WHAT TO REPORT TO YOUR DOCTOR IMMEDIATELY

Approximately 90 percent of pregnancies progress normally but, sometimes there may be a complication. There are some potential problems or symptoms your doctor will want to know about as soon as they occur. Do not hesitate to call, even if it is late at night, a holiday or on the weekend. These symptoms do not necessarily indicate a problem. Rather, they may require some treatment to help prevent a complication. If ANY of the signs or symptoms listed below occur, call our office immediately at: (770) 475-1666 Alpharetta, (770)844-0546 Cumming or (770) 924-6255 Woodstock. DO NOT wait for the next office visit. Please have your pharmacy telephone number ready in case we need to phone in a prescription for you.

- Ten contractions within one hour
- Any sign of bloody discharge from the vagina
- Persistent headaches
- Absence of movement of the baby
- Decreased movement of the baby
- Severe nausea and vomiting. "Severe" means several times within an hour Swelling of the ankles, feet, and hands, particularly if there is a rapid increase in size or your rings feel tight. (Slight swelling of the legs or ankles during the last month of pregnancy during hot weather is probably normal.)
- Chills and fever over 100 degrees Fahrenheit
- Abdominal pains or back pains
- A sudden gush of "water" from the vagina
- Frequent burning upon urination
- An increased unusual thirst with reduced amount of urine. If you do not urinate for an entire day, even though you have had a normal intake of fluids, report the condition immediately.
- Blurring of vision or spots before the eyes
- Pain on the right or left side
- If you think you have an emergency, go to the nearest Emergency Room

We mentioned earlier that your intelligent observations are important. Ask your provider which of these symptoms, if any, deserves special attention in your case. Some of these may occur during a normal pregnancy. For instance, abdominal pains could be due to something you ate; a sudden gush of "water" may precede the beginning of labor; unpleasant odors may make you dizzy or nauseated. Yet sometimes the above signs do signal the possibility of a miscarriage, toxemia, urinary infections, or other serious complications of pregnancy.

We have tried to cover the most common physical situations that may occur during pregnancy. Be assured that no one woman experiences every discomfort. The majority of pregnant women rarely experience more than one or two symptoms. Being prepared to handle any situation calmly and logically will help you and your baby.

QUESTIONS TO ASK

1._____

2._____

NAUSEA DURING PREGNANCY

Nausea and vomiting are common complaints of pregnancy. It has been described as a "sick feeling, but not anything serious that a person can't handle." Another mother described it as "extremely queasy feeling that you can't quit thinking about." In a recent survey, 80% of pregnant women experienced nausea and 56% experienced vomiting.

For most women, nausea and vomiting begins when they get up or shortly after breakfast. These attacks usually last less than one hour. Nausea and vomiting usually get better after the third month of pregnancy. Factors that make the nausea and vomiting worse include food odors, smoke, and riding in a car. Preparing meals can be a difficult task for pregnant women. Other daily activities may be interrupted due to attacks of nausea and vomiting.

SUGGESTIONS TO RELIEVE NAUSEA AND VOMITING

1. Before getting up in the morning try eating dry toast or crackers
2. Get up slowly and avoid sudden movements
3. Eat small, frequent meals (every two or three hours as needed)
4. Avoid liquids one hour before and after meals
5. Try sipping ginger-ale or coca-cola when nauseous
6. Avoid greasy, fried, and spicy foods
7. Try eating hard candies when nauseous
8. Avoid irritating odors like spices coffee and cigarette smoke
9. Eat a snack at bedtime from the milk or protein food group
10. Select cold foods to eat or foods that require little cooking time
11. Stay out of the heat after eating
12. Try deep breathing exercises when nauseous

NOTIFY OUR OFFICE IF:

1. You are unable to keep any liquids down for 12 hours or;
2. You have a fever (101) along with the nausea and vomiting

SUGGESTED DIET FOR NAUSEA AND VOMITING

Before you get out of bed: 2-3 crackers or dry toast
Breakfast - Protein-boiled egg, cheese or peanut butter, cooked cereal with margarine or sugar, toast with margarine or jelly as tolerated
Mid-morning snack - Crackers with peanut butter or cheese, milk
Lunch - Lean meat, fish or chicken (not fried), potato or rice, bread with margarine as tolerated, milk
Afternoon snack - Fruit or fruit juice, crackers or plain cookies (avoid chocolate and nuts)
Dinner - Lean meat, fish or chicken (not fried), vegetables as tolerated, bread with margarine as tolerated, plain dessert like pound cake or angel food cake, jelly, milk
Bedtime snack - Sandwich (with peanut butter or other proteins), milk

