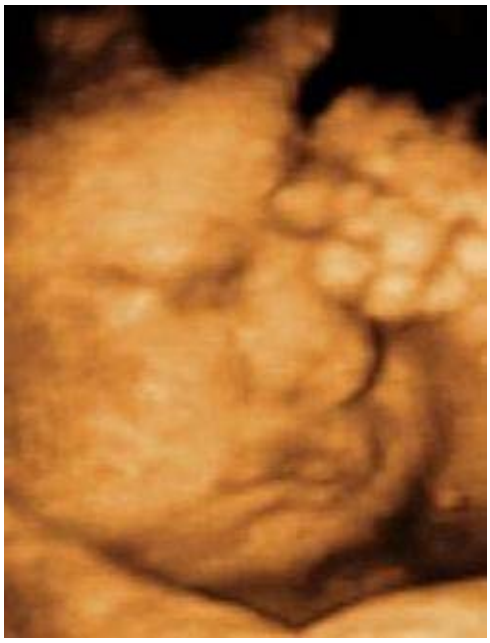
Fair Oaks Women's Health

Convenience • Caring • Cutting-Edge

Pregnancy Guidebook



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Welcome to the practice and congratulations on your pregnancy!

We would like to explain our philosophy and approach to your prenatal care here.

The philosophy of our practice is quite simple. It is our intention to maintain and maximize the health and safety of both you and your baby (or babies!) during the pregnancy, using current and up-to-date medical knowledge and technology along with your input and participation. If any concerns arise, we will discuss them thoroughly so that you understand as best as possible how the situation should be handled.

You should be informed of all your options so that you may actively and intelligently participate in the decisions made for the management of your pregnancy. We respect patients as individuals, and your feelings and opinions are important to us. Having a baby is something that happens only a few times in a woman's lifetime. It is an experience that should be cherished.

Having an open-minded approach to the events of the birth is well advised so that unexpected situations or arrangements do not interfere with your having a positive birth experience. Please discuss your desires with your doctor or any of our staff. Remember, as much as medical safety will allow, we will try to honor your birth preferences and expectations.

Most of our patients are low-risk but our practice is also comfortable with 'high-risk' pregnancy. Many different factors can make a pregnancy high-risk. These include history of previous problems (such as premature birth, diabetes, toxemia), history of infertility or of multiple miscarriages, multiple gestation and advanced maternal age to list a few. We would like you to know that if you become high-risk, we make every effort to provide the appropriate care that you need and deserve.

This book contains a great deal of useful information to help you manage your pregnancy. We discuss diet, vitamins and nutrition; activities that should be avoided while pregnant and others that we feel are safe; approaches to dealing with common symptoms, including some approved over-the-counter medicines; and advice on morning sickness. At the back we have a list of Pediatricians, a pregnancy "homework" checklist, an Index, and an excellent section on postpartum care and breast feeding. We are so glad you decided to let us take care of you for this pregnancy!

Table of Contents

1) FAIR OAKS WOMEN'S HEALTH (FOWH)

Our mission statement will tell you who we are and what we are committed to: which is "to provide exceptional, personalized women's health care in a warm and welcoming environment, to incorporate modern technology in our practice and to be at the forefront of knowledge in our field."

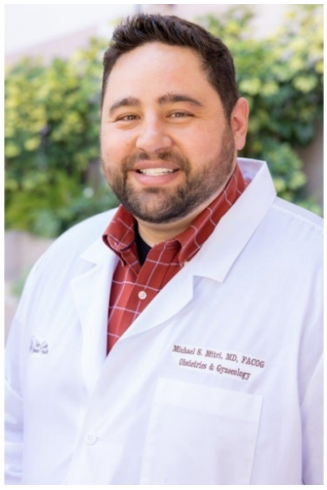
2) OUR PROVIDERS

A. DELLA J. FONG, MD, FACOG

Dr. Della Fong is a Fellow of the American College of Obstetricians and Gynecologists (FACOG) and is Board-Certified by the American Board of Obstetrics and Gynecology since 1998. Dr. Fong received her Bachelor of Science degree from UC Riverside in 1989, earned her MD degree from the UCLA School of Medicine in 1992, completed her Ob/Gyn residency at Kaiser Los Angeles in 1996, and joined FOWH in 2011. Dr. Fong is a busy obstetrician and an excellent Gyn surgeon with a special expertise in laparoscopic as well as vaginal surgery.

Dr. Fong says that "It is a blessing and honor to walk beside my patients during their periods of transition. From the joys of first pregnancy to the changes of menopause and every challenge in between, I promise to provide my patients with the most up to date information to aid their medical decisions and to provide the best medical care I can with thoughtfulness, kindness and compassion."

B. MICHAEL S. MITRI, MS, MD, FACOG



Dr. Michael Mitri is a Fellow of the American College of Obstetricians and Gynecologists (FACOG) and is Board- Certified by the American Board of Obstetrics and Gynecology. Dr. Mitri graduated from UC Riverside with a Bachelor's degree in Biology and also earned a Master's degree in Biochemistry.

He received his MD degree from the Medical College of Wisconsin, completed his Ob/ Gyn residency at Penn State Hershey Medical Center in 2013 and then joined FOWH. Dr. Mitri is a busy Ob/Gyn who is well-skilled in performing complex laparoscopic surgeries, including laparoscopic hysterectomies. Michael's patients have given him over 100 Five Star Yelp ratings, demonstrating he is well loved indeed.

Dr. Mitri is an east side LA native and has grown his family and practice since joining Fair Oaks Women's Health in 2013. He and his wife Maggie moved to Encino in 2021 with their two daughters and their dachshund Daisy to be closer to family. Knowing the importance of family, Dr. Mitri is working hard day and night to care for his OB patients, making sure that they too can safely welcome their own little miracles to the world.

In his own words, "As a caregiver in women's health, I recognize that my role is not only that of physician but also confidant, coach and friend. From puberty to childbirth and through menopause, women experience the highs and lows of what makes us human, and it is an honor for me to help my patients along that journey."

C. SHWETA K. SHAH, DO, FACOG

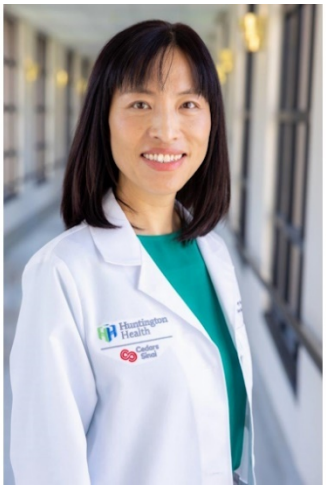
Dr. Shweta Shah is a Board-Certified Ob/Gyn physician and a Fellow of the American College of Obstetrics and Gynecology. In 2019, Dr. Shah completed her Ob/Gyn residency at Baystate Medical Center in Massachusetts. She then moved to New York City where she worked in private practice for the next 3 years.

In early 2022, Dr. Shah moved to Los Angeles and joined our group, and we're happy she is here. Dr. Shah is a delightful person, full of life and energy, and is extremely dedicated to her patients.

Dr. Shah has a fascinating life story. She has lived all over the world, having grown up in Mombasa, Kenya. She was educated in Kenya, England, India and the U.S. She speaks multiple languages including Hindi, Guajarati and Kiswahili. In her free time Dr. Shah loves to walk, hike, travel, go out to eat, and she loves coffee (maybe a bit too much sometimes).

Dr Shah says that "my journey has allowed me to grow personally and professionally; made me culturally competent and given me an opportunity to reflect on my own ability as well as identify areas in need of improvement. I am confident that my perseverance, integrity and dedication will enable me to be a well-rounded physician. Every hurdle I have faced has made me stronger, more mature and taught me new lessons. I am prepared for a lifelong commitment of staying abreast of a complex, dynamic and ever-expanding body of knowledge so I can become the best ob/gyn physician possible."

D. RONG FAN, MD



Like Dr. Shah above, Dr. Rong Fan has also lived in many countries. Shew grew up in Shanghai, China, attended medical school there and also completed a full ob/gyn residency training program. Afterwards she practiced ob/gyn medical care and surgery in China for a while, until she met her future husband, who was a Canadian citizen.

After getting married, Dr. Fan moved to Canada to be with her new husband but she was not able to practice medicine initially. She spent a few years learning English, starting her family, and then due to a special program, Dr. Fan became an RN in Canada. She started working in a High-Risk OB clinic. After a few years doing this, she became eligible for a U.S. medical residency and was accepted into the Ob/Gyn program at the Icahn School of Medicine at Mount Sinai, New York.

In 2023, Dr. Fan completed this residency, passed her written boards exam and became a U.S. Ob/Gyn physician. She joined our group a few months later. Soon Dr. Fan will take her oral exam, the final step to becoming Board-Certified. Dr. Fan is fluent in English, Mandarin, and speaks some Cantonese. Dr. Fan believes in something Mother Teresa said, "Kind words can be short and easy to speak, but their echoes are truly endless." Her patients would agree.

E. AUSTIN MCEVOY, MD

Dr. Austin McEvoy joined our group in May 2024. Her medical career began at the American University of the Caribbean, where she graduated with honors at the top of her class. Her passion for women's health led her to pursue a residency in Obstetrics and Gynecology, which she completed at Nassau University Medical Center in Long Island, New York. At one point, she worked alongside Dr. Rong Fan (above). As a resident physician, Dr. McEvoy demonstrated a commitment to advancing women's health through original research. Her work has been published in peer-reviewed journals and she authored multiple book chapters. Her exceptional academic performance earned her the role of Academic Chief in her final year of residency.

Dr. McEvoy is an advocate for preventative medicine, emphasizing the importance of nutrition, exercise, and the mind-body connection in promoting overall well-being. She applies this holistic approach to all her patients, from new mothers to post-menopausal women. Dr. McEvoy has experience in high-risk obstetrics as well as complex gynecology. Beyond her professional pursuits, Dr. McEvoy enjoys weightlifting, yoga, hiking, and exploring new restaurants. She is fluent in English and proficient in medical Spanish.

Dr. McEvoy says that "As an OB/GYN and women's health advocate, my goal is to always make my patients feel heard and supported. Through shared decision-making, I offer a holistic approach to medicine focusing not only on treating problems, but preventing them as well."

F. MANDY L. LITTLEFIELD, FNP – NURSE PRACTITIONER

Mandy Littlefield, NP earned her Nurse Practitioner Master's Degree at California State University, Los Angeles. Mandy is a Board-Certified Family Nurse Practitioner, and she has chosen to focus her Nurse Practitioner career in Obstetrics and Gynecology.

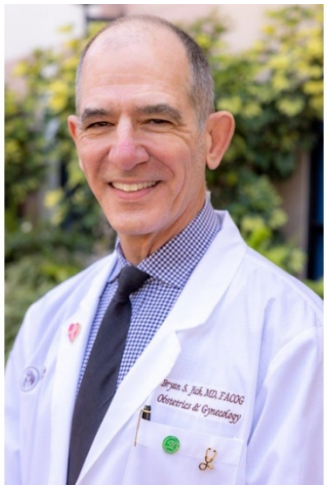
In addition to years of Ob/Gyn experience, during her 20 years in the medical field, Mandy has also worked as a Registered Nurse providing bedside care to critically ill patients in the Cardiac and Intensive Care units as well as providing care during special procedures performed in Interventional Radiology.

Mandy believes in empowering women through education. She strives to provide a welcoming and protected environment to allow her patients to feel free to ask questions and learn about themselves. She is compassionate in providing safe and effective care while promoting health and well-being.

In her free time, Mandy enjoys sports, music, movies, and spending time with her family and friends.

Mandy says, "I enjoy helping women with their healthcare needs. Having two daughters and daily experiences with women, I have learned how important it is to educate women about their health and their bodies. I wish to empower women and I want to be an active participant in their journey to achieving and maintaining a safe and healthy lifestyle. I strive to create a warm and protected environment for my patients, so they feel comfortable asking about and educating themselves about their own health and well-being."

G. BRYAN S. JICK, MD, FACOG



Dr. Bryan Jick is the founder of Fair Oaks Women's Health (FOWH). He is a Fellow of the American College of Obstetricians and Gynecologists (FACOG) and has been Board- Certified by the American Board of Obstetrics and Gynecology since 1990. Dr. Jick graduated Phi Beta Kappa and Summa Cum Laude from UCLA.

Dr. Jick earned his MD degree from the University of California at San Diego in 1984 and completed his Ob/Gyn residency at Kaiser Los Angeles in 1988. Dr. Jick provides a full range of gynecologic and well-woman care. In 2021 he became a Menopause Society Certified Practitioner (MSCP), recognized for expertise in menopause management.

Dr. Jick is married to Marina Jick, RNP, who runs Marina's Oasis, a medical aesthetics spa at FOWH.

H. JENNIFER PARK, MD, FACOG

Dr. Park has been part of Fair Oaks Women's Health since it was founded in 2009. A few years back she changed the focus of her practice to Gynecology care only. She is recognized widely as our resident bio-identical hormone guru, and she has helped thousands of women with menopausal and pre-menopausal hormone problems and treatments.

Dr. Park went to UC San Diego undergrad and medical school in St. Louis, MO. In 2004, she graduated from St. John's Mercy Medical Center Residency in Obstetrics and Gynecology, in St. Louis, MO. She became Board-Certified soon afterwards.

Dr. Park practiced Ob/Gyn in Palm Springs for 5 years, living there while her physician-husband completed his military services as a physician. In 2009, they moved to San Marino where her husband grew up and this is when Dr. Park joined Fair Oaks Women's health as one of the founding physicians.

I. MARINA JICK, MSN, FNP (CALL 626-MY-OASIS) – NURSE PRACTITIONER

Marina (Dr. Jick's wife of 40 years) runs Marina's Oasis, a medical aesthetics boutique located in our office. In 2016, Marina earned her Master of Science in Nursing with a Family Nurse Practitioner (FNP) credential. We are all very proud of her!

Marina is also a Licensed Aesthetician, and she has enjoyed specializing in skin care and medical aesthetics for more than 20 years. She takes pride in making a difference in her clients' appearance and the way they feel about themselves.

With a light personal touch in a soothing, pampering environment, Marina offers corrective and rejuvenating aesthetic services. Her offerings include adult and teen skin care, facial peels, MicroNeedling, MicroDermabrasion, Dermaplaning, Laser and IPL hair removal, Botox Cosmetic®, Juvederm XC®, Volure®, Volbella® and Voluma® XC dermal fillers, IPL, PhotoFacials, Kybella® and more.

Consultations are complimentary at Marina's Oasis, and all questions are welcome! Please contact Marina directly: 626.MY OASIS (626.696.2747). email: marina@marinasoasis.com. online: www.marinasoasis.com

3) OFFICE POLICIES AND PROCEDURES

A. WE ARE A DIVISION OF CEDARS-SINAI

As of April, 2023, Fair Oaks Women's Health joined Huntington Health, an affiliate of Cedars-Sinai! Huntington Health and Cedars-Sinai continue to develop strong partnerships with many well-regarded medical groups in the community, and we're proud to be part of this highly respected health system.

B. OUR ADDRESS

We are located in the Huntington Pavilion Medical Building at the SW corner of California Blvd. and Fair Oaks Ave. Our address is: 625 South Fair Oaks Avenue, Suite 255, South Lobby, Pasadena, CA 91105. (626) 304-2626.

C. PARKING AND DIRECTIONS

Take the 210 Freeway to the Fair Oaks Avenue off-ramp. Head south past about 7 traffic lights. Look for the unmarked driveway a short distance past California and turn right. This will take you to the parking structure for the Huntington Pavilion Medical Building.

Walk to the South Lobby, and we are on the second floor right after you exit the elevator lobby. We do not validate for parking.

D. OFFICE HOURS AND PHONE NUMBERS

- We are open Monday to Friday 8 am to 5 pm and closed for lunch from 12 pm to 1:30 pm.
- We are closed on most major holidays
- Our Main number is 626-304-2626
- Our Fax number is 626-585-0695.

E. E-MAIL AND WEB SITES

- Our Practice Web site: www.fowh.com has contact information.
- Our office e-mail address is: obgyn@fowh.com.
- We accept e-mail from our patients. It is reviewed during office hours only.
- **For urgent matters, please DO NOT send e-mail.** There are times where e-mail may not be looked at for up to 72 hours (a 3-day weekend for example).
- For urgent matters, please call us at 626-304-2626, 24 hours a day.

F. CELL PHONE POLICY – PLEASE TURN OFF CELL PHONES WHILE HERE IN THE OFFICE

We realize that people do not want to miss important calls, but cell phones can interfere with communication between the patient and the doctor or our staff. This can cause delays, or worse can lead to distractions that may result in less-than-optimal medical care and attention.

For the safety and for the privacy of all our patients, we kindly request that all cell phones be turned off or placed in vibrate only mode after you arrive at our office. Furthermore, it is illegal to record audio or video of anything being said or done during your medical visit to this office unless express written permission to record has been given.

Thank you for your understanding.

G. LAB RESULTS

We will always try to contact you once an abnormal lab result has been obtained. Routine blood test results are usually available within 2-3 working days, and culture results within 4 working days. Certain tests take longer. These include the California State afp test, and most DNA tests (such as MaterniT21 Plus, Genetic Carrier Screens, blood or tissue DNA analyses or vaginal DNA swabs). Our on-site lab is part of Huntington Hospital.

We use different labs for different tests. It's possible that some of these labs are not contracted with your health insurance plan. Different plans tend to prefer different labs and it's not possible for us to know which plan prefers which lab because this changes often. If you wish to have your blood work, culture, Pap smear or tissue sample performed or processed at a different lab, let us know in advance. Thank you for your understanding.

H. APPOINTMENTS

We request that you make your next prenatal appointment at the completion of your office visit. Additionally, you can always call during office hours to make an appointment.

Please be courteous enough to call us in advance if you will be late or unable to keep your appointment.

There may be times when, due to emergencies, your scheduled doctor is unavailable. In those cases, you may be able to be seen by another doctor or a nurse practitioner or might be asked to reschedule or to wait a bit longer.

In case of an emergency, we will try to contact you in advance, but this is not always possible. We try to minimize your waiting, and we hope that you understand that one day your doctor may have to make other patients wait because he/she is taking care of your emergency.

We request 24 hours' notice in advance if you will be unable to make your appointment. This allows us to offer the appointment to another patient who needs to be seen. If you do not call and do not come to your appointment, this goes down on your file as a "no-show." Patients with multiple "no-shows" may be asked to find another doctor.

I. OUR "NURSES"

Our back-office staff consists of medical assistants, licensed vocational nurses (LVN's) and Nurse Practitioners. It is common and traditional in a doctor's office to refer to the medical assistants as "nurses". When the front desk connects you to the doctor's "nurse", in most cases you will be speaking with an experienced Ob/Gyn medical assistant, but she is not a licensed RN. An LVN is a licensed medical professional. A Nurse Practitioner is an RN who has gone back to school and earned an advanced practice degree (equivalent to a Master's Degree) and their license and scope of practice is beyond that of an RN, closer to that of a Physician.

J. PRESCRIPTION REFILLS

These are accepted during office hours only. Please do not contact the on-call doctor when the office is closed for a refill unless running out of the medication poses a risk (e.g. medication to treat premature labor). To arrange a refill just call your pharmacy and ask them to call our office.

K. BILLING/BOOKKEEPING

Despite the personal nature of the doctor-patient relationship, the practice of medicine is a business. We agree to be responsible for taking care of you and your unborn baby to the best of our ability. In return, you agree to be responsible for paying your share of all fees and charges incurred.

L. INSURANCE COMPANY ISSUES

It is a good idea to contact your insurance company as soon as you learn that you are pregnant, and again about one month before your due date to be sure that your maternity coverage is valid. Also, you will need insurance for the newborn, which can be provided by either parent's policy. If you are billing your own insurance, you can use our superbill form, which we can provide to you after the delivery. Enter the baby's birthday on the form and send it to your insurance company.

M. CONFIDENTIALITY

Pregnancy can be a stressful time for a couple. Sometimes there are health concerns, tests are being done and medical questions arise. We understand that at times, the spouse or partner of the patient might have questions for us or would like us to report the test results directly to him or her. Due to legal and ethical issues regarding patient confidentiality, we are unable to do this. We are only allowed to share medical information directly with the patient. Patients are entitled by law to strict confidentiality, and we strive our utmost to maintain this.

If the patient would like us to freely discuss their health concerns, questions or test results with their spouse or partner, this can be arranged. We will need a letter written to us by the patient giving us permission to discuss any and all medical visits, findings or test results with another individual (provide their name and relationship to the patient). There is a HIPPA release form authorizing disclosure of your PHI (protected health information).

N. FEEDBACK

We welcome feedback regarding our employees, providers, services, and facility. If at any time you feel unsatisfied, uncomfortable or uncertain about any aspect of your medical care or any interaction with any member of our practice, we want to hear from you. You may choose to write us a letter, send an e-mail or speak to someone not involved in the issue. Our office supervisor is a good place to start. Just call the office and ask for the office supervisor.

Many web sites ask people to rate their interactions with professionals in the community. If you feel that your experience with us has been positive, we would love for you to share this on the web with others.

If you have a complaint, we ask that you deal with us directly rather than immediately post a bad review online. We might be able to resolve it quickly or make amends. There might a simple miscommunication that can be cleared up. It might feel "good" to post that negative review but later you might look back and wish that you had tried less public ways to try and achieve satisfaction.

4) EMERGENCIES AND ON-CALL COVERAGE – CALL 626-304-2626

Our Ob doctors (Dr. Fong, Dr. Mitri, Dr. Shah, Dr. Fan and Dr. McEvoy) take turns being on-call. Even if your own OB doctor is not on call, there is always a qualified FOWH Ob/Gyn physician available 24 hours a day. If you call when the office is closed, you will reach a voice mail system. Listen carefully and follow the instructions.

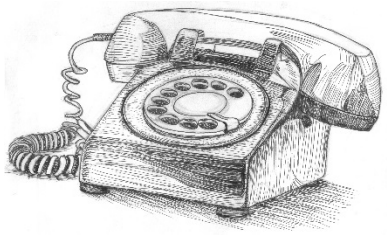
If you have a true emergency please call 911 for the fastest response.

On-Call Schedule

On weeknights starting at 5 pm and on weekends and Holidays, in most situations, the on-call FOWH Ob/Gyn Physician will provide all your emergency medical and OB care including vaginal deliveries and emergency surgeries. We all cover for our colleagues allowing them to be off duty. We trust our on-call colleagues with the care of our patients, and it is important that you trust and respect each of them in case the on-call doctor ends up providing your care.

A. TYPES OF AFTER-HOURS PHONE CALLS:

1. **This is a "life or death" emergency.** Although rare, an emergency like this should be dealt with by calling 911 for the most rapid response possible.



2. **"This is an urgent problem and the doctor needs to be paged immediately."**

3. **Call (626) 304-2626 and listen to the message.**
Press 1 for urgent, and then listen to the next message.
You will be told how to get hold of the on-call ob/gyn doctor.

Use this approach whenever there is a problem that you feel cannot wait until the office is open. When the voice mail message begins, listen and follow the instructions.

