if needed. **[Grade D, Level 5]**[2]

No routine chest physiotherapy, bronchial hygiene, nebulization with normal saline solution, steam inhalation, topical solution, bronchodilators and herbal medicines. **[Grade D]**[2]

TABLE 3. GRADES OF RECOMMENDATION AND LEVELS OF EVIDENCE (PPS, 2004)

GRADE	LEVEL OF EVIDENCE	THERAPY	DIAGNOSIS
A	1a	Systematic review [SR] with homogeneity of randomized controlled trials [RCT]	SR with homogeneity of level 1 diagnostic studies or a clinical practice guideline validated on a test set
	1b	Individual randomized controlled trial with narrow confidence interval	Independent blind comparison of an appropriate spectrum of consecutive patients, all of whom have undergone both the diagnostic test and the reference standard
	1c	All or none	SpPin and SnNout*
B	2a	SR with homogeneity cohort studies	SR with homogeneity of level ≥ 2 diagnostic studies
	2b	Individual cohort study [including low quality RCT e.g. <80 follow-up]	Independent blind comparison but either in non-consecutive patients or confined to a narrow spectrum of study individuals [or both], all of whom have undergone both the diagnostic test and the reference standard; or a diagnostic clinical practice guideline not validated in a test set.
	2c	"Outcomes" research	
	3a	SR with homogeneity of case control studies	
	3b	Individual case control study	Independent blind comparison of an appropriate spectrum but reference standard was not applied to all study patients
C	4	Case series and poor quality cohort	Reference standard was not applied independently or not applied blindly
D	5	Expert opinion	Expert opinion

*SpPin: When a sign/test/symptom has high Specificity, a Positive result rules in the diagnosis.
SnNout: When a sign/test/symptom has high Sensitivity, a Negative result rules out the diagnosis.

Hospital Discharge

PCAP C or D patients may be discharged when they improve and are re-classified as PCAP A or B. These are patients with stable vital signs for age and ability to maintain oral intake.[1]

References (Search Date: August 2005)

1. *PhilHealth Health Technology Assessment Committee. Proceedings of Workshop on the Critical Appraisal of Clinical Practice Guidelines and Development of Policy Statements. September 19-21, 2005.*
2. *Philippine Pediatric Society (PPS). Clinical Practice Guideline in the Evaluation and Management of Pediatric Community Acquired Pneumonia (Immunocompetent Filipino Children Aged 3 months to 19 years). 2004.*

ACUTE APPENDICITIS

Clinical Diagnosis

Prolonged right lower quadrant pain and tenderness with a duration of at least 7-12 hours may suggest acute appendicitis. **[Cat. A, Level I]**[3] In children, pain and tenderness may not be localized. **[Grade D]**[1]

Diagnostic Tests

White blood cell with differential count may be requested. **[Cat. A, Level I]**[3]

Abdominal CT scan, abdominal ultrasound or diagnostic laparoscopy for equivocal appendicitis may be requested with proper justification. **[Cat. A, Level I and II]**[3]

Plain abdominal x-ray, barium enema, and scintigraphy are not recommended. **[Cat. A, Level II]**[3] No routine gram stain and culture/sensitivity of intra-operative specimens. **[Cat. A, Level II]**[3]

Treatment

Appendectomy is the appropriate treatment for acute appendicitis. **[Cat. A, Level II]**[3]

For UNCOMPLICATED acute appendicitis, the following antibiotics may be used for surgical prophylaxis: **[Cat. A, Level I]**[3] **Cefoxitin** (2 grams IV single dose for adults or 40 mg/kg IV single dose for children), **ampicillin-sulbactam** (1.5-3 grams IV single dose for adults or 75 mg/kg IV single dose for children), or **gentamicin** 80-120 mg IV single dose **plus clindamycin** 600 mg IV single dose for adults or gentamicin 2.5 mg/kg IV single dose plus clindamycin 7.5-10 mg/kg IV single dose for children).

For COMPLICATED acute appendicitis, the following antibiotics may be used with cost consideration: **[Cat. A, Level I]**[3] Tazobactam-piperacillin, ciprofloxacin plus metronidazole (for adults), imipenem-cilastatin (for children), or gentamicin plus clindamycin.

For post-operative pain management, acetaminophen **[Grade S]**[1], ibuprofen **[Grade S]**[1], ketorolac **[Grade C & E]**[1], and morphine **[Grade S]**[1] may be used.

Hospital Discharge

A patient may be discharged when fully recovered from anesthesia, afebrile for 24 hours, tolerates a regular diet, achieves pain control on oral medication, and for complicated acute appendicitis, has suitable home environment to assure post-op antibiotic administration.[2]

TABLE 4. STRENGTH OF RECOMMENDATIONS AND LEVELS OF EVIDENCE (PCS, 2002)

CATEGORY	DESCRIPTION
A	Recommendations that were approved by consensus (at least 75% of the multisectoral panel)
B	Recommendations that were somewhat controversial and did not meet consensus
C	Recommendations that cause real disagreements among the members of the panel

TABLE 5. LEVELS OF EVIDENCE (PCS, 2002)

LEVEL	DESCRIPTION
I	Evidence from at least one properly designed RCT or meta-analysis
II	Evidence from at least one well designed clinical trial without proper randomization, from cohort or case-controlled analytic studies (preferably one center), from multiple time-series, or from dramatic results in uncontrolled experiments
III	Evidence from opinions of respected authorities on the basis of clinical experience, descriptive studies, or reports of expert committees

TABLE 6. GRADES OF RECOMMENDATION (CHMC, 2002)

GRADE	DESCRIPTION
A	Randomized controlled trial: large sample
B	Randomized controlled trial: small sample
C	Prospective trial or large case series
D	Restrospective analysis
E	Expert opinion or consensus
S	Review article
M	Meta-analysis

References (Search Date: September 2005)

