Dr. John Macey - Dr. Kristin Dobay - Dr. Roger Sherman
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Welcome! We are so excited that you are expecting! This Document is intended to help answer and stimulate questions you might have and help your doctors provide you with the best care.

You may consider one doctor to be your primary Obstetrician and see him for most or all of your pregnancy. It is important to know, however, that the doctors share "coverage" for our patients, both pregnant and non-pregnant, on weekends and nights, and sometimes during busy days. It is fairly likely that you will be able to have your chosen doctor present for your delivery; but it is not guaranteed. Sometimes a physician from an outside group may cover during weekends. Emergency calls are handled by the doctor on call. We are available around-the-clock by calling the office number 615-815-7646. While we do not want to discourage any emergency calls, we ask you to use this resource for true emergency medical issues. Know in advance that a call considered an emergency is likely to lead the doctor advising you to be seen in an urgent care or emergency room or in a labor & delivery triage or assessment center. Usually it is not prudent practice and not fair to you or to the physician on call to try to diagnose and treat an emergency problem on the phone.

Obstetric Milestones

The first visit for which you see a physician may be primarily to confirm your pregnancy and establish that everything is apparently proceeding normally. Usually an examination is performed, and sometimes lab work or an ultrasound is indicated. (In terms of ultrasound, this test is very useful, but should not be overused.) Once it is established that your pregnancy seems to be getting started normally, we will schedule you an initial obstetric appointment. This will be the first of about 14 routine scheduled visits during your prenatal care. These visits are every 4 weeks or so until 28 weeks, and then become more frequent after that, until you are seen weekly during the last month. If you have complications, high risk factors, or other (non-obstetric) problems occurring during your pregnancy, it is possible that additional visits or hospitalizations may be required outside your routine care.

It is important to establish as accurately as possible the gestational age of your pregnancy in order to appropriately obtain tests and attempt to make sure that your baby is born on time (not too early and not too late.) Obstetricians traditionally describe "weeks gestation" as the number of weeks from the first day of a normal (28 day) last menstrual cycle. This means that the day you ovulate and conceive you would be "2 weeks pregnant," and the day you miss your period (day 28, when a pregnancy test might be positive) we label you 4 weeks pregnant. Your "due date" is assigned for the end of 40 weeks gestation, or 280 days from the first day of your last menstrual period. Your "due date" is an average expected delivery date, but you are most likely to deliver a little before or after that date.

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At around 10 weeks gestation, we might be able to hear the fetal heart tones with a Doppler stethoscope. Hearing the heartbeat is a very reassuring milestone, but it is not always possible to hear heart tones that early. Once you have passed this milestone, the risk of miscarriage has declined from a baseline of around 30% to less than 5%.

Testing

There are several tests which are available to make sure you are progressing normally and to assess for problems related to your pregnancy. Some of the tests are routine for all pregnancies; some are optional and require you to do some decision making.

Lab work which is routinely obtained at your first Obstetric visit include urine culture, blood cell counts, serologic tests for syphilis, hepatitis B, HIV, herpes, rubella immunity. Pap test, gonorrhea, and Chlamydia tests of the cervix are usually obtained as well. Urine for dipstick urinalysis is obtained at every prenatal visit if possible.

Optional testing available during your pregnancy include a blood test for maternal cystic fibrosis carrier state, and several available tests for determining your pregnancy's risk for fetal genetic abnormalities and spina bifida. It should be noted that the problems which these tests help detect are not "curable." It is prudent, therefore, to consider in advance how you might utilize information gained from these tests. These tests are described in more detail in separate brochures, but a few points are worth pointing out here.

Genetic abnormalities may occur in the pregnancy of any couple, but the primary factor which increases risk is advanced maternal age. Traditionally delivery at age 35 or later was considered "high risk," but that cut off is really rather arbitrary. The risk of 35 year old pregnant patient carrying a chromosomally abnormal fetus to term is around 1 in 180. For comparison, at age 42, the risk is 1 in 42. Only you as a patient can decide whether you consider yourself "high risk." The tests described below are available to any pregnant woman, regardless of age. Insurance coverage for the tests may vary depending on your age and your particular insurance plan. If you wish to verify insurance coverage for one of these tests, it is your responsibility to find out to what extent the test is a covered benefit.

