

## Enjoying your pregnancy

As you begin this journey of creating life, I welcome the opportunity to care for you and share in this venture. My goal is for you to have a wonderful experience, both in becoming a new mother (or a mother again) and also as a patient in my practice. I have put together this handbook to help orient you to my office. I try running an efficient practice and placing a high priority on seeing you at the time of your scheduled appointment. I try to run on-time, but please realize that deliveries and emergencies may cause me to be late or may require rescheduling of appointments. Please remember I may eventually close during office hours to attend to your delivery.

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## I Believe I'm Pregnant

For most women, pregnancy is not verified until the fourth or fifth week of their cycle (around the time or just after a missed period). Most home urine pregnancy tests are quite reliable and provided there is no bleeding, you can be reasonably assured of the results. If there are questions or if you are not sure that you did the test right, come on into the office and we can do a test for you. If it's positive, CONGRATULATIONS!!!

Something truly miraculous has begun within your body, and as this process begins there are several important pieces of information you need to know to get you through the first several weeks.

Here is a list of the most common pregnancy related symptoms you may be experiencing and their significance:

1. **Bleeding:** This is perhaps the most important problem to address in the first few weeks of pregnancy. Approximately 25% of newly pregnant women will spot or bleed to some degree in the first several weeks of pregnancy. When an ultrasound examination after 7 weeks finds a living embryo, the risk of miscarriage is about 3 – 5%. If I am unable to confirm the presence of a beating heart it may be that you are earlier than your menstrual dates predict. If heavy bleeding occurs, call my office day or night and if you need to be seen before the office opens, go the nearest emergency room. Provided bleeding is not extremely heavy I may ask you to come in for an ultrasound evaluation and have you do some blood work. If bleeding is very heavy I may ask you to go to the emergency room. If in the middle of the night there is spotting only, and you are not experiencing pain, you may wait until morning to call. If bleeding is recent, and your blood type is Rh neg, you will need an injection of Rhogam, a medicine that prevents a build-up of maternal antibodies that may harm the present or future pregnancies.
2. **Pain:** Some cramping during early pregnancy is quite normal. Severe cramping, however, is outside of what should be expected. Pain only on one side of the pelvis or severe rectal pressure may be a significant warning sign of something wrong. Symptoms of a tubal or ectopic pregnancy may include severe one-sided lower abdominal pain, vaginal bleeding, sudden dizziness, and right sided shoulder pain. It is always safe to take Tylenol (regular or extra strength) as directed on the bottle. Try not to take Motrin, Advil, Ibuprofen, Aspirin unless I have indicated that it is safe. Taking these medicines routinely may hurt your baby. Narcotics like Vicodin, Darvocet, Fioricet, etc. are not dangerous in pregnancy and may be necessary for treating extreme pain such as with migraines. Embryogenesis is complete around 10 weeks so taking meds after this time is theoretically safer
3. **Fatigue:** Extreme fatigue is one of the most common symptoms you may experience. My advice: Don't fight it. Nap if you can. If you have small children, then you know that when they nap, you can get things done. But, I recommend that you get some sleep, instead. This fatigue will last until about 14 to 16 weeks. Adequate sleep, at least 8 – 10 hours a night, is essential and very important in preventing an exacerbation of headaches/migraines.
4. **Nausea and vomiting:** Also very common, and frustrating. These symptoms usually go away by 14 to 16 weeks, but sometimes can persist for longer. I can prescribe medications to help if

you absolutely need them, but sometimes using little tricks can suffice, i.e., eating dry bread or crackers, sipping ginger ale or other clear sodas, sipping the juice from canned peaches or pears, and avoiding foods that make the sensation of nausea worse. Ginger products i.e., ginger ale, ginger snap cookies, ginger tea, etc. has been shown in scientific studies to reduce nausea. A wrist watch (RELIEF BAND/[www.reliefband.com](http://www.reliefband.com)) that has been used effectively in cancer patients undergoing chemotherapy may help and is completely natural. Taking Vitamin B6 (50 mg at bedtime) can be helpful. Adding Unisom (yes I know it is a sleeping pill so only take it at bedtime) with the active ingredient Doxylamine (25 mg) with the Vit B6 can work wonders. Sometimes it is the iron in your prenatal pill that can be causing your nausea. Either ask about a new prenatal vitamin Rx or stop your prenatal vitamins and take supplemental folic acid (400 ug) and calcium (1000 mg). In some severe cases of nausea and vomiting, I need to admit patients into the hospital and re-hydrate them with intravenous fluid. Several prescription meds are available and have used them for the past 15 years in hundred's of patients and (Zofran being my first choice) believe them to not be harmful. If you are losing weight I typically advise taking prescription meds and strongly recommend hospitalization for 24 – 48 hours for re-hydration and resumption of bland diet.

5. **Breast tenderness:** This is almost inevitable, so be prepared. Wear gradually larger bras that are comfortable, but well supportive.
6. **Headaches:** These may be very uncomfortable, and migraine sufferers are most likely to experience an increase in frequency and intensity. If you can, get by with Tylenol (regular or extra-strength). If you think you need something stronger, please call me and we will discuss other treatment strategies. The migraine “busters” like Imetrex are not recommended in pregnancy. I typically use Fioricet (butalbital/caffeine/Tylenol) for migraine sufferers and do not consider it harmful. If you have a headache that is not going away with meds, please call since you may benefit from in patient management.

In the next section, we'll explain the purpose and flow of prenatal visits.

## **A Schedule of Visits**

**Initial ultrasound visit at 6-8 weeks** This is scheduled to confirm that your baby is growing and has a heartbeat. The purpose is three-fold: a) to confirm that your pregnancy is intrauterine and effectively rule out an ectopic (tubal) pregnancy or impending miscarriage, b) to accurately date the pregnancy and avoid having to guess the due date, and c) to provide you with the first picture for your baby's scrap book. You will be given a lab slip for routine blood and urine tests. Special screening tests may be ordered based on your ethnicity and family history. If these special labs were not checked on your lab slip prior to leaving the office, and you are filling out your prenatal genetic history and think other labs need to be performed, please ask at your next visit and they can be ordered. You should be taking a prenatal vitamin with folic acid and omega 3 essential fatty acids. We will provide you with samples and when you determine which one you like and can afford, let us know at your next visit and a prescription will be written. Costco has the cheapest prices for prescription strength prenatal vitamins.

**First official Obstetrical visit 9-12 weeks** At this visit we will obtain a thorough history and perform a complete physical examination. Lab results from blood drawn for routine tests will be reviewed, and you will be advised of prenatal classes available both early and late in your pregnancy. Don't forget to register on line at the hospital's web site prior to 15 weeks ([johnmuirhealth.com](http://johnmuirhealth.com)). Dr. Jeff Traynor and Dr. Rosa Hon are the only Perinatologist's (John Muir Perinatal Center) I refer to for your genetic screening tests, amniocentesis, and targeted mid pregnancy ultrasounds. You were given a form requesting specific services at your last appointment with their phone number and local address. By now you should have called their office and scheduled any planned first or second trimester genetic screening ultrasounds and appointments for amniocentesis (see genetics section) as many of these tests are time critical. Scheduling visits with the John Muir Perinatologist's early is important because many doctors refer their patients to this office and many of the tests are done at specific time frames. Vitamin supplementation will be reviewed.

**Monthly interval examinations will continue until about 27 weeks** If you have symptoms of bleeding or cramping, or if you have other concerns, please discuss them with us during these visits. By your 14-16 week appointment, genetic screening tests should have been done and results recorded in your chart. All normal labs will be reviewed at your next visit so there is no need to call, and we will remind you to have a routine targeted fetal anatomic ultrasound at a Perinatology. If an amniocentesis is planned this is done at 16 weeks, otherwise it is done at 18-20 weeks. At 28 weeks, a gestational diabetes screening blood test will be drawn, and we will check for anemia. If you have an Rh-negative blood type, we will give you an injection of Rhogam (a medicine to help protect your baby from maternal antibodies).

**Bi – Tri weekly (every 2-3 weeks) examinations will continue until 36 weeks** These are quick visits. I typically recommend you schedule out at least 2 visits since the schedule gets more packed the closer you get to your due date. Questions will be answered, and we will check fetal growth and listen to the baby's heart rate. This is a good period of time to

interview Pediatricians. We have a list of physicians we routinely refer to including pediatricians. Getting personal recommendations from neighbors, family and friends about their pediatrician may be helpful. If you have not registered on-line at the hospital's website ([johnmuirhealth.com](http://johnmuirhealth.com)) and you have done your diabetes test, you should register in person. In addition, vaginal cultures will be performed at 34 weeks to identify those moms who harbor the bacteria called Group B streptococci. You should have started and nearly completed childbirth classes by 36 weeks.

**Weekly visits will continue from 36 weeks until delivery** In addition to checking growth and the heartbeat, we may be checking periodically for changes in the cervix. After 36 weeks pregnancy if it is not safe to leave you pregnant or you go into spontaneous labor, it is time for a birthday party. If you ever have a contractions that are consistently 10 minutes apart for 2 hours, bleeding, think you are leaking water, or worried about your babies movement, call my office 24 hours a day to speak with me or a colleague on call about going to labor and delivery. Information on stem cell retrieval will be provided if you want to bank your babies cord blood.

**A Postpartum visit** should be scheduled for 6 weeks following your delivery. If you have had a cesarean section, in addition to your 6 week post partum visit, I will have you come in for an incision check 10-14 days after your cesarean section. We will discuss contraception, resumption of sexual activity, exercise, etc.

## **Purpose of Prenatal Visits**

Frequent visits to my office serve multiple functions: monitoring you and the baby, and educating you about the changes taking place in your body. Obviously, most pregnancies are uncomplicated and end in the delivery of a healthy infant to a healthy mom. Although rare, unexpected problems can arise in women with the fewest risk factors. I believe that frequent monitoring of you and baby can identify problems earlier so that treatments are instituted promptly. The result of this type of care is a greater chance for a healthy outcome. In addition, questions can be answered regarding the health of your baby, normal and abnormal symptoms experienced during pregnancy, weight gain, exercise and activity restrictions, sexuality, and plans for labor and delivery. I also have to dispel all of the myths and folklore taught by the lay person (“social professionals”): sex determined by fetal heart rate or the way you are carrying; head full of hair if you have lots of indigestion. I can reassure you about the appropriateness of your baby’s growth and development. Any visits to other physician’s office’s (Perinatology) or allied health professionals (diabetic educators, etc.) will not take the place of your regularly scheduled visits at my office.

## **What to Expect in my Office**

Your prenatal care appointments will take approximately 20 minutes, 10 minutes of which will be with your doctor. On the way back to the exam room, my medical assistant will ask you to weigh yourself, and to provide a sample of urine to be tested for the presence of glucose (indicator for diabetes) and protein (indicator for urinary tract infections or dehydration, both of which may be present without any symptoms). It also may provide evidence of developing toxemia if present in combination with elevated blood pressure. Once in the room, your blood pressure will be taken. If you are 36 weeks or later in your pregnancy or if you are experiencing abnormal uterine activity, you may be asked to undress from the waist down for a cervical examination.

I will then come in to ask questions and to examine you. Before twenty weeks, the exam consists mostly of listening to the baby’s heartbeat. After twenty weeks, I will ask more detailed questions about you and your baby, and will measure your uterus to assess proper fetal growth. It is very important to tell me if you’ve experienced a decrease in your baby’s movement patterns, if you’ve had vaginal bleeding or leaking of water from the vagina, or if you’ve had contractions. I will also check for adequate weight gain and answer questions you may have regarding any aspect of your pregnancy.

## **Regarding Ultrasounds**

Typically, I perform an ultrasound on the first two visits. This is to allow me to confirm your due date with confidence and to let you see first hand the miracle that is growing inside of you. This ultrasound is not harmful to you or your baby and is considered safe by the American College of Ob/Gyn. I will be able to determine if there are twins, see the heart beat and fetal movement, position of the placenta, and any potential uterine or ovarian abnormalities. A detailed or “targeted” ultrasound performed at a perinatal office is offered to all patients. This ultrasound is typically done around 20 weeks and it is recommended that you call two months in advance. If you are considering an amniocentesis to rule out Down’s syndrome, etc this is typically done at 16 weeks and your targeted ultrasound is still done at 20 weeks. I recommend that you see Dr.’s Traynor or Hon at John Muir Perinatal across the street from John Muir Hospital for all genetic counseling appointments, ultrasounds, and necessary amniocentesis. Ultrasounds near the end of the pregnancy are not necessary unless I need to evaluate position of your baby, the amount of fluid, or decreased fetal movement.

## **My Medical Staff**

If you have questions and are unsure whom to ask, speak with my physician assistant Hope Rubin PA-C. She will be able to help you directly or find out where your question can best be answered.

For administrative questions please speak with my office manager, OB benefit Coordinator, who is in the office Monday-Thursday. She knows the answer to just about everything. OB benefit Coordinator also handles all of the billing. She is responsible for sending statements and reconciling your account balance with the explanation of benefits we get from your insurance company.

Dolly is responsible for getting authorizations and checking insurance benefits for durable medical equipment, procedures, and surgeries. After you begin your care, Dolly will submit a pre-certification request to your insurance company regarding pregnancy benefits, co-pays, deductibles, etc. She will set up a payment plan if necessary, so that your balance will be paid in full one month prior to your delivery. This coverage is only for my services and not hospital, anesthesia, pediatrician, etc. If you have questions about authorizations, i.e. status of, obtaining, etc. please speak to Dolly.

For Lab results or scheduling lab draws, please speak to Debi. Normal labs will be placed in your chart and reviewed at your next appointment. We will not call you about normal labs. If there is a lab that needs follow-up prior to your next appointment, Debi will call you and arrange for a lab request to be faxed to the lab you have your blood work done at.

For questions about scheduling or canceling appointments, please speak to Nariza at the front desk.

## **Call Coverage**

There is a doctor available 24 hours a day, 7 days a week, 52-weeks a year. You need only to call my office (925) 935-6952 and during office hours M-Th 9-12am, 2-5 pm, Fri 9-2 pm my office staff will take care of you. After hours and on the weekends the phones are transferred to my answering service. When you get my answering service please identify that you are a patient of mine and they will contact me. I attend all of my patient's deliveries 24 hours a day when I am in town. You don't have to worry about who is on call. If it is a weekend, and you have called my service, you will be triaged by one of my colleagues or myself. (Dr Wells, Dr. Hanna, Dr. Hughes, Dr. Katz) but I will attend the delivery unless I am not physically available. If the answering service is not helpful in putting you in contact with a physician, call John Muir labor and delivery at 9475330 and speak with the charge nurse who should be able to get you in touch with a physician.

