Women's Clinic of Johnson County

Information for Obstetric Patients

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Dear Patient,

Congratulations on your pregnancy. Our practice is dedicated to providing you with quality obstetrical care throughout your pregnancy, your delivery and your post-delivery period.

We hope you find this booklet helpful in providing information about your obstetrical care and in answering commonly asked questions. Educational brochures will be offered to you throughout your pregnancy to provide more detailed information about many conditions, tests and concerns of pregnancy. Our office is staffed with trained professionals to answer your questions and concerns you may have throughout your pregnancy. Do not hesitate to call us at anytime.

We look forward to working with you throughout your pregnancy.

The Physicians and Staff of
Women's Clinic of Johnson County

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I. OBSTETRICAL VISITS

THE FIRST VISIT

The first obstetrical visit should occur 6-8 weeks after your last menstrual period. The first visit will take longer than subsequent visits because it is designed to give your physician or nurse practitioner information about your general health prior to the pregnancy.

Information will be gathered about your health and the health of your baby's father. You will be asked questions about your gynecological and obstetrical history. Specific questions will be asked about this pregnancy, nutrition and life style (exercise, smoking, nutrition, etc.). It is important to answer each question as completely as possible.

The physical examination at your first visit will include a careful assessment from head to toe. The internal pelvic examination will help your care provider determine if there are any conditions that may affect the pregnancy, labor and delivery. Your blood pressure and weight will also be taken.

The following tests will be performed at your first obstetrical visit. Information from these test results will help your care provider more closely monitor your health and the health of your baby:

- A urine specimen will be obtained to test for protein and glucose. The urine may also be checked for the presence of a bacterial infection.
- A pap smear will be taken
- Blood Pressure and weight will be checked
- Blood will be drawn to perform a number of tests:
  - Blood type/Rh factor
  - Antibody screen
  - Red blood cell count (hemoglobin/hematocrit)
  - Rubella antibody titer (German measles)
  - Syphilis screen
  - Hepatitis B
  - HIV antibodies
- Other tests may be performed as indicated by your particular situation such as toxoplasmosis, sickle cell screen, CMV, or Cystic Fibrosis.

DUE DATE

At your first prenatal visit, an expected due date will be determined. This due date is calculated from the first day of your last menstrual period. Keep in mind that this date is an estimate; rarely are babies born exactly on this date. An average pregnancy is 280 days, or 40 weeks from the first day of your last period or 266 days from ovulation. If your cycles are not regular, it is not as accurate to calculate your expected due date from the first day of your last menstrual cycle. A sonogram may be ordered to help determine the due date.

FOLLOW-UP VISITS

If you are healthy without any specific risk factors, office visits are scheduled every four weeks through the 28th week; then every two weeks until the last month of pregnancy when you should make weekly visits. However, anytime during the pregnancy, do not hesitate to call if you have any concern that would require additional visits.

At each visit, your health care provider will discuss your progress and any problems or questions you may have. Don't be afraid to bring any questions with you to your appointments.

Husbands or any other significant others are always welcome to any of your visits.

Routine assessments obtained at each visit include:

- Weight
- Blood pressure
- Baby's heartbeat (This can be heard at every visit after 10-12 weeks gestation.)
- Uterine Measurement. A tape measure may be used after 20 weeks to measure the height of the uterus in centimeters. This measurement should closely correlate with the weeks of pregnancy
- Urine for glucose and protein
- Assessment for swelling
- Cervical checks routinely after 37 weeks, sooner if needed

Additional tests may be performed or offered throughout the pregnancy (see tests section)

BETWEEN VISITS

If you have any problems or questions during your pregnancy, do not hesitate to call your physician's phone nurse. If you have a medical condition such as a cold or flu and you have a PCP, you may be asked to contact them for care.

AFTER HOURS

After office hours, the answering service will contact the doctor on call who will then contact you.

II. IMPORTANT WARNING SIGNS

Any of the following may signal a need for medical help. Do not hesitate to call if you have a question or concern.

