Pregnancy Guidebook

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also see:
www.pasadenapregnancy.com
Welcome to the practice and congratulations on your pregnancy!

We would like to explain our philosophy and approach to your prenatal care here.

The philosophy of our practice is quite simple. It is our intention to maintain and maximize the health and safety of both you and your baby (or babies!) during the pregnancy, using current and up-to-date medical knowledge and technology along with your input and participation. If any concerns arise, we will discuss them thoroughly so that you understand as best as possible how the situation should be handled.

You should be informed of all your options so that you may actively and intelligently participate in the decisions made for the management of your pregnancy. We respect patients as individuals, and your feelings and opinions are important to us. Having a baby is something that happens only a few times in a woman's lifetime. It is an experience that should be cherished.

Having an open-minded approach to the events of the birth is well advised so that unexpected situations or arrangements do not interfere with your having a positive birth experience. Please discuss your desires with your doctor or any of our staff. Remember, as much as medical safety will allow, we will try to honor your birth preferences and expectations.

Most of our patients are low-risk but our practice is also comfortable with ‘high-risk’ pregnancy. Many different factors can make a pregnancy high-risk. These include history of previous problems (such as premature birth, diabetes, toxemia), history of infertility or of multiple miscarriages, multiple gestation and advanced maternal age to list a few. We would like you to know that if you become high-risk, we make every effort to provide the appropriate care that you need and deserve.

This book contains a great deal of useful information to help you manage your pregnancy. We discuss diet, vitamins and nutrition; activities that should be avoided while pregnant and others that we feel are safe; approaches to dealing with common symptoms, including some approved over-the-counter medicines; and advice on morning sickness. At the back we have a list of Pediatricians, a pregnancy “homework” checklist, an Index, and an excellent section on postpartum care and breast feeding. We are so glad you decided to let us take care of you for this pregnancy!
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UPDATED OCTOBER 2016
1) FAIR OAKS WOMEN’S HEALTH

Our mission statement will tell you who we are and what we are committed to: which is "to provide exceptional, personalized women’s health care in a warm and welcoming environment, to incorporate modern technology in our practice and to be at the forefront of knowledge in our field."

2) OUR PROVIDERS

A. BRYAN S. JICK, MD, FACOG

Dr. Bryan Jick is a Fellow of the American Congress of Obstetricians and Gynecologists (FACOG), and he has been Board-Certified by the American Board of Obstetrics and Gynecology since 1990. Dr. Jick graduated Phi Beta Kappa and Summa Cum Laude from UCLA, he earned his MD degree from the University of California at San Diego, and in 1988 he completed his Ob/Gyn residency at Kaiser Hospital, Los Angeles. He has been in private practice ever since.

Dr. Jick is a member of the Huntington Hospital iDoc Committee (strategic planning for the hospital’s IT needs) and many Ob/Gyn Department committees. In addition to providing a full range of obstetric, gynecologic and well woman care, Dr. Jick has special expertise in high-risk pregnancy, multiple gestation (he has delivered over 200 sets of twins!), and advanced laparoscopic surgery. Dr. Jick greatly enjoys the high tech side of medical practice and he dedicates some of his time to writing articles, managing the practice website and working with their EMR (Electronic Medical Record).

Dr. Jick is married to Marina Jick, who runs Marina’s Oasis, a medical aesthetics spa located at FOWH. Marina went back to school and in 2016 earned her MSN and FNP degrees (Masters in Nursing, Family Nurse Practitioner). They have been happily married over 30 years and have two grown sons: Andrew (J.D. from UC Berkeley; currently a litigation associate in a Los Angeles law firm) and Kevin (a professional digital artist).

B. JENNIFER Y. PARK, MD, FACOG

Dr. Jennifer Park is a Fellow of the American Congress of Obstetricians and Gynecologists (FACOG) and is Board-Certified by the American Board of Obstetrics and Gynecology. In 2004, she completed her Internship and Residency at St. John’s Mercy Medical Center in St. Louis, Missouri. She started in private practice in Palm Springs, California and joined Fair Oaks Women’s Health in 2009.

Dr. Park graduated Phi Beta Kappa and Summa Cum Laude from the University of California at San Diego in 1995 with a BS in Biochemistry and Cell Biology, and she earned her MD degree in 2000 from the St. Louis University School of Medicine. Originally from Portland, Oregon, Dr. Park lives in Pasadena with her husband, Dr. Steve K. Park, a Board-Certified Internist, and their two children, Ryan and Sydney.

With a true passion for women’s health, Doctor Park brings her special interest in menopause and perimenopause, bio-identical hormone therapy, minimally invasive gynecologic surgery and ob/gyn ultrasound to our practice.

Dr. Park states that “It is rewarding to guide women through all stages of their lives: adolescence, pregnancy and menopause. Each stage has its unique challenges. I promise to listen, educate, treat and support you in all your healthcare needs.”
C. DELLA J. FONG, MD, FACOG

Dr. Della Fong is a Fellow of the American Congress of Obstetricians and Gynecologists (FACOG), and has been Board-Certified by the American Board of Obstetrics and Gynecology since 1998. Dr. Fong received her Bachelor’s of Science from UC Riverside in 1989 and received her MD degree from the School of Medicine at UCLA in 1992. In 1996, Dr. Fong completed a four year Ob/Gyn residency at Kaiser Hospital, Los Angeles and has been in private practice since then.

In 2011, Dr. Fong joined Fair Oaks Women’s Health and she has been busy since day one! Dr. Fong’s husband is a Radiologist at Kaiser West Los Angeles and they have two teenage children: a son attending public school in San Marino and a daughter, who is a student at Westridge. Dr. Fong is very active in Girl Scouts with her daughter, volunteers for her church and kids’ schools and loves to bake and to stamp (ask her what it means to stamp, and it’s not a dance!).

Dr. Fong says that “It is a blessing and honor to walk beside my patients during their periods of transition. From the joys of first pregnancy to the changes of menopause and every challenge in between, I promise to provide my patients with the most up to date information to aid their medical decisions and to provide the best medical care I can with thoughtfulness, kindness and compassion.”

D. MICHAEL S. MITRI, MD

Dr. Michael Mitri grew up in La Canada, where he earned the rank of Eagle Scout, and graduated from high school from Delphi Academy. In 2004, he graduated Cum Laude with a Biology degree from UC Riverside and then went on to earn a Master’s in Biochemistry in 2005. He braved the winters of the Midwest for 4 years to attend medical school at the Medical College of Wisconsin until 2009 where he met his lovely wife, Dr. Maggie Torsney-Weir. They both headed to Pennsylvania next where Dr. Mitri completed Ob/Gyn residency at Penn State Hershey Medical Center in 2013.

Dr. Mitri and his wife Maggie live in Pasadena with their cocker spaniel Albert. They welcomed their first child, Evelyn, to the world on January 1, 2015, an easy birthday for all of his colleagues to remember. Dr. Mitri is a very happy new daddy and he is still working day and night to take care of his own OB patients, making sure that they too can safely welcome their own little miracles.

In his own words, “As a care-giver in women’s health, I recognize that my role is not only that of physician but also confidant, coach and friend. From puberty to childbirth and through menopause, women experience the highs and lows of what makes us human and it is an honor for me to help my patients along that journey.”

E. JOANNA Y. WOO, DO

Dr. Joanna Woo is a Junior Fellow of the American Congress of Obstetricians and Gynecologists (ACOG). Dr. Woo graduated from the University of Southern California (USC) in 2007 and in 2012, she earned her medical degree from the Arizona College of Osteopathic Medicine. Doctors of Osteopathic Medicine (DOs) are fully licensed physicians who practice in all areas of medicine. Additionally, they receive special training in the musculoskeletal system, the body's interconnected system of nerves, muscles, and bones. As a DO, Dr. Woo believes in the philosophy of caring for people, not just treating individual symptoms. In 2016, she completed her Ob/Gyn residency in Michigan, where she also served as a clinical instructor at Michigan State University College of Medicine.
Dr. Woo grew up in Taiwan and moved by herself to the United States at age 15 to further her education. She is deeply appreciative for her parents’ support for that opportunity. While her mom still lives in Taiwan, her younger brother now resides in Southern California as well. Dr. Woo loves to contribute to the local Chinese community and is fluent in both written and spoken Mandarin Chinese. In her spare time, Dr. Woo enjoys hiking, baking, yoga, and volunteering at animal shelters.

Dr. Woo works with her patients to individualize their care by educating them, offering traditional or complementary medicine, or performing minimally invasive surgeries. She believes it is a privilege to guide women through the joys and challenges of their reproductive life cycles, from adolescence through menopause and beyond, and to empower women to make their own choices about caring for their bodies.

F. DIANE K. GUERRERO, RNC, WHNP – WOMEN’S HEALTH NURSE PRACTITIONER

Diane is an Ob/Gyn Nurse Practitioner. She earned her R.N. degree in 1977 from Los Angeles County (LAC-USC) Nursing School and she has worked in the Ob/Gyn field since 1980. She has been with Dr. Jick since 1989, working as his office nurse. In 1998, Diane became a Women’s Health Nurse Practitioner. Diane is married to Donald, and they have 2 daughters, Dawn and Dena (they like the letter D).

In 2016, Diane welcomed her first grandchild, Michael, to her daughter Dawn. She is very happy but is not used to being a grandma yet. She has a pet Akita dog named Kai. Her personal interests include arts and crafts, gardening, she’s especially proud of her more than 50 plumeria plants and she loves shopping at Michael’s.

