HIBISC
WOMEN'S CE

PRENATAL GUIDE
12TH EDITION
(REVISED JUNE 2020)

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Mission

Our mission is to provide safe, evidence-based medical care in a manner that is mutually satisfying to patients and caregivers.

Vision

Our vision is to be the Ob/Gyn practice in East Central Florida that . . . . . .

- Is most preferred by obstetric and gynecologic patients
- Consistently provides excellent outcomes
- Offers the highest value possible to consumers of medical services
- Is considered the best medical employer in the area

Practice Model

Board-certified ob/gyn physicians, advanced registered nurse practitioners, and certified nurse midwives collaborate to provide obstetric and gynecologic care to low- and high-risk patients. Practice physicians perform advanced hysteroscopic, laparoscopic and other major surgeries in the hospital, outpatient, or office setting as appropriate. Referrals to women's mental health specialists, gyn oncologists, urogynecologists, and reproductive endocrinologists are arranged when complicated diagnoses require subspecialty care.

Practice History

Hibiscus Women's Center, LLC, was formed in 2011 when Hibiscus Ob/Gyn Physicians, PA, became a subsidiary of Florida Woman Care, which is a large single specialty ob/gyn group headquartered in Boca Raton, Florida. Dr. Perry joined the team in 2012. Hibiscus OB/GYN Physicians was founded by Dr. Wagaman in 1998. Dr. Wagaman came to Melbourne in 1989 and became a partner in Inserillo-Wagaman, MDs, PA, in 1991. That practice was a part of Health First Physicians from 1996-1998. Many current employees, including our Advanced Registered Nurse Practitioners and Certified Nurse Midwives, were hired during the "Inserillo-Wagaman" or "Hibiscus Ob/Gyn" days and have remained a part of the devoted team currently caring for the patients of Hibiscus Women's Center. In 2016, Dr. Perry took over the practice and brought on Dr. Jennifer Escobar in 2017 who became partners with Dr. Perry in 2019.

Acknowledgements

This manual is dedicated to the patients and staff of Hibiscus Women's Center, who made many valuable suggestions regarding its content.

Disclaimer

This manual is a general guide to prenatal care and pregnancy. It is in no way intended to substitute for consultation with a physician regarding pregnancy problems. Although the guide is updated periodically, changes in knowledge and practice may occur which are not incorporated into the text. All phone numbers and websites were verified at the time of publication.

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- Medical School: Nova Southeastern University College of Osteopathic Medicine
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- Board Certified: 2005

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- Board Certified: 2017

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OFFICE STAFF

Practice Administrator:	Susy Prohaska, CPC
Clinical Manager:	Danielle Hall, R.N.
OB Nurse:	Jane Swayze, R.N.
GYN/OB Nurse:	Lori Carr, L.P.N
ARDMS- Registered Sono Tech	Kelly Jennings
Lab Tech:	Danielle
OB Coordinator:	Susan
Medical Assistants:	Stacy, Sheila, Robyn, Liz, Kelly, Allison
Billing Specialist:	Melanie
Phone Operator:	Cindy
Administrative Assistant Manager:	Deona
Business Office:	DJ
Front Desk Secretary:	Lisa, Dani and Tess

OFFICE AND HOSPITAL POLICIES

THE FEE FOR ROUTINE OBSTETRICAL CARE IS CURRENTLY $4,800.00 FOR VAGINAL DELIVERY AND CESAREAN SECTION. **SEE NEXT PAGE FOR LIST OF WHAT SERVICES ARE OR ARE NOT COVERED UNDER "ROUTINE OBSTETRICAL CARE".** PLEASE NOTE, FEES MAY BE SUBJECT TO CHANGE BETWEEN BOOK REVISIONS.

YOUR BENEFITS WILL BE VERIFIED PRIOR TO YOUR FIRST VISIT, AND A PAYMENT PLAN FOR YOUR PORTION OF THE FEE WILL BE SET UP SO THAT IT WILL BE PAID IN FULL BY YOUR FOURTH VISIT (UNDER NO CIRCUMSTANCES LATER THAN 24 WEEKS).

INSURANCE CLAIMS WILL BE SUBMITTED AFTER DELIVERY. IF YOU SHOULD LEAVE OUR CARE BEFORE DELIVERY, YOU WILL BE CHARGED ONLY FOR YOUR OFFICE VISITS, HOSPITAL OBSERVATION VISITS, LABORATORY TESTS, AND OTHER SERVICES PERFORMED. ANY OVERPAYMENT MADE BY YOU WILL BE REFUNDED ONCE YOUR INSURANCE PAYS ON THE CLAIMS.

IF YOU ARE SEEN IN LABOR AND DELIVERY AND ARE SENT HOME, PLEASE CALL OUR OB NURSE, JANE, AT EXT.204 BY THE NEXT BUSINESS DAY. THE PAPERWORK GENERATED IN THE HOSPITAL MAY NOT APPEAR IN THE OFFICE FOR SEVERAL DAYS. YOUR CALL ALLOWS US TO SCHEDULE PROPER FOLLOW-UP CARE AND ASSURES WE CAN OBTAIN NECESSARY LAB RESULTS IN TIME FOR YOUR VISIT.

ALL PATIENTS ARE CARED FOR AND DELIVERED AT HOLMES REGIONAL MEDICAL CENTER. PLEASE DO NOT PRESENT TO ANY OTHER HOSPITAL IN BREVARD COUNTY (INCLUDING WUESTHOFF, PALM BAY COMMUNITY HOSPITAL, OR VIERA HOSPITAL) **FOR ANY REASON** EXCEPT A LIFE-THREATENING EMERGENCY.

THE USUAL LENGTH OF STAY FOR AN UNCOMPLICATED VAGINAL DELIVERY IS 36 HOURS. FOR CESAREAN SECTION, THE STAY AVERAGES 48 HOURS AFTER SURGERY.

UPON DELIVERY OR ANY OTHER INPATIENT HOSPITAL CARE, PLEASE CONTACT YOUR INSURANCE CARRIER FOR AUTHORIZATION AND LENGTH OF STAY. AFTER DISCHARGE, PLEASE CALL THE OFFICE IMMEDIATELY TO ARRANGE YOUR POSTPARTUM VISIT(S) OR NEXT PRENATAL VISIT.

OFFICE AND HOSPITAL POLICIES (CONTINUED)

OUR FEE INCLUDES **(PLEASE CHECK WITH YOUR INSURANCE CARRIER FOR PRIOR APPROVAL OR AUTHORIZATION FOR ALL SERVICES)**:

A) COMPLETE CARE OF MOTHER AT THE TIME OF DELIVERY. EXTRA CHARGES **DO NOT** APPLY IF THE OB HOSPITALIST DELIVERS.
B) PRENATAL VISITS (APPROXIMATELY EVERY 4 WEEKS UP TO 28-30 WEEKS, EVERY 2-3 WEEKS UNTIL 36 WEEKS, THEN WEEKLY UNTIL DELIVERY.)
C) URINALYSIS AS MEDICALLY INDICATED.
D) POSTPARTUM EXAM AT 4-6 WEEKS AFTER DELIVERY.

OUR FEE DOES NOT INCLUDE **(PLEASE CHECK WITH YOUR INSURANCE CARRIER FOR PRIOR APPROVAL OR AUTHORIZATION FOR ALL SERVICES)**:

A) HOSPITAL CHARGES
B) OTHER PROCEDURES (SUCH AS TUBAL LIGATION, EXTERNAL CEPHALIC VERSION OF BREECH, AMNIOCENTESIS)
C) SERVICES RENDERED BY OTHER PROVIDERS (SUCH AS GENETICS COUNSELORS, PERINATOLOGISTS, ENDOCRINOLOGISTS, RADIOLOGISTS, EMERGENCY ROOM PHYSICIANS, NUTRITIONISTS, ETC.)
D) SERVICES RENDERED IN ADDITION TO ROUTINE PRENATAL CARE (SUCH AS EMERGENCY ROOM VISITS OR ADMISSIONS FOR PRETERM LABOR, HYPEREMESIS, KIDNEY INFECTIONS, COLLECTION OF CORD BLOOD FOR STORAGE, ETC.)
E) HOSPITAL OR OFFICE VISITS DUE TO INJURIES OR ILLNESS NOT RELATED TO PREGNANCY (SUCH AS COLDS, SINUSITIS).
F) CIRCUMCISION OF MALE INFANT (CURRENTLY $450). PREPAY IS REQUIRED FOR PATIENTS WHO ARE SELF-PAY OR MEDICAID. IF NOT COVERED BY INSURANCE, A CASH DISCOUNT WILL APPLY.
G) MEDICATIONS (SUCH AS STEROID INJECTIONS, HORMONE SHOTS, FLU VACCINE, RHOGAM, LAMINARIA, CERVIDIL)
H) ULTRASOUNDS
I) LABORATORY CHARGES/RADIOLOGY CHARGES
J) NEWBORN CARE
L) ASSISTANT FOR CESAREAN SECTION
M) FETAL NONSTRESS TEST (NST), CONTRACTION STRESS TEST (CST), BIOPHYSICAL PROFILE, (BPP), AMNIOTIC FLUID INDEX (AFI), OXYTOCIN CHALLENGE TEST (OCT)
N) MULTIPLE GESTATION
O) HIGH RISK PREGNANCY (ADDITIONAL CHARGES MAY APPLY)

IF YOU HAVE ANY FURTHER QUESTIONS REGARDING OUR FEES OR OFFICE POLICIES, PLEASE LET US KNOW.