4. **If you cannot reach the doctor and the problem is urgent.**

Rarely, there is a problem with the beeper service, or the doctor(s) are actively involved in another emergency. You may then call the direct line to the 24/7 Voice Mail paging service for Fair Oaks Women's Health which is (877) 568-8550. This is the phone number that we Call Forward to whenever the office is closed.

Additionally, for any obstetric emergency after 20 weeks of pregnancy, you may go directly to Huntington Hospital Family Birth Center (626-397-5069). There are nurses and a 24-hour on-call obstetrician available. Because this is the actual phone number for L & D, please use it only if absolutely necessary.

5. **For any non-urgent message for the office that can wait until the office re-opens, there is a "leave a message" option available on our voice mail line.**

7. **CALL AGAIN if you do not get a call back from the doctor within 15 minutes.**

The doctor might be doing a delivery or surgery when you place your call. Also, please do not assume that technology is 100% effective. Phone calls sometimes do not go through. Pagers might have low batteries. Cell phones too. Doctors might be inside a building where the signal is blocked. There are MANY reasons why a doctor might not be returning your call in a timely manner.

If you do not get a call back within 15 minutes, please call the on-call doctor again. Our job is to be available to help you. Your job is to get hold of us if you need our help.

B. OB ED (OBSTETRICAL EMERGENCY DEPARTMENT)

Huntington Hospital has an OB ED (Obstetrical Emergency Department). This is a separate area located in the Family Birth Center. ALL OB patients 20 weeks pregnant or beyond who come to Huntington Hospital for urgent problems or emergencies are directed to the OB ED. There are Ob/Gyn physicians on the premises 24 hours a day assigned to the OB ED.

Reasons to go to the OB ED include conditions such as:

- possible labor or premature labor
- possible rupture of membranes
- vaginal bleeding or spotting
- decreased fetal movement
- suspicious symptoms such as a severe headache or other type of severe pain
- major illness after 20 weeks of pregnancy such as vomiting, diarrhea, asthma, etc.
- evaluation after a fall or accident
- and others

5) YOUR FIRST PRENATAL APPOINTMENTS

A. PREGNANCY CONFIRMATION

Ideally, we would like to have you see either a doctor or a nurse practitioner for an early pregnancy visit, even by 5-6 weeks, if possible. This is called your pregnancy confirmation visit. (We also call it an amenorrhea visit - amenorrhea means “no period”). This visit gives us a chance to make sure you are doing well and to see if there are any signs of a possible problem, such as pain or spotting, that might suggest a risk of miscarriage or rarely an ectopic pregnancy.

During this visit we provide you with some forms and handouts, discuss genetic testing, start your prenatal vitamins and arrange for your first ultrasound and your future physician visits. We also hand out an OB Bag full of useful information and some goodies. Blood work is usually performed also.

Some OB patients are or may later become “high-risk”. For these patients, we often arrange extra visits and extra testing. The doctor will assess your history to see if your pregnancy is high-risk.

If this first visit is with your OB physician, they might provide your OB Consult at this time. If you are seeing the Nurse Practitioner, the OB consult will be soon, usually by 10 weeks.

Please plan on arriving about 30 minutes early for this appointment to make sure all your paperwork is completed. All our forms can be downloaded as pdf documents from our web site.

B. FIRST ULTRASOUND

The first ultrasound visit is very important! It helps establish that the pregnancy is normal and healthy, whether there is one or a multiple gestation, and helps us to accurately determine your due date. This is also an opportunity to get your first baby pictures!

C. THE OB CONSULT

The doctors try to have a consultation with every OB patient ideally by 10-11 weeks pregnant, or perhaps you had your consult at your 6 week confirmation visit. We call this the OBC – OB Consult visit.

The doctor has reviewed your file prior to this visit and if high-risk factors are noted, the consult might be arranged sooner. At this appointment we discuss symptoms you might be having, review your medical history (filled out in advance), ask about your previous pregnancies, and review your labs. A prenatal plan is discussed including decisions to be made such as Genetic testing, frequency of visits and ultrasounds, issues related to delivery, high risk pregnancy determination and any specific medical needs that are present.

D. THE DUE DATE

We calculate the due date using a combination of menstrual timing, ovulation timing (if known), IVF dating (if done), and the results from early ultrasounds. The "textbook" pregnancy due date is based on a 28-day cycle and the normal due date is 40 weeks from the first day of the last menstrual period (LMP).

The true length of gestation is 38 weeks from conception. With a textbook 28-day cycle, conception takes place on day 14. When conception occurs on day 14, the due date is accurate just by knowing the LMP. But ovulation and conception don't always take place exactly on day 14. Some cycles are longer or shorter than 28 days. Some pregnancies start with placement of a frozen 6-day old embryo. Thus, determining the true due date can sometimes be tricky!

Note that the first day you "are late" for your period, you are already 4 weeks pregnant!

If the due date based on LMP is different than the due date based on ultrasound, we need to decide which due date is correct, and this is done by the doctor at the OB consult visit. We always look at how many weeks pregnant you are at each visit, so an accurate due date is essential.

How many months pregnant are you?

Many people think that 4 weeks equals a month, and this is not quite accurate, since a month is closer to 4½ weeks. To know how many months, try this. Calculate that 9 weeks equals 2 months: so at 18 weeks you are 4 months, at 27 weeks you are 6 months and at 36 weeks you are 8 months along.

The first trimester ends at 14 weeks and the second trimester ends at 28 weeks. A pregnancy that is ongoing and viable by 14 weeks has less than a 1% risk of subsequent miscarriage.

E. TRANSFERRING CARE HERE

Sometime patients need to or choose to switch OB doctors in the middle of a pregnancy. We welcome all pregnant patients who'd like to be seen, at any stage of pregnancy. If you've had any OB care elsewhere, please provide us a copy of your medical records, including blood tests, ultrasounds and physician notes. You can mail these, fax them or attach them to an e-mail (obgyn@fowh.com), whichever is easiest !

6) PRENATAL CARE AND TESTING

There are 2 types of testing done during prenatal visits. The first consists of traditional, routine measurements and tests. These include checking your weight, a urine test for sugar, protein or infection, measuring your blood pressure, obtaining the fetal heart tones, monitoring the growth of the uterus and checking for any possible obstetrical complications. During the visit we also encourage you to ask us questions and discuss any and all concerns.

The other category involves tests that are made available to you at specific times during the pregnancy. Some examples of these tests are genetic screening blood tests, ultrasounds, Strep B vaginal cultures, alpha-fetoprotein (afp) testing, and others.

A. BLOOD TESTS -

The first panel of routine tests (we call it the B-1) is usually done shortly after the first visit. Most of these tests are required by State Law. It will include some or all of the following:

- Blood count to check for anemia
- Blood type and Rh factor determination
- Antibody screening for incompatibilities
- Testing for exposure to HIV, syphilis, gonorrhea and chlamydia (all required by State Law)
- Screening for diabetes, thyroid disorders, and other issues such as liver or kidney problems
- Immunity status for German measles (Rubella Antibody) and Chicken Pox (VZV antibody)
- Hepatitis B screening (*see below)

- urinalysis and urine culture to look for infection
- Possible other tests specific to your medical history

*(Hepatitis B, also known as serum hepatitis, can be present in an individual in a chronic carrier state. This means that although the person carrying the Hepatitis B virus may have no symptoms, she can transmit it to her unborn child (transmission occurs at delivery), can transmit it to her partner through sexual relations, and her blood can potentially transmit the disease to anyone exposed who isn't immune. ALL pregnant women are tested for this condition early in pregnancy. More than 1 million Americans are chronic carriers of Hepatitis B. All blood donors are also tested for this, so exposure will not occur from a blood transfusion. A vaccine exists, and currently nearly all newborns receive it. Sexual partners of an individual known to be a Hepatitis B carrier must be tested, and if they test negative, they should be vaccinated.)

NIPT: non-invasive prenatal testing. This optional test checks for fetal DNA in the mother's blood and can help detect possible Trisomy 13, 18 and 21 (and fetal sex) and other genetic conditions and can be done as early as 9 weeks gestation. See ahead.

Nuchal Translucency Screening test – see ahead. This optional test consists of an ultrasound and possible blood tests done at 12-13 weeks gestation.

Alpha-fetoprotein testing – quadruple marker testing. This optional test to check for spina bifida is done about 16 weeks gestational age. It is discussed below.

Another panel of routine blood tests (we call it the B-2) is done about the 7th month (earlier when there are twins or other risk factors). It will include the following:

- Repeat blood count to check for pregnancy induced anemia.
- Repeat antibody screen (if you are Rh negative).
- Screening for diabetes -- the glucola test. The glucola screen for diabetes requires that you drink a solution of 50 grams of glucose (called glucola) one hour before the blood is drawn. This test does not need to be done fasting; it can be done any time of day.
- Repeat syphilis testing.
- Thyroid tests as needed.

B. GENETIC TESTING AND CONDITIONS

1. **Genetic Carrier Testing**

Various labs offer DNA tests for rare genetic conditions, including the tests listed below, and more. In each case, the genetic condition being tested for is a recessive trait (or a mutation) also called a carrier state. The carrier state is invisible, thus the only way to find out if someone is a carrier is to perform a DNA blood test.

If the mother and the father of an unborn baby both test positive for the same carrier state, then there is a 1 in 4 chance that their child could be born with a genetic disease. Some of the diseases that are inherited in this manner include Cystic Fibrosis, Spinal Muscular Atrophy, Tay-Sachs disease and Sickle-Cell Anemia.

Statistics show that when we test for many rare conditions, there is a chance that a person will have at least one rare genetic mutation. In that case, we would test the father of the baby to make sure that he does not test positive for the same mutation.

Please feel free to ask us any questions you may have about Genetic Carrier testing.

2. **Cystic Fibrosis (CF)**

Cystic Fibrosis (CF) is a genetic disease affecting about 30,000 people in the U.S. It is diagnosed early in childhood, occurring in about 1 out of 2,500 births. This condition causes the bodily glands to produce extremely thick secretions or mucus. The lungs, the intestines and the pancreas can be seriously affected. CF is a severe, chronic, debilitating illness with many affected individuals dying as teens or young adults.

One out of 28 Caucasians, Ashkenazi Jews, or persons of European heritage are carriers of the CF genetic mutation, but the carriers are completely unaffected. CF occurs when the newborn inherits two copies of the mutated gene, one copy from each parent. This is called a recessive trait. For a child to be affected, both parents must be carriers of the CF mutation. We can easily detect whether a person is a carrier for the CF mutation. The American College of Ob/Gyn recommends that we offer this carrier test to eligible pregnant women. If the test is positive, then the partner should be tested as well.

3. **Sickle Cell Anemia**

Individuals of African-American descent have about a 10% chance of being a silent carrier for the sickle-cell mutation. The carrier is unaffected, but two carriers have a 1/4 chance of producing an affected child. If both parents are African-American and have not been tested for sickle-cell carrier trait, we would offer to run this test.

4. **Tay-Sachs Disease and Ashkenazi Background**

Tay-Sachs disease is a genetic disease inherited in the same manner as CF (see above). Ashkenazi Jews have about a 1/27 chance of being a carrier for this condition. Ashkenazi Jews also have a 1/29 chance of being a carrier for CF and a 1/40 chance of being a carrier for a genetic disease called Canavan Syndrome. All these carrier states can be identified if looked for. If both parents are of Ashkenazi heritage, then a panel of tests specific to Ashkenazi is advised. This panel tests for more than 20 rare conditions. Both Tay-Sachs disease and Canavan disease cause progressive neurological deterioration and are incurable. Even with the best medical care, infants born with either of these conditions usually die by age 5. For more information go to: www.jewishgeneticdiseases.org.

5. **Spinal Muscular Atrophy (SMA)**

What is SMA?

Spinal Muscular Atrophy (SMA) is a rare inherited disease characterized by muscle atrophy and loss of motor function, caused by the absence of or defect in the Survival Motor Neuron 1 (SMN1) gene. This gene ensures the survival of a motor neuron protein (called SMN) and this protein is critical to the survival and health of motor neurons, which are nerve cells in the spinal cord responsible for muscle function. As the muscle motor neurons become unhealthy due to the reduced levels of the SMN protein, muscles progressively weaken and eventually become paralyzed.

According to the American College of Medical Genetics, SMA meets established criteria for population-based genetics screening. It is a severe disease, there is a relatively high frequency of gene carriers in the population, and an accurate genetic test is available, along with prenatal diagnosis and genetic counseling. Therefore, this test should be made available to all families.

6. **Fragile X Syndrome (FXS)**

What is Fragile X Syndrome?

Fragile X Syndrome (FXS) is the most common cause of inherited mental impairment (or mental retardation). This impairment can range from learning disabilities to more severe cognitive or intellectual disabilities. FXS is the most common known cause of autism or "autistic-like" behaviors. Symptoms can also include characteristic physical and behavioral features and delays in speech and language development.

Fragile X Syndrome is an X-linked genetic disease This means that the mutation exists on the X-chromosome. X-linked conditions are more severe in males than females, because males have only a single X-chromosome (males are 46 XY) and females (who are 46 XX) have two, so one gene might have the mutation but the other gene will be normal. Other common X-linked genetic diseases are hemophilia and color blindness, also much more common in males. X-linked inheritance means that half of the children of carrier mothers will receive the mutation. If the father is the carrier of the mutation, none of the sons and all of the daughters will receive the mutation.

Approximately 1/350 females and 1/1,000 males carry the FXS mutation and about 4% of males and 8% of females of Northern European descent will carry the mutation. Approximately 1/4,000 males have Fragile X Syndrome. Testing for FXS is recommended for individuals seeking reproductive counseling who have a family history of Fragile X syndrome, a family history of undiagnosed mental retardation or a woman with a family history of premature ovarian failure.

C. CHICKEN POX IMMUNITY

Chicken Pox is caused by a virus called Varicella Zoster. If someone has ever had chicken pox, they are generally forever immune, and the unborn baby cannot get the chicken pox even if the person is exposed to it while pregnant. If a woman is pregnant and develops chicken pox, there can be serious harm to the unborn baby.

D. NON-INVASIVE PRENATAL TESTING (NIPT) – FETAL DNA BLOOD TEST

Many expecting parents worry that their unborn baby might have Down Syndrome or some other genetic abnormality. Genetic diseases nearly always develops after conception and therefore are rarely inherited from the parents. Amniocentesis has long been available as a diagnostic test but poses a small risk of losing the pregnancy.

The NIPT blood test (sometimes called cell-free DNA) can be done on the mother's blood and can determine with over 99% accuracy if the baby she is carrying does or does not have Down Syndrome and other genetic conditions as well. The test is generally referred to as NIPT (non-invasive prenatal testing) and is offered by many different labs. One version of the test that we like is called the MaterniT21 Plus test, available from Integrated Genetics (a division of LabCorp).

Down Syndrome, also called Trisomy 21, means that the fetus has 3 copies of chromosome 21 instead of the normal 2 copies that the rest of us have. The MaterniT21 Plus test can identify microscopic fragments of DNA from the baby that are present in the mother's bloodstream. The amount of DNA from fetal chromosome 21 is compared to DNA from all the other chromosomes in the blood sample (mother and baby). If the amount of chromosome 21 DNA is normal, then the baby does not have Trisomy 21.

The MaterniT21 Plus test full report includes testing for Trisomy 21 (Down Syndrome), Trisomy 18 (Edward Syndrome), and Trisomy 13 (Patau Syndrome). Fetal sex determination (gender) is provided. Detection of abnormal amounts of X or Y chromosome DNA can identify what are called SCA's (sex chromosome anomalies) such as X0 (45-X or Turner Syndrome), XXY, XYY and other types of SCA's (mosaics for example).

Microdeletion syndromes can be detected using this test. This is when a piece of a chromosome is missing. There is a full genome version of this test which checks all 23 chromosome pairs. There is a new version of the test called a "reflex" which starts with Maternity-21 Plus and then automatically tests the full genome (23-pairs) if anything abnormal is found on the 21-plus test.

In conclusion, a simple blood test, done as early as 9-10 weeks of pregnancy, can in the great majority of cases provide needed reassurance to concerned expectant parents by providing fetal DNA information - all done without posing any risk of pregnancy loss or having to go through an invasive medical procedure.

COST ISSUES with NIPT TESTING

NIPT tests are expensive and sometimes are not covered even when we think they should be. Some labs will limit the patient's out-of-pocket expense even if the test is denied by the insurance. Some will approve the test but will apply your costs to your deductible. We can help you work through this issue, but you might wish to contact your health insurer if you plan to have this test done to find out what your cost is. There is a cost estimation program online for the MaterniT21 Plus test.

Click here for an online cost estimator program: https://womenshealth.labcorp.com/patients/cost-estimator#/

E. NUCHAL TRANSLUCENCY

A Nuchal Translucency ultrasound (the NT Scan) is ideally done between 11 and 13 weeks gestation. The ultrasound examines an area on the back of the neck of the fetus, called the nuchal translucency (NT). If the NT is enlarged, this can be a sign of possible Down syndrome or other anomaly (such as Turner Syndrome, Trisomy 18, congenital heart defect, and others). We are certified by The Fetal Medicine Foundation to provide this test. If the NT scan is abnormal, further testing of the fetus is advised.

Some centers do blood work with the NT ultrasound. If NIPT was done, blood work is not needed. If NIPT is not done, the NT scan and the blood work can all be normal, and in a small percentage of cases, a Down Syndrome baby can be missed.

F. ALPHA FETOPROTEIN TESTING (AFP)

Alpha-fetoprotein (afp) screening (also called quadruple marker testing) can help identify fetal spinal cord or cranial defects (also known as neural tube defects or NTD's), chromosomal abnormalities as well as other possible birth defects. It is a blood test (on your blood) taken at about 16-18 weeks of pregnancy. Four components in your blood are measured so this is why it is also called the Maternity Quad Screen.

The results of this test are combined with the results of the Nuchal Translucency Test (if it was done) to provide us with a single number to represent the overall risk of Down Syndrome in the pregnancy and another number to represent the overall risk of Trisomy 18 in the pregnancy. The afp test also provides results on the risk of spina bifida, something that the NT test does not.

A normal test result (called ***Screen Negative***) means the following. First, it is extremely unlikely that your baby will have an open spinal or cranial defect (i.e. spina bifida). Second, it is also highly unlikely that Down's syndrome or any other chromosomal abnormality is present.

An abnormal test result is called a ***Screen Positive*** result. This does not mean that your baby will have a defect. In fact only about 1-2 % of all Screen Positive pregnancies turn out to have an abnormal fetal condition. **A Screen Positive test result only suggests that further study is needed.**

If an NIPT test was done and showed negative for Down Syndrome, our policy is to only look for spina bifida, which can be associated with a high level of afp in the mother's blood. The report will not reveal a Down Syndrome risk score due to the NIPT being a far more accurate test.

If there is any abnormality with your alpha-fetoprotein blood test, you will be referred to a specific testing center, authorized for afp follow-up by the State of California. Please see our web site for a more detailed discussion on afp testing.

G. CALIFORNIA STATE PRENATAL SCREENING PROGRAM

Our office has carefully studied the State of California (CDPH) prenatal program. They offer NIPT but do not test for micro-deletions. They do not provide an NT scan. It does not cover any parental genetic screening.

Our group has decided to provide just the California State afp test. The other tests we order are more comprehensive that what is provided by the State, and are nearly always covered by private medical insurance.

H. ULTRASOUNDS (ALSO CALLED SONOGRAMS OR SCANS)

Ultrasound during pregnancy has been available for more than 30 years. Its safety in pregnancy has been studied extensively. To date there are no documented adverse fetal side effects from ultrasound. However, as with all biological tests, it is impossible to guarantee its absolute safety.

1. Routine ultrasounds: Every patient is scheduled for a minimum of 3 ultrasounds during the pregnancy.

a) The first routine is about 7-8 weeks gestation. We call it the "check viability" ultrasound. This is to make sure that the pregnancy is normal and healthy (or viable), to establish the due date accurately, and to see how many babies there are (twins occur about 1% of the time).

b) The second routine ultrasound is about 18-20 weeks gestational age. It is designed to help assess the growth, development and anatomy of the baby, looking for possible major birth defects. Any abnormal findings will be carefully followed up on.

c) The third routine ultrasound is at about 30-32 weeks. This ultrasound helps in managing the third trimester. We check the size and position of the baby, checking for breech position, look at the placenta and the amniotic fluid, and measure the Umbilical Cord Doppler flow (discussed below).

2. Doppler Ultrasound

Doppler ultrasound is used to examine blood flow through vessels located in the umbilical cord, the placenta and/or the baby's heart and brain. We do a Doppler flow study at 32 weeks and with every growth scan. Doppler ultrasound measures the resistance to blood flow. A higher resistance means that the baby's heart is working harder to pump its blood, a possible early sign that the baby might not be receiving enough blood flow from the placenta.

3. "Detailed" Ultrasound

This consists of a highly detailed evaluation of fetal anatomy. Special concerns are the inspection of the fetal brain, heart, spine, renal (kidney) system, gastrointestinal system, skeletal system, and craniofacial anatomy. This type of ultrasound is generally reserved for patients who have previously had babies with birth defects, patients "at risk"

for babies with birth defects, patients undergoing amniocentesis, or patients with other pregnancy risk factors possibly affecting fetal well-being. We refer patients to a perinatal specialist for this exam as needed.

4. **Cervical Length Ultrasound**

We can measure the length of the cervix at various stages of pregnancy. In particular, between 16 and 28 weeks, we can identify if the cervix is becoming progressively shorter. A normal cervix is longer than 25 mm, often 40 to 60 mm long. A "short" cervix is considered a risk factor for premature birth or possibly incompetent cervix. Being able to detect the short cervix before anything else has occurred might allow us to possibly prevent a pregnancy loss or a premature birth. Every patient has their cervical length looked at during their 18-20 week ultrasound and high risk patients are scanned earlier than that and repeatedly. Often this scan requires a vaginal approach.

5. **Growth Scan**

If we need to measure the size and weight of the baby, we perform a "growth scan." Sometimes we do these on a regular basis such as every 2 weeks or every 4 weeks. This helps to make sure the baby is continuing to grow at the rate expected. Slowdown in growth or weight gain or decrease in amniotic fluid are possible signs of a malfunctioning placenta and might require early delivery or other medical interventions. These are done quite often in the third trimester for twins and other high-risk conditions like high blood pressure.

6. **Follow-Up Scan**

This type of scan is brief, usually to check fetal and placental position and amniotic fluid volume. We often do these during our high-risk protocol which starts about 32 weeks and involves a non-stress test twice a week and an ultrasound weekly. One scan is for growth (see above), alternating a week later with a quick follow-up scan.