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1) *Ultra*-screen is a test which combines specialized first trimester *ultra*-sound with a blood test to more precisely define the risk (1 in some number) of chromosomal abnormality in your pregnancy. This test is performed in one of several specialized Obstetric ultrasound centers near our office between 11 and 14 weeks gestation. This test is not invasive or dangerous to perform; ACOG (American College of OB/GYN) has, therefore, directed obstetricians to offer this test to all pregnant patients.
2) CVS – Chorionic Villus Sampling is an invasive test performed by a maternal-fetal medicine doctor usually between 11 and 14 weeks gestation. It involves ultrasound guided sampling of the placental tissue for direct chromosome analysis of the pregnancy. The results of this test are more specific, with a "normal chromosomes" or "abnormal chromosomes" being reported, along with the gender of the baby. There are significant fetal risks associated with this procedure (even miscarriage) up to around 1%.
3) Triple screen is a (non invasive) blood test offered routinely to all pregnant women between 15 and 18 weeks gestation (and generally covered by insurance to the same extent as would be other routine lab testing.) Its purpose is to more accurately define the risk (1 in some number) of chromosomal abnormality in your pregnancy, and to determine risk of neural tube defects (such as spina bifida.)
4) Amniocentesis is an invasive procedure which can be performed for various reasons at any time after the first trimester of pregnancy. For chromosomal analysis is usually performed between 16 and 20 weeks gestation. It involves ultrasound guided sampling of the amniotic fluid around the fetus and testing of the chromosomes of the fetal cells floating in that fluid. When performed during the second trimester, there are significant fetal risks associated with this procedure (even miscarriage) up to around ½ % (1 in 200).
5) The Harmony test and Materniti 21 test are great new additions to our available genetics testing. Rather than being invasive tests like CVS and amniocentesis, these are simple blood tests on the mother any time after 10 weeks gestation. They measure free floating chromosomes in the maternal blood, some of which has leaked from the pregnancy (baby's blood) While these tests don't test for every chromosome abnormality, they can effectively rule out the three main anomalies, Trisomy 21 (Down syndrome), and Trisomy 13 and 18. They can also tell the baby's gender.

As stated above, this list is not meant to replace discussion with your physician or more in depth written information. It is meant to summarize in a way to assist you in making decisions. We are not recommending for or against these tests. It is a completely personal decision.

Here's a guide for what you might expect when during your pregnancy

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4-6 weeks	pregnancy confirmation
8-10 weeks	first OB visit – complete necessary lab work and physical, possible transvaginal ultrasound
10-11 weeks	hear fetal heart tones with Doppler
11-14 weeks	offered Harmony, ultrascreen, CVS if "high risk"
16-18 weeks	offered triple screen
17-20 weeks	offered amniocentesis if "high risk"
20 weeks	ultrasound – Lena will make you a commemorative DVD
24 weeks	check cervix – birth plan – glucose screening test
28 weeks	Rhogam (if your blood type is Rh- and spouse Rh+ or unknown)
28-34 weeks	visits every 2 or 3 weeks
36-40 weeks	weekly visits (check cervix)
40-42 weeks	schedule delivery if undelivered

- At every OB visit, your blood pressure and weight will be measured, and your urine will be analyzed.

There will be other decisions to make and questions to be answered along the way during your pregnancy, delivery, and afterward.

Here are some issues to consider:

1) Which vitamins should I take?
   There are lots of different prescription vitamins available and all the companies claim superiority.

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There is much information circulated which is unproven, so keep in mind that there is no magic bullet to make your baby "more perfect." While it is certainly necessary to eat a nutritious diet in pregnancy, the benefit of extra supplements is unproven. What is known is that folate (folic acid) deficiency can potentially increase the risk of a certain type of birth defect called NTD (neural tube defects), such as spina bifida, or open spine. This effect is probably most important at the time of conception and very early in pregnancy. For that reason, it is recommended that all patients who might become pregnant begin supplementation with folate. At least 400 micrograms is recommended. Most over-the-counter prenatal vitamins contain 800 micrograms of folate. Any greater levels of folate in a vitamin require a prescription and may cost significantly (inordinately) more money. Patients who may be high risk for a baby with neural tube defect are advised to take extra folate to total 4000 micrograms (4 milligrams) as extra tablets (also available without a prescription.)

Choline may also play an important role in neural tissue development and could be a factor in NTD risk reduction.