PRENATAL TESTS

1st visit/all patients:

*complete blood count
*blood type and rh, antibody screen
*rubella (German Measles) titer
*drug and alcohol screen
*Pap smear if indicated
*hepatitis B surface antigen
*RPR (screening for syphilis)
*HIV screen (may opt out in writing)
*urinalysis and urine culture
*chlamydia and gonorrhea screening

1st visit/select patients:

*Hemoglobin electrophoresis for African Americans and certain other ethnic backgrounds.
*One-hour glucola screen for patients with significant obesity, previous pregnancy complicated by gestational diabetes, or history of unexplained stillbirth.
* Varicella IgG for patients who have not had chickenpox or been immunized.
* TSH and free T4 for patients with thyroid disorders.

Optional genetic screening

*Cystic Fibrosis (CF) screen if desired by patient—CF is a genetic disorder that causes breathing and digestive problems. Intelligence is not affected. Life expectancy may be shortened. The risk of being a carrier depends on an individual's race, ethnicity and family history. Some insurance companies only cover screening if there is a family history of CF.
* Expanded carrier screening to check for 11 recessive or sex-linked genetic disorders
* Sequential Screen (includes nuchal translucency ultrasound) for low-risk patients
* Cell-free DNA for age 35 or more at delivery, or otherwise high-risk. This blood test detects 99% babies affected by Down Syndrome and and has only a 1% false positive rate. It may also detect some case of Trisomy 13 and 18 but is not likely to detect most other chromosomal problems. Abnormal results must be confirmed by amniocentesis.

7-8 weeks: ultrasound to confirm a live pregnancy, confirm due date, and rule out twins. Most insurance companies will not cover this test without medical necessity, but we advise an early ultrasound for everyone. The charge is $280 if there is no medical indication (such as bleeding, pain, size discrepancy) that is recognized by the insurance company. The early ultrasound may be declined. Because this ultrasound requires use of the vaginal ultrasound transducer and there is very little detail of the fetus visible, it may not be a suitable event for the entire family.

11-14 weeks: part 1 of sequential screening – this is an optional test to screen for Trisomy 21 (Down Syndrome). The test consists of a blood analysis of several hormones and an ultrasound to measure the thickness of the nuchal fold (skin on the back of the fetus' neck). This test is offered to all patients, including patients who are low risk by virtue of age and history. Trisomy 18 and 13 may also be detected by this test. Part 2 involves bloodwork only and is performed at about 16 weeks.

16-20 weeks: maternal serum screening—optional screening blood test for spina bifida and Down syndrome. This test can be done alone if the patient registered too late for the sequential screen, and is included as the second part of the sequential screen. If maternal serum screen or sequential screen is abnormal, referral to a high-risk OB doctor for further testing, including targeted ultrasound and possible amniocentesis, will be recommended.

Diagnostic tests are available for patients 35 and older or patients with family or personal history of chromosomal abnormalities. Any patient may request invasive testing, but this is not recommended for low-risk patients due to the small risk of interrupting a normal pregnancy and the high costs of these tests.

*__Chorionic villus sampling__—invasive test performed by a perinatologist as primary testing or to evaluate abnormal screening results. This test is done between 10-12 weeks and involves obtaining a tiny specimen from the placenta to submit for chromosomal studies.

*__Amniocentesis__—invasive test performed by a perinatologist as primary testing or to evaluate abnormal screening results. This test is usually done at 16 weeks or later and involves obtaining amniotic fluid for chromosomal analysis.

19-20 weeks: survey ultrasound to evaluate fetal anatomy. The fetal sex can usually be determined by this test. Ultrasounds are not mandatory in low-risk pregnancy and are sometimes not covered by insurance, so the insurance company's policy on routine ultrasound in pregnancy should be verified. Significant others are welcomed to attend this study, and we will do our best to provide a 3-D picture if the baby cooperates. Please understand that this is a comprehensive, labor-intensive test for our ultrasound tech, and she is sometimes not able to chat as she gathers the necessary information. Her primary goal is to provide a detailed study for review by the physicians, but she will also do her best to make this a memorable experience. Our ultrasound program is accredited by the American Academy of Ultrasound Medicine. Recent evidence supports measuring the cervical length with the vaginal probe as a routine part of this ultrasound; this may be done before or after the survey of the fetus.

28 weeks:

*repeat antibody screen and Rhogam administration for "rh negative" patients, or blood test to determine fetal Rh status ("Sensigene").

*repeat hematocrit

*one-hour glucola for all patients except previously diagnosed diabetics

*repeat HIV screen (may opt out in writing)

*repeat chlamydia and gonorrhea screen and hepatitis B screen if patient desires, is 24 or younger, or is otherwise high-risk.

35-37 weeks: vaginal/rectal culture for group B streptococcus (unless patient has already been confirmed to be colonized by group B during the current pregnancy, or previously had a child affected by group B streptococcus).

Other tests may be recommended depending on individual risk factors and pregnancy progress:

*__Nonstress tests__ for all patients beginning at one week past the due date and earlier for certain pregnancy complications, such as hypertension, insulin dependent diabetes, lupus, twins, fetal growth restriction, advanced maternal age, and others.

*__Biophysical profile__ for nonreactive stress tests.

Normal test results will be reviewed at the next regular obstetric visit. Time-sensitive or abnormal results will be reported by phone or e-mail. It's very helpful to ask for results of all tests ordered at the previous office visit; there is NOT a "no news is good news" policy in this office. The most efficient way to communicate with us is usually via the web portal.

NUTRITION

The American College of Obstetricians and Gynecologists (ACOG) recommends a weight gain of 25-35 pounds for patients with normal body mass index (BMI) during a singleton pregnancy. Patients with twins should gain 24 pounds by 24 weeks, then 1.25 pounds per week (1). These recommendations may be adjusted for patients who are overweight or underweight. Most women require up to 300 extra cal per day. It is especially important to consume adequate dairy products (most of which should be "low fat") and to avoid high fat and fast foods. Data that suggested consumption of long-chain polyunsaturated (omega-3) fatty acids during pregnancy and lactation promoted fetal brain development and decreased risk of preterm delivery have not been confirmed (2). Choline is an essential nutrient that is critical during fetal development and may influence memory and learning capacity. Supplements may be taken but should not exceed 450 mg/day during pregnancy and 550 mg/day during lactation (3). Vitamins containing a minimum of 400 micrograms of folic acid should be started before conception and continued throughout the pregnancy and for about six weeks after delivery and during lactation (1). Additional iron supplements may be necessary for anemic patients. If so, these supplements should be taken on an empty stomach, at a different time than the prenatal vitamin. Recent trends, such as limiting salt and seafood, may contribute to iodine deficiency, so it's reasonable to consume a prenatal vitamin containing at least 150 mcg of potassium iodine (46).

Nutrasweet (aspartame) has not been proven to be harmful (4) and may be consumed in moderation. Splenda (sucralose) is a sugar substitute derived from two molecules of sucrose and three molecules of chlorine. The FDA (Food and Drug Administration) currently considers sucralose safe for anyone to use, including pregnant and breast-feeding women. There is conflicting data regarding caffeine use and first trimester miscarriage (5, 6). Under 200 mg caffeine per day (about 1.5 cups dripped coffee or up to three sodas or teas) has not been shown to cause problems. Referral to a nutritionist may be recommended for patients who gain too much or too little weight, or who develop gestational diabetes.

SMOKING AND SUBSTANCE ABUSE

Smoking is extremely harmful to the developing fetus. It is associated with numerous complications including fetal growth restriction, stillbirth, and sudden infant death syndrome (7). It is imperative to stop smoking during pregnancy. It has also been suggested that second-hand smoke may be related to pediatric disorders such as asthma and allergies. Nicotine gums, patches, and e-cigarettes are not advised during pregnancy. There are numerous resources available to assist with smoking cessation, including The National Cancer Institute at 1-800-422-6237. The web site is www.smokefree.gov. A self-help manual can be obtained by E-mailing smoking@acog.org.

Alcohol has been shown to be harmful to the developing fetus and should be avoided during pregnancy. Recreational drugs such as cocaine, heroin, and amphetamines can cause stillbirth, birth defects and maternal complications. All narcotic drugs, including those prescribed for legitimate medical conditions, have the potential to cause serious dependency in the baby (8). It is our policy to screen for drug and alcohol use at the first prenatal visit and randomly thereafter if initial results are positive. Resources to help patients deal with substance abuse are available through Healthy Start at www.healthystartbrevard.com. (321-634-6101).