## **Keeping you and your baby safe**

My staff and the physicians I am associated with are here to keep you and your baby safe. Attending scheduled appointments and calling after hours when appropriate, allows me to know the most about your needs and those of your baby. My promise is to pay close attention to all the facts about your pregnancy to ensure you are both safe.

## Prenatal Checklist

Keep referring to this page as you go through your prenatal care in our office. It will help remind you when to get certain special tests and to schedule classes. Keep in mind that not all tests will coincide with your office visits, and some tests are time sensitive (there is a “window of opportunity”). After you’ve completed each task, **CHECK IT OFF!!!**

### First trimester: First 13 weeks

- \_\_\_\_\_ 1) Blood draw for routine prenatal laboratory tests. (This may have been done at your ultrasound visit or at your first “obstetrical” visit).
- \_\_\_\_\_ 2) Do you have young children that go to day care or school? You may need to be screened for the virus that causes “slap cheek” aka 5<sup>th</sup> disease. Parvo B19 virus is potentially harmful to your growing fetus and if you are immune (been exposed prior to your pregnancy and have immunity) you need not be worried. Please see the page in this book regarding 5<sup>th</sup> disease. It is not the same parvovirus that lives in dogs.
- \_\_\_\_\_ 3) Do you need to be screened for Cystic Fibrosis, Tay Sachs, Canavan, thalasemia, sickle cell? Please see prenatal history you are filling out and mailing back. If you think these tests should be ordered, please ask and you will be given a lab slip or one can be faxed to a lab of your choice.
- \_\_\_\_\_ 4) Genetic testing for Downs Syndrome and Trisomy 18 may be done with a Nuchal Translucency (NT) screen between 11-13 weeks, targeted ultrasound 18-20 weeks at John Muir Perinatology
- \_\_\_\_\_ 5) Are you doing your kegels? If you are unsure about doing them correctly please ask Hope or myself about vaginal weight training. “We are here to pump you up”
- \_\_\_\_\_ 6) Register at the hospitals web site [johnmuirhealth.com](http://johnmuirhealth.com) by 15 weeks.

### Second Trimester: Weeks 14 - 26

- \_\_\_\_\_ 7) Maternal AFP if you did not have an NT screen in the first trimester.
- \_\_\_\_\_ 8) Obstetrical Anatomic Ultrasound (Call ASAP for a 20 – 21 wk appointment).
- \_\_\_\_\_ 9) Go on line [johnmuirhealth.com](http://johnmuirhealth.com) and check link to the women’s center by 24wks to schedule Prenatal Classes.

I recommend for first time parents:

- Childbirth education
- Care of the Newborn / Breastfeeding
- Infant CPR
- there are now online birth classes but no option for on line deliveries

- \_\_\_\_\_ 10) Amniocentesis is done around 16 weeks. You will have an ultrasound done at that time for the purposes of the amniocentesis. This will not be the ultrasound that looks at all the baby’s specific features like, face, lips back, heart, etc. This will be done at separate ultrasound around 20 weeks.

### **Third Trimester: Weeks 27 – 39**

- \_\_\_\_\_ 11) Blood draw at 26wks (give or take one week).
  - 1 hour post glucola (screening test for diabetes)
  - repeat CBC (to check for anemia)
  - Antibody screen for mom's who have Rh-negative blood
- \_\_\_\_\_ 12) Vaginal culture to identify Group B streptococcus 34-36 weeks.
- \_\_\_\_\_ 13) Rhogam injection at 28wks ONLY for mom's who have Rh-negative blood.
- \_\_\_\_\_ 14) Call and interview with a Pediatrician if you do not already have one.
- \_\_\_\_\_ 15) Have you had your car seat inspected/installed by a police safety officer?
- \_\_\_\_\_ 16) Discuss whether you want to save your babies umbilical blood (info about reputable stem cell banks available from my office) typically recc Via Cord or CBR
- \_\_\_\_\_ 17) Disability paperwork filled out (see office policy disability paperwork)

### **Postpartum**

- \_\_\_\_\_ 18) Schedule an appointment for 6 weeks following your delivery (2 weeks if you've had a cesarean). At this visit we'll perform a pelvic exam and discuss contraception.
- \_\_\_\_\_ 19) Have you been having any post partum blues that are so severe you might have post partum depression? If you are unsure then take the enclosed questionnaire and bring it to your post partum visit.
- \_\_\_\_\_ 20) Have you had a problem losing urine when you cough/sneeze/laugh that has bothered you? I will go over how to Kegel properly and review the importance of pelvic floor muscle rehabilitation. If you are unable to Kegel I will review options for a physical therapy program.
- \_\_\_\_\_ 21) I will remind you about when to return for an annual exam and Pap smear. My office will send you a reminder letter.
- \_\_\_\_\_ 22) Don't forget to tell 2 friends who are newly pregnant to come to the office and take your place.

## Prenatal Vitamins

Because of the increased nutritional demands during pregnancy, prenatal vitamins are essential. Prenatal supplements must provide increased amounts of folic acid, calcium and iron for both mother and baby. Research conducted over the last decade has verified the importance of specific supplementation before and throughout pregnancy. More information is at [www.marchofdimes.com](http://www.marchofdimes.com)

**Folic acid**, in the amount of 1 mg per day, is now recommended to protect against neural tube defects (spina bifida, meningomyelocele, and anencephaly). By consuming adequate amounts of folic acid, 70% of all such neural tube defects may be prevented as well as other birth defects including cleft lip and palate, cardiovascular, urinary tract and limb defects. Because many of these structures form very early in pregnancy we strongly recommend beginning supplementation prior to attempting conception. As pregnancy is not always a planned event, we recommend starting as soon as pregnancy is diagnosed.

**Calcium** is a very important supplement. It is estimated that more than ninety percent of American women have diets lacking in adequate amounts of calcium. Deficiency of this important mineral has been linked to early onset pregnancy induced hypertension. Although the exact role calcium plays in this process is not clear, supplementation of between 1000 and 1500mg per day is recommended. Vitamin D is an important cofactor for the maximal absorption of calcium and 200 IU/day is minimum recommendation. Understanding that an 8-oz glass of milk contains only 95mg of elemental calcium makes it clear that supplementation beyond normal dietary sources is required. Insufficient dietary calcium and Vit D during pregnancy can inhibit mineral accrual during childhood and lead to higher risk of osteoporotic fractures in adulthood.

**Iron** is needed specifically in pregnancy for the production of fetal and maternal red blood cells. Because there is a natural tendency for anemia to develop during pregnancy, it is important to have adequate supplies of iron for red blood cell production. Low red cell counts have been associated with premature labor, and significant anemia at the time of delivery increases the likelihood of requiring a blood transfusion should an intra-partum or postpartum hemorrhage occur. In pregnancy the demand for red cell production is so great that it is difficult to meet iron needs by diet alone. A check for anemia will be done at your 26-week labs and if your Hemoglobin is around 10 mg/dl, I will recommend you take Repliva, which is prescription strength iron that is easy on your stomach. For maximum tolerability and absorption, oral iron should be taken in 3 to 4 small doses preferably between meals and at bedtime. Total adult dosage should be 150 – 200 mg of elemental iron daily

Two **polyunsaturated essential fatty acids** (PUFA's), docosahexaenoic acid (DHA), an omega-3 PUFA and arachidonic acid (AA) an omega-6 PUFA, are particularly important in the development of the nervous system. Omega-3 PUFAs were available to early humans who consumed fish, wild game, and unprocessed grains. Omega-3 fatty acids are no longer common in most modern foods and are deficient in many women's diets. DHA is the largest source of omega-3 PUFA's in the brain and retina, where it is found in the highest concentration in the body. AA is similarly important in the brain and other organ development, but is common in modern diets. Omega-3 PUFA's have been associated with higher IQ scores, better visual acuity, and decreasing pre term labor. Recommended amounts of DHA is 300 mg daily. This supplement has been associated with reduction in preterm labor and lower rates of post partum depression.

Avoid unhealthy fats particularly saturated and trans fats (partially hydrogenated vegetable oils invented in the 29<sup>th</sup> century to solidify vegetable oils. Trans fats decrease HDL (good cholesterol) and increase LDL (bad cholesterol), and block transport of omega-3 PUFA's across the placenta. Trans fats are found in snacks, processed foods, and baked goods. Fasting longer than 13 hours during pregnancy stimulates the production of corticotropin-releasing hormone a stress hormone that increases the risk of preterm delivery.

### **My Recommendation...**

Although many prenatal vitamins may appear equivalent when comparing labels, the absorption characteristics vary greatly from brand to brand. An excellent prenatal supplement package is one that provides you with the most “bio-available” vitamins and minerals with the fewest side effects. In choosing what is right for you, keep in mind that a vitamin that fails to be absorbed provides you and your baby no benefit at all.

In choosing a prenatal vitamin I recommend prescription strength, non-generic supplements that are sure to provide adequate quantities of folic acid, calcium, essential fatty acids, and iron because of superior absorption characteristics. I must reiterate that generic forms (those brands most patients with insurance cards would receive because of special contracts) simply do not display the same absorption characteristics as name brand supplements. Vitamins that are not prescription are not held to any quality standards when it comes to manufacturing and may be made in countries where toxic metals and dangerous chemicals are able to be incorporated into your vitamin. While you are pregnant it is worth paying the extra money for a safe and appropriate vitamin. I have been told that Costco's pharmacy has branded prenatal vitamins and are cheaper than any pharmacy in the community. Branded prenatal vitamins cost around \$35.00 - \$45.00/monthly.

## **PROGESTERONE: Preventing “early” Miscarriage and “early” Labor**

### **Preventing early miscarriage:**

If progesterone is so bad, then why do thousands of doctors, including myself, and most IVF programs worldwide use progesterone supplementation when appropriate during the first 3 months of pregnancy? The fact is there are many different types of progesterone, and the kind that we use today is quite different from what was prescribed in the past. In the late 1950's, when researchers were gathering data on the correlation between progesterone and birth defects, doctors were prescribing synthetic or laboratory-produced hormones that were created from other compounds.

However, the progesterone we use today is primarily natural progesterone (injections or vaginal suppositories) or injectable 17-hydroxyprogesterone caproate (17-OHPC), which is not a synthetic product. It is a purified version of a hormone extracted from natural substances and is similar in structure to progesterone that is produced in a woman's ovaries.

The decision to take any medication in pregnancy is a difficult one. No expectant mother wants to expose her child to danger. In our many years of practice, we have not observed any malformations due to progesterone intake during pregnancy. However, because the Food and Drug Administration do not recognize progesterone (says on package insert do not use if you are pregnant) for use in pregnancy, and your possessing this book states your awareness of this contraindication, and that the use of progesterone in pregnancy is still considered experimental, and is not yet approved.

A low progesterone diagnosed at 7 weeks in 15% of women who are bleeding may be an early indication that something potentially unusual with the pregnancy, and not necessarily an indication that progesterone supplementation is necessary. When progesterone insufficiency is diagnosed as a possible cause of repeated miscarriages it is usually started within 5-7 days of conception. A progesterone insufficiency developing at 7 weeks de novo is rare. Nonetheless, my colleagues and I may prescribe progesterone to women who are bleeding during their early pregnancy if we think that progesterone levels are insufficient. Prometrium tablets used for early progesterone supplementation should be put in your vagina at bedtime thru 10-12 weeks.

### **Preventing early labor:**

Several recent large trials have shown that women at high risk for pre term delivery have benefited from weekly injections of 17-hydroxyprogesterone caproate (17-OHPC). The American College of Ob/Gyn in 2003 recommended that progesterone may be used to help prevent preterm birth but should be restricted to women with documented history of spontaneous labor and delivery less than 37 weeks. A recent meta analysis of several studies showed that progesterone reduced the overall odds of preterm labor by 43%, and the odds of preterm birth by 50%. Newer studies have looked at oral forms of micronized progesterone (Prometrium) which have shown efficacy in preventing preterm birth.

A separate study conducted by the National Institutes of Child Health and Human Development Maternal-Fetal Medicine Units Network randomized 459 pregnant women who had at least one previous preterm birth to receive weekly injections of 17-OHPC or placebo starting between

gestational weeks 16 and 20. The study was stopped early when it became evident that 17-OHPC decreased the risk for preterm birth before 37 weeks by 34%.

**If you have any of the following risk factors, please review them with Hope or myself:**

Having regular and rhythmic tightening (more than 6 contractions/hr for 2 or more hours) of your uterus? IF SO, YOU MAY BE IN PRETERM LABOR IF YOU ARE LESS THAN 36 WEEKS. PLEASE CALL THE OFFICE.

Have you delivered a baby before 37 weeks?

Were you ever hospitalized for more than 48 hours and placed on medicine for pre term labor?

Is this an IVF pregnancy? Do you have twins? Did you undergo multi-fetal reduction?

Have you ever had surgery to remove a part of your cervix for an abnormal pap smear?

Have you ever had any trauma to your cervix or told it was short?

Do you smoke?

Have periodontal disease? It is ok to get routine and deep cleaning. In summary, keep up with your dental hygiene.

## Genetic Testing

One of the most basic concerns a woman will have during her pregnancy is regarding the health and “normalcy” of her baby. Out of 100 newborns, only 2-3 has a major birth defect and 70% of the babies born with a birth defect, the cause is not known. Although no single test during pregnancy will reassure a mother more than “counting fingers and toes” after delivery, we now have the capability to identify pregnancies at risk for genetic and structural abnormalities. GENETIC SCREENING (give estimate of risk) AND DIAGNOSTIC (tell you if your baby has a syndrome) TESTING OPTIONS WILL BE REVIEWED AT YOUR EARLY VISITS. I WILL RESPECT ANY INFORMED DECISION YOU MAKE REGARDING ANY OF THESE TESTS. SCHEDULEING APPOINTMENTS AT KEY TIMES IS IMPORTANT AND I CAN’T STRESS ENOUGH THE IMPORTANCE OF SETTING UP THESE VISITS ASAP.

Risk Factors that increase the chances of birth defects

- Family or personal history of birth defects
- Previous child with birth defect
- Certain medicines used around the time of conception
- Diabetes before pregnancy
- Maternal age 35 and older when the baby is due

The earliest screening tests involve questions about your past medical/family/and obstetrical history at your initial visit. These answers may give us clues to predict an increased risk for certain inheritable disorders.