7. **Fetal echocardiography**

Fetal echocardiography is a type of specialized ultrasound. This means that the ultrasound and Doppler are used to carefully inspect the fetal heart. Abnormalities in the heart's structure (the chambers, the blood vessels leading to and from the heart and the heart valves) and the heart's function can be detected. Not all are serious, and many resolve spontaneously either during pregnancy or after delivery. Some are serious, however, and may require further evaluation and treatment. **We refer patients to a specialist for this exam as needed.**

8. **3-D (Three-Dimensional) Ultrasound**

Using 3-D (and even 4-D) technology, it is possible to obtain a detailed three-dimensional ultrasound image. With the use of surface rendering techniques, one can see body parts in 3D such as the face, limbs, etc. almost like looking at a sculpture. Although not a standard ultrasound, there may be situations where a valid medical indication suggests a need to perform a 3-D scan. Some people arrange to have one just to be able to "see" their baby before it is born. 3-D and 4-D Ultrasounds are now available here in the office. This technology can provide startlingly life-like views of the fetal face and body. Please ask the front desk about our 3D/4D package.

9. **Limitations of Ultrasound – not all birth defects can be seen or detected**

It is important to be aware of the limitations of ultrasound. At the minimum, proper detection of abnormalities requires good equipment, a well-trained ultrasound technologist or doctor and a detectable abnormality. Not all abnormalities are detectable. Sometimes the abnormality shows up later in pregnancy and is not detectable earlier. Sometimes the abnormality is so small that it is not "seen" during the exam (e.g. small holes in the heart). Sometimes the position of the baby, the placenta and the amniotic fluid are such that the abnormality is obscured.

Rarely a small spinal cord abnormality called a meningomyelocele can be missed if it is low in the spine and the backside of the baby is pressed against the uterine wall. Sometimes babies are born with visible abnormalities that are not looked for during ultrasound (such as how many fingers per hand). Some abnormalities present at birth are not detectable during routine ultrasound (such as newborn hearing deficits). Some unusual heart defects can be missed on normal anatomy scans. We do our best to detect what can be detected, but there is still the possibility that our ultrasound may fail to detect a condition that is discovered after the baby is born.

I. CVS (CHORIONIC VILLOUS SAMPLING)

After ten weeks of pregnancy, through a procedure known as CVS, a tiny sample of the placenta can be removed and chromosomal studies of the fetus can be done. The advantage is earlier detection of a chromosome abnormality. With CVS there is a slightly higher risk of miscarriage compared to amniocentesis, about 1 percent overall. Due to

this elevated risk, we tend to advise CVS only when the likelihood of a genetic abnormality is increased, such as for pregnant women at or beyond age 38-40, those with a family history of a genetic defect, those with a previously affected child or perhaps an abnormality was detected on an ultrasound exam or NIPT test.

Micro-Array DNA Testing

This type of DNA analysis can find much smaller chromosome abnormalities compared to the traditional DNA analysis called a karyotype. This allows for the detection of DNA microdeletion conditions. Many of these microdeletion DNA conditions have been identified. Some are known to cause disease, some are known to be normal variations, and some have not been adequately studied yet. This can be "added on" to a CVS analysis.

J. AMNIOCENTESIS

Most patients nowadays are doing the NIPT test which checks for fetal DNA in the mother's blood. Because of this, we rarely send an OB patient for an amniocentesis. This is a big change in obstetrical practice brought about by the advancements in DNA testing technology. We discuss it here for the sake of completeness.

Amniocentesis is a simple office procedure involving the removal of a small amount of amniotic fluid (the fluid which surrounds the baby). It is performed most often at about 16-17 weeks (a "genetic amnio") to evaluate the fetal chromosomes (e.g. to determine the presence of Down Syndrome). We also learn the fetal sex from the amnio and we learn the level of alpha-fetoprotein (afp) level in the amniotic fluid.

The primary risk of amniocentesis is miscarriage. This may occur in about 1/250 to 1/500 procedures (2-4 per 1000). The risk of injuring the fetus with the amniocentesis needle is very low. Generally, results are available about 10 days after the amniocentesis is performed. We call all patients with their results as soon as they are available. A test called FISH (fluorescence in-situ hybridization) can provide preliminary results in as little as 2 days.

K. STREP B SCREEN (GBS)

Group B Strep (GBS), also called Strep B or Beta Streptococcus (Strep B) is a bacterial strain found in up to 30% of women. It is a normal inhabitant of the vagina and is not considered an infection. There are no symptoms and no associated vaginal discharge. Following the guidelines of the American College of Obstetricians and Gynecologists (ACOG), we perform a test for Strep B at about 35-37 weeks. If the test is positive, we note this in your record and we instruct you that you will need intravenous antibiotics when you are admitted to the hospital in labor, or if any premature labor develops.

If you test positive for GBS, please mention this diagnosis to your labor nurse at the time you are admitted in labor or if your membranes have ruptured. This helps to ensure the promptness of your treatment.

7) NUTRITION, WEIGHT GAIN, VITAMINS & CALCIUM

A. NUTRITION AND WEIGHT GAIN

One of the foremost concerns a patient has about pregnancy, other than having a healthy baby, is her weight gain. Let us be blunt…You will gain weight during pregnancy! We try to focus more on eating a healthy diet instead of counting every pound.

Overall: The average weight gain during pregnancy is 30-40 pounds and this is probably too high. Many women gain more than 50, and some up to 100 pounds (yes, this does happen). If a woman starts pregnancy at a normal weight, our opinion is that 25 pounds is a great weight gain, although a difficult target to achieve, as many women will gain more than this. Please keep in mind that 6 weeks after a normal delivery, weight loss is about 15 pounds from the final pregnancy weight, so even if pregnancy weight gain is just 25 pounds, there is usually still about 10 pounds to lose to reach the pre-pregnant weight.

Nutrition: There is really no specific diet that one should eat while pregnant. A common-sense balanced diet is the key. Proteins, carbohydrates, fruits and vegetables – you should eat some of each every day. Vitamins and supplements can be beneficial (see ahead). Three servings per day of dairy can provide enough calcium. Non-meat eaters can get sufficient protein from nuts, eggs, fish, dairy, protein powder and/or meat substitutes. Weight gain can be reduced by cutting down on high-fat and high-carb foods such as chips, fried foods, salad dressings, cheeses, baked goods and sweets. Minimize fruit juices (very high sugar content).

Protein sources: Protein is the most important nutrient during pregnancy but large quantities are not required. Experts debate the exact number but around 75 to 100 grams per day of protein for a one baby (singleton) pregnancy is enough. Women carrying twins need more. Good sources of protein include beef, veal, chicken (breast is healthier), turkey (breast is healthier), pork, lamb, bison (low fat), organ meats (liver, etc., but these are higher fat), shellfish (cooked, not raw), salmon, and other small fish. Fish should be smoked (lox) or cooked, not raw. **Avoid tuna, swordfish and other high mercury fish.**

Other protein sources include yogurt (unsweetened is healthier and Greek yogurt is high protein), cheese, milk, kefir, eggs (very healthy during pregnancy), nuts, nut butters (peanut, almond, these are great snacks), soybeans, tofu, meat substitutes, non-dairy "milks" (almond milk, soy milk), vegan proteins (beans, legumes, lentils, corn) and protein powder (add to smoothies).

Vegans are normally well informed on how to get enough protein, and especially how to get all the essential amnio acids by combining various foods in one meal (complementary protein sources).

Eating Pattern: We recommend that pregnant women try to eat 6-7 times per day. Something should be eaten about every 2½ to 3 hours. Try not to let yourself get too hungry because the blood sugar can drop causing unpleasant symptoms such as irritability, cravings for junk food, even lightheadedness. A good snack combines carbohydrates and protein, such as peanut butter and bread, cheese and crackers, milk and a bran muffin, nuts, protein bars, or cottage cheese and fruit. Have vegetables with meals. Carrots by themselves would not be a good snack item.

1st trimester: Many patients experience varying degrees of pregnancy sickness. In turn, this can affect their weight. Frequent vomiting may cause weight loss in the first trimester (see Chapter 11). Frequent nausea, without much vomiting, may lead to low food intake and limited weight gain. Alternatively, many find that only high-calorie, carbohydrate and fatty foods (so-called “comfort foods) help them to quell the nausea resulting in weight gain during the first trimester, despite the presence of nausea (not fair!). If the appetite is not normal, focus on protein-rich foods, soft fruits and easy-to-digest vegetables. It might be better to minimize salads and high-fiber. Goal: Gain 0 to 10 lbs. during the first trimester.

2nd trimester: For many women, the appetite comes roaring back. This is the trimester of more rapid weight gain. It is possible to eat 6-7 meals a day and still get hungry between meals. And food seems to taste so good! One way to balance the weight gain is to increase calorie-burning activities. Walk every day, swim, do something aerobic. Goal: Gain about 3-4 lbs. per month during second trimester.

3rd trimester: Patients tend to get full more easily, especially the last 1-2 months. However, water retention may occur, causing the weight to go up despite not eating as much. Water weight gain will come off after delivery, but this can take weeks. Goal: Gain about 2-3 lbs. per month third trimester.

Total: Gain about 25 pounds total for the entire pregnancy. Patients who are heavy at the start of pregnancy can safely limit their weight gain to under 25 pounds. Please discuss these concerns with us.

Water Retention: Many pregnant women experience swelling (we call it edema). It might start in the feet and then later show up as leg swelling. Sometimes the vulva will swell also. Water retention is due mainly to pregnancy hormones (such as progesterone), and it can add lead to more weight gain than expected. The excess water will be eliminated postpartum, usually in the first 2-4 weeks. We have seen patients lose 40-50 pounds after childbirth due to elimination of excess water retained while pregnant.

B. VITAMINS, CALCIUM, IRON, DHA

We recommend that you take prenatal vitamins throughout the pregnancy and for the duration of breast-feeding, or at least until the six-week postpartum checkup. During the first trimester, vitamins may aggravate pregnancy-related nausea. In this case, take only the folic acid, 1 mg. daily, until the nausea has abated. We do not suggest any particular brand.

Every pregnant woman needs a minimum of 1000 to 1200 milligrams daily of Calcium, equivalent to about 3 to 4 dairy servings daily. Dairy sources include milk, yogurt, cottage cheese, cheese, tofu, soymilk and ice cream (limited!). Supplementation is advised (usually 300 to 600 mg. daily) if this dairy intake is not met.

We do not routinely put patients on an iron supplement. There is a lot of iron in the prenatal vitamin (but not in GUMMY versions, see below), and iron can be constipating. However, if your lab tests show anemia, we may ask you to take extra iron.

Evidence suggests a fetal benefit from omega-3 and omega-6 vitamins, found in fish oil or flaxseed oil. The fish oil does not have the mercury risk as does certain fish (read the labels). Many prenatal vitamins are incorporating DHA (one of the omega-3 fatty acids), and this has become a standard supplement for pregnancy.

C. PRENATAL VITAMINS AND SUPPLEMENTS WE RECOMMEND

- There are various vitamins and supplements we advise for pregnancy such as extra iron, extra folic acid, extra calcium and Vitamin D, extra DHA. It's not easy to get all these in a single prenatal vitamin (PNV) so sometimes additional supplements are necessary.

- Prenatal Vitamins (PNV): Over-the-counter (OTC) prenatal vitamins are usually fine at providing many of the extra nutrients needed during pregnancy. Some OTC prenatal vitamins contain a large number of herbs, supplements, and chemicals. People seem to think that the more stuff on the label, the better the vitamin. We don't feel that way. For example, Nature Made PNV, which are great, run about $6 per month and some "designer" PNV with 180 pills per bottle cost over $100 but the fine print says to take 6 pills a day, making the cost over $100 per month. Most of that extra "stuff" is present in very low amounts and not proven or shown to have any additional health benefits.

- Prescription PNV are sometimes necessary for medical reasons, such as a folate metabolism genetic condition known as MTHFR.

- Calcium with Vitamin D: Most PNV have a little calcium, but not enough. Most calcium supplements contain calcium carbonate, the lowest cost form of calcium (Tums, OsCal). This has low absorption by the body, which can lead to GI side effects such as bloating and gas. We prefer CitraCal or Caltrate calcium, with about 1,000 units of added Vitamin D, once daily.

- Iron: Most contain ferrous sulfate. The body does not absorb most of the iron you swallow. Excess iron comes out in the stool, causing it to turn dark. Iron can also cause GI side effects such as heartburn and indigestion. It should be taken with meals, usually dinner. We like Slow-Fe, a slow release form of iron.

  There are liquid iron preparations that many people prefer to iron pills. One liquid iron we like is called Floravital. Take 1-2 tablespoons a day. Available on amazon.

- DHA: Also called omega-3 fatty acids. Most Prenatal Vitamins now contain DHA so an additional supplement may not be necessary. Nordic Naturals has an excellent high-quality line of DHA.

- GUMMY VITS: We **do not advise** taking Gummy PN Vitamins. They are lacking in important nutrients, especially iron. They leave it out for fear that children will eat these vitamins as candy and iron can be poisonous for small children. It is shameful that they are labeled as prenatal vitamins when a key ingredient is lacking. If you love your gummy prenatal, please take extra iron daily!

8) NORMAL VS. HIGH-RISK PREGNANCY

Many patients come to us because they have had problems in a previous pregnancy, have health conditions that can cause increased risks of pregnancy complications, or sometimes both. For example, we see many patients with multiple gestation, with pregnancy after previous infertility, with pregnancy after age 35, with a previous complicated pregnancy or history of pregnancy loss.

Additionally, we are always aware that a patient whose pregnancy begins seemingly normal can develop problems later that will cause the pregnancy to become high-risk.

One aspect of our practice that we are proud of is our ability to offer nearly all necessary OB medical services here in our office. We perform ultrasound and doppler studies in the office. We do fetal monitoring and premature labor monitoring here in the office. We perform intravenous hydration in the office when needed. Furthermore, we can arrange for medical care at your home as well, such as a fetal non-stress test or home intravenous therapy.

Below is a brief discussion of some of the extra services available as well as special considerations when there are problems or complications with the pregnancy.

A. SPECIAL BLOOD TESTS

There are hundreds of blood tests available should the situation warrant it. Thyroid panels, anemia panels, thrombophilia testing, genetic testing, progesterone levels, TORCH titers (viral antibodies), lupus panels, coagulation panels, and anticardiolipin antibody panels are just a few.

B. PROGESTERONE THERAPY

Sometimes early in pregnancy there are problems which suggest a need for additional progesterone (for example, twins, history of previous miscarriage, or bleeding during the first trimester). We have a program of supplementation with pure, natural progesterone (oral capsule, vaginal suppository or vaginal gel) and blood level monitoring for those situations.

Progesterone has also been shown to help reduce the risk of premature birth in women with a history or prior premature birth and in women who develop a short cervix in the middle of a pregnancy. Sometimes it is prescribed as a vaginal suppository every night until 36 weeks.

C. NON-STRESS TESTS

A non-stress test (NST) is a type of fetal monitoring, similar to fetal monitoring during labor. It is used to determine the wellbeing of the baby, and also to look for uterine contractions. This test is done for medical indications, and normally is done during the last 1-2 months of the pregnancy when indicated. It can be done in our office and takes about 30 to 60 minutes. It involves lying down with fetal monitors placed on your abdomen, and there is no discomfort. A non-stress test means you are not in labor. If you were in labor, we would call it a stress test.

D. HIGH RISK PREGNANCY TESTING PROTOCOL

We have a special plan for conducting NST and ultrasound for high-risk OB patients. We call this our NST protocol. Starting about 32 weeks, we schedule you for an NST twice a week, typically on a Monday-Thursday or a Tuesday-Friday schedule. This is continued until you deliver. We also perform a weekly ultrasound to check for fluid, cord blood circulation, and periodically check for fetal growth and fetal weight.

We like to say that you'll have one "long" visit per week and one "short visit". The long visit is the NST, the scan and then see the doctor. The short visit is the NST only (assuming the baby passes the test!).

E. BILLING CONSIDERATIONS

If an excess number of prenatal visits are required due to complications of your pregnancy, we may charge a "high-risk" fee or may bill for extra prenatal visits beyond the standard. Please see the separate OB Fees Handout.

9) MORNING SICKNESS

1. What causes morning sickness?

Many articles link morning sickness to the pregnancy hormone hCG. Morning sickness tends to be worse with multiple gestation (a high hormone state) and it tends to be minimal in pregnancies that end in miscarriage (a low hormone state). It may not make any sense, but the sicker you, the "better" the pregnancy. On the other hand, you can have absolutely no morning sickness with a perfectly normal pregnancy.

2. Why does morning sickness exist? An evolutionary explanation

The best theory is that morning sickness is Mother Nature's instinctive toxin avoidance mechanism. It is our biological radar, warning us when something potentially hazardous is coming our way. The evidence supporting this theory is extensive. For example, fetal organ development is usually completed by week 14 of pregnancy. During those first 14 weeks, the fetus is exquisitely sensitive to the damaging effects of toxins. The first trimester is also when nearly all miscarriages occur. Most cases of morning sickness resolve by the end of week 14.

3. Severe morning sickness

About 1-3% of pregnant women experience severe morning sickness. It can lead to profound dehydration, mineral and electrolyte abnormalities and acid-base changes in blood chemistry. Treatment might require intravenous fluids and possibly hospitalization. There are prescription drug on the market, Diclegis and Bonjesta, that can really help reduce the nausea and vomiting. This medication has earned a rare A grade from the FDA for safety during pregnancy. Non-prescription Unisom SleepTabs with Doxylamine, combined with 50 mg of Vitamin B6 is a low-cost substitute for Bonjesta and Diclegis, and uses the same ingredients. Avoid diphenhydramine (Benadryl).

Contact the office right away if you have any of the following symptoms:

- Vomit everything, food and liquids, for more than one to two days.
- Loss of more than 5% of your body weight (for example a 120 lb. woman loses 6 pounds) compared to your pre-pregnant weight.
- Feeling excessively dizzy, lightheaded, weak and you have a dry, pasty mouth, or fast heartbeat (above 100 at rest).
- You may be dehydrated and in need of IV fluids.

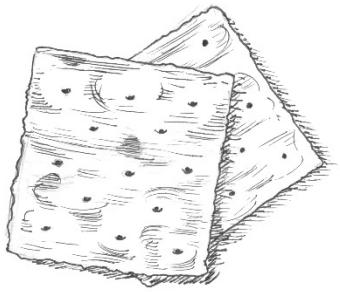
4. **Management of mild morning sickness**

First, trust your instinctive food aversions. If it doesn't smell good, look good, or "sound" good to you to eat, then don't. Below are two lists, the “things to avoid” list and the “things to try” list. Review these lists and try to incorporate as many suggestions as you can, and you should see some improvement in your symptoms.

5. **Things to avoid that may help mild morning sickness**

- Avoid odors as much as possible. Have your husband take breath mints. Use odorless hygiene and laundry products. Avoid odor-filled places (crowded public places, public restrooms, smelly gyms, etc.). Have your home cleaned to try and eliminate any musty or moldy household odors. Get rid of smelly stuff in the fridge and place opened boxes of baking soda inside.
- Avoid most raw vegetables and canned fruits and vegetables. Stick with fresh, ripe fruits.
- Avoid greasy and high-fat foods (although dairy products are usually okay).
- Avoid burnt foods. Avoid barbecued food.
- Avoid raw fish (sushi) and avoid nuts.
- Avoid spices, spicy foods and herbs: garlic, onion, dill, oregano, etc.
- Avoid food flavorings and condiments: ketchup, mustard, steak sauce, etc. Small amounts of salt are okay.
- If vomiting more than once a day, stop all vitamins (yes, even prenatal vitamins) except folic acid (1 mg. daily) and B-6 (25-50 mg. daily).
- Avoid coffee, tea, chocolate, and any substance that is bitter in its native form (before sugar and fat have been added to it).

6. **Things to try**



- Keep saltine crackers on your nightstand. Eat one as soon as you awake, while still lying down if possible. Then wait a few minutes before getting up. The crackers will absorb stomach acid that may have accumulated during the night.
- Eat things a baby would like (boring, bland stuff), like plain white breads, cereal, noodles, rice, and plain yogurt.
- Eat ripe soft fruits. Drink fresh-squeezed fruit juices, ice cold and watered down a bit.
- Try a blender-shake made with ice, plain yogurt or milk, and ripe fruit or fresh fruit juice. Whey or soy protein powder can be added if your diet is low in protein. Add honey for sweetening.
- Eat white cheese. It digests slowly and lessens stomach acid production.
- Dry, white meats like turkey breast are well tolerated.
- Drink flat Seven-up or Ginger Ale (pour into a cup, and then stir).
- If vomiting, drink Gatorade-type drinks rather than water to replace minerals.
- Drink liquids with crushed ice, using a straw.
- Eat small meals all day long, up to 10 times a day.
- If you have to cook, try to microwave, steam or boil foods. This lowers the "burned food" odors.
- To help nausea, try the following: Vitamin B-6, 25 to 50 milligrams two or three times per day. Try ginger, either tea or candied (helps nausea). Try Atomic Fireball candy (one patient swears they help). Or lemon drops.
- Prilosec is available over-the-counter. It reduces stomach acid and can be very helpful and is safe to use if there is a heartburn component.
- Safe, FDA-approved, prescription medication is also available. Ask us about Diclegis or Bonjesta.

10) MEDICATIONS, FOOD SAFETY, SUBSTANCE USE AND INFECTIOUS DISEASES

A. GUIDELINES

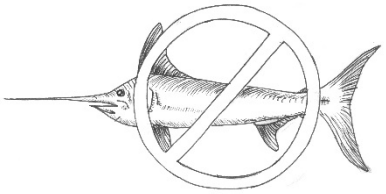
The general rule is not to take any medication, even drug store medicines, during pregnancy, unless there is a significant need. Although no drug (whether it is over-the-counter or prescription) has been proven absolutely safe, there are many widely used medications that have no reported adverse consequences to the mother or unborn baby. Ultimately, the risk of taking the medication must be weighed against the benefit.

Prescription medication should not be taken during pregnancy without the doctor's advice and approval.

B. FOOD PRODUCTS TO AVOID

1. **High Mercury Fish**

In 2004, the Food and Drug Administration (FDA) and the Environmental Protection Agency (EPA) reissued joint advice recommending that pregnant women, nursing mothers, young children, and women who may become pregnant not consume fish high in mercury such as shark, swordfish, king mackerel, and tilefish, and not consume more than 12 ounces (340.2 g) of other lower mercury fish (tuna) per week. These groups were encouraged to eat up to 12 ounces (340.2 g) of low mercury fish per week to get the health benefits of fish.



These guidelines are continually revised and updated so we refer you to the FDA pages for the latest information. For example, in 2019, the FDA announced the availability of revised advice about eating fish which updated the advice that FDA and the U.S. Environmental Protection Agency (EPA) jointly issued in January 2017.

The latest advice is that women who are pregnant or breastfeeding eat 2 to 3 servings (8 to 12 ounces) of lower-mercury fish per week. This includes tuna, salmon, shellfish and most smaller and/or freshwater fish.

For more information: call the FDA hotline at 1 (888) SAFEFOOD

2. Listeria Risk: These food-borne bacteria can cause a rare infection called listeriosis. According to the FDA, an outbreak in 1985 in Los Angeles resulted in 142 cases of listeriosis including 46 deaths; 85 percent of the cases were Perinatal (pregnant women). The outbreak was traced to a soft, Mexican-style cheese, manufactured with contaminated milk (Jalisco cheese). This infection causes mild flu-like symptoms in an adult, but can have a more dangerous effect on a fetus, and can cause stillbirth.

