**Isoimmunization**

Prenatal patients are universally screened for isoimmunization in the prenatal lab panel. If an antibody is identified on the **antibody screen**, the first task is to identify whether the antibody is at risk of causing hemolysis in the fetus. Tables exist in all OB/ perinatology texts or online--phone consultation with OB or perinatology can assist in this task. The irregular antibody is frequently the result of a prior pregnancy or transfusion. Both major and minor antibodies can cause harm.

The antibody titer must be of sufficient levels to potentially cause harm. A greater than 1:8 to 1:16 titer is generally the level of concern but this can vary with a given antibody and, again, consultation is suggested. (Usually 1:16 for D, 1:8 for other antibodies)

Serial titers about monthly need to be followed if the initial result is not in a concerning range.

Irregular antibodies are of no concern if paternity is certain and FOB is negative for the corresponding antigen. Screen FOB for the corresponding antigen.

Patients with an irregular antibody of sufficient titer to cause hemolysis are then followed to identify if hemolysis is causing fetal anemia. Fetal middle cerebral artery (MCA) doppler sonography by perinatology at weekly intervals beginning at 20 wk EGA is the surrogate marker of choice in this situation. Schedule at EBPMA or Diablo Valley Perinatology and discuss plan with corresponding Perinatologist. Perinatology should be following the patient closely with you.

Antepartum testing for fetal well-being with modified BPP (NST, AFI) is also recommended usually from 32 wks EGA.

Intrauterine fetal transfusion at a referral center, usually UCSF, is indicated for severe anemia remote from term (<32wk EGA)

Early induction is indicated if MCA dopplers reveal significant hemolysis or if antepartum testing is nonreassuring. (>32wk EGA)

Generally patients at risk are induced at term even if testing is reassuring.