The first trimester screen measures the fold of skin of your baby’s neck (nuchal fold) and is called the Nuchal Translucency (NT) Ultrasound. This ultrasound will also include some blood work that needs to be drawn between 11-14 weeks. This ultrasound is typically done at a perinatal referral center like John Muir Perinatology in Walnut Creek (their card was given to you at your first appointment). This test only screens for Downs syndrome and Trisomy 18 (no evaluation for spina bifida or abdominal wall defects, but these abnormalities will not be missed at your 20 wk ultrasound). Please see the enclosed brochure that explains first trimester screen. Most insurance companies pay for this screening test as it has become the standard of care. The sensitivity of this test is better and there are fewer false positives compared to the AFP. The only reason to do the MSAFP (second trimester screen) is if an NT was not done in the first trimester. I don’t recommend that you do both first and second trimester screening test as you only get more false positives.

The second trimester screening option is the Expanded Maternal Serum Alpha Fetal Protein (MSAFP) which involves blood test that is drawn between 15 and 20 weeks gestation (16 - 18 wks is the ideal time). This test is a screen for fetal open neural tube defects such as spina bifida and anencephaly), abdominal wall defects (abnormal openings in the abdomen which allow the liver or intestines to protrude through), Down syndrome, and Trisomy 18. If you have done the NT screen, don’t worry about missing the screen for spina bifida, your targeted ultrasound will be checking to make sure your baby’s spine and stomach are normal.

In conjunction with the first or second trimester genetic screens a level II (aka targeted) ultrasound is performed by a radiologist or perinatologist. This ultrasound gives accurate information about the structural anatomy of your baby. It can effectively rule out the presence of major anatomic abnormalities commonly associated with genetic and non-genetic disorders. The ultrasound is usually very exciting and interesting, so be sure to bring your husband. John Muir Perinatology does not allow young children and videotaping at your appointment. You may find out the sex if you so choose and

your baby allows. Twenty weeks is the ideal time for the ultrasound, as everything is formed and easily identified.

**If you are under 35 years of age, the big decision is the NT ultrasound or Expanded AFP test.** These **are elective genetic screening tests** and not all women decide to have tests. The NT is a better screen than AFP (more sensitive) and when it is positive you will be potentially triaged to a diagnostic test earlier than amniocentesis. The most common reason expressed by women who decline the test is “we wouldn’t do anything if the baby was abnormal anyway so why get it done?” **We must emphasize that this test and the results may influence decision making beyond the immediate concern of whether or not to carry the pregnancy to term.** Some abnormalities may require a cesarean section as opposed to a vaginal delivery for the safety of the baby. Antenatal testing (non stress tests and ultrasounds in the last trimester) may be necessary to more closely monitor your baby. Conversely a mother may elect not to have an emergency cesarean section for fetal distress during labor if she knew her baby had a 100% lethal genetic abnormality. There may be a bill for \$105 sent to you from the AFP Program that you should submit to your insurance company. Realistically, you may have to submit this bill several times (an unfortunate reality as insurance companies are not always prompt in paying bills in a timely manner).

## **Genetic Testing, cont.**

If you screen negative, the risk of certain birth defects is low enough that the State program does not feel follow-up tests are necessary. **90% of pregnant women screen negative.**

**If you screen positive, DON’T PANIC.** The most common reason for the “screen positive” is inaccurate dates (believe it or not, it happens very commonly), multiple pregnancies, or the substances measured in the blood varied more than usual for an unknown reason, having nothing to do with the fetus. **If the screen is positive, the State will pay for genetic counseling/ultrasound/amniocentesis at John Muir Perinatology.** During this meeting with a genetic counselor, questions will be answered and you can decide whether or not to pursue further testing. If you decide to proceed, an ultrasound will be performed to look for structural abnormalities. In addition, an amniocentesis may be offered to determine the chromosomal makeup of your baby (i.e., normal or abnormal chromosomes). Keep in mind that there is about a 1 in 1500 chance for a procedure related miscarriage. I will be available to answer questions that may arise during this whole process. Typically for every 20 “screen positive test” there is only one true positive confirmed by amniocentesis.

**If you are 35 years old by the time your baby is due, you have the same options including amniocentesis.** You may elect to see a genetic counselor thru John Muir Perinatology in addition to having any of the aforementioned genetic screening tests. The counselor will explain your choices and answer questions. Your choices may be to proceed directly with amniocentesis **standard** at 15 to 20 weeks / risk of miscarriage about than 1:1500) or **chorionic villus sampling** at 10 - 12 weeks / risk of miscarriage approx 1:250). The community standard of care is for amniocentesis at 16 weeks to be offered to all women who will be 35 at time of their baby’s birth. If you are certain that you are going to do an amniocentesis, please also schedule an NT screen because if this test comes back positive, you will be triaged to an earlier diagnostic test call CVS. After CVS is done, preliminary data on your baby’s chromosomes may be available within 24-48 hours. If your child has an abnormal complement of chromosomes, and you elect to stop this pregnancy, this surgery may be done by the physicians at John Muir Perinatology before you get out of the first trimester. When a decision is made to stop a

pregnancy for a genetic abnormality, it is safer for you to do this in the first trimester than in the second. If you are uncertain but want to make the option of amnio available, then do the screening tests and still schedule your ultrasound/possible amnio at 16 weeks. If you are certain you are not doing the amnio, schedule your targeted ultrasound for 18-20 weeks.

What are the risks of delivering an affected infant per age (keeping in mind that a percentage of these fetuses will be lost spontaneously during the second and third trimester due to their own inherent structural and physiologic abnormalities)?

20 through 29-year-old women have about a 1 in 1400 chance of delivering a child with Down syndrome.  
30-year-old women have about a 1 in 952 chance  
35-year-old women have about a 1 in 378 chance  
36-year-old women have about a 1 in 289 chance  
37-year-old women have about a 1 in 224 chance  
38-year-old women have about a 1 in 173 chance  
39-year-old women have about a 1 in 136 chance  
40-year-old women have about a 1 in 106 chance  
41-year-old women have about a 1 in 82 chance  
42-year-old women have about a 1 in 63 chance  
43-year-old women have about a 1 in 49 chance  
>45-year-old women have about a 1 in 30 chance

Websites with information about genetic testing include:

[www.modimes.org](http://www.modimes.org) (march of dimes)  
[www.sbaa.org](http://www.sbaa.org) (spina bifida assoc of America)  
[www.mostgene.org/support/](http://www.mostgene.org/support/)

## Medical problems

1. **Hypertension.** High blood pressure may be pre-existing to pregnancy, called “chronic hypertension” or may arise during pregnancy. If you have chronic hypertension, it is important that it is under control prior to conception. Some anti-hypertensive medications are not safe during pregnancy. Therefore, it is important that you speak with your doctor so that you may change your medication if needed to one that is known to be safe during pregnancy. Major risks during pregnancy in women with chronic hypertension include having a baby that is too small or premature separation of the placenta from the wall of the uterus prior to delivery. In addition, chronic hypertension may lead to a potentially more serious hypertensive illness known as toxemia. If you are measuring your blood pressure please make sure you have the instruction sheet on how to do it properly. When you are monitoring your blood pressure, record the values in a log book and bring this log to your appointments so it can be reviewed. If you are feeling “different” take your blood pressure and if significantly different (> 20 points for either top or bottom number), please call my office 24 hours a day. If you notice a new and severe headache, blurry vision, untreatable indigestion, swelling in your upper extremities, hands or face, please call and speak to me or one of the physicians on call

### 2. **DIGESTIVE DISORDERS**

The most common encountered gastrointestinal disorders in pregnancy include nausea and vomiting (hyperemesis), gastroesophageal reflux disease (GERD), peptic ulcer, irritable bowel and constipation.

#### Nausea and Vomiting

50 – 90% of pregnant women, most commonly in first trimester, worse w/ multiples OTC meds include Vitamin B6 and doxylamine, (look if first few pages of this book) Rx antiemetics include Reglan (cat B) and my favorite Zofran, which does not appear to increase fetal risk for malformations.

Hyperemesis is severe form of N/V that usually needs inpatient management  
Acupuncture has been shown to be more effective than Reglan in clinical trials

#### GERD

40-80% of pregnancy patients when it starts it rarely goes away until after pregnancy is over first measures are to avoid fatty foods, citrus juices, caffeine, chocolate, NSAID's  
elevate head of your bed 15 cm at night time, decr food and water 4 hr prior to sleep antacids with aluminum, magnesium, or calcium are safe in pregnancy 50% of pregnant women receive relief within 2 weeks, if not need Rx meds H2 blockers like Zantac OTC have demonstrated safety Pepto Bismol should be avoided in pregnancy.

#### Constipation

Dietary modification w/ incr fiber, water is first line treatment  
Supplementation of fiber with psyllium, methylcellulose, Metamucil 25-40 g/day  
Polyethylene glycol, lactulose are hyperosmolar laxatives can be safely used  
Stimulant laxatives like bisacodyl 5-15 mg as needed and senna 2 tablets daily is safe

#### Acute Diarrhea

Most cases self-limited caused by viruses, bacteria and last 5-7 days  
Usually supportive therapy is all that is necessary, i.e. maintain hydration  
Loperamide (cat B) is ok, diphenoxylate with atropine is contraindicated

3. **Diabetes.** This condition if it exists prior to pregnancy should absolutely be under control prior to conception. There is a blood test called Hemoglobin A1C, which will indicate the adequacy of glucose control prior to conception. The reason that control prior to conception is important is that diabetes is associated with a high rate of fetal malformations if it is not controlled before the period of organogenesis (6 - 10 wks of pregnancy or 2 to 6 wks past a missed period). If you take insulin regularly prior to pregnancy you will be co-managed with your endocrinologist, a Perinatologist, and myself. Risks associated with “pre-existing diabetes” include development of toxemia, polyhydramnios (overproduction of amniotic fluid which can cause premature labor and delivery), macrosomia (a larger than normal baby that may complicate a spontaneous vaginal delivery), birth defects, miscarriage, and stillbirth. If you have had “gestational diabetes,” or pregnancy induced diabetes during a previous pregnancy, then you should have early testing to see if the condition is recurrent. It is okay to be cared for by a regular Obstetrician as long as you attend visits at a hospital based diabetes center. You should be seen in each trimester by an ophthalmologist to have your eyes checked.
4. **Asthma.** This lung disorder that causes wheezing and breathing problems fortunately does not necessarily worsen because of pregnancy. Most women with asthma can go safely through pregnancy. Most of the medicines are safe to take. Pregnant women with acute exacerbations should be treated aggressively, however, to maintain good oxygen flow to the growing fetus. Remember, if you are not breathing your baby is not breathing.
5. **Epilepsy.** If you have a seizure disorder, you will need to discuss which medication you are taking, as some medications are to be avoided during pregnancy. As a general rule, however, if your seizures have been frequent but are controlled on a specific medication, we will most likely keep you on that medication for the duration of your pregnancy. In this situation, the risk of the illness is greater than the risk to the fetus. You should be taking a higher dosage of folic acid than is found in all prescription prenatal vitamins. Folgard is a supplement you should be taking daily along with your prenatal vitamin.
6. **Lupus, rheumatologic illnesses, clotting disorders.** Systemic lupus erythematosus (SLE) is a disease that can affect nearly every organ system in the body. There is an associated risk of miscarriage, preterm birth, fetal heart defects and arrhythmias, and stillbirth in pregnancies complicated by SLE. Typically, pregnant women with SLE and other arthritic illnesses such as rheumatoid arthritis will need Perinatology consultation early in pregnancy. In addition, corticosteroids (safe for the fetus) and aspirin-like medications will need to be taken during pregnancy. Some women need to inject themselves daily with a medicine (heparin) to lower the chance of forming blood clots and improve the likelihood your pregnancy will proceed to term. These medicines should be ideally stopped 24 hours prior to delivery if there are plans for getting an epidural. I will discuss the coordination of stopping the medicine and timing the delivery in the third trimester.
7. **Thyroid disease.** The demand for thyroid hormone increases during pregnancy. If you have hypothyroidism, it will be important to make sure your dose is adjusted correctly prior to the start of your pregnancy. Studies have identified that approx 85% of women will need a dose adjustment throughout their pregnancy, so we will check your thyroid every 4-6 through 34 weeks. Some mom’s without a prior history of abnormal thyroid function have new onset post partum thyroid problems of either too much or too little. If you are more than 6 weeks post partum and are having abnormal bleeding after (most mom’s who exclusively breast feed don’t menstruate until they stop nursing), problems with heat or cold intolerance, nervousness, excessive fatigue, or problems with going to sleep, please call because you may need to have thyroid tests performed.

8. **Heart disease.** Mitral Valve Prolapse (MVP) is very common and should not complicate your pregnancy. If you have MVP (ballooning) with an incompetent valve (the leaflets open and separate) it is recommended that you take antibiotics for delivery, consequently you will be given prophylactic antibiotics 30 minutes prior to delivery. Other structural heart defects must carefully be reviewed, as some are quite dangerous for a woman because of fluid changes associated with pregnancy. If you are aware that you have a structural heart defect such as Mitral stenosis, Tetralogy of Fallot (uncorrected), Marfan syndrome, pulmonary hypertension, or a history of a myocardial infarction, please discuss this early in pregnancy. You will need to see a perinatologist due to the high-risk nature of these defects.
  
9. **Depressive and anxiety disorders** affect 17% & 4.7% of reproductive-aged women, respectively. The primary treatments for these disorders are selective serotonin reuptake inhibitors (SSRI's) like Prozac, Zoloft, Paxil etc and serotonin norepinephrine reuptake inhibitors like Effexor. Gestational use of these medicines is not associated with an increase risk of fetal anomalies (exception is Paroxetine); however the common use of these drugs has shifted attention to other domains of reproductive toxicity, such as neonatal behavioral signs. Signs of withdrawal may include restlessness, agitation, feeding difficulties, gastrointestinal signs that are all usually mild and resolve within 2 weeks. The FDA and drug manufacturers have recently agreed to labeling changes that cautions physicians and patients about neonatal complications associated with late pregnancy exposure. The label lists the clinical features of the SSRI related neonatal withdrawal syndrome, and states that tapering the drug in the third trimester might be considered.

**DON'T ABRUPTLY STOP ANY OF THESE MEDICINES AT ANY TIME.** Untreated depression and anxiety in pregnancy include well documented health risks to mom's and babies, and may significantly get worse if left untreated in the post partum period.