G. MARINA JICK, MSN, FNP (CALL 626-MY-OASIS) – NURSE PRACTITIONER

Marina, Dr. Jick’s wife of 30 years, runs Marina’s Oasis, a medical aesthetics boutique located in our office. In 2016, Marina completed 3 years of graduate school and earned her Master of Science in Nursing with a Family Nurse Practitioner (FNP) credential. We are all very proud of her!

Marina is also a Licensed Aesthetician, and she has enjoyed specializing in skin care and medical aesthetics for more than 15 years. She takes pride in making a difference in her clients’ appearance and the way they feel about themselves.

With a light personal touch in a soothing, pampering environment, Marina offers corrective and rejuvenating aesthetic services. Her offerings include adult and teen skin care, facial peels, MicroNeedling, MicroDermabrasion, Dermplaning, Laser and IPL hair removal, Botox Cosmetic®, Juvederm XC® and Voluma® XC dermal fillers, IPL PhotoFacials, and more.

Consultations are complimentary at Marina’s Oasis, and all questions are welcome! Please contact Marina directly: 626.MY OASIS (626.696.2747). email: marina@marinasoasis.com, web: www.marinasoasis.com

3) OFFICE POLICIES AND PROCEDURES

A. OUR ADDRESS

We are located in the Huntington Pavilion Medical Building at the SW corner of California Blvd. and Fair Oaks Ave. Our address is: 625 South Fair Oaks Avenue, Suite 255, South Lobby, Pasadena, CA 91105

B. PARKING AND DIRECTIONS

Take the 210 Freeway to the Fair Oaks Avenue off-ramp. Head south past about 7 traffic lights. Look for the unmarked driveway a short distance past California and turn right. This will take you to the parking structure for the Huntington Pavilion Medical Building.
Walk to the South Lobby, and we are on the second floor right after you exit the elevator lobby.

We are sorry but we do not validate for parking.

C. OFFICE HOURS AND PHONE NUMBERS

- We are open Monday to Friday from 8:00 a.m. to 5:00 p.m.
- We are closed for lunch from 12:00 p.m. to 1:30 p.m.
- We are closed on most major holidays
- Our Main number is 626-304-2626
- Our Fax number is 626-585-0695.

D. AFTER HOURS VOICE MAIL – CALL 626-696-2688

We have a separate line for voice mail messages during non-working hours. Messages left on this voice mail line will be retrieved the following business day. You may call and leave us any type of non-urgent message. Call 626-696-2688.

E. E-MAIL AND WEB SITES

- Dr. Jick: drjick@fowh.com
- Dr. Park: drpark@fowh.com
- Dr. Fong: drfong@fowh.com
- Dr. Mitri: dmitri@fowh.com
- Dr. Woo: drwoo@fowh.com
- Our Practice Web site: www.fowh.com has e-mail links on it.
- Web Site for OB patients only: www.pasadenapregnancy.com
- We accept e-mail from our patients. It is reviewed during office hours only.
- **For any urgent matter, please DO NOT send e-mail.** There are times where e-mail may not be looked at for up to 72 hours (a 3-day weekend for example).
- For urgent matters, please call us at 626-304-2626, 24 hours a day.

F. WEB SITE WWW.FOWH.COM AND WWW.PASADENAPREGNANCY.COM

Please look at our web sites. There are dozens of articles covering many different obstetrics conditions. There is an appointment request form, a prescription refill request form and a comments form. There is an expanded web version of this Pregnancy Guide Book (www.pasadenapregnancy.com) with additional information, resources and links (and some cool photographs). See what the Hospital Birthing rooms look like. There are links to some books, DVD’s and medical products that we recommend. Please let us know what you think of the web site.

G. CELL PHONE POLICY – PLEASE TURN OFF CELL PHONES WHILE HERE IN THE OFFICE

As the use of cell phones has grown, we have become aware how intrusive they are in a medical office. We realize that people do not want to miss important calls, but cell phones can interfere with communication between the patient and the doctor or our staff. This can cause delays, or worse can lead to distractions that may result in less than optimal medical care and attention.

For the safety and for the privacy of all our patients, we kindly request that all cell phones be turned off after you arrive at our office or at least placed in silent mode. It is also illegal to record audio or video of anything being said or done during your medical visit to this office unless express permission to record has been given.

Thank you for your understanding.
H. LAB RESULTS

We will always try to contact you once an abnormal lab result has been obtained. Routine blood test results are available within 2 working days, and culture results within 4 working days. Certain tests take longer. These include the California State afp test, and any fetal DNA tests (such as MaterniT21 Plus and Progenity), and amniocentesis and final CVS results.

We use Primex Lab for our Blood, Urine and Culture Tests. They are a reliable, high quality lab whom we trust, they provide results in a timely fashion and they are conveniently located right in our office. Please read the section on the next page.

We use Pasadena Cytopathology Group at Huntington Hospital for Pap Smears and Tissue Specimens. It is possible that these labs may not be contracted with your health insurance plan. There are many different plans; each with their own preferred labs. There is no way for us to stay on top of which plan uses which lab because this changes so often. If this is a concern, we urge you to contact your insurance company or health plan or look online to find out if Primex is a contracted provider.

If you wish to have your blood work, Pap smear or tissue sample performed or processed at a different lab, it is your responsibility to let us know in advance. Thank you for your understanding.

I. PRIMEX LABS

1. Primex Labs is NOT part of Fair Oaks Women's Health

According to their website, "Primex Clinical Laboratories, Inc. is a clinical diagnostic laboratory that is dedicated to providing the highest quality laboratory services to our clients and their patients. As a leader in the medical testing field, we employ the latest innovations and techniques. Our goal is to be the laboratory of choice for high quality, reliable diagnostic testing."

- As a courtesy to our patients, we have arranged for space in our office for a Primex Labs specimen collection center. Fair Oaks Women's Health provides this as a service to our patients only. We are not affiliated in any way with Primex Labs. They are a separate company and conduct separate billing for their services.
- You are free to use any lab that you want. Some patients have to go to QUEST labs due to their health insurance. Primex Labs is provided as a convenience for our patients.
- Fair Oaks Women's Health does not profit from any of the testing provided by Primex Labs nor do we bill any patient for any of their lab work.
- The fees for any test performed by Primex Labs are the responsibility of the patient. Any billing matters or disputes having to do with Primex Labs should be directed to them and not to Fair Oaks Women's Health.

2. Insurance Issues

At the present time, Primex Labs does NOT have a contract with CIGNA or Beech Street Health Plans. If you are covered by one of these Health Plans, your lab fees will likely be denied or paid at a lower rate by your medical insurance provider. If you have CIGNA or Beech Street coverage, you should use QUEST labs for all of your laboratory medical testing.

3. Contact Information for Primex Labs

Primex Clinical Labs
16742 Stagg St. #120
Van Nuys, Ca 91406

Billing Department
800-295-6595
818-779-0130

Main Phone
800-961-7870
818-779-0496

FAX Billing Department
818-779-1326
J. APPOINTMENTS

We request that you make your next prenatal appointment at the completion of your office visit. Additionally, you can always call during office hours to make an appointment. We also have an appointment request feature on our web site at: http://www.fowh.com/appts.html.

Please be courteous enough to call us in advance if you will be late or unable to keep your appointment.

There may be times when, due to emergencies, your scheduled doctor is unavailable. In those cases, you may be able to be seen by the other doctor or our ob/gyn nurse practitioner, or might be asked to reschedule or to wait a bit longer.

In case of an emergency, we will try to contact you in advance, but this is not always possible. We try to minimize your waiting, and we hope that you understand that one day your doctor may have to make other patients wait because he/she is taking care of your emergency.

We request 24 hours notice in advance if you will be unable to make your appointment. This allows us to offer the appointment to another patient who needs to be seen. If you do not call and do not come to your appointment, this goes down on your file as a “no-show.” Patients with multiple “no-shows” may be asked to find another doctor.

K. OUR “NURSES”

Our back office staff consists of medical assistants and our nurse practitioner. It is common and traditional in a doctor’s office to refer to the medical assistants as nurses. When the front desk connects you to the doctor’s “nurse”, in most cases you will be speaking with an experienced Ob/Gyn medical assistant, who is not actually a licensed RN. However, a Nurse Practitioner is an RN who has gone back to school to earn an advanced practice degree (equivalent to a Master’s Degree) and their license and scope of practice is beyond that of an RN.

L. PRESCRIPTION REFILLS

These are accepted during office hours only. Please do not contact the doctor when the office is closed for a refill unless running out of the medication poses a risk (e.g. medication to treat premature labor). To arrange a refill just call your pharmacy and ask them to call our office. They can leave a message on our 24/7-voice mail line (626-585-0614).

***Please try our online Prescription Refill Form at: http://www.fowh.com/rxrefill.html. This page can also be reached from the www.fowh.com home page by clicking on Useful Forms, then clicking Prescription Refill Request Form.***

M. BILLING/BOOKKEEPING

There will be a meeting with you to discuss your financial responsibility for the pregnancy. Despite the personal nature of the doctor-patient relationship, the practice of medicine is a business. We agree to be responsible for taking care of you and your unborn baby to the best of our ability. In return, you agree to be responsible for paying your share of all fees and charges incurred. You will be asked to review and sign an agreement called the Obstetrical Fees Policy.

N. INSURANCE COMPANY ISSUES

It is a good idea to contact your insurance company as soon as you learn that you are pregnant, and again about one month before your due date to be sure that your maternity coverage is valid. Also, you will need insurance for the newborn, which can be provided by either parent’s policy. If you are billing your own insurance, you can use our superbill form, which we can provide you after the delivery. Enter the baby’s birthday on the form and send it to your insurance company.

