CONGRATULATIONS ON YOUR PREGNANCY!

We are delighted that you have chosen Balcones Ob/Gyn for your prenatal care. We look forward to assisting you and being with you during this very significant time in your life. Throughout your pregnancy and during the postpartum period, our staff will be available to you for all of your questions and concerns. Our goal is to provide you with exceptional medical care as well as support during this amazing, although sometimes challenging, time of your life.

This booklet will help you know what to expect during your visits to our office for prenatal care and will also answer many of the most common questions pregnant women have. This booklet does not cover every important pregnancy issue, however, and we would like to recommend that you purchase the following book as the best prenatal guide for all of your pregnancy questions and concerns:

Your Pregnancy & Birth, 5th Ed. by ACOG (The American College of Obstetricians and Gynecologists).

This can be ordered for $14.95 at www.acog.org or by calling ACOG at 1-800-762-2264.

Again, we feel privileged that you have chosen to entrust us with your care while pregnant, and we look forward to getting to know you and sharing in the miracle of new life with you.

Dr. Nancy Binford and staff

AGENDA FOR PRENATAL VISITS

FIRST VISIT

Your first prenatal visit is done around 12 weeks of pregnancy and is quite extensive. (Pregnancy is counted in weeks from the first day of the last period, not conception. The due date is the 40th week of the pregnancy.) The following is a list of what is a standard part of any first prenatal office visit:

- Medical history questionnaire—We will ask you specific questions about both you and your partner's medical information including both of your families' medical histories. This will be reviewed by a nurse as well as the doctor. Risks will be determined and discussed thoroughly, and the recommended plan of care will be determined by doctors.
- Full physical exam
- Ultrasound—This is important to confirm that the fetus is living, whether there may be more than one fetus present, and to determine the due date if that was not done at your pregnancy confirmation visit. (Since menstrual periods are often not accurate at estimating ovulation and the conception time frame, the due date may be chosen based on the measurement of the fetus at the first visit rather than from the last menstrual period.)
- Labwork—The standard lab tests required are: pap smear, urinalysis, urine culture, vaginal culture, gonorrhea and chlamydia tests, blood count, metabolic panel, blood type and Rh factor, Rubella antibody titer, Hepatitis B antibody test, HIV, syphilis, and indirect Coombs test (antibody test). Additional tests which will be done if deemed necessary by Dr. Binford include hemaglobin electrophoresis, toxoplasmosis, thyroid screen, and others.
- Discussion of prenatal vitamins, DHA supplement, diet, & exercise—Our nurses are highly trained and experienced and will review what is recommended for you.
- Discussion of birth defect testing options—There are many options available to you for testing for birth defects. These will be discussed at length at the first visit by both the nurse and the doctor as well as in this handout.

You will be seen by Dr. Binford at your first prenatal visit. You will meet with our nurse practitioner, Holly Bullion, at some of your subsequent visits, and some of your prenatal visits may be conducted by one of our registered nurses if it is a routine prenatal visit and there are no medical problems at that time. Dr. Binford is usually available for consultation if there is a concerning medical issue evident at a visit conducted by their nurse practitioner or nurse. In circumstances in which Dr. Binford is not available, one of her call partners will be available for consultation.

Dr. Binford shares weeknight and weekend call with The Ob/Gyn Group of Austin : Dr. Patrick Nunnely, Dr. David Reue, Dr. Lyda Sweeney, Dr. Sally Grogono, Dr. Jason Gooch, Dr. Karen Kish, and Dr. Shannon Abikhaled.

The remainder of the prenatal visits will be described after discussing birth defect testing options. Routine prenatal care requires monthly visits until about 28

weeks, then visits every two weeks until 36 weeks, then weekly visits until delivery. Ultimately, the frequency of visits will be determined by whatever pregnancy issues arise.

BIRTH DEFECT TESTING OPTIONS

There are many categories of birth defects. One category is that of genetic birth defects, such as cystic fibrosis and Tay-Sachs disease. These birth defects occur when a gene is passed through the family. We screen your pregnancy for genetic birth defects through our genetic disease questionnaire, and gene testing is available for most genetic diseases.

Another category of birth defects is anatomical birth defects, such as when the brain or abdomen or heart has not been formed correctly. These birth defects are screened for with the 20-week sonogram.

A third category of birth defects is that of chromosomal birth defects, such as Down Syndrome and Trisomies 13 & 18. These birth defects are not inherited from the family in most cases. They occur spontaneously and can occur at any maternal age, although the chances increase as the age of the mother increases. Chromosomal birth defects may not be found by the 20-week sonogram; therefore, the testing options listed below are typically the only way to screen for them.