- Severe or persistent headache
- Blurred vision or spots before your eyes
- Severe abdominal pain or cramps
- Severe or persistent vomiting
- Severe, unexplained pain in the shoulder
- High fever over 101 F
- Sudden swelling in your upper body, (face or hands)
- Sudden, unexplained weight gain in just a few days
- Vaginal bleeding
- Gush or flow of watery fluid from your vagina
- Sudden, unexplained decrease in urine output
- Regular contractions, menstrual like cramps, that get worse with time
- Sudden decrease or no fetal movement after the fifth month of pregnancy

III. TESTS DURING PREGNANCY

TIME	FREQUENCY	ASSESSMENT
6 – 8 weeks after last menstrual period	Initial Visit	Antibody screen Blood Type Determination Complete Blood Count Hepatitis B Virus Screen HIV Screen** Pap Test (Thin Prep) Rh Negative and Rhogam Rubella Sickle cell screen* Syphilis screen Toxoplasmosis* Urinalysis
12 – 13 weeks		Ultra Screen
8 – 20 weeks	Visits every 4 weeks	Amniocentesis* Chorionic Villus Sampling*
15 – 20		Serum Maternal Alpha-Fetoprotein X-tra** (triplemarker or triplescreen)
20 – 22 weeks		Ultrasound Fun Scan
24 – 28 weeks	Visits every 2 weeks	Diabetes screening Repeat Complete Blood Count Repeat antibody screen for unsensitized RH negative patients* Administration of Rho (D) immune globulin*
28-30 weeks	Visits every 2 weeks	Kick counts NST Biophysical Profile
35 – 37 weeks	Visits every week	Group B strep screening

* if indicated
** optional test – based on patient preference

IV. TESTS AND DEFINITIONS

We recommend screening of all our pregnant patients with certain laboratory and diagnostic tests. Some patients may require additional testing based on their history or physical examinations. On the following pages is the schedule we follow for laboratory and diagnostic tests. This section contains a brief description of each test. At your second obstetrical visit you will be asked to sign a form acknowledging that you are familiar with the various tests and allowing you to accept or decline various optional tests. If you have any questions or concerns about these tests please discuss them with your physician.

(A) 6 – 8 WEEKS

ANTIBODY SCREEN

The antibody screen is a blood test which will detect antibodies (proteins) made by the mother which may affect the baby.

BLOOD TYPE DETERMINATION

Your blood type can be O, A, B, or AB. Your Rh type is either negative or positive. Most people have a protein on their red blood cells called the Rh factor. These people are Rh positive. People without this protein are Rh negative. A simple blood test tells your blood type and your Rh type.

COMPLETE BLOOD COUNT (CBC)

This test is used primarily to detect anemia (a “low blood count” or “low Iron”) found frequently in pregnant women.

HEPATITIS B VIRUS SCREEN

Babies who contract hepatitis B from an infected mother require special treatment at birth. This blood test will detect mothers who carry the hepatitis B virus but may have no symptoms of the disease.

HIV SCREEN – Human Immunodeficiency Virus

This blood test detects HIV, the virus which can cause AIDS. The test may be negative in women who have contracted the virus in the 6 months prior to testing. Women who have used IV drugs or have a partner who has used IV drugs in the 6 months prior to testing should be retested in 6 months. As HIV screening is voluntary, you do have the right to request that this test be omitted from your prenatal lab.

PAP TEST (Thin Prep) (Smear) or (Cervical Cytology)

This test screens for cancerous and precancerous conditions of the cervix (opening to the uterus or womb). (A pap smear will probably not be done if you have had a normal pap in the last year.) A swab is taken from the cervix and placed in a vial of liquid. The vial is sent to a laboratory where a machine separates the cells from unnecessary material, such as blood and mucus. The remaining cells are then placed on a slide in a clear and uncrowded way. This approach makes the slide easier to read.

RH NEGATIVE AND RHOGAM

A blood test is done in early pregnancy that determines whether or not a mother's blood contains the Rh factor. If the mother's blood contains the Rh factor, her blood is considered to be Rh +. If her blood does not contain the Rh factor, her blood is considered to be Rh -. If the mother's blood is Rh- and the father of the baby's blood is Rh +, the baby may inherit the Rh + factor. In this case, the mother's blood may look at the baby's Rh+ blood as a foreign invader and develop antibodies to the Rh+ baby's blood. This does not affect the first Rh+ baby, but will affect future Rh+ babies. To prevent an Rh- mother's blood from developing antibodies to Rh+ blood, Rhogam (Rh immune globulin) is given by intramuscular injection at 28 weeks of pregnancy to all Rh- mothers. Rhogam will also be given to the mother within 72 hours after delivery if the baby is found to be Rh +. After any vaginal bleeding during pregnancy,miscarriage or abortion, the Rh- mother will also be given the Rhogam injection. If the mother's blood is Rh+, Rhogam is not needed.

RUBELLA

This is a blood test which determines whether you are immune to Rubella (German Measles). Typically, the last rubella vaccine a person receives is at 15 years of age. If you do not retain immunity to rubella after this vaccine, you are encouraged to avoid exposure to anyone who may have the disease. Fortunately, because of standardized immunization, rubella has become rare. If a woman develops rubella during the first three months of pregnancy , a baby may develop severe problems such as brain damage, deafness or heart problems. If you are found to be rubella non-immune in pregnancy, you will receive the rubella vaccine after delivery.