Vitamin D deficiency is very common and particularly important to rectify in pregnant women. Vitamin D deficiency has been associated with increased risk of preterm labor, Cesarean section, gestational diabetes, vaginitis, preeclampsia, low birth weight and childhood asthma.

The new hot topic is the supplementation of certain fatty acid products which have been touted to improve mental capabilities in babies when added to formula. These include α3Ω fatty acids and DHA. There have been some indications of benefit to such supplementations (for any one, not just pregnant women, fetuses, and babies), but there is nothing proven at this time. It is highly likely that your parents and ours were not supplemented with these substances, but then again fish intake was not limited in the past. These substances are available in many prenatal vitamins (usually two-pill combinations) or over the counter as fish oil capsules.

Other important supplements during your pregnancy include iron and calcium. These elements are likely not to be consumed in high enough quantities in your diet, and must be supplemented. After the first trimester, you are likely to become significantly anemic if you are not taking supplemental iron or a prenatal vitamin with iron. At the end of the second trimester, we will check a blood count to see how you are doing in terms of avoiding anemia. Some patients will need to take extra iron at that point to avoid being too anemic at the time of delivery, when significant blood loss is expected. All women need 1200 mg. of calcium daily, and pregnant women need 1500 mg. This becomes more important after the first trimester when the fetus starts significant bone production. The fetus will get the calcium it needs, but at the detriment to your skeletal mass unless you supplement. You will be given a list of various sources of calcium in your diet and available as supplements without prescription. For starters, a glass of milk provides 300 mg.

2) What foods should I eat?

A balanced diet is the right answer for pregnancy just as it is for most of our lives. You should try to consume fruits, vegetables, and whole grains above all. Meats and dairy products are good sources

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of protein and calcium. Foods that contain "empty calories" such as sweets and chips should be severely limited. In general patients who restrict carbohydrate intake (pasta, potatoes, white bread) are happier with their weight gain and may have fewer pregnancy complications. (diabetes, hypertension, large baby)

Care must be taken in eating fish, as certain types of fish are potentially higher in mercury levels. Care must also be taken to avoid foods which may harbor listeria infections (which can lead to miscarriage.) Please see the attached cheat sheet for more information.

3) How much weight should I gain?

Weight gain in pregnancy is a touchy subject. Pregnancy is a time when women will gain more weight, more quickly than any other time in their lives. It is probably safe to say that most women don't like the idea of gaining weight… so what to do? There is no proper number of pounds to gain while pregnant. Good outcomes with normal babies and normal deliveries can occur with any weight gain. Guidelines for weight gain are based on best outcomes. In general around 35 total pounds of weight gain is ideal. Babies born to mothers with excessive weight gain tend to be larger, leading to more difficult vaginal deliveries and increasing the risk of cesarean section. Insufficient weight gain can increase the risk of poor fetal growth. It is especially important for patients starting out underweight and patients with multiple pregnancies to gain sufficient weight.

a. What medicines can I take?

In general, the best advice is to minimize medications in pregnancy. If you are taking a daily medicine for a chronic medical condition, you need to discuss with your physician whether it should be continued. Ideally, this discussion will take place before you conceive. All prescription medications should be taken only under direction of a physician. In terms of over-the-counter medicines, there are a few drugs that it is best to avoid. NSAID medicines such as aspirin, ibuprofen (Advil / Motrin) naproxen (Aleve) and ketoprofen (Orudis) should not be taken without physician direction. If your symptoms dictate that you must take a medicine, it is preferable to take only what you need. This means that it would be better not to take combination medicines such as "Tylenol flu." It would be better to take the individual components of a multi-symptom medicine based on what your symptoms are. Below is a list of such medicines and the symptoms for which they are beneficial. Generics are fine.

Tylenol (acetaminophen) – fever, pain, headache.

It is best to treat a fever especially in early pregnancy. It is important to try to keep your core body temperature normal. Benadryl (diphenhydramine) – allergy symptoms, itchy watery eyes, sneezing

Robitussin / Mucinex (guafenesin) – thins mucous secretions to help with cough or nasal drainage

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Robitussin DM (dextromethorphan) – suppresses cough when there is not much to cough up
Saline nasal spray or irrigation - nasal sinus congestion / stuffiness (Preferred therapy)

DECONGESTANTS –

Recent data suggests that decongestant use may lead to a slightly higher risk of some birth defects. These medicines such as Sudafed (pseudoephedrine or phenylephrine) and Afrin nasal spray (oxymetazoline) are used to relieve sinus congestion / stuffiness should limited to as few doses and days. You can use all the saline you want.