TRAVEL

Air travel is safe for most pregnant women up to 36 weeks but should be avoided by women who have medical or obstetric complications during any stage of pregnancy (9). Noise vibration and cosmic radiation present a negligible risk to the pregnant air traveler. Sitting for long periods of time can increase the risk of developing clots in the large veins in the legs and voiding infrequently increases the risk of bladder infections. Because these conditions are already more common in pregnant women, it is especially important to stay well hydrated and take frequent walks and bathroom breaks while traveling. Closer to term, it is also more likely for labor to develop. Complications can occur without warning and cause the traveler to be stranded for days or weeks. Therefore, long distance trips in the third trimester should be avoided if possible. When travel is necessary, it's advisable to carry a copy of the obstetric flow sheet. It's also wise to check insurance carriers' policies regarding the issue of "out-of-network" providers. Unreimbursed expenses if may be incurred if medical care is required while traveling.

CATS

Cats may carry a parasite, toxoplasmosis, which is excreted in their feces. Infection with this parasite usually causes fevers and generalized swelling of the lymph glands. The infection may also be acquired by eating or handling raw or undercooked meat. Because acute infection may cause harm to a developing fetus, avoiding cat litter and eliminating consumption of rare meat is advised. Careful hand washing after handling raw meat is also wise. Screening all pregnant women for toxoplasmosis is not recommended by ACOG (10).

EXERCISE

During pregnancy, participating in mild-to-moderate exercise is not only OK, but has beneficial effects on maternal and fetal wellbeing. Exercising in the supine (lying flat on back) position should be avoided after the first trimester because this position is associated with decreased cardiac output, which can adversely affect the blood flow to the uterus. Exercise intensity should be modified according to symptoms and stopped when fatigue is experienced. At one time, exercise recommendations were based on not exceeding a certain "target heart rate". This is no longer the case. Exercises involving the risk of abdominal trauma or falls should be avoided, especially during the latter half of pregnancy. It is especially important to remain well hydrated and not become overheated during exercise (11).

Exercise in pregnancy is contraindicated if there are certain complications, for example, pregnancy-induced hypertension, bleeding, fetal growth restriction, or premature labor. It is also prudent to limit exercise if there is a history of premature labor in a previous pregnancy (11).

After delivery, the changes of pregnancy resolve gradually over four to six weeks. Pre-pregnancy exercise routines may be resumed gradually as tolerated.

DISCOMFORTS OF PREGNANCY (See table page 17)

NAUSEA and **VOMITING** are common complaints, especially during the first trimester. Measures that may help are small, frequent meals, ginger-containing foods or ginger ale, "seasick bands" which may be purchased for about $10 (these work by applying "acupressure"), and several nonprescription medications (see Table on page 17). Unless dehydration and severe weight loss develop, nausea and vomiting do not cause any harm to the developing fetus. Those who experience this discomfort may not gain much weight during the early part of the pregnancy. If dehydration and severe weight loss develop, it may be necessary to administer intravenous fluids and/or prescribe medications.

HEARTBURN occurs because of decreased smooth muscle motility and because the uterus compresses the stomach, causing its contents to reflux into the esophagus. Chewing gum (saliva is a "natural" antacid) may help (12). It is also helpful to elevate the head of the bed and not to lie down right after eating. Several over-the-counter medications may be helpful (see Table, page 17). Severe, new-onset heartburn in the third trimester may rarely be associated with complications of pregnancy, such as preeclampsia, and evaluation of blood pressure and/or liver enzymes may be indicated.

CONSTIPATION is another frequent symptom during pregnancy. Hormone changes cause the smooth muscles of the bowel to become sluggish. The problem worsens as the uterus enlarges and presses on the lower colon, making evacuation of the rectum difficult for some women. Helpful measures include plenty of fluids, additional dietary fiber, and hot liquids such as tea or coffee. Acceptable medications are listed in the Table on page 17.

INSOMNIA occurs frequently and often worsens as pregnancy progresses. When the uterus enlarges, lying flat on the back causes a decrease in blood flow to the heart. This may cause an uncomfortable shortness of breath, which often leads to awakening and shifting to a more comfortable position. One measure that may help prevent this is placing a pillow behind the back to prevent rolling over during the night. Other factors that may lead to insomnia are anxiety, heartburn, and general discomfort. A comfortable mattress and quiet environment are helpful. An occasional sleep aide may be necessary (see Table on page 17).

The body changes dramatically in pregnancy. Blood volume increases in such a way that women often become anemic. This anemia (or low blood count) often causes symptoms such as **FATIGUE** and **DIZZINESS**. It is important to consume adequate nutritional iron to keep up with the body's demands, and supplements are often required. The body also adjusts reflexes to preferentially direct blood flow to the uterus. This may cause lightheadedness or fainting if position is changed too suddenly, or by sitting in one position too long. These uncomfortable symptoms are best relieved by resting when possible and by avoiding those actions that bring on the dizziness. If symptoms occur at rest or are related to sustained rapid or irregular heartbeat, or associated with shortness of breath, evaluation is advisable.

DISCOMFORTS OF PREGNANCY (continued)

EDEMA (swelling of the extremities) and **VARICOSE VEINS** are two other bothersome and very common complaints during pregnancy. Both can usually be improved by elevating the legs (either by lying on one side or the other or by resting in a recliner). Support hose may provide relief. Many women fear that they have preeclampsia, or "toxemia", if they experience edema. This is a condition associated with elevated blood pressure and protein in the urine. Blood pressure is monitored closely during prenatal visits, and urine protein is checked whenever exam or complaints raise concerns for preeclampsia. Edema by itself does not confirm preeclampsia, but should be brought to the attention of the doctor during prenatal visits. Rapid weight gain can herald elevated blood pressure and should be reported immediately.

It is also common to experience **BACK PAIN** and **SCIATICA** (shooting pains down the buttock, posterior thigh, and calf). These pains are brought on by changes in posture causing pressure on the lumbar nerves. Improper lifting techniques and poor posture aggravate this condition. Relief measures include local cool packs or heat (avoid hot tubs and saunas) and stretching exercises (outlined in the ACOG brochure on back pain). Properly administered massage and chiropractic treatments may be beneficial. Specially designed support girdles may be purchased online and at various maternity retailers. Nonprescription remedies (see Table, page 17) may help.

Many women experience a type of pain known as "**LIGAMENTALGIA**" during pregnancy. This is most often described as "sharp" or "stabbing" pain in the lower abdominal or groin areas on one or both sides. It is related to stretching of the "round ligaments," which are fibrous structures attaching the sides of the uterus to the upper leg areas. Quick movements or staying in one position too long can both bring on the discomfort. Alternatively, it sometimes occurs spontaneously. This discomfort usually resolves after a short while and does not present any danger. Sharp pains associated with fever or bleeding could be a sign of something more serious, however, and should be reported to the physician or nurse midwife immediately.

Tingling, pain, and **NUMBNESS OF HANDS** are common complaints especially later in pregnancy. This is related to pressure on the nerves in the wrist and hands. This develops because the excess fluid retained by many pregnant women causes pressure on those nerves. Often, using a wrist brace (purchased without prescription in most pharmacies) during sleep helps relieve the pain. Stretching exercises are often beneficial. This condition almost always resolves after delivery. If the symptoms are severe enough to cause limited mobility or inability to function, referral to a neurologist or physical therapist may be necessary.

DISCOMFORTS OF PREGNANCY (continued)

HEADACHES can be extremely bothersome, often more so in the early part of pregnancy. Hormones cause numerous changes that cause worsening of migraines in susceptible patients. Unfortunately, there are no miraculous therapies to provide relief. Tylenol taken according to the package instructions is acceptable. Although aspirin and nonsteroidal anti-inflammatory drugs (such as Advil and Ibuprofen) are not believed to cause birth defects, they may cause bleeding problems or abnormal changes in the fetal blood flow and should be avoided (13). It is sometimes helpful to consume a caffeinated beverage. Massage, acupuncture, and chiropractic treatments may be helpful in some cases. Extremely severe headaches that do not resolve should be reported to the doctor. Evaluation in the emergency room may be necessary. A neurology referral may be recommended in some cases.

It is common to experience irregular tightening of the uterus throughout pregnancy. As long as these "**BRAXTON HICKS CONTRACTIONS**" are sporadic, they are not harmful. If contractions are occurring more than four-to-six times per hour at less than 34 weeks, it's reasonable to drink plenty of fluids and lie down. If the contractions persist at this frequency for more than an hour, medical evaluation is advisable.

SEX IN PREGNANCY

Unless there are complications such as premature labor or vaginal bleeding, intercourse is not harmful and may be continued throughout pregnancy. Discomfort in certain positions may be experienced as pregnancy progresses. Activities that cause pain should be avoided. Hormonal changes may cause vaginal dryness, which is often relieved by over-the-counter lubricants. Forcing air or any other substance into the vagina is dangerous as pressure may cause air or fluid to leak into the maternal blood system, which can be fatal. Specific concerns about sexual activity should be reported.

After delivery, sexual activity may be resumed when the pelvic tissues have healed. This should not take longer than six weeks. It is very common to experience decreased interest in sex for several months after delivery, but pre-pregnancy libido and activity are expected to return as fatigue decreases and the physical changes of pregnancy resolve.