To be on the safe side, it may be advisable to avoid any raw or unpasteurized dairy product (such as raw milk), soft white cheeses such as brie, camembert, fresh blue cheese and Mexican white cheeses.

Listeria has been rarely found in hot dogs, bologna, other pre-packaged luncheon meats, ham, bacon, and lox. It has been found in candied apples, lettuce, cantaloupes, ricotta cheese, and chocolate chip cookie dough ice cream.

Our advice is to wash your fruits and vegetables, eat your meat hot and medium cooked or better, and only eat pasteurized dairy products (not raw). No raw cookie dough either.

3. Sushi:

During the first trimester, it might be reasonable to avoid sushi. Many "experts" advise pregnant women to refrain from eating sushi altogether. This of course would be the absolutely most cautious approach, but is it reasonable? Some sushi is vegetarian, that seems perfectly safe. Some sushi such as shrimp, crab and eel is cooked, so that seems safe. In the U.S., sushi is flash frozen on the ship right after it is caught which kills almost all parasites.

Sushi containing any of the fish on the high-mercury list should NOT be eaten. And always make sure the fish is fresh and the establishment is of high quality. It might be better to avoid "discount" sushi for example.

In Japan, pregnant women consume sushi based on the above precautions. In our opinion, carefully selected sushi should be considered safe during pregnancy, but the choice is yours.

4. Uncooked meats: There is a risk of ingesting a food parasite such as toxoplasmosis when eating uncooked meat. For this reason, we discourage eating raw beef dishes such as steak tartare, beef carpaccio or very rare steaks (medium rare is probable safer). All poultry products should be fully cooked (not pink) before eating.

5. Peanuts: Previous versions of this Guidebook advise avoiding peanuts during pregnancy to help prevent your baby from becoming allergic to peanuts later in life. As with many areas in medicine, new information has resulted in

a complete reversal of this advice. The new studies show exactly the opposite! If you ingest specific foods during the pregnancy such as peanuts or peanut-containing foods, like peanut crackers or pea nut butter, studies now show that your baby will have a lower chance of developing a peanut allergy in the future.

C. NON-PRESCRIPTION MEDICATIONS TO AVOID

- Aspirin or related products such as Advil, Motrin, Aleve, ibuprofen and others, especially during the third trimester. Occasional use is not harmful, but Tylenol (a non-aspirin product) is preferable.
- Stimulant laxatives such as Ex-lax, Dulcolax, or enemas
- Nicotine patches or nicotine gum
- Weight Loss products of any kind
- Megavitamins, especially high doses of Vitamins A or E. Note that cod liver oil is very high in Vitamin A.

D. SUBSTANCES

Herbal supplements: It is difficult to provide accurate, scientific advice about the effects of herbs on an unborn child. Many herbs are safe, and many are potentially dangerous. In general, unless the herb is widely known to be safe (such as herbal cough drops), it is safer to avoid them while pregnant. Commercially purchased herbal teas are felt to be safe.

Homeopathic Remedies: True homeopathic remedies involve highly dilute solutions, so these are considered generally safe during pregnancy. But most doctors believe that these products are no better than plain water.

NutraSweet, Sweet'N'Low, Equal, Splenda, Truvia, Stevia: These are food additives, and have no known risk when taken in normal amounts.

Caffeine: caffeine should not exceed two cups of coffee, three to four cups of black or green tea, or two to three colas daily. Chocolate is so low in caffeine, it is not a significant source (Yippee!). According to the American College of Ob/Gyn (Committee Opinion 462, (reaffirmed in 2020): moderate caffeine consumption (less than 200 mg per day) does not appear to be a major contributing factor in miscarriage or preterm birth.

Smoking (of anything) or Vaping: strongly discouraged, can lead to low birth weight, premature birth.

Alcohol: strongly discouraged, overuse can lead to fetal alcohol syndrome, mental retardation, birth defects. Minimal safe levels of alcohol intake have not been established.

Marijuana, CBD, THC: None of these substances are safe to use while pregnant. Pot, THC and CBD are not well studied and are becoming more widely used in pregnancy. Some preliminary data link these products to premature birth and other obstetrical complications. It is tempting to use marijuana or CBD to treat morning sickness but remember that the first trimester is the most important time for fetal brain development, and there is NO long-term data suggesting that these compounds are safe.

E. NON PRESCRIPTION MEDICATIONS FELT TO BE SAFE

Some over-the-counter medications have been available for many years, and thus have "stood the test of time." Homeopathic preparations are also safe to take. For the following health conditions, we have listed some drug store medicines that are generally safe in pregnancy, and can be taken if there is a strong need:

Allergy Symptoms: Chlortrimeton, Allerest, Claritin or Claritin-D, Zyrtec, Benadryl, Nasa-Cort, Flo-Nase

Backache: Tylenol, Heat or Cold applied locally (see the section on low back pain)

Constipation: Colace, DOSS, Metamucil, Citrucel, Fibercon, Miralax. If severe, Milk of Magnesia

Coughing: Robitussin or Robitussin DM, Mucinex, Vicks cough drops, Recola lozenges

Diarrhea: Kaopectate, Immodium AD (please note that the Immodium package says to avoid its use during pregnancy – we strongly disagree).

Fever: Tylenol, regular or extra strength. AVOID aspirin, Advil, Motrin, Ibuprofen, Aleve, etc.

Gas Pains: Maalox Plus, Mylicon, Gas-X, Tums

Head Cold: Contac, Dristan, Zinc Lozenges (never nasal Zinc), Vicks, Sudafed.

AVOID ZINC NASAL SPRAY (In rare cases this has been linked to permanent loss of the sense of smell)

Headache: Tylenol, regular or extra strength, follow package directions for dosages. Excedrin (non-aspirin version) is safe for severe headaches such as migraines (the amount of caffeine is safe and it helps a lot)

Hemorrhoids: Preparation H, Anusol HC, Tucks (witch hazel) pads or foam (on amazon), Preparation-H wipes

Indigestion/Heartburn: Tums, Mylanta or Maalox. If severe, Pepcid AC or Pepcid Complete, or Prilosec or Nexxium (great for reflux or GERD).

Insomnia: Benadryl, Unisom, Tylenol PM

Itchy skin rash: Hydrocortisone 1% cream or ointment (Ringworm rash, use Tinactin or Micatin)

Lact-Aid: enzyme products, like milk or tablets (containing lactase) pose no known risk.

Leg Cramps: Calcium (Tums, CitraCal), or a Calcium/Magnesium combination (Cal-Mag). Take 2 Tums in the early evening or 2 Cal-Mag tablets, or 400 mg of pure Magnesium to help reduce night-time leg cramps.

Nausea: Unisom (Sleep Tabs, not Sleep Gels), Dramamine, Transdermal Scopolamine patches

Sinus Congestion: Sudafed 12 hour, Saline nasal mist, Flo-Nase. We prefer avoiding Afrin as it can lead to dependence.

Sore Throat: Sucrets, Chloraseptic, Recola, Listerine gargle.

Vaginal Yeast Infection: Monistat 1 day, 3-day or 7-day, Gyne-Lotrimin, Gynazole.

F. INFECTIOUS DISEASES

1. **COVID-19**

COVID-19 is still a concern. At the present there is almost universal consensus that COVID vaccines are safe during pregnancy, that vaccinated women transmit antibodies via blood and breastmilk which helps protect their newborns, and that the dangers of COVID, such as premature births and increased stillbirth, far outweigh the minimal risk of the vaccines.

Anti-viral medication for COVID is available in pill form as well as intravenous. These medications are not cures but they are proven to shorten the course of the disease and reduce its severity. At the present, the safety of these medications during pregnancy is not determined.

Because information about this virus changes constantly, we urge people to check authoritative online sources such as the Center for Disease Control (CDC) and state and local health departments for the latest information. Also please refer to our web site for additional information.

2. **Zika Virus**

In 2015-2016, there were reports in Brazil of microcephaly and other poor pregnancy outcomes in babies of mothers who were infected with Zika virus while pregnant. Microcephaly is when the size of the newborn's head is far smaller than expected, which unfortunately also means that brain development has likely been affected.

By 2020, Zika seems to have just about disappeared. In the US in 2019, only 36 cases of Zika fever were reported, in individuals with travel history to a country or area experiencing Zika virus activity.

3. **Toxoplasmosis**

Toxoplasmosis, caused by a one-celled parasite called Toxoplasma gondii, is one of the most widespread infections in the world, affecting roughly 50% of the world’s population, regardless of gender. Generally a mild, harmless infection, Toxoplasmosis can be of grave concern to pregnant women because of the risk of birth defects due to congenital toxoplasmosis.

Cats can acquire the parasite by eating an infected rodent or bird. They then can transmit the parasite from their feces into the litter box, or wherever they may defecate such as the garden or a child’s sandbox. Up to 60% of all domestic cats harbor Toxoplasma in their body, but surprisingly, they only release infectious particles for 3 weeks in their lifetime, occurring just after they have become infected.

Toxoplasmosis can also be acquired from eating raw or undercooked meat such as beef, pork or lamb and throughout the world; this is the most common means by which people become infected.

Prevention of Toxoplasmosis

- Avoid contact with cat litter or wear gloves. Wear gloves while gardening because the organisms can live in the soil. Cats also like to defecate in children's sandboxes.
- Cook all meat, particularly sheep, beef, and pork, to a minimum of 150 degrees F (66 degrees C). Cook poultry to 180 degrees F. Heat up all lunch meats, meaning ideally avoid cold meat sandwiches.
- Thoroughly wash all fruits and vegetables or peel them. Using soap and hot water, wash all surfaces that have come into contact with raw meat or poultry.
- Do not drink unpasteurized milk or milk products, especially goat's milk products.

4. **CMV**

CMV stands for cytomegalovirus. This is a very common virus and by adulthood most people have been exposed to it, almost always without any symptoms. CMV is spread by person-to-person contact (kissing, sexual relations, bodily fluids). For example, it can spread if someone touches fluids from an infected individual, and then accidentally touches their own mouth. This is why hand-washing is so important. A common source of CMV is small children, so day-care workers and teachers are at increased risk for CMV exposure.

CMV is a concern because an infection during pregnancy can allow the virus to spread to the developing fetus, and can lead to birth defects such as deafness, blindness or mental retardation. One in 750 babies in this country is born with or later develops disabilities due to CMV infection passed from their mother during childbirth.

There is no vaccination and no treatment (except in severe cases). Precautions include: frequent hand washing, especially when around young children; avoid mouth-to-mouth kissing; do not share any cups or silverware. A blood test can be done to check for existing immunity. More than 50% of women are already immune to CMV.

5. **Parvovirus B-19 (Fifth Disease)**

Fifth Disease (also called erythema infectiosum) is caused by the virus parvovirus B-19. It is common in kids ages 4 to 14 and can lead to a flu-like illness often with joint pains and a characteristic facial rash sometimes called the "slapped cheek" rash. This is a contagious viral illness with an incubation period of about 1-3 weeks. About 1 in 5 adults can have this infection without any symptoms.

Parvovirus B-19 s a concern during pregnancy because the virus can lead to an infection in the fetus, particularly affecting the fetal bone marrow. This can lead to decreased production of fetal red blood cells, causing fetal anemia and possibly a serious condition called fetal hydrops. Frequent ultrasounds can be used to monitor the pregnancy for signs of hydrops, and in severe cases intrauterine blood transfusion can be done to treat the fetal anemia.

There is no vaccination and no treatment. Precautions include: frequent hand washing, avoid mouth-to-mouth kissing; do not share any cups or silverware. A blood test can be done to check for existing immunity. More than 50% of women are already immune to Parvovirus B-19.

G. TERATOGEN INFORMATION

MotherToBaby CA, formerly known as the California Teratogen Information Service (CTIS) Pregnancy Health Information Line and Clinical Research Program, is a statewide service. Our goal is to promote healthy pregnancies through education and research. Teratology is the study of birth defects caused by exposures during pregnancy.

Go to https://affiliates.mothertobaby.org/california/ or call Toll-Free (866) 626-6847.

11) VACCINES DURING PREGNANCY

A. COVID-19 VACCINE

Although these vaccines are yet to be FDA-approved for pregnant women, there is widespread agreement from women's health experts that all the COVID vaccines are safe during pregnancy and that vaccinated women transmit antibodies via blood and breastmilk which helps protect their newborns. The dangers of COVID include premature birth, long-COVID (permanent deficits due to COVID infection) and a proven increased risk of stillbirth, and these far outweigh the minimal risk of the vaccines.

B. PERTUSSIS – FACTS ABOUT BOOSTER IMMUNIZATION DURING PREGNANCY

Pertussis ("whooping cough"), a once obscure disease, is a potentially lethal respiratory illness that is making a huge comeback. According to the L.A. Times (1/3/2011), in 2010, 10 infants were killed by pertussis and "more people were sickened than in any year since 1947."

The age group hit the hardest by pertussis is children under 6 months of age, because they have not completed their infant series of vaccine shots and so they are more susceptible. This is why experts advise pregnant women, their spouses and other caretakers in the home to have a pertussis booster vaccine (called TDaP), to prevent exposure to the pertussis bacterium from the infant's close contacts.

In the 1940's, prior to the introduction of the vaccine, there were 250,000 cases per year of the illness in the U.S., and a significant number of infant deaths. In 1976, there were only 1,000 cases reported, but since 2003, that has increased to 10,000 cases annually. In California, only 700 people had pertussis in the year 2000 but in 2010 there were 7,800 cases reported!

The TDaP vaccine is safe and effective even during pregnancy. Pregnant women and their immediate family members are urged to have this booster immunity in order to prevent the transmission of deadly pertussis to their infants. The vaccine can be administered postpartum as well and will take effect within a few weeks at most.

C. INFLUENZA ("THE FLU") AND COVID

Should a pregnant woman get a flu shot or COVID vaccine? In short, the answer is almost always yes! The same information below also applies to COVID.

Usually the flu (and COVID) is a 5-10 day illness with fevers, chills, muscle aches, nausea and loss of appetite, weakness and upper respiratory symptoms. People feel pretty sick, but they get better, and rarely does the flu lead to anything very serious. But the key word is rarely! Although normal healthy adults rarely develop serious complications from the flu, however, the same cannot be said for pregnant women.

Here is what the CDC says about Influenza and Pregnancy: https://www.cdc.gov/flu/highrisk/pregnant.htm

1. The Flu Shot is the Best Protection Against Flu

Getting a flu shot is the first and most important step in protecting against flu. The flu shot given during pregnancy has been shown to protect both the mother and her baby (up to 6 months old) from flu. (The nasal spray vaccine should not be given to women who are pregnant.)

2. The Flu Shot is Safe for Pregnant Women

Flu shots are a safe way to protect the mother and her unborn child from serious illness and complications of flu. The flu shot has been given to millions of pregnant women over many years. Flu shots have not been shown to cause harm to pregnant women or their babies. It is very important for pregnant women to get the flu shot.

3. Early Treatment is Important for Pregnant Women

If you get sick with flu-like symptoms call your doctor right away. If needed, the doctor will prescribe an antiviral medicine that treats the flu. Having a high fever caused by flu infection or other infections early in pregnancy can lead to birth defects in an unborn child. Pregnant women who get a fever should treat their fever with Tylenol® (or store brand equivalent) and contact their doctor as soon as possible.

4. When to Seek Emergency Medical Care (If you have any of these signs, call 911 right away):

- Difficulty breathing or shortness of breath
- Pain or pressure in the chest or abdomen
- Sudden dizziness
- Confusion
- Severe or persistent vomiting
- High fever that is not responding to Tylenol® (or store brand equivalent)
- Decreased or no movement of your baby

D. RSV VACCINE

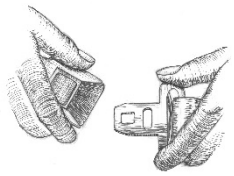
Introduced in 2023, RSV vaccine for pregnant women from 32 to 36 weeks during the winter RSV "season" is now advised. The vaccine induces antibodies in the mother that pass through her blood to the baby and can reduce the risk of RSV pneumonia during the infant's first 6 months of life. RSV pneumonia is the #1 cause of hospitalization in the U.S. for infants under 1 year of age with about a 1% mortality.

12) EXERCISE AND PHYSICAL ACTIVITIES DURING PREGNANCY

We encourage patients to be physically fit and active during pregnancy if they so desire. Many aerobics activities are safe and worthwhile during pregnancy. However, many sports activities, pose a risk of falling, or a risk of collision with another participant. Listed below are activities we feel are safe, and those we feel should be avoided while pregnant.

A. ACTIVITIES GENERALLY SAFE DURING PREGNANCY

- Aerobic exercise such as walking, jogging, swimming, non-competitive tennis, etc. Health club equipment such as treadmills, stationary bikes, elliptical trainers.
- Aerobic classes designated as low-impact. The instructor should be made aware that you are pregnant. Avoid intense aerobic activities such as kickboxing, spinning, sprinting, etc.
- Weight lifting using upper and lower body, lower weights, higher reps. Later in pregnancy it might be better to avoid direct abdominal exercises such a sit-ups and crunches. Avoid heavy lifting requiring straining. Avoid lying flat on the back after the 5th month. Prenatal Yoga is an excellent exercise.
- Seat Belts: These should be worn at all times while in a moving vehicle. When the abdomen is enlarged, the waist belt should be worn below the abdomen, across the hips, and the shoulder strap should go across the shoulder above the abdomen.



- High Altitude: Airlines pressurize their cabins to the equivalent of about 6,000 to 8,000 feet elevation, so this altitude (whether in the air or on the ground) is generally safe while at rest. However, strenuous activities above this height can lead to altitude sickness (headache, fatigue, weakness, nausea). Please consider this issue when planning trips to any mountainous areas while pregnant.

B. ACTIVITIES TO AVOID DURING PREGNANCY

- RISK OF FALLS/COLLISION: avoid riding a bicycle, scooters, horses, snow skiing, water skiing, skateboarding, rollerblading, racquetball, surfing, etc.
- ROUGH and BUMPY ACTIVITIES: avoid roller coasters, jet skis, high speed boating, off-road vehicles, etc.
- RISKY ACTIVITIES: avoid hang gliding, sky diving, scuba diving, bungee jumping, street luge, and all Generation X sports. What? No street luge or parasailing? Oh well.
- OVERHEATING: avoid hot tubs, dry sauna, steam rooms, Jacuzzis. Warm baths are fine.
- LYING FLAT ON YOUR BACK: Many patients are told that in the second half of pregnancy it is dangerous to lie flat on the back, and they have to lie on their left side. In my opinion, this warning is highly overemphasized and causes a great deal of anxiety in patients. If lying on your back feels fine, then GO AHEAD. Occasionally lying flat can cause lightheadedness or other discomforts, especially after the 5th month. If so, don't do it. The "books" then advise lying on the left side, but lying on the right or left side is equally all right.

C. SEXUAL RELATIONS WHILE PREGNANT

For patients with normal low-risk pregnancies, there are no specific restrictions on traditional sexual intercourse. There may be slight discomfort requiring the use of different positions. Female on top and side-to-side positions are generally safer and more comfortable, and later in pregnancy, rear-entry might be the only comfortable position . There can be occasional spotting after sex. If this occurs, please let us know. Also, libido can change due to pregnancy and can increase or decrease.

Male to female oral sex is not advised during pregnancy, as there have been rare reports that air entering the vagina can cause a serious condition called an air embolism. Patients with high-risk pregnancies, such as twins, premature labor, high blood pressure, bleeding, etc., may need to abstain. Feel free to discuss your concerns with us at any time.

D. EXERCISE DURING PREGNANCY

There is a benefit from mild to moderate exercise during pregnancy, at least 30 minutes per session, at least 3 times per week. For cardiovascular exercise target heart rates goals are between 60% and 80% of an individual's maximum heart rate. The maximum rate can be determined using the formula 220 minus your age. If you are 40, your maximum would be 180 and your target heart rate would be between 108 and 144. Untrained women should aim for the lower end of this range, whereas fit women can aim for the high end.

Many experts feel that swimming is the ideal exercise while pregnant. People stay cool, and the buoyancy effect can be a real relief in and of itself. Late in pregnancy, swimming on the back may allow for easier breathing (the opposite advice compared to lying on the back!).

Prenatal Yoga can be very beneficial. It can help with back pain, flexibility, strengthening and relaxation. We like the prenatal classes at Yoga House in Pasadena. Squats and Planks are very good for strengthening thighs and buttocks.

Warning: Any exercise during pregnancy should not be done to such an intense degree as to cause discomfort, shortness of breath or profuse sweating. The ability to speak in a normal manner without being short of breath is a desirable endpoint for exercise intensity. Exercise should be directed at fitness, not training for competition.

Precautions while exercising

- Avoid supine exercise after the first trimester, particularly resistance exercises such as bench press.
- Avoid using abdominal muscles such as sit-ups, crunches.
- Loss of balance can be a concern, particularly in the third trimester, so step aerobics may not be the best type of exercise at this time.
- Adequate hydration before, during and afterwards is important. Loose-fitting clothing appropriate to the environment can help prevent overheating.

E. DENTAL CARE DURING PREGNANCY

We encourage our patients to keep up their regular routine of preventive dental care. Routine dental exams are perfectly safe during pregnancy as are most minor dental procedures. The use of "Novocain" for dental procedures is considered safe, and taking penicillin if advised by the dentist is also safe. If dental X-Rays are needed, then the pregnant abdomen should be shielded with a lead apron. Some dentists will even "double-shield" which means using 2 aprons. This is okay, but probably more of a precaution than is absolutely necessary.

Studies show that women with poor dental hygiene are at risk for pregnancy complications, particularly premature labor and premature birth. One study showed that pregnant women with severe gum disease were 7 times more likely to deliver prematurely!

F. AIR TRAVEL DURING PREGNANCY

In November, 2009, the American College of Ob/Gyn issued an updated report on the safety of airplane travel while pregnant. They felt that low-risk patients could safely fly as late as 36 weeks of pregnancy (35 weeks for international flights). Traveling is discouraged if the patient has been diagnosed with pregnancy complications.

The airplane cabin is slightly depressurized, equal to being at an altitude of about 6,000 to 8,000 feet elevation. This will rarely cause symptoms such as thirst, nausea or headache, which can be relieved by breathing oxygen. It is advised to avoid carbonated beverages (or gas-producing foods) before flying as the gas can expand after take-off causing some abdominal cramping.

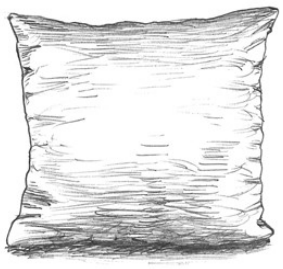
During long flights, it is important to be active periodically. Prolonged immobilization can increase the risk of a rare complication known as a deep vein thrombosis (DVT). This is when a blood clot forms in the lower leg. The clot can then travel to the lungs and rarely (extremely rarely) cause serious injury, even death. Prevention includes walking for a few minutes at least every 1-2 hours. Air turbulence can also occur, so pregnant women should always wear their seatbelts while sitting on the plane. ASK FOR AN AISLE SEAT.