O. CONFIDENTIALITY

Pregnancy can be a stressful time for a couple. Sometimes there are health concerns, tests are being done and medical questions arise. We understand that at times, the spouse or partner of the patient might have questions for us or would like us to report the test results directly to him or her. Due to legal and ethical issues regarding patient confidentiality, we are unable to do this. We are only allowed to share medical information directly with the patient. Patients are entitled by law to strict confidentiality and we strive our utmost to maintain this.
If the patient would like us to freely discuss any and all of their health concerns, questions or test results with their spouse or partner, this can be arranged. We will need a letter written to us by the patient giving us permission to discuss any and all medical visits, findings or test results with another individual (provide their name and relationship to the patient).

P. FEEDBACK

We welcome feedback regarding our employees, our doctors or our services. If at any time you feel unsatisfied, uncomfortable or uncertain about any aspect of your medical care or any interaction with any member of our practice, we want to hear from you. You may choose to write us a letter, send an e-mail or speak to someone not involved in the issue. Our office manager is a good place to start. Just call the office and ask for the office manager.

Internet Feedback

Many web sites ask people to rate their interactions with professionals in the community. If you feel that your experience with us has been positive, we would love for you to share this on the web with others.

Here are some links:

- www.yelp.com/pasadena-ca-us (enter “dr. bryan jick”, “dr. jennifer park”, “dr. della fong”, “dr. michael mitri” or “dr joanna woo” in the ‘search for’ box and specify Pasadena, CA)

4) EMERGENCIES AND AFTER HOURS ON-CALL COVERAGE – CALL 626-304-2626

Dr. Jick, Dr. Park, Dr. Fong, Dr. Mitri and Dr Woo are on-call often. They try to deliver nearly all of their own patients (even when not on call), but like anyone, doctors do take some time off to be with their families and to take occasional vacations.

Be assured that there is always an Ob/Gyn doctor available (on-call) 24 hours a day. If you call when the office is closed, you will either reach a voice mail system or an answering service (“The Exchange”). If you reach a voice mail, listen carefully and follow the instructions. If you reach the doctor’s exchange, you need to discuss your condition with the operator, a non-medically trained individual.

A. ON-CALL DOCTORS

Our doctors are part of an on-call rotation. There are also other doctors who might be on-call when the office is closed. They are: Dr. Frances Teng, and Dr. Natalie Moniaga (with Healthcare Partners) and Dr. Beth Julian-Wang who is in private practice across the hall from us.

All of these doctors are Board-Certified (or Board-Eligible) Ob/Gyn physicians, well established here at Huntington Hospital, and are well-regarded physicians whom we trust. Please rest assured that all of these doctors will do whatever is necessary to insure the safety and well being of both you and your baby.

B. TYPES OF AFTER-HOURS PHONE CALLS:

1. **This is a “life or death” emergency. Although rare, an emergency like this should be dealt with by calling 911 for the most rapid response possible.**

2. **“This is an urgent problem and the doctor needs to be paged immediately.”**

Call (626) 304-2626, and listen to the message. Press 1 for urgent, and then listen to the next message.

You will be told how to get hold of the on-call ob/gyn doctor.

Use this approach whenever there is a problem that you feel cannot wait until the office re-opens for business. When the voice mail message begins, listen to see which doctor is on-call and then follow the instructions.
For **emergencies during lunch hours** (12 p.m. -1:30 p.m.) when the office is closed, we use a lunch time only numeric pager. Call 626-304-2626 and follow the instructions. (for urgent matters, page us directly by calling 626-932-2768, then enter your callback number. Note this is a numeric only pager).

3. **If you can't reach the doctor and the problem is urgent.**
   
   Rarely, there is a problem with the beeper service or the doctor(s) are actively involved in another emergency. You may then call the direct line to the paging service for Fair Oaks Women’s Health which is (877) 568-8550. This is the phone number that we **Call Forward** to at the end of each day.
   
   Additionally, for an obstetric emergency after 20 weeks of pregnancy, you may call directly to Huntington Hospital Labor and Delivery, 626-397-5069. There are nurses and a 24-hour on-call obstetrician available. **Because this is the actual phone number for L & D, please use it only if absolutely necessary.**

4. **For any non-urgent message for the office that can wait until the office re-opens.**
   Call our voice mail line at 626-696-2688 and leave a message for any of our employees.

5. **CALL US BACK if you do not get a call back from the doctor after paging.**

   The doctor might be scrubbed in to a delivery or surgery when you place your call. Also, please do not assume that technology is 100% effective. Phone calls sometimes do not go through. Pagers might have low batteries. Cell phones too. Doctors might be inside a building where the signal is blocked. There are MANY reasons why a doctor might not be returning your call in a timely manner.

   If you do not get a call back within 15 minutes, please call the on-call doctor again. Our job is to be available to help you. **Your job is to get hold of us if you need our help.**

C. **OB ED (OBSTETRICAL EMERGENCY DEPARTMENT)**

   Effective in 2015, Huntington Hospital has opened up their OB ED (Obstetrical Emergency Department). This is a special area located in the Labor and Delivery Unit. ALL Ob patients, who are 20 weeks pregnant or beyond, coming to Huntington Hospital for urgent problems or emergencies are directed to the OB ED.

   This includes conditions such as:
   - possible labor or preterm labor
   - possible rupture of membranes
   - vaginal bleeding or spotting
   - decreased fetal movement
   - major illness after 20 weeks of pregnancy
   - evaluation after a fall or accident
   - and more

5) **YOUR FIRST OFFICE APPOINTMENTS**

   A. **PREGNANCY CONFIRMATION**

      Ideally, we would like to have you see either the doctor or the nurse practitioner for an early pregnancy visit, even by 6 weeks, if possible. This is called your pregnancy confirmation visit. It gives us a chance to make sure you are doing okay and to see if there are any early signs of a possible problem, such as pain or spotting, that might suggest a risk for miscarriage or rarely an ectopic pregnancy. At this visit we provide you with some paperwork, start your prenatal vitamins and then arrange for your first ultrasound.

   B. **FIRST ULTRASOUND**

      The first ultrasound visit is very important! It helps establish that the pregnancy is normal and healthy, whether there is one or a multiple gestation, and helps us to accurately determine your due date. This also an opportunity to get your first baby pictures! **Please plan on arriving about 30 minutes early for this appointment to make sure all of your paperwork is completed.**
At this appointment we will provide you a prescription for prenatal vitamins, arrange for your first prenatal blood tests, and determine if there are any medical situations that require the doctor to evaluate you immediately. You should also receive a folder containing this handbook plus other important forms (and some goodies, too).

After this visit, you will make your appointment for the OB Consult, usually within a few weeks (sooner for high-risk patients). This is a meeting with the doctor to discuss your obstetrical care. At this visit the doctor will address your concerns about the pregnancy and discuss medical recommendations for your prenatal care.

C. THE OB CONSULT

The doctors try to have a thorough consultation visit with every patient usually by 10-11 weeks pregnant. The doctor has already reviewed your file prior to this visit and if high-risk factors are noted, then the consult might be arranged even sooner. At this appointment we discuss any symptoms you might be having, we review your obstetrical database (filled out in advance), we ask about your previous pregnancies, and we review your labs. Then, a prenatal plan is discussed including decisions to be made such as Down Syndrome and Genetic testing, possible CVS or amniocentesis, frequency of visits and ultrasounds, issues related to delivery, and any specific medical needs that are present.

D. THE DUE DATE

We calculate the due date using a combination of menstrual timing, ovulation timing (if known) and the results from early ultrasounds. The “textbook” pregnancy due date is based on a 28-day cycle, ovulation and conception occurring on day 14, and therefore the due date is 40 weeks from the first day of the last menstrual period (called LMP), or 38 weeks from conception. The day that you miss your period, you are 4 weeks pregnant.

If the due date based on LMP is different than the due date based on ultrasound, we need to decide which due date is correct, and this is done by the doctor at the OB consult visit. We always look at how many weeks pregnant you are at each visit, so an accurate due date is essential.

**How many months pregnant are you?** Many people think that 4 weeks equals a month, and this is not quite accurate, since a month is closer to 4 ½ weeks. It is better to calculate that every 9 weeks equals 2 months: so at 18 weeks you are 4 months, at 27 weeks you are 6 months and at 36 weeks you are 8 months along.

E. TRANSFERRING CARE HERE

Sometime patients need to or choose to switch OB doctors in the middle of a pregnancy. We welcome all pregnant patients who would like to be seen, at any stage of pregnancy. If you have had any OB care elsewhere, please provide us a full and complete copy of your medical records, including blood tests, ultrasounds and physician notes. You can mail these, fax them or attach them to an e-mail, whichever is easiest!

6) PRENATAL CARE AND TESTING

There are 2 types of testing done during prenatal visits. The first consists of traditional, routine measurements and tests. These include checking your weight, a urine test for sugar, protein or infection, measuring your blood pressure, obtaining the fetal heart tones, monitoring the growth of the uterus and checking for any possible obstetrical complications. During the visit we also encourage you to ask us questions and discuss any and all concerns.

The other category involves tests that are made available to you at specific times during the pregnancy. Some examples of these tests are genetic screening blood tests, ultrasounds, beta strep vaginal cultures, alpha-fetoprotein (afp) testing, and possibly amniocentesis.