1. *Cincinnati Children's Hospital Medical Center (CHMC). Evidence-Based Clinical Practice Guideline for Emergency Appendectomy. 2002.*
2. *PhilHealth Health Technology Assessment Committee. Proceedings of Workshop on the Critical Appraisal of Clinical Practice Guidelines and Development of Policy Statements. September 19-21, 2005.*
3. *Philippine College of Surgeons (PCS). Evidence-Based Clinical Practice Guidelines on the Diagnosis and Treatment of Acute Appendicitis. 2002.*

HYPERTENSION

Clinical Diagnosis

Hypertension is considered in a patient with BP of 140/ 90 mmHg or higher, recorded on at least two occasions. It may be classified as stage 1 (SBP = 140 – 159 or DBP = 90 – 99) or stage 2 (SBP ≥ 160 or DBP ≥ 100). [3]

Diagnostic Tests

Fasting blood glucose, serum potassium, creatinine, and urinalysis are recommended. [Grade A][2]

When indicated, 12-lead ECG, hematocrit, calcium, lipoprotein profile may be requested. For patients with diabetes or kidney disease, the measurement of urinary albumin excretion/albumin creatinine ratio may also be included in the routine laboratory tests. Appropriate diagnostic procedures may be considered to identify causes of HPN among patients in whom there is a high index of suspicion (age, history and physical examination, severity of hypertension, and initial laboratory findings are suggestive of specific causes) and among patients who respond poorly to drug therapy.[3]

Hospital Admission

Patients with hypertensive emergencies should be admitted in the hospital. [3]

Patients with hypertensive urgencies, or those with upper levels of Stage II hypertension associated with severe headache, shortness of breath, epistaxis or severe anxiety may also be admitted.[1]

Treatment

For hypertension stage I without compelling indication, thiazide diuretics are the primary drugs of choice. [3]

A second drug, either as a separate prescription or in fixed-dose combinations with thiazide diuretics may be used when the BP remains uncontrolled or when BP is >20 mmHg above systolic goal or 10 mmHg above diastolic goal, These include loop and potassium-sparing diuretics, aldosterone receptor blockers, beta-blockers, ACE inhibitors, angiotensin II antagonist, calcium channel blockers, alpha I blockers, central alpha II agonists, direct vasodilators, additional combination drug: ACEI + CCB. [3]

For hypertension with compelling indications the following may be used: [3]

a. Diuretics – heart failure, high coronary disease risk, diabetes, recurrent stroke prevention

b. Beta-blockers – post-MI, heart failure, high coronary disease risk, diabetes

c. ACE Inhibitor – heart failre, high coronary disease risk, diabetes, recurrent stroke prevention, chronic kidney disease, post MI

d. Angiotensin Receptor Blocker – heart failure, diabetes, chronic kidney disease

e. Calcium Channel Blocker – high coronary disease risk, diabetes

f. Aldosterone Antagonist – heart failure, post-MI

The following formulary parenteral drugs may be used for hypertensive emergencies: vasodilators (Na nitroprusside, nicardipine HCl, nitroglycerin, hydralazine HCl) and adrenergic inhibitor (esmolol HCl).[3]

Patients with hypertensive urgencies may be given oral short-acting agent such as captopril and clonidine followed by several hours of observation.[3]

References (Search Date: September 2005)

1. *PhilHealth Health Technology Assessment Committee. Proceedings of Workshop on the Critical Appraisal of Clinical Practice Guidelines and Development of Policy Statements. September 19-21, 2005.*
2. *Philippine Society of Hypertension (PSH). The Philippine Clinical Practice Guidelines on the Detection and Management of Hypertension. 1996.*
3. *The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure. 2003.*

TABLE 7. GRADES OF RECOMMENDATION (PSH, 1996)

GRADE	DESCRIPTION
A	The recommendation is based on one or more studies at level 1
B	The best evidence available is at level 2
C	The best evidence is at level 3
D	The best evidence available is lower than level 3, and included experts' opinions, clinical experience and common sense. These recommend-ations address practical issues of implementation and other factors existing in the

DYSPEPSIA

Clinical Diagnosis

To diagnose dyspepsia, the following symptoms should be sought: **chronic or recurrent epigastric discomfort or pain with bloatedness, gnawing or burning sensation**, more prominent at daytime, for at least two (2) weeks. **[Grade A]**[2]

Hospital Admission

Confinement is not usually needed.[3]

Treatment

Treat with a **proton-pump inhibitor, a prokinetic agent for 2-4 weeks.** H2-blocker, sucralfate and antacids may be used as alternative. **[Grade A]**[2]

References (Search Date: September 2005)

1. *American Gastroenterological Association (AGA). Evaluation of Dyspepsia. 1998.*
2. *The Family Medicine Research Group (FMRG) and the Department of Family and Community Medicine Consensus Panel, UP-PGH. Clinical Practice Guideline for the Management of Dyspepsia in Family Practice.1998.*
3. *PhilHealth Health Technology Assessment Committee. Proceedings of Workshop on the Critical Appraisal of Clinical Practice Guidelines and Development*

TABLE 8. GRADES OF RECOMMENDATION FOR DYSPEPSIA (FMRG, 1998)

GRADE	DESCRIPTION
A	Good evidence to support the recommendation that the option be specifically considered. The recommendation was made based on at least one level I published evidence.
B	Fair evidence to support the recommendation that the option be specifically considered. The recommendation was made based on at least one level II published evidence.
C	Poor evidence regarding inclusion or exclusion of the option, but the recommend-ation was made on other grounds (experts' opinion, consensus panel, or committee reports)
D	Fair evidence to support the recommendation that the option be specifically excluded from the consideration. The recommendation was made based on at least one level II published evidence.
E	Good evidence to support the recommendation that the option be specifically excluded from the recommendation. The recommendation was made based on at least one level I published evidence.