It is good to get up every couple hours, walk around and use the restroom. This can help prevent leg swelling, common from prolonged sitting and may help prevent bladder infection. Stay well hydrated. Support stockings might be useful for a long flight. Loose clothing is advised as well.

G. SLEEPING

Many pregnant women have trouble sleeping. Typically, they can get to sleep okay, but then wake up in the middle of the night, often to use the restroom. Then, it can be difficult to get back to sleep. This is normal, but here are some helpful tips:

- Try to limit fluid intake after 6 pm if you are waking up to urinate
- Use extra pillows to try and get comfortable
- If your spouse snores, have him try the breath-right nasal strips
- Consider the use of a nighttime sleep aid such as Tylenol PM or Unisom, sparingly
- Take a nap every day if you are able. Many studies show that a 30 minute "power nap" in the afternoon can actually help you to function better the rest of the day, and help your brain to enter the phase of deep sleep which is needed during the night to provide truly restful, rejuvenating sleep (sounds like a mattress commercial).



13) LOW BACK PAIN DURING PREGNANCY

(Includes Hip pains, Sciatic and Lumbar area pains)

This is a nearly universal problem for pregnant women, due to multiple factors. High hormones soften the supportive ligaments of the low back, causing pain even early in pregnancy for some women. The growing weight of the uterus adds to the strain on the low back muscles.

A. PREVENTION

Avoid bending at the waist, try bending the knees. Avoid carrying anything heavy enough to cause low back discomfort while holding it. Be sure any chair used for prolonged periods of time is "ergonomic" (designed for extra low back support). Good posture while sitting and standing is very important. Avoid "slouching" as it can put sever strain on the low back over time. Special firm lumbar cushions for support can be very helpful. Chair height should allow both feet to rest flat on the floor. If a lot of time is spent sitting at a desk, then both arms should be even with the desktop. Special stretches can be done daily to maintain spine flexibility. Low back strengthening exercises as outlined in most prenatal books can be helpful but must be done for a few minutes each day to be effective.

B. REMEDIES AND TREATMENTS

Prevention: Many "little" things done well can help prevent back pain. Good posture, limited weight gain, proper sitting positions, ergonomic chairs, low heels, proper bending and lifting, a firm mattress, minimize reaching above the head all can help.

1. **Low back strengthening exercises**

Many pregnancy books provide descriptions and images regarding exercises such as the pelvic tilt (and the dromedary droop) which can help reduce low back pain. Guess what? They work!, but need to be done frequently.

2. **Relax the Back Store (online also)**

There are a variety of items here that may be helpful. Full-length body pillows, footrests, lumbar support cushions and back support belts can help. The employees are quite knowledgeable about back pain but they also want to sell you the $2,000 gravity recliner (but it sure is comfortable).

3. **Supportive devices**

The most common is the maternity support belt sold at most maternity stores. This is a long elastic band with Velcro at each end that is worn below the pregnant belly in front, and across the low back.

Target sells waist trainers that can be wider and less expensive than maternity support belts. Belly Bands are popular also. There are many variations of maternity support including harnesses and complicated looking contraptions, and some are quite costly. Maybe you can borrow one from a recently pregnant friend!

4. **Gel Foam (Memory Foam) Mattress Covers**

These come in different sizes and different thicknesses. A thick memory foam or gel foam mattress pad provides extra comfort and padding, which can help sore backs and sore hips.

5. **Medical Care**

Heating pads to the low back are okay. Cool gel packs or ice packs can help if the pain is strong. Patients can be referred to specialists. Physical therapists can help low back pain. They can be seen independently or through the office of most orthopedists.

Physical Therapists or Chiropractors can be helpful, but some caution is needed. A chiropractor should have special expertise in pregnancy, use a special table for pregnant women, and use gentle techniques. Avoid the "holistic" chiropractors that claim to be able to cure cancer and diabetes and who promote Chinese herbs and other "non-traditional" therapies.

14) MULTIPLE GESTATION (TWINS AND TRIPLETS)

The care of patients with multiple gestation is an important part of our practice. Since being in practice, we have had the privilege to participate in the care and delivery of over 250 patients carrying either twins or triplets. We have special protocols for caring for patients with multiple gestation. We perform many more office visits and many ultrasounds. We use different nutritional supplements. We educate patients extensively about the early warning signs of preterm labor. We discuss activity levels and restrictions, curtailing of exercise, when to stop working and when to begin increased bed rest. We use cervical length ultrasound to assess for risks of premature labor, and sometimes admit patients to the hospital for the final weeks of their pregnancy. We will do whatever we can to try and keep those babies inside as long as possible!

15) PREPARING FOR CHILDBIRTH

A. HUNTINGTON HOSPITAL CHILDBIRTH EDUCATION CLASSES (626-397-8768)

1. **Childbirth Preparation Series (online)**

Huntington Hospital is "proud to offer Virtual Live classes to help prepare you for your birth experience, breastfeeding and baby care. In today's challenging environment, we are offering these customized live classes to our Huntington parents, at no charge, to provide you the information you need in a safe and convenient way."

https://www.huntingtonhealth.org/our-services/womens-health/huntington-baby/classes-tours/

2. **Online Classes Available - Virtual Live Class Descriptions:**

We are proud to offer a comprehensive set of virtual live classes just for Huntington Hospital parents. We are offering these classes as a complimentary service to our parents during this challenging time. Classes will be delivered live by certified and credentialed instructors. Registration is free but required.

- Pregnancy & Newborn Nutrition
- Childbirth Preparation: A Three-Part Series
- Breastfeeding: A Three-Part Series
- Caring for Baby: A Three-Part Series
- Parenting Preemies: From NICU to Home
- Diabetes During Pregnancy

For the above classes, it is a good idea to register well in advance, since these classes are very popular and time slots fill up quickly.

For more information, please call the Childbirth Education Office at 626-397-8768. If you do not receive a return phone call or confirmation of your registration within a few days, please call again.

Online Birthing registration is available. Registration web page:

https://www.huntingtonhealth.org/our-services/womens-health/huntington-baby/preparing-for-your-stay/#pre-registration

B. THE FAMILY ROOM (626) 234-2106

The entire focus of The Family Room is on the expecting couple and their newborns and infants. The owner has assembled numerous experts, covering the fields of prenatal education, prenatal exercise, diet and nutrition (for pre-pregnancy, during pregnancy and during lactation), breastfeeding support and more. They have postpartum doulas who can come to your home after you deliver.

They teach many different classes. Topics include classes on Grandparenting, preparing for twins (the owner has a set of twins and a singleton), getting pregnant, breastfeeding, infant care, infant CPR, mommy and me, pre- and post-natal exercise, and many more.

They are on the web at www.familyroomcenter.com and also on Facebook.

C. BIRTH PLANS AND BIRTH PREFERENCES

The Birth Plan (we prefer the term Birth Preferences) refers to a patient's (couple's) preferences regarding her (their) labor and delivery. Sometimes it is a brief conversation with the OB doctor. Sometimes it is a piece of paper with a few general comments. Sometimes it is a many paged single-spaced list of requests.

Many Birth Preferences are similar. We do understand what pregnant women often want and hope for, that is part of our job. Given that, we still encourage you to communicate with us anything you wish regarding your pregnancy and your hopes for how the delivery will go.

In general, our understanding is that patients want to have mobility during labor, they want to minimize invasive procedures, they want delayed cord clamping, they want to have their husband (partner) cut the baby's cord, they want the option of a drug-free natural birth, perhaps with the possibility of epidural if requested, and they would like to try to avoid episiotomy and hope to avoid a Cesarean Section. Moms want skin-to-skin as soon as possible after the baby is born and they usually also want to breastfeed as soon as possible.

We understand the need and desire to have the events of your birth proceed as closely as possible to your view of what is ideal, and we do our best to try and help you achieve these goals. However, the events of anyone's labor or delivery cannot be predicted. In general, the more aspects of the delivery that you feel need to be a certain way, and the more control that you feel you need to have, the more likely that actual events will deviate, and the more likely you might end up disappointed. We definitely do not want that !

Every labor is different. Every birth is different. Sometimes, no matter how healthy and prepared you are, the childbirth experience goes awry. This is why we deliver babies in the hospital, and this is why you go to an Obstetrician for your prenatal care and delivery. We cannot predict the future, but we will always do our utmost to make sure that no matter what happens, we deliver a healthy baby while keeping mom safe and healthy as well.

Our preferred Birth Plan is a verbal conversation. However, if you have prepared written "Birth Preferences", they should be reviewed by one of our OB doctors so we can discuss them together. You may have requests or preferences that we feel are not safe medically, and which should be discussed prior to going into labor. **We request that your "preferences" are kept to one page double-spaced, and avoid words such as "refuse", "must" or "won't". We also prefer that the title "Birth Preferences" be used as it indicates a sense of flexibility.**

We strongly urge couples to keep an open mind regarding the events of their upcoming childbirth. The last thing we want is for you to be disappointed after delivery because everything did not go exactly as hoped or planned.

Our goals are: first, a healthy baby and healthy mom; and second, a safe vaginal delivery. We promise to do the utmost, to use all our experience, skill and judgment to help you have a safe (and beautiful) childbirth experience as close to that which you desire. That is our Birth Plan.

Please see the appendix at the end for our typical Birth Plan items.

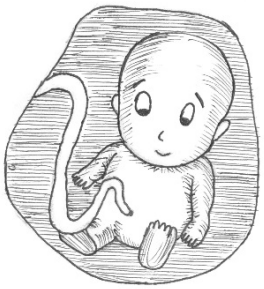
D. THE PEDIATRICIAN

After the baby is born, he/she immediately becomes the patient of the Pediatrician whom you have selected. Therefore, it is important to decide in advance of the delivery who this will be. We recommend that you choose your Pediatrician during the final 2 months of the pregnancy.

We provide a list of some local Pediatricians (at the back of this booklet). Some patients will have to choose doctors from amongst those who are on their insurance plan. If the Pediatrician is not located here in Pasadena, find out if he/she has admitting privileges at Huntington Hospital. If the doctor does not have admitting privileges, we can select a Pediatrician to be responsible for the baby from birth, until the baby is discharged home.

16) CORD BLOOD BANKING

Cord Blood Banking (Stem Cell Preservation)



At the time of delivery, excess umbilical cord blood can be preserved. This blood is the baby's, and it is rich in a type of cell called umbilical cord stem cells. These cord blood stem cells can become bone marrow cells, and they have been shown to save lives when used as donor cells for a bone marrow transplant. Bone marrow cells produce the red blood cells, the white blood cells (immune fighters) and the blood platelets (blood clotting cells). Over 75 different diseases have been cured using cord blood stem cells in this manner, and to date there have been over 35,000 cord blood transplants performed throughout the world.

Cord blood cells can be given back to the same individual if that person needs a bone marrow transplant in the future. This is the ideal situation because the cells are genetically identical. These cells also might match a brother or sister and can be used if they ever need a bone marrow transplant. A genetically similar donor will greatly lower the risks of this high-risk procedure.

Regenerative Medicine

There is growing understanding that cord blood stem cells have additional potential. In the laboratory, these cells have shown the ability to help repair other damaged organs such as heart, brain or spinal cord. This field of study is called **regenerative medicine**. Some scientists are studying the use of cord blood cells to try and cure juvenile diabetes. Success stories are few so far, but there are over 200 research trials underway presently.

Three Options

There are 3 choices on what to do with cord blood at the time of delivery. One is to pay money to save it for your own use. This is called Family banking. Another choice is to donate the cord blood to a public bank. Currently there are no local banks doing this. The third is to throw away the blood. This is what happens 95% of the time.

The decision on whether to use Family banking of your baby's extra cord blood depends on many factors. There is a significant cost for obtaining and preserving umbilical cord blood plus yearly storage fees, however many companies offer payment plans and discounts.

Also, the chance that your own child will one day need a bone marrow transplant is low, but as genetic research advances, there may be new indications for this procedure that to date we are not aware of. **This decision cannot be made in the delivery room. It should be made at least 1-2 months before the due date.**

Which Company?

If you have decided to save the cord blood, you also need to decide which company to go with. There are many that advertise. One company we like is the Cord Blood Registry (www.cordblood.com). They were the first company to do this, and they are the largest service provider of this procedure. They have an excellent web site. For more information, please call the Cord Blood Registry at 1-888-CORDBLOOD (1-888-267-3256). They also offer the option of saving a segment of the umbilical cord itself.

Another excellent company is StemCyte (www.stemcyte.com). They, too have a very informative web site. Call them at 626-646-2500. They are a local company and they offer tours of their facility. StemCyte also allows you to save the cord segment in addition to the cord blood.

If you are researching the world of cord blood banking, public donations vs., private family banking, a good web site is: www.parentsguidecordblood.org, sponsored by the Parents Guide to Cord Blood Foundation.

17) CIRCUMCISION

Circumcision refers to the surgical removal of excess foreskin from the tip of the male newborn's penis. It is usually performed in the hospital on or after the day after the baby's birth, and at Huntington Hospital usually by the attending obstetrician. Local anesthesia is used routinely, but the baby may fuss and cry briefly. The procedure takes less than 2-3 minutes. Circumcision is not routine nor required. It is an optional procedure.

1. What are the benefits of newborn circumcision?

Some studies have shown that circumcised newborn males are less prone to urinary tract infections (UTI's) infections during their first year of life. Circumcision can protect males from sexually transmitted diseases (STD's). Uncircumcised males have a slightly higher risk of acquiring HIV, herpes (HSV) and human papillomavirus (HPV) as adults compared to circumcised males.

2. What about the risks of the procedure?

One of the most common reasons not to perform a circumcision is concern about future diminished sexual sensation in circumcised males. This is not easy to study, but in a review of the literature (according to the American Academy of Pediatrics), "there is fair evidence that no significant difference exists between circumcised and uncircumcised men in terms of sexual function." There are others who would disagree with this statement, who feel that sexual pleasure as an adult is lower than it might have been because a newborn circumcision had been performed.

The rate of complications of this procedure is quite low, on the order of 1 in 500 procedures. Bleeding, the most common complication, is usually minimal and easily treated. The rate of serious complications, such as penile injury, is less than 1 in 2,500 cases.

3. What about pain medication?

For many years, our policy is to use some type of pain medication such as injectable or topical lidocaine during newborn circumcision.

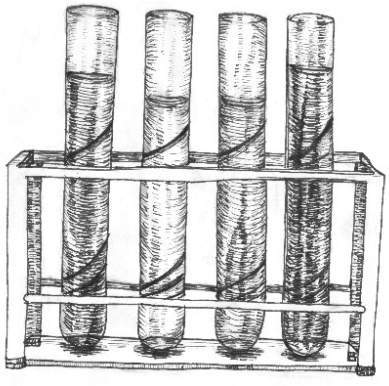
4. Summary

Newborn circumcision is a safe procedure. It can be performed quickly and nearly painlessly, normally taking place in the hospital soon after birth. There are pros and cons to having a newborn circumcision performed. We urge all expectant parents to research the facts and make a joint decision on whether to have the procedure done. There is a growing sense in the public that perhaps the procedure should be avoided until the boy is old enough to decide for himself, unless it becomes necessary due to medical problems.

All our physicians perform newborn circumcisions. There is a separate fee for this which is your responsibility to pay. For Care after circumcision: see postpartum instructions.

18) NEWBORN SCREENING TESTS

The California Newborn Screening Program screens newborns for dozens of conditions, including PKU, disorders of hemoglobin, thyroid disorders, adrenal disorders and fatty acid metabolism disorders. The test is done by drawing a few drops of blood from the baby's heel about 18-24 hours after birth, and sending it to a state laboratory. The results are then sent to your Pediatrician. All babies have this testing done automatically.



The value in performing newborn screening is that there are rare conditions which can be identified immediately at birth, long before any harm or damage has occurred to the baby. After making the diagnosis, treatment can be implemented immediately, either completely preventing or at least minimizing the extent of harm that can be caused by the condition identified. For more information, you may contact the Genetic Disease Branch of the California Dept. of Health Services at 510-412-1502.

19) FETAL TESTING – NON-STRESS TESTS (NST'S)

We provide routine NST testing for many reasons, which include advanced maternal age, not delivering by the due date, babies that seem to be too large or too small, cord around the baby's neck on ultrasound, multiple gestation, decreased fetal movement, high-risk pregnancy or patients with medical conditions such as high blood pressure, diabetes, premature labor and for other reasons as well.

A non-stress test is an office visit that takes from 30 to 60 minutes. You are placed on an external fetal monitor, similar to what is used during labor, and then you lie down and rest. There is no discomfort. The monitor creates a paper printout (called the tracing) showing the fetal heart rate changes and uterine contractions. We read the tracing and determine if the baby is getting enough oxygen and blood flow, which is the case the great majority of the time. Abnormal NST's can be managed many ways such as by repeating the test the next day, or sometimes by sending the patient to Family Birth Center for additional testing.

20) OVERDUE

The textbook definition of a full-term pregnancy is 37 to 41 weeks. Many obstetricians consider 41 weeks to be overdue, but others feel that even 1 day past the due date (40 weeks) is overdue.

1. **Being overdue is associated with the following possible problems:**

   - increased size of the baby leading to increased chance for a C/S and increased potential harm to the baby or the mother even with vaginal birth (for example a bigger tear).
   - increased chance that the baby will pass meconium (have a bowel movement while still inside the womb) during labor. Meconium can sometimes get in the baby's lungs before the birth which might lead to breathing problems after delivery.
   - increased chance that the placenta will lose some function because it is "aging." This is gradual and not usually a problem, but placental aging can lead to decreased placental blood flow to the baby. This in turn can lead to decreased oxygen to the baby creating what we call fetal "stress." Fetal stress is often worse during labor due to the contractions which reduce blood flow even more. Therefore babies under stress are at higher chance of being born by C/S.

2. **We begin twice a week non-stress testing starting at about 39 weeks. We monitor the level of amniotic fluid and we check the cervix. Sometimes we will advise inducing labor due to being close to overdue. When the baby is doing well on the testing, sometimes we will continue to watch and wait, knowing (and hoping!) that the patient can go into labor at any time (hopefully soon).**

21) HUNTINGTON HOSPITAL*

(*some of these policies have changed due to the COVID Pandemic)

A. FAMILY BIRTH CENTER

We perform all our deliveries at Huntington Hospital. The Main Building contains the Family Birth Center, Postpartum (Maternity or Mother-Baby Unit), the Newborn Nursery and the Neonatal Intensive Care Nursery (NICU) on the same floor. These are all in the East Tower. Vaginal Deliveries occur in LDR (Labor, Delivery and Recovery) rooms. In this room you can labor, have a vaginal delivery and about a 1-2 hour recovery time all without changing rooms. Afterwards, you transfer to the postpartum (Mother-Baby Unit), where nearly all rooms are private. We also have Operating Rooms (the O.R.) that can be used for Cesarean birth or vaginal birth.

B. SKIN TO SKIN

Skin to skin is a practice that involves placing the newborn baby on the mother's skin right after the delivery. Many of us deliver the baby right onto the mother's abdomen and leave him/her there for a while. Be aware that right out of the womb the baby is normally covered with fluid, blood and often the baby voids or defecates as well. Newborns are a kind of messy.

Skin-to-skin helps to promote mother-infant bonding and is a very special time. It also helps to promote breastfeeding. Once you are transferred to the Maternity Unit, we encourage both moms and dads to try skin to skin contact. It feels great and babies love it too!

C. SPECIAL SERVICES

Huntington offers a comprehensive range of services designed to provide you with the maximum amount of safety and security should the need arise. There is an excellent Neonatal Intensive Care Unit should the newborn have any problems, with 24-hour availability of a Neonatologist (newborn care specialist). There is 24-hour availability of an OB Anesthesiologist solely responsible for Labor and Delivery patients. There is 24-hour-a-day availability of Operating Room personnel should an emergency arise requiring immediate surgery. There is also a 24-hour-a-day "emergency" Obstetrician who is assigned to the Family Birth Center should an emergency arise, and your attending physician has not yet arrived.

D. NEONATAL INTENSIVE CARE UNIT (NICU)

Huntington Hospital has one of the biggest, busiest and best NICU's in Southern California. There is a NICU physician in the hospital 24-hours-a-day. During delivery, there may be circumstances where we need to have the neonatal team at the birth. Some reasons for this are meconium-stained amniotic fluid, fetal distress or premature birth, to name a few. When the "team" is present, right after delivery the baby is placed in the warming bed and they begin their evaluation. Afterwards, they may decide that the baby needs to be admitted directly to the NICU, but usually they determine that the baby is fine and can proceed to the normal newborn nursery.

If your baby is admitted to the NICU, be sure to take advantage of emotional support offered by The Parent Connection. Composed of a group of parents who have had babies hospitalized in the NICU, they have regular meetings and provide one-on-one support. For more information, call 626-398-8509.

E. THE LABORIST PROGRAM AT HUNTINGTON HOSPITAL

There is a program at Huntington Hospital called the Ob Hospitalist Service, but many of us use the term laborist. A laborist is a Board-Certified Ob/Gyn doctor who is physically present in the Family Birth Center 24 hours a day. This doctor works for the hospital and provides services to patients in the Family Birth Center depending on the situation.

The most important reason for the presence of the laborist is in case of emergency. Sometimes an incident can occur at any time of the day or night where the immediate presence of an experienced obstetrician is vital. Private doctors are on-call but are not always physically present in the hospital, especially at night, weekends and holidays. The laborist is available in case of an emergency when your own private obstetrician is not present in the hospital.

Laborists are also willing to provide services for our labor patients in non-emergency situations. Your private obstetrician may request the assistance of a laborist from time to time as the need arises.

F. RONALD MCDONALD HOUSE

If your baby is admitted to the NICU, sometimes he/she may need to remain in the hospital even after you have been discharged. If you would like to be close to the hospital 24/7, you may want to contact Ronald McDonald House. Located across the street from Huntington, they offer a lovely bed and breakfast-like atmosphere at a very low cost and are open to any family whose child is in the Hospital. Please call them at 626-585-1588.

G. HOSPITAL FOOD – AFTER DELIVERY – CALL EXT 3663

Huntington has a Room Service program for all meals. You are provided a menu and can call in your meal order. It may take 30 to 45 minutes for the food to arrive. There are set windows for mealtimes, for example dinner is only served from 4 pm to 7 pm. Please be aware of this. If you are hungry at off-times and are on a normal diet (called a regular diet), you can eat whatever you like, so someone can bring food to you. Just ask them. No one says no to a new mom! (*no outside food is allowed during the pandemic).

The hospital cafeteria in the West Tower is wonderful. At the north end is an outdoor patio and fountain. It is very pleasant. The cafeteria is open about 20 hours out of 24 and pretty decent food can be obtained there, plus they sell a lot of snacks (healthy ones, and traditional) and many healthy juices. Also, there is no restriction on food brought in from outside, so you may want to pack some non-perishable snacks for after delivery or have someone bring you something to eat or drink after you arrive in the postpartum Maternity Unit. (*closed to visitors during the pandemic).