A. BLOOD TESTS -

1. **The first panel of routine tests (we call it the B-1) is usually done shortly after the first visit.** Most of these tests are required by State Law. It will include some or all of the following:
   - Blood count to check for anemia
   - Blood type and Rh factor determination
   - Antibody screening for incompatibilities
• Testing for exposure to syphilis (required), gonorrhea and chlamydia
• Screening for diabetes
• Screening for thyroid disorder
• Immunity status for German measles (Rubella) and chicken pox (VZV antibody)
• Hepatitis B screening (*see below)
• HIV Test
• urinalysis and urine culture to look for infection
• Possible other tests specific to your medical history

*(Hepatitis B, also known as serum hepatitis, can be present in an individual in a chronic carrier state. This means that although the person carrying the Hepatitis B virus may have no symptoms, she can transmit it to her unborn child (transmission occurs at delivery), can transmit it to her partner through sexual relations, and her blood can potentially transmit the disease to anyone exposed who isn’t immune. ALL pregnant women are tested for this condition early in pregnancy. More than 1 million Americans are chronic carriers of Hepatitis B. All blood donors are also tested for this, so exposure will not occur from a blood transfusion. A vaccine exists, and currently nearly all newborns receive it. Sexual partners of an individual known to be a Hepatitis B carrier must be tested, and if they test negative, they should be vaccinated.)

2. **Nuchal Translucency Screening test** – see ahead. This optional test consists of an ultrasound and blood tests done at 12 weeks gestation.

3. **NIPT: non-invasive prenatal testing.** This optional test checks for fetal DNA in the mother’s blood and can help detect possible Trisomy 13, 18 and 21 (and fetal sex) and other genetic conditions. See ahead.

4. **Alpha-fetoprotein testing – quadruple marker testing.** This optional test is done close to 16 weeks gestational age. It is discussed below.

5. The final panel of routine blood tests (we call it the B-2) is done about the 7th month. It will include the following:
   • Repeat blood count.
   • Repeat antibody screen (if you are Rh negative).
   • Screening for diabetes -- the glucola test. The glucola screen for diabetes requires that you drink a solution of 50 grams of glucose (called glucola) one hour before the blood is drawn. This test does not need to be done fasting; it can be done at any time of day.

B. **GENETIC TESTING AND CONDITIONS**

1. **Genetic Carrier Testing**

   DNA testing technology has made huge advances in recent years. We can now test for many conditions and for less cost than ever thought possible.

   Various labs offer a DNA tests for rare genetic conditions, including every test listed below, and more. In each case, the genetic condition being tested for is a recessive trait (or a mutation) also called a carrier state. The carrier state is invisible, thus the only way to find out if someone is a carrier is to perform a DNA blood test.

   If the mother and the father of an unborn baby both test positive for the same carrier state, then there is a 1 in 4 chance that their child could be born with a genetic disease. Some of the diseases that are inherited in this manner include Cystic Fibrosis, Spinal Muscular Atrophy, Tay-Sachs disease and Sickle-Cell Anemia.

   Statistics show that when we test for many rare conditions, there is a chance that a person will have at least one of these rare genetic mutations. In that case, we would test the spouse (father of the baby) to make sure that he does not test positive for the same mutation.

   Please feel free to ask us any questions you may have about Genetic Carrier testing.
2. **Cystic Fibrosis (CF)**

Cystic Fibrosis (CF) is a genetic disease affecting about 30,000 people in the U.S. It is diagnosed early in childhood, occurring in about 1 out of 2,500 births. This condition causes the bodily glands to produce extremely thick secretions or mucus. The lungs, the intestines and the pancreas can be seriously affected. CF is a severe, chronic, debilitating illness with many affected individuals dying as teens or young adults.

One out of 28 Caucasians, Ashkenazi Jews, or persons of European heritage are carriers of the CF genetic mutation, but the carriers are completely unaffected. CF occurs when the newborn inherits two copies of the mutated gene, one copy from each parent. This is called a recessive trait. For a child to be affected, both parents must be carriers of the CF mutation. We now have special blood tests that can detect whether a person is a carrier for the CF mutation. The American College of Ob/Gyn recommends that we offer this carrier test to eligible pregnant women. If the test is positive, then the partner should be tested as well.

3. **Sickle Cell Anemia**

Individuals of African-American descent have about a 10% chance of being a silent carrier for the sickle-cell mutation. The carrier is unaffected, but two carriers have a 1/4 chance of producing an affected child. If both parents are African-American and have not been tested for sickle-cell carrier trait, we will need to run this test.

4. **Tay-Sachs Disease**

Tay-Sachs disease is a genetic disease inherited in the same manner as CF (see above). Ashkenazi Jews have about a 1/27 chance of being a carrier for this condition. Carriers have no symptoms. Ashkenazi Jews also have a 1/29 chance of being a carrier for CF and a 1/40 chance of being a carrier for a rare disease called Canavan Syndrome. All of these carrier states can be identified if looked for. If both parents are of Ashkenazi heritage, then all three of these genetic conditions are usually tested for.

Both Tay-Sachs disease and Canavan disease cause progressive neurological deterioration and are incurable. Even with the best medical care, infants born with either of these conditions usually die by age 5.

****According to the California Tay-Sachs Disease Prevention Program, women who are pregnant CAN NOT have the usual Tay-Sachs screening test. They need to go to a special testing center. One is at Cedars-Sinai Hospital. In L.A., please call 818-881-1061, or call the program directly (San Diego) 858-822-6400.

5. **Ashkenazi Jewish Background**

As genetic tests become easier to perform, many are being combined into a panel. In particular, people of Ashkenazi Jewish descent have been found to be at increased risk for being a carrier of many different genetic conditions.

If both parents are Ashkenazi, then one parent, ideally, should be tested for the following conditions (or more), **now available as a panel**: Tay-Sachs, Cystic Fibrosis, Gaucher Disease, Canavan Syndrome, Niemann-Pick Disease Type A, Bloom Syndrome, familial dysautonomia, mucolipidosis type IV, glycogen storage disease 1a and Fanconi's anemia. Other conditions are being added to this panel as well. For more information go to: [www.jewishgeneticdiseases.org](http://www.jewishgeneticdiseases.org).

6. **Spinal Muscular Atrophy (SMA)**

What is SMA?

Spinal Muscular Atrophy (SMA) is a rare, inherited disease characterized by muscle atrophy and loss of motor function, caused by the absence of or defect in the Survival Motor Neuron 1 (SMN1) gene. This gene ensures the survival of a motor neuron protein (called SMN) and this protein is critical to the survival and health of motor neurons, which are nerve cells in the spinal cord responsible for muscle function. As the muscle motor neurons become unhealthy due to the reduced levels of the SMN protein, muscles progressively weaken and eventually become paralyzed.

According to the American College of Medical Genetics, SMA meets established criteria for population-based genetics screening. It is a severe disease, there is a relatively high frequency of gene carriers in the population, and an accurate genetic test is available, along with prenatal diagnosis and genetic counseling. Therefore, this test should be made available to all families.
7. Fragile X Syndrome (FXS)

What is Fragile X Syndrome?

Fragile X Syndrome (FXS) is the most common cause of inherited mental impairment (or mental retardation). This impairment can range from learning disabilities to more severe cognitive or intellectual disabilities. FXS is the most common known cause of autism or "autistic-like" behaviors. Symptoms can also include characteristic physical and behavioral features and delays in speech and language development.

FXS is due to a mutation in the X-linked FMR1 gene. Males with Fragile X Syndrome almost always exhibit mental retardation. One well recognized consequence for women who carry the mutation is an increased risk for premature ovarian failure (POF), defined as the cessation of menses before the age of 40. Among women who carry the mutation, approximately 21% have POF compared to only 1% in the general population.

Fragile X Syndrome is an X-linked genetic disease

This means that the mutation exists on the X-chromosome. X-linked conditions are more severe in males than females, because males have only a single X-chromosome (males are 46 XY) and females (who are 46 XX) have two, so one gene might have the mutation but the other gene will be normal. Other common X-linked genetic diseases are hemophilia and color blindness, also much more common in males.

The Fragile X mutation follows the traditional rules of X-linked inheritance: Half of the children of carrier mothers will receive the mutation. If the father is the carrier of the mutation, none of the sons and all of the daughters will receive the mutation.

Approximately 1/350 females and 1/1,000 males carry the FXS mutation. Also about 4% of males and 8% of females of Northern European descent will carry the mutation. Approximately 1/4,000 males have Fragile X Syndrome.

Universal testing for this disorder is NOT the standard. Testing for FXS is recommended for individuals seeking reproductive counseling who have a family history of fragile X syndrome, a family history of undiagnosed mental retardation or a woman with a family history of premature ovarian failure.

Links

- Spinal Muscular Atrophy Foundation: http://www.smafoundation.org

C. CHICKEN POX IMMUNITY

Chicken Pox is caused by a virus called Varicella Zoster. If someone has ever had chicken pox, they are generally forever immune, and the unborn baby cannot get the chicken pox even if the person is exposed to it while pregnant. If a woman is pregnant and develops chicken pox, there can be serious harm to the unborn baby.

D. 1ST TRIMESTER GENETIC SCREENING – NUCHAL TRANSLUCENCY

The State of California genetic testing program incorporates both the Nuchal Translucency (NT) Screening Test and the afp (quadruple marker) test. This approach is called Integrated Screening and is provided by the California Prenatal Screening Program (www.cdph.ca.gov/programs/pns). Integrated screening combines results from the NT screening test at 12 weeks with the results of the afp second trimester screening blood test, usually done at 16 weeks.

The Nuchal Translucency Screening Test consists of an ultrasound and a blood test, which we schedule between 11 and 13 weeks gestation. The ultrasound examines an area on the back of the neck of the fetus, called the nuchal translucency (NT). If the NT is enlarged, this can be a sign of possible Down syndrome or other anomaly (such as Trisomy 18 or a congenital heart defect). We are certified by The Fetal Medicine Foundation (http://www.fetalmedicine.com/fmf/) to provide this test.
Using the Nuchal Translucency Screening Test we can detect about 85-90% of all cases of Down syndrome. Unfortunately, this means that some patients will have normal results and ultimately might still deliver a baby with Down syndrome. On the other hand, since most of these results come back normal, we can advise many women not to have an amniocentesis, saving them from the possible risk of miscarrying a normal pregnancy (about 2-4 per 1000 amnios).