SYPHILIS SCREEN

While syphilis is relatively uncommon, babies exposed to this infection prior to birth may have serious birth defects if the disease is not detected early and treated.

TOXOPLASMOSIS

Toxoplasmosis is a disease that is caused by a protozoa. The disease is usually mild in adults but can be very severe-even deadly-to the developing fetus. Cats and raw meat are the two most common sources of toxoplasma gondii, the parasites that cause toxoplasmosis. To decrease exposure, get someone else to change the litter box if you have a cat. If you or your neighbors have outdoor cats, wear gloves when doing gardening or yard work. Thoroughly cook all meat eaten during pregnancy. At the first prenatal visit, blood will be tested for antibodies to toxoplasma gondii indicating recent or past exposure. If past exposure is found, there is no concern for the developing fetus. If antibodies indicate current or recent exposure, referral will be made to a perinatologist for evaluation and counseling.

URINALYSIS

This test detects sugar, protein and sometimes infection in the urine. A urine specimen will be tested for protein, glucose and possibly for nitrites, bilirubin and/or ketones. The urine may also be checked for the presence of a bacterial infection.

(B) 8 – 20 WEEKS

AMNIOCENTESIS (optional)

Amniocentesis is a diagnostic procedure that can be used to detect certain birth defects and may also be used in later pregnancy to assess fetal lung maturity. This procedure removes a small amount of amniotic fluid (fluid around the baby) by inserting a small needle into the mother's abdomen. An ultrasound is used to precisely guide the needles insertion. Amniocentesis to detect genetic conditions is usually done between the 13th and 16th week of pregnancy. However, ruling out certain genetic disorders does not guarantee the birth of a healthy baby. There are some genetic conditions that cannot be detected by amniocentesis.
Women who may consider amniocentesis include: women over 35 years of age, family history of genetic disorders, previous baby born with genetic/chromosomal condition or birth defect, fetal lung maturity for delivery. Amniocentesis is not risk-free. However, in some pregnancies the benefits may far outweigh any potential risk. Talk to your physician to see if this procedure would be appropriate for you.

CHORIONIC VILLUS SAMPLING (CVS) (optional)

Chorionic villus sampling is a procedure that analyzes samples of chorionic villi (tissue that will become the placenta). It allows for earlier identification of abnormalities that may be found later in pregnancy by amniocentesis. CVS procedure is performed by a perinatologist between nine and 11 weeks of pregnancy. The perinatologist removes the tissue sample by passing a catheter through the cervix under ultrasound guidance . Under some conditions, a needle may be passed through the abdominal wall to obtain chorionic villi. Disadvantages of CVS include a higher rate of complications such as bleeding and miscarriage. You and your physician will discuss if this test would be appropriate for you.

(C) 11 – 13 WEEKS

EARLY SCREEN OR ULTRA SCREEN

Early Screen is a blood test combined with an 11-13 week ultrasound exam which estimates your chance of having a baby with Down Syndrome, Trisomy-18 or Trisomy-13. These are the most common chromosome conditions. They are caused by a change in number or structure of the information within our cells. The risk of having a baby with a chromosome condition increases with the mother's age but can occur at any age.

Early Screen is a screening test which estimates your risk but does not give a diagnosis like CVS or amniocentesis testing. Early Screen may falsely reassure some patients who, even after screening, have an increased risk for other chromosome conditions due to age or family history.

(D) 15 – 20 WEEKS

ALPHA FETOPROTEIN SCREEN

Alpha fetoprotein (AFP) is a substance produced by the baby which can be detected in the mother's blood. The level of AFP is generally higher than normal in cases of certain birth defects, such as spina bifida (open spine). In up to 5% of patients, it may also be elevated when the baby is normal particularly if there was an error in calculating the due date. Spina bifida and related abnormalities

occur in 1 our of every 1000 pregnancies where there is no family history of these abnormalities. Patients with a family history are at higher risk. Low levels of AFP, coupled with low levels of estriol and HCG (all substances which are measured in a blood test) indicate women who are at increased risk of having a baby with Down's syndrome. These women will be offered amniocentesis. When used as a screen this test will detect about 75-80% of women carrying babies with Down's syndrome. We offer this blood test as an optional test to all of our pregnant patients. Women who are 35 years or older or who are otherwise at increased risk for Downs syndrome will also want to consider amniocentesis or Chorionic Villus Sampling.