Another birth defect commonly checked for in pregnancy is spina bifida (a type of neural tube defect) and occurs due to multifactorial inheritance, a fourth category of birth defects. This means that multiple inherited genes plus environmental factors are involved in causing the birth defect. Screening is done by checking an alphafetoprotein level in mom's blood (or in the amniotic fluid if amniocentesis is done). Defects of the brain and spine of the baby are also thoroughly checked for during the 20-week ultrasound. Other examples of birth defects caused by multifactorial inheritance include congenital heart disease, cleft lip and palate, pyloric stenosis, clubfoot, and congenital hip dislocation. Except for hip dislocation which is typically found at birth during the baby's 1st examination by the baby's pediatrician, the other multifactorial birth defects are checked for with the 20-week ultrasound.

Although many of our lab tests are a required part of our prenatal care, testing for chromosomal birth defects, cystic fibrosis, SMA, Fragile X, and spina bifida is your option. Deciding to test can be a difficult decision-making process. Dr. Binford will review your risks of these birth defects at your first visit, and then she will discuss the options listed below and the pros and cons of testing. Some couples ultimately decide not to test at all for these birth defects. This is reasonable if a couple decides that they would not terminate the pregnancy for any of these birth defects and that the knowledge that the baby has one of these defects would not help them in any way prior to delivery. Many couples do choose to test, and the many testing options are described below:

OPTIONS AT 12 WEEKS:

Ultra-Screen

This test is a combination of a blood test and a special ultrasound done between 11 and 14 weeks of pregnancy. The blood is analyzed for two proteins called freeBeta-hCG and PAPP-A which are normally found in the blood of all pregnant women. The ultrasound—done by a sonographer at a perinatologist's office—examines the baby's neck, measuring the amount of fluid accumulation behind the neck of the baby, called the nuchal translucency (NT). When done together, the blood work and the NT measurement can detect over 91% of babies with Down syndrome (with a 5% false positive rate), 98% of babies with Trisomy 18 (with a 1% false positive rate), as well as 40% of babies with congenital heart defects. (The false positive rate is the rate at which the testing reports an abnormality that is actually not present.) Although Ultra-Screen cannot check for open neural tube defects (like spina bifida), an additional blood test called MSAFP can be done at 16 weeks to screen for this birth defect.

When Ultra-Screen is found to be abnormal, patients will be offered further definitive testing options such as CVS or amniocentesis.

The advantage of Ultra-Screen is that it is the earliest non-invasive (no risk) test available for chromosomal birth defects. The disadvantages are that it is not 100% accurate and rarely may not be covered by insurance companies.

Chorionic Villous Sampling (CVS)

CVS is done by a specialist called a perinatologist between 10 and 12 weeks of pregnancy. A small sample of cells is taken from the placenta where it attaches to the wall of the uterus. These cells have the same chromosomes as the fetus. CVS can detect all of the same chromosomal birth defects as amniocentesis. Open neural tube defects cannot be checked with CVS, but can be screened for at 16 weeks with a blood test call MSAFP.

The advantage of CVS is that it is the earliest possible testing that is 99% accurate. The disadvantage of CVS is its 1% risk of miscarriage, slightly higher than with amniocentesis which is reported to have a miscarriage risk of about ½%. Because of the miscarriage risk, this test is only offered to women over 35 years of age or if Ultra-Screen is reported as abnormal.

OPTIONS AT 16 WEEKS:

AFP4

This blood test is best done between 15 and 18 weeks of pregnancy. It detects 81% of babies with Down syndrome, 80% of babies with trisomy 18, and 80% of babies with open neural tube defects (i.e., spina bifida).

The advantages of AFP4 are that it is non-invasive (no risk) and is typically covered by insurance companies. There are two disadvantages of AFP4 testing. One disadvantage is that testing is not possible as early as Ultra-Screen which may be important for patients who may desire termination of the pregnancy for a chromosomal birth defect or who just wish to have this information as early as possible. Another disadvantage is the inaccuracy of AFP4 which includes a small false negative rate (meaning that the test may say the baby is normal, but it really has a birth defect) and small false positive rate (meaning that the test reports a birth defect, but the baby is in fact normal). If testing reports an abnormality, then patients will be offered further definitive testing through amniocentesis.

MSAFP

This acronym stands for maternal serum alphafetoprotein. This test is done between 15 and 23 weeks as a screen for neural tube defects (like spina bifida). This test is recommended for patients who have done Ultra-Screen or CVS in the 1st trimester since those tests do not test for neural tube defects. MSAFP detects 80% of neural tube defects.

The advantage of MSAFP is that it is non-invasive (no risk). The disadvantage is that it is not 100% accurate.

Cystic Fibrosis (CF) Gene Testing

CF is a genetic disease. This means that it does not occur spontaneously, but is passed by a gene through one's family. CF causes the body to produce abnormally thick mucus, leading to life threatening lung infections, digestion problems, diarrhea, poor growth, and male infertility. CF does not affect intelligence. Although symptoms vary from mild to severe, the average life span for individuals with CF is 33 years.