MEDICATIONS DURING PREGNANCY

We prefer that you limit your medications to the following list during your pregnancy:

1. Sudafed (daytime use only)
2. Actifed, if plain Sudafed ineffective
3. Tylenol plain and extra strength
4. Tylenol with CODEINE
5. Robitussin
6. Antibiotics - Ampicillin, Keflex, Erythromycin, Z-Pack, etc.
7. Salt water gargles
8. Throat lozenges
9. Maalox or Mylanta, Rolaids, Tums, Gaviscon
10. Benadryl, Claritin, Zyrtec
11. Phenergan, Zofran
12. Kaopectate, Lomotil
13. Monistat Vaginal Cream
14. Metamucil, Citrucel, or Colace
15. Anusol HC Supp. or Cream
16. Prenatal vitamins (over the counter) or as prescribed
17. Or any medication prescribed by your Obstetrician, Physician Assistant or Nurse Practitioner.

TRIPLE SCREEN

The Triple Screen measures three substances in the mother's blood. Based on the results of these three parameters, a probability is calculated for the risk of Down's Syndrome and/or a neural tube defect. Please note that the triple test measures alpha-fetoprotein, human chorionic gonadotropin (HCG) and estriol. These hormones are primarily produced by the placenta. Levels of HCG are higher than normal in most pregnancies if the fetus has Down's syndrome. Estriol levels are lower than normal in most pregnancies in a fetus with Down's syndrome. Therefore, by combining these three tests we can calculate the likelihood of Down's syndrome. A low triple screen test is used in conjunction with maternal age to predict the risk for Down's syndrome. Ultrasound and Amniocentesis are generally recommended if the risk approaches one out of 270 or if the calculation indicates an abnormal risk. The exact causes of neural tube defects are not known but are thought to be multi-factorial. In the United States approximately 1 out of every 1,000 pregnancies results in a neural tube defect and APPROXIMATELY 95% OF ALL CASES OCCUR IN COUPLES WHO DO NOT HAVE ANY PREVIOUS OR PERSONAL FAMILY HISTORY OF NEURAL TUBE DEFECTS. There is an increased risk of neural tube defect if a couple had a previous child with a neural tube defect or has a close relative who had a neural tube defect. The triple screen test must be performed between 15 and 18 weeks of pregnancy. Therefore, it is a " timed test" and must be done at a certain time during the pregnancy (15 to 18 weeks) . The general risk of having a live baby with Down's syndrome is:

Age:	20	1/1,167
Age:	25	1/1,250
Age:	30	1/700
Age:	35	1/285
Age:	40	1/106
Age:	49	1/11

Trisomy 21 results when there is an additional chromosome #21. If you have further questions or concerns about this screening test please discuss them with your provider at your next visit or call our office at: (770) 475-1666 Alpharetta, (770) 844-0546 Cumming or (770)924-6255 Woodstock.

DETECTION OF DIABETES IN PREGNANCY

The one hour (1) glucose test - a screening test for gestational diabetes.

Pregnancy is potentially diabetogenic. Clinical diabetes may appear in some woman ONLY during pregnancy. Therefore, we test all pregnant women for diabetes with the one hour glucose test. This is a blood test that is performed at approximately 26 to 28 weeks of gestation.

Please note that this is a non fasting screening test in which you drink 50 grams of glucose solution.

The normal plasma value is less than or equal to 140 mg/dl. If the screening test is abnormal, a three hour fasting oral glucose tolerance test should be performed.