QUAD MARKER TEST

The quad marker test screens for Down's Syndrome (Trisomy 21), open neural tube defects (such as Spina Bifida), and Trisomy 18. the blood test is optional and is offered between 15 and 20 weeks of pregnancy. The original test employed only Alfa fetoprotein (AFP), a protein produced by the baby's liver and detected in the mother's bloodstream. Used alone, it can detect up to 85% of all open neurotube defects but is less sensitive for Down's Syndrome and Trisomy 18 (25%). When Human Chorionic Gonadotropin (HCG), Unconjugated Estriol (UE3, an estrogen), and Dimericinhibin A (DIA) are added, the detection rate for Down Syndrome and Trisomy 18 are increased up to 60%. The false positive rate is approximately 3-5%. A false positive result can be from miscalculation of the last menstrual period or from undiagnosed twin gestation. If your test results are positive, you will be referred to a perinatologist (specialist in high risk pregnancies) for further evaluation that may include genetic counseling, a Level II sonogram, and possible amniocentesis.

DOWN SYNDROME

Down syndrome (Trisomy 21) is a chromosomal abnormality causing mental retardation and physical malformation. Down syndrome is caused when a baby is born with an extra copy of the 21st chromosome. In the general population, it may occur in about 1 in 750 births, but at age 35 the risk is 1 in 365 and at age 45 the risk is about 1 in 40. You and your physician will discuss the options of amniocentesis or CVS.

Below is a table of the risk of delivering a baby with Down's Syndrome, based on the mother's age at delivery. Risks may vary for women with a family history of genetic abnormalities:

Maternal Age	Risk of Downs Syndrome	Total Risk for Chromosomal Abnormalities
20	1/1667	1/526
21	1/1667	1/526
22	1/1429	1/500
23	1/1429	1/500
24	1/1250	1/476
25	1/1250	1/476
26	1/1176	1/476
27	1/1111	1/455
28	1/1053	1/435
29	1/1000	1/417
30	1/952	1/385
31	1/909	1/385

32	1/769	1/322
33	1/602	1/286
34	1/485	1/238
35	1/378	1/192
36	1/289	1/156
37	1/224	1/127
38	1/173	1/102
39	1/136	1/83
40	1/106	1/66
41	1/82	1/53
42	1/63	1/42
43	1/49	1/33
44	1/38	1/26

(E) 20 – 22 WEEKS

ULTRASOUND

Ultrasound (sonogram) uses high-frequency sound waves to create images of the fetus. A Level I ultrasound may be ordered for a number of different reasons including to determine due date, to evaluate cause of vaginal bleeding, to locate placental position, and to evaluate fetal structures. A screening sonogram is typically ordered at 20-22 weeks. These sonograms may be performed in our Shawnee Mission or Menorah offices. Ultrasounds may be performed earlier or later in pregnancy depending on circumstances of each individual pregnancy. In some cases a Level II sonogram may be ordered. A perinatologist performs this targeted sonogram at their offices. Some instances when a Level II sonogram may be ordered include: positive AFP result, history of a baby born with birth defects, abnormal fetal growth patterns, abnormality found on level I ultrasound, or mother with Type I diabetes. A perinatologist will also perform a sonogram during an amniocentesis to allow for precise location of the placenta, umbilical cord, and fetus before needle insertion.

FUN SCANS

In addition to targeted and screening sonograms, we also offer a service called Baby Windows. These are elective sonograms. We understand that although insurance does not cover non medical sonograms, many moms and families would like to follow the their baby's growth, position, and appearance or confirm the gender. An incredible amount of reassurance can come from seeing an active, happy baby. It is also fun to allow other family members a chance to visit the baby; such as, anxiously awaiting grandparents or a curious big brother or sister. Bonding is enhanced every time we see our baby and realize what a little "person" he or she is becoming.

(F) 24 – 28 WEEKS

GESTATIONAL DIABETES

Diabetes in pregnancy develops in about 2 to 4 percent of pregnant women. This develops as a result of the hormonal alterations of pregnancy. After delivery the difficulty in blood sugar control resolves. Pregnant women are usually tested for gestational diabetes between 24 and 28 weeks of pregnancy. If you were gestational diabetic in a past pregnancy, you may be tested earlier in pregnancy. Management of gestational diabetes involves diet control, exercise, and blood sugar monitoring. With good blood sugar control, a good pregnancy outcome is expected.

