

Prenatal Routines

Office Visits

You will come to our office for your first visit. In early pregnancy, we will see you about every four weeks until the 28th week of pregnancy. We'll see you every two weeks from the 28th through the 36th week, then weekly until you give birth. At approximately the 36-week visit, we will visit you at your home. Some women will need more visits but none will need fewer.

Plan on about an hour for the first two visits. At the first visit, we will take care of paperwork, discuss your family and medical history and obtain specimens for the following lab work: Complete blood count, Syphilis test, a test for Rubella (German Measles) immunity, blood type and Rh Group, a test for any antibodies that might harm the baby, and a urinalysis and culture to make sure you don't have a bladder infection. We don't order HIV or additional STD testing without your knowledge and consent. You can request HIV testing at your first visit or at any other time during your pregnancy. We recommend HIV or additional STD testing if there is any chance you may have been exposed because the risk of transmitting the virus to the baby can be greatly reduced with medication taken during pregnancy.

At the second visit, we will do a physical exam, including a pelvic exam, pap smear and tests for vaginal infection. We will also review the results of your lab work.

Each subsequent visit will take approximately 30 minutes. We strongly encourage you to bring your partner, children and anyone else who will attend your birth to at least a few of your appointments. Sharing information is one of the most important aspects of the prenatal care we provide and your visits can be a valuable time for discussion and to answer the questions you and your family will have. Your visits are also a time for emotional support and a time to share the joys, frustrations and concerns you may have. Most expectant parents find this approach builds confidence and is reassuring.

At each visit, we will be checking to see how you are doing. We routinely check the following vital signs of mother and baby:

Mother

1. weight
2. urine
3. blood pressure

Baby

1. growth
2. fetal heart tones
3. position

Mother

Weight: We generally recommend a weight gain of 25-35 pounds over the entire pregnancy. Women who are underweight might need to gain more while those who begin pregnancy overweight might gain less. Optimally, this gain is small in the first trimester and increases to about a pound a week in the second and third trimesters. A slow, steady gain is a normal pattern. While there can be 'growth spurts' during pregnancy, a sudden increase of three or more pounds in a week can be due to excessive fluid retention which can be an indication of pre-eclampsia. A certain amount of fluid retention is normal in pregnancy but swelling in your hands and feet that doesn't go away after a good night's rest should be reported to us.

Urine: During pregnancy your blood volume increases by one third over your non-pregnant state. The extra blood places a strain on your kidneys, which must now filter the blood for two of you. Your urine serves as an indicator of the functioning of several body systems. Tests routinely done on urine include:

Protein: Protein measuring more than a trace by dipstick is not normal in urine. It can be a sign of kidney damage or infection. It is one of the signs of pre-eclampsia in pregnancy. Protein in the urine, along with swelling and increased blood pressure, are the three classic symptoms by which we diagnose pre-eclampsia. Protein beyond a trace will require further investigation by your midwife.

Glucose: Glucose does not normally appear in the urine, but because of the greater blood volume in pregnancy, the rate at which the kidneys can filter the blood also increases. With this increased rate of filtration, it is sometimes normal for a pregnant woman to spill glucose (sugar) in her urine. However, it can also be a sign of gestational, or pregnancy-induced, diabetes.

Blood Pressure: As previously stated, your blood volume increases tremendously during pregnancy. Taking your blood pressure is one way to check on how your circulation is handling the increased volume. Blood pressure refers to the measurement of the pressure that the blood exerts on the blood vessel walls as the heart beats. Normal blood pressure for a healthy young woman can range from around 90/50 to 130/80.

The systolic, or top, number is the pressure against the walls of the arteries when the heart contracts and pushes the blood at peak force. Emotions and environment easily influence your systolic measurement. Increase in this number alone is not significant until it reaches 30mm above normal.

The diastolic, or bottom, number is the pressure in your arteries when the heart is at rest between beats. An elevation of 15mm or more over your normal blood pressure is considered significant, and a sign of strain on your system. Increased blood pressure can occur together with edema (swelling) and protein in your urine, indicating pre-eclampsia. It can also occur by itself, indicating stress on your system but not pre-eclampsia. In both cases we will recommend rest, particularly on your left side. This position allows your kidneys to filter your blood more effectively since as your uterus grows and rises out of your pelvis and into the abdomen, it rotates to the right. As it grows, the bulk of it begins to interfere with the blood flow through your body. It can have the effect of either raising or lowering your blood pressure. Lying on your left side rolls the uterus off your blood vessels, allowing free circulation and better kidney function. Just lying on your left side frequently returns your blood pressure to normal.