Although CF is a disease that is passed through the family, it is possible that there may be only CF gene carriers in the family and no one in the family who actually has the disease.

CF disease can only occur if both parents of a child are CF gene carriers. Therefore, we would typically offer the mother CF gene testing first. If she does not carry the CF gene, then the father does not need to be tested. If the mother does carry the CF gene, then the father is tested next. If both parents carry the CF gene, there is a 25% chance that the baby will have the disease. CVS or amniocentesis can be done if both parents are carriers and desire definitive prenatal diagnosis.

One advantage of CF gene testing is that the testing need only be done in a parents' 1st pregnancy. Once your CF gene carrier status is determined, that applies to all future pregnancies. The disadvantage of CF gene testing is that a negative result does not completely eliminate the chance of being a CF gene carrier.

Extremely rare abnormalities (mutations) in the CF gene are not included in carrier testing.

Spinal Muscular Atrophy (SMA)

SMA is genetic disorder that destroys the nerves that effect the muscle movement used for breathing, swallowing, head/neck control, crawling and walking. SMA does not effect intelligence.

It is recommended for the mother to be tested first and if she tests negative, then the father does not need to be tested. If the mother does carry the SMA gene, then the father is tested next. If both parents carry the SMA gene, there is a 25% chance that the baby will have the disease. CVS or amniocentesis can be done if both parents are carriers and desire definitive prenatal diagnosis.

Fragile X Syndrome

Fragile X is caused by an alteration in the FMR1 gene that can be passed from generation to generation. Only one parent needs to be a carrier of the altered gene for it to be passed on. Women who are Fragile X carriers have a 50% chance to have a child with Fragile X Syndrome.

Fragile X syndrome causes a variety of symptoms which can include developmental delays and mental retardation.

Individuals with a family history of Fragile X syndrome or developmental delays, autism, unexplained infertility problems, ovarian failure, unexplained problems with balance or tremor maybe at greater risk of being a carrier.

Screening will detect about 99% of individuals who are Fragile X carriers.

Amniocentesis

This test is done between 16 and 18 weeks of pregnancy by a specialist called a perinatologist. A sample of amniotic fluid is withdrawn through a needle from the sac that surrounds the fetus. Amniotic fluid contains cells that have been shed from the fetus. These cells are then checked for their chromosomal make-up. This testing is able to detect over 99% of all chromosome abnormalities as well as neural tube defects (unlike CVS).

The advantage of amniocentesis is its accuracy at detecting chromosomal birth defects. The disadvantages are its ½% risk of miscarriage (which is slightly lower than the 1% miscarriage rate of CVS) and that it is done in the 2nd trimester (a month later than CVS). Because of the risk of miscarriage this test is only offered to women who are 35 or older or who have had an abnormal Ultra-Screen.

AGENDA FOR PRENATAL VISITS, CONTINUED

SECOND VISIT

Your second prenatal visit is done around 16 weeks of pregnancy. The following is a list of the routine parts of this visit:

- Review and discuss lab results—We will review all results from the 1st prenatal visit as well as discuss Ultra-Screen if done.
- Vital sign check—This includes your blood pressure, weight, and checking your urine for protein and glucose. These tests will be done at every prenatal visit.
- Fetal heart rate check—This will be done with a Doppler and will also be done at every prenatal visit. The fetal heart rate is normally in the 160 to 170 beats per minute range in early pregnancy. As the heart grows larger during the pregnancy, it can pump more blood, and as time goes by, the heart rate normally slows down to about 120 beats per minute by the time of the due date. The fetal heart rate also normally fluctuates with the activity of the fetus. Generally, we expect a fetal heart rate of 120 or above at any given visit.
- Discussion of testing plans for the third visit—See the birth defect testing options listed previously.

THIRD VISIT

Your third prenatal visit is done around 20 weeks. Here are the normal parts of this prenatal visit:

- Review and discuss lab results
- Vital sign check
- Fetal heart rate check
- Birth defect testing—This plan was determined at previous visits.
- Scheduling of the screening anatomical ultrasound—This important ultrasound checking the baby's anatomy will be done by a sonographer at a perinatologist's office between 18 - 20 weeks.
- Begin fundal height measurements—This is the distance in centimeters from the top of the pubic bone to the fundus, or top of the uterus. This measurement simply reassures us that the baby is growing appropriately between visits. It is difficult to estimate the fetus' actual weight this way.