GLUCOLA – DIABETES SCREENING

Because the hormones of pregnancy may increase blood sugars in the later part of pregnancy, all pregnant women are screened for gestional diabetes (diabetes of pregnancy). A standard amount of sugar is given in the form of a sweet drink (glucola), and blood is drawn one hour later. If the blood sugar level is normal, no futher testing is necessary. If the level is elevated, a three hour glucose tolerance test is performed to see if you have gestational diabetes.

(G) 28 – 30 WEEKS

NONSTRESS TEST

A nonstress test is used in certain conditions to monitor the baby's health. Usually this test is performed in our office two times a week until delivery. During a non-stress test two belts are placed on your abdomen and your baby's heart rate pattern is recorded. There should be adequate variability in the heart rate and the heart rate should increase 15 beats from the baseline for a minimum of 15 seconds. This increase should take place twice in a 20-minute period

KICK COUNTS – FETAL MOVEMENTS

Most women begin to feel baby's movement during their fifth month of pregnancy (20-24 weeks). Some women feel movement earlier; some women feel movement later. As you get closer to delivery (32-40 weeks) fetal movement may change. You may feel more little movements and nudges rather than big kicks. Between 28 and 32 weeks your doctor may explain Fetal Kick Counts. By counting the baby's kicks, you can determine if the baby is healthy. You should feel 10 baby movements in a two hour time period. If you don't feel this many movements, you should eat a snack or a meal, drink water or juice and lay on your left side for at least one to two hours. If you don't feel 10 movements at the end of the two hour period, call your doctor.

(H) 35 – 37 WEEKS

GROUP B BETA STREP

Group B Strep (GBS) is carried by 15-40% of pregnant women in their vagina and/or rectum. Women may not have symptoms of GBS even though they harbor the bacteria in their vagina or rectum. GBS can be spread to babies during delivery. Although 99% of the babies infected with GBS are completely asymptomatic, 1% of the GBS positive babies become very sick, usually within 6 hours after birth. Cultures of the vagina and rectum are usually done between 34 and 36 weeks of pregnancy. If your test is positive for GBS, you will be treated with intravenous antibiotics during labor.

V. COMMONLY ASKED QUESTIONS

In this section we have included some brief information about commonly asked questions, If you would like more detailed information about any of the following areas or have any additional questions, do not hesitate to ask.

AEROBIC EXERCISE

A regular exercise program during pregnancy can be helpful in dealing with common discomforts of pregnancy. Before beginning an exercise program, consult with your physician. There are certain health conditions that may be present before pregnancy or occur during pregnancy that will prohibit any form of exercise. If you exercised before pregnancy, you can probably continue your exercise routine throughout the pregnancy. Some modifications may have to be made in your exercise routine. Following are some general guidelines:

- Warm up slowly and cool down gradually
- Wear comfortable clothing and shoes. A supportive bra will make exercising more comfortable.
- Keep your heart rate lower than 140 beats per minute and your body temperature less than 100.6 degrees F.
- High-impact aerobics may be too strenuous on your joints; switch to low-impact program or water aerobics.
- Deep flexing or extending joints should be avoided. Jumping, jarring motions or rapid changes in direction should be avoided. Don't do exercises that require bearing down.
- Don't lie flat on your back after you complete your fourth month. The weight of the uterus and the baby can compress major blood vessels and decrease the blood supply to you and the baby.
- Gradually rise from lying on the floor. This helps avoid dizziness.
- Drink plenty of fluids before, during and after exercise.
- Don't overdo it – listen to your body

BATHS

You can take regular tub baths or showers throughout the pregnancy unless otherwise directed by your physician. The temperature of the bath water should not exceed 100 F as this could harm the developing fetus. You should also avoid saunas, steam baths and hot tubs throughout pregnancy but especially during the first trimester. Be very careful getting in and out of the bathtub. Your added weight may make it easy to lose your balance. If your bag of water has broken, do not take a tub bath.

CALCIUM

An adequate supply of calcium is needed to develop baby's bones and teeth in addition to keeping you healthy. If you don't get enough calcium you may be irritable and have difficulty sleeping. You may also have cramps in your legs. An intake of 1200 to 1300 mg. of calcium fortified with Vitamin D per day is recommended. Foods such as spinach, beet greens, chocolate and very concentrated carbohydrates may interfere with calcium absorption. However, drinking chocolate milk is better than drinking no milk at all. Try to avoid soft drinks because they contain large amount of phosphorus, which upset calcium-phosphorus balance. Bone meal or dolomite containing calcium supplements are not recommended because they contain lead. Lead can cross the placenta and can be secreted in breast milk to affect the baby.