H. HOSPITAL STAY

Discharge from the hospital after delivery is flexible. After vaginal delivery the length of stay is about 24-48 hours. The day after a vaginal delivery, a patient may go home if she feels fine and wishes to leave. After cesarean section the usual stay is 2-3 days. Discharge time is about 12:00 noon.

I. MAIN ENTRANCE

During normal daytime hours, there is always someone present at the main entrance. From 10 p.m. until 5 a.m., the main entrance doors are locked. The Hospital provides telephone access (see the posted signs) as well as close availability of security personnel.

J. VISITING HOURS AND RESTRICTIONS

(*please see the Hospital website for visitor restrictions during the pandemic)

Normal visiting hours for the Hospital are from 11:00 a.m. until 8:00 p.m. We try to minimize visiting between 2 pm and 4 pm to allow new mothers some extra rest and alone time with their baby.

All visitors need to obtain a visitor's pass, which is a colored sticky label for the clothing. These can be obtained at the information desk in the main lobby. No more than 3 visitors are allowed in a patient's room at a time, and one of them must be the spouse or designated support person. Passes need to be returned when the visitor leaves.

PLEASE ask your guests not to litter the property with the visitor stickers when they leave. They are showing up on the grounds and columns outside the Main Entrance and are hard to remove.

K. HOSPITAL L&D PRE-REGISTRATION FORM

Pre-registration for your birth can be done digitally via the Huntington baby web site and also using your My Chart CS-Link patient portal.

L. VIDEORECORDING AND PHOTOGRAPHY DURING LABOR AND DELIVERY

Huntington Hospital has Restrictions on video recording (including cell phones or camcorders) and photographing childbirth. They do not allow direct filming/recording of any medical procedure, including the actual moments of birth, and any newborn medical care. Video recording and photography of the patient before and after the delivery, and of the baby after the delivery is allowed if the mother and/or the baby are considered medically stable.

This policy reflects a trend that we are seeing across the country, which is a concern that routine gestures, procedures and comments can be scrutinized, reinterpreted and replayed to such an extent that those viewing the images will believe that something improper has taken place. Furthermore, hospital personnel expect privacy and do not wish to be photographed or recorded without their permission.

22) FAMILY BIRTH CENTER (ALSO CALLED LABOR AND DELIVERY)

A. WHAT TO TAKE TO THE HOSPITAL

From your first arrival in the hospital until your discharge home, your stay may include between 3 and 6 different rooms. Light packing is the key and bring a minimal amount of stuff to the labor suite. Do not bring expensive items such as watches or jewelry and do not bring large amounts of cash.

- Cord Blood Banking kit, if you are doing this. Keep the kit in the open so we know that it's there. Be sure the nurse draws extra blood for use in the Cord Blood Kit (avoids a 2nd blood draw later).
- Listening to music during labor is nice. Many people bring an ipod, iPad, iWhatever.
- Labor support items such as tennis ball and other back rubbing devices, small fans, special photos
- Any prescription medication you are taking. All prescription drugs must be in their original container with the medical label attached.
- Chap stick is a good idea.
- Slippers or warm socks (older ones are better in case they get soiled).

- Perhaps a favorite pillow.
- If you wear contact lenses, bring glasses as a back-up.
- Cell phone and charger. Don't forget the charging cords – for your cell phones, iPads, cameras, tablets, laptops, etc.
- Bottled water or clear juice. Perhaps some snacks for afterwards or for guests or dad.
- If epidural is planned, you may have "free time" during labor. Reading materials, playing cards, DVD's and laptop PC's may come in handy (don't laugh).
- All items needed postpartum, such as overnight toiletries and clothing should be kept in a separate case, maybe even in the car, to be retrieved after your arrival in the postpartum area.

B. WHEN TO COME TO THE HOSPITAL FOR NORMAL DELIVERY

After you have reached 37 weeks, you are considered full-term. Only at this point in pregnancy do the following guidelines apply:

- <u>If this is your first baby,</u> for routine labor pains you should try to wait, and call us once the contractions are regular, about every 5 minutes, lasting 45 to 60 seconds, and are strong and uncomfortable (it is difficult to talk through the contraction) and this has been continuing for about 1-2 hours.
- The "**5-1-1**" rule: contractions every **5** minutes, **1** minute long, for **1** hour (and strong).
- If this is a subsequent pregnancy, call when the contractions are regular, about every 6-8 minutes and uncomfortable (not yet painful). Basically, when you feel like you are in labor, you probably are.
- Also, if there has been any leakage of fluid per vagina that could be amniotic fluid, you should call us.
- *In the middle of the night (usually 10 p.m. to 6:00 a.m.), if the above occurs, you should go directly to Labor and Delivery without calling the doctor. You will be checked after your arrival by the laborist and they will contact us to report how you are doing.
- Please DO NOT CALL for bloody show or for signs of early labor. The idea is to call us when it is likely that it is time to come to the hospital to deliver. Bloody show and early labor mean that it is too soon to come to the hospital. As always, do not hesitate to call us if you are concerned, or if you are not sure what to do.

C. THE OB EMERGENCY DEPARTMENT (OB ED)

The OB ED (Obstetrical Emergency Department) is a special area located in the Family Birth Center. ALL Ob patients, who are 20 weeks pregnant or beyond, coming to Huntington Hospital for urgent problems or emergencies, are directed to the OB ED.

This includes conditions such as:

- possible labor or preterm labor
- possible rupture of membranes
- vaginal bleeding or spotting
- abdominal pain after 20 weeks of pregnancy
- decreased fetal movement
- major illness after 20 weeks of pregnancy
- evaluation after a fall or accident
- and other reasons as well

<u>Medical Screening Exam (MSE)</u>

The purpose of the OB ED is for you to be evaluated as soon as possible after your arrival. For this to consistently occur, there is an Ob/Gyn physician (the laborist) assigned to the OB ED 24 hours a day. His or her job is to perform a Medical Screening Exam (MSE) on every patient presenting to the OB ED, to determine if your condition is stable, or urgent, or rarely a life-or-death emergency.

D. LABOR MANAGEMENT (SEE APPENDIX FOR BIRTH PLAN COMMENTS)

If you have no complications of pregnancy, we do not subject you to many "routine" procedures during labor and delivery. We do not request perineal (vaginal) shaving. We do recommend an IV (intravenous) line during labor, although a saline lock is an option (this is a short IV catheter filled with saline, so you do not have to be connected to the full IV line and bag of fluid).

We believe in the routine use of external electronic fetal monitoring. This need not be continuous, and we offer intermittent monitoring at your request. Internal fetal monitoring is performed for specific medical indications and is not routine. You are not "strapped down" in bed during labor. Patients may ambulate during labor, go to the restroom, even shower if they wish to (and if there is no medical contraindication). Wireless external fetal monitors are available also.

Episiotomy is an incision made in the area between the vagina and the rectum at the time of the delivery of the baby's head. It is done to try to prevent spontaneous lacerations or tears of the vulva, vagina, urethra or clitoris. Many patients wish to avoid an episiotomy and we rarely perform them. However, at times there may be a medical indication for episiotomy, such as fetal distress, or to prevent a potentially large tear. Our goal is for you to go home with the fewest stitches possible!

E. TWO PATIENTS

An obstetrician is responsible for two patients, the mother and the unborn baby. If a situation presents itself that appears to put the fetus at risk, the doctor has to suggest and encourage interventions designed to minimize and/or prevent a possible adverse outcome. This might mean disregarding a "Birth Plan" and implementing various degrees of medical care including the possibility of Cesarean Section. Labor is unpredictable, and there are sometimes situations where we must intervene using all our skills and training to help make sure mother and baby are safe.

Some patients wish to have an entirely natural delivery with no medical intervention, no medications, no fetal monitoring, no intravenous, almost like a home birth. Our advice is that you would be better off finding another birthing provider who would be more accommodating to these preferences or consider transferring your care to a natural birthing center or finding a midwife who can help you to have this type of birth experience.

F. DOULAS

The use of a doula as a support person during labor can be quite helpful. Their role is to provide emotional support and comfort for the laboring patient, which they usually do quite well. The reason most people hire a Labor Doula is that they want a fully natural childbirth without any pain medication. If an epidural is planned, the role of the Doula becomes diminished and might not be as valuable to you.

Doulas have limited medical training, and they should inform you that they are not medical care providers. Many doulas have been certified by an organization called DONA (Doulas of North America). Please see the DONA website for more information: http://www.dona.org. We have worked with many different doulas and overall have found their assistance encouraging and positive.

Unfortunately, there are some doulas that have a negative attitude toward traditional medical care, hospitals and doctors. Although childbirth is a natural process, we feel that it is best done in a hospital due to the occasional serious and unexpected problems that can arise. When this occurs, a doula that tends to distrust hospital personnel can sometimes interfere with the delivery of proper medical care, and this will not be allowed. There are also doulas that specialize in postpartum care for mother and baby after they arrive home from the hospital.

We emphasize that doulas are not trained healthcare providers. When stressful situations arise during labor, we hope that you will not turn to them for medical advice or opinions.

G. EPIDURAL ANESTHESIA

Anesthesia (pain relief) is available 24 hours a day. Huntington Hospital offers 24/7 dedicated obstetrical anesthesia coverage. There is a different anesthesiologist on-call for emergency room and trauma patients. Therefore, an anesthesiologist is always in or near the labor area. Epidural anesthesia is always available upon your request. You do not have to "make a reservation" and it is rarely "too late" to have your epidural.

At Huntington, we provide PCEA which stands for patient controlled epidural anesthesia. You are provided a small button that you can press (only you, nobody else) to receive an extra dose of medication if needed. It has safety features that prevent repeated doses too close together (called a lockout interval).

1. **Epidural Myths**

Myth: Epidurals can make you paralyzed.

We have seen thousands of patients who have received labor epidurals but have almost never seen someone permanently injured by one, but this is remains a rare possibility. (We also drive on the freeway and travel by airplane knowing that there is a remote risk of death or severe injury with these activities as well.) Rarely, a nerve stretch injury can occur and can take weeks to months to resolve. For example, sometimes the legs are stretched way back during the pushing phase of labor. The epidural masks the pain that would normally result. Thus, a nerve stretch injury in the groin or buttock area can occur. It is good to be aware of this. Low back pain for a few days, weeks or occasionally months can occur. We have seen leg weakness after epidural that took longer than expected to recover.

Myth: Epidurals lead to a higher risk of Cesarean.

There was some data years ago that suggested giving an epidural too early in labor increased the chance for a C-section. We generally try to wait until the patient is at least 4 centimeters dilated (signaling the onset of the active phase of labor) before allowing an epidural and this has bene shown not to increase the C/S rate. In many cases epidurals might prevent a C/S, by relaxing an otherwise anxious and suffering labor patient.

Myth: Epidurals will stop labor.

If given too early, epidurals can slow down labor. By waiting until 4 cm. dilatation before placing the epidural, this rarely happens. If the labor does slow down, we can use Pitocin to carefully and gradually bring the labor back to a "normal" pattern, or we can allow the epidural to wear off (most patients do NOT want this option). Pitocin is a safe drug when used appropriately, and it is common for epidural patients to receive a little Pitocin “augmentation” during labor (if required).

Myth: "I won't be able to push."

There are times where the patient is so numb that she cannot push, but this happens rarely. Typically, the patient doesn't FEEL the urge to push, but with good coaching she can still push quite effectively. We have delivered LOTS of babies to moms with great epidurals who pushed REALLY WELL, and yet didn't feel severe pain while pushing or when the baby delivered. Some doctors routinely turn off epidural pumps when it's time for the patient to push, but this is rarely necessary.

Myth: REAL WOMEN DON'T NEED EPIDURALS.

No comment.

2. **Epidural Truths**

TRUTH: Labor with an epidural can be fun!

We have seen patients enjoy their labor and have fun because of the epidural. Patients can take naps, watch TV, send texts, update their FB, enjoy music, play cards or socialize, all while their body is in booming labor! The birth itself can be nearly painless, and many patients sit up to watch the baby as it emerges from their birth canal.

TRUTH: Natural childbirth is not possible for all women.

Many patients experience so much pain during labor that they seem to “lose themselves”. They can be in so much pain that they scare themselves or their loved ones. For these individuals, the epidural is nothing short of a miracle. To make these women feel guilty, to imply that they are bad mothers, or that they are wimps because they didn't go natural is upsetting and unfair. Nobody can feel another person's pain, and the choice of having an epidural should not be stigmatized or somehow interpreted as a “failure” or sign of weakness.

TRUTH: There is a trade-off with using an epidural.

With natural childbirth, during the pushing, there is an intensity in the room. The coaches are counting loudly, the patient is working hard, sweating, moaning and maybe yelling, and usually really hurting! Then comes the actual moment of birth. There is a prolonged sharp pain, a final, big push -- accompanied at times by a drawn out intense groan from the patient, followed by a loud and lusty newborn baby cry, whereupon the patient's wail is transformed in the same breath into a tearful exclamation of pain, joy and relief all at the same moment! The experience is unbelievable, and we understand why many women are determined to have a natural childbirth. The “price to be paid” with epidural is that your birth will likely not be as intense as the above description, but it will still be beautiful, memorable, and special.

CONCLUSION

We support your freedom to choose how you manage your labor pain. We will support you if you desire drug-free natural childbirth, and we will support you if you want your epidural as soon as you check in to the hospital! Epidurals have proven themselves to be a safe and effective means of excellent pain relief during labor, however there are some risks and side effects to having epidurals as well.

H. TAKING HOME THE PLACENTA

You may take home your placenta after delivery. Exception to this include if there was some type of infection or some other unusual birth-related issue where we would need to send the placenta to the lab. The Hospital will prepare it for you to take home. Make sure to tell your Labor nurse. There is a minimum 48 hour hold on all placentas.

There is a service called placental encapsulation. This means trimming off and saving just the meaty portion of the placenta, which is then heated up, sterilized, freeze-dried, ground into powder and placed in small gelatin capsules, enough to last for months. PROPER TECHNIQUES ARE CRITICAL FOR THIS TO BE SAFE.

EVERYONE will tell you that taking these capsules can help prevent postpartum depression. This is a good example of how the public believes something even though there is no medical data or scientific proof of any kind.

(If a movie star does it, then it must be a good idea, right?)

According to a June 2015 CBS news report: "… after reviewing the existing scientific literature on the subject, Dr. Crystal Clark, a psychiatrist specializing in reproduction-related mood disorders at Northwestern University, found that there is no data to support these claims. What's more concerning, she says, is that there are no studies examining the potential risks of eating the placenta, which filters out toxins and pollutants during pregnancy to protect the developing fetus.

"Bacteria and elements such as mercury and lead have been identified in the post-term placenta," Clark told CBS News. "So if the theory is that we retain nutrients and hormones such as estrogen and iron that could be beneficial, then the question becomes what harmful substances can also be retained that could harm the mother or the baby if she is breastfeeding."

Clark and her research team reviewed 10 published studies on the topic, covering both the attitudes and motivations for eating the placenta and the consumption of animal and human placenta by nonhuman mammals. There are no studies of scientific rigor available on placentophagy in humans. The results were published in Archives of Women's Mental Health.

(http://www.cbsnews.com/news/no-proven-health-benefits-unknown-risks-of-eating-placenta/).

In June 2017, the CDC published a report of a newborn who developed severe Group B strep infection caused by the mother ingesting her encapsulated dehydrated placenta (www.cdc.gov/mmwr/volumes/66/wr/mm6625a4.htm).

Once the placenta leaves your body, it is a dead organ. There are no more "vital" hormones or nutrients left inside, and it is basically like raw meat.

Conclusion: We do not advise eating the placenta, even though it has become "popular."

I. VAGINAL SEEDING – DO NOT DO THIS

There are trillions (thousands of billions) of naturally occurring bacteria representing hundreds of different strains that live in the human large intestine (colon). Collectively this is referred to as intestinal flora or the "**gut biome**." There are also potential disease-causing organisms that live in the gut which can cause serious infection if they enter other areas of the body.

Some studies have shown that the bacteria in the gut biome of a baby born vaginally is different than the gut biome of a baby born by Cesarean Section (C/S). The vaginally born baby has a gut biome closer to that of the mother's vagina than a C/S born baby. Some studies also reportedly show a higher incidence in some auto-immune diseases later in life if the birth was by C/S. These preliminary findings have led to a strange practice, known as vaginal seeding.

The practice of vaginal seeding is when a pregnant woman who has a C/S inserts a gauze inside her vagina after the C/S and then wipes the bloody gauze over the baby's face and mouth to try and introduce these bacteria into the baby's GI tract. Somebody on the Internet invented this to help "restore" the natural gut biome of the C/S baby.

We mention this practice only so we can condemn and criticize it. There is NO SCIENCE to show that this is safe. We do not know if this works to repopulate the baby's gut biome. We do not know if altering the baby's gut biome can prevent disease later in life. We DO KNOW that a newborn has a weak immune system, and this practice

can introduce potentially life-threatening bacteria into a baby where they do not belong (the lungs for example). For example, Group B strep is a colonic bacteria from the mother that can lead to a life-threatening illness in a newborn and some newborn deaths have been reported since people starting doing this.

Until there is data that vaginal seeding is safe and effective, we DO NOT SUPPORT this practice. It is also prohibited by ACOG (the American College of Ob/Gyn).

J. INDUCTION OF LABOR

Induction of labor is a procedure where medication or other methods are used to either initiate the onset of labor, or to maintain or strengthen labor. Intravenous Pitocin is commonly used for this. Pitocin causes uterine contractions and is given in very low doses using a computer-controlled continuous intravenous pump. The initial setting is at the lowest dose, and then the dose is gradually increased until satisfactory contractions have been obtained. We can also induce labor using other medications such as a vaginal or oral tablet called Cytotec (misoprostil) or the insertion of a small balloon through the vagina and the cervix into the lower uterine area.

There are many reasons why labor might need to be induced. The most common medical indications are full-term or overdue babies, elevated maternal blood pressure, history of rapid labor, and suspected big babies (we can induce a bit before the due date, before the baby gets "too big"). Sometimes we induce labor because patients live far away, or have other 'situational' reasons, which are referred to as "logistical" indications.

Many patients wonder if there is way to "make themselves" go into labor. Ob/Gyn's often advise vigorous physical activity, dancing, walking a lot, having intercourse. All might help. One interesting approach is the famous "Maternity Salad." This is available at a restaurant called Caioti, in Studio City. Good luck! (p.s. we are NOT big fans of castor oil. It can work, but can also lead to diarrhea, gas pains, and abnormally strong contractions).

K. ATTEMPTED VAGINAL BIRTH AFTER CESAREAN (VBAC)

*This is also called TOLAC (Trial Of Labor After C/S)

If you have had a previous Cesarean (or uterine fibroid surgery), you could be a candidate for a chance at vaginal birth. There are risks associated with attempting VBAC, such as the possible risk of uterine rupture (tearing of the uterus in the area of the prior uterine scar). Uterine rupture can have serious consequences, including hemorrhage, blood transfusion, hysterectomy, placental separation and/or oxygen deprivation to the baby, rarely leading to fetal brain injury and/or death. Recent data suggests that these risks are higher than previously believed. Patients who have had two or more previous Cesarean sections are normally not candidates for VBAC but exceptions can occur.

The benefit of attempted VBAC is that there is a good chance you may be able to deliver vaginally. This allows for the birth experience that did not occur with the prior C/S birth, and normally allows for a shorter hospital stay and easier recovery, assuming all goes well. This is an important decision and should be discussed with your Ob doctor.

23) CESAREAN SECTION

Many patients ask us about this, and we can talk about this subject at length. About one-fourth to one-third of all babies are delivered by Cesarean section, and there are many reasons for this. Medical indications include but are not limited to: failure of the cervix to fully dilate, failure of the baby to descend in the birth canal during pushing, fetal distress (fetal heart rate drops), twins, breech presentation, herpes, placenta previa, pre-eclampsia (toxemia), previous cesarean section, babies suffering from intrauterine growth restriction (IUGR) or babies that are too large to fit through the pelvis.

Our Cesarean birth rate (as many people ask us) is not the lowest in town, and it is not the highest. We feel that every Cesarean Delivery we do is for appropriate medical reasons. At the time that this decision is made, we thoroughly explain the reasons for the choice so that it is felt by both the parents and the physician to be the safest and best decision given their particular situation.

Cesarean By Request: The American College of Ob/Gyn supports the concept of a Cesarean Section based on the patient's request. In this case, the patient would not have to go through labor, and the Cesarean Section would be scheduled about one week before the due date. Our job is to inform you of the potential risks and benefits of this approach when compared with the standard approach of trying for normal vaginal delivery. Some experts believe that Cesarean Section can prevent certain vaginal and pelvic problems that some women experience later in life such as urinary incontinence and pelvic organ prolapse. If you choose to have your baby by a planned Cesarean, we can arrange this for you.

Cesarean Pre-Op

If we know that your delivery is going to be a planned C/S, we arrange a pre-op office visit usually about 1-3 days before the delivery. During this visit, we perform a physical exam and then review the C/S instructions and procedures. This is also a good time to modify your diet by trying to eliminate gassy-type foods (broccoli, beans or other green veggies), to help minimize post-op discomfort from gas pains (typically they occur the day after the C/S).

24) PLANNED OUT-OF-HOSPITAL BIRTH

You have the right to deliver your baby in a hospital, at home, at a birthing center, or wherever you wish. However, our doctors do not provide prenatal care to any OB patient who is not planning a hospital birth. If we learn during your pregnancy that you are planning an out-of-hospital birth, you will be discharged as a patient from our group. We also do not provide labor or delivery care to any OB patient who left our group during pregnancy (or was asked to leave), even if the patient shows up later in Labor and Delivery. The on-duty laborist will be able to help you should you end up in the hospital due to problems during an attempted out-of-hospital birth.

25) TUBAL LIGATION OR BILATERAL SALPINGECTOMY (TUBAL "STERILIZATION")

Tubal Ligation (a "tubal") is an operation to perform permanent sterilization on a woman. The fallopian tubes allow the sperm and egg to meet, and this is where conception occurs. When the tubes are "tied" a small piece of each tube is surgically removed. The other internal female organs (uterus, cervix and ovaries) are not involved in the procedure, so there should not be any changes in sensation or function of any female organs after a tubal ligation has been performed. Salpingectomy means that most of the tube is removed.

Tubal Ligation or Salpingectomy can be done at the same time as a Cesarean Section or it can be done shortly after vaginal birth, referred to as a postpartum tubal ligation. When done at the time of a C/S, there is very little additional risk, additional pain or change in the post-operative recovery. It also adds only a few minutes to the overall length of the operation.

As a postpartum procedure, it is performed about an hour after the delivery; however, emergencies in the Family Birth Center take precedence, and there is a chance that the tubal may be delayed or cancelled. A small incision is made just below the belly button, and the procedure usually takes about 15 to 30 minutes. Discomfort is moderate initially but is minimal by the second postpartum day making this form of sterilization a very appealing option.

Tubal sterilization is considered permanent and not reversible. Instead, women turn to in-vitro fertilization (IVF) to attempt conception if they later decide to have another baby. Thus, it is important to be 100 percent sure before having a tubal sterilization done. In other words, 'maybe' means 'no'.