Untreated Depression in pregnancy is associated with adverse pregnancy outcomes including Pre term delivery, low birth weight infants, fetal growth restriction, postnatal problems. Newborns of women with untreated depression cry more and more difficult to console Later in life, children of untreated depressed mothers are more prone to conduct problems, suicidal behavior, emotional instability and more often require psychiatric care.

If you have a history of depression you are at greater risk throughout this pregnancy and post partum. If you are feeling depressed and not on any medicine or in therapy, please ask for help so that I can help.

The incidence of neonatal SSRI syndrome has not been established which is to say not all newborns will show signs of withdrawal. The metabolic removal of the drug from the fetal compartment occurs gradually as the maternal dose and serum level declines, the SSRI could be tapered and discontinued approximately 2 weeks prior to the due date if we believe you may not need to be on an antidepressant. (Prozac can be tapered quicker because of its long half life. and resumed immediately post partum). Optimal treatment of maternal depression must remain a primary concern. **DON'T STOP YOUR MEDICINES WITHOUT FIRST CONSULTING YOUR PRIMARY CARE DOCTOR OR ME.**

Breastfeeding and the use of antidepressants can benefit both mom and baby. Most medications are transferred thru the breast milk, although most are found at very low levels and likely not clinically relevant to the neonate. Medication exposure during lactation is considerably lower than transplacental exposure to these same SSRI's during gestation. Long-term neurobehavioral studies of infants exposed to SSRI antidepressants during lactation have not been conducted. (See the Moody Blues section on post partum depression).

**If you are aware of any other medical problem that you feel may cause a problem for you during your pregnancy, please let us know. Consultation and specialty referral will be made so I can keep you and your unborn baby safe.**

# Medications and Pregnancy

Most medications can be safely used during pregnancy, however we recommend their use only when clearly indicated. We have prepared a list of most medications that are commonly used during pregnancy. Although sometimes necessary, it is best to avoid use of medications during the interval period of “organogenesis.” This begins at week 6 and continues until about week 10.

Drugs are categorized based on clinical information about their relative safety

Category A	Safe, Controlled studies show no risk to humans
Category B	No evidence of human risk
Category C	Risk can't be ruled out, human studies lacking or animal studies suggest harm
Category D	Positive evidence of risk to humans, benefits of drug may outweigh risk
Category X	Not safe in pregnancy, Contraindicated.

## Sore Throat / Cough Lozenges:

1. Cepacol
2. Halls
3. Robitussin

## Cough & Cold Preparations

1. Tylenol for general aches and pains, including joint pain and headaches and body aches. Use in such doses as necessary. As one regular Tylenol rarely will make a person feel any better, take it in the same way you would if you were not pregnant. Tylenol PM may be taken at night.
2. Sudafed or Actifed for runny nose and congestion
3. Robitussin DM for cough. Robitussin AC is available by prescription for patients with a cough not relieved by Robitussin DM and who are not allergic to Codeine.
4. **I still recommend rest, chicken soup, and time as the best medication for colds. Antibiotics are widely desired by patients for colds, but unfortunately colds are almost universally VIRAL in origin, which means that antibiotics are not helpful in their treatment.**
5. **Other cough syrups, pills, and multi-symptom preparations:**
  - a. Robitussin (Dextromethorphan Hydrobromide)
  - b. Triaminic (phenylpropanolamine / Chlorpheniramine)
  - c. Dimetapp
  - d. Thera-flu (Dextromethorphan/Chlorpheniramine /Pseudoephedrin
  - e. Actifed Cold & Sinus (Triprolidine)

## **What do the ingredients in cough syrups do?**

Guaifenesin ---Works as an expectorant. It enhances output of lower respiratory tract fluid. The enhanced fluid is less viscid, which promotes removal of more mucous. The result is making a dry non-productive cough more productive and less frequent.

Phenylpropanolamine acts on alpha-adrenergic receptors producing vasoconstriction, which results in shrinkage of swollen mucous membranes and an increase in nasal airway patency. This medication may cause drowsiness.

Pheniramine maleate is an “anti”-histamine. Histamine release causes capillary leaking, which leads to swollen mucous membranes. Marketed also as Brompheniramine and Chlorpheniramine.

Dextromethorphan is simply an anti-tussive or anti-cough medication that raises a person's threshold for needing to cough.

# Medications and Pregnancy, con't.

## Allergy Medications

1. Benadryl
2. Actifed
3. Sudafed
4. Tavist – 1
5. Chlortrimaton
6. Afrin nose spray
7. Claritin otc
8. Allegra or Zyrtec (by prescription)

## Yeast Infections

1. Over the counter preparations such as Monistat or Gyne-Lotrimin are safe to use in pregnancy. The applicators can safely be inserted up to two inches into the vagina. If used only externally, yeast infections will rarely be treated appropriately.
2. Oral yeast medications such as Diflucan should not be used during pregnancy.

## Nausea & Vomiting

When the usual preventative measures you have read about do not work well enough, we can prescribe a number of medications, depending on severity and duration of symptoms. At times, medications alone aren't enough. For prolonged periods of nausea and vomiting, severe dehydration may result, which may require hospitalization for rehydration and electrolyte management.

1. Compazine or Phenergan. Both come orally or in rectal suppositories.
2. Reglan. This stimulates gastric muscles to empty the stomach quicker, thus decreasing nausea.
3. Zofran. A powerful anti-nausea medication used for stubborn cases. This works very well.
4. Vit B6 50 mg and Doxylamine 25 mg (Unisom) at bedtime

## Headaches

1. Tylenol usually suffices. Take 2-3 extra-strength if needed.
2. For migraine sufferers, we typically prescribe Midrin, which is taken as follows: 2 pills orally, followed by 1 pill every hour until headache is gone. There is a maximum of 8 pills used per 24 hours.
3. Alternatives for severe headaches include Tylenol with codeine, Vicodin, Fioricet.
4. Don't take aspirin unless you were instructed to take it as part of an IVF program or have a history of blood clots.
5. Don't take non-steroidal (Motrin, Aleve, Ibuprophen, etc.) in the first or third trimester.

## Skin Rashes

1. 1% Hydrocortisone cream. Since this medication is poorly absorbed through the skin and does not cross the placenta, it is recommended for use with various skin rashes.

## Hemorrhoids

1. Hydrocortisone cream 1%. This works well. For severe hemorrhoids, this may be obtained via prescription in a stronger 2.5% formula.
2. Cortizone 10
3. Preparation H
4. Anusol HC
5. Tucks medicated pads (contains 50% Witch-hazel)
6. Nupercainal
7. Make sure your prenatal vitamin has a stool softener

## **Medications and Pregnancy, con't.**

### **Diarrhea**

1. Kaopectate or Imodium AD. If diarrhea persists for several days despite use of these medications, please let us know.

Constipation (see medical problem section on digestive disorders)

1. Colace 100mg twice daily
2. Milk of Magnesia 30 cc's twice daily
3. Metamucil
4. Konsyl

### **Gas Pain**

1. Gas – X
2. Simethicone

### **Milk Intolerance**

1. Lactaid
2. Dairyease

### **Indigestion**

1. Maalox
2. Mylanta
3. Tums
4. Zantac OTC

### **Vaginal Dryness**

1. Replens
2. Lubrin
3. Vagisil

### **Sleep Aids**

1. Benadryl 50 mg
2. Hot Shower
3. A very occasional Glass of Wine
4. Boring book (this blue book) or philosophical discussion about cloth or disposable diapers with your husband
5. Ambien (category B)

### **Muscular aches and pains**

1. Tylenol for minor aches and pains of pregnancy.
2. Flexeril is a potent muscle relaxer that may be used safely in pregnancy for severe muscle strains. This comes by prescription only.
3. Rest and a heating pad. Probably the best medicine.

### **Hyper lipidemia**

The anti-hyperlipidemic class of drugs can be subdivided into the following classes

1. *Bile acid sequestrants* (cholestyramine, colistipol, and colesevelam) form insoluble complexes with bile acids in the intestine and are safe in pregnancy (cat B). The complexes are then excreted in the feces, removing cholesterol from the body. Cholestyramine is used for total body itching that is caused by elevated bile acids. These medicines can bind fat-soluble vitamins (A, D, E, K) in the gut, and deficiencies may result.

## **Medications and Pregnancy, con't.**

### **Hyperlipidemia cont.**

2. *Statins* (Lipitor, mevacor, pravachol), which are the most commonly prescribed meds for high cholesterol, are all contraindicated in pregnancy (cat X)
3. Fibrates (lopid, tricor) are not recommended in pregnancy since animal studies show developmental toxicity and may pose a risk the human embryo or fetus
4. *Ezetimide* (cat C) selectively inhibits the intestinal absorption of cholesterol. At 10 times the recommended human dose the drug is teratogenic in rats but not rabbits. There is not human data or use during pregnancy. This is likely safer than statins.
5. *Niacin* is converted in the body to niacinamide, the active form of vitamin B6. But high doses (up to 2000 mg/day) used for high cholesterol have not been studied in pregnancy. Because niacinamide is actively transported to the fetus and newborn than in the mother, niacin is best avoided during pregnancy and lactation.

### **Antibiotics**

The antibiotics NOT recommended during pregnancy include Doxycycline and Tetracycline, and Sulfur containing antibiotics. Penicillin, erythromycin, and cephalosporins, which are commonly, used upper respiratory infections and dental procedures

### **Miscellaneous:**

Other medications for medical conditions include the following: Synthroid / levo-thyroxine for hypothyroidism, inhalers for asthma such as Proventil, atro-vent, and steroid containing inhalers, Terbutaline for premature labor, and Progesterone shots for bleeding early in pregnancy. These medications can be used safely during pregnancy.

## DAILY BABY KICK COUNTING

Fetal movement awareness (or baby kick counting) has long been known to indicate the well being of the baby while inside the uterus. The range of normal fetal movements varies greatly between babies and pregnancies. Unfortunately, there is no exact number of baby movements that automatically indicates that the fetus is at risk for problems or may be developing a problem. Babies move less closer to your due date because there is less room to move around. However, a significant decrease in fetal movements may be associated with a baby in distress or a baby somehow in jeopardy inside the uterus.

By counting your baby's movement daily, you can monitor the baby yourself to reassure you and us on a daily basis that all seems to be going smoothly for the baby before it is born.

1. When counting fetal movements, try to lie on your left side or just sit quietly and comfortably. Baby movements are often difficult to feel or be aware of when the mother is active, so this "test" of movement monitoring requires mom to be in a "quiet" mode.
2. How you experience "movements" will vary. They may be a "jab", a "roll", a "kick" or you may feel the baby "balling up inside". Whichever of these you feel you should count as one movement. Do not count hiccups and flutters as "movements". If you are having difficulty feeling movement from "inside", try placing your hands on your abdomen.
3. Count "baby kick counts" or fetal movements two to three times a day. It is best to do this after you have completed a meal. This is a time the baby is most likely to move since it responds to your digestive sounds. The baby should move 4-5 times in the hour following your meal, or 10 times in the 2 hours after you have finished eating. NOTE: If the baby moves 4-5 times in 15 minutes after your meal, you do not have to continue counting for the whole hour. You can stop counting as soon as you have felt 4-5 movements.
4. If the baby does not move as directed above, get up, drink a big glass of cold juice, and try counting again after about 10 minutes. If the baby still has a decrease in movements, call me at (925) 935-6952 to report your findings so I can arrange a non-stress test. This requires that you go to the hospital, have a monitor placed externally on your abdomen, so we can hear and record the baby's heart rate. Babies that are doing well have characteristic heart rate patterns. **Call at the time you are testing.** I do not want you to wait. Even if this is on a weekend or at night, **I WANT TO KNOW ABOUT IT THEN, NOT LATER.** Don't ever feel you are bothering me when you call. This is important.

Thank you for helping me evaluate your baby on a daily basis!

## Childhood Illness During Pregnancy

### Fifth Disease (a.k.a. Slap-Cheek)

The agent which causes “fifth disease” (erythema infectiosum, or “slap-cheek”) is actually a VIRUS called parvovirus B19 that affects only humans. It is transmitted by spread of respiratory secretions and hand-to-mouth contact. As many pregnant women are concerned about exposure and affects on the fetus, we have listed “the true facts” related to the virus:

1. The infected person is contagious 5 – 10 days after exposure yet prior to the onset of the characteristic rash or other symptoms.
2. **Approximately 50% of pregnant women are IMMUNE to Parvovirus B19. In other words, half of women can't get it because they've had it before and are unlikely to get it again.**
3. Only 5% of women who are casually exposed will become infected (if they are part of the susceptible 50%).
4. Susceptible women who have intense and prolonged exposure to Parvovirus B19 infection (teachers in a school with a parvovirus epidemic) have about a 20% risk of infection.
5. Women in households where children or other household members are infectious have up to a 50% risk of infection.
6. When maternal Parvovirus B19 infection occurs in pregnancy, **THE FETUS IS USUALLY NOT AFFECTED.** The maternal-fetal transmission rate is about 20%
7. The risk of fetal death related to infection appears to be less than 10%. The major risk of infection is miscarriage (between 10 and 20 weeks). Fetal anomalies (deformities) have not been associated with maternal infection.

#### **What to do if exposed:**

If you are directly exposed to “slap-cheek,” don't panic. First, let's find out if you're immune. I might have tested you with your first set of prenatal labs. Call me and I will have you come in for a blood test (if you didn't already do it in the first trimester) to see if you've been previously exposed, developed antibodies against the virus and are protected. If the blood tests indicate that you're immune, that's the end of it. If you are not immune, we'll have you return in two weeks to have the same blood tests to see if you've become infectious.

If you become infectious, we will begin following you with ultrasounds to see if the growing fetus begins to show signs of infection. Keep in mind that the **FETUS IS USUALLY NOT AFFECTED...**

One extra note: If your child was exposed to another child infected with Parvovirus B19 at school, it does not count as an exposure to you.

### Chickenpox

This is the most common childhood illness. If you have had chicken pox when you were smaller, you are immune. The illness often begins with symptoms like those of a common cold. These symptoms are followed by a fever and itchy, fluid filled bumps on the skin. Chicken pox as an adult can be more

severe if you are pregnant. Early in pregnancy, the chance of harm to your baby is low. If you get chickenpox a week or more before giving birth or immediately post partum, the disease may be passed on to your baby. Your baby in this scenario may not have been able to acquire maternal antibodies, thus at risk. If you think you have been exposed to chickenpox and don't know if you ever had this illness, please call and I will order some labs.