CIRCUMCISION

One of the earliest decisions you will make about your baby boy is whether or not to have him circumcised. Despite its common practice, it is not a medical necessity. It is more of a personal decision. Regular bathing and practicing good hygiene can prevent some of the same problems that circumcision does. Discuss this decision with your pediatrician.

CONSTIPATION

During pregnancy the enlarging uterus displaces the digestive system and hormones slow intestinal movement. Some vitamins also can lead to constipation. To help prevent or relieve constipation, drink 10 to 12 glasses of fluids a day; eat raw fruits and vegetables, eat whole grain cereals, and exercise daily. Avoid using mineral oil which can remove vitamins A,D and E. If constipation continues despite everything you have tried, consult with your care provider about the use of stool softeners.

CONTRACTIONS

A) PRETERM LABOR (CALL US)

- Persistent or rhythmic low back pain that feels differently than what you have experienced throughout pregnancy
- Menstrual-like cramps
- Intestinal cramps with or without diarrhea
- Pelvic pressure that feels different from what you have experienced in the past
- Watery discharge or a gush of fluid from your vagina
- Vaginal bleeding

B) CONTRACTIONS OF LABOR

- Occur at regular intervals
- Increase in frequency over time (become closer with time)
- Increase in duration as time passes
- Don't stop by change in position or relaxing
- Cause discomfort in back and lower abdomen with pelvic pressure

C) BRAXTON-HICKS CONTRACTIONS (not true labor contractions)

- Irregular and erratic
- Do not become closer with time
- Do not last longer with time
- Usually feel better with rest and position change
- May cause discomfort in lower abdomen without pelvic pressure or backache
- Do not cause the cervix to dilate

DENTAL CARE

During pregnancy, the mouth's normal bacteria and acid-alkaline balance is altered and may make you more prone to cavities. It is important to continue brushing and flossing daily. If you need

dental care, be sure to let your dentist know that you are pregnant. If you have any medical conditions requiring, prophylactic antibiotics before dental procedures, ask your physician which antibiotics are acceptable during pregnancy. If necessary, dental xrays may be taken with a protective shield being used.

DIURETICS

Many years ago "water pills" (diuretics) were recommended to help pregnant women reduce swelling in their legs. We now know that diuretics flush many needed substances from your body and could harm the baby.

DOUCHING

Douching in pregnancy is **NOT** recommended because it can be dangerous to the baby and you. It can introduce an infection into the uterus; air into your circulatory system; or in late pregnancy, could cause your water to break. If you have douched in the past to treat a vaginal infection, report your symptoms to your physician. She may want you to be seen for evaluation or may prescribe something for you over the telephone.

ECTOPIC PREGNANCY

Normally a fertilized ovum moves down the fallopian tube into the uterus where it implants and grows. Rarely, the fertilized ovum implants in the fallopian tube, abdomen, or pelvis. Women who have had pelvic inflammatory disease, endometriosis, fertility problems, abdominal surgery or previous ectopic pregnancy are at more risk for tubal deformity and also ectopic pregnancy. Signs of ectopic pregnancy include: dull or sharp abdominal pain that may come on suddenly and last; erratic vaginal bleeding which may be lighter or heavier than a usual menstrual period; weakness, dizziness or fainting; shoulder pain. If you experience these symptoms, call your physician. A blood test (HCG) and/or a sonogram may be ordered. If an ectopic pregnancy is diagnosed, surgical treatment may be recommended. In some cases a medication called methotrexate may be used to stop the growth of the pregnancy and allow the body to absorb it.

GENITAL HERPES

A woman who has herpes or who develops herpes during pregnancy will be carefully managed. Herpes causes painful sores or blisters which may affect the labia, vagina, cervix, and rectum. There is no known cure, but there are medications, which can be used during pregnancy. These medications shorten the length of each herpetic episode and decrease the possibility of passing the virus to the fetus during delivery. If you have an active lesion during labor, you will be delivered by caesarean section.

LOVEMAKING

Unless otherwise recommended by your physician, there are no prohibitions against lovemaking during pregnancy. Intercourse will not harm you or your baby. For some women, sexual desire is increased in pregnancy. Other women experience the exact opposite reaction. Whatever the case, lovemaking in pregnancy requires patience and a sense of humor, especially as your size increases. If you experience vaginal bleeding, pain or leakage of amniotic fluid, your physician may advise you to discontinue sexual activity.

MISCARRIAGES

Most early miscarriages (first trimester) result when a flawed ovum and/or sperm cannot develop normally. More than one half of women who experience early symptoms of miscarriage (spotting or cramping) do not lose the pregnancy. In some cases, a hormonal imbalance can be detected and treated successfully. However, if miscarriage does occur in the first trimester, it probably could not have been prevented. As difficult as it will be, if you do miscarry at home, you should try to save the tissue for analysis. Miscarriage can be a very emotionally draining experience for the mother and father. Do not hesitate to contact us if you feel you need professional help in dealing with your loss.