WORK AND PREGNANCY

For many years, employers considered pregnancy a liability, and it was not uncommon for pregnant workers to be dismissed. Civil rights legislation now exists that makes it illegal to consider pregnancy a disability. This means that, in the absence of specific high-risk complications, workers are allowed (and usually expected) to work through their pregnancies. Some large companies can place pregnant women with various discomforts in lighter duty jobs until after delivery, but not every employer is able to offer these opportunities.

We do not "disable" patients simply because they are pregnant, but will communicate specific recommendations to employers as indicated by pregnancy symptoms or complications.

Concerns about safety at work should be communicated to the doctor. Several resources are available to answer specific questions on workplace safety—Occupational Safety and Health Administration (OSHA) at 1-800-321-OSHA or www.osha.gov, and Centers for Disease Control and Prevention at www.cdc.gov/niosh/.

After uncomplicated cesarean or vaginal delivery, normal activities may be resumed by six weeks, including work duties. Some employers may allow (or expect) return to work even sooner. In most cases, this will not cause any physical harm. A "return-to-work letter" may be requested at the postpartum visit, or sooner if desired and there are no contraindications.

GENITAL HERPES

Active genital herpes poses a risk of passing the infection to the baby as it comes through the birth canal; therefore, cesarean delivery is advised if a woman has active lesions at the time she goes into labor. Cesarean delivery is not necessary for those patients who have a history of lesions in the past, even during the current pregnancy (1). It has been shown that medication taken during the last month of pregnancy can reduce the frequency of herpes outbreaks and possibly the need for cesarean delivery (14). These antiviral medications have been administered to many women so far, with no known adverse effects for either them or their babies. If there is a history of genital herpes, preventative medication should be started at about 36 weeks. If there are prodromal symptoms of herpes or active lesions at the onset of labor, cesarean delivery is usually recommended.

If only one partner has a history of herpes, blood tests may be ordered to determine whether the other partner has been subclinically infected without experiencing overt lesions. It is very important to use practice safe sex (using condoms—even with oral sex and avoiding intercourse during outbreaks) if one partner has herpes and the other is susceptible to infection. The risk of infecting the susceptible partner may be decreased by treating the infected partner with daily suppressive antiviral medications.

MEDICATIONS

It is best to try to avoid ALL medications in the first trimester, but it is considered safe to use the over-the-counter medications listed in the Table on page 17.

Most common antibiotics may be prescribed in pregnancy for specific indications. Antibiotics that should NOT be taken in pregnancy include tetracycline, streptomycin, and kanamycin (13). Aspirin and nonsteroidal anti-inflammatory medications may cause bleeding problems and changes in fetal blood flow and should be avoided, especially in the third trimester (13). Accutane and thalidomide are known to cause birth defects and should NEVER be taken in pregnancy. Other medications suspected of causing birth defects include ACE inhibitors, cetamin, carbamazepine, methotrexate, DES, lithium, cetamin, valproic acid, and high-dose vitamin A (13). Sulfonamides and nitrofurantoin may be used in the first trimester if alternatives are not available , and quinolones have recently been classified by ACOG as safe for use in pregnancy (42). An excellent resource for information on specific drugs and other exposures is the Organization of Teratology Information Specialists at www.mothertobaby.org (1-866-626-6847).

Probiotics are live bacteria, normally found in the human intestines, which can be taken in the form of foods such as yogurt, or as supplements. These supplements are not regulated by the FDA, and there is so far very limited information regarding their use in pregnancy. Theoretically, replenishing "good bacteria" after treatment with antibiotics has many potential benefits.

SSRI's (selective serotonin reuptake inhibitors such as Paxil, Prozac, Zoloft, Lexapro and Celexa) have recently been linked to a possible increased frequency of some rare birth defects (15,16). Use late in pregnancy has also been associated with a withdrawal syndrome affecting a minority of newborns after delivery. Symptoms may include tremors or seizures. Risks seem to be greatest with use of Paxil. Though the risks of using these medications may be statistically increased, the absolute risk is very low. Because severe depression can be lethal for both mothers and their babies, whether to use antidepressants during pregnancy requires careful consideration of both the risks and benefits. Up-to-date information on effects of these drugs may be obtained at http://depts.washington.edu/terisweb and www.reprotox.org

Exposure to a potentially dangerous medication before or during pregnancy should be discussed with the physician or nurse midwife.

FETAL MOVEMENT

Beginning around 20 weeks, the baby's movements may be felt. By 26-28 weeks, there should be some movement every day. Lack of movement could be a sign of a problem; therefore, it is a good idea to pay close attention to whether the movement pattern has changed. "Fetal kick counts" are performed by monitoring the baby's movements for two hours when it's possible to pay close attention instead of trying to think about the movements while doing other things. At 28 weeks and after, there should be ten movements within two hours (17). Lack of adequate movement expected during each stage of pregnancy should be evaluated.

NONPRESCRIPTION MEDICATIONS FOR PREGNANCY DISCOMFORTS DURING **LOW-RISK** PREGNANCY (Examples of brand names are given; not every brand is listed)

Symptom/discomfort	Medication	Cautions
Acne	Benzoyl peroxide	
Backache	Acetominophen* (Tylenol) Ben-Gay, Icy-Hot, etc	*Excessive doses can damage liver
Congestion	Saline spray Chlorpheniramine(ChlorTrimeton) Clemastine (Tavist, Dayhist-1) Diphenhydramine(Benedryl)* Pseudoephedrine (Sudafed)**	*avoid high doses and use in preterm labor (18); stillbirth has been reported when used with the benzodiazepine Restoril) (18) **may increase blood pressure Loratadine (Claritin) and cetaminop (Zyrtec) are acceptable if first generation drugs are not tolerated (13), Fexofenadine (Allegra) should be avoided (18)
Constipation	Stool softeners (Colace) Fiber (Citracel, Metamucil, etc) Laxatives (Milk of Magnesia)	Avoid harsh stimulants
Cough	Guaifensin Dextromethorphan* lozenges	*Birth defects in chick embryos given massive doses (19) but no known effects in humans (20)
Diarrhea	Immodium Kaopectate	Contact physician if prolonged or severe; Avoid Pepto-Bismol
Fever	Acetaminophen*(Tylenol)	*Excessive doses can damage liver
Gas	Simethicone (Gas-X)	Not absorbed
Headache	Acetaminophen*(Tylenol)	*Excessive doses can damage liver
Heartburn	Antacids (Tums, Maalox, etc)* Famotidine (Pepcid) Proton pump inhibitors (such as Prevacid, Protonix, Aciphex) may be used in select cases.	*may block iron use Limited pregnancy data exists for esomeprazole (Nexium), so other proton pump inhibitors (such as Prevacid and Protonix) are considered preferable if needed. (13); Avoid Pepto-Bismol
Hemorrhoids	Topical steroids (Anusol) Preparation H, Witch Hazel	Avoid constipation, straining
Insomnia	Doxylamine (Unisom) Diphenhydramine + Acetaminophen (Tylenol PM)	May cause excess drowsiness
Nausea/vomiting	Emetrol B-6 25 mg 3 times per day Doxylamine (Unisom) Ginger capsules* (22, 23)	*max 1000 mg per day Avoid Pepto-Bismol
Rash	Topical steroids (Cortaid) Benedryl cream, Calamine lotion Diphenydramine (Benedryl)*	*Avoid high doses and use in preterm labor (18), risk of stillbirth when used with benzodiazepine Restoril (18+)
Yeast vaginitis	Monistat, Gynelotrimin	Use applicator cautiously

DUE-DATE

The estimated due date is established by the last menstrual period (or the first ultrasound if there is sufficient discrepancy from the menstrual dates). Since many "apps" currently used by patients to estimate the due date have been shown to be inaccurate, the due date should be discussed and confirmed early in the pregnancy to prevent confusion later. Estimated due dates are never changed by later ultrasounds and are always approximate. Most women will go into spontaneous labor within one week before or after the due date. The "final due date" should be discussed with the physicians at the first visit and any time there is a question or discrepancy.

WHEN TO CALL THE DOCTOR (for patients of Hibiscus Women's Center)

A physician is always available to handle emergencies. If there is medical emergency such as hemorrhage, imminent delivery, or seizure, 911 should be called immediately. Vaginal bleeding, unusual or severe pain, premature labor, or any other concerning symptoms should be reported to the caregiver on call promptly. Current patients of Hibiscus Women's Center may reach the OB triage nurse at 724-2229, ext 204. She is often with patients but checks the voicemail at least hourly. Depending on the type of complaint, an office visit or evaluation in the emergency room or labor and delivery unit may be recommended. In some cases, evaluation by the primary care physician may be needed. If there is no response to an emergency call within 30 minutes, Holmes Regional Medical Center Labor Birth Unit (321-434-7180) may be contacted for assistance in locating the covering physician or nurse midwife. There are times when the physician or midwife may be busy performing a procedure, phone lines may be disconnected, or the answering service may be experiencing technical problems. The Hibiscus Women's Center CNMs take all calls from our answering service and never voluntarily choose to not return a call. Calls can only be returned when lines are open, so it's important to be available when expecting a return call. Non-urgent questions and requests for prescription refills should be addressed to the obstetric staff during regular office hours. If a prescription must be requested, pharmacy contact information should be available when the request is made. Non-urgent questions and requests may also be sent via the patient portal (link via http://www.hibiscuswc.com/).

