Preconception Counseling and Interventions

The goal is to optimize a woman's preconception health, health behaviors and knowledge regarding pregnancy. During preventive health care visits in women who could become pregnant, the following should take place:

1. Assessments as a basis for counseling:
   a. Discussion of family planning and pregnancy spacing as appropriate
   b. Maternal and paternal family history, genetic history and medical history
   c. Gynecologic, obstetric history and physical exam
   d. Current medications, prescription and nonprescription
   e. Substance use including alcohol, tobacco, recreational and illicit drugs
   f. Exposure to violence and intimate partner violence
   g. Nutritional status
   h. Exposure to environmental and occupational teratogens
   i. Socioeconomic, educational and cultural context

2. Review of immunization status.
   a. Since some vaccines may pose a risk to the fetus, women at risk or susceptible to certain diseases should complete vaccination series before pregnancy. See www.cdc.gov/vaccines for additional information on vaccines in pregnancy.
   b. Inactivated flu vaccine can and should be given early in the flu season for both pregnant and nonpregnant women.

3. Screening or diagnostic studies may be offered as appropriate:
   a. Sexually transmitted infections: Chlamydia and gonorrhea have been strongly associated with ectopic pregnancy, infertility and chronic pelvic pain.
      i. Screen for chlamydial infection annually for all sexually active women aged 25 years or younger
      ii. Provide targeting screening for gonorrhea in women at increased risk of infection
iii. Consider preconception HIV testing to allow for informed decisions regarding
treatment and timing of pregnancy.
b. Genetic counseling and carrier screening should be provided taking into consideration
racial and ethnic background and may include:
   i. Cystic fibrosis
   ii. Ashkenazi Jewish population for Tay-Sachs disease, Canavan disease, cystic
       fibrosis, familial dysautonomia
   iii. African-Americans for sickle cell disease and thalassemia’s
c. Chronic Medical Conditions
   i. Diabetes – achieve A1c at or below 6.0 mg/dL to decrease risk of spontaneous
      abortion, birth defects and macrosomia
   ii. Thyroid disease – treat hypothyroidism or hypothyroidism to decrease risk of
      miscarriage and preterm delivery
   iii. Maternal PKU – Adhere to low-phenylalanine diet before conception and during
      pregnancy to decrease risk of having children with mental retardation and other
      birth defects
   iv. Address asthma, hemoglobinopathies, inherited thrombophilia’s, obesity,
       history of bariatric surgery, hypertension, and other maternal conditions.
4. Counseling on the following should be offered:
   a. Substance use and abuse
      i. Women who smoke cigarettes or use any other form of tobacco should be
         identified and encouraged and supported in an effort to quit.
      ii. Women who are trying to become pregnant should be counseled to refrain from
         all alcohol use.
      iii. Address the abuse of prescription and nonprescription recreational drug use.
         Refer to appropriate resources and follow up to access adherence to
         recommendations.
   b. Medication use
      i. In general, recommend use of lowest effective dose of only necessary
         medications
      ii. Known teratogenic medications: warfarin, antiseizure drugs, ACE inhibitors
   c. Nutrition, physical activity
      i. Well-balanced diet
      ii. Avoid dieting for quick weight loss, skipping meals; assess for eating disorders
      iii. Additional risk factors for nutrition problems should be assessed including:
         adolescence, tobacco and substance use, history of pica in a previous
         pregnancy, high parity, mental illness
      iv. Vitamin supplementation including 0.4mg of folic acid daily to help reduce
         major brain and spinal cord birth defects
      v. Work toward achieving a near-normal BMI before attempting conception
      vi. Exercise at least 30 minutes on most days of the week
Antepartum Care

Prenatal care should begin in the first trimester. The frequency of follow-up visits is determined by the individual needs of the woman and an assessment of risks. A general guideline for an uncomplicated pregnancy is examination every 4 weeks for the first 28 weeks, every 2 weeks until 36 weeks of gestation and weekly thereafter. The frequency and regularity of scheduled prenatal visits should be sufficient to enable practitioners to accomplish the following:

1. General Evaluation and Interventions
   a. Assess the well-being of the woman and her fetus
   b. Provide ongoing, timely and relevant prenatal education
   c. Complete recommended health screening studies and review results
   d. Detect medical and psychosocial complications and institute indicated intervention
   e. Reassure the woman as needed
   f. Evaluation of pregnancy history and necessary individualized care accordingly
   g. Consideration of special populations including adolescents, incarcerated women, homeless women, women with disabilities

2. Each prenatal visit should include:
   a. Evaluation of blood pressure
   b. Evaluation of weight
   c. Evaluation of uterine size for progressive growth and consistency with estimated date of delivery
   d. Presence of fetal heart activity at appropriate gestational ages
   e. After quickening is reported, evaluation of fetal movement, contractions, leakage of fluid or vaginal bleeding