If a patient has the new fetal DNA test (NIPT test, see below) that detects fetal DNA in the mother’s blood, we do not perform the nuchal blood draw. The fetal DNA test is a better test for the two conditions on the NT (Trisomy 21 and Trisomy 18) so it does not make sense to run a less accurate test after we have done a better test.

Note that the Nuchal Translucency Screening Test does not screen for spina bifida (neural tube defects).

E. NON INVASIVE PRENATAL TESTING (NIPT)

**Blood test for EARLY detection of Down Syndrome (and other conditions also)**

Many expecting parents worry about the chance that their unborn baby has Down Syndrome. This genetic disease nearly always develops after conception and therefore is NOT inherited from the parents. Amniocentesis has long been available as a diagnostic test but poses a risk of losing the pregnancy.

This blood test can be done on the mother’s blood and can determine with 99% accuracy if the baby she is carrying does or does not have Down Syndrome and other conditions as well. The test is generally referred to as NIPT (non-invasive prenatal testing) and is offered by many different labs. One version of the test that we like is called the MaterniT21 Plus test, available only from Sequenom Labs. Another is the Verifi test from Progenity.

Down Syndrome, also called Trisomy 21, means that the person (fetus) has 3 copies of chromosome 21 instead of the normal 2 copies that the rest of us have. The MaterniT21 Plus test uses breakthrough technology to identify microscopic particles of DNA from the baby that are present in the mother’s bloodstream. The amount of DNA from the fetal chromosome 21 is compared to DNA from other chromosomes in the blood sample. If the amount of chromosome 21 DNA is normal, then the baby does not have Trisomy 21.

Further advances in this type of testing continue to be made. For example, the MaterniT 21 Plus test full report includes testing for Trisomy 21 (Down Syndrome), Trisomy 18 (Edward Syndrome), Trisomy 13 (Patau Syndrome) fetal sex determination, and detection of abnormal amounts of X or Y chromosome DNA. Some Microdeletion syndromes can also be detected using this test.

In conclusion, a simple blood test, done as early as 10 weeks of pregnancy, can in the great majority of cases provide needed reassurance to concerned expectant parents by providing fetal DNA information - all done without posing any risk of pregnancy loss or having to go through an invasive medical procedure.

**COST ISSUES with NIPT TESTING**

An unexpected problem has developed due to these new DNA tests. They are very expensive and sometimes covered by insurance and sometimes they are not covered even when we think they should be. Some labs will limit the patient’s out-of-pocket expense even if the test is denied by the insurance. We will help you work through this issue but you might have to contact your insurer if you plan to have this test done to find out what your cost is.

F. ALPHA FETOPROTEIN TESTING (AFP)

The integrated screening program discussed above also includes the afp blood test.

Alpha-fetoprotein (afp) screening (also called quadruple marker testing) can help identify fetal spinal cord or cranial defects (also known as neural tube defects or NTD's), chromosomal abnormalities as well as other possible birth defects. It is a blood test (on your blood) taken at about 16-17 weeks of pregnancy. Four components in your blood are measured.

The results of this test are combined with the results of the Nuchal Translucency Test (if it was done) to provide us with a single number to represent the overall risk of Down Syndrome in the pregnancy and another number to represent the overall risk of Trisomy 18 in the pregnancy. The afp test also provides results on the risk of spina bifida, something that the NT test does not.

A normal test result (called Screen Negative) means the following. First, it is extremely unlikely that your baby will have an open spinal or cranial defect (i.e. spina bifida). Second, it is also highly unlikely that Down's syndrome or any other chromosomal abnormality is present.
An abnormal test result is called a **Screen Positive** result. This does not mean that your baby will definitely have a defect. In fact only about 1-2% of all Screen Positive pregnancies turn out to have an abnormal fetal condition. A **Screen Positive test result only suggests that further study is needed.**

If there is any abnormality with your alpha-fetoprotein blood test, you will be referred to a specific testing center, authorized for afp follow-up by the State of California. Please see our web site for a more detailed discussion on afp testing.

**G. ULTRASOUNDS (ALSO CALLED SONOGRAMS)**

Ultrasound has been available for many years. Its safety in pregnancy has been studied extensively. To date there are no documented adverse fetal side effects from ultrasound. However, as with all biological tests, it is impossible to guarantee its absolute safety.

1. **Routine ultrasounds: Every patient is scheduled for a minimum of 3 ultrasounds during the pregnancy.**
   a) The first is about 7-8 weeks gestation, and we call it the “check viability” ultrasound. This is to make sure that the pregnancy is normal and healthy (or viable), to establish the due date accurately, and to see how many babies there are.
   b) The second ultrasound is about 18-20 weeks gestational age. It is designed to help assess the growth, development and anatomy of the baby, looking for possible major birth defects. Any abnormal findings will be carefully followed up on.
   c) The third ultrasound is at about 30-32 weeks. This ultrasound helps in managing the third trimester. We check the size and position of the baby, look at the placenta and the amniotic fluid, and measure the Doppler flow (discussed below).

2. **Doppler Ultrasound**

   Doppler ultrasound is used to examine blood flow through vessels located in the umbilical cord, the placenta and/or the baby's heart and brain. We do a Doppler flow study with every 32-week ultrasound. This measures the resistance to flow. A higher resistance means that the baby’s heart is working harder to pump its blood, a possible early sign of a baby that may not be receiving enough blood flow from the placenta.

3. **“Standard” Ultrasound**

   A “standard” ultrasound is sometimes called a "genetic ultrasound". It includes a highly detailed evaluation of fetal anatomy. Special concerns are the inspection of the fetal brain, heart, spine, renal (kidney) system, gastrointestinal system, skeletal system, and craniofacial anatomy. This type of ultrasound is generally reserved for patients who have previously had babies with birth defects, patients "at risk" for babies with birth defects, patients undergoing amniocentesis, or patients with other pregnancy risk factors possibly affecting fetal well being. We refer patients to a specialist for this exam as needed.

4. **Cervical Length Ultrasound**

   We can measure the length of the cervix at various stages of pregnancy. In particular, between 16 and 24 weeks, we can identify if the cervix is becoming progressively shorter. A normal cervix is longer than 25 mm, often 40 to 60 mm long. A “short” cervix is considered a risk factor for premature birth or possibly incompetent cervix. Being able to detect the short cervix before anything else has occurred might allow us to possibly prevent a pregnancy loss or a premature birth. Every patient has their cervical length looked at during their 18-20 week ultrasound and high risk patients are scanned earlier than that and repeatedly.
5. Fetal echocardiography

Fetal echocardiography is a type of specialized ultrasound. This means that the ultrasound and/or Doppler are used to carefully inspect the fetal heart. Abnormalities in the heart's structure (the chambers) and the heart's function can be detected. Not all are serious, and many resolve spontaneously either during pregnancy or after delivery. Some are serious, however, and may require further evaluation and treatment. **We refer patients to a specialist for this exam as needed.**

6. 3-D (Three-Dimensional) Ultrasound

Using 3-D (and even 4-D) technology, it is possible to obtain a detailed three-dimensional ultrasound image. With the use of surface rendering techniques, one can actually “see” body parts such as the face, limbs, etc. almost like looking at a sculpture. Although not a standard ultrasound, there may be situations where a valid medical indication suggests a need to perform a 3-D scan. Some people arrange to have one just to be able to “see” their baby before it is born.

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3-D and 4-D Ultrasounds are now available here in the office. This technology can provide startlingly life-like views of the fetal face and body. Please ask the front desk about our 3D/4D package!

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7. Limitations of Ultrasound

It is important to be aware of the limitations of ultrasound. At the minimum, proper detection of abnormalities requires good equipment, a well-trained ultrasound technologist or doctor and a detectable abnormality. Not all abnormalities are detectable. Sometimes the abnormality shows up later in pregnancy and is not detectable earlier. Sometimes the abnormality is so small that it is not “seen” during the exam (e.g. small holes in the heart). Sometimes the position of the baby, the placenta and the amniotic fluid are such that the abnormality is obscured.

Rarely a small spinal cord abnormality called a meningomyelocele can be missed if it is low in the spine and the backside of the baby is pressed against the uterine wall. Sometimes babies are born with visible abnormalities that are not looked for during ultrasound (such as how many fingers per hand). Some abnormalities present at birth are not detectable during routine ultrasound (such as newborn hearing deficits). We do our best to detect what is there to be detected, but there is still the possibility that our ultrasound may fail to detect a condition that is discovered after the baby is born.

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H. CVS (CHORIONIC VILLOUS SAMPLING)

After ten weeks of pregnancy, through a procedure known as CVS, a tiny sample of the placenta can be removed and chromosomal studies of the fetus can be done. The advantage is earlier detection of a chromosome abnormality. With CVS there is a slightly higher risk of miscarriage compared to amniocentesis, about 1 percent overall. Due to this elevated risk, we tend to advise CVS only when the likelihood of a genetic abnormality is increased, such as for pregnant women at or beyond age 38-40, those with a family history of a genetic defect, or those with a previously affected child.

**Micro-Array DNA Testing**

The newest form of DNA testing is called Micro-Array testing. This is a type of DNA analysis that can find much smaller chromosome abnormalities compared to the traditional DNA analysis called a karyotype. This allows for the detection of DNA microdeletion conditions. Many of these microdeletion DNA conditions have been identified. Some are known to cause disease, some are known to be normal variations, and some have not been adequately studied yet.