GROUP B STREPTOCOCCUS (GBS) (36 weeks)

Group B Streptococcus has been identified as a significant pathogenic organism for both mother and the baby. These bacteria can cause maternal-fetal infection and newborn sepsis (50% neonatal mortality rate). There is an association between maternal cervical infection, premature rupture of membranes, preterm labor and chorioamnionitis. Mothers may be GBS carriers and the carrier rate ranges from 42 to 72%. GBS remains a major cause of maternal and perinatal mortality and morbidity. Perinatal morbidity may result from direct infections of GBS and/or from the indirect effects of prematurity. A controversial aspect of maternal cultures involves a positive culture that is obtained prior to labor. Our current protocol allows treatment of this positive culture and it seems prudent to aggressively treat GBS with appropriate antibiotics following positive cultures or a strong clinical suspicion of GBS. (Refer to current ACOG guidelines)

Clinical neonatal disease may be divided into early onset and late onset disease. Early onset disease usually becomes clinically apparent during the first three days of life but may occur anytime during the first seven days of life. Late onset disease occurs after the seventh day of neonatal life and the most common clinical presentation is meningitis (85%). Mortality rates for late onset disease are lower (15-20%). The identification and treatment of maternal carriers to prevent neonatal exposure, colonization and infection with GBS is controversial. Routine cervical and vaginal cultures of all pregnant women and treatment of GBS mothers are not a simple matter and wide spread maternal screening and treatment has many problems. Currently, we are routinely screening mothers for GBS at 36 weeks of gestation by performing a vaginal culture. The current recommendations are to treat positive cultures during labor. However, in certain high risk populations, treatment with Penicillin may be indicated at 6 week intervals. In women found to harbor GBS in the genital tract, treatment should consist of intrapartum intravenous Penicillin.

HIGH BLOOD PRESSURE DURING PREGNANCY

DEFINITION: Pre-eclampsia (Toxemia) is the development of high blood pressure during pregnancy. If severe or untreated, it may progress to eclampsia which is high blood pressure causing seizures during pregnancy.

CAUSE: The cause is unknown but it only occurs during pregnancy. Certain women are at greater risk for developing it:

1. Teenagers and women over 30 that are pregnant for the first time
2. Overweight women
3. Women that had high blood pressure before pregnancy
4. Women who do not eat enough protein (i.e. meat, eggs, etc.)

EFFECTS: An increase in blood pressure may decrease the amount of blood flowing through the placenta because of vessel construction. This means less oxygen and fewer nutrients are given to the baby which may result in slowed growth or a low birth weight baby. A decrease in oxygen may cause feta distress, mental or physical impairment, premature delivery or very rarely a stillbirth. Very high blood pressure may damage many of the mother's organs including her heart, lungs, eyes, kidneys, brain and liver. Sometimes seizures can occur. These complications are rare if the prescribed treatment is followed and the patient is monitored by her doctor.

TREATMENT: Initial treatment for mild pre-eclampsia is bedrest which helps to lower blood pressure. Intravenous (IV) sedatives may be needed. If the blood pressure does not decrease on bedrest, then hospitalization and magnesium sulfate IV may be given while the patient is monitored in the intensive care unit or in labor and delivery. Delivery is often necessary, regardless of gestational age.

WHAT CAN YOU DO:

1. Keep all of your appointments and follow your doctor's advice
2. Eat extra protein (meat, eggs. beans and cheese) and drink plenty of fluids each day
3. Watch for these danger signs and report them immediately to your doctor:
    a. Sudden weight gain (greater than 2 pounds per week)
    b. Swelling of the hands, feet or face
    c. Headaches, blurred vision, irritability or seeing spots
    d. Nausea, vomiting, diarrhea or abdominal pain
    e. Vaginal bleeding, spotting or a gush of fluid
    f. Decreased fetal movement

IF YOU HAVE ANY QUESTIONS CALL OUR OFFICES:

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PREMATURE LABOR

1. *HOW COMMON IS PREMATURE LABOR?*

   Premature labor complicates approximately seven percent (7%) of pregnancies. It requires prompt medical intervention.

2. *WHAT ARE THE WARNING SIGNS?*

   a. Uterine contractions
   b. Menstrual - like cramps
   c. Intestinal cramps
   d. Back pain
   e. Pelvic pressure
   f. Abdominal pain or pressure
   g. Bladder pressure
   h. Vague feelings of discomfort, etc.