ACUTE BRONCHITIS

Clinical Diagnosis

Cough for one week productive of purulent sputum may suggest a diagnosis of acute bronchitis.**[Grade A]**[1] Fever, chills, difficulty of breathing, easy fatigability and hoarseness may suggest other conditions.[2]

Hospital Admission

TABLE 9. GRADES OF RECOMMENDATION FOR ACUTE BRONCHITIS (FMRG, 1998)

GRADE	DESCRIPTION
A	Good evidence to support the recommendation that the option be specifically considered. The recommendation was made based on at least one level I published evidence.
B	Fair evidence to support the recommendation that the option be specifically considered. The recommendation was made based on at least one level II published evidence.
C	Poor evidence regarding inclusion or exclusion of the option, but the recommend-ation was made on other grounds (experts' opinion, consensus panel, or committee reports)
D	Fair evidence to support the recommendation that the option be specifically excluded from the consideration. The recommendation was made based on at least one level II published evidence.
E	Good evidence to support the recommendation that the option be specifically excluded from the recommendation. The recommendation was made based on at least one level I published evidence.

Confinement is not usually needed.[2]

Diagnostic Tests

No routine lab tests are needed for uncomplicated acute bronchitis.[2]

On Monitoring Response to Therapy

Prognosis is good and special monitoring or referral for specialty care is not required**. [Grade C]**[1]

Treatment

No antibiotics are needed for uncomplicated acute bronchitis. **[Grade C]**[1]

Inhaled bronchodilators may be given. **[Grade A]**[1]

References (Search Date: September 2005)

1. *The Family Medicine Research Group (FMRG) and the UP-PGH Department of Family and Community Medicine Consensus Panel. Clinical Practice Guideline for the Management of Acute Bronchitis in Family Practice. 2000.*
2. *PhilHealth Health Technology Assessment Committee. Proceedings of Workshop on the Critical Appraisal of Clinical Practice Guidelines and Development of Policy Statements. September 19-21, 2005.*

ADULT ASTHMA

Clinical Diagnosis

To make a diagnosis of asthma, the following should be sought in the patient's history: **on and off cough that gets worse at night, wheezing, dyspnea and chest tightness** often aggravated by exposure to allergens, irritants, exercise, and viral infections, **a history of asthma in the family, and improvement of condition with the use of anti-asthma medications.** [1]

Diagnostic Tests

Objective measures **[Grade A][2]** **like Forced Expiratory Volume in 1 second (FEV_1), Peak Expiratory Flow Rate, and airway hyperresponsiveness** are needed to diagnose asthma.

Treatment

Classify all patients with asthma according to severity to help determine the need for therapy (*See Table 12)*[2]

For Formulary Treatment of Asthma see Table. *(See Table 14)*

The following medications may be administered to patients with acute asthmatic attacks:

* **Inhaled ß2–agonists** **[Grade A][2]**
* **Systemic or oral steroids** **[Grade A][2]**
* **Inhaled ipratropium bromide + inhaled ß2–agonists** **[Grade A][2]**

The following medications maybe administered to patients with **persistent asthma:**

* **Inhaled corticosteroids** **[Grade A][2]**
* **Fixed dose combination of long-acting ß2–agonists and inhaled corticosteroids** to control symptoms and improve lung function. **[Grade A][2]**

Hospital Admission

Patients with status asthmaticus and those who do not respond to treatment of acute asthmatic attacks in the emergency room should be admitted.

Long term treatment of asthma can be started while the patient is still admitted in the hospital.[1]

TABLE 10. GRADES OF RECOMMENDATION (PCCP, 2004)

GRADE	DEFINITION
A	The recommendation is based on one or more studies at Level I
B	The best evidence available is at Level II
C	The best evidence is at Level III
D	The best evidence available is lower than 3, and include experts' opinions, clinical experience, and common sense. These recommendations address practical issues of implementation and other factors existing in the local setting.

TABLE 11. LEVELS OF EVIDENCE (PCCP, 2004)

LEVEL	DEFINITION
1	All 5 of the following criteria are satisfied: a. There was an independent interpret-ation of the results of the diagnostic test (without knowledge of the results of the gold standard). b. There was an independent interpret-ation of the results of the gold standard (without knowledge of the results of the diagnostic test). c. The study patients consisted of patients (but not known) to have the disorder of interest. d. The diagnostic test and gold standard are both described in sufficient detail to allow reproducibility. e. The study population consists of at least 50 patients with and 50 patients without the disorder of interest.
2	4 of the 5 criteria are met
3	3 of the 5 criteria are met.
4	2 of the 5 criteria are met.
5	1 of the 5 criteria are met.
6	None of the 5 criteria are met.

TABLE 12. NEW CLASSIFICATION OF CHRONIC ASTHMA SEVERITY (PCCP, 2004)

PARAMETER	Severity		
	Intermittent	Persistent	
		Mild-Moderate	Severe**
Daytime symtoms	Monthly	Weekly	Daily
Nocturnal awakening	Less than monthly	Monthly to weekly	NIghtly
Rescue ß $_2$-agonists use	Less than weekly	Weekly to daily	Several times a day
PEF or FEV_1 *	>80% pred.	60 - 80% pred.	<60% pred.
Treatment needed to control asthma	Occasional *prn* ß $_2$-agonists only	Regular ICS + LABA combination	Combination ICS + LABA + OCS

TABLE 13. TREATMENT BASED ON ASTHMA SEVERITY (PCCP 2004)

Severity	Recommended treatment		
	Daily controller medications	Alternative controller	Reliever medications
Intermittent	None needed		SABA as needed
Mild to Moderate Persistent	ICS + LABA combination as single inhaler	ICS high dose or ICS regular dose + any of the ff: -SR Theophylline -Antileukotriene -Oral SR ß $_2$-agonist	SABA as needed
Severe Persistent	Oral steroids + ICS + LABA combination as single inhaler + any of the ff: -SR Theophylline -Antileukotriene -Oral SR ß $_2$-agonist		SABA as needed

Hospital Discharge

Patients with stable vital signs for 24 hours and have the ability to maintain oral intake may be discharged.[1]

References (Search Date: September 2005)