I. AMNIOCENTESIS

Amniocentesis is a simple office procedure involving the removal of a small amount of amniotic fluid (the fluid which surrounds the baby). It is performed most often at about 16-17 weeks (a "genetic amnio") to evaluate the fetal chromosomes (e.g. to determine the presence of Down Syndrome). We also learn the fetal sex from the amnio and we learn the level of alpha-fetoprotein (afp) level in the amniotic fluid.
Genetic amniocentesis is offered to patients who will be 35 years old or older at the time of delivery. It may also be suggested to patients who have had a previous baby with birth defects or have been exposed to situations associated that can cause possible chromosome damage. Also amniocentesis is recommended if the expanded alpha-fetoprotein blood test has an abnormal result.

The primary risk of amniocentesis is miscarriage. This may occur in about 1/250 to 1/500 procedures (2-4 per 1000). The risk of injuring the fetus with the amniocentesis needle is very low. The decision for an amniocentesis is a very personal one. Some patients under the age of 35 might want to have an amniocentesis. They feel that they would rather accept a small risk of miscarriage rather than take the chance of missing a detectable severe abnormality. In general, amniocentesis is suggested if you will be at least 35 years old at the time of delivery, or if you have other indications and risk factors as noted above and only if termination of an abnormal pregnancy would be considered. Formal genetic counseling is available for a detailed evaluation of your situation.

Generally, results are available about 10 days after the amniocentesis is performed. We call all patients with their results as soon as they are available. Please let us know in advance whether or not you would like to know the sex of the baby. *A test called FISH (fluorescence in-situ hybridization) can provide a preliminary amniocentesis result in as little as 2 days.

J. BETA-STREP SCREEN (GBS)

Group B Strep (GBS), also called Beta Streptococcus (Strep B) is a bacterial strain found in up to 30% of women. It is a normal inhabitant of the vagina and is not considered an infection. There are no symptoms and no associated vaginal discharge. Following the guidelines of the American College of Obstetricians and Gynecologists (ACOG), we perform a culture (or DNA analysis) for Strep B at about 34-36 weeks. If the culture is positive, we note this in your record and we instruct you that you will need intravenous antibiotics when you are admitted to the hospital in labor, or if any premature labor develops.

If you test positive for GBS, please mention this diagnosis to your labor nurse at the time you are admitted in labor or if your membranes have ruptured. This helps to ensure the promptness of your treatment.

7) NUTRITION, WEIGHT GAIN, VITAMINS & CALCIUM

A. NUTRITION AND WEIGHT GAIN

One of the foremost concerns a patient has about pregnancy, other than having a healthy baby, is her weight gain. Let us be blunt…You will gain weight during pregnancy! We try to focus more on eating a healthy diet instead of counting every pound.

Overall: The average weight gain during pregnancy is 30-40 pounds and this is probably too high. Many women gain more than 50, and some up to 100 pounds (yes, this does happen). If a woman starts pregnancy at a normal weight, our opinion is that 25 pounds is a great weight gain, although a difficult target to achieve, as many women will gain more than this. Please keep in mind that 6 weeks after a normal delivery, weight loss is about 15 pounds from the final pregnancy weight, so even if pregnancy weight gain is just 25 pounds, there is usually still 10 pounds to lose to reach the pre-pregnant weight.

Nutrition: There is really no magic diet that one should eat while pregnant. A common-sense balanced diet is the key. Proteins, carbohydrates, fruits and vegetables – you should eat some of each every day. Vitamins and supplements can be beneficial (see ahead). Three servings per day of dairy can provide enough calcium. Non-meat eaters can get sufficient protein from nuts, eggs, fish and dairy. Weight gain can be reduced by cutting down on high-fat foods such as chips, fried foods, salad dressings, cheeses and sweets. Minimize fruit juices (very high sugar content). Vegans need to understand their protein needs and might benefit from protein powder supplements (which can be added to their kale-spinach-fruit smoothies!).

Eating Pattern: We recommend that pregnant women try to eat 6-7 times per day. Something should be eaten about every 2½ to 3 hours. Try not to let yourself get too hungry because the blood sugar can drop causing unpleasant symptoms such as irritability, cravings for junk food, even lightheadedness. A good snack combines carbohydrates and protein, such as peanut butter and bread, cheese and crackers, milk and a bran muffin, nuts, protein bars, or cottage cheese and fruit. Have vegetables with meals. Carrots by themselves would not be a good snack item.
1st trimester: Many patients experience varying degrees of pregnancy sickness. In turn, this can affect their weight. Frequent vomiting may cause weight loss in the first trimester (see Chapter 11). Frequent nausea, without much vomiting, may lead to low food intake and limited weight gain. Alternatively, many find that only high-calorie, carbohydrate and fatty foods (so-called “comfort foods) help them to quell the nausea resulting in weight gain during the first trimester, despite the presence of nausea (not fair!). If the appetite is not normal, focus on protein-rich foods, soft fruits and easy-to-digest vegetables. It might be better to minimize salads and high-fiber. Goal: Gain 0 to 10 lbs. during the first trimester.

2nd trimester: For many women, the appetite comes roaring back. This is the trimester of rapid weight gain. It is possible to eat 6-7 meals a day and still get hungry between meals. And food seems to taste so good! One way to balance the weight gain is to increase calorie-burning activities. Walk every day, swim, do something aerobic. Goal: Gain about 3-4 lbs. per month during second trimester.

3rd trimester: Patients tend to get full more easily, especially the last 1-2 months. However, water retention may occur, causing the weight to go up despite not eating as much. Water weight gain will come off after delivery, but this can take weeks. Goal: Gain about 2-3 lbs. per month third trimester.

B. VITAMINS AND CALCIUM

We recommend that you take prenatal vitamins throughout the pregnancy and for the duration of breastfeeding, or at least until the six-week postpartum checkup. During the first trimester, vitamins may aggravate pregnancy-related nausea. In this case, take only the folic acid, 1 mg. daily, until the nausea has abated.

Every pregnant woman needs a minimum of 1000 to 1200 milligrams daily of Calcium, equivalent to about 3 to 4 dairy servings daily. Dairy sources include milk, yogurt, cottage cheese, cheese, tofu, soymilk and ice cream. Supplementation is advised (usually 300 to 600 mg. daily) if this dairy intake is not met.

We do not routinely put patients on an iron supplement. There is a lot of iron in the prenatal vitamin, and iron can be constipating. However, if your lab tests show anemia, we may ask you to take extra iron.

Some evidence suggests a benefit from omega-3 and omega-6 vitamins, found in fish oil or flaxseed oil. The fish oil does not have the mercury risk as does certain fish (read the labels). Many prenatal vitamins are incorporating DHA (one of the omega-3 fatty acids), and this has become a standard supplement for pregnancy.

C. VITAMINS AND SUPPLEMENTS WE RECOMMEND

- **Prenatal Vitamins:** We like prescription prenatal vitamins more than over-the-counter. The prescription vitamins contain more folic acid and more iron. Also, many insurance plans will pay for prescription vitamins.

- **Calcium with Vitamin D:** Most contain calcium carbonate. This is the least expensive form of calcium (Tums, OsCal) and has low absorption by the body, which can lead to GI side effects such as bloating and gas. We prefer CitraCal and Caltrate calcium, plus about 1,000 units of added Vitamin D.

- **Iron:** Most contain ferrous sulfate. The body does not absorb most of the iron you swallow. Excess iron comes out in the stool, causing it to turn dark. Iron can also cause GI side effects such as heartburn and indigestion. It should be taken with meals, usually dinner. We like Slow-Fe, a slow release form of iron.

There are liquid iron preparations that many people prefer to iron pills. One liquid iron we like is called Floravital. 2 teaspoons contains 10 milligrams, so you should take 1-2 tablespoons a day. (website: [http://www.florahealth.com/flora/home/usa/products/r64775.asp](http://www.florahealth.com/flora/home/usa/products/r64775.asp)).

- **DHA:** Also called omega-3 fatty acids. Most Prenatal Vitamins now contain DHA so an additional supplement may not be necessary. Nordic Naturals has a fantastic line of DHA.

- **WARNING:** We do NOT advise taking Gummy PN Vitamins. They are lacking in important nutrients, especially iron. The leave it out for fear that children will eat these vitamins as candy and iron can be poisonous for small children. It is shameful that they are labeled as prenatal vitamins when a key ingredient is lacking.
8) NORMAL VS. HIGH-RISK PREGNANCY

Many patients come to us because they have had problems in a previous pregnancy, or have medical problems that create increased risks in this pregnancy (or both). For example, we see many patients with multiple gestation, with pregnancy after previous infertility, with pregnancy after age 35, or with a previous complicated pregnancy. Not everyone with risk factors is automatically considered by us to be a high-risk pregnancy. Generally we reserve that term for patients who require extra medical care during this pregnancy.

Additionally, we are always aware that even a patient whose pregnancy begins seemingly normal can develop problems later on sufficient to make the pregnancy a high-risk situation.

One aspect of our practice that we are proud of is our ability to offer nearly all possible medical services to you here in our office. We perform ultrasound and doppler studies in the office. We do fetal monitoring and premature labor monitoring here in the office. We perform intravenous hydration in the office when needed. Furthermore, we can arrange for medical care at your home as well, such as a fetal non-stress test, premature labor monitoring or home intravenous therapy.

Below is a brief discussion of some of the extra services available as well as special considerations when there are problems or complications with the pregnancy.

A. SPECIAL BLOOD TESTS

There are hundreds of blood tests available should the situation warrant it. Thyroid panels, anemia panels, thrombophilia testing, progesterone levels, TORCH titers (viral antibodies), lupus panels, coagulation panels, and anticardiolipin antibody panels are just a few.