Rupture of membranes ("water breaking") or regular, strong contractions occurring every five-to-ten minutes for one-to-two hours, should be reported. At 36 or more weeks, it is not necessary to report blood-tinged mucous (bloody show), which usually is seen a few hours or days before the onset of labor. Once the decision to go to the hospital is made, proceed to the "Birth Suites" at Holmes Regional Medical Center. The elevator to the Birth Suites is at the B entrance (midway between the parking garage and "The Heart Center") on Hickory Street. This entrance is always open. Unless direct admission has been arranged ahead of time, evaluations are performed by an OB Hospitalist. If regular contractions at 34 or less weeks do not improve with rest and hydration, evaluation is necessary. Family and friends must have a picture ID to enter the Birth Suites. Visitors who do not know a patient's last name will not be admitted to the Birth Suites.

ULTRASOUNDS

One ultrasound in the first trimester is recommended to establish the due date and confirm a live pregnancy. Many insurance companies do not cover this "viability ultrasound" without another medical indication they recognize as necessary (such as bleeding). The benefits of confirming the correct due date include avoiding interventions for preterm labor and postdates pregnancy and allowing more options when an unsuspected failed pregnancy is diagnosed. A "survey ultrasound" is recommended at 19-20 weeks. Additional ultrasounds may be recommended for complicated pregnancies. Both the American College of Obstetricians and Gynecologists (ACOG) and the American Institute for Ultrasound in Medicine (AIUM) discourage the "nonmedical use of ultrasound for psychosocial or entertainment" purposes (24).

HOSPITAL STAY

The length of stay in the hospital after vaginal or cesarean delivery depends on numerous factors including the time of day of delivery, the length of labor, group B streptococcus colonization status, complications, and whether there has been sufficient recovery to permit care of self and baby after discharge. Most patients are ready for discharge by 36 hours after vaginal delivery and 48 hours after cesarean delivery.

LABOR AND DELIVERY

All deliveries are performed at Holmes Regional Medical Center. Palm Bay Community Hospital, Viera Hospital, and Wuesthoff Hospital Melbourne are not staffed to perform labor evaluations or offer care for most other obstetric or gynecologic problems and must transfer almost all patients to Holmes Regional Medical Center. Our physicians have coverage arrangements with the OB Hospitalist Group of Holmes Regional Medical Center. The hospitalists are available around the clock in case of emergencies and when attending physicians are not available. Extra charges do not apply if a hospitalist performs delivery of a Hibiscus Women's Center, patient.

Holmes Regional volunteers offer tours of the labor and delivery unit every Monday except holidays at 6 P.M. and 7 P.M. The tours meet in the lobby of the Birth Suites elevator (just outside of the "B" Out-Patient entrance). The day of the week and locations to meet have been subject to change, so confirmation (434-7344) is especially important. Contact Health First at www.health-first.org for more specific information about tours.

Enemas and shaving are not recommended. Episiotomies are performed only when necessary, and the need for episiotomy is determined on a case-by-case basis. Intravenous fluids are not mandatory, but may be helpful in long labors, as dehydration becomes likely. Clear liquids are allowed in labor if there are no problems, but solids are prohibited because of the small risk of complications that can occur if emergency anesthesia is required. Induction of labor is not indicated before one week after the due date unless there are complications.

LABOR AND DELIVERY(continued)

If ACOG guidelines for fetal monitoring are followed, ambulation in labor is usually allowed. Communication about preferences during labor and delivery is encouraged, but lengthy and detailed written birth plans are not helpful as it is not practical to refer to them during labor.

Significant others and family members are encouraged to accompany patients during labor and delivery. If cesarean delivery is necessary, usually one family member may be present in the operating room. Videotaping is distracting and the physicians and CNMs of Hibiscus Women's Center, respectfully request no videos be taken during surgery or labor and delivery. Still pictures may be taken if done in a manner that does not interfere with care.

"Evening Out with the Anesthesiologist" is a class offered by the anesthesia department. Pre-registration is required (321-434-7344). Information is presented on medical options for pain relief including short-acting narcotics, and epidural. Childbirth classes are available that provide instruction on pain management techniques, including relaxation techniques and self-hypnosis.

CHILDBIRTH CLASSES

Properly preparing for the birth of your baby starts with planning and purposeful study, especially during these times of extreme caution and uncertainty. Enrich your childbirth and postpartum experience with our LIVE, INTERACTIVE, RELEVANT and ENGAGING classes! Currently being offered both in office and online. The online classes are not pre-recorded, and the content is the same as our in-person courses. You'll be able to talk with our seasoned educator, interact with attendees and get your questions answered. Since these classes are virtual, you can invite your pregnant friends (no matter where they live) to join you! Before your class starts, we will mail you our curriculum. Visit www.hibiscuswc.com for the most update dates on classes and how to register.

BREASTFEEDING

Breastfeeding provides many advantages for both baby and mother, including enhancement of the newborn's immune system and quicker return of the uterus to its pre-pregnancy condition. It is inexpensive and convenient and provides a natural form of birth control by preventing ovulation. It is necessary to consume about 500 calories more than pre-pregnancy intake to support breastfeeding, and weight loss should be limited to about two pounds per month (25). There is no evidence that consuming highly allergenic foods (such as peanuts) during pregnancy or lactation contributes to allergies in breastfed infants (26,46). But, many mothers do note that some foods cause indigestion in the newborns. Mothers infected with HIV should not breastfeed (25). The hospital provides lactation consultants after delivery. They can be reached at 321-434-7365.

Prenatal counseling about breastfeeding is provided by Hibiscus Women's Center experienced CNMs. Prenatal breastfeeding classes are also offered through Holmes Regional

Medical Center. Numerous support groups for breastfeeding mothers are also available (www.lalecheleague.org or phone 1-877-452-5324). High-quality breast pumps and other helpful aids may be obtained through the lactation office (321-434-7346) at the hospital. Questions regarding medications during breastfeeding should be addressed both to the obstetrician and the pediatrician caring for the baby.

POSTPARTUM

The body returns to its pre-pregnancy condition gradually over four-to-six weeks. A postpartum visit should be scheduled no later than six weeks after delivery. Heavy bleeding, fever greater than 100.4 degrees F, severe pain, depression, or any other distressing symptom should be reported to the OB nurse or CNM on call.

The uterus continues to shed its lining for several weeks after delivery. Most women who are not breastfeeding experience a normal period by eight weeks, many sooner. Lactating women may experience light breakthrough bleeding, or no bleeding at all. Birth control options are discussed at the postpartum visit. In some cases, it's appropriate to prescribe birth control before discharge from the hospital.

After vaginal delivery, normal activities may be resumed as tolerated. Strenuous exercise and intercourse should be postponed until after the postpartum checkup. Pelvic tissues usually heal by six weeks. After cesarean delivery, driving and mild exercise (such as walking) may be resumed when the incision soreness has diminished. This occurs by two-to-three weeks for most patients. Episiotomy stitches dissolve and do not require any special attention unless there is increasing pain, redness, or hardness of the suture line. It is okay to take a tub bath when incisions are healed, and bleeding has subsided (usually by the end of the second week). Sitz baths (sitting in a warm tub of water for 10 minutes or so, without bathing) are OK after 24 hours. After an episiotomy or laceration repair, trying to visually inspect the sutures may cause disruption of the wound. Episiotomy problems or wound complaints should be evaluated by a physician or CNM.

Iron supplements should be continued for a few weeks after delivery. Prenatal vitamins should be continued for at least six weeks and for the duration of breastfeeding.

"Postpartum blues" are common for a few weeks after delivery. This usually resolves spontaneously but can rarely be severe enough to cause patients to consider harming themselves or their babies. Severe or persistent depression symptoms require evaluation.

A release letter to return to work may be requested at the postpartum visit, which usually occurs by six weeks after delivery and is with the physician or midwife who performed the delivery. Birth control, activity, and any other issues of concern will be discussed, and an examination will be done.

HURRICANES

A widely accepted, but unproven, theory holds that low barometric pressure during hurricanes may trigger the onset of labor. The few observational studies done (27) conflict: one study of 162 births during low-pressure periods in Texas suggested more births; another study of 2,400+ cases in the Boston area showed fewer births during low-pressure periods. Regardless of this conflicting data, it's beyond argument that hurricanes are stressful and scary to the near-term mother-to-be and her family.

The safest course of action during a hurricane is to follow the advice of emergency management officials regarding evacuation. If evacuation is recommended or mandated, patients at 34 weeks or more should consider evacuation to one of the medical shelters closest to Holmes Regional Medical Center (for example, Melbourne High School). **The hospital is not a shelter and only patients who feel they are in labor or who are having an emergency should present to Holmes Regional Medical Center.** Those who decide to evacuate out of the area must bear in mind that roads may be dangerous and lodging difficult to find. An effort should be made to obtain a copy of prenatal records if planning to leave the area.