FOURTH VISIT

Your fourth prenatal visit is done around 24 weeks. Here is what will be done at this visit:

- Review and discuss lab results
- Vital sign check
- Fetal heart rate check
- Discussion of available prenatal classes—We have a host of classes available to help you prepare for childbirth and the care of your new baby. These include: childbirth, infant & child CPR, newborn care, breastfeeding, and a class for siblings of the new baby. We will give you specific information on available classes.
- Discussion of choosing a pediatrician—Picking a pediatrician for your newborn to see for their care after birth is an important decision to be made ideally before your 3rd trimester. (In case of an early delivery, it would be nice to know whom you plan to use.) Getting recommendations from other parents is always valuable. In addition, we can provide our patients with a list of pediatricians who we are familiar with and can highly recommend.
- Receive the Seton Maternity Center handout and preregistration form
- Receive information regarding cord blood stem cell collection
- Receive instructions and the glucola drink – You will have the test for gestational diabetes at your next visit.

FIFTH VISIT

This visit is done around 28 weeks and will include the following:

- Vital sign check
- Fetal heart rate check
- Discussion of preterm labor symptoms—It is important during this time of the pregnancy that mothers are looking for any signs of preterm labor. It is crucial that preterm labor is found early so that interventions may be initiated in order to avoid preterm delivery. You need to notify the office if at any time you are experiencing vaginal bleeding of any color or amount, an increase in clear, watery vaginal discharge soaking your underwear, or contractions of the uterus that are occurring every 5 to 10 minutes apart (counting from the beginning of one to the beginning of the next) for an hour or more that are not decreasing with hydration and rest.
- Labwork to test for anemia, hiv and gestational diabetes—You will do this testing at our our office. We will draw your blood exactly one hour after finishing the glucola. For our patients who are Rh negative, an indirect Coombs (a blood antibody test) will be checked also, and a Rhogam injection will be given.
- Discussion of kick count testing—The fetus moves abundantly from as early as 7 or 8 weeks of pregnancy. However, the baby is not large enough for the

mother to feel this movement until 18 to 22 weeks of pregnancy. When mothers feel fetal movement in the 2nd trimester, it is normal that it may not be felt very regularly. However, this changes, and by 28 weeks of pregnancy, regular fetal movement felt episodically throughout each day is a very important indication of fetal well-being. From 28 weeks until delivery, it is important that mothers pay attention and notice if fetal movement is roughly the same amount from day to day.

If there is any question that the movement may be decreased one day from the previous, then mothers should do a kick-count test. This is done by drinking a very cold glass of water or juice or even a caffeinated drink (some people have called this the "Coke test"), then sitting or lying down if possible for an hour to count fetal movements. If the baby moves ten times in that hour, then it is reassuring that the fetus is healthy and not having any trouble. If the baby does not move ten times in the hour after the cold drink, then mothers should contact the office (or the on-call doctor if the office is closed) and must be seen for evaluation promptly.

SIXTH VISIT

This visit is done around 30 weeks and involves:

- Vital sign check
- Fetal heart rate check and fundal height measurement
- Review and discuss lab results
- Scheduling of 3rd trimester ultrasound for the next visit

SEVENTH VISIT

This visit occurs around 32 weeks and includes:

- Vital sign check
- Fetal heart rate check and fundal height measurement
- Ultrasound—This sonogram is done by Dr. Binford at our office to confirm that the fetus is head-down prior to delivery, to assess the fetal size and predict the baby's birth weight, and to assess fetal well-being. However if you are still concurrently seeing a Perinatologist, all sonograms will continue to be done with your specialist.

EIGHTH VISIT

This visit is done around 34 weeks and includes the following:

- Vital sign check
- Fetal heart rate check and fundal height measurement
- Discuss Group B Strep screen

NINTH VISIT

This visit is done around 36 weeks and includes:

- Vital sign check
- Fetal heart rate check (fundal height measurements will be deferred at all remaining visits given their inaccuracy during the last two months of pregnancy)
- Group B Streptococcus vaginal culture—This bacteria can be a normal inhabitant of the vagina. If it is abundant at the time of a vaginal delivery, babies can potentially become seriously ill. It is routine to test all mothers about one month prior to the due date. If the test is positive, then mothers will be given IV antibiotics while in labor to eliminate the presence of Group B Strep immediately prior to delivery.
- Cervical exam
- Discussion of symptoms of labor—When mothers are in labor at 34 weeks of pregnancy or later, the labor is allowed to proceed. Symptoms of labor include vaginal bleeding, vaginal leaking of clear fluid, and contractions that are occurring every 5 minutes for an hour or more.
- Discussion of whom to call and what to do when in labor—We ask that you call our office if you are in labor during our office hours. Determining if you are in active labor and are ready to be admitted to the hospital is a much more expedited process if done in the office. If you believe you may be in labor after office hours, we ask that you call and speak to the on-call doctor prior to driving to the hospital. If you have special circumstances such as a history of rapid labor or a lengthy drive to Seton hospital from your home, these instructions will be modified.