B. PROGESTERONE THERAPY

Sometimes early in pregnancy there are problems which suggest a need for additional progesterone (for example, twins, history of previous miscarriage, or bleeding during the first trimester). We have a program of supplementation with pure, natural progesterone (either as a capsule, vaginal suppository or cream or injections) and blood level monitoring for those situations.

Progesterone has also been proven to reduce the risk of premature birth in women with a history or prior premature birth and in women who develop a short cervix in the middle of a pregnancy. This involves weekly injections of a long-acting progesterone called 17 hydroxy P, starting from 16 to 20 weeks until 34 weeks or sometimes it is prescribed as a vaginal suppository every night until 34-35 weeks.

C. NON-STRESS TESTS

A non-stress test (NST) is a form of fetal monitoring, similar to fetal monitoring during labor. It is used to determine the well being of the baby, and also can be used to look for uterine contractions. This test is done for medical indications, and usually is done during the last 1-2 months of the pregnancy. It can be done here in our office and take about 30 to 60 minutes.

D. BILLING CONSIDERATIONS

If an excess number of prenatal visits are required due to complications of your pregnancy, we may have to charge a "high-risk" fee. Please see the separate OB Fees Handout.

9) MORNING SICKNESS

1. What causes morning sickness?

Many articles link morning sickness to the pregnancy hormone hCG. Morning sickness tends to be worse with multiple gestation (a high hormone state) and it tends to be minimal in pregnancies that end in miscarriage (a low hormone state). It may not make any sense, but the sicker you, the "better" the pregnancy. On the other hand, you can have absolutely no morning sickness with a perfectly normal pregnancy.
2. Why does morning sickness exist? An evolutionary explanation

The best theory is that morning sickness is Mother Nature's instinctive toxin avoidance mechanism. It is our biological radar, warning us when something potentially hazardous is coming our way. The evidence supporting this theory is extensive. For example, fetal organ development is usually completed by week 14 of pregnancy. During those first 14 weeks, the fetus is exquisitely sensitive to the damaging effects of toxins. The first trimester is also when nearly all miscarriages occur. Most cases of morning sickness resolve by the end of week 14.

3. Severe morning sickness

About 1-3% of pregnant women experience severe morning sickness. It can lead to profound dehydration, mineral and electrolyte abnormalities and acid-base changes in blood chemistry. Treatment might require intravenous fluids and possibly hospitalization. There is a prescription drug on the market, called Diclegis. 2 pills twice a day can really help reduce the nausea and vomiting. This medication has earned a rare A grade from the FDA for safety during pregnancy. Zofran has been used for years, but some studies now suggest a slightly higher incidence of minor birth defects from 1st trimester use of Zofran.

Contact the office right away if you have any of the following symptoms:

- Throw up everything, food and liquids, for more than a couple of days.
- Losing more than 5% of your body weight (for example a 120 lb. woman loses 6 pounds) compared to your pre-pregnant weight.
- Feeling constantly dizzy, lightheaded, very weak and you have a dry, pasty mouth.

4. Management of mild morning sickness

First, trust your instinctive food aversions. If it doesn't smell good, look good, or "sound" good to you to eat it, then don't. Below are two lists, the “things to avoid” list and the “things to try” list. Review these lists and try to incorporate as many suggestions as you can, and you should see some improvement in your symptoms.

5. Things to avoid that may help mild morning sickness

- Avoid odors as much as possible. Have your husband take breath mints. Use odorless hygiene and laundry products. Avoid odor-filled places (crowded public places, public restrooms, smelly gyms, etc.). Have your home cleaned to try and eliminate any musty or moldy household odors. Get rid of smelly stuff in the fridge and place opened boxes of baking soda inside.
- Avoid most raw vegetables and canned fruits and vegetables. Stick with fresh, ripe fruits.
- Avoid greasy and high-fat foods (although dairy products are usually okay).
- Avoid burnt foods. Avoid barbecued food.
- Avoid raw fish (sushi) and avoid nuts.
- Avoid spices, spicy foods and herbs: garlic, onion, dill, oregano, etc.
- Avoid food flavorings and condiments: ketchup, mustard, steak sauce, etc. Small amounts of salt are okay.
- If vomiting more than once a day, stop all vitamins (yes, even prenatal vitamins) except folic acid (0.4 mg. daily) and B-6 (25-50 mg. daily).
- Avoid coffee, tea, chocolate, and any substance that is bitter in its native form (before sugar and fat have been added to it).

6. Things to try

- Keep saltine crackers on your nightstand. Eat one as soon as you awake, while still lying down if possible. Then wait a few minutes before getting up. The crackers will absorb stomach acid that may have accumulated during the night.
• Eat things a baby would like (boring, bland stuff), like plain white breads, cereal, noodles, rice, and plain yogurt.
• Eat ripe soft fruits. Drink fresh-squeezed fruit juices, ice cold and watered down a bit.
• Try a blender-shake made with ice, plain yogurt or milk, and ripe fruit or fresh fruit juice. Whey or soy protein powder can be added if your diet is low in protein. Add honey for sweetening.
• Eat white cheese. It digests slowly and lessens stomach acid production.
• Dry, white meats like turkey breast are well tolerated.
• Drink flat Seven-up or Ginger Ale (pour into a cup, and then stir).
• If vomiting, drink Gatorade-type drinks rather than water to replace minerals.
• Drink liquids with crushed ice, using a straw.
• Eat small meals all day long, up to 10 times a day.
• Try “Preggie Pops” ginger lollipops or the new ginger-saltine crackers (Mother’s Tranquil Tummy™)
• If you have to cook, try to microwave, steam or boil foods. This lowers the "burned food" odors.
• To help nausea, try the following: Vitamin B-6, 25 to 50 milligrams two or three times per day. Try ginger, either tea or candied (helps nausea). Try Atomic Fireball candy (one patient swears they help). Or lemon drops. “Preggie Pops” are available at some stores. Wear wristbands, also known as acupressure or "sea" bands.
• Prilosec is available over-the-counter. It reduces stomach acid and can be very helpful, and is safe to use.

10) MEDICATIONS, FOOD SAFETY, SUBSTANCE USE AND INFECTIOUS DISEASES

A. GUIDELINES

The general rule is not to take any medication, even drug store medicines, during pregnancy, unless there is a significant need. Although no drug (whether it is over-the-counter or prescription) has been proven absolutely safe, there are many widely used medications that have no reported adverse consequences to the mother or unborn baby. Ultimately, the risk of taking the medication must be weighed against the benefit.

Prescription medication should not be taken during pregnancy without the doctor’s advice and approval.

B. FOOD PRODUCTS TO AVOID

1. MethylMercury Hazard: In January, 2001, the FDA released an advisory warning that women who might become pregnant or who are pregnant not to eat shark, swordfish, king mackerel or tilefish because these fish may contain high levels of Methylmercury. Methylmercury is responsible for the outbreak of Minimata disease in Japan during the 60’s, characterized by multiple neurologic deficits. In pregnant women, the fetal brain accumulates the methylmercury, and testing has revealed a high incidence of Cerebral Palsy (CP), developmental delay and learning disabilities in affected children. Many experts also feel that the consumption of canned and fresh tuna should also be limited while pregnant.

Here are some quotes from one article on mercury in fish:

“For now, a review of FDA’s mercury measurements in 39 seafood varieties shows:

- Salmon, oysters, whitefish, sea bass, freshwater trout and sardines contain both high levels of heart-healthy omega-3s and low mercury levels, below 0.13 parts per million.
- Other low-mercury choices include perch, king crab, flounder, sole, pollock, catfish, croaker, scallops, crawfish, shrimp, clams and tilapia. They contain less omega-3s, but servings can add up.
• Tuna is controversial, because different varieties contain different amounts of both mercury and heart-healthy fats. Canned light tuna contains a small amount of omega-3, about as much as shrimp, and fairly low 0.13 ppm (parts per million) mercury. But fresh tuna steaks and the more expensive canned white or albacore tuna contain three times as much mercury, and almost as much omega-3 as salmon.
• That puts albacore in the medium-mercury range. So many consumer groups recommend that pregnant women and children stick to modest amounts of the lower-mercury light tuna - about 9 ounces a week for women and 3 ounces for youngsters.
• Also in the medium-mercury range are saltwater trout, bluefish, lobster, halibut, haddock, snapper and crabs. Grouper and orange roughy are at the high end of this group. FDA's advisers said women of childbearing age probably should limit these fish to a serving a week.
• The FDA advises women of childbearing age to avoid swordfish, king mackerel and shark.
• For more information:
  o call the FDA hotline at 1 (888) SAFEFOOD
  o http://www.fda.gov/Food/FoodborneIllnessContaminants/Metals/ucm393070.htm (June 2014 update)
  o http://www.fda.gov/Food/ResourcesForYou/HealthEducators/ucm083324.htm

2. Listeria Risk: These food-borne bacteria can cause a rare infection called listeriosis. According to the FDA, an outbreak in 1985 in Los Angeles resulted in 142 cases of listeriosis including 46 deaths; 85 percent of the cases were Perinatal (pregnant women). The outbreak was traced to a soft, Mexican-style cheese, manufactured with contaminated milk (Jalisco cheese). This infection causes mild flu-like symptoms in an adult, but can have a more dangerous effect on a fetus, and can cause stillbirth.

To be on the safe side, it may be advisable to avoid any raw or unpasteurized dairy product (such as raw milk), soft white cheeses such as brie, camembert, fresh blue cheese and Mexican white cheeses.

Listeria has been rarely found in hot dogs, bologna, other pre-packaged luncheon meats, ham, bacon, and lox. It has been found in candied apples, lettuce, cantaloupes, ricotta cheese, and chocolate chip cookie dough ice cream.