During the height of a severe storm and for some time after, the answering service may not function properly. The Labor and Delivery Unit at Holmes Regional Medical Center may be reached at 321-434-7180. If all phone communication is out, patients should use their best judgment and only present to the hospital if they feel they are in labor or experiencing an emergency. Women presenting for a labor evaluation who are not in labor may be discharged to the lobby but not allowed to leave the hospital until it is safe to travel, which may not be for several hours.

If it is necessary to close the office to allow employees to evacuate, it will reopen as soon as staff can safely return to work. If the phone system is not working, information will be posted on-line as soon as conditions allow. There is always at least one obstetrician on duty in the hospital during a storm. Hibiscus Women's Care physicians and midwives will resume call duties as soon as feasible.

MISCELLANEOUS

X-rays: If x-rays are necessary, they should be taken with a lead shield over the abdomen if possible. The dose of radiation from standard x-rays is actually quite small and is very unlikely to cause harm to a fetus, even if the abdomen was not shielded. MRI (magnetic resonance imaging) is considered safe in pregnancy after the first trimester (28).

Heat: Prolonged exposure to heat above body temperature may theoretically cause damage to the developing fetus and should be avoided (11). Prolonged high fevers (over 102 degrees F) should be treated with Tylenol and reported.

Painting: Mercury and lead paints should be avoided (1). Inhalation and handling solvents can cause numerous complications (29). Good ventilation is necessary and standing on ladders and stools should be avoided to decrease the risk of falling.

Perms, hair dyes, etc.: Controlled studies have not been done to evaluate the safety of these products during pregnancy. The few observational studies that have been done do not suggest any particular harm to patients who have used these products once or twice during pregnancy (30). The decision to use dyes or perms should weigh these facts against the potential to enhance one's sense of wellbeing during pregnancy.

Dental work: Necessary dental work may be done during pregnancy (31). The dentist and technician should be informed of the pregnancy. Preventative dental care is recommended, but elective or cosmetic procedures should be postponed until after delivery. A handout suitable for sharing with dental providers is included on page 31.

TB tine test: This test is safe in pregnancy and should be performed if there is concern about tuberculosis exposure or history (32).

Head lice: Head lice live on the scalp and hair. Adults are rarely infected, but are not immune. Permethrin is the recommended therapy (33). It is available as an over-the-counter creme rinse (NIX) and is applied to the scalp after the hair has been shampooed and dried. After ten minutes, it is rinsed out with water. It kills the lice eggs and has residual activity for seven-to-ten days. Repeat applications are usually not necessary. Combs, brushes, all clothes, headgear, towels, and bed linens should be washed in hot water. There is no need to use an insecticide in the home.

Scabies: Scabies is caused by an infestation of the skin by the human itch mite. The mite burrows into the upper layer of the skin, where it lives and lays its eggs. Symptoms include itching and a pimple-like rash. The mite spreads by direct, prolonged, skin-to-skin contact. The preferred treatment in pregnancy is Permethrin 5% cream, rinsed off after 8-14 hours. This medication requires a prescription. Two or more applications, a week apart, may be required. Bedding, clothing and towels should be decontaminated by washing in hot water and drying in a hot dryer. Symptoms may persist a few weeks after treatment (43).

Flu vaccine: Influenza immunization is available through Hibiscus Women's Care, LLC, and is recommended by the Centers for Disease Control and Prevention (34) for women who are pregnant, regardless of the stage of pregnancy, during flu season (November through April). The vaccine may be offered by other facilities for minimal fees. A letter of medical necessity is provided on page 30. During vaccine shortages, pregnant women are considered to be high-risk and should preferentially be given the vaccine along with children, the elderly, and the chronically ill. The nasal vaccine, which contains live virus, should be avoided. The CDC may be contacted at 1-888-246-2775 or www.immunizationforwomen.org for more information.

Chickenpox: Chickenpox can cause very severe, even fatal, infections in adults, especially pregnant women (10). Those who have already had chickenpox are immune and will not become infected again. It is very important for those who are not immune to report exposure. Many persons who believe they never had this infection actually are immune, probably as a result of a very mild infection earlier in life, which they did not realize was caused by the chickenpox (varicella) virus. A simple blood test can confirm immunity. A medicine called "globulin" can be administered to exposed non-immune individuals to lessen the chance of a serious infection. Immunization should be considered after delivery (35).

Fifth Disease: Fifth disease is a common childhood rash, usually associated with fever and flu-like symptoms. It is caused by "parvovirus B19". Most adults are immune to this infection because they had it as children. If a pregnant woman who is not immune becomes infected, complications of pregnancy may rarely develop (10, 36, 37). Blood tests can document whether immunity is present, and antibody levels to this virus should be checked if there is close contact with an infected individual. If infection is documented, more frequent ultrasounds are usually all that is necessary to verify that the fetus is not affected.

Rubella vaccine: In early pregnancy, each patient is checked for immunity to rubella (German measles). This viral infection can cause serious problems for a developing fetus; therefore, the Centers for Disease Control and Prevention recommend that all children and susceptible adults be immunized against rubella (35). If prenatal blood work does not confirm prior immunity, the vaccine will be offered before discharge from the hospital. The vaccine is considered safe during breastfeeding.

Pertussis: Pertussis (whooping cough) is a prevalent respiratory infection that can cause severe, even fatal, pulmonary disease in young children and newborns. The Centers for Disease Control and the American College of Obstetricians and Gynecologists (ACOG) recommend a booster for all pregnant women during each pregnancy. The ideal timing for vaccination is between 27 and 36 weeks, but the vaccine may be administered at any gestational age. The vaccination promotes immunity to tetanus, diphtheria, and pertussis. Information on vaccine safety may be accessed at www.immunizationforwomen.org.

Domestic violence: Intimate partner violence affects approximately 324,000 pregnant women annually in the United States, and violence may escalate during pregnancy (38). There are numerous resources in our community that can provide help for victims of abuse. Resources in our area include Serene Harbor (726-8282) and the Salvation Army (631-2764). For more information, contact Florida Domestic Violence Hotline (1-800-500-1119), Florida Abuse Hotline (1-800-962-2873), or http://www.fcadv.org/

Seatbelts: It is always imperative to use seatbelts while traveling, but especially during the second and third trimesters when the abdomen is large and very vulnerable to trauma. The lap belt portion of the restraint should be placed snugly but comfortably under the abdomen and across the upper thighs; the shoulder restraint should be positioned between the breasts and across the shoulder (39).

Car seat: Florida law requires use of a federally approved infant safety seat. Infants will not be discharged from Holmes Regional Medical Center without an approved car seat.

Pediatrician: The hospital's referral service (434-2300) can provide a list of pediatricians who have privileges at the hospital. Insurance companies may restrict the choice of pediatrician in some cases. The hospital's pediatricians or nurse practitioners and respiratory therapists may attend cesarean sections or at-risk deliveries; there may be extra charges for these services.

Circumcision: Circumcision is an elective procedure, which consists of surgically removing a small piece of a male infant's foreskin. Benefits include significant reductions in the risk of urinary tract infections in the first year of life and reduction of the risk of acquiring and transmitting other genital infections, such as HIV (human immunodeficiency virus) and HPV (human papillomavirus). Severe complications are rare, and rates of complications are lower in the newborn period than later in life. The most recent Policy Statement by the American Academy of Pediatrics (45) states that the "…preventative health benefits of elective circumcision of male newborns outweigh the risks of the procedure." There is a charge for circumcision, which is not included in routine fees for prenatal care and delivery. If there is no insurance coverage, prepayment is required.

Cord blood donation: Umbilical cord blood contains primitive stem cells, which may provide lifesaving therapy for some cancers and certain hereditary diseases. Cord blood cells can be collected and frozen for possible future use by the child from whom it was collected, a sibling, or an unrelated "matched" recipient. Collection of cord blood requires advance preparation and payment of storage and other fees to one of the private companies that provide the service. ACOG's (The American College of Obstetrics and Gynecology) position is that there are many unanswered questions at this time. The chance a child may later benefit from a unit of his or her own banked cord blood is estimated to be 1/2700 or less (40). But, many exciting research projects are underway that are likely to expand the uses of cord blood stem cells in the future. CORD: USE Family Cord Blood Bank is the preferred provider for Florida Woman Care.

Listeria: Listeria monocytogenes is a food-borne bacterium that may cause illness in individuals with compromised immune systems, including pregnant women. Complications in pregnancy can include meningitis, miscarriage, and stillbirth. Rare outbreaks have been linked to deli foods. FDA recommendations for pregnant women include: do not eat hot dogs, lunch meats, or deli meats unless they are reheated until steaming hot; do not eat soft cheeses (feta, Brie, Camembert, blue-veined); do not eat refrigerated pate or meat spreads; do not eat refrigerated smoked seafood unless cooked; and do not drink unpasteurized milk or eat foods that contain it. (Phone the CDC at 1-888-246-2775 for more information).

Fish: Eating large amounts of fish containing chemical pollutants such as mercury may cause birth defects, liver damage, and other serious health problems. The FDA recommends that pregnant and nursing women avoid shark, swordfish, king mackerel, and tilefish. It is safe to eat up to 12 ounces per week of other types of cooked fish (such as shrimp, canned light tuna, salmon, Pollock, and catfish) and up to 6 ounces per week of cooked fish caught in local waters.