TENTH AND REMAINING VISITS

The last month's weekly visits occur between 37 to 41 weeks and include:

- Vital sign check
- Fetal heart rate check
- Cervical exam
- Discussion of labor symptoms

- Discussion of indications for induction of labor—Our goal for all of our patients is spontaneous labor. However, for the safety of mothers and their babies, induction of labor is sometimes medically necessary. Inductions may be recommended for a number of reasons, however, the most common are for: 1) pregnancy induced hypertension (also called preeclampsia) which endangers mother and baby and 2)for being postdates, or being pregnant past 41 weeks (more than one week after the due date) which endangers baby. The decision to proceed with induction will be made after detailed discussion with Dr. Binford.

SUGGESTIONS FOR NAUSEA & VOMITING IN THE 1ST TRIMESTER

Nausea and vomiting are common problems in early pregnancy, and there are many ways to help minimize these symptoms. Please try the following suggestions unless you are vomiting excessively—more than twice per day. If vomiting becomes severe, it is important to call the office for medication in order to avoid dehydration which can quickly necessitate hospitalization for IV fluids. (Dehydration can harm the fetus if untreated.) Medication can also be used for severe nausea (even without vomiting) if the following suggestions are not helping.

- Eat small, frequent meals—Instead of eating the usual three large meals per day, try eating small meals 5 to 6 times per day, or about every 2 to 3 hours. Keeping food on your stomach throughout the daytime and evening often is a great help.
- Eat protein in the morning—While you may usually do well with fruit or cereal in the morning, these energy sources are used up quickly by the body (within an hour or two). Protein (like in eggs, meat, peanut butter, & yogurt) is a longer-acting energy source and may help to keep away nausea when consumed within a short time after waking.
- Keep crackers by your bedside—Nibbling on crackers even before sitting up in the morning helps some moms.
- Avoid greasy, fried, spicy, and odorous foods—You will quickly learn what you can and cannot tolerate.
- Separate solids and liquids—Drinking fluids at a different time than eating meals can help.
- Don't forget to eat an afternoon snack and earlier dinner than usual—Often moms do well in the morning and feel the most sick in the evening. This may be helped by eating every two hours in the afternoon and evening and including protein in snacks. Waiting to eat dinner until 7 p.m. may not be realistic during the 1st trimester! Moving dinnertime to 5 p.m. can help.
- Get plenty of rest—Going to bed early, resting in the evenings, taking extra naps, and saying "no" to long shopping excursions, all-day outdoor events, or other physically-taxing invitations are wise.
- Stay hydrated—If you have not been diligent in the past about consuming 8 to 10 glasses of water per day, now is the time to make this a priority. If you are nauseated, do not gulp large amounts at a time; sip small amounts of water frequently. If you are vomiting and unable to keep fluids down for several hours, you must call the office for intervention.
- Change your prenatal vitamin to Citranatal B-Calm—It is common that the iron present in all prenatal vitamins can worsen nausea. If this seems to be the case, call the office and you can temporarily change to B-Calm which only contains folic acid and vitamins B6 (which are thought to possibly help nausea). After nausea has passed (hopefully between 12 and 16 weeks of pregnancy), it is important to change back to your previous prenatal vitamin.

- Other suggestions—Some mothers have found that watermelon, grapes, lemonade, ginger tea, ginger ale, ginger cookies, raw celery, colas, and "sea sick" wristbands available at the pharmacy can help nausea.

NUTRITION AND EXERCISE IN PREGNANCY

Remaining physically active and eating a healthy diet are important in pregnancy. The following suggestions should be helpful tips but may need to be modified if there are special concerns in your pregnancy.

Nutrition

- The amount of weight you should gain is relative to your weight prior to pregnancy. For mothers with normal weight for their height, 25 to 35 pounds of weight gain is recommended during pregnancy. This amount will be modified for mothers who are overweight or underweight at the beginning of pregnancy.
- Eating at home instead of at restaurants, avoiding junk food and fast food, and limiting desserts will help you avoid gaining excessive weight. Gaining too much weight when pregnant is associated with having larger than average babies and is also a concern for your overall long-term health.
- It is recommended that you consume three servings of protein every day and 3 to 4 servings of fruits and vegetables per day, preferably fresh.
- Increased calcium is important in the diet during pregnancy, and four servings of dairy products per day are recommended. If you cannot tolerate dairy products or eat them in this quantity every day, you should start calcium supplementation, taking 500mg 1 to 2 times per day.
- Avoiding the following foods while pregnant will protect you from ingesting harmful bacteria such as listeria: unpasteurized products (such as bottled fresh juices and soft cheeses); raw seafood, meat or eggs; unheated deli meats; and unwashed fresh fruits and vegetables.
- Limit tuna consumption to twice per week. Do not eat swordfish, tilefish, king mackerel, or shark due to their high mercury content. Limit freshwater fish to once per week. All other fish are safe and a very healthy part of the diet while pregnant.
- Avoid alcohol completely in pregnancy.
- Caffeine is considered safe throughout pregnancy, but should be limited to 1 to 2 servings per day. Avoid Nutrasweet. Splenda is considered safe while pregnant.
- Avoid medicinal herbal teas and products.