1. *PhilHealth Health Technology Assessment Committee. Proceedings of Workshop on the Critical Appraisal of Clinical Practice Guidelines and Development of Policy Statements. September 19-21, 2005.*
2. *Philippine College of Chest Physicians (PCCP) Council on Asthma. Philippine Consensus Report on Asthma Diagnosis and Management. An Evidence-based Update. 2004.*
3. *Philippine College of Chest Physicians (PCCP) Council on Asthma. Philippine Consensus Report on Asthma Diagnosis and Management. 1996.*

TABLE 14. FORMULARY DRUGS FOR THE TREATMENT OF ASTHMA (PCCP, 2004)

Anti-inflammatory Controllers	Generic Name
Inhaled corticosteroid + LABA	Budesonide + Formoterol
	Fluticasone + Salmeterol
Inhaled Corticosteroid	Beclomethasone Dipropionate
	Budesonide
	Fluticasone
Oral Corticosteroid	Methylprednisolone
	Prednisone
Anti-leukotrienes	Montelukast
Mast cell stabilizer	Na cromoglycate
Bronchodilator Controllers LABA	
Inhaled	Formoterol
	Salmeterol
	Procaterol
Oral	Formoterol
	Procaterol
	Salbutamol
	Terbutaline
Xanthine derivative	Theophylline
Bronchodilator Relievers SABA	
Inhaled	Salbutamol
	Terbutaline
SABA	
Oral	Salbutamol
	Terbutaline
Anti-cholinergic	Ipratropium
Anti-cholinergic + SABA	Ipratropium + Fenoterol
	Ipratropium + Salbutamol
Xanthine derivative	Theophyllne

COMMUNITY ACQUIRED PNEUMONIA IN ADULTS

Clinical Diagnosis

Cough, fever, difficulty of breathing, and/or chills within the past 24 hours to less than 2 weeks [A-II][1, 5] associated with **tachypnea** (RR > 20 breaths/min), **tachycardia** (CR > 100/min), and **fever** (T > 37.8'C) with at least one abnormal chest finding of **diminished breath sounds, rhonchi, crackles or wheeze** [Grade B][6] suggest community-acquired pneumonia.

Diagnostic Tests

Chest x-ray is recommended for all patients clinically diagnosed of pneumonia [A-II/Grade A][3,6] Gram stain and culture of appropriate pulmonary secretions [Grade A][6] and pretreatment blood cultures [A-II][3] may be requested when drug resistance is suspected and for etiologic diagnosis.

Hospital Admission

Classify patients by risk categories to help determine the need for hospitalization. Only moderate and high-risk CAP should be admitted. [GRADE A][6] (See Table 15)

Treatment

Initial empiric therapy based on initial risk stratification is recommended. [Grade B][6] Among patients with identified etiologic agent, appropriate antimicrobials should be instituted.[3] (See Table 16).

Monitoring Response to Initial Therapy

Look for symptom resolution. **Follow-up chest x-ray is not needed.** [Grade A][6]

TABLE 15. CLINICAL FEATURES OF PATIENTS WITH CAP ACCORDING TO RISK (PSMID, 2004)

Low Risk CAP	Moderate Risk CAP	High Risk CAP
Stable vital signs *RR < 30 breaths/min *PR < 125 beats/min *SBP ≥ 90 mmHg *DBP ≥ 60 mmHg No or stable comorbid conditions No evidence of extrapulmonary sepsis No evidence of aspiration Chest x-ray: *Localized infiltrates *No evidence of pleural effusion nor abscess *Not progressive within 24 hrs	Unstable vital signs: *RR ≥ 30 breaths/min *PR ≥ 125 beats/min *Temp ≥ 40'C or < 35'C Unstable comorbid condition *(i.e. uncontrolled diabetes mellitus, active malignancies, progressing neurologic disease, congestive heart failure (CHF) Class II-IV, unstable coronary artery disease, renal failure on dialysis, uncompensated COPD, decompensated liver disease)* Evidence of extrapulmonary sepsis (hepatic, hematologic, gastrointestinal, endocrine) Suspected aspiration Chest x-ray: *Multilobar infiltrates *Pleural effusion or abscess *Progression of findings to > 50% in 24 hrs	Any of the clinical feature of moderate risk CAP plus any of the following: shock or signs of hypoperfusion *hypotension *altered mental state *urine output < 30 mL/hr hypoxia (PaO_2 < 60 mmHg) or acute hypercapnea ($PaCO_2$ > 50 mmHg) Chest x-ray: *as in moderate risk CAP
These patients are suitable for outpatient care [Grade A][6]	These patients need to be hospitalized for parenteral therapy [Grade A][6]	These patients warrant admission in the intensive care unit [Grade A][6]

TABLE 16. USUAL RECOMMENDED DOSAGES OF FORMULARY ANTIBIOTICS IN 50-60 KBW ADULTS WITH NORMAL LIVER AND RENAL FUNCTIONS (PSMID, 2004)