3. Additional routine antepartum care
   a. Estimated date of delivery (EDD) should be calculated for planning, interpretation of tests, determination of fetal size, designing interventions to prevent preterm and post term births
   b. Lab testing may include
      i. Blood and Rh type
      ii. Antibody screen
      iii. Gestational diabetes screening
      iv. Group B streptococcal disease screening
      v. CBC
      vi. VDRL/RPR
      vii. Urine screening and culture
      viii. HBsAg
      ix. HIV counseling/testing
      x. Chlamydia
      xi. Gonorrhea (when indicated)
      xii. Mantoux TB skin test
      xiii. Diagnostic testing for genetic abnormalities including aneuploidies as warranted and desired by the pregnant woman
   c. Fetal ultrasound imaging to determine gestational age, fetal number, fetal anatomy, viability and placental location
d. Anti-D Immunoglobulin should be administered to unsensitized D-negative patients at 28-29 weeks of gestation as well as at times of increased risk of fetal-to-maternal blood exposure.

e. Deliveries before 39 weeks of gestation should not be done without a maternal or fetal indication. Accuracy of the gestational age, cervical status, and consideration of any potential risks to the mother or fetus are paramount in any discussion of a nonmedically indicated delivery. Term gestation should be confirmed using the following criteria:
   i. Ultrasound measurement at less than 20 weeks of gestation supports gestational age of 39 weeks or greater
   ii. Fetal heart tones have been documented as present for 30 weeks by Doppler ultrasonography
   iii. It has been 36 weeks since a positive serum or urine hCG test

f. Group B Streptococcus prophylaxis should be administered when appropriate

g. Biophysical assessment including stress testing as appropriate

4. Patient education
   a. First visit
      i. Scope of care provided in the office
      ii. Laboratory studies and their indications
      iii. Expected course of the pregnancy
      iv. Signs and symptoms to be reported to the physician
      v. Role of members of the health care provider team
      vi. Anticipated schedule of visits
      vii. Physician or midwife schedule and labor and delivery coverage
      viii. Practices to promote health maintenance
      ix. Risk counseling, to include substance use and abuse
      x. Psychosocial topics in pregnancy and the postpartum period

   b. First trimester
      i. Discuss genetic counseling and available prenatal diagnostic testing (invasive and non-invasive)
      ii. Nutrition: well-balanced, varied, nutritional food plan consistent with access to food and preferences; special or individual needs require nutritionist referral.
         Prenatal vitamin supplementation
      iii. Weight gain is dependent on prepregnancy BMI
         1. Underweight: gain 28-40 lbs
         2. Normal weight: 25-35 lbs
         3. Overweight: 15-25 lbs
         4. Obese: 11-20 lbs

   c. Second and third trimester
      i. Work status
      ii. Childbirth education classes
      iii. Choosing a newborn care provider
      iv. Anticipating labor
      v. Potential complications
      vi. Travel plans and limitations
      vii. Hospital admission and discharge
      viii. Breastfeeding plans
Postpartum

1. In the early postpartum period, staff should help the woman learn how to care for her own general needs and those of her neonate. They should identify and address potential problems.
   a. Urogenital care needs should be addressed
   b. Breast care including breastfeeding support should be addressed
   c. Postpartum analgesia should be addressed
   d. Postpartum immunizations should be addressed

2. The length of the medically necessary hospital stay following delivery will be determined by the physician and mother. The following minimum maternal criteria must be met for discharge:
   a. Normal vital signs - Afebrile with pulse and respirations of normal rate and quality; blood pressure within normal range
   b. Uterine fundus is firm; amount and color of lochia are appropriate for the duration of the recovery
   c. Urinary output is adequate
   d. No abnormal physical or emotional findings
   e. Any surgical repair/wound has minimal edema and no evidence of infection; appears to be healing without complication
   f. Able to eat and drink without difficulty, ambulate with ease, adequate pain control
   g. Arrangements have been made for postpartum follow-up care
   h. Demonstrates readiness to care for self and newborn
   i. Pertinent lab results are available and have been reviewed
   j. Instructions on postpartum activity and exercises and common discomforts and remedies have been provided
   k. Instruction in self and baby care at home has been provided and mother is prepared to recognize and respond to postpartum symptoms and danger signs
   l. ABO blood group and Rh-D type are known and, if indicated, appropriate D immune globulin administered
   m. Support person(s) are available for the first few days of discharge

3. Approximately 4-6 weeks after delivery there should be a postpartum review and examination. It should include:
   a. Interval history including adaptation to newborn
   b. Inquiry regarding breastfeeding and support and education if applicable
   c. Assessment for postpartum mood disorders
   d. Physical examination including weight, BP, breasts and abdomen as well as a pelvic examination, episiotomy repair and uterine involution evaluation, PAP test
   e. Birth control review/initiation as appropriate
   f. Preconception counseling for future pregnancies