Rh prophylaxis Guideline for Pregnancy Complications and Medical/Surgical Abortions before 12 Weeks Gestation

Rh prophylaxis through the administration of Rh immunoglobulin has been shown to be a successful primary prevention strategy against the development of hemolytic disease of the fetus/newborn (Rh disease). However, the benefit of Rh prophylaxis has been shown to be gestational age dependent, and its administration is not as important in early pregnancy. Ineffectual use of this resource should be minimized. Additionally, there are potential benefits to individuals and health care providers when barriers such as blood testing and Rh prophylaxis can be avoided. Given this information and following careful consideration of the best available evidence, the Rh Program of Nova Scotia has altered its guidance for the management of Rh prophylaxis before 12 weeks gestation for early pregnancy complications and medical/surgical abortions.

1) Before 8 weeks gestation the benefit of administering Rh immune globulin has not been demonstrated and Rh prophylaxis is not recommended.
2) Between 8 and 12 weeks gestation the risk of sensitization is not clear although the epidemiologic literature suggests sensitization risks are low. Rh prophylaxis should still be considered and always offered; however, depending on clinical circumstances and after appropriate counseling could also be avoided.
3) Rh prophylaxis is recommended after 12 weeks gestation for appropriate indications

These guidelines are available on our website. Please contact the Rh Program of Nova Scotia for further information. http://rcp.nshealth.ca/rh

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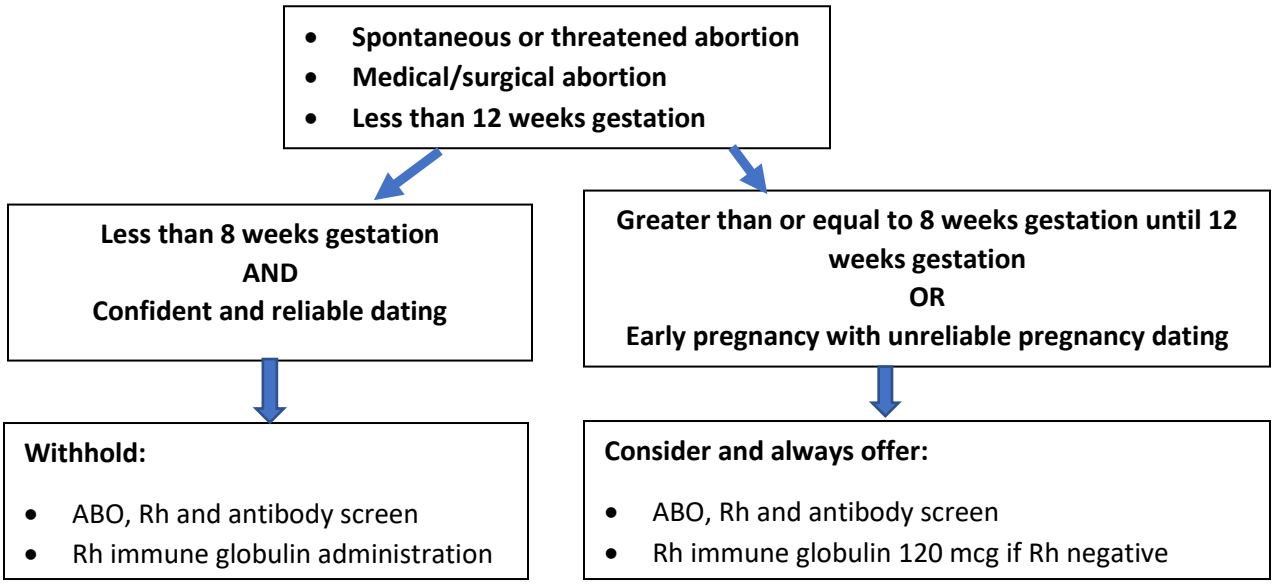
Rh immune globulin (RhIg) is not always recommended in early pregnancy for spontaneous, threatened or medical/surgical abortions when there is **confident and reliable** pregnancy dating. Reliable dating includes any of the following:

- Ultrasound dating
- Certain conception dating
- Known first day of LMP for individuals having regular (28-day) cycles and, in the three months prior to conception, absence of lactation, hormonal contraception or IUD use.[1]
  The risk of anti-D alloimmunization before 8 weeks gestation is negligible [2][3][4] and Rh prophylaxis is not recommended. The benefits of omitting prophylaxis include reducing resource utilization as well as removing barriers to timely abortions. Between 8 and 12 weeks gestation, the literature is not clear on the risk of sensitization thus Rh prophylaxis should still be considered and always offered; however, depending on clinical circumstances and after appropriate counseling, could also be avoided.
- After 12 weeks, Rh prophylaxis is recommended.



[1] Bracken H, Clark W, Lichtenberg E, Schweikert S, Tanenhaus J, Barajas A, Alpert L, Winikoff B. Alternatives to routine ultrasound for eligibility assessment prior to early termination of pregnancy with mifepristone-misoprostol. BJOG, 2011;118:17-23.
[2] Wiebe E, Campbell M, Aiken A, Albert A. Can we safely stop testing for Rh status and immunizing Rh-negative women having early abortions? A comparison of Rh alloimmunization in Canada and the Netherlands. Contraception: X 1 (2019) 100001
[3] Horvath S, Tsao P, Huang Z, Zhao L, Du Y, Sammel M, et al. The concentration of fetal red blood cells in first-trimester pregnant women undergoing uterine aspiration is below the calculated threshold for Rh sensitization. Contraception 102 (2020) 1-6.
[4] https://www.nice.org.uk/guidance/ng140/chapter/Recommendations#anti-d-prophylaxis