4) Can I get my hair colored?

We get asked this all the time! If only there were an easy answer! Over the years, there have been animal studies trying to shed light on this matter. Some studies have shown a few of the chemical compounds in hair dyes to be teratogenic (meaning they can cause birth defects). However, in many cases, the animals were exposed to extremely high doses of these chemicals, doses that far exceed the amount a woman would receive from coloring her hair every month or two. Clearly, the chemicals in both permanent and semi-permanent hair dyes are not highly toxic. However, no one knows for sure whether low-level exposures are risky. There is not enough information to guarantee that using chemical dyes on your scalp during pregnancy is completely safe, but there's no evidence that using these dyes every month or two will cause birth defects, either. The decision is yours! If you are going to color your hair, it would be best to wait until after the first trimester if possible. We also recommend that you consider highlighting, painting, or frosting your hair. You absorb hair-coloring agents into your system through your skin (scalp), not through your hair shaft. So, any process, such as streaking, that puts less of the chemical in contact with your scalp reduces your exposure to the compounds in dyes. It's also a good idea to make sure there is plenty of ventilation to minimize the amount of fumes inhaled.

5) How much alcohol can I drink?

Unfortunately, the answer is "none." Gone are the days when it was OK to have the occasional glass of wine. Fetal alcohol syndrome is a real preventable birth defect. No dose is known to be a safe dose. By the same token, if you consumed some alcohol early before you realized you were pregnant, rest assured that it is very unlikely to have any effect whatsoever.

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6) How much exercise should I get?

Exercise is good for you. Pregnancy is not the time to become a couch potato. Moderate low impact aerobic exercise (such as brisk walking or swimming) has many benefits to the pregnancy. Patients who exercise find beneficial changes in energy, appropriate appetite and weight gain, sleep, back pain, bowel function, and stress reduction. Emphasis is placed on the word moderate. This is not the time to get into shape. Heavy lifting, high impact, and risky activities (such as roller skating, basketball, horseback riding, and skiing) should be avoided. Listen to your body – don't get too winded or too hot when you exercise in pregnancy.

7) What about hot tubs? Hot tubs are not a good idea unless for very brief dips. Your core body temperature needs to be normal especially in early pregnancy.

8) What about pets?

Cats can sometimes carry a disease called toxoplasmosis. Although it's estimated that about half of the American population has the antibodies to fight off toxoplasmosis already, it's still important to follow a few safety tips. First if you have a cat, you might want to take it to your vet to be tested for Toxoplasma gondii. If your cat has an active infection, ask a friend or neighbor to take care of him/her until you're further along in your pregnancy. After about six months, the chances of this organism crossing the placenta are slim. If your cats are not infected, keep them that way by not letting them eat raw meat and keeping them indoors as much as possible. Secondly, it's important to stay away from the litter box, and as always, remember to stay away from cats you are unfamiliar with. If you get scratched by your cat while you are pregnant, please let us know.

With dogs, although we don't expect any complications, you may want to make sure your pet is up-to-date on his rabies shots. As an extra precaution, you can have him or her examined for parasites at regular intervals throughout your pregnancy.

9) What about sex?

In general, sexual relations are not prohibited in pregnancy. There may be circumstances which cause your doctor to advise against intercourse, such as when miscarriage is threatened or when there is concern for preterm labor. Listen to your body. If you experience significant discomfort or

contractions or cramping related to sexual activity, you may be wise to abstain for a while.

10) What about work? What about disability? What about maternity leave?

Pregnancy is a condition which might lead to circumstances which interfere with your ability to work. For many women, work can be continued on up until time of delivery. For others, discomforts or complications related to pregnancy may limit the ability to work. The type and flexibility of the work you do will have a lot to do with how well pregnancy and work "mix." In terms of pregnancy leave, disability and paid time off, there are many variables involved. If you work for an employer in Tennessee who, based on number of employees, is held to the FMLA (Family Medical Leave Act), then you may be allowed to have up to four months off related to your pregnancy without losing your job. That does not mean that you are entitled to pay. Whether you are entitled to paid time off for your pregnancy leave, and to what degree (duration and amount) is up to your employer and whether you have disability insurance. In terms of disability, we are often called upon to determine whether a pregnant patient is "disabled," and thereby "entitled" to disability insurance payments. We do not consider a patient to be disabled unless working is felt likely to be detrimental to the health of the mother or the health of the baby. Frequently such a circumstance would render the patient confined to some degree of bed rest. That does not mean you are disabled if you are too uncomfortable or too tired to work. It may be necessary to start your pregnancy leave in such a circumstance, but you may not be considered disabled.