ANTIBIOTIC	DOSAGE	ANTIBIOTIC	DOSAGE
LOW RISK CAP *(all taken orally)* *B-lactams:* Amoxicillin *Trim/sulfonamide:* Cotrimoxazole *Macrolides* Azithromycin Clarithromycin	 500 mg TID 160/800 mg BID 500 mg OD 500 mg BID	*B-lactams w/ B-lactamase inhibitor:* Co-amoxiclav Sultamicillin *2nd gen. Cephalosporins* Cefuroxime axetil	 625 mg TID or 1 g BID 750 mg BID 500 mg BID
MODERATE RISK CAP *Macrolides* Erythromycin IV Azithromycin PO or IV Clarithromycin PO or IV Gatifloxacin PO or IV *B-lactams w/ B-lactamase inhibitor:* Sulbactam-Ampicillin IV	 0.5-1 g q 6h 500 mg q 24h 500 mg q 12h 400 mg q 24h 1.5 g q 8h	*2nd gen. Cephalosporins* Cefuroxime IV Cefoxitin IV (w/ anaerobic activity) *3rd gen. Cephalosporins* Ceftriaxone IV Cefotaxime IV	 1.5 g q 8h 1-2 g q 8h 1-2 g q 24h 1-2 g q 8h
HIGH RISK CAP *(all routes are IV)* *Macrolides* Erythromycin Azithromycin Clarithromycin Gentamicin Netilmicin Tobramycin *B-lactams w/ B-lactamase inhibitor:* Sulbactam-Ampicillin	 0.5-1 g q 6h 500 mg q 24h 500 mg q 12h 3 mg/kg q 24h 7 mg/kg OD 3 mg/kg q 24h 1.5 g q 6-8h	*3rd gen. Cephalosporins* Ceftriaxone Cefotaxime Ceftizoxime *Anti-pseudomonal B-lactams:* Ceftazidime Cefepime Ticarcillin-clavulanate Piperacillin-tazobactam Sulbactam-cefoperazone Imipenem Meropenem *Others:* Oxacillin Clindamycin Metronidazole	 1-2 g q 24h 1-2 g q 8h 1-2 g q 8h 2 g q 8h 2 g q 8-12h 3.2 g q 6h 2.25-4.5 g q 6-8h 1.5 g q 12h 500 mg q 6h 1-2 g q 8h 1-2 g q 4-6h 600 mg q 8h 500 mg q 6-8h

Supportive Care

Oxygen, hydration, and antipyretics may be given if needed.[5]

Streamlining empiric antibiotic therapy

In selected patients, **switch to oral therapy** when signs of infection are resolving within 72 hours. [Grade A][3] (See Table 16)

Hospital discharge

Patients with stable vital signs for 24 hrs and able to maintain oral intake may be discharged.
[Grade B][6]

References (Search Date: August 2005)

1. *Bartlett JG, Dowell SF, Mandell LA et al. Practice Guidelines for the Management of Community-Acquired Pneumonia in Adults. Infectious Diseases Society of America. Clin Infect Dis Aug 2000; 31(2):347-82.*
2. *Field MJ, Lohr KN, Eds. Clinical Practice Guidelines: Directions for a New Program. Institute of Medicine 1990*
3. *Mandell, LA, et al. Infectious Diseases Society of America. Update of Practice Guidelines for the Management of Community-Acquired Pneumonia in Immunocompetent Adults. Clin. Infect Dis. Dec 1, 2003. 37(11):1405-33.*
4. *Niederman MS, Mandell LA, Anzueto A et al. Guidelines for the Management of Adults with Community-Acquired Pneumonia. Diagnosis, Assessment of Severity, Antimicrobial Therapy and Prevention. Am J Respir Crit Care Med June 2001; 163(7):1730-54.*
5. *PhilHealth Health Technology Assessment Committee. Proceedings of Workshop on the Critical Appraisal of Clinical Practice Guidelines and Development of Policy Statements. September 19-21, 2005.*
6. *Philippine Society of Microbiology and Infectious Diseases, Inc. (PSMID) Philippine Clinical Practice Guidelines on the Diagnosis, Empiric Management and Prevention of Community-Acquired Pneumonia in Immunocompetent Adults 2004 Update.*

TABLE 17. ANTIBIOTIC DOSAGE OF ORAL AGENTS FOR STREAMLINING OR SWITCH THERAPY (PSMID, 2004)

Antibiotic	Dosage
Cefuroxime	500 mg BID
Cefixime	100-200 mg BID
Co-amoxiclav	1 g BID
Sultamicillin	750 mg BID
Azithromycin	500 mg OD
Clarithromycin	500 mg BID
Gatifloxacin	400 mg OD
Moxifloxacin	400 mg OD

TABLE 18. GRADES OF RECOMMENDATION (PSMID, 2004)

GRADE	DEFINITION
A	Good evidence to support a recommendation for use
B	Moderate evidence to support a recommendation for use
C	Poor evidence to support a recommendation for or against use
D	Moderate evidence to support a recommendation against use
E	Good evidence to support a recommendation against use

TABLE 19. IDSA GRADING SYSTEM FOR RATING RECOMMENDATION (IDSA, 2003)

CATEGORY, GRADE	DEFINITION
STRENGTH OF RECOMMENDATION	
A	Good evidence to support a recommendation for use
B	Moderate evidence to support a recommend-ation for use
C	Poor evidence to support a recommendation
D	Moderate evidence to support a recommendation against use
E	Good evidence to support a recommendation against use
QUALITY OF EVIDENCE	
I	Evidence from ≥1 properly random-ized, controlled trial
II	Evidence from ≥1 well-designed clinical trial, without randomization; from cohort or case controlled ana-lytic studies (preferably from > one center); from multiple time-series; or from dramatic results of uncontrolled experiments
III	Evidence from opinions of respected authorities, based on clinical experi-ence, descriptive studies, or reports of expert committees

URINARY TRACT INFECTION

Clinical Diagnosis

To make a clinical diagnosis of urinary tract infection, one or more of the following should be sought in the patient's history: **dysuria, frequency, hematuria, fever, flank pain, lower abdominal pain, absent vaginal discharge, absent vaginal irritation, and back pain.[6]**

UTI should be categorized as one of the following: cystitis, pyelonephritis, asymptomatic bacteriuria, recurrent UTI, complicated UTI. [6]

Diagnostic Tests

Routine urinalysis is not needed to diagnose UTI.