Many times we remove both tubes altogether. This is called "bilateral salpingectomy." This has been shown to help lower the chance of developing ovarian cancer later in life. Studies show that cancer cells can start in the tube and then drip onto the ovaries, possibly leading to ovarian cancer one day. Removing the tubes can help prevent this.

26) BLOOD TRANSFUSION AND BLOOD SAFETY

There is always going to be some blood loss with the delivery of a baby. Normally, by the end of pregnancy, the woman's body has been able to produce about 500 cc extra blood (equivalent to a 1 unit blood donation). This is one reason why taking extra iron and folic acid is important during pregnancy.

Sometimes the blood loss is higher than average. This can occur with a Cesarean Section or if there is a delivery complication such as placenta previa, retained placenta, or postpartum hemorrhage. Most of the time, the body can sustain a great deal of blood loss without a transfusion being necessary. However, in the event of excessive blood loss, a blood transfusion may become necessary to preserve the life and/or health of the patient.

If a blood transfusion becomes necessary, the need is immediate and therefore volunteer donor blood bank blood must be used. It takes days to prepare blood from a relative before it is ready to be transfused. All donor blood is stringently tested per Red Cross and FDA regulations; however, despite thorough testing, there is still a remote chance of acquiring an infectious disease from blood such as HIV (odds are 1 in 1.5 million) or Hepatitis C (odds about 1 in 250,000).

If you would not accept blood under any circumstances, even those deemed to be life threatening, it is important that you inform us of this situation. Otherwise, we will assume that you agree to a blood transfusion if it becomes necessary.

27) DISABILITY

A. DEFINITIONS

The law states that a physician can place a patient on disability only if the patient has a medical condition that prevents her from performing her regular job. Patients with high-risk pregnancies can be placed on disability at any time during the pregnancy continuing until 6-8 weeks postpartum. Normal pregnant women can go on disability 4 weeks before their due date (at 36 weeks) and can remain on disability until 6 weeks after a vaginal delivery (or up to 8 weeks after a Cesarean Section). However, a normal, healthy pregnant woman may choose to continue working past 36 weeks gestation if she wishes to.

B. DISABILITY INSURANCE

Once a doctor declares that a patient is medically disabled, the patient may be eligible for benefits provided she has disability insurance coverage. This coverage may be a private policy, an employer-provided benefit or may be through the State of California, which is called the SDI (State Disability Insurance) program.

C. CALIFORNIA SDI

The State of California pays disability benefits to employed pregnant women, provided that they are covered under SDI, which is a payroll deduction. Not every employee qualifies for this benefit, and if you are eligible, you still need to file a claim form. We can provide you with the proper claim form, or you can contact any branch of the E.D.D. (Employment Development Dept.). You fill out a brief section, and we do the rest. SDI benefits do not begin until the 8th day after the onset of your disability and they extend until 6 weeks after the due date (or up to 8 weeks if a Cesarean Section). If you are still disabled at that time, you will receive a disability extension form from the State that we need to fill out. All of the above can be done online.

If your disability policy is other than SDI, there likely will be different forms, different guidelines and possibly different terms of coverage. You will need to clarify these with whoever is providing the coverage. We will provide you with a physician's certificate of disability, and we will be glad to help you fill out your disability coverage forms.

Please note: Wait until AFTER you have stopped working before you file a claim for SDI. You have to report the last date that you actually worked.

How to File an Online Claim with SDI

1. Go to https://edd.ca.gov
2. Click on File and Manage a claim.
3. They will get you set up with an account give you a username and password.
4. You will then need to fill out SDI forms (supplemental Disability form).
5. Once you fill out your portion of the form it will give you a receipt number (example: R1000000452139).
6. Call OUR office with receipt number (or send an email to obgyn@fowh.com).
7. Our office will then do our part online.
8. It usually takes about 5-7 days for them to process after we enter our data in the system.

D. DMV HANDICAPPED PARKING PERMITS

Some high-risk patients might benefit from being able to park in handicapped spaces. This can be arranged, so please let us know if you feel that you need this service. It is a temporary permit only.

E. PREGNANCY LEAVE

Disability Leave

If you are disabled and work for an employer with 5 or more employees, you have the right to take **unpaid** pregnancy disability leave for up to 4 months.

Family Medical Leave Act (workplace more than 50 employees) (FMLA)

Under the federal Family and Medical Leave Act and the California Family Rights Act, female employees are entitled to up to **12 weeks of unpaid leave** for the birth of a child (and for other reasons not mentioned here). This leave is unrelated to pregnancy disability leave and may be taken **in addition to** any disability leave the pregnant employee is entitled to under the Fair Employment and Housing Act. HealthCare insurance coverage must be maintained during this leave.

F. CALIFORNIA PAID FAMILY LEAVE PROGRAM (PFLA)

California offers **paid** family leave. Workers can get up to 6 weeks of partial pay per year (within a 12-month time period) while taking time off from work to care for a new baby. Most people get about 55% of their usual pay. The program is funded by an SDI payroll deduction from your paycheck and the payments come from the EDD, a state agency, not the employer. Any worker who currently pays into the SDI program is automatically eligible for this paid family leave. New mothers who are eligible for 6 weeks of postpartum SDI are also eligible for this paid family leave to bond with the new baby.

For more information, call the EDD at 1-800-480-3287. or go to their web site: http://www.edd.ca.gov. Also see http://www.paidfamilyleave.org/law.html.

G. PREGNANCY DISCRIMINATION

1. Discrimination or harassment against an employee based upon their pregnancy is prohibited by California State Law (the California Fair Employment and Housing Act applies to employers with 5 or more employees) and by Federal Law (the Pregnancy Discrimination Act of 1978 applies to employers with 15 or more employees).
2. Employers must treat pregnant employees who are unable to do certain tasks the same as other temporarily disabled employees.
3. An employer cannot force a pregnant employee to take mandatory leave if she can still perform her **essential job functions**.
4. California law requires that employers must provide you with any reasonable accommodation for pregnancy that they are capable of providing (such as more frequent breaks for trips to the restroom, or a transfer to a less strenuous or dangerous position while pregnant).
5. Harassing or unwelcome conduct relating to pregnancy, childbirth or related medical conditions is a form of sexual harassment and is prohibited under California and Federal law. An employer is responsible even if the harassment is by a fellow employee or supervisor, *if the employer knew or should have known about it and did not take immediate steps to correct it.*
6. If you believe that you have been discriminated against:
   - You should begin keeping a paper trail as detailed as possible listing names, dates and content of conversations, keeping copies of all correspondence.
   - Try to work at the least official levels first such as with your direct supervisor. Then proceed up the chain of command. Include your company's Human Resources Dept. (if there is one). If you are in a union, talk to them. If there is a grievance mechanism, use it.
   - Be aware of deadlines if you decide to file a complaint with a government agency.
   - You need to file a complaint with the Dept. of Fair Employment and Housing **less than one year** from the date of the discriminating act, and with the Equal Employment Opportunity Commission **less than 300 days** from the earliest act.
7. California Department of Fair Employment and Housing (DFEH) 800-884-1684, U.S. Equal Employment Opportunity Commission (EEOC) 415-356-5100 (San Francisco) or 510-637-3230 (Oakland). U.S. Department of Labor 800-959-3652 (general information line).

28) BREAST FEEDING

A. BENEFITS OF BREAST-FEEDING

We believe that breast-feeding offers many advantages over bottle-feeding. Breast milk provides maternal antibodies and white blood cells that help boost the newborn's immune system. This is particularly beneficial for the first 4-6 weeks after birth. Additionally, breast milk fed babies have been shown to have fewer problems with food allergies when they are older. Breast-feeding can be more convenient than bottle-feeding since the milk is always warm, fresh, clean and readily available. Lastly, the emotional bond between mother and child is quite intense and satisfying during feedings.

Exclusive Breast-Feeding: Some experts claim that for breast-feeding to be successful, the goal should be for the baby to be breast-fed 100%, starting right from birth. This can be a challenge. See ahead for concerns about trying to exclusively nurse during the first week of life.

B. ENGORGEMENT

The milk usually "comes in" between the second and fifth day postpartum. For first timers, sometimes not until day 7, earlier for veteran moms. The breasts swell, and can become hard, sore and tender. Proper nursing techniques, along with some hot packs (hot, wet, wrung-out hand towels) should help the let-down. This phase lasts a few days.

C. SCHEDULING OF FEEDINGS

Some moms are advised to try and put the newborn on an exact 3-hour breast-feeding schedule. We are opposed to this for newborn infants. For the first 3 months of life, as much as possible, breast-feeding should be done "on-demand." When the baby is hungry, he/she should be fed! The baby needs to develop trust, to know instinctively that his/her needs will be met. Most newborn babies are not biologically capable of following a schedule. They may sleep 4-6 hours straight or get hungry again an hour after eating. You must learn to trust your parental instincts. Don't let your newborn baby cry and suffer in order to satisfy some expert who says that you should "train" the baby to feed exactly every 3 hours.

D. BREAST-FEEDING IN THE HOSPITAL

For many new moms it may come as a surprise that breastfeeding can be quite a challenge initially! The baby is sleepy, won't latch on, sucks for a minute and then stops, or sucks too long causing pain. Furthermore, despite the best intentions of the nurses, new moms often get conflicting advice. What follows are a few breastfeeding tips based on our experience: (this advice applies mainly to the first few days when initiating nursing):

- The breast is NOT a pacifier. Do not let the baby suck too long. Ten (10) minutes per side should be enough. Many new moms think the baby will stop sucking when he/she is satisfied. Not true. Sucking is an instinct and babies LOVE to suck. Sucking is not HUNGER. Sucking too long may damage the nipple, causing cuts, bruising, pain, bleeding, and increased risk of breast infection. After breast-feeding is well established, longer times on the breast are fine if the nipple is not being injured.
- Repeat: Sucking is not Hunger. There are early hunger cues such as rooting, sticking out the tongue and fussing. The baby may feed well if these signs are present. If these signs are not noticed, then the baby may begin to cry and be difficult to console other than by feeding. Ideally, the baby goes to the breast when the hunger signs are present, but crying has not yet begun. Crying that is easily relieved by hugging, holding, swaddling, playing, diaper-changing, etc. suggests that hunger is not the issue, and perhaps it is not yet time to nurse.
- When babies are hungry, they will latch on readily and suck vigorously. Strong sucking will also help stimulate more milk production for the next time. It is better to feed a very hungry baby every 2-3 hours than a barely hungry baby every hour.
- If you nurse both breasts at one feeding, remember which side was second. Start on that side next time. This way the same breast is not fed from first each time, which over time can cause that breast to become larger than the other one.
- When the baby comes off the breast, the areola is very wet. Let it air dry a few minutes before covering up. Then lanolin (or a few drops of breast milk) can be used to moisturize the nipple and areola.
- Lactation Support: If you are having problems nursing, we can recommend the services of a lactation specialist. Electric breast pumps are also available for rental.
- Huntington Hospital is considered a "Baby Friendly" hospital. This is a special designation that took a long time for the hospital to earn and they must submit data to show that they are maintaining these standards. In

a “Baby Friendly” hospital, there is an expectation that most moms will exclusively breast-feed. Providing even one drop of formula to the baby will not count when the hospital submits their data. Thus, you can understand that the Maternity staff really want all new moms to nurse exclusively.

- The nurses might not suggest a bottle or formula for your baby, unless you ask, or if the Pediatrician feels it is medically necessary. During the first few days, there may be little milk production. There is colostrum, which is healthy for the baby, but only a small amount is produced. If no formula is given, the baby will not starve, but will likely lose some weight before leaving the hospital and may not be a very good sleeper. One of the reasons babies sleep so much the first day or two is Mother Nature’s way of minimizing their hunger and need for food while breast milk production is minimal. But a well-fed baby does sleep better also!

CONCERNS AND ADVICE

- Dedication to breastfeeding at all costs can sometimes lead to underfed babies. A dehydrated newborn can appear sleepy and listless, signs of a serious medical problem. Newborns are often admitted to the ICU for IB hydration due to being underfed. Supplementing babies with formula when the milk supply is low will normally prevent this complication. This might only be necessary for the first week or two.
- During the first few days, some babies sleep quite a bit, others perhaps not enough. Hungry babies do not sleep well. Nursing a hungry baby when little to no milk is present is frustrating for mom and tiring for baby. The tired baby might fall asleep from exhaustion and wake up soon due to hunger than has not been satisfied.
- Nurses may suggest “cluster feeding.” This means nursing the baby very often, perhaps every 1-2 hours. We are not fans of this approach as we have seen moms develop sore, cracked, painful injured nipples as well as signs of post-partum depression due to their disappointment, pain, and exhaustion at trying to follow this practice.
- We do not mean to be contrarian, but after years of experience with the Hospital’s “Baby Friendly” approach, we have some disagreements. We feel that feeding a hungry baby should be the number one priority for a mom and newborn. When milk production is delayed or low, we support the use of formula on a hopefully short-term, temporary basis. The Hospital has formula on hand and will provide it if you ask.
- Holle Organic formula. This is a natural formula we have had good feedback from patients about. It comes from Germany but is available online.

E. BREAST PUMPS: THE GOOD AND THE BAD

Many women start to use breast pumps immediately postpartum. Pumping can help with milk letdown and can stimulate production. Alternatively, milk can be pumped and then fed to the baby in a bottle, allowing for others to feed the baby, and allowing the quantity of milk consumed to be monitored. Some women “pump ahead” and purposefully try to produce more milk than the baby needs so that extra can be stored. This is often done in preparation for returning to work. This is the good part, but there is also a negative aspect to using breast pumps.

Relying on breast pumps, even partly, can lead to breast milk overproduction and to lack of synchronization with the baby. What is synchronization? This is when a breast-feeding woman’s milk production and timing is closely related to the baby’s feeding cycles. Not every nursing mom achieves this, but many come close. When the baby is breastfed exclusively on demand, and no pump is used, it is possible for the mother’s milk production to match the baby’s needs. When the baby is hungry, the breasts are hard and full about the same time. At night, the mother might wake up because her breasts become hard and tender, and within moments the baby is also waking up and is hungry.

If the pump is used too often, milk overproduction disrupts this synchronization. The breasts may become hard, sore and full while the baby is asleep. Pumping will empty them, but then an hour later when the baby gets hungry, he/she will be fed with breast milk in a bottle, and this can keep on happening. It can be very tiring to pump the breasts 6-8 times a day (about 10-20 minutes per session), and to bottle feed the baby 6-8 times per day as well.

F. DELAYED MENSTRUATION – LOW HORMONE STATE – BIRTH CONTROL

It is normal for nursing mothers not to have their menstrual periods while breastfeeding. This is due to a low estrogen state. Other consequences of low estrogen are vaginal dryness, decreased sex drive and some degree of contraceptive benefit. Breastfeeding women can experience symptoms like menopausal women, including hot flashes and night sweats, due to this low estrogen production.

The first menstrual period usually occurs about 6-8 weeks after weaning, but some women develop regular monthly cycles while still continuing to nurse. Lack of periods is a form of birth-control but we say this is like a 90% protection, not a 99.9% one. The very first time your body ovulates while breastfeeding will be invisible. If you do not accidentally get pregnant, your first period will show up soon after. But occasionally we see a return OB patient who became pregnant while nursing and never even had her first period.

G. MEDICATIONS WHILE BREAST-FEEDING

There is a general fear of taking any medication while breast-feeding, however, many medications can be taken with minimal risk. There is a great deal of information available on this subject. Of course, you should discuss the particular details with your Pediatrician, but doing some homework in advance may be helpful.

The following substances and/or medications are felt to be safe to take while breastfeeding: alcohol in small amounts, B-Vitamins, Birth Control Pills, caffeine in small amounts, Codeine, Inderal, Motrin or Advil, Penicillin, Prednisone, Procardia, Progesterone or similar drugs like the "mini-pill" or levonorgestrel, Tylenol, Zovirax and many others.

H. SEX WHILE BREAST-FEEDING

After the six-week postpartum check-up, the patient is usually given the "green light" to resume sexual activity. Many husbands are anxiously awaiting their partner's answer to the question, "Honey, what did the doctor say?"

However, just because you have the 'green light' does not obligate you to put the car into drive! Many women are not ready for sexual activity at 6 weeks. You may be exhausted and sleep deprived. Additionally, there are physical changes in your body due to breast-feeding that may result in diminished desire for sex. For example, estrogen levels are naturally very low while breastfeeding. This is why breastfeeding women usually do not get their periods and why they are less fertile. But it also may lead to diminished or absent libido (sex drive).

Another consequence of low estrogen levels is vaginal dryness. This condition is also common in women after menopause for the same reason -- low estrogen levels. However it is fully reversible once the patient has weaned. Vaginal dryness may make sex uncomfortable. This can be greatly improved by using vaginal lubricants such as K-Y jelly or liquid, or Astro-Glide. Some women may benefit from the use of a low-dose vaginal estrogen cream. Lastly, some form of birth control is still advisable while breastfeeding. Please see the discussion ahead.

I. MASTITIS

If you develop redness, hardness and pain in one breast, especially with a fever above 101^0, this could be a breast infection (mastitis). If left untreated, it can progress to an abscess. Please call the office right away if you develop any of these symptoms.

J. SUPPRESSION OF MILK PRODUCTION

In August 1994, bromocriptine (Parlodel) was decertified by the manufacturer for the indication of suppression of lactation. There were case reports of maternal seizures and some deaths. Consequently, there is no longer any FDA-approved medication for the purpose of lactation suppression. In many countries, cabergoline (Dostinex) is used for this purpose but again, the FDA does not consider cabergoline indicated to suppress lactation because the similar drug bromocriptine caused hypertension, stroke, seizures and psychosis when used for this purpose.

Two systematic reviews found that cabergoline was generally well tolerated for use in suppressing lactation, but dizziness, headache, nausea and vomiting occur occasionally. A popular illegal drug is called domperidone, often purchased from Canada, but it is not deemed safe and is not FDA-approved. Overall, the safest way to prevent or stop lactation involves natural methods, not meds.

If you do not wish to breast-feed, you can help prevent the development of painful engorgement by doing the following: Wear a tight-fitting bra up to 24 hours per day for about 2 weeks. For breast soreness apply an ice pack to the breasts for 15-30 minutes, 3-4 times per day; take two Advil (or its equivalent) every 4-6 hours; avoid breast stimulation or hot water on the breasts; and, avoid any hand expression of milk. Call us if you have problems with engorgement.

K. INCREASING MILK PRODUCTION

Sometimes there is not enough breast milk to completely feed the baby. Many different approaches have been tried to increase milk production. Breast pumps can be useful. Certain herbs such as fenugreek and milk thistle have been recommended with varying degrees of success. A prescription medication called Reglan can be tried, but side effects such as dry mouth and restlessness are common. Lastly, a medication from Canada called domperidone has been shown to help, but this drug is illegal in the U.S. and has been shown to cause sudden deaths in some users.

A new fad is the breast milk brownie. These are very high fat, high calorie and tasty treats that are promoted to help increase milk supply. There is no data, so all the evidence comes from testimonials. Other than causing weight gain, these appear safe, but we cannot comment on their effectiveness.

L. CHOOSING NOT TO BREAST FEED

There are many reasons for deciding not to breast feed. These include having to take medication that is not safe for the baby, prior history of severe difficulties nursing, or personal preference. Furthermore, some women try very hard in the beginning and things just don't work out. There might be severe pain, or insufficient milk supply, or just too much frustration. We believe that bottle-feeding a newborn can be safe and nutritious and for some women this might be the best option. Deciding not to breast feed is the right of every new mother, and if this is the best choice for you, we support it.

29) POSTPARTUM INSTRUCTIONS

A. GENERAL ACTIVITY

Your amount of activity can gradually increase but try to avoid getting overly tired. Household activities should be resumed gradually, beginning with the easiest, and later adding the more difficult tasks. You should expect to be able to do almost all your activities within 3-4 weeks. Try to rest as much as possible, for example take a daily nap the first few days. Try to sleep when the baby sleeps.

*Avoid driving for about 1-2 weeks, and do not drive if you are still taking narcotic-type pain medication. Being a passenger is okay. Do not begin driving until you feel that your reflexes are normal, and you can make fast or sudden movements without hesitation.

AFTER A CESAREAN BIRTH: You should be doing most light activities by 2-3 weeks, but a full recovery may take 6-8 weeks. Avoid driving for the first 2 weeks.

IN THE HOSPITAL: You will generally spend 3-4 nights in the hospital. We urge you to have someone who can sleep over in your room with you, especially the first night or two. This person can be very helpful in case the nurses are too busy. Just having someone close by to hand you something, get you some water, help you up to the restroom or to call the nurse for you can make a big difference in your recovery.

B. DIET AND VITAMINS

In general, you may eat whatever you wish. Breastfeeding mothers tend to avoid spicy or odorous food such as garlic, onion, pepper, etc. You still need 3-4 servings per day of dairy or calcium supplementation. High fiber is helpful to maintain bowel regularity. Prenatal vitamins and DHA or Omega-3 supplements should be taken daily.

C. PAIN RELIEF

Prescription pain medication will be written for you at the time of discharge home. Pain in the episiotomy area gets better quickly, usually within one week. Warm sitz baths (shallow warm bath), Tucks pads and Dermoplast spray (topical anesthetic available non-prescription) and Tylenol or Motrin may help. You might need hemorrhoid medication, and we like Preparation H with HC or Anusol HC.

AFTER A CESAREAN BIRTH: You will be given prescription pain medication at discharge. Tylenol or Motrin may also be taken for pain relief. By 1-2 weeks, you may no longer need it. There will be discomfort in the area of the incision for a while but usually of a mild degree by the third or fourth week after surgery. Occasionally, numbness around the incision may persist for many months.

D. HYGIENE

You may wash your hair, shower, or take warm hot sitz baths as you wish. Continue perineal care as you have been instructed in the hospital, but do not douche, use tampons or resume intercourse before your SIX-WEEK postpartum visit. Avoid full immersion in water such as a pool, jacuzzi or full bath until after the 6-week check.

AFTER A CESAREAN BIRTH: Keep the wound dry after bathing by blow-drying it, or by air-drying. Call the office if you notice drainage, separation or redness around or from the incision.

E. VAGINAL BLEEDING/DISCHARGE

Some vaginal discharge or bleeding ("lochia"-initially red, later on pink to brown to yellow) will usually last for 3-6 weeks after giving birth, and occasionally longer. There is usually less lochia after cesarean birth than after vaginal. Use pads only, not tampons. With excessive activity the lochia may return to a redder color for a few days. The return of menses is variable. If you are nursing, you may not have any menses throughout the nursing period, or you may

have random spotting. The 1st period may be from 6-12 weeks after cessation of nursing. On the other hand, you can have regular menses even while still breast-feeding. Lochia is usually lighter after C/S than after vaginal delivery.

If you are not nursing, the first period may be from 6-12 weeks after delivery. The first period can be unusually heavy with clots, and it may take a few months for regular menses to resume.