11) What about travel?

Travel is usually not a problem in pregnancy, but there are a few things to consider. In terms of being out of town, there is nothing magic about Nashville. Problems which arise and might be addressed by your doctor here can be addressed in most any major American city. If you decide to travel to Atlanta or San Francisco near term, you are taking the risk that you might have your baby out of town. This is likely to be inconvenient, but unlikely dangerous. If, however, you are traveling on a cruise or in an underdeveloped nation, you might be taking some risk. We recommend staying in the country.

Car trips are a part of life. We have pregnant patients who live 1-2 hours away and come to Nashville for prenatal visits and delivery. Short car trips are not much of an issue, but the longer the trip, the more you need to pay attention to your comfort and circulation. It is important to stop and get out of the car and walk around every hour or two. Stay hydrated, despite the needed bathroom breaks.

Plane travel is not inherently dangerous for pregnant women, but you must realize a couple of things. Airplane cabins are not usually pressurized to sea level, so some feelings of minor shortness of breath or dizziness may be increased. Short flights are preferred to long flights for this reason. You should get up and move around every hour or so. Good luck navigating a big belly and the airplane lavatory! Airline representatives may require that you have your doctor's permission to fly. What this means is that the airline does not want to accept any responsibility for any problems which may

occur related to flying. Guess what – neither does your doctor. When we write a note giving my "permission," it states that you understand and assume responsibility for all risks related to flying while pregnant. Obviously, loss of cabin pressure could be a bad event for any passenger. Such a catastrophe could be even worse for the fetus and pregnant patient. General recommendations are to limit airplane travel to the first two trimesters unless it is "essential." If you are more than 36 weeks pregnant, some airlines will not let you fly for fear that you'll deliver on board.

12) When can I find out the sex of the baby?

Today's technology allows for you to find out the fetal gender at around 17-20 weeks with ultrasound. We usually schedule a routine ultrasound for around 20 weeks at which time we can get a good look at fetal anatomy and look for any problems. Just as an aside – some think labor and delivery is much more fun if you don't know what you are having!

13) Does ultrasound guarantee me a healthy baby?

Ultrasound is an excellent tool for obstetrics. Usually we can visualize the major organ systems and rule out many structural anomalies. It is not, however, a perfect test; and each study can be limited by several factors, such as fetal position and size and maternal anatomy. Also many fetal problems are subtle in nature and may be very difficult or impossible to detect with ultrasound. For this reason, a normal ultrasound cannot guarantee that your baby will problem free. You should, however, be reassured, that the likelihood of problems is very low with normal findings on ultrasound.

A word about ultrasounds. 3D and 4D ultrasounds are remarkable advances for imaging fetuses. We do have a 3D ultrasound, and in special circumstances there is a need for this technology. However, ultrasounds are not toys, and we discourage going to "specialty shops" to get images just for keepsakes. The FDA has come right out and condemned this practice. If you have $300 burning a hole in your pocket, buy your baby a savings bond.

14) Which hospital should I use?

We deliver at Baptist (St. Thomas Midtown) Hospital and Centennial Women's Hospital. There are minor advantages and disadvantages to each hospital, but we as your doctors are comfortable with both. You may wish to investigate and go to see both facilities to help you decide your preference for delivery location. One warning – with the higher number of babies being born, sometimes the hospitals (especially Baptist) might be too busy to accommodate our needs; therefore, it might be a good idea to be familiar with both choices. Please be advised that Baptist Hospital no longer allows sterilization procedures.

15) Should we take childbirth classes?

Childbirth classes are not required, but they are a helpful way for first timers to get more familiar with the childbirth experience and get ready to be new parents. Classes are available for a fee at both

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hospitals in the evenings for several weeks or on some longer weekend days. We should have a schedule for you to look at your 24 week visit.

16) What about an epidural?