Urinalysis or urine gram stain may be requested for the following conditions: acute uncomplicated pyelonephritis **[Grade B][6]**, acute cystitis in pregnant women **[Grade C][6]**, and acute uncomplicated cystitis in women with gynecological (vaginal) signs and symptoms **[Grade B][6]**, and uncomplicated cystitis in men. **[Grade C][6]**

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Urine culture and sensitivity may be requested for patients with worsening signs and symptoms **[Grade C]**[6], for screening asymptomatic bacteriuria among pregnant women **[Grade B]**[6], for acute uncomplicated pyelonephritis, acute pyelonephritis in pregnancy and suspected complicated UTI. Follow-up urine culture is not necessary for patients clinically responding to therapy. **[Grade C]**[6]

Renal ultrasound and plain abdominal X-ray should be done only in the presence of gross hematuria during UTI episode, obstructive symptoms, clinical impression of persistent infection, infection with urea-splitting bacteria, history of pyelonephritis, history of or symptoms suggestive of urolithiasis, history of childhood UTI and elevated serum creatinine. **[Grade C]**[6]

Blood culture should only be considered if with sepsis**. [Grade C]**[6]

Hospital Admission

Hospitalization is not needed [Grade C][6] except

* In acute uncomplicated pyelonephritis in women who are unable to accept oral hydration or oral medications; or with complications such as sepsis;
* In acute pyelonephritis in pregnant women;
* In complicated UTI;
* In urinary candidiasis patients who are: under critical care, neutropenic, post-renal transplant, or about to undergo neurological procedures.

Treatment

Antibiotic management depends on the initial and definitive UTI condition. [5]

For mild to moderate complicated UTI, oral fluoroquinolones are recommended. [Grade A][6]

Ampicillin and amoxicillin should not be used. **[Grade E]**[6]

Any of the antibiotics listed in Table 21 and Table 22 can be used for UTI depending on local susceptibility patterns and host factors.

References (Search Date: September 2005)

1. *American College of Radiology - Medical Specialty Society. ACR Appropriateness Criteria for Imaging in Acute Pyelonephritis. www.guideline.gov. August 2005*
2. *American College of Radiology - Medical Specialty Society. ACR Appropriateness Criteria for Recurrent Lower Urinary Tract Infection in Women. www.guideline.gov August 2005*
3. *Institute for Clinical Systems Improvement - Private Nonprofit Organization. Uncomplicated Urinary Tract Infection in Women. www.guideline.gov. July 2004*
4. *Orenstein R and Wong ES. Urinary Tract Infections in Adults. American Family Physician. March 1999; 59(5). http://www.aafp.org/afp/990301ap/1125.html*
5. *PhilHealth Health Technology Assessment Committee. Proceedings of Workshop on the Critical Appraisal of Clinical Practice Guidelines and Development of Policy Statements. September 19-21, 2005.*
6. *Philippine Practice Guidelines Group in Infectious Disease Task Force on Urinary Tract Infections Philippine Society for Microbiology and Infectious Diseases. The Philippine Clinical Practice Guidelines on the Diagnosis and Management of Urinary Tract Infections in Adults. CPG vol. 2 number 1 update 2004.*

TABLE 20. GRADES OF RECOMMENDATION (PSMID, 2004)

CATEGORY, GRADE	DEFINITION
A	Good evidence to support a recommendation for use
B	Moderate evidence to support a recommendation for use
C	Poor evidence to support a recommendation for or against use
D	Moderate evidence to support a recommendation against use
E	Good evidence to support a recommendation against use

TABLE 21. EMPIRIC TREATMENT REGIMENS FOR UNCOMPLICATED ACUTE PYELONEPHRITIS (PSMID 2004) [GRADE A]

ANTIBIOTICS	DOSE, FREQUENCY
ORAL	
Ofloxacin	400 mg BID
Ciprofloxacin	500 mg BID
Gatifloxacin	400 mg OD
Cefixime	400 mg OD (only 100 & 200 mg capsule are in 6th ed of PNDF)
Cefuroxime	500 mg BID
Co-amoxiclav	625 mg TID
PARENTERAL (given until patient is afebrile)	
Ceftriaxone	1-2 gm Q 24
Ciprofloxacin	200-400 mg Q 12
Gatifloxacin	400 mg Q 24
Gentamicin	3-5 mg/kg BW (+/- ampicilin) Q 24
Ampi-sulbactam	1.5 gm [when gram stain shows gram (+) organisms] Q6
Piperacillin-tazobactam	2.25 – 4.5 gm Q 6-8

TABLE 22. ANTIBIOTICS THAT MAY BE USED AS EMPIRIC THERAPY FOR COMPLICATED UTI (PSMID 2004) [GRADE B]

ANTIBIOTICS	DOSE, FREQUENCY	DURATION
ORAL		
Ciprofloxacin	250-500 mg BID	14 days
Ofloxacin	200 mg BID	14 days
PARENTERAL (given until patient is afebrile)		
Ampicillin	1 gm q 6 hrs + gentamicin 3 mg/kg/day q 24h	
Ampi-sulbactam	1.5 gm – 3 gm q 6h	
Ceftazidime	1-2 gm q 8h	
Ceftriaxone	1-2 gm q 24h	
Imipenem-cilastatin	250-500 mg q 6-8h	
Piperacillin-tazobactam	2.25 gm q 6h	
Ciprofloxacin	200-400 mg q 12h	
Ofloxacin	200 - 400 mg q 12h IV	

ACUTE GASTROENTERITIS

Clinical Diagnosis

Acute gastroenteritis is diagnosed in patients presenting with **changes in the character and frequency of stool and maybe accompanied by signs of dehydration.** **[A-II]**[1]

Hospital Admission

Patients with **severe dehydration, as well as patients who remain to have some dehydration despite initial treatment and any child with bloody diarrhea and severe malnutrition should be admitted.**[3]

Diagnostic Tests

Fecalysis may be done in patients admitted for acute gastroenteritis. [2]

For patients not responding to standard treatment, selective fecal studies may be requested.[3]

Knowing the levels of serum electrolytes rarely changes the management of children with diarrhea. [3]

Treatment

ORS solution and IV fluids are the standard treatment for dehydration caused by diarrhea and these are administered based on the degree of dehydration. [3]

Zinc at a dose of 10-20 mg/day may be given for 10-14 days to all children with diarrhea.[3]

Malnourished children or children who develop diarrhea during or shortly after measles may be given **oral vitamin A** at a dose of 200,000 units/dose and again the next day: 200,000 units/dose for age 12 months to 5 years, 100, 000 units for age 6 months to 12 months, and 50,000 units for age less than 6 months. [3]