## **Measles, Mumps, Rubella**

Most people are immune because of vaccination programs when you were a child. In any case, your prenatal panel included a test for rubella and if you were non immune I would have recommended that you get a booster shot post partum. If we did not discuss this you can assume you have immunity to rubella. Acute rubella infection early in pregnancy can cause stillbirth, miscarriage, and preterm birth. About 50% of the babies whose mothers have rubella in the first month of pregnancy have problems. If you had recently received rubella vaccine, don't worry and know that it is not recommend you have an abortion.

## **Toxoplasmosis**

Toxo is a microorganism that can cause harm to your developing baby. Exposure is possible by eating raw meat or handling cat feces. You can use gloves to change the liter box or get put this on you honey do list for you hubby.

## **Vaccines and Pregnancy**

The only vaccine that is recommended in all pregnant women at any time is for FLU. This is safe at all times and is recommended by the American College of Ob/Gyn. You will be passively immunizing your baby in utero and thru breast milk. The vaccine is typically administered in the months of October & November. I try to have supply for my pregnant patients and will administer it for a nominal fee. If you get the flu it will not harm your baby. The indirect effects of dehydration may cause inadvertent contractions and necessitate a hospital stay until you are well.

## **Pregnancy/Delivery and Changes with Your Bladder**

“ I thought this only happened to my grandma”

You may have noticed a significant change in bladder habits since becoming pregnant. Going more often (“I go so much I might as well put a cot in bathroom”) and in smaller amounts occurs in all pregnant women because of the hormonal changes in bladder function and the increased fluid volume shifts. Usually there is no sense of urgency or pain with voiding which may be a sign of a bladder infection. I have everyone do a urine culture with their initial prenatal labs because asymptomatic bacteria in your urine can lead to a UTI and possible kidney infection. If you notice burning and urgency along with going more please let me know so I can have you do a urine culture. If you have UTI symptoms, fever, and pain in your upper back/flank, this may signify a kidney infection, which usually requires in patient intravenous antibiotics for 48 hours. Some women who have recurrent UTI’s during their pregnancy take an antibiotic daily (like a vitamin) to prevent serious infections, which may lead to preterm labor.

Other changes with your bladder may involve the unplanned loss of urine when you cough, sneeze, simply bend over, or push your stroller. Urinary incontinence has a prevalence of 3-22% in women who have never had kids, but it rises to 35-65% during an initial pregnancy. This incontinence usually resolves postpartum, with only 13-30% of women reporting persistent symptoms at 3 months. The likelihood your symptoms may persist is associated with

- Increasing numbers of vaginal deliveries (particularly 4 or more)
- Increased age at first delivery
- Obesity (BMI > 25)
- Prolonged pushing phase (over 2 hours)
- Large fetal head circumference (now go ahead and hit your husband)
- Episiotomy
- Forceps or vacuum assisted delivery
- Constipation 4-8 weeks post partum

These changes may occur when injury to the pudendal nerves and pelvic floor peripheral nerves innervating pelvic floor muscles occurs from head compression in the birth canal. The majority of injury to these nerves occurs during labor and delivery. Submucosal support tissue may become detached from the pelvic sidewall, which can lead to bladder neck hyper mobility, thereby disrupting anatomical mechanisms that maintain continence. Just as there can be injury to the bladder, rarely there can be disruption to the anal sphincter, which can lead to problems with losing gas and stool. If these are problems during and after your delivery, please make me aware of them so interventions can be discussed.

Wow that’s a lot of information to digest and your probably thinking it’s too late to do anything (hit your husband again). That is not true but just like you brush your teeth every day to keep them healthy, you may need to pay daily attention to your pelvic floor muscles. Kegel exercises done regularly have been shown to reduce the risk for postpartum urinary incontinence. Pelvic floor exercises have been associated with fewer cases of active pushing in the second stage of labor lasting longer than 60 minutes. If you don’t know how to do Kegel exercises or are not sure if you are doing them correctly, please ask Hope or myself about ways to learn proper technique. It is important to not do them while sitting on the toilet and going to the bathroom. If you regularly start and stop your bladder while you pee, your bladder may develop some very bad habits. If you can stop the flow of

urine while voiding, this may serve as an occasional friendly reminder that you are doing kegels correctly. Please don't tighten your buttocks (ok Forrest Gump) or your abdominal muscles as these should be completely relaxed when you kegel. Typical schedule involves doing a set of kegels 2-3 times daily where a set involves 20-30 squeezes. Timing them to meal planning, yellow traffic lights, teeth brushing, or hitting your husband will get you into the habit of doing them daily. It is a use it or lose it phenomena. If you think you are doing them but not getting better, please speak with Hope or myself, you may not be doing your Kegels correctly and might benefit from formal physical therapy.

## **TRAVEL DURING PREGNANCY**

Most women can travel safely until close to their due date by following a few simple guidelines. Women who have special health problems that may need special medical care should consult their doctor prior to any travel, as it may not be advisable.

The most comfortable time for most pregnant women to travel is during the second trimester (14-28 weeks of pregnancy). I do not recommend travel in the third trimester after 35 weeks unless specifically cleared by the physician.

A copy of your prenatal records should be obtained and carried with you (on your person) at all times. You may request this from our receptionist prior to your departure.

### **TIPS FOR PLANE TRAVEL:**

Get an aisle seat so that you can walk around and get to the bathroom easily. Also do leg extension and flexion exercises to help prevent swelling and leg cramps.

The forward part of the plane usually provides a more stable ride.

Wear a few layers of light clothing that will allow you to bundle up or remove a layer or two. Wear shoes and clothing that doesn't bind.

Eat lightly to avoid being airsick. Take some crackers, juice, or other light snacks with you to prevent nausea.

Drink plenty of fluids because the air in the cabin is dry.

Walk around frequently – every hour or so. This decreases swelling and helps make you more comfortable.

### **TIPS FOR AUTO TRAVEL:**

Make each day's drive short enough to be fun. No more than five or six hours of driving each day is a good target. Take 10 – 15 minute "stretch" breaks every hour.

Air bags do not replace seat belts. It is always safer to wear a seat belt than not to wear one. Unless the mother has a serious injury, the fetus is not likely to be harmed. However, if you are in an accident, you should see your doctor to make sure that you and your fetus are okay.

Flexion and extension of the legs periodically will help with swelling and leg cramping if they occur. Do these frequently as a preventive measure.

## **Week Ten - Thirteen**

“It’s time to listen”

### Overview

This is the first opportunity during your pregnancy to actually begin to hear the heart beat of this miraculous process evolving inside of you. At this point, the embryo is approximately one inch in length and an incredible amount of differentiation has already occurred: skeletal frame, heart, eyes, and lungs have formed and are now growing and developing. You have known you are pregnant for only a few weeks and already so much has happened. “Embryogenesis”, which is where all the discreet organs are formed, has occurred.

Today will be your first official “OB visit.” You will have a complete medical history and physical exam. Based on your history and physical, pregnancy risk factors will be discussed. Routine prenatal blood tests will be reviewed. Importance of vitamin supplementation, diet and exercise are reviewed in this blue book. I will inform you of classes available to you during your pregnancy such as prepared childbirth classes, breast-feeding, and newborn care classes that may be helpful later on. Today we will attempt to hear the heartbeat and if we can’t we will perform an ultrasound to put your mind at ease. Hearing your baby’s heartbeat is a wonderful event and an important milestone for your pregnancy.

This appointment is a great time to begin asking questions and for us to cover a few important issues:

1. Vitamins / Calcium / Iron: Which supplements are the best and most easily tolerated during pregnancy?
2. Symptoms: Are the symptoms I feel normal and how long will they last?
3. Genetic screening tests: The expanded AFP vs. Amniocentesis vs. First Trimester Nuchal Translucency. Which, if any, is right for me? When should they be done, and what are the risks? (Be sure to read our section on Genetic Testing). If you are or will be 35 when your baby is due, we should have reviewed options for genetic screening tests. The Nuchal Translucency (NT) ultrasound is done by 13 weeks and if not done by now should have been already scheduled.
4. If you are do for a pap this can be done and should be done while you are pregnant.

## **Week Fourteen - Seventeen**

“Time for a different wardrobe”

### **Overview**

By this time the vast majority of differentiation has occurred. At fourteen weeks, your baby is about 3 ½ inches long and weighs about two ounces. The arms, legs, fingers, and toes are fully formed, complete with fingerprints! The external and internal sex organs are apparent by this time. The stage has been set now for intensely rapid growth.

Hopefully the nausea, vomiting, headaches, and fatigue you may have been experiencing have begun to pass. If you still suffer from these problems, hang in there. They should pass in the next few weeks.

If you are sixteen weeks at this visit, then it's time for the expanded AFP if you decide to have it drawn.

Here are some important issues to review today:

1. Laboratory tests: Were the ones done at my first visit all normal? What is my blood type? Am I anemic?
2. Genetic testing: You have options, so please read our section on genetic testing and be prepared to ask questions. If you have elected to proceed with the first trimester screen (NT screen), then the Expanded AFP blood test is not recommended. The AFP test can not be done earlier than 15 weeks or after 20 weeks and would be recommended if you did not do the first trimester screen. If there is an abnormality in any of your screening tests, know that I will contact you promptly and assist with follow up. Otherwise, normal results will be reviewed with you at your next visit. If you are or will be 35 when your baby is due, and you have opted for the amniocentesis, this is usually scheduled around 16 weeks. The results take from 10 to 15 days, and you should receive results from the office that performed the test. Ultrasounds are otherwise done between 18 and 20 weeks.
3. Targeted ultrasounds and amniocenteses are done at the offices of Dr.'s Traynor and Hon, across the street from John Muir Hospital. My office will obtain any necessary preauthorization. Most insurance companies will cover the cost associated with this exam.

# Week Eighteen - Twenty one

“This is definitely real”

## Overview

Can you believe you are about halfway through this event? The top of your uterus is about at your navel. At eighteen weeks, your baby is about seven inches long and weighs about four ounces. Eyebrows and eyelashes are present, and your little one may be sucking on a finger or toe.

Here are some important subjects to discuss this visit:

1. First Trimester Screen (if you chose to do it), expanded AFP test (if you chose to do it): this was probably drawn last week but if you are less than 20 weeks and haven't had it drawn yet it's time. Again, this test is optional. The results will be available in about 2 weeks. If it is abnormal, we will notify you as soon as we have the results. No news is good news and normal results will be reviewed at your next visit.
2. Weight gain: Am I on target? Do I need to adjust what I'm eating or my activity level? Fetal Movement: When will I feel my baby move?
3. Start planning for classes and thinking of a pediatrician.
4. Do you have questions about banking your babies cord blood?
5. Your Questions:

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# Week Twenty two - Twenty five

## “I can feel my baby move”

### Overview

Quickening is the term we use which refers to the perceived movement of the fetus inside the uterus. Most first time mothers sense this later than those who have been down this path before. The movement you feel is “exercise” for your baby’s growing muscles. At this time, your baby weighs over a half of a pound and is 10 to twelve inches long

This visit is usually a quick one. If there are no problems, no blood tests will be ordered and there are no tests to schedule before the next visit.

Here are some important questions to discuss this visit:

1. Were any abnormalities noted on the ultrasound report?
2. What were the results of my AFP test or Amniocentesis?
3. When do I need to sign up for childbirth education classes?
4. When do I need to choose a Pediatrician?
5. Don’t leave without your glucose drink. It comes in orange, lemon lime and cola.
6. If you are Rh negative you will need to have an additional test marked to be done on you lab sheet. You will receive RhoGam shot next visit. If your husband is Rh negative you don’t need this shot. He may find out his blood type by asking his primary care doctor for a lab test for Type and Screen.
7. Your Questions:

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# Week Twenty six - Twenty eight

## “Cruising but I’m Beginning to Not See My Ankles”

### Overview

If all is well, you are on “auto-pilot” at this time. You are probably used to the pregnant look, and yet you haven’t reached that uncomfortable period you hear your friends talk about. Skin changes and leg cramps may be more noticeable, though.

Your baby’s sleep cycles are regulated at this time, so don’t be surprised if you don’t feel movements for several hours periodically throughout the day. Calcium is being stored in your baby’s bones, causing them to begin hardening. Your baby weighs about 1-½ pounds, now.

Here are some important issues to discuss this visit:

1. If I’m Rh negative, when do I get my Rhogam shot?
2. Other tests: Screens for gestational diabetes, anemia, and abnormal antibodies (if your blood type is Rh negative).
3. You may need to take some extra iron if your anemia is severe. No more the two pills a day is recommended. The iron can irritate your stomach, will often make your stools darker, and can cause constipation. Vitamin C can increase iron’s absorption.
4. Adequate sleep is important so when you are tired take naps or go to bed without watching Leno or Letterman.
5. Your Questions:

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## Week Thirty - Thirty one

“When is my due date again?”

### Overview

Your baby is now about 2 ½ pounds. Kicks may change from jabs to rolls, as the baby takes up more space in your uterus. Braxton-Hicks contractions may become more frequent. These are often painful, irregular (important distinguishing feature from preterm labor contractions), and last 20 to 30 seconds. You may notice some swelling in your ankles, but this is common. Hemorrhoids may become quite painful and are best treated with warm sitz baths 2-3x daily, stool softeners, lots of water (even more than you have been drinking thus far), and topical hemorrhoidal creams. Sometimes they may bleed but it is important to distinguish blood from your vagina or your rectum. You have probably started your prepared childbirth classes by now. You should be planning to interview Pediatricians by now. In addition, you may still want to take prenatal classes on line thru the women’s health center, which can be accessed thru the hospital’s web site.

John Muir Hospital Website: [www.johnmuirhealth.com](http://www.johnmuirhealth.com)

Today’s visit is very easy. In addition to checking the heartbeat and growth, I will go over results of your diabetes-screening test.

Here are some important questions to discuss this visit:

1. How frequently will I be seen from now on?
2. What should I expect from future visits?
3. How active can I be? How late can I travel distances?
4. Be sure to tell us of any symptoms you think are unusual.
5. Your Questions:

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## Week Thirty two - Thirty three

“Is there enough room in my body for this?”

### Overview

Your baby’s eyes now open and close regularly. Hair on the head is filling out. The skin is still red and wrinkled. Your baby now weighs about 3 ½ pounds. Most women worry about early delivery, but the reality is that most babies born at this gestational age do very well in the nursery and have little risk of long-term physical or developmental problems. So relax...