Exercise

- If you have not been exercising prior to pregnancy, walking and swimming are the best exercise options. Biking, skiing, rock climbing, horseback riding,

and any activity which has a high risk for falling must be avoided while pregnant.

- As when not pregnant, it is recommended that you exercise about 30 minutes to an hour five days each week. If this is more than your previous amount, increasing exercise gradually is important.
- Incorporating prenatal yoga into your exercise routine is recommended.
- Weight training in pregnancy is acceptable with light weights only and so long as you are never straining.
- Avoid any exercises on your back after 20 weeks of pregnancy.
- Increase your water intake and eat healthy snacks on the days you exercise.
- Avoid exercising in excessive heat or becoming overheated—listen to your body!

OTHER RECOMMENDATIONS FOR PREGNANCY

This is a listing of our recommendations for the many miscellaneous concerns and issues that our pregnant patients have.

- The flu shot is recommended for all pregnant women if pregnant during flu season. Pregnant women are considered high risk. This means that if infected with the influenza virus, the disease could be much more severe than usual, often requiring hospitalization and possibly being life-threatening. The flu shot is safe at all stages of pregnancy. We stock and administer the flu shot to consenting pregnant patients at our office during flu season each year.
- Traveling by car or airplane is safe in pregnancy although Dr. Binford recommends against traveling after 24 weeks. When traveling, walking every hour or so is important to avoid getting a blood clot. If you wish to travel after 24 weeks, please discuss this with Dr. Binford prior to buying tickets or making plans to travel.
- You may color or perm your hair after the 1st trimester. Manicures and pedicures are safe throughout pregnancy. Avoid laser hair removal while pregnant.
- Avoid tanning while pregnant. Your skin is more susceptible to burning while pregnant, and this increases your skin cancer risk. Wearing sunscreen when outdoors is strongly recommended.
- You may assist in painting your home so long as rooms are well-ventilated.
- You may sleep on your back until the last few months of pregnancy when it is uncomfortable to do so. You are not limited to your left side when sleeping—you may sleep equally on your left and right sides.
- Intercourse is safe throughout pregnancy unless the doctor asks you to abstain for certain pregnancy problems.
- Hot tubs should be avoided throughout pregnancy, but a fairly hot bath at home is safe. Heating pads may be used on your back, but never on your abdomen.
- Dental cleanings are important to continue while pregnant and are safe. If x-rays are needed, they are safe so long as you have a lead apron draped to cover your entire abdomen. If you need dental work done, local anesthesia is safe, but never nitrous oxide gas. Be sure to let your dentist know you are pregnant.
- Swimming is safe throughout pregnancy unless your water is broken.
- If you are involved in a car accident and injured, you should allow EMS to take you to Seton Hospital (or a closer hospital if your injuries are severe). If it appears that you are uninjured, call our office as soon as possible for an office visit the same or next day.
- If you are exposed to Fifth's Disease or CMV, you will likely not be infected since most mothers already possess antibodies to these viruses. However, call our office for blood testing to determine your status.
- You may have your home exterminated while pregnant so long as rooms are well-ventilated.

- Most women take between 6 and 12 weeks off after delivery depending on their employer's policies. It is considered medically necessary to take off at least six weeks.

SUGGESTIONS FOR COMMON COMPLAINTS

There are so many joys when pregnant, but many challenges as well. Here are suggestions for the many physical problems that can arise when pregnant.