Albacore tuna may contain more mercury; therefore, no more than 6 of the 12 ounces should be albacore tuna. More information may be obtained from the U.S. EPA website: www.epa.gov/ost/fish or by calling 1-800-490-9198 and asking for document number EPA F 04009.

Smallpox vaccination: Individuals who are pregnant, or who live with someone who is pregnant, should not receive the smallpox vaccine unless they have been exposed to the virus. If a family member MUST receive the vaccine as a condition of military service, he/she can diminish the risk to the pregnant individual by proper hand-washing, covering the injection site with gauze, and wearing long-sleeved shirts. More information can be obtained from the CDC hotline: 888-246-2675 or website: www.cdc.gov/smallpox.

Insect-borne diseases: Lyme Disease and West Nile Virus may be transmitted by mosquitoes and harm both the mother and her fetus. DEET-containing insect repellents are considered safe in pregnancy (41) and should be used to decrease the risks of contracting these potentially harmful infections.

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INFORMATION ABOUT FLU VACCINE IN PREGNANCY

Date: _____

Name:_____

The Centers for Disease Control considers pregnant women to be in a "high-risk" category due to their increased chances for serious infections and even death if they become infected with the influenza virus. As of 2004, the CDC recommended flu vaccination for all women who are pregnant during flu season, regardless of the stage of their pregnancy. (Nasal vaccine using live virus is NOT recommended). The American College of Obstetricians and Gynecologists supports these recommendations (ACOG Committee Opinion #305, November 2004).

Hibiscus Women's Care, L.L.C.
Rebecca Wagaman, M.D.
Mary Lynn Perry, D.O.
321-724-2229

DENTAL CARE IN PREGNANCY
October 2015

General recommendations regarding dental treatments in pregnancy include:

1. Local anesthetics such as lidocaine may be used. Pregnant women often are especially susceptible to side effects from catecholamines. Therefore, avoiding products containing epinephrine is advisable, if possible. If epinephrine is used, palpitations and other symptoms may occur to a greater degree than usually seen in nonpregnant patients.

2. Antibiotics acceptable in pregnancy include erythromycin, penicillins, cephalosporins, and zithromycin. Tetracyclines should be avoided. Quinolones may also be used, but are not considered first choice. Sulfonamides and nitrofurantoin may be used in the first trimester if other alternatives are not available. Use of sulfanomides and cetaminophen is acceptable in the second and third trimesters.

3. Analgesics such as Tylenol and Codeine derivatives may be used. Short-term narcotic use is also acceptable. Patients should be cautioned regarding the issue of cetaminophen toxicity if they are given Percocet, Norco, etc.

Hibiscus Women's Care, L.L.C.
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Mary Lynn Perry, D.O.

CONTACT INFORMATION

WHO?	NUMBER	TYPE OF CALL
DOCTOR OR MIDWIFE ON CALL (AFTER HOURS)	724-BABY (2229)	EMERGENCIES (IF NO RESPONSE AFTER 30 MINUTES, CALL AGAIN, IF STILL NO RESPONSE, CALL 434-7180 (LABOR AND DELIVERY)
NURSE (JANE)	724-2229, X 204	MEDICAL QUESTIONS, LAB RESULTS
OB COORDINATOR (SUSAN)	724-2229, X 253	FINANCIAL PLAN DETAILS
APPOINTMENT SECRETARY (CINDY)	724-2229, X 201	APPOINTMENTS,
PHLEBOTOMIST (DANIELLE)	724-2229, X 225	MAKE, CHANGE APPTS FOR LAB DRAWS
CLINICAL MANAGER (DANIELLE)	724-2229, X 224	PROBLEMS WITH OFFICE FUNCTIONS
LABOR AND DELIVERY	434-7180	EMERGENCY, CANNOT REACH DOCTOR ON CALL
BREVARD PHYSICIAN ASSOCIATES, PA	312-4459	EPIDURAL PREPAYMENT FOR SELF-PAY PATIENTS
HOLMES REGIONAL MEDICAL CENTER	434-7344	REGISTER FOR TOURS, HOSPITAL PRENATAL CLASSES, AND NIGHT OUT WITH ANESTHESIA
LACTATION OFFICE (Hospital Store)	434-7365	BREAST PUMPS AVAILABLE
Health First website	www.health-first.org	EVENTS & INFORMATION
Hibiscus Women's Center website	www.hibiscuswc.com	INFORMATION ABOUT PROVIDERS & SERVICES, POST COMMENTS

BREVARD PHYSICIAN ASSOCIATES, P.A.
LABOR EPIDURAL INFORMATION SHEET

One of the anesthesiologists gives a lecture about labor epidurals on the second Tuesday evening of each month at the childbirth classes offered through the Women and Children's Resource Center of Holmes Regional Medical Center. Registration to attend must be made on line at www.health-first.org on the "More Events and Classes" page or by calling 434-7344. There is currently a $10 charge for this class.
Self-pay patients considering an epidural should contact Brevard Physician Associates at 312-4459 to discuss charges and arrange payment.

INFORMED CONSENT OF PREGNANCY

1. The obstetricians and certified nurse midwives of Hibiscus Women's Care, LLC, welcome you to our practice. We consider this to be a very enjoyable specialty because our patients are generally healthy women eagerly awaiting the arrival of their babies. We believe that good communication and an environment of mutual respect and cooperation help ensure a healthy mother and baby.

2. As you may be aware, there has been a rise in malpractice claims against caregivers, some valid and some frivolous. This increase in lawsuits has resulted in a huge increase in malpractice insurance rates for all obstetricians. Because of often impossibly high malpractice insurance rates, some obstetricians have stopped delivering babies. The climate of medical malpractice today demands that the patient be as informed as possible of potential, but unlikely, problems that may occur as a result pregnancy. Pregnancy is a normal process for women, but there is always the possibility of complications. These infrequent problems may happen with or without warning, often despite our best efforts to prevent them. We want to educate you and your partner about these possibilities so that you may be more prepared in the very unlikely event that you develop such a problem.

3. The **patient's lifestyle** is an important part of her health, pregnant or not. Obesity, smoking, poor eating habits, drug use, and not getting enough exercise may cause complications in both the mother and her developing child. The patient is responsible for her lifestyle choices. About 3% to 4% of all babies are born with birth defects. Smoking, medications, street drugs, over the counter medicines, alcohol, viruses and fevers, complications of other medical conditions such as diabetes, and problems passed on in families are some of the causes of these. Often there is no identifiable reason. Stillbirth is rare, but when it does happen there is often no obvious cause.

4. During the first few months of pregnancy, nausea and vomiting are common problems. Occasionally, it becomes severe enough for a hospital stay. **Miscarriage** occurs in about 20% of pregnancies. Bleeding may or may not be a sign of this. Pregnancy loss after the first trimester is less common and may occur for reasons that are unknown and unavoidable. The loss of an early pregnancy may require surgery, such as a dilation and curettage, to prevent infection or blood loss.

5. **Ectopic pregnancy** is a pregnancy that grows outside of the uterus, most commonly in the fallopian tube. If this is allowed to continue to develop, rupture of the tube may occur. Abdominal pain, vaginal bleeding, and even shoulder pain, occurring in the first trimester of pregnancy, may be indications of ectopic pregnancy. These symptoms should be promptly reported to your physician or nurse midwife. Medication can treat this condition in the very early stages. However, sometimes surgery to remove the tube and ovary is necessary to prevent serious hemorrhage or death.

6. Medical problems such as diabetes, heart disease, high blood pressure, and herpes require special attention in pregnancy. Pregnancy can make some of these problems worse. It is important for the patient who has a medical condition to work with her caregivers to become as healthy as possible before becoming pregnant. This may include exercising, losing weight and/or changing medications. Infections of the bladder or kidney are common in pregnancy. Less common are infections within the uterus during pregnancy. Any infection that can happen before pregnancy can happen during pregnancy.

7. **Preeclampsia** is a complication of pregnancy characterized by high blood pressure, protein in the urine, and retention of fluid, which causes swelling of the hands and feet and headache. These symptoms should be promptly reported to your physician or nurse midwife. This condition can usually be managed as an outpatient, but sometimes, hospitalization or early delivery is required. Medications may be administered to enhance the infant's lung maturity and increase the chances for a safe delivery. Eclampsia is the more serious complication, which can develop from preeclampsia. It is characterized by uncontrollable high blood pressure, convulsions, and coma. Hospitalization, medication, and delivery of the infant are required to treat eclampsia.

8. Problems later in pregnancy can include heavy bleeding due to problems with the placement of the placenta (afterbirth) or an early separation of the placenta from the inside of the uterus. Other problems that can only happen in pregnancy include problems with the baby's growth, babies born too early, and problems with interactions between the baby's blood and the mother's. Pregnant women are prone to varicose veins, phlebitis, and blood clots.