Here are some important questions to discuss this visit:

1. Premature contractions vs. Premature labor
2. If you are less than 34 weeks and think you are in labor, I will likely have you go to John Muir Hospital for your babies care if you deliver early. Mom’s and babies after 34 weeks are able to be cared for the pediatricians at John Muir hospital.
3. Childbirth education classes—how are they going?
4. Birth Plans: Are they right for you? (Don’t feel pressured to come up with an extravagant birth plan. Keep in mind that I want the same things you want... simplicity and a memorable experience. I pretty much do all of the things as a routine that you may come up with on a birth plan).
5. Can we talk? I will review the indications for an episiotomy (a cut to make the vagina bigger) and situations when a vacuum may be necessary.
6. Your Pediatrician – Who is it?
7. Have you registered at the hospital yet?
8. My thoughts about having a birth doula.
9. No, you can’t get your epidural now for the remainder of the pregnancy. (but it is ok as soon as you go to the hospital and are in labor)
10. Your Questions

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## Disability Form Policy

To my patients,

Taking care of you is a privilege I take seriously and one that requires much paperwork, time, and coordination of care. This note is intended to inform you of a new policy that pertains to filling out your disability papers and insurance forms. Many patients have multiple options from the state and employer's for collecting disability after surgery or as a part of having a child. Some patients go on extended disability and need their forms filled out monthly. As more patients have come to trust my office with their care, the volume of paperwork to provide that care has exponentially increased. This need to fill out paperwork and submit information to insurance companies takes time away from seeing patients, which affects the overall financial health of the practice. New laws allow for paid FMLA (family medical leave), which is not disability, but allows for paid time away from work to care for a newborn or significant other. I am often asked to fill out and sign the papers for patient's spouses which doubles the volume of requests for forms to filled out. I believe it is my obligation to help with these forms and as such will fill out all of the medical justification portions for disability/leave of absence forms **first form at no charge**. If you have multiple forms they must be filled out at the same time so we may consistently fill out the forms with the proper dates. These forms may be state disability, FMLA, or papers unique to your employer or third party administrator. A date stamp will be placed on the forms will be used on the first free form and any additional requests to fill out new forms no matter how big or small will be done after receiving \$10.00 per form/signature. Requests for clarification or addendums to forms previously filled out by my office will be done for free. The sheet of paper I have in my office for return to work or excuse from work will continue to be done for free. As always thank you for letting my office help with keeping you healthy and coordinating your care.

Sincerely,

Timothy A. Leach M.D., F.A.C.O.G.

## **Week Thirty four - Thirty five**

“This is getting old” & “Will I ever see my ankles again?”

### **Overview**

At this point, the lungs are beginning to mature. Your baby may now be causing havoc in your lower pelvic region. The head grinding on your pubic bone and bladder is sure to cause you momentary distress. The only real change in your baby at this point is the size.

Here are some important questions to discuss this visit:

1. Kick counts: How, why, and when to do them. See the enclosed summary.
2. Getting ready to start disability next visit at 36 weeks if you want. You may be eligible for disability compensation form from your employer. You can obtain state disability forms from my front office receptionist. Fill out your section then bring it into our office at your thirty-six week visit. We'll then fill out our part and send it in for you. If your work needs something extra, i.e., a note, then tell us. Please fill out my disability questionnaire as to which dates you will go out on disability. Putting down inaccurate dates may delay your disability checks.
3. Any questions brought up during your birth classes? What do I think about episiotomies, vacuum deliveries, and doulas?
4. You will notice more swelling in your lower extremities, usually worse at the end of the day. If you have swelling in you upper extremities, hands, face associated with headaches, please call immediately.
5. If you think your uterus is tightening 6x an hour for 2 hours or more, then please call so I can evaluate for any preterm labor. Typically any labor less then 36 weeks is stopped with medicine in the hospital.
6. Your Questions

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## Week Thirty six - Thirty seven

### “Home Stretch”

#### Overview

If you go into labor at this time, I will probably not stop you. You have now made it to the last leg of your journey. I may check your cervix to assess for any changes. Changes I may report to you are the dilation (how many centimeters your cervix is open), effacement (how shortened or thinned out the cervix is), and station (how low in your pelvis the baby is). These changes are of some interest to us but unfortunately don't allow me to predict with any accuracy when your labor will begin. You should be seen weekly for the remainder of the pregnancy.

Here are some important questions to discuss this visit:

1. Labor Precautions—when to call me. See section for a preview of when to call.
2. Kick counts should be done if you think the baby's movement is less than you are expecting.
3. Review special concerns that you should convey to the labor and delivery nurses when you go in, i.e., Group B-streptococci status, blood type, previous cesarean section, significant medical illnesses, etc. If you can't remember all of the important stuff, don't worry. There are copies of your prenatal records at the hospital by this time.
4. Group B-Streptococci (GBS) vaginal culture: I routinely screen every pregnant woman to identify those who carry GBS bacteria in the vagina. This organism is a normal intestinal bacterium that is commonly present in the vagina and rectum, usually producing no symptoms in women and men who carry the bacteria. On this visit, the culture will be obtained with a cotton swab from the vagina. If your vaginal culture returns positive, **as it does in 30% of pregnant women**, don't worry. No treatment is necessary prior to the onset of labor, although I will treat you with an intravenous antibiotic during your labor to protect your baby. I treat my patients who harbor the bacteria because studies have shown an association between neonatal pneumonia and/or meningitis and maternal vaginal “colonization” of Group B-streptococcus bacteria. The risk of serious illness without treatment is still very low, but I feel more comfortable treating mom's who are carriers to further reduce risk

## **WHAT IS GROUP B STREPTOCOCCUS INFECTION?**

Since the early 1970s, the bacteria Group B Streptococcus (GBS) have been identified as a cause of infections in newborn babies.

This bacterium is normally found in the vagina and/or lower intestine of 15% to 35% of all healthy, adult women. Those women who test positive for GBS are said to be “colonized”.

These bacteria should not be confused with the Streptococcus, which causes strep throat.

Fortunately, there is testing and a preventive treatment available that can help prevent GBS infections.

### **GBS and Pregnancy**

If 1,000 women, regardless of race or socioeconomic status, had a vaginal culture taken, 150-350 would test positive for GBS. Because GBS usually does not cause problems for the adult female, most women carry it and do not know it. Yet, it can cause illness in babies born to women who carry the bacteria.

Since GBS is normally found in the vagina and/or the rectum of colonized women, one way it can colonize another individual is through sexual contact. However, this bacterium usually does not cause genital symptoms or discomfort and is generally not linked with increased sexual activity. Therefore, GBS is not considered to be a sexually transmitted disease.

Out of every 1,000 births, three babies will become ill with GBS. Why only certain infants become sick with this infection is not completely known.

GBS is also responsible for causing infections in nearly 50,000 pregnant women each year including fever after birth, uterine inflammation, and infections following cesarean sections.

### **When is GBS a Threat?**

GBS is considered a potential threat both during pregnancy and at the time of delivery.

There is increased risk with GBS when labor is premature, when there is premature rupture of membranes, when there is prolonged rupture of membranes before the baby is born, if the mother has a fever before or during labor, and in women who have a history of GBS previously.

### **Prevention**

Research indicates that giving antibiotics intravenously to the mother during labor can greatly reduce the frequency of GBS infection in the baby after birth or during the first week of life. Treating the mother with oral antibiotics during pregnancy may decrease the amount of GBS for a short time, but it will not eliminate the bacteria completely. Also, waiting to treat the mother or baby with antibiotics after birth is often too late to prevent illness, which is why IV therapy is recommended.

## **How Do I Know if I Carry GBS?**

The American College of Ob/Gyn recommends that doctors routinely screen for GBS by doing cultures on their patients at 35-36 weeks of pregnancy. These cultures may be taken from the vagina, rectum, cervix or urine. Vaginal cultures will yield more positive results than cervical or urine cultures. Women who are found to carry the bacteria can then be treated with antibiotics in labor which decreases the chance of vertical transmission at time of birth. Just like any other bacteria on the human body, GBS can be present in small amounts on one day, which would result in a negative culture. Therefore, one negative culture result does not guarantee that you will be negative on the day you deliver. This is another reason why prepregnant history is important. If your GBS culture is positive, please remind me or my colleagues when you call and think you are in labor.

Researchers are actively working on the development of a GBS vaccine, which would protect infants and mothers in the future. Use of the vaccine in adult women would create an immunity, which during pregnancy could cross the placenta and protect the baby. Although widespread use of a vaccine is still years away, this is the solution that will protect future babies regardless of risk factors.

## **Weeks Thirty seven - Forty (one)**

“Any day now”

This is a time to review and make sure everything is in order. By this time you should have: Picked the pediatrician, registered at the hospital, arranged for child care if you have other small children, packed your hospital bags, and mapped out the route to the hospital (in case you haven't been there three or four times already...). EVERYTHING READY??? Okay. **Now all you can do is hurry up and wait!!!** Be encouraged by weekly changes in your cervical exam. Walk lots if there are no contraindications i.e. toxemia, etc. If you are still pregnant on your due date, I will start talking about inducing your labor by 41 weeks. Pregnancies at 41 weeks are associated with higher rates of cesarean section, operative vaginal delivery (use of vacuum or forceps), meconium passage in utero (baby pooped in the bag, oh I wish they came out potty trained). Otherwise these term visits are relatively simple. Basically, I will check your baby's heartbeat, measure your uterus, and check your cervix during these quick visits. Electively inducing your labor can be safely considered at 39 weeks (the time repeat cesarean sections are done).

Here are some important instructions to clarify this visit:

### **1. Labor precautions -- When to Call:**

- a. **Contractions:** When they occur every 5 minutes for an hour AND are so intense that you are not smiling any more (every 10 minutes if you've been down this road before).
- b. **Bleeding:** No need to call us if you've passed blood streaked mucous, i.e., the “mucous plug.” But if you are having bright red blood per vagina, please call us immediately.
- c. **Ruptured membranes:** If you feel a gush of fluid, or a continuous trickle of fluid, please call us immediately. If the fluid is greenish or brown, tell us so when you call.
- d. **Decreased fetal movement:** Perform “kick counts” several times daily. If you notice a significant decrease in your baby's movement, please call us immediately.

### **2. Labor precautions -- Who to call**

- a. **Call the office phone number first.** If it's “after hours,” the medical exchange will answer your call then will page me, transferring the call so I can speak directly with you. Then I will call Labor & Delivery if it is time to go to the hospital. Please tell the operator at the medical exchange which hospital you are delivering, especially on the weekend, so the correct doctor on call can be notified.
- b. If you are unable to reach us in a reasonable amount of time (10 minutes), call directly to **Labor & Delivery at John Muir Medical Center (947-5330).**

**3. Any plans for saving umbilical blood? I have the kits for some of the companies so please enquire if you have questions. See the enclosed office policy on the collection of cord blood.**

## **Weight Gain and Pregnancy**

All women ask if they are gaining the right amount of weight at different times throughout their pregnancy. I don't focus on individual gains from one visit to the next, as much as pay attention to the overall weight gain by the end of the pregnancy. If you are consistently putting on significant weight this may increase your risk for gestational diabetes, cesarean section, need for vacuum assist to get your baby delivered. I have included a nutrition pregnancy wheel from ACOG (American College of Ob/Gyn) and handouts related to nutrition. The ideal weight gain in pregnancy is between 25-35 pounds though most will gain slightly less or more. You have control over the types of foods you eat and their relative portions. You have control over the calories you spend through various exercise options. Moderate exercise 3-4 times a week is recommended by ACOG and this may include walking, jogging, running, swimming, biking, etc. Drink plenty of fluids and don't get dehydrated. Try not to lay flat on your back with floor exercises as this may cause you to feel dizzy and pass out. Try to keep your heart rate at 70% your maximal heart rate and don't get short of breath. If you can carry on a conversation during your exercise routine, without sounding winded, then you are doing ok. Don't worry about sweating or feeling like your temperature is going up, you can't overheat your baby if you keep well hydrated and don't work out to the point of exhaustion. Moderation is the key, listen to your body.

## **Sex in the City**

While you are pregnant it is ok to watch reruns of the HBO sitcom in lieu of sex. But, it is also ok to have sex in whatever city you live in so long as it is comfortable and there is no bleeding. Pregnancy will undoubtedly present many physical changes some of which may heighten sexual intimacy. Don't be afraid of having an orgasm and don't worry that your husband's penis is hurting your baby, it doesn't happen. Semen has prostaglandins, which may cause a few contractions, but typically you won't go into labor. You may be told to observe "pelvic rest", which means no vaginal intercourse, if the placenta is down by the cervix, have an increased risk for pre term labor, or are having bleeding. It is never safe to have anal intercourse at any time while you are pregnant as this may stimulate uterine contractions. Try not to have any nipple stimulation, as this will release oxytocin, which will definitely give you contractions and sometimes cause milk let down. As you get to the later stages of your pregnancy, you may not feel physically comfortable with having sex and it is OK to tell your husband, but you may want to explore new avenues of intimacy involving touch and talk.

## **Fish Consumption and Mercury Exposure**

See the enclosed handout "What you need to know about mercury in Fish and Shellfish"  
[www.cfsan.fda.gov/seafood1.html](http://www.cfsan.fda.gov/seafood1.html)  
[www.epa.gov/ost/fish](http://www.epa.gov/ost/fish)  
[www.epa.gov/mercury](http://www.epa.gov/mercury)

## **Cord Blood Banking**

**Cord blood** is the blood that remains in the umbilical cord and placenta following birth and is routinely discarded with the placenta and umbilical cord. Now a process called **cord blood banking** allows you to have your baby's cord blood saved for potential medical uses.

Your baby's cord blood is a rich source of stem cells, which are genetically unique to your baby and family. Stem cells are the body's "master" cells because they give rise to all other tissues, organs, and systems in the body. The stem cells' ability to differentiate, or change, into other types of cells in the body, is a new discovery that holds tremendous promise for treating and curing some of the most common diseases such as heart disease, cancers, stroke, and Alzheimer's.

These valuable cells can only be collected in the minutes after your baby's birth. Preserving your baby's stem cells is considered to be a type of "safeguard," or biological resource for your family.

Collecting the cord blood poses no risk to your baby and collections can take place after vaginal or cesarean births. The collection procedure, which takes only a few minutes, is simple, safe, and painless.

Your baby's cord blood stem cells are unique to your family and have several benefits over other types of stem cells:

- The immune cells in cord blood are "younger" and are more likely than bone marrow to be a suitable match between family members. .
- Your baby's stem cells are immediately available if needed, and may help with more rapid treatment.

Although not all diseases treated with stem cells have been treated specifically with cord blood stem cells, doctors have been using cord blood in lifesaving treatments since 1988. And recently, scientists have discovered some amazing new possibilities for treating diseases and injuries in the future.