- Feeling faint—If you feel lightheaded or dizzy, pay attention. Do not ignore this feeling or you may lose consciousness and fall and injure yourself. No matter where you are or what you're doing, lie down on your side to get your head at the same level as your heart. Drink water or juice if you may be low on fluid intake and eat a snack if you've gone too long since eating. This feeling is common throughout pregnancy, especially if sitting very still or standing too long. Please talk to the doctor if this feeling is occurring very frequently or you actually lose consciousness.
- Round ligament pains—These sharp, stabbing, brief pains on one or both sides of the pelvic area are caused by rapid growth of the uterus and stretching of the ligaments nearby. Avoiding sudden movements, turning slowly in bed, and sitting up slowly can help. Severe pain which does not go away should be reported to the office.
- Headaches—These are common throughout pregnancy, and perhaps a little more often in the 2nd trimester. You may use extra-strength Tylenol as directed on the package. Aspirin, ibuprofen, and prescription migraine medications may not be used when pregnant. If headaches are severe or excessively frequent, please call the office.
- Backache—This is common in early pregnancy, even when you may not be showing yet, and is nearly universal toward the end of pregnancy. Make an effort to maintain good posture. If your mattress is an old one, pregnancy is a great time to consider investing in a new, supportive mattress. Massage—whether by a loved one or professional—can be helpful. A fairly hot bath and a heating pad on a low to medium setting can help your back pain. (Never use a heating pad on your abdomen.) Extra-strength Tylenol may be used as directed. Maternity belts can relieve back strain in late pregnancy. Chiropractic adjustments are OK in pregnancy so long as the chiropracter knows you're pregnant. Rarely, physical therapy may be needed.
- Increased vaginal discharge—This is a normal symptom from the hormonal changes of pregnancy. Wearing a pantiliner can help keep the extra moisture from bothering the skin. Bathing more frequently can also help. Avoid scrubbing the genital area when cleaning, and always wipe from the front to back when using the bathroom. Do not use vaginal sprays or douche. If you notice itching, irritation, redness, swelling, or a foul odor, you may have an infection that needs treatment, and you should call the office.
- Nasal congestion and nose bleeds—These are common in pregnancy due to vascular congestion. (You have twice as much blood circulating in your body while pregnant.) Avoid use of Afrin since it can lead to rebound nasal congestion. Many antihistamines are safe in pregnancy as listed in the following section. Nose bleeds can occur frequently, but are not a concern if

the bleeding stops within a few minutes by reclining the head and holding a tissue to the nose.

- Constipation—Hormonal changes make this common in early pregnancy, and taking iron supplementation can worsen symptoms. Drinking at least 10 glasses of water per day, walking daily, and eating high fiber foods (like bran and fruits and vegetables) should help. If not, then starting an over-the-counter fiber supplement and taking a dose daily can make all the difference in achieving daily bowel movements. If stool is hard and difficult or painful to pass, then adding a stool softener (like Colace or Surfak) is important. If these tips are not helpful, then be sure to call the office.
- Hemorrhoids—The most important tip to avoid getting hemorrhoids (which are bulging veins in the anal area) is to avoid constipation and straining with bowel movements by following the suggestions above. If you do get hemorrhoids and they are hurting, sitting in fairly hot water each night and using any over-the-counter hemorrhoid cream with hydrocortisone in it will help. If hemorrhoids bleed slightly, this is not a concern, but if bleeding is excessive, please call the office.
- Swelling—The amount of swelling experienced while pregnant is highly variable. Sometimes it is quite mild, and at other times it can be severe. Staying well-hydrated and avoiding excessive salt intake is helpful. Usually lying down will relieve dependent edema of the feet and legs. Toward the end of pregnancy, many women will find that this is no longer helpful. If swelling becomes extreme and/or is around the eyes, please bring this to our attention at your next visit.
- Indigestion/Heartburn—The esophageal sphincter (which prevents gastric juices from flowing upward from the stomach into the esophagus) is looser in pregnancy due to hormonal changes. Most patients experience acid reflux on occasion from mid to late pregnancy. Many mothers may not experience burning or discomfort in their chest, but may instead feel nauseated or even have vomiting. Avoiding spicy and acidic foods can be helpful to avoid reflux. Tums and Mylanta will neutralize any acid build-up if symptoms are bothersome. Toward the end of pregnancy, some mothers will begin to have symptoms every day no matter what they eat. If this is the case, acid-blocking medications can be taken daily to prevent reflux, and this treatment can be discussed with the doctor.
- Insomnia—Most pregnant women have difficulty with sleep at some point in pregnancy due to hormonal changes, anxiety, and the discomforts of pregnancy. Regular exercise, waking at the same time every day, avoiding lengthy afternoon naps (more than 2 hours), and avoiding caffeine late in the day can help. Taking benadryl or Tylenol PM (which contains Tylenol and benadryl) is safe in pregnancy and often very helpful. If these suggestions are not helping, please discuss your insomnia with the doctor.
- Leg cramps—These can be very painful and disruptive when they occur in the middle of the night, and in pregnancy may be due to calcium deficiency. Adding a calcium tablet 1 to 2 times per day may help.
- Numbness, tingling, and pain in the hands—Due to increased fluids in the body causing compression of a nerve in the wrist, some mothers will develop

carpel tunnel syndrome while pregnant. It is often first noticed during the night and may progress to occurring throughout the day as well. "Cock-up" wrist splints (which can be found at a medical supply store) may help since they keep the wrists held in a position to limit nerve compression. If this is not helping, please let the doctor know. You may be referred to a specialist for further evaluation and treatment. Luckily, this condition is temporary and resolves after delivery.