Most women in Nashville make use of the option of an epidural for labor and delivery. Epidural anesthesia involves placement of a catheter into the (epidural) space around the spinal canal, and continuous or repeat dosing of anesthetic medication through this catheter. This method of pain relief ideally relieves you of the majority of the pain associated with the birth process while enabling you to continue to maintain the muscular function necessary to push in the second stage of labor. If cesarean section becomes necessary, higher doses of medicine can be given through the indwelling catheter to render you completely numb for surgery. Epidural is not risk free and sometimes not perfect, but it is generally the most effective method to relieve pain. Epidural may be associated with slightly higher rates of cesarean section, fever, and postpartum headache. You can learn more about this option during childbirth classes or from the anesthesia personnel on labor and delivery floor.

If you do not wish to have an epidural, or if you are not a candidate for epidural because of severe back problems, you may wish to go through Lamaze classes to help you through the labor process. If you think you may have limitations related to severe back problems you would be advised to contact an anesthesiologist at the hospital of your choice to determine whether you are a candidate for epidural. Know that some pain relief may be achieved through administration of narcotic medications through your IV.

17) What is a spinal?

While an epidural involves placement of a catheter into the (epidural) space around the spinal canal, spinal anesthesia involves placement of medication directly into the spinal canal with a single injection. This method is used to render your lower body completely numb for a short time period (2-3 hours) so that surgery may be performed. Spinal has become the preferred mode of anesthetic administration for scheduled cesarean sections. The reason for this preference is that spinal is quicker and easier and more reliable in achieving complete pain relief during surgery.

18) Is there a chance I could be put to sleep?

If you require a cesarean section for delivery and your epidural or spinal anesthetic proves ineffective, you might need to have general anesthesia. Some reasons we prefer to avoid general anesthesia in pregnancy are

(1.) The baby is exposed to the agents used to put you to sleep and might therefore need to have respiratory support while these agents wear off.

(2.) Pregnancy leads to slowed emptying of the maternal stomach, and some laboring patients might have recently eaten. A full stomach can increase your risk related to general anesthesia.

(3.) Pregnant patients may be a little harder to intubate due to swelling

(4.) You would miss your baby's first cries!

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Nevertheless, general anesthesia is performed routinely on labor and delivery; so you should not be concerned if it is necessary in your case.

19) Who should be there when I deliver?

It is tempting to have the whole family present for the birthday party, but usually it is a good idea to limit the number of visitors in the room. Most of time dads are present for the delivery. That might be enough. If you decide to have your sister or your mother or friend present as well, make sure your spouse is comfortable with the plan. Remember it is his day, too. We don't think it's a good idea to have other males in the room, nor do we think there should be too many observers. Childbirth is not a performance. Too many people in the room can lead to self-consciousness in you, your spouse, or the doctor. Also, the more people invited, the more others will get hurt feelings if not invited.

20) How will I know when I am in labor?

This is sometimes a difficult to answer. Most of the time it is true to say "YOU WILL KNOW!" It is amazing to me, however, that we get this question from second or third time moms-to-be. Something about our memories must block out some of the difficult memories. In general, the way to distinguish between false and real labor is by frequency, duration, regularity, intensity, and location. False labor contractions, sometimes known as Braxton-Hicks contractions, are infrequent, lasting less than a minute, irregular, mild to moderate in intensity, felt as tightening/discomfort in the abdomen. Real labor, meaning contractions effective at causing change in the cervix, is usually characterized by regular contractions every 5 minutes or sooner for an hour, lasting a minute or longer each, coming regularly, with increasing intensity and pain felt in the vaginal / pelvic / rectal area as well as in the abdomen. Unfortunately, the above descriptions apply only when your body and your uterus are average. Sometimes the uterus has not "read the book" on how it is supposed to behave.

a. Preterm labor, defined as labor occurring prior to 37 completed weeks, is a complication of pregnancy which can lead to health problems with your newborn baby. Babies born prematurely are more likely to experience medical problems (at times serious) such as infection and problems with breathing, feeding, circulation, and neurologic development. A baby born prematurely is more likely to need to be admitted to the NICU (neonatal intensive care unit.) For this reason, we want you to be attentive to your body. Preterm labor may be more subtle than term labor. Be sure to report any symptoms you have such as contractions ("tightening, balling up,") menstrual-like cramping, low dull back pain, fluid or mucous discharge from the vagina, and increased pressure in your pelvis. Any or all of these symptoms could be experienced in a normal pregnancy, but we must be vigilant to do what we can to prevent or prepare for preterm labor and childbirth.
b. Precipitous delivery is one which occurs so fast that it is difficult for the doctor (or nurse) to attend. You might have heard stories about deliveries at home or en route to the hospital.