Antiemetics, cardiac stimulants, blood or plasma, steroids, or purgatives are not recommended in acute gastroenteritis. [3]

TABLE 23. THE FOLLOWING ANTIMICROBIALS MAY BE ADMINISTERED TO SELECTED PATIENTS WITH DIARRHEA [WHO, 2005]

CAUSE	ANTIBIOTIC(s) OF CHOICE [a]	ALTERNATIVE(s)
Cholera [b,c]	Doxycycline Adults: 300 mg once, *or* Tetracycline *Children:* 12.5 mg/kg 4 times a day x 3 days *Adults:* 500 mg 4 times a day x 3 days	Erythromycin *Children:* 12.5 mg/kg 4 times a day x 3 days *Adults:* 250 mg 4 times a day x 3 days
Shigella dysentery [b]	**Ciprofloxacin** *Children:* 15 mg/kg 2 times a day x 3 days *Adults:* 500 mg 2 times a day x 3 days	**Pivmecillinam** *Children:* 20 mg/kg 4 times a day x 5 days *Adults:* 400 mg 4 times a day x 5 days Ceftriaxone *Children:* 50-100 mg/kg once a day IM x 2 to 5 day
Amoebiasis	Metronidazole *Children:* 10 mg/kg 3 times a day x 5 days (10 days for severe disease) *Adults:* 750 mg 3 times a day x 5 days (10 days for severe disease)	
Giardiasis	Metronidazole[d] *Children:* 5 mg/kg 3 times a day x 5 days *Adults:* 250 mg 3 times a day x 5 days	

a. All doses shown are for oral administration. If drugs are not available in liquid form for use in young children, it may be necessary to use tablets and estimate the doses given in this table.

b. Selection of an antimicrobial should be based on sensitivity patterns of strains of *Vibrio cholerae* O1 or O139, or *Shigella* recently isolated in the area.

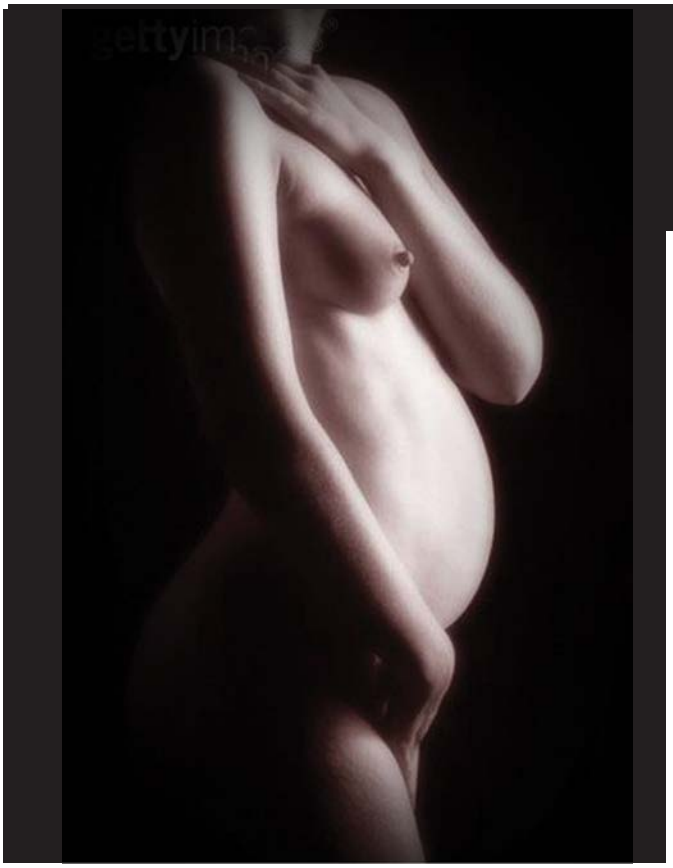
c. An antimicrobial is recommended for patients older than 2 years with suspected cholera and severe dehydration.

TABLE 24. GRADES OF RECOMMENDATION

GRADE	DEFINITION
A	Good evidence to support a recommendation for use
B	Moderate evidence to support a recommend-ation for use
C	Poor evidence to support a recommendation for or against use
D	Moderate evidence to support a recommend-ation against use
E	Good evidence to support a recommendation against use

References (Search Date: September 2005)

1. *Infectious Diseases Society of America. Practice Guidelines for the Management of Infectious Diarrhea. 2001.*
2. *PhilHealth Health Technology Assessment Committee. Proceedings of Workshop on the Critical Appraisal of Clinical Practice Guidelines and Development of Policy Statements. September 19-21, 2005*
3. *World Health Organization. The Treatment of Diarrhea: A Manual for Physicians and Other Senior Health Workers. 2005.*



MATERNITY CARE

ANTENATAL CARE

The following interventions are recommended at all visits:

Blood pressure measurement is recommended for all pregnant women at each prenatal visit following the guidelines of National High Blood Pressure Education Program.[4]

Mild to moderate exercise 3 or more times per week during pregnancy is recommended for all healthy pregnant women.[4]

Monitoring of weight gain in pregnant women should be assessed every visit.[4]

The use of tobacco and alcohol should be screened at 6-8 weeks AOG.[4]

Immunization status for **tetanus toxoid** booster should be determined at the initial prenatal visit. If there is no documentation of Td booster within the last ten years, Td booster should be provided. There are no contraindications other than a previous severe reaction to Td vaccination, such as anaphylaxis, generalized urticaria, or angioedema.[4]

Hepatitis B surface antigen determination should be done at the initial prenatal visit.[4]

Routine **urinalysis** should be done at the initial prenatal visit as screening for asymptomatic bacteriuria.[4]

Testing for the major **blood groups ABO** is recommended during the first antenatal visit.[3]

Routine screening for Syphilis during pregnancy is recommended using non-treponemal serologic test VDRL or RPR.[3]

Measurement of **fundic height** starting at 18 weeks AOG until the third trimester is recommended at every prenatal visit.[4]