3. *ARE SOME WOMEN MORE LIKELY TO GO INTO PREMATURE LABOR?*

   Yes, a history of a premature birth increases the risk of a subsequent premature delivery approximately three times. Other predisposing factors are poor nutrition, infection, high blood pressure, heart disease, kidney disease, twin gestation, fetal abnormalities, smoking, use of alcohol and drugs. In approximately fifty percent (50%) of cases the cause is unknown.

4. *HOW CAN PREMATURE LABOR BE TREATED?*

   Hospitalization, bed rest and medication to suppress uterine activity can all be used to treat premature labor. The goal is to extend the pregnancy until fetal maturity is reached. Home monitoring can be used in selected cases.

5. *WHAT IF MY BABY IS DELIVERED PREMATURELY?*

   Specialized care is needed for premature infants. The primary risk to those infants is due to lung immaturity. The lungs are simply not developed enough to provide the necessary oxygen to the baby. The premature baby will most likely require a ventilator to breath for him/her.

PLEASE CALL OUR OFFICE IMMEDIATELY IF YOU HAVE ANY OF THE ABOVE SYMPTOMS OR YOU THINK YOU ARE IN PREMATURE LABOR

PAIN RELIEF DURING LABOR

To make childbirth more satisfying for both parents, several methods of pain relief can be used. The goal of pain relief methods is to provide maximum pain relief with minimal side effects in mother and baby. Requirements for pain relief often change as labor progresses. Seventy percent of first time mothers request medications for pain during labor.

EPIDURAL ANESTHESIA: Epidural anesthesia can provide almost complete relief for all stages of labor and delivery and does not interfere with your level of consciousness or the course of your labor. You are alert and able to participate in the childbirth experience. Epidural anesthesia can also be used for cesarean deliveries. Some women are not candidates for epidural anesthesia. These include women with spinal deformities, back problems, back surgery, active neurological disease and bleeding disorders. Epidural anesthesia is the best pain relief for normal labor and delivery.

FACTORS AFFECTING PAIN DURING LABOR: Reactions to childbirth are individual and varied. Previous experience with pain and especially previous labors can influence how one handles pain during childbirth. Your view of labor can also affect how you handle pain during labor. Women who are tired, and/or sleep-deprived have less energy for labor and a decreased ability to deal with pain. Unfamiliarity with the process of childbirth can cause you to be anxious, which can cause you to become tense and can experience more pain.

NON-PHARMACOLOGICAL METHODS OF PAIN RELIEF :(LeBoyer, Lamaze) Education about the process of childbirth can decrease your anxiety and fear of the unknown. Reading about labor, watching films, attending prepared childbirth classes, learning about breathing and relaxation, and taking a tour of Labor and Delivery are all ways you can learn about labor. Ask your clinician about prepared childbirth classes. In addition, most women find it helpful to have a support person present during labor.

NARCOTICS: Medications called narcotics, such as Demerol and Fentanyl, can be given in your IV during labor. In 3-5 minutes after receiving a narcotic, you begin to feel the relaxing effects. A narcotic does not eliminate the pain; instead, it dulls your perception of the pain. It allows you to cope better during a contraction, and to rest/sleep between contractions. The relaxing effect lasts from 1 to 3 hours. Since narcotics do cross the placenta they will depress the baby's respirations.

EPISIOTOMY

Episiotomy is a surgical incision in the perineum that is sometimes necessary during delivery. There are several types, however the most common type is a midline episiotomy. The purpose of the episiotomy is to substitute a neat surgical incision for the ragged laceration that otherwise usually results from passage of the baby's head through the vagina and perineum. The episiotomy may shorten the second stage of labor and make the birth process easier for the baby. Additionally, some studies now show there is a decrease of subsequent uterine prolapse (uterus falling out), cystocele (bladder falling out), rectocele (rectum falling out), and stress incontinence (loss of urine). An episiotomy is sutured with dissolving sutures and usually heals quickly without complications

FETAL MOVEMENT CHART

Patient Name_____EDC:_____

To help the providers follow the well-being of your baby, it is important for you to record the number of fetal movements every day, during certain time periods.

This fetal movement charting is best done while resting on your left side for thirty minutes, twice a day.

Please make a check in the column provided for each fetal movement during that thirty minute time period.

	Morning 8:00AM	Noon	Night 7:00PM
Date:			