## Current/Future Stem Cell Applications

- Diseases of the blood and immune system i.e. Leukemia's (Current)
- Autoimmune diseases (Current)
- Experimental at present
  - Multiple Sclerosis (Experimental)
  - Rheumatoid Arthritis (Experimental)
  - Systemic Lupus Erythematosus (Experimental)
  - Potential Future Stem Cell Applications\*
  - Alzheimer's Disease\*
  - Diabetes\*
  - Heart Disease\*
  - Liver Disease\*
  - Muscular Dystrophy\*
  - Parkinson's Disease\*
  - Spinal Cord Injury\*
  - Stroke\*

Since your only opportunity to save your baby's cord blood is at the time of birth, you'll want to make an informed decision about cord blood banking well in advance of your due date. Arrangements for collection are normally made 60 to 90 days before birth. Although collections can be performed at the last moment, they are more costly. This is a decision you don't want to postpone.

Cord blood collection is a simple procedure that usually takes less than five minutes and can be performed in vaginal or cesarean deliveries and for multiple births. Cord Blood Registry ([www.cordblood.com](http://www.cordblood.com)) and Via Cord ([www.viacord.com](http://www.viacord.com)) are two of the industry leaders and both offer the syringe or bag collection methods, which give your caregiver a choice to use the method he or she prefers. My preference is the bag method of collection. After your baby has been born and the cord has been clamped and cut, the blood will be drawn from the umbilical cord before it is discarded. The bag collection method is similar, only gravity is used to drain the umbilical cord blood into the collection bag. Your doctor will not alter normal birthing procedures for cord blood collection.

If you have further questions regarding the procedure, or how to proceed, please discuss it with Hope or Dr. Leach at your next visit. Please see the office policy on cost for collection, which is often not a covered benefit.

## **Routine Postpartum Instructions**

### **ACTIVITY AND EXERCISE:**

At home you may resume your normal household activities, beginning with those which are minor and avoiding becoming overly fatigued. Let the feeling of tiredness be your warning and guide. Use common sense. Avoid heavy work, or lifting until your six-week check-up. Try to lie down for at least an hour every afternoon during the first 2 weeks. You may ride or drive in a car for short distances at any time.

Because of the changes in the abdominal muscles resulting from the pregnancy, exercises to strengthen the abdominal wall are desirable and may be started after the episiotomy is healed, usually in about 1 week. Head raising, bent-leg raising, and sit-up exercises will be beneficial. Strong abdominal muscles will often help with low back pain. Most active athletic exercise programs may be resumed after vaginal delivery in 3-4 weeks and after cesarean section in 6 weeks.

Sexual intercourse or douches can usually be resumed 4 weeks postpartum, but be sure to use a contraceptive agent to prevent pregnancy (that certainly may occur even if you are breastfeeding).

Discourage friends and relatives from flocking to your home for the first 2 weeks. Too much handling is stressful for both you and your baby, and you both need the rest.

### **HYGIENE:**

You may shower, shampoo, or take tub baths at any time after delivery of your baby, using non-slip tub and floor mats; twice daily and after each bowel movement, the vaginal area should be gently cleansed. This is especially important for patients who have stitches. Care must be taken to wash the perineum (the space between your vaginal and rectum) from front to back to avoid contamination from the rectum. Moistened cotton pledgets or Tucks, available at any drugstore, provide gentle and thorough cleansing. Tucks medicated pads may be placed over the perineum and are helpful in preventing irritation from sanitary pads. Sitting in a warm tub of water (sitz bath) 2 or 3 times a day will help relieve the discomfort from either episiotomy or hemorrhoids. Swimming is fine

Douching is usually not necessary but can be used after 4 weeks if desired.

### **CESAREAN SECTION PATIENTS:**

Patients who have had cesareans should make an appointment to be seen in the office 10-14 days after delivery. At this postoperative visit Hope or I will answer any questions you might have, check your incision, and remove steri-strips that were applied to the incision. Until that visit, your incision will probably need no special attention. It is good to keep it dry when you shower by covering it with plastic wrap or telfa pads. It is not serious if it gets wet, but avoid soaking it as you would in a bathtub. Baths are fine after the incision is completely healed (usually within 10 days). Swimming is ok after 2 weeks

If the incision becomes reddened, painful, develops a large lump, bleeds, or drains more than slightly, or develop a temperature of 101, please call our office.

You may drive or travel anytime after your post-operative check-up. Swimming and jacuzzis are okay after 2 weeks.

In planning activities, continue to keep common sense principles. If something makes you tired, don't do it. You should limit your activities for the first few weeks to less than changing beds or vacuuming. It is good for you to be dressed and ambulatory. You may socialize, go to church, dinners, or parties, but remember that your endurance is short. Don't get over committed.

## **Routine Postpartum Instructions, cont.**

### **POSTPARTUM APPOINTMENT:**

WITHIN ONE WEEK AFTER LEAVING THE HOSPITAL, be sure to call my office 935-6952 and make an appointment for a six-week check-up. Every effort should be made to keep this appointment so I can provide you with your preferred method of birth control. Please discuss your choice of contraception with your husband before this appointment.

### **DIET:**

Concentrate on having a well-balanced daily diet, liberal in protein foods such as meat, cheese, and eggs. Eat fresh fruits and vegetables daily. Whole grain breads and cereals are of value. Drink 6 to 8 glasses of fluid daily, some of which should be low fat milk. You should be continuing to take your prenatal vitamins, calcium, and iron supplements for the entire duration of breastfeeding. If you are nursing, avoid chocolate, alcohol, fruits and gas producing foods such as broccoli and cabbage in large quantities.

### **CARE OF BREASTS:**

NON-NURSING MOTHERS should wear a good, tight, supportive bra 24 hours a day to help prevent engorgement of the breasts. If engorgement does occur, hormones and other medications are of no value. Apply ice packs to the breasts and in 2 or 3 days the engorgement will be relieved considerably. Do not pump the breasts nor decrease your intake of fluids. You may take 2 aspirin or Tylenol tablets every 3 hours for discomfort.

NURSING MOTHERS should wear a nursing bra which has flaps that drop down for the nipples to be exposed to the air periodically. Use a clean bra every day. The use of soap on the nipples is unnecessary. Soreness can be prevented and treated by keeping them dry or applying A&D ointment or Vitamin E directly onto the nipples. These products are available at your drugstore. Do not allow wet tissue, gauze, or pads to remain over the nipples. Expose nipples to air if they are leaking. This will prevent cracking. If the breasts are full after nursing, pump or express the excess milk. If you develop severe cracking of nipples, redness and localized pain in the breasts, or high fever, please call for special instructions. Again, it is important to continue prenatal vitamins while you are nursing.

### **BODY FUNCTIONS:**

Following the delivery, you may have a discharge for 1 to 4 weeks. The discharge may be dark brown, red, or pinkish white, and gradually will become lighter in color and less in amount. Tampons may be used after 2 weeks. If the discharge has a foul odor or you develop a fever, please call our office for instructions.

The length of time before your first menstrual period is unpredictable. It ranges from 1 to 3 months and, if nursing, probably will be delayed even further. Do not become alarmed if your first 2 or 3 periods are heavy, irregular, or prolonged.

Regularity of bowel movements is important. To avoid constipation, take 1 or 2 Doxidan or Peri-Colace capsules each night. If this fails, use a disposable Fleets enema. You may use either Preparation H, Anusol suppositories, or 1% Nupercainal ointment for hemorrhoids. All of these can be purchased at any drugstore without prescription.

### **UMBILICAL CORD:**

The umbilical cord stump will usually drop off within 10 days. Keep the area clean with alcohol or hydrogen peroxide.

### **MINOR PROBLEMS:**

If you have any specific questions that cannot wait until your six-week check-up, please call the office.

# The Moody Blues and Wearing Darker Shades Because Your Future is so Bright

So you've finally come home with your little miracle. Hopefully, your experience was as pleasant as childbirth can be. Keep in mind that it is common to have mixed emotions about your newly and dramatically changed life. In fact, as many as 80% of women will experience POSTPARTUM BLUES ("baby blues") after delivery. This transient mood disturbance is VERY common. It most typically occurs within 3 to 10 days after delivery, and can last from days to several weeks. If you are tearful for no apparent reason, feel fatigued, irritable, unable to sleep or sleep all of the time, or if you are moody and feel like you can't cope with the new changes, then you may have the postpartum blues. These symptoms are common, as caring for your newborn is a 24-hour a day job. This new responsibility is demanding and at times can be very frustrating. If you find yourself experiencing the blues, try to set aside time during the day just for yourself doing other things that you enjoy, like taking a hot bath, exercising, writing letters, or even just catching up on sleep! Find family members or close friends to watch your infant for just a few hours periodically to give you "sanity time" for yourself. Keep in mind that this sense of feeling down will most likely pass in a couple of weeks.

If a few weeks have passed since your delivery and you feel that the "Baby blues" have not passed and in fact have worsened, you may have POSTPARTUM DEPRESSION. This condition may also be accompanied by feelings of guilt and worthlessness, or having dangerous thoughts about yourself or your infant. Women who are more likely to develop postpartum depression are those moms who have a personal or family history of depression or those who have suffered from severe PMS. Although less common than the postpartum blues, postpartum depression affects about 10-15% of all mothers.

Postpartum depression can last up to 6 – 9 months. If treated, it carries an excellent prognosis. Unfortunately, 80% of the time this problem goes undetected and untreated. Delayed diagnosis unnecessarily prolongs the depressive state and makes it more difficult to treat. In addition it can have a devastating effect on a woman's life and the health of her family, as she sinks deeper and deeper into depression. Therefore, diagnosis and prompt treatment consisting of support, psychotherapy, and medication are of paramount importance.

If you feel like you may have symptoms of postpartum depression, please make the effort to let me know. Simple measures can be instituted early so that you can be on the road to recovery in a short period of time. I can refer you to several counseling centers that specialize in the complex issues associated with postpartum depression. In addition, I can prescribe medications that are extremely safe and very effective in treating hormonal imbalances that are found in women with this condition. Lastly, national organizations devoted to the study of postpartum depression also provide literature and newsletters for the general public. There is a book by a local renowned expert in the field that you can purchase thru the web or get from my office at no charge. Go to [www.beyondtheblues.com](http://www.beyondtheblues.com) and see how this website can help today.

The only way I can help you determine whether or not you are suffering from this relatively common and very treatable problem is if you share with me what you are experiencing. See the post partum depression questionnaire and call me if you need help.

## The Edinburgh Postnatal Depression Scale

As you have recently had a baby, I would like to know how you are feeling. Please underline the answer that comes closest to how you have felt **in the past 7 days**, not just how you feel today.

Here is an example

I have felt happy despite having spittle on all my clothes

- |                              |                |
|------------------------------|----------------|
| Yes, all the time            | Score 0        |
| <u>Yes, most of the time</u> | <u>Score 1</u> |
| No, not very often           | Score 2        |
| No, not at all               | Score 3        |

This would mean: "I have felt happy most of the time" during the past week.

I have been able to laugh and see the funny side of things.

- |       |                                |
|-------|--------------------------------|
| _____ | As much as I always could      |
| _____ | Not quite so much now          |
| _____ | Definitely less than I used to |
| _____ | Hardly at all                  |

I have looked forward with enjoyment to things

- |       |                                |
|-------|--------------------------------|
| _____ | As much as I ever did          |
| _____ | Rather less than I used to     |
| _____ | Definitely less than I used to |
| _____ | Hardly at all                  |

I have felt anxious or worried for no good reason \*

- |       |                       |
|-------|-----------------------|
| _____ | Yes, most of the time |
| _____ | Yes, some of the time |
| _____ | Not very often        |
| _____ | No, never             |

I have felt anxious or worried for no good reason

- |       |                 |
|-------|-----------------|
| _____ | No, not at all  |
| _____ | Hardly ever     |
| _____ | Yes, sometimes  |
| _____ | Yes, very often |

I have felt scared or panicky for no good reason \*

- |       |                  |
|-------|------------------|
| _____ | Yes, quite a lot |
| _____ | Yes, sometimes   |
| _____ | No, not much     |
| _____ | No, not at all   |

Things have been getting the best of me \*

- \_\_\_\_\_ Yes, most of the time I haven't been able to cope at all
- \_\_\_\_\_ Yes, sometimes I haven't been coping as well as usual
- \_\_\_\_\_ No, most of the time I have coped quite well
- \_\_\_\_\_ No, I have been coping as well as ever

I have been so unhappy that I have had difficulty sleeping \*

- \_\_\_\_\_ Yes, most of the time
- \_\_\_\_\_ Yes, sometimes
- \_\_\_\_\_ Not very often
- \_\_\_\_\_ No, not at all

I have felt sad or miserable \*

- \_\_\_\_\_ Yes, most of the time
- \_\_\_\_\_ Yes, quite often
- \_\_\_\_\_ Not very often
- \_\_\_\_\_ No, not at all

I have been so unhappy that I have been crying \*

- \_\_\_\_\_ Yes, most of the time
- \_\_\_\_\_ Yes, quite often
- \_\_\_\_\_ Only occasionally
- \_\_\_\_\_ No, never

The thought of harming myself has occurred to me \*

- \_\_\_\_\_ Yes, quite often
- \_\_\_\_\_ Sometimes
- \_\_\_\_\_ Hardly ever
- \_\_\_\_\_ Never

Response categories are scored 0,1,2,3 according to the increased severity of the symptom. Items marked with an asterisk are reversed scored (i.e. 3, 2, 1, and 0). Add the scores of the ten questions. Total scores above a threshold 12-13 may be indicating a depressive illness of varying severity. Please call if you have any questions.

## Do I Have a Breast Infection?

Who? 3-5% of breast-feeding mom's have an infection (Temp >99.8)

25% of breast-feeding mom's have non-infectious engorgement (Temp < 99.8)

### Risk Factors

History of Mastitis  
Cracked Nipples  
Fatigue  
Plugging of Milk Ducts  
Improper Positioning  
Improper Latch  
Use of Breast Pumps  
Changes in feedings  
Incomplete Emptying

	Milk Stasis	Non Infectious Inflammation	Acute Mastitis
Fever	Low Grade <99.8 F	Low Grade <99.8 F	High Grade >99.8 F
Breast	Engorged Nodular	Tender, Swollen Red, Hot	Tender, Swollen Red, Hot

### What Do I Do About Nursing?

Continuing to nurse is recommended, because in spite of the breast infection, infants who continue to nurse do not become clinically ill. This is OK if there is not a breast abscess (a well circumscribed lump that is tender, warm, and red). Women with a breast abscess (pus pocket) is usually sicker, have higher fevers (100- 103F) chills, sweats, joint and muscle aches. Some infants may reject the breast which leads in continued engorgement and worsening of the infection. Emptying the breast regularly is key. If your infant is unable to empty the breast, you should massage the breast in the shower to express the milk.