Auscultation of **fetal heart sounds** starting at 20 weeks AOG is recommended at every prenatal visit.[4]

Universal screening of pregnant women for **gestational diabetes mellitus (GDM)** using the 50-gram Glucose Challenge Test between 24 and 28 weeks' gestation is recommended. A test value > 140 mg/dl or 7.8 mmol/li for plasma glucose is considered elevated.[3]

Pregnant women with signs and symptoms of preterm labor like low, dull backache, menstrual-like cramps, abdominal cramping (may be associated with diarrhea) and four or more uterine contractions per hour should be educated.[4]

All pregnant women should be instructed to perform **daily fetal movement counting** starting at the third trimester of pregnancy.[4]

The patients' with the following **past medical history** are recommended for referral to physician on first visit.[4]

Past OB/GYN History:
- Prior preterm delivery (<37 weeks)
- Intrauterine fetal demise (IUFD) – 10 weeks with no cardiac activity
- Prior cervical/uterine surgery
- Prior preterm labor requiring admission (e.g., early cervical change)
- Fetal anatomic abnormality (e.g., open neural tube defects in prior child or first degree relative)
- Past complicated pregnancy

Medical History:
- Pre-existing diabetes
- Gestational diabetes
- HIV
- Chronic hypertension
- Systemic disease that requires ongoing care (e.g., severe asthma, lupus, and inflammatory bowel disease)
- Current mental illness requiring medical therapy
- Cancer
- Seizure disorders
- Hematologic disorders
- Recurrent urinary tract infections/ stones

Psycho-Social:
- Substance use disorders
- Eating disorders
- Postpartum depression

Conditions in Current Pregnancy:
- Age (<16 or >35 years at delivery)
- Vaginal bleeding

INTRAPARTUM CARE

Intermittent auscultation is recommended for monitoring fetal

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well being during normal labor. **[Level I-B]**[2]

There is **no need for restriction of food** except in situations where intervention is anticipated. Routine IV infusion is not recommended during labor. **[Level II-B]**[2]

Routine enema is not recommended during early labor. **[Level I-E]**[2]

Routine shaving of perineal area is not recommended prior to delivery. **[Level I-E]**[2]

The routine use of **anesthesia and analgesia is not part** of the care during delivery. **[Level I-C]**[2]

The **routine use of episiotomy is not** recommended during delivery. **[Level I-D]**[2]

Derivatives of polyglycolic acid appear to be the absorbable material of choice for both deep and skin closure. **[Level I-A]**[2]

Routine 'active management' is superior to 'expectant management' in terms of blood loss, postpartum hemorrhage and severe postpartum hemorrhage and other serious complications of the **third stage of labor**. **[Level I-A]**[2]

Active management of labor includes:

1. Administration of a prophylactic oxytocin after delivery of the baby
2. Early cord clamping and cutting, and
3. Controlled cord traction of the umbilical cord [2]

The use of the combination preparation (oxytocin and ergometrine) as part of the routine active management of the 3rd stage of labor appears to be associated with a statistically significant reduction in the risk of postpartum hemorrhage when compared to oxytocin when blood loss is less than 1000mL. **[Level I-D]**[2]

POSTPARTUM CARE

Postpartum Visit

Postpartum follow up is recommended within 8 weeks after delivery. This should cover family planning, to include various temporary contraceptive means and/or permanent sterilization.[2,4]

Early Breastfeeding

Early breastfeeding is recommended for all pregnant women after delivery.[2,4]

References (Search Date: September 2005)

1. *PhilHealth Health Technology Assessment Committee. Proceedings of Workshop on the Critical Appraisal of Clinical Practice Guidelines and Development of Policy Statements. September 19-21, 2005*
2. *Philippine Board of Obstetrics and Gynecology. Clinical Practice Guidelines for Normal Labor and Delivery. Task Force on Clinical Practice Guidelines in the Management of Normal Labor and Delivery. 2002.*
3. *Task Force on Philippine Guidelines on Periodic Health Examination. Philippine Guidelines on Periodic Health Examination, Effective Screening for Diseases among Apparently Healthy Filipinos. 2004.*
4. *Veterans Health Administration, Department of Defense. Clinical Practice Guideline for the Management of Uncomplicated Pregnancy. 2002*
5. *World Health Organization, Standards for Maternal and Neonatal Care, Department of Making Pregnancy Safer.*

TABLE 25. GRADES OF RECOMMENDATION (PBOG 2002)

GRADE	DEFINITION
A	There is good evidence to support the recommendation of the practice in the management of normal labor and delivery
B	There is fair evidence to support the recommendation of the practice in the management of normal labor and delivery
C	There is insufficient evidence to recommend for or against the inclusion of the practice in the management of normal labor and delivery.
D	There is fair evidence to support the recommendation that the practice be excluded in the management of normal labor and delivery.
E	There is good evidence to support the recommendation that the practice be excluded in the management of normal labor and delivery.

TABLE 26. LEVEL OF RECOMMENDATION (PBOG 2002)

LEVEL	DEFINITION
I	Evidence from at least 1 properly randomized controlled trial (RCT)
II-1	Evidence from well-designed controlled trials without randomization
II-2	Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group
II-3	Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments could also be included here
III	Opinions of respected authorities, based on clinical experience; descriptive studies and case reports or reports of expert committees

We'd like to hear from you!

For your comments and suggestions, you can e-mail us at ***htaforum@philhealth.gov.ph*** or write us:
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DISCLAIMER

These recommendations and restrictions were based on available evidence and may be modified based on the availability of new evidence. Furthermore, they should not replace good, up-to-date clinical judgment based on the present circumstances in each case.

All medicinal products mentioned in the policy statements have an inherent risk profile and have to be used with prudence and caution in the clinical setting. Drugs can cause unexpected and unwanted adverse drug effects and reporting these events to BFAD is recommended in line with public safety. The prescriber should read the product information carefully and help the patient understand these risks in relation to the benefits offered by these medicines. Drugs are safe when used in the proper way.