Hemoglobin: Although we do measure your hemoglobin at every visit, it is an important measure of maternal-fetal well being. It measures the iron-containing pigment in your red blood cells that carries oxygen. The higher the hemoglobin, the higher your iron count and the higher the oxygenation of your blood. A non-pregnant woman's hemoglobin is between 11-15 g/dl. During pregnancy it is normal for the hemoglobin to go down due to the expanded blood. The increased blood volume serves to 'dilute' the amount of iron in your blood. In addition, the baby is building his iron stores from the iron in your body. Usually, your hemoglobin will fall slowly until the 28th week or so and then begin to rise again. If your hemoglobin is below 11 g/dl at the beginning of your pregnancy, we will usually recommend a diet containing iron-rich foods and an iron supplement. If your hemoglobin falls below 10 g/dl and does not begin to rise, we may order iron studies (lab work) to determine the exact cause of your anemia. The reason for our concern about your hemoglobin levels, in addition to the fact that it measures the oxygen-carrying capacity of your blood, is that women with low hemoglobin levels become fatigued more easily, are more likely to experience excessive bleeding at delivery, are more prone to infection, and are subject to a longer recovery period.

Baby

Growth: During the first trimester (12 weeks), the uterus grows more due to the influence of hormones than from the growth of the baby. Thereafter, the uterus grows approximately one centimeter per week of gestation. Every time you visit we measure the height from the pubic bone to the top (fundus) of the uterus. The fundal height measurement is roughly equivalent to the number of weeks of gestation. A steady rate of growth is an important indicator of how the baby is doing.

Fetal Heart Tones: We listen to the baby's heart tones at every visit. A baby's heart beats between 120 and 160 times a minute, about twice as fast as ours.

Position: Once the baby is big enough, we will determine his/her position in the uterus. Over 93% of all babies are born in the head down, or vertex, position. Another 4-5% are born in the breech position, with buttocks or feet presenting first. The remaining babies are either transverse (sideways across the mother's abdomen) or oblique. Babies in these positions cannot be born vaginally unless they convert either spontaneously or with help to either a vertex or breech presentation. Until around 34 weeks of pregnancy, position is relatively unimportant since there is usually as much fluid as there is baby and the baby can easily move from one position to another. After 30 weeks, if it looks as if the baby will settle into a breech position, we will give you special exercises to do to encourage the baby to move into a head-down position.

We will also show you how to feel your baby's head, back and limbs. With a little practice, it's easy and fun to do.

Other Testing

MSAFP or Quad Screen: This is an optional test to screen for certain types of central nervous system abnormalities and Down Syndrome. The test does not give us definitive answers but can tell us if there is an increased risk of birth defects or genetic disorders. If the MSAFP indicates an increased risk, further testing such as ultrasound and amniocentesis are needed to make a more definite diagnosis.

Genetic Counseling: There is a questionnaire included with our standard prenatal forms, which helps assess your risk of birth defects. If you know that inherited disorders or birth defects run in your family or your partner's family, we can help you arrange genetic counseling.

Amniocentesis: This is usually offered to women who will be 35 or older when the baby is born, or for those at increased risk for certain birth defects or genetic disorders. We can make a referral for the procedure and will discuss it with you prenatally.

Glucose Testing: Gestational Diabetes occurs in 3 to 12% of all pregnant women. Uncontrolled gestational diabetes can result in an exceptionally large baby, low blood sugar in the newborn, increased risk of jaundice in the newborn, increased risk of respiratory distress in the newborn and an increased risk of stillbirth.

Rh-Negative Moms: If your blood type is "negative", additional lab work might be required. If the baby's father has negative blood then no additional lab work is needed. If the father's blood type is positive or unknown, you will need to have blood drawn at 28 and 36 weeks to check for antibodies that could harm a baby with 'positive' blood. In addition, you will be offered Rhogam at 28 weeks to prevent the formation of those antibodies. After the birth, a sample of the baby's cord blood will be tested to determine his/her blood type. If the baby is positive then you will again be offered Rhogam within 3 days of the birth to prevent the formation of antibodies that could be harmful for future babies.

Ultrasound: We don't routinely order a first trimester ultrasound but will schedule a sonogram if you are uncertain about dates, experience vaginal bleeding or if you'd like to do early screening for genetic disorders. Additionally, a scan to check on placental location, fetal anatomy and gender is usually done at approximately 18 to 20 weeks.