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This circumstance is very uncommon, but does happen. We will want to keep a close check on cervical changes as your due date approaches.

c. Because labor is sometimes more subtle than others, you may have more than one false alarm in our efforts to avoid preterm childbirth or a precipitous delivery. There is no shame in taking a precautionary trip to the doctor's office or the evaluation area of the labor and delivery suite of the hospital. If it is difficult for you to tell if you are in labor, it is even more difficult for the doctor or nurse on the phone to tell you that you are not. Ultimately the decision to be seen to rule out labor is up to you.

21) What about an episiotomy?

Episiotomy is an incision made at the perineum to allow more room for the baby to deliver. Your doctor will not cut an episiotomy unless it appears necessary for delivery, or if it appears to be preferred to an uncontrolled laceration. There is not a right or wrong way to allow for room for delivery. Your doctor's goal is to minimize trauma and necessary healing while allowing safe and comfortable delivery.

22) What about filming the delivery?

The hospitals prohibit filming of the delivery, and we support this policy. You may film during the labor process and after the delivery has been accomplished.

23) What about cesarean sections?

Cesarean section is a common method of delivery. About 25% of babies born in Nashville are delivered by c/section. Some of these are scheduled for one reason or another – others become necessary when vaginal birth is not accomplished. Several factors may lead to unplanned c/section. The most common reason is failure to progress in labor. When the cervix stops dilating despite adequate contractions or when the fetal head does not fit through the pelvis, c/section becomes necessary. Other reasons to perform c/section include fetal intolerance of labor, breech or other abnormal presentation, history of prior c/section, and maternal desire for cesarean birth.

This last reason is called "elective" c/section. In some situations, pregnant patients might chose to avoid vaginal delivery. This is a big decision and must be considered carefully, with full understanding of risks and benefits. In general, vaginal birth is considered safer and more appropriate for most patients to attempt, especially if you are planning to have several kids.

24) What is a VBAC ?

VBAC stand for vaginal birth after Cesarean section. Frequently, patients who have had a cesarean section can attempt to have a vaginal birth the second time around. Successful vaginal birth may be accomplished around 65% of the time. There are several factors which must be considered in deciding whether a patient is a good candidate to try for a VBAC. There are risks and benefits to both

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repeat cesarean and VBAC. This topic deserves more discussion if it applies to you.

25) Can I have my tubes tied in the hospital?

Having elective sterilization is a common choice for women at the completion of childbearing. If you are having a c/section, performing tubal ligation adds negligible additional risk and a small amount of time to the procedure. The primary risk to be accepted is that of basing the decision for sterilization on the very short time your new baby has been observed. If for some reason your baby appears to be having any problems soon after birth, you or your doctor may make the decision not to proceed with tubal ligation. Please be advised that Baptist Hospital no longer allows sterilization procedures as of 1/1/09, but it will be no problem at Centennial.

Some physicians perform tubal ligation directly after vaginal birth. We discourage the use of this procedure for several reasons. In general the risk / benefit analysis favors waiting several weeks after delivery with performance of laparoscopic tubal ligation or office hysteroscopic tubal ligation.

26) What about insurance for my baby?

You will need to verify what procedures are necessary to obtain insurance on your newborn baby. This should be addressed before completion of the second trimester to cover for the unlikely but very costly event of premature delivery. Your baby will begin to accumulate hospital charges immediately upon arrival.

27) Who will be the baby's doctor?

You will need to select a pediatrician for your baby before the big day arrives. Several factors deserve your consideration. Most of this can be discovered with a phone call. Ask your friends and neighbors and family for recommendations. We have ideas as well.

(1.) Do I want a man or a woman? How old?
(2.) Is the office convenient?
(3.) Does the pediatrician take my insurance?
(4.) Does the pediatrician come to see new babies at Baptist and Centennial?
(5.) Am I comfortable with the doctor and the office?

Some patients may want to make an appointment to meet with the doctor to discuss these issues prior to childbirth. This is optional. Pediatricians are accustomed to being called by the nursery with news of "a new patient." They then might meet the parents of the new baby in the hospital for the first time.