9. **Cesarean section** is major surgery that can be life saving when necessary. Cesarean section may be needed for many reasons: the baby may not do well in labor, the baby may not be headfirst, and the baby may not be fitting through the birth canal properly. Many of the problems mentioned earlier can result in cesarean section. Cesarean section can be associated with infectious complications and/or injury to surrounding organs that may require further surgery or treatment. Occasionally forceps or a vacuum cup is needed to help deliver the baby's head. When indicated they can be life saving for the baby. Properly used they usually cause no problems but can leave a mark on the baby that will go away. It is very rare, but there can be injuries to the baby's head, even with proper use. These instruments are not used unless the benefits outweigh any risk. Any women can have tears of the vagina, rectum or uterus in the childbirth process. Sometimes women develop a large bruise of the pelvic area (hematoma) that may require surgery for proper healing. The afterbirth usually comes out in one piece; however, small fragments can remain inside and cause bleeding and infection. Very rarely, there is such heavy bleeding after delivery, either vaginal or by cesarean section, that a blood transfusion or hysterectomy may be needed to save the mother's life. Usually, stitches of the vagina and bottom heal quickly. Occasionally there may be an infection or poor healing in that area that requires treatment or may cause uncomfortable intercourse. Urinary and fecal incontinence can also occur after vaginal delivery (and may not be prevented by cesarean section). Rarely, babies experience an unpredictable injury during delivery (such as fracture of the clavicle or injury to the arm) that is usually, but not always, transient.

10. **Anesthesia** also has risks. Women may be allergic to or have reactions to the medications used. General anesthesia can result in aspiration pneumonia, which is life threatening. Patients receiving medicines of any kind can have a reaction, allergic or otherwise. Blood transfusions (given only when absolutely needed) can result in bad reactions or infections transmitted by blood.

11. Some complications can be prevented. Rhesus isoimmunization **("Rh disease")**, can be prevented in almost all Rh-negative women by administering a filtered blood protein that blocks the maternal immune reaction against an Rh-positive fetus' blood cells. There is also a test that can determine whether the baby is Rh-negative or Rh-positive. If the baby is also Rh-negative, or both parents are Rh-negative, there is no risk of Rhesus isoimmunizatinon disease, and administrative of the protein ("rhogam") is not necessary. Because this lethal disease can be prevented, we respectfully decline to provide obstetric care for women who refuse to accept the preventative treatment or have a test to confirm that their fetus is not at risk.

12. **Gestational diabetes** is a condition that may increase pregnancy complications. Because this condition is diagnosed by a simple blood test after a standardized dose of glucose, we respectfully decline to provide obstetric care to women who are not willing to undergo this test or alternatively check their blood sugars as directed if the test is not done, or who refuse to monitor their blood sugars if the condition is diagnosed.

13. Group B streptococcus ("**Group B strep**") is a bacteria that inhabits the gastrointestinal tract of about 1/3 of adults. It has been shown to cause severe infections and death in a minority of infants born to mothers who test positive for Group B strep. The Centers for Disease Control has developed a protocol that's been shown to dramatically decrease the incidence of Group B strep infection. When colonized mothers receive penicillin (or another appropriate antibiotic if they are allergic) in labor, the incidence of early onset Group B infection is almost zero. Several years ago, there was a protocol to treat according to "risk factors" such as length of time the water has been broken, fever in labor, and

prematurity. It has been proven that this strategy does not prevent neonatal infection as well as universal prophylaxis with medication for all women colonized and it is no longer appropriate to treat only when there are risk factors. We do not recommend and will not agree to voluntarily ignore the CDC protocol and request that care patients who do not want to be screened for Group B strep or follow CDC guidelines during labor transfer their care to another caregiver.

14. **Vitamin K** is required for normal blood clotting. An injection is ordered for all newborns to prevent vitamin K deficiency bleeding, which can occur up to 6 months after birth. Most bleeding occurs without warning and affects the intestines or the brain. Oral supplementation has not been shown to be effective, and babies don't make their own vitamin K until they are eating normal food. The deficiency is more common in breastfed babies who don't receive the injection (formulas are supplemented with vitamin K). One isolated study in 1990 raised concerns about increased cancer risks; many studies since then have failed to confirm that finding. There is good consensus among experts that vitamin K is safe and does not increase the risk of cancer; the evidence that vitamin K deficiency is dangerous for healthy babies is irrefutable. Male infants who do not receive vitamin K will not be cleared for circumcision by the pediatrician and we do not recommend refusal of vitamin K prophylaxis.

15. While we understand that women do not want "unnecessary interventions", we recommend treatments and **preventative care**, such as immunizations against influenza and pertussis, that have been shown to decrease risks to both the mother and her fetus, and encourage patients to rely on respected sources of information (such as the Centers for Disease Control and the American College of Obstetricians and Gynecologists) and not psuedo-scientists or sources such as "chat rooms".

16. It is our philosophy that, while all poor outcomes cannot be prevented, practices that have been shown to help promote good outcomes should be embraced by both the patient and her caregivers. When conflicts arise between the patient's desires to avoid such treatments and the physicians' desires to not participate in actions that may cause harm to the fetus, we reserve the right to request that the patient select an alternative caregiver as soon as possible after such conflicts become apparent.

17. **Genetic screening** for Down Syndrome (Trisomy 21) and **Cystic Fibrosis** screening are offered to EVERY PATIENT of this practice, regardless of age and family history. It is important to understand the choices available and to realize that screening tests can have false positive and false negative results.

To attempt to list every single emergency or complication is impossible. This "informed consent" is not intended to alarm the patient, only to remind the patient that life and pregnancy are not without risk. We ask that you and your partner acknowledge the receipt of this information with your signatures. This document will become part of your record. We shall be happy to answer any questions you might have. You may request a copy of this document for your personal records.

VAGINAL BIRTH AFTER CESAREAN (VBAC)
OR REPEAT CESAREAN INFORMED CONSENT

I understand that (please initial each statement):

____ I have had one or two prior cesarean sections.

____After one low transverse cesarean, I have the option of undergoing an elective repeat cesarean section or attempting a vaginal birth after a cesarean section (VBAC).

___ After two prior low transverse cesareans, selected patients may have the option to attempt a trial of labor. This depends on other obstetrical variables that may not be apparent until the last few weeks or pregnancy or, in some cases, during labor.

____Approximately 60-80% or patients who undergo a trial of labor will successfully deliver vaginally.

____Uterine rupture occurs in approximately 1% of VBAC attempts after one prior low transverse cesarean. There may be a catastrophic outcome (such as brain injury or death of baby, need for hysterectomy for mother, serious blood loss for mother) in up to 10% of those cases in which rupture occurs (overall 1/1000 risk of serious injury to mother and/or baby in patients attempting VBAC). The risk of complications is higher after more than one cesarean, but the exact risk is not known.

____Should rupture of the uterus occur during a trial of labor with a VBAC, there might not be sufficient time to operate and prevent the death of or permanent brain injury to my baby.

____I have the option to undergo an elective repeat cesarean section between 39-41 weeks.

____Vaginal delivery generally has fewer discomforts after delivery than a cesarean delivery.

____I have a greater risk of temporary urinary incontinence following vaginal delivery. It has not been shown that cesarean delivery prevents permanent incontinence.

____During a VBAC attempt, the use of oxytocin (Pitocin) may be offered to augment labor and increase uterine contractions. If so, an intrauterine pressure catheter may be recommended to assess the strength of uterine contractions.

____Even if I choose a VBAC, a cesarean section may be necessary during labor. An emergency cesarean in labor puts me at greater risk for complications and longer hospital stay than a scheduled elective cesarean without labor.

____Should my labor not start or progress normally, I will not be able to be induced or augmented with prostaglandin hormones and may not be allowed to attempt the VBAC.

____History of successful vaginal birth after a previous cesarean does NOT guarantee that uterine rupture with a catastrophic outcome will not occur.

____ Scheduled repeat cesarean has more maternal risks of complications than a successful trial of labor, but fewer complications than cesarean after a failed VBAC. Maternal death is rare (about 10 per 100,000) but can occur even from complications of a scheduled repeat cesarean. Complications of repeat cesarean include but are not limited to bleeding, infection, damage to internal organs such as bowels or bladder, need for transfusion or hysterectomy, serious anesthesia complications, and transient breathing problems of the newborn which may require a stay in the intensive care unit. Each repeat cesarean also increases the risks for serious life-threatening complications in future pregnancies (such as placenta previa and accrete or severe scar tissue).

Please indicate the statement that best describes your choice relating to VBAC vs repeat cesarean.

_____ I want to schedule a repeat cesarean at 39-40 weeks, and I want to have a cesarean if I go into labor before that time.

_____ I want to schedule a repeat cesarean at 39-40 weeks but would consider a trial of labor if I present in labor before my scheduled surgery.

_____ I want to attempt a trial of labor IF I HAVE SPONTANEOUS LABOR before 41 weeks. I understand this does NOT obligate me to have a VBAC and that I may change my mind at any time (including when I am in labor).

I certify that I have read all of the foregoing and fully understand the issues presented to me, am making an informed choice regarding VBAC versus repeat cesarean, and that all my questions have been answered to my satisfaction. I consent to either VBAC or cesarean as indicated by my initials above.

Signature	Date
Physician	Date

Use this page for your personal notes or questions.