PREECLAMPSIA

Preeclampsia is only experienced in pregnancy and if left untreated, can be dangerous to mother and baby. Preeclampsia symptoms usually develop in later pregnancy. Sometimes the mother doesn't even feel "ill". Symptoms may include sudden swelling, rapid weight gain, high blood pressure and protein in the urine. In severe cases, the mother may experience severe abdominal pain , severe headache or blurred vision. Unfortunately, there is no known cause for preeclampsia. Treatment often involves decreasing daily activity, frequently involving limiting work hours. Bedrest and even hospitalization may be recommended. Because the mother may not feel "ill" in the early stages of preeclampsia, she may not take treatment recommendations seriously. Physicians do not take preeclampsia lightly; you shouldn't either.

PREPARED CHILDBIRTH

Childbirth preparation classes are encouraged. Plan to begin classes in the seventh month of pregnancy. Because some classes are in higher demand than others, contact childbirth class coordinator as early as 24 weeks in pregnancy. Ask our office for the phone numbers to sign up for childbirth classes or contact the hospital you plan to deliver at for the phone number.

TRAVEL

Generally, travel throughout most of pregnancy is permitted unless otherwise indicated by your physician. Most out-of-town trips are prohibited after 32 weeks of pregnancy. Some airlines may discourage flying after 28 weeks gestation. Some things to keep in mind when traveling include:

- Fasten seat belt loosely across lap and under protruding abdomen
- Eat and drink sensibly to avoid dehydration
- Elevate feet if possible
- Wear comfortable clothing and shoes as feet and legs may swell during flight
- Get up and walk around and use the restroom facilities frequently

SEAT BELTS

Wearing a seat belt in pregnancy is as important as it is at any other time. Fasten your seat belt so the lap part of the belt is under your abdomen and the shoulder strap is situated between your breasts. Even with air bags, seat belts are needed for full protection. Death of the mother is a major cause of fetal death in a car crash. Using a seat belt can save your life and your baby's life along with it. You may continue to ride or drive throughout pregnancy as long as your doctor has

not limited your activity. For long trips, stop every 1 to1 ½ hours to walk around and use the rest room. Before your baby is born, purchase an approved child safety seat. This is needed every time you and baby travel.

STRETCH MARKS

About 90% of women have some stretch marks. Stretch marks occur at the cellular level when the skin cannot be as elastic as necessary for fetal growth. The severity of your stretch marks are to a large part genetically determined. Because stretch marks are caused internally, external treatments such as expensive creams will not prevent or remove them. Stretch marks may not disappear totally after delivery, but they will lighten to a silvery color.

VAGINAL DISCHARGE

During pregnancy, women often experience an increase in vaginal discharge. Most of the time this is completely normal and results from increased blood supply and hormonal changes. Unfortunately, some pregnant women experience more vaginal infections due to the vaginal changes during pregnancy. To help prevent infections: avoid clothes that are tight in the crotch, wear cotton panties, wear a minipad, DO NOT douche. If your discharge burns, smells bad, itches or causes swelling, your physician will want to have you evaluated for proper treatment. If the discharge is watery or blood tinged, call your physician.

VARICOSE VEINS

Varicose veins and spider veins are very common in pregnancy and often cannot be prevented. Don't stand for long periods of time. Whenever possible, rest several time during the day with your feet up. Support hose may be helpful.

WEIGHT GAIN

Recommended weight gain in pregnancy is between 25 and 35 pounds. More weight gain is expected if you are underweight at the beginning of the pregnancy, and less weight gain is recommended if you are overweight at the beginning of the pregnancy. Typically, weight gain is distributed throughout the mother and baby. For example:

Baby	7.5 pounds
Placenta	1.5 pounds
Amniotic Fluid	2.0 pounds
Breast tissue	1.0 pound
Uterus	2.5 pounds
Blood	3.5 pounds
Other Fluid	2.75 pounds
Other	3.25 pounds

MATERNAL CLASSIFICATION		WEIGHT GAIN
(Pre-pregnant weight)	Total lbs	Rate (lb/4wk)
Underweight	28 – 40	5.0
Normal weight	25 – 35	4.0
Overweight	15 – 25	2.6