If your baby is born prematurely or requires admission to the special care nursery, one of the neonatal ICU physicians on staff will be the baby's doctor for the hospital admission.

28) What about circumcision?

Circumcision is the surgical removal of the foreskin, a tubular flap of skin that covers the glans, or head of the penis at birth. This procedure is performed usually within a few days of birth,

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typically before the baby is discharged from the hospital. Healing after the procedure is generally complete in 7 – 10 days.

As you may know, decision for circumcision is somewhat a controversial issue and amounts to a matter of personal choice of parents of newborn boys. There are some individuals and physicians who have strong opinions regarding circumcision, and the doctors of Nashville OB/GYN Associates are sensitive to the fact that opinions can differ without necessarily being wrong. The decision for circumcision of the newborn boy is one that should be carefully weighed, as this does amount to a surgical procedure. Like any surgical procedure, there are potential risks and benefits, as well as a cost to the procedure. In terms of potential benefit, circumcision has been shown to decrease risk of urinary tract infection and penile carcinoma. There are other potential hygienic benefits as well. These problems are not common, however, and are probably not the most common reason for parents to decide in favor of circumcision. In this country, most male infants are circumcised, and decision for circumcision is generally more a cultural or religious issue than a medical issue. In other countries, such as in Europe, the majority of males are not circumcised.
Risks associated with any surgical procedure include: bleeding, infection, scarring or damage to the area being operated on. Removal of the foreskin of the penis can be considered a cosmetic procedure and results may vary. Suboptimal cosmetic appearance after circumcision is a potential shortcoming of the procedure. Significant infection or bleeding is rare but possible, as well as damage to the penis or urethra during the procedure or the healing process.

Dr Macey has been performing circumcisions since 1986. If you would like for him to circumcise your baby boy, just let him and your pediatrician know your preference.

29) Should I breast feed? Which formula should I use?

Yes we think every mother who is so inclined should try to breast feed. The reasons are innumerable. The bottom line is that it is better for your baby's health and your health and it is much less expensive both in terms of food costs and health care costs. That having been said, the decision to breastfeed is your decision only. If you decide to bottle feed for whatever reason, that is fine. Don't let guilt creep in. Guilty nursing never works.

The decision to breastfeed is a commitment that starts off harder but gets easier than bottle feeding. The first two weeks are the hardest. You will have help from lactation specialists in the hospital. There are also great books available and an optional session as part of prenatal classes. If you are planning to nurse, the length of time you breastfeed is up to you. Whether planning 2 weeks or a year, it is worthwhile.

Some women are unsuccessful with nursing for one reason or another. Eventually most babies end up on formula for some length of time. Which formula to use is up to you and your pediatrician.

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30) How will I manage with a newborn?

God only knows, but somehow you will manage. Prepare to have a messy house, poor meals, little sleep, and not much time to yourself. It is a tough transition whether it is number one or number six. Just remember, you're not alone. When you are up at three a.m. so are hundreds of other new parents. We hope you will have some extra family or friend help for a few days to get you situated. This is the time to call in favors!

31) What about depression?

The paragraph above sounds depressing, while a little humorous. There is nothing humorous, however, about postpartum depression. Just when you really need your energy and motivation, it can be zapped away in a sea of sorrow. We have all heard of the postpartum blues. There is a natural condition of just easy crying and feeling unsettled for a couple of weeks after delivery. The cause is uncertain. Some is situational, some probably hormonal; but it should not last. If you are not back to yourself in a couple of weeks, you should schedule an appointment with your doctor to see if you might be suffering from clinical depression requiring treatment.

32) What about birth control?

You probably don't want to get pregnant immediately after delivery. We generally recommend avoiding sexual intercourse for six weeks after c/section and three to six weeks after vaginal birth, depending on the extent of vaginal healing necessary. When you do resume sexual activity, all the usual options for contraception will be available to you with the exception of estrogen containing methods while nursing. If you are breastfeeding and desire hormonal contraception, we would recommend a progestogen-only method such as the "minipill" or depo provera injections or progestogen implant or progestogen containing IUD. Usually it is advisable to wait about a month to begin such contraceptives.

We hope you have found this information helpful. We decided to begin to write it down because we are sure to forget to share everything with every patient. Undoubtedly there are many other unanswered questions. Bring 'em on! That's what prenatal care is all about!