- Varicose Veins—Bulging veins can occur in the legs, anal area, and vulvar area. Varicosities tend to be worse each pregnancy. They can throb and be quite uncomfortable. Lying down usually helps. However, when up and about during the day, if they have become severe and extremely painful, supportive undergarments can make a huge difference. Supportive pantyhose can help with mild varicose veins. When they are severe, it is typically necessary to invest in thick "TED" hose found at medical supply stores. There are also undergarments which are very helpful when veins in the vulva are bulging and causing pain, and these can be found at specialty stores, specifically Special Addition on N. Lamar. Varicose veins greatly decrease after delivery, but may never resolve completely. Varicose veins are not typically a concern for blood clots. (These occur in the deep veins of the leg that are not visible.)
- Shortness of Breath—It is common toward the end of pregnancy to feel breathless and unable to take deep breaths. This is due to the baby being near the bottom of the ribcage and limiting lung expansion. Sleeping with your head elevated can help during the night. If there is any pain with breathing, call the office.
- Low pelvic pain—As the baby grows heavier and lies lower in your body near the end of pregnancy, it is normal to have pressure and pain in the low pelvic area so long as it is mild. Severe pain or pain that occurs with regular tightening in your abdomen (contractions) need to be evaluated in the office.
- Braxton-Hicks contractions—By definition, these contractions of the uterus are not painful and do not occur regularly. You may notice that a few times each day the abdomen feels tight and hard but does not hurt. These may be more frequent when exercising, but will dissipate with hydration and rest afterward. If the tightening are hurting and occurring every 5 to 10 minutes for nearly an hour and not helped by hydration and rest, then you may be experiencing true labor contractions, and you should call the office. Many mothers may never experience Braxton-Hicks contractions during their 1st pregnancy. It is common that they occur more and more with each subsequent pregnancy.

MEDICATIONS THAT ARE SAFE IN PREGNANCY

Most over-the-counter medications are safe in pregnancy otherwise they would not be available for women to take who may not realize that they are pregnant. Many prescription medications are safe as well. There are some exceptions, and the following is a brief list of our suggestions of the medications to avoid and to try for the common problems that can come up while pregnant.

- It is best to avoid all medications in the 1st trimester (unless deemed necessary by Dr. Binford at your 1st prenatal visit) while the most important fetal development is occurring. If you are ill and need treatment while in your 1st trimester, please call the office to discuss what is reasonable and safe to take from the list below. You do not need to call before taking any of the medications below once you have passed 12 weeks of pregnancy.

- Colds/Allergies—TRY: Actifed, Sudafed, Tylenol Cold & Sinus, Claritin plain & D, Clarinex, Zyrtec, benadryl, Tylenol PM, Robitussin DM, Mucinex plain & DM, throat lozenges, saline nasal spray and prescription steroid nasal sprays such as Nasocort. Allergy shots may be continued by your allergist while pregnant (if given immediately prior to pregnancy). AVOID: Allegra and Afrin.

- Headache/Pain/Fever—TRY: extra-strength Tylenol. AVOID: aspirin, ibuprofen, and prescription migraine medications. For fever over 100.4 degrees, call the office.

- Diarrhea—TRY: Kaopectate or Immodium AD. Call the office if diarrhea is severe and not helped by these medications.

- Constipation—TRY: fiber supplements like Metamucil, stool softeners like Colace. AVOID: laxatives which can cause intestinal as well as uterine contractions.

- Indigestion/Heartburn—TRY: Tums, Mylanta, Maalox. Zantac, Pepcid, and Prevacid can be used, but discuss with the doctor first.

- Vaginal infections—It is best to discuss all vaginal symptoms with the doctor. Often testing is necessary to determine if fungal or bacterial so that the proper treatment can be started. Over-the-counter antifungals like Monistat are safe, but may not be what is needed. Probiotics are also considered safe to take.

WHEN TO CALL THE DOCTOR

We encourage you to be in touch with us for any questions or concerns that come up while pregnant. When in doubt, it is usually best to call our office for advice. The following are symptoms that typically require calling the office for advice and/or an office visit.

- Abdominal pain that is severe or when mild pain is persistent
- Contractions that are painful and occurring every 5 to 10 minutes and not decreasing with hydration and rest
- Any vaginal bleeding regardless of color or amount
- A sudden gush of vaginal fluid or fluid that is trickling out persistently
- Fever over 100.4 degrees
- Vomiting or diarrhea that is persistent

After 28 weeks, you should call the doctor for:

- Any of the above symptoms
- Severe headaches, visual changes, and/or constant pain under the right ribcage—all symptoms of pregnancy induced hypertension (also known as preeclampsia)
- Decreased fetal movement when a kick count test (described on page 8) has not brought about 10 fetal movements within an hour