F. HEMORRHOIDS AND CONSTIPATION

Constipation is common postpartum, particularly while nursing (due to fluid losses). Please follow the same advice given during pregnancy. Prevention is the key. Drink plenty of water throughout the day. Have a good daily intake of fiber (fruits, vegetables and bran). For constipation, you can try prune juice, Metamucil or Citrucel (adds bulk), Colace (a mild stool softener), or MOM (Milk of Magnesia). For hemorrhoids, we recommend fiber and bulk supplements to help produce soft stools (bran, bran and more bran), sitz baths at home, Preparation H or Anusol (with or without hydrocortisone), or Tucks pads.

G. EXERCISE

We recommend taking it easy the first week or two. Walking is good exercise initially. By 3-4 weeks you may be able to begin some stretching and mild exercises.

AFTER A CESAREAN BIRTH: Don't expect to begin regular exercise for 6-8 weeks. Walking is good for you but be careful not to overdo it. Some stretching and exercises that avoid the abdominal area may be initiated 2-4 weeks after the operation. Actual sit-ups or other direct abdominal exercises should wait until at least 2 months after C/S.

H. CARE AFTER CIRCUMCISION

Immediately after the procedure, the penis is wrapped in Vaseline gauze. There will be a small amount of dark blood on the gauze – this is normal and expected. The gauze might fall off on its own. If it does, leave it off. If it does not fall off, then it should be removed in 24-48 hours. If you are still in the hospital, you can ask a nurse to remove it if you wish. To remove the gauze, apply a little Vaseline or A&D ointment first, and the gauze will easily slide right off. Another method is to slowly unwrap it.

After the gauze is removed, the circumcised area of the penis usually looks red and swollen. There may be some creamy secretions visible, do not wipe them off. The healing phase takes about 2 weeks. During this time, the redness gradually fades to pink and the swelling resolves. The pink area becomes the new skin. The red area you see initially is new skin, like you might see after a blister pops or after a bad sunburn peels. It is very tender. As it heals, secretions are normal. These can be white or yellow. New skin will come in and may look glistening white. Don't touch this area. Once you see normal, pink-looking skin, the healing phase is complete.

During the 2 weeks of healing, there is not much to do. The most important thing is to keep the end of the penis covered with Vaseline or A&D ointment as often as you can. Every time you place a new diaper, cover the area with more ointment, or place the ointment on the diaper so when you close the diaper, it covers the circumcised area. You can gently clean the area by running lukewarm water over it. Then, very gently pat it dry with a soft cotton pad or gauze, apply the ointment and you are done. Do not be alarmed if there is a small amount of blood when you dry it.

IMPORTANT – READ THIS

One problem that you should look for is when the newly cut skin sticks to the edge of the exposed tip of the penis (called the glans). You should check more than once a day for this, especially the first few days.

After a circumcision, the skin on the shaft of the penis is supposed to be below the glans. Sometimes the skin slides up and over the edge of the glans and starts to attach itself. Since this is new skin, it has to be pulled back down or else it might heal this way and remain there permanently. The result will be a cosmetic issue only, not a functional issue but this is preventable.

Sometimes you will see swollen tissue that is visually blocking the edge of the glans. This is normal. But, if you see penile skin covering the edge of the exposed glans, you will have to pull it down gently to prevent it from sticking there permanently. Here is what you do:

1. Get your supplies. q-tips, small cotton gauze pads or the equivalent, Vaseline (or A&D).
2. Two people are needed. One will hold the baby's legs apart. Be firm, they are very strong!

3. Carefully inspect the area. Is the penile skin attached and covering the edge of the glans? Pull down a little on the skin below the glans to make sure. If it is, then…

4. The other person uses a moist q-tip or a q-tip covered with Vaseline. Use the q-tip to press down on the glans of the penis and push the sticky skin down and away, beneath the edge of the glans. It just takes a few seconds. The goal is for the entire edge of the glans to be visible with no skin attached to it.

5. A few drops of blood might appear when you do this. Apply pressure with a Vaseline covered cotton gauze or pad for about a minute. Done.

If you have any questions (and if one of our doctors performed the circumcision), call our office and make an appointment for one of the doctors to see your baby. Call 626-304-2626.

I. AFTER DISCHARGE FROM THE HOSPITAL

Please call the office (626-304-2626) to schedule your postpartum check-ups. We like to see you at 6 weeks postpartum after vaginal delivery, and about 1-2 weeks and then 6 weeks postpartum for cesarean birth. Feel free to bring the baby to your check-ups also!

J. CALL THE OFFICE RIGHT AWAY IF YOU HAVE ANY OF THE FOLLOWING:

- Severe or worsening pain anywhere, especially in the abdominal or the perineal areas
- Shaking chills or fever (temperature greater than 101^0)
- Frequency and/or burning with urination or any difficulty with urination
- Significant increase in vaginal bleeding, especially heavy, bright red bleeding
- Feeling faint, lightheaded or weak and dizzy
- Swelling, tenderness, or redness in either breast, or the episiotomy site
- (If C/S): redness around the wound or drainage of any kind from it

K. POSTPARTUM BLUES AND POSTPARTUM DEPRESSION

Postpartum Blues refers to a mild and brief episode of distress occurring in up to 80% of new mothers within the first few weeks after childbirth. A woman can feel weepy, exhausted, anxious or tense, but these feelings generally resolve after the first few weeks. If not, then it is possible that the condition is postpartum depression.

Postpartum Depression is more than the “baby blues.” It may occur immediately after birth or many months later. It can happen after any birth, not just the first time. Up to 15% of new mothers can develop postpartum depression. The symptoms can develop gradually or have a sudden onset, and they include:

- feelings of hopelessness, loneliness, isolation
- crying for no obvious reason
- anxiety
- sleeping problems, insomnia or excessive sleepiness
- eating problems such as loss of appetite or binge eating
- frightening thoughts or fantasies
- the feeling that something is “not right”

Postpartum Depression is different from the normal stress and exhaustion most parents experience when adjusting to a new baby. It can be a serious health condition that can interfere with a woman’s ability to take proper care of herself, her new baby and/or her family. It is also quite treatable, but the person has to first seek help.

TAKE OUR ONLINE QUIZ: https://fowh.com/forms/postpartum-depression-quiz

The following strategies have been shown to help prevent postpartum depression:

- The responsibilities of motherhood are learned, so try to prepare in advance.
- Get help from spouse (or sig other), dependable friends, and relatives.
- If you are feeding the baby from a bottle, we suggest not to delegate this important duty to others. During feedings, babies provide warmth and comfort to the person feeding them, which should be you.
- Make friends with other couples who are experienced with child-bearing and the stress of managing a newborn.
- Don't overload yourself with unimportant tasks. Delegate whenever possible.
- Don't be overly concerned with keeping up appearances of either yourself or your surroundings.

- Get plenty of rest and sleep! Try to sleep when the baby sleeps.
- Don't be a nurse or social hostess to relatives and others at this time.
- Confer and consult with spouse, family and experienced friends, and discuss your feelings and concerns.
- Arrange for help, so you can have some down time.

For more information, contact:

- Huntington Hospital has a postpartum depression program. Call 626-397-2330.
- Postpartum Net (www.postpartum.net) home of Postpartum Support International. Their support line is: 800-944-4773

If your symptoms seem to worsen over time, if you feel that you are overwhelmed and not able to fully take care of your and your baby's needs, if you are so exhausted or lacking energy that you can barely get around or if your thoughts are racing and sometimes irrational or scary, PLEASE GET HELP.

Call our office and ask for an urgent appointment. Tell someone close to you that you are not doing well. If you have any thoughts whatsoever of possibly harming your baby or yourself, you MUST CALL 911 RIGHT AWAY.

L. POSTPARTUM THYROID PROBLEMS

Not all postpartum fatigue is due to sleep deprivation. About 5% of women can experience postpartum thyroiditis, an inflammation of the thyroid gland that can cause thyroid dysfunction. The thyroid gland regulates the body's metabolism. Both underactive and overactive thyroid can cause serious problems and both conditions can occur with postpartum thyroid dysfunction.

Underactive thyroid can cause fatigue, weakness, intolerance to cold, swelling, hair loss and weight gain. Overactive thyroid can cause insomnia, palpitations, anxiety, intolerance to heat and weight loss. If you experience more than 2-3 of any of these symptoms, please contact our office right away. These conditions are easy to diagnose and easy to treat, but only if you let us know!

M. BIRTH CONTROL OPTIONS POSTPARTUM

Whether you are breast-feeding or not, and whether you are having any periods or not, you can still conceive soon after having the baby. Birth Control will be discussed at your 6-week postpartum visit. If you are breast-feeding, your options include condoms, the IUD (intra-uterine device), and the mini-pill (a progesterone-only hormonal contraceptive which is FDA approved for nursing mothers). If you are not breast-feeding, then the Birth Control Pill is also an option.

One of the best contraceptive methods for breast-feeding women is the Mini-Pill, which contains a low-dose progesterone derivative. Taken daily, it provides up to 98% contraception to nursing mothers, and is FDA approved for this situation. The side effects are minimal, including lack of regular periods, possible spotting, and possible mild bloating. This is different than the regular birth control pill as there is no estrogen in the Mini-Pill.

The Copper-T IUD (called Paragard) is FDA approved for up to 10 years continual use and the Mirena IUD is FDA-approved effective for 6-years with fewer side effects than the Copper-T. Other FDA-approved progesterone-releasing IUD's include Kyleena, and Liletta.

The above is a partial list of the major options in birth control. There are others not mentioned, and new developments continue to occur, but it is helpful before the visit to have an idea of what is available so that you can be prepared.

N. WEIGHT LOSS POSTPARTUM

It is likely that you will weigh more at your 6-week check-up than you did prior to becoming pregnancy. Typically, a patient loses 15 to 20 pounds comparing their weight just before delivery with their weight at the 6-week check-up. DO NOT DESPAIR!

The most important thing is to accept that this is normal, it is going to happen, but with a bit of work and a commitment, it will be a temporary situation. Please do not immediately start trying to diet and exercise right after delivering. Your body needs energy (food) and rest to properly heal and recover and especially if you are nursing.

O. AFTER THE 6-WEEK CHECK

After the 6-week check-up, we usually give patients the "green light." This means we allow you to resume intercourse and to resume or begin exercise and/or dieting. If you are breast-feeding, it is still possible to lose weight, but the timing needs to be gradual, maybe aiming for one pound per week of loss.

Exercise – We prefer that you start off slowly, maybe 30 minutes, 2-3 times a week for the first 1-2 weeks, then gradually increase to the level that you would like to attain. Initially, we advise focusing on cardiovascular ('CARDIO') type exercises, as this is how the body develops stamina. Treadmill, walking, hiking, stationery biking, dance or aerobics classes, or swimming are all excellent forms of 'cardio.' One fun type of cardio is the "stroller strides" type of class which combines walking the baby in the stroller with various types of cardiovascular and strengthening exercises.

P. RESOURCES FOR POSTPARTUM HELP

- The Family Room (626-234-2106) provides postpartum doula services. In their own words, "We are a family resource center providing information and support before and after baby, and in the early years of parenthood. Located in San Marino, The Family Room combines all the essential resources for parents to thrive before and after baby, under one roof — for example, childbirth prep, breastfeeding support, mommy and me classes, safe and effective exercise for all stages and much more. Plus, a community to share the adventure." www.familyroomcenter.com (626-234-2106).
- Some Doula agencies will provide postpartum doula services.

Q. FINAL COMMENTS

Thank you for entrusting your obstetrical care and the birth of your baby (or babies) to us. Every doctor in our group loves delivering babies and we have dedicated our careers to this. We strive to help you achieve the safest possible outcome for you and your baby while doing everything we can to help make your birth experience joyful and memorable. Our staff love taking care of ob/gyn patients and many have decades of experience.

As physicians, we are dedicated to helping you in any way possible. Please let us know if you need our help. No matter what your concern is, we want to hear from you. Call us, e-mail us, leave a message, just make sure to let us know that you need some help. If your message was not responded to, or a prescription was not sent in, we may have been so busy that we did not get to it yet, or it may have been a technology glitch (those never happen, right?). Contact us again so we can take care of it.

We are here for you twenty-four hours a day. Stay safe, be well, and we hope you have a great pregnancy!

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

The medical practice of Fair Oaks Women's Health recognizes and respects the rights of each patient as an individual with unique health care needs and we are committed to providing considerate, respectful, confidential and high quality personalized medical care to each and every patient. In turn, we believe that our patients have specific responsibilities to our practice.

The following outlines these rights and responsibilities.

PATIENT RIGHTS

1. I have the right to receive appropriate informed consent in advance of any treatment (test, prescription, procedure or surgery) being performed on me. This means that I will be informed of the reasons for the treatment, the alternatives, the risks and benefits of the treatment, and the risks if I choose not to have this treatment.
2. I have the right to privacy. This means that all information about my health and in my medical record is absolutely confidential and cannot be disclosed to any other individual or organization (including my spouse or life partner), except when I give my written permission, or when disclosure is mandated by law.
3. I have the right to receive a complete copy of my medical record in a timely fashion upon my written request, and I agree to pay a reasonable fee for the work involved in providing me this copy.
4. I have the right to be seen in a timely manner. I will be informed of any delay and have the right to reschedule if the delay is too lengthy.
5. I have the right to be informed in a timely manner of all test results.
6. If I have an urgent medical condition, I have the right to speak to someone immediately when I call and to be seen as soon as possible based on my condition.

PATIENT RESPONSIBILITIES

1. I have the responsibility to understand my insurance plan and benefits.
2. I have the responsibility to take prescribed medications as directed, and if I do not understand the directions, I will call the office for clarifications.
3. In order to insure my good health, I have the responsibility to follow through on all of the doctor's recommendations, including having tests performed, seeing other physicians I have been referred to and returning for follow-up appointments.
4. I have the responsibility to be on time for all scheduled appointments and to notify the office at least 24 hours in advance when I need to cancel or reschedule an appointment.
5. I have the responsibility to pay my co-payment at the time of service.
6. I have the responsibility to pay a $25 charge for any check returned by my bank.
7. If I fail to pay for services rendered and my account is assigned to collections, I have the responsibility to pay all of the costs of collections including reasonable attorney's fees.
8. If I am pregnant, I have the responsibility to notify this office (in advance if possible) of any change in health insurance. I understand that failure to do this may result in my maternity coverage being denied by my new health insurance plan.
9. I understand and agree that this office can only submit a bill for a diagnosis or medical condition documented in my medical record, and that to do otherwise could be considered fraudulent.

30) PEDIATRICIAN NAMES AND PHONE NUMBERS

Note: Everyone delivering at Huntington Hospital needs a Pediatrician for their newborn baby who is ON STAFF at the Hospital. All the physicians below (except in Glendora) are on staff at Huntington.

Huntington Pediatrics - Pasadena
55 E. California Blvd.
Pasadena, CA 91105
626-449-7350

Dr. Holly Wang and Associates
Kindercare Pediatrics
50 Alessandro Pl # 200
Pasadena, CA 91105
626-696-1234

Dr. Irma Gonzalez
960 E Green St L-12
Pasadena, CA 91106
626-795-8822

Dr. Isaac Haddad
2990 E. Colorado Blvd #105C
Pasadena, CA 91107
626-793-3700
He also speaks Arabic, Armenian and French

Dr. Daniel Scaff
960 E Green Street #168
Pasadena, CA 91106
626-432-4600

Huntington Plaza Pediatric Group
800 S. Fairmount Suite 110
Pasadena, CA 91105
626-795-7051

Kids and Teens Medical Clinic
504 S Sierra Madre Blvd
Pasadena, CA 91107
phone number (626)795-8811
www.ktdoctor.com

San Marino Pediatrics
375 Huntington Dr Ste F
San Marino, CA 91108
(626) 270-1580

Dr. David Wang
210 N Garfield Ave # 300,
Monterey Park, CA 91754
Phone: 626-307-9009
Fax: 626-307-7491
Speaks Mandarin

Glendale Pediatrics
1500 E. Chevy Chase #250
Glendale, CA 91202
818-246-7260

Michelle Kolsi, MD
www.michellekolsimd.com
110 W Stocker St
Glendale, CA 91202
(818) 244-7237

Descanso Pediatrics
1346 Foothill Blvd. #201
La Canada, CA
818-790-5583
Dr Chou: Speaks Mandarin

Huntington Pediatrics - Arcadia
301 W. Huntington Dr., Suite 320
Arcadia, CA
Phone : 626-447-3516
www.huntingtonmedical.com

Arcadia Pediatrics Medical Group
612 W Duarte Rd, Ste 603
Arcadia, CA 91007
Phone: (626) 445-8666
Fax: (626) 445-8685
Speaks Mandarin

Healthcare Partners
Marinda Tu MD
450 E Huntington Dr,
Arcadia, CA 91006
Phone Number : (626) 462-1893

Children's Hospital Arcadia Specialty Clinic
468 E Santa Clara St
Monrovia, CA 91016
626-795-7177

Glendora Area
Janet Fermin, M.D.
Amjad Mahfoud, M.D.
210 S. Grand Ave #202
Glendora, CA 91741-4269
626-335-0211
Note: these doctors are NOT on staff at Huntington, but they come highly recommended.

31) BIRTH PLAN COMMENTS

Birth Plan Items	Physician Comments
Intermittent Fetal Monitoring	This is fine if the fetal heart tracing is reassuring. A reassuring electronic fetal monitoring signal is important during labor.
Walking during labor	If your fetal heart tracing is reassuring, you are free to walk during labor. We do not "strap you down" and for the last 20 years we never have.
Saline lock instead of IV	This is fine but you do need to stay well hydrated during labor. At a minimum, a laboring patient should have a saline lock in place because IV access might be needed in an emergency. A clear liquid diet allowing up to 6-8 ounces of liquids per hour is advised. The saline lock can be very important if a sudden emergency happens such as uncontrollable bleeding or sudden fetal distress.
Explain all tests and procedures to me	We always do this. Patients make the final decisions whenever a medical test or procedure might be indicated. We explain everything to help you decide.
Use of Pitocin	This is not done automatically or for no reason, but there are situations where Pitocin usage is very important, such as when the contractions are too weak (common after epidurals), or after the placenta is delivered. If Pitocin is used to help your labor, the goal is for your contractions to be effective enough for your labor to progress towards a normal vaginal birth and help prevent a C/S.
Epidural – timing and indications	It is almost never too late for an epidural. This procedure is your choice. Some women feel guilty about choosing an epidural, and this should not be the case. If this is a first labor, there is no way to know in advance how strong the pain will be.
Different positions for pushing	You can squat (we have a squat bar), or can push while lying on the side or sitting up. Epidurals can cause your legs to be too weak to support you, so pushing is often done in a semi-reclining position, which is actually a good position for pushing!
Try to avoid episiotomy	Some people begin perineal and vaginal massage weeks before the delivery to try and stretch the vaginal opening to help avoid episiotomy. This might work, but also might cause the vagina to remain somewhat stretched in the future. We try to avoid episiotomy when possible, but sometimes a bad tear can be more painful and result in more stitches than an episiotomy. **Our goal is for you to go home with the fewest stitches possible**. We do not perform episiotomy routinely, but in some situations this surgical cut can prevent a worse vaginal tear.
Baby on mother's chest, skin-to-skin	As soon as the baby emerges from the birth canal, we try to place the baby on the mother's chest for skin-to-skin contact. This keeps them warm, and moms (and babies) really like it! The nurse needs to quickly dry off the very wet newborn, perform a brief assessment, check vitals and breathing. They try to do all of this while baby is on mom's chest, but sometimes the baby needs to go to the warming station for better care
Clamp cord after it stops pulsing	Delayed cord clamping is routine. This allows extra blood from the placenta to go into the baby's body.
Taking Home the Placenta	You may take home your placenta after delivery. Exception to this include infection or certain birth complications. Mention this to the Labor nurse before you deliver. Despite what Dr. Google says, there is no evidence that eating the placenta can prevent postpartum depression. In addition, newborn infection and even deaths have been reported from bacterial contamination of the placenta that persists after "processing." **We do not recommend that people eat the placenta whether it is encapsulated, cooked, or raw.**

32) PREGNANCY CHECKLIST

- ❑ Take prenatal vitamins once a day. We also advise a daily DHA supplement (but many PN Vitamins now include DHA). We also advise a daily Calcium Supplement with Vitamin D.
- ❑ Have your first prenatal lab panel done. Most labs can be drawn in our office, unless your insurance plan requires you to go to an outside lab. If you transfer care to us, we still need to run these prenatal tests.
- ❑ Consider having genetic mutation screening done. Often we test the mother first and then if any abnormalities are found would then test the father, but both parents can be tested at the same time.
- ❑ Decide if you would like non-invasive prenatal testing (called NIPT). This is a test to detect fetal DNA in the mother's blood and can be done about 9-10 weeks. It is very accurate but can be expensive. This web site allows you to check your estimated cost: https://womenshealth.labcorp.com/patients/cost-estimator#/
- ❑ You will receive information from the State of California about Prenatal Screening. Please review this information prior to your first OB consultation with the doctor.
- ❑ The nuchal translucency scan (the NT) is done at 12-13 weeks gestation here in our office. This is the first part of a 2-part prenatal screening program and involves an ultrasound, and sometimes a blood draw.
- ❑ At 16 weeks, the second part of the 2-part prenatal screening test is done. This is the afp blood test.
- ❑ All patients are tested for possible gestational diabetes about 26-28 weeks. (twins-sooner). In addition, if you are Rh Negative, you will need a Rhogam injection at the 28-week blood draw appt.
- ❑ By the 7th month, decide about childbirth preparation classes. First-time patients may want to take the Huntington prepared childbirth classes, breast-feeding, infant care or others (*cancelled due to COVID).
- ❑ By the 7th month, submit your Labor and Delivery pre-registration to Huntington Hospital. If you do not yet have a Pediatrician, you may leave that section blank. The form can be downloaded from the Huntington Hospital web site. Click on Our Services, Pregnancy and Childbirth, Preparing for your Stay.
- ❑ Select a Pediatrician for the baby's care while in the hospital. We can recommend one, but many patients wish to ask around and pick someone of their own choosing. Verify that your selected Pediatrician is on your child's medical insurance plan and is on staff at Huntington.
- ❑ If you are planning on having a tubal ligation (tying the tubes), please be sure that you have signed the California State Sterilization Consent Form.
- ❑ Make a decision about umbilical cord blood banking. See the section in our booklet for more information.
- ❑ If you work, once you have determined your last day of work, we can help you submit a disability claim. You may also be eligible for the California Paid Family Leave program. See the section in this booklet.
- ❑ Contact your insurance carrier about 1 month before your due date to be sure that they are aware that you are pregnant, and that there have been no unexpected problems with your coverage. If you are planning on having a Cesarean, or a tubal ligation, or both, be sure they know about these issues as well.

AFTER DELIVERY

- ❑ After you deliver, we will bill your insurance. If you are billing them, you will need a "SUPERBILL" from us. Write the baby's birthday on the superbill before sending it to the insurance company.
- ❑ Read the Postpartum section in the OB Guidebook. There is good information on breastfeeding.
- ❑ After delivery, call to schedule your postpartum appointment. We would like to see you 6 weeks after having a vaginal delivery, and 1-2 weeks after having a Cesarean delivery.

Congratulations!

33) INDEX