Obese	15 or less	2.0
Twins	35 – 45	6.0

VI. OVER THE COUNTER MEDICATIONS

Many commonly used over-the-counter medications can pass directly through the placenta and harm the baby. Below is a list of some over-the-counter medications that can be taken without consulting your doctor. Caution should be exercised when using herbs and homeopathic remedies. For example, many cough and cold medications contain alcohol that should be avoided in pregnancy. If you have a question about any medication, please call if the medication is not found in the following list:

Cold or Sinus
Tylenol (Plain or E.S.)
Plain Sudafed
Plain Actifed
Claritin
Zyrtec
Musinex
Tylenol Cold

Headache
Tylenol X-Strength

Sore Throat
Chloraceptic Spray
Cepacol Lozenges
Sucrets

Indigestion
Mylicon
Mylanta
Riopan
Gelusil
Maalox
Tums
Rolaids
Gaviscon
Zantac
Pepcid AC
Prilosec

Nausea
Vitamin B-6 100 mg 3 times/per day
Emetrol
Nestrex

Stool Softener
Surfak
Colace - generic
Metamucil (effervescent)
Citrucel
Miralax

Cough
Benylin Expectorant
Robitussin plain or DM

Hemorrhoids
Preparation H
Annusol
Tucks

Diarrhea
Kaopectate
Donnagel- PG
Imodium - AD

VII. SUBSTANCES AND MEDICATIONS

There are many substances legal and illegal that could potentially harm you and/or the baby. If you would like additional information about any of the information in this section, please contact your doctor or your doctor's nurse.

ALCOHOL

Every time you drink alcohol, so does your baby. The placenta does not keep alcohol from the baby. Alcohol use during pregnancy can lead to increased incidence of miscarriage and can also cause a permanent condition called fetal alcohol syndrome (FAS). In this syndrome, babies may be born smaller with possible physical problems such as kidney disorders, heart defects, and genital and facial abnormalities. Fetal alcohol syndrome is the major cause of mental retardation in the United States. Nobody knows how much alcohol is too much; so save any celebrations involving alcohol for after delivery. If you need help to stop drinking during pregnancy, please ask for help!

CAFFEINE

Caffeine is a stimulant and use should be avoided or limited. Excessive use has been associated with miscarriage or birth defects.

MARIJUANA

All the reasons not to smoke nicotine cigarettes in pregnancy apply to smoking marijuana during pregnancy. Smoking marijuana increases the risk of miscarriage, premature delivery or stillbirth. The placenta is often smaller and less healthy making the baby smaller and less developed at birth. There also appears to be a connection between marijuana use and later behavioral abnormalities (hyperactivity/irritability).

SMOKING

Smoking can be very harmful to your baby as well as to yourself. Cigarette smoking decreases the available oxygen to the baby and decreases the placenta's ability to filter wastes from the baby. Women who smoke have a higher risk than nonsmoking mothers of having miscarriages, placental separation (abruption), premature deliveries, and stillbirths. After delivery, babies of smoking mothers are found to be smaller and less well developed. These babies are more susceptible to respiratory problems and more likely to die in infancy. You will never have a better reason to stop smoking. This is also a perfect time for family members to stop smoking. Babies are also affected by second hand smoke. If you need help, talk with your physician.

VIII. OTHER INFORMATION

PHONE CALLS

Routine questions can be answered by calling our office at 913-491-4020 during regular office hours 9:00-4:00 M-F. If you call during this time you will be able to leave a message for your doctor's nurse. The nurse will call you back after she is able to pull your chart. We request that you call during this time as we can provide better care when we have access to your medical records. If you have an emergency or if you think you are in labor please tell our operator so we can take care of you quickly.

AFTER HOURS AND EMERGENCY CONTACT

If you have an emergency or think you are in labor after hours, call the answering service at 913-338-8208 and they will page the doctor. If the doctor does not return your call within 20 minutes, call the answering service again and inform them that you have not received a call yet. (On rare occasions there may be a problem with a pager, etc.)

Emergencies include bleeding, regular contractions or cramping pain (especially if you are less than 37 weeks pregnant), decreased or absent fetal movement (after 20 weeks) or other similar conditions.

PAYMENT POLICY

You are responsible for any fees incurred during your care. For your convenience, we will file insurance claims for you. If your insurance denies a claim we will look to you for payment.

You are encouraged to be sure you understand the terms of your insurance plan. Some tests, procedures or sonograms, may not be covered by your insurance.

All obstetric patients will be assigned an Obstetrical Coordinator who will work with you to answer any questions which may arise. The Obstetrical Coordinator work with you to set up a payment plan for any care that you will need to pay for yourself. You should discuss this with your Obstetrical Coordinator as early in the pregnancy as possible.