### Additional Things To Help Get better Faster.

Continued Nursing  
Warm/ Moist Compresses  
Rest and Fluid Intake  
Decrease Salt Intake  
Tylenol 1000 mg every 6 hours or Motrin 800 mg every 6 hours

### Antibiotics

Dicloxacillin  
Keflex  
Erythromycin

## Contraception while breast-feeding

The World Health Organization and the American College of Obstetricians and Gynecologists (ACOG) have made recommendations for non-hormonal and hormonal contraception during lactation.

**Lactation has limited effectiveness in preventing pregnancy** after the first three months postpartum. Women who breastfeed have a delay in resumption of ovulation. In women who breastfeed full-time without the use of supplements, 93 percent do not ovulate for three months postpartum, and 88 to 89 percent for up to six months. Women who breastfeed full time and are amenorrheic are more than 98 percent protected from pregnancy for the first six months. Women who use supplemental feedings and those who menstruate are more likely to ovulate. **It is prudent to resume contraceptive use** in the third postpartum month for those who breastfeed full-time, and by the third postpartum week for those who do not breastfeed or who do so infrequently.

When breastfeeding, many types of contraception are safe. You can discuss this at your post partum visit. We will cover the reliability of each method and the safety aspects for you and your baby, which will assist you in making an informed decision.

**Suitable methods for breastfeeding women are:**

### **Mini-Pill**

- A progesterone-only Pill, which is taken at the same time every day
- Efficacy rate is 96 percent to 99 percent
- The Mini-Pill contains progesterone only (as opposed to estrogen and progesterone in the Pill).

### **How does it work?**

The progesterone makes the cervical mucus thicken. This mucus then acts as a plug, which prevents the sperm from entering the uterus and fertilizing the egg. The Mini-Pill is 96 percent to 99 percent effective.

The Mini-Pill suits Mini-Pill has no effect on breast milk or the baby

What are the disadvantages/side effects?

- An increased risk of spotting between periods
- Irregular bleeding
- No periods

### **IUD: Copper Para guard and Mirena™**

The currently available intrauterine devices (IUDs) are safe and effective methods of contraception.

What is a **Paraguard** IUD?

The intra uterine device (IUD) is made of flexible plastic with fine copper wire wound firmly around it; the device is placed in a woman's uterus. A nylon string is attached to the stem of the IUD for easy removal by a health care professional.

## Paraguard cont'd

- The copper IUD is an intrauterine device placed in the uterus during a minor procedure. It works to inactivate the sperm and provide a changed intrauterine environment that prevents implantation of a fertilized egg.
- A copper IUD lasts for ten years and can be removed before this, if required.
- The efficacy rate is greater than 99 percent.

How does it work?

Because the copper IUD is toxic to sperm, it prevents fertilization of the egg. The IUD also stops any fertilized egg from implanting in the uterus.

What are the advantages?

- Does not interfere with sexual intercourse
- Cost-effective
- More suitable for women who have had children

What are the disadvantages/side effects?

- Needs to be inserted as an office procedure
- May cause an increase in menstrual bleeding and cramps
- The IUD may expel itself from the uterus, usually during a period. The woman may not be aware that this has happened and should always check that the string is in place after her period is finished.
- There is a small risk of infection in the three weeks following insertion.
- Because pelvic infections can lead to infertility, it is important that a woman with an IUD be particularly careful about protecting herself from sexually transmissible infections
- The IUD may perforate the wall of the uterus. This is a very rare occurrence which may happen when the IUD is being inserted.
- Although rare, when an IUD fails and the woman becomes pregnant, the device must be removed as soon as possible. An IUD in a pregnant woman increases the risk of miscarriage
- There is also the risk of an ectopic pregnancy (where the fertilized egg implants in the fallopian tubes) when the IUD fails (again, rarely)

## **Mirena™**

The Mirena™ IUD is an intrauterine device placed in the uterus during a minor procedure. The shaft of the Mirena™ has a progesterone hormone-infused section that releases progesterone slowly over five years. Very little of the hormone passes into the blood stream. This means that side effect are minimal and only about 10 percent of women will feel any effect. This acts to reduce bleeding which can sometimes be a problem for copper IUD users. The Mirena™ changes the intrauterine environment, thus preventing the implantation of the fertilized egg.

- The Mirena™ IUS lasts for five years but can be removed before this, if required. The efficacy rate is greater than 99 percent.

### Advantages

- Unlike traditional IUDs, Mirena™ does not cause heavy bleeding or vaginal bleeding between periods once it has been in place for some months
- It is almost 100 percent effective
- It can be used for up to five years
- A doctor performs the simple procedure, although it may require a general anesthetic
- Fertility returns, with over 90 percent of women conceiving within twelve months after removal.

### What are the disadvantages/side effects?

- Headaches
- Breast pain and tenderness
- Acne
- Mood changes
- there may be initial irregular bleeding for up to 6 months.

## **Depo-Provera (Depot medroxyprogesterone acetate)**

- An intramuscular injection taken every 12 weeks.
- Best to be started six weeks post-delivery to reduce bleeding problems.
- Is effective in seven days.
- Efficacy rate is 99 percent or greater.
- Most women have a return of fertility 6 to 9 months after the time the next injection would have been given, but fertility can be delayed for up to 18 months after cessation of DMPA. This mode of contraception may not be ideal for women who may wish to become pregnant soon after cessation of contraception.
- It does not decrease milk production.
- It is administered by intramuscular injection and results in effective contraception for three months. Its theoretical and actual effectiveness is 99.7 percent. Its primary action is inhibition of ovulation.

### **Side effects**

- Amenorrhea (no periods)
- Irregular bleeding
- Additional side effects may include acne, weight gain, depression, and headache.

Depo-Provera has been associated with an increase in bone resorption and a significant reduction in bone mineral density. It is not known whether DMPA use will increase the risk of osteoporotic fracture in later life

‡ The diaphragm and male condom are less effective and less convenient than hormonal methods. However, they are the most readily reversible methods and not associated with side effects.

## Sterilization

Sterilization is the most common and effective form of contraception.

While tubal ligation and vasectomy may be reversible, these procedures should be considered permanent, and therefore performed only after careful patient counseling.

**Vasectomy** (ligation of the vas deferens) can be performed in an urologist's office under local anesthesia. It is a safe procedure that is highly effective.

**Tubal obstruction or ligation** refers to any procedure that prevents pregnancy by occluding or disrupting tubal patency. It is usually performed under general or regional anesthesia, either as a laparoscopic or hysteroscopic procedure in outpatients or in postpartum women shortly after they give birth. The techniques used include ligating or removing a section of the fallopian tubes; mechanical blockade using clips, rings, coils, or plugs; and coagulation-induced blockage using electrical current. Laparoscopic sterilization has been the most common technique in women who are not postpartum up until recently where it is now possible to undergo an awake procedure in my office that permanently blocks your tubes. More information about office sterilization can be found at [www.essure.com](http://www.essure.com).

## Diaphragm

- A dome-shaped rubber cap with a flexible ring that fits into the vagina and covers the cervix. It acts as a barrier preventing sperm from entering the cervix.
- It can be used as soon after delivery as is comfortable, but as the birth canal has been stretched for delivery, a fitting is best done at least six weeks after delivery. If a diaphragm were used before pregnancy, a refitting must be done because the shape of the vagina will have changed.
- Efficacy rate is 85 percent to 95 percent.

## Cervical cap

- A dome-shaped rubber cap that fits directly onto the cervix. It acts as a barrier preventing sperm entering the cervix.
- It can be used as soon after delivery as is comfortable. The cervix should return to normal state within six weeks after delivery
- The efficacy rate is 80 percent to 98 percent.

## Condoms

- A barrier form of contraception
- Can be used as soon as the woman feels comfortable enough having intercourse
- If used correctly is effective 95 percent to 97 percent of the time
- Condoms are cheap and widely available from pharmacies, supermarkets, petrol stations, family planning clinics, etc.
- No doctor's appointment or prescription is required

- Condoms are only used when they are needed
- Condoms decrease the risk of contracting STIs.

What are the disadvantages/side effects?

- Condoms are not suitable for men who are not able to achieve a full erection. They may break or slip off. Some people feel that condoms reduce sexual pleasure.
- A very small fraction of the population is allergic to either the latex or the lubricant used in condoms. When this is the case, try using a female condom or a polyurethane condom. Non-latex, polyurethane condoms for men have the advantage of being stronger and thinner than latex condoms. They are also safe to use with oil-based lubricants, and they warm up to body temperature, conducting heat well. They are an alternative when latex allergy is a problem.

**NOTE:** If the condom breaks or slips off during sex, it is important to contact our office within 96 hours as there are forms of emergency contraception that you can take to prevent pregnancy.

### **Spermicides**

Spermicides are not a highly effective method of contraception when used alone (without a barrier method).

Women willingly to accept a moderate risk of pregnancy may choose this method.

The probability of pregnancy for each nonoxynol-9 preparation during six months of typical use was:

52.5 mg **gel** (22 percent),

100 mg **gel** (16 percent),

150 mg **gel** (14 percent), **film** (12 percent),

**suppository** (10 percent).

Although the risk of pregnancy was significantly higher with the 52.5 mg gel, none of the preparations reliably prevented pregnancy.

Spermicides are not recommended for the purpose of preventing the spread of sexually transmitted infections.

**Abstinence** -- The woman is able to decide whether/when she is ready to resume having sexual intercourse.

## It's worth repeating: TV isn't good for children

Article and Opinion by John Rosemond PhD ([www.rosemond.com](http://www.rosemond.com))

From the "I told you so" department: In 1979 I wrote a feature-length article in the Charlotte Observer in which I opined that we knew enough about how the brain develops to conclude with reasonable certainty that television was bad for children.

Specifically, bombarding the developing brain with television's incessant "flicker" was a recipe for a significantly shortened attention span and, by extension, poor impulse control. I emphasized that since all television programs produce said, "flicker," that it did not matter what a child was watching – Sesame Street was as harmful to the developing brain as a high-action movie.

Over the intervening 25 years, I have revisited this theme a number of times, proposing that television was contributing, and significantly so, to the epidemic of attention deficit disorder (ADD).

My recommendation: No television at all prior to the establishment of full literacy, which generally occurs around the age of 8-9. I was ridiculed by a good number of "experts," many of whom excoriated me for "blaming" parents of ADD kids, and called an "extremist" by lots of parents, many of whom pointed out that in moderation, nothing is harmful. Some professionals even went so far as to call my ideas "dangerous."

Now a team of researchers representing some of the best and brightest in the field has determined that even a moderate amount of television watching during the formative years has an adverse effect on attention span. That's all well and good, and I do indeed feel significantly vindicated (apologies anyone?), but said researchers have yet to spell out the obvious: to wit, that a short attention span compromises one's ability to exercise impulse control.

Although by no means the sole cause of ADD, I am confident that further research will find that when television-watching tips over the attention span "domino," ADD is the likely end result. Confirming anecdotes abound, such as the one I recently received from the mother of a now 5-year-old who was, at age 3, an enthusiastic television-watcher whom she says was "mouthy" and belligerent.

One morning, at wit's end concerning the child's misbehavior, she and her husband pulled the plug on the television. She writes, "What happened in the ensuing days (not weeks or months) was amazing. The misbehavior, most of which I put down as being an 'age thing,' went away completely, and the creativity that television had siphoned off emerged with a vengeance."

"Suddenly, tents began appearing in the play room, which became his 'operations center.' He became a chief for a while, then an explorer, then and a scientist. We began the habit of reading the newspaper together every morning, a ritual that continues to this day. The most amazing change occurred, however, was in his overall attitude. He went from surly and belligerent to cheery and cooperative almost overnight.

I hadn't realized how much his behavior had been adversely affected by television, even the small amount that we had previously allowed. Our television had been "broken" now for more than two years. He occasionally watches something at someone else's house but here, in our home, we have completely replaced it with other things too numerous to mention including blessed silence. Today, my former rebel without a cause is a highly energetic, creative, occasionally misbehaving 5-year-old. This experiment had and continues to have a happy ending."

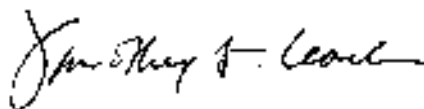
Thanks to said mom for a wonderful and inspiring story, at least I hope it inspires.

## **Dr. Leach's final thoughts and secrets to good parenting**

You spent so much time taking good care of yourself during this pregnancy, purifying and sanctifying the temple as it was by eating healthy and living strong. You may have taken vitamins with essential fatty acids known to have a direct effect on the developing brain and retina. You wanted to do everything just right while you were pregnant, to give your child the gift of a healthy body and mind on their first day of life. **Don't stop now.** Your new responsibility is to nurture their minds (read many books, listen to classical music, expose them to fine arts), teach them the importance about healthy bodies (get outside and play, dance, or hike Mt Diablo so as to not let them get overweight), and by your actions show them the importance of fairness while they learn about good citizenship (we are all created equal). As children they need your protection from the vagaries of TV and the unpredictability of the world, which potentially adulterate their early and formative experiences, thus keeping them from being just "kids". They need and want structure and are hungry for your time and attention. Help them choose their friends wisely by organizing playtime with the kids of parents whose values you share. Don't ask them too many questions about what they want, rather have them pick from a few choices pertaining to what they need. Children are a gift that we unwrap daily and should never be taken for granted. **Active parenting** requires that you are involved in their lives and help them understand the difference between right and wrong. Do not ask some well intended TV/video cartoon character to **passively – parent** and teach those important life lessons that are your responsibility. Good kids come from 24 hour a day parents who realize that raising kids is more important than anything. They are a reflection of your words, actions, and good deeds. Though this job is not rocket science, it is both challenging and very fulfilling when done correctly. Active parenting requires that you show up every day and work hard at having fun. We all have the potential to be great parents by choosing to be involved in the lives of our children. Have a great time and thank you for letting me share in this new beginning.

It has been a joy sharing this important time in your lives and I am humbled by your trust.

Sincerely,

A handwritten signature in black ink, appearing to read "James H. Leach". The signature is written in a cursive, flowing style with a long horizontal line extending to the right.