Our advice is to wash your fruits and vegetables, eat your meat hot and medium cooked or better, and only eat pasteurized dairy products (not raw). No raw cookie dough either.

http://www.fda.gov/Food/ResourcesForYou/HealthEducators/ucm083320.htm

3. Sushi:
During the first trimester, it might be reasonable to avoid sushi. Many "experts" advise pregnant women to refrain from eating sushi altogether. This of course would be the absolutely most cautious approach, but is it reasonable? Some sushi is vegetarian, that seems perfectly safe. Some sushi such as shrimp, crab and eel is cooked, so that seems safe. In the U.S., sushi is flash frozen on the ship right after it is caught which kills almost all parasites.

Sushi containing any of the fish on the high-mercury list should NOT be eaten. And always make sure the fish is fresh and the establishment is of high quality. It might be better to avoid "discount" sushi for example.

In Japan, pregnant women routinely consume sushi based on the above precautions. In our opinion, carefully selected sushi should be considered safe during pregnancy, but the choice is yours.

4. Uncooked meats: There is a risk of ingesting a food parasite such as toxoplasmosis when eating uncooked meat. For this reason, we discourage eating raw beef dishes such as steak tartare, beef carpaccio or very rare steaks (medium rare is probable safer). All poultry products should be fully cooked (no pink) before eating.

5. Peanuts: Previous versions of this Guidebook advise avoiding peanuts during pregnancy to help prevent your baby from becoming allergic to peanuts later in life. As with many areas in medicine, new information has resulted in a complete reversal of this advice. The new studies show exactly the opposite! If you ingest specific foods during the pregnancy such as peanuts or peanut-containing foods, like peanut crackers or pea nut butter, studies now show that your baby will have a lower chance of developing a peanut allergy in the future.
C. NON-PRESCRIPTION MEDICATIONS TO AVOID

- Aspirin or related products such as Advil, Motrin, ibuprofen and others, especially during the third trimester. Occasional use is not harmful, but Tylenol (a non-aspirin product) is preferable.
- Stimulant laxatives such as Ex-lax, Dulcolax, or enemas
- Nicotine patches or nicotine gum
- Weight Loss products
- Megavitamins, especially high doses of Vitamins A or E. Note that cod liver oil capsules are very high in Vitamin A.

D. SUBSTANCES

Herbal preparations: It is difficult to provide accurate, scientific advice about the effects of herbs on an unborn child. Many herbs are safe, and many are potentially dangerous. In general, unless the herb is widely known to be safe (such as herbal cough drops), it is safer to avoid them while pregnant.

Homeopathic Remedies: True homeopathic remedies involve highly dilute solutions, so these are considered generally safe during pregnancy.

Nutrasweet, Sweet’N’Low, Equal, Splenda, Truvia, Stevia: These are food additives, and have no known risk when taken in normal amounts.

Caffeine: caffeine should not exceed one coffee, two teas, or two colas daily (chocolate is so low in caffeine, it is not a significant source. Yippee.). According to the American College of Ob/Gyn (Committee Opinion 462, reaffirmed in 2013): moderate caffeine consumption (less than 200 mg per day) does not appear to be a major contributing factor in miscarriage or preterm birth.

Smoking: strongly discouraged, leads to low birth weight, premature labor.

Alcohol: strongly discouraged, overuse can lead to fetal alcohol syndrome, mental retardation, birth defects. Minimal safe levels of alcohol intake have not been established.

E. MEDICATIONS FELT TO BE SAFE DURING PREGNANCY

Some over-the-counter medications have been available for many years, and thus have “stood the test of time.” Homeopathic preparations are also safe to take. For the following health conditions, we have listed some drug store medicines that are generally safe in pregnancy, and can be taken if there is a strong need:

- Allergy Symptoms: Chlortrimeton, Allerest, Claritin or Claritin-D, Zyrtec, Benadryl, Nasa-Cort
- Backache: Tylenol, Heat or Cold applied locally (see the section on low back pain)
- Constipation: Colace, DOSS, Metamucil, Citrucel, Fibercon, Miralax. If severe, Milk of Magnesia, Miralax
- Coughing: Robitussin or Robitussin DM, Vicks cough drops, Recola lozenges
- Diarrhea: Kapectate, Imodium AD (please note that the Imodium package says to avoid its use during pregnancy – we strongly disagree).
- Fever: Tylenol, regular or extra strength. AVOID aspirin, Advil, Motrin, Ibuprofen, Alleve, etc.
- Gas Pains: Maalox Plus, Mylicon, Gas-X, Phazyme, Tums
- Head Cold: Contac, Dristan, Zinc Lozenges (Cold-EZE), Vicks, Sudafed.
- AVOID ZINC NASAL SPRAY (In rare cases this has been linked to permanent loss of the sense of smell)
- Headache: Tylenol, regular or extra strength, follow package directions for dosages. Excedrin (the non-aspirin version) is safe for severe headaches such as migraines (the amount of caffeine is safe and it helps a lot)
- Hemorrhoids: Preparation H, Anusol HC, Tucks (witch hazel) pads, Preparation-H wipes
- Indigestion/Heartburn: Tums, Mylanta or Maalox. If severe, Pepcid AC or Pepcid Complete, or Prilosec OTC (great for reflux or GERD)
Insomnia: Benadryl, Unisom, Tylenol PM  
Itchy skin rash: Hydrocortisone 1% cream or ointment (Ringworm rash, use Tinactin or Micatin)  
Lact-Aid: enzyme products, like milk or tablets (containing lactase) pose no known risk.  
Leg Cramps: Calcium (Tums, CitraCal), or a Calcium/Magnesium combination (Cal-Mag). Take 3 Tums at once in the evening for night-time leg cramps or 1 to 2 Cal-Mag tablets  
Nausea: Unisom (Sleep Tabs, not Sleep Gels), Dramamine, Transdermal Scopolamine patches  
Sinus Congestion: Sudafed 12 hour, Saline nasal mist. We prefer avoiding Afrin as it can lead to dependence.  
Sore Throat: Sucrets, Chloraseptic, Recola, Listerine gargle  
Vaginal Yeast Infection: Monistat 1 day, 3-day or 7-day, Gyne-Lotrimin, Gynazole  

F. INFECTIOUS DISEASES (INCLUDING ZIKA VIRUS)  

1. Zika Virus  
   Zika virus is spread to people through mosquito bites. The most common symptoms of Zika virus disease are fever, rash, joint pain, and conjunctivitis (red eyes). The illness is usually mild with symptoms lasting from several days to a week. Severe disease requiring hospitalization is uncommon. The virus can be found in the bloodstream of an infected individual 1-2 weeks or perhaps longer according to recent data. There is no evidence that the same virus will show up in the body again in the future (unlike other viral diseases such as herpes, chickpox, and HIV for example).  
   
   There have been reports in Brazil of microcephaly and other poor pregnancy outcomes in babies of mothers who were infected with Zika virus while pregnant. Recent studies have confirmed this relationship. More studies are planned to learn about the risks of Zika virus infection during pregnancy. Microcephaly is when the size of the newborn's head is far smaller than expected, which unfortunately also means that brain development has likely been affected.  
   
   CDC has issued a travel notice (Level 2-Practice Enhanced Precautions) for people traveling to regions and certain countries where Zika virus transmission is ongoing. Until more is known, CDC recommends special precautions for pregnant women and women trying to become pregnant.  
   
   Pregnant women in any trimester should consider postponing travel to the areas where Zika virus transmission is ongoing. Pregnant women who do travel to one of these areas should talk to their doctor or other healthcare provider first and strictly follow steps to avoid mosquito bites during the trip. Women trying to become pregnant should consult with their healthcare provider before traveling to these areas and strictly follow steps to prevent mosquito bites during the trip.  
   
   Because specific areas where Zika virus transmission is ongoing are difficult to determine and likely to change over time, CDC will update their travel notice as information becomes available. Check CDC's Zika Travel Information website frequently for the most up-to-date recommendations.  
   
   Pregnant women are advised to use condoms or abstain from sex for the duration of the pregnancy if their sexual partner has traveled to a known Zika transmission area.  
   
   For the most up-to-date information about Zika and pregnancy, please see the CDC web site at:  

2. Toxoplasmosis  
   Toxoplasmosis, caused by a one-celled parasite called Toxoplasma gondii, is one of the most widespread infections in the world, affecting roughly 50% of the world’s population, regardless of gender. Generally a mild, harmless infection, Toxoplasmosis can be of grave concern to pregnant women because of the risk of birth defects due to congenital toxoplasmosis.  
   
   Cats can acquire the parasite by eating an infected rodent or bird. They then can transmit the parasite from their feces into the litter box, or wherever they may defecate such as the garden or a child’s sandbox. Up to 60% of all domestic cats harbor Toxoplasma in their body, but surprisingly, they only release infectious particles for 3 weeks in their lifetime, occurring after they have become infected.
Toxoplasmosis can also be acquired from eating raw or undercooked meat such as beef, pork or lamb and throughout the world; this is the most common means by which people become infected.

**Prevention of Toxoplasmosis**

- Avoid contact with cat litter or wear gloves. Wear gloves while gardening because the organisms can live in the soil. Cats also like to defecate in children’s sandboxes.
- Cook all meat, particularly sheep, beef, and pork, to a minimum of 150 degrees F (66 degrees C). Cook poultry to 180 degrees F.
- Thoroughly wash all fruits and vegetables, or peel them. Using soap and hot water, wash all surfaces that have come into contact with raw meat or poultry.
- Do not drink unpasteurized milk or milk products, especially goat’s milk products.

3. **CMV**

CMV stands for cytomegalovirus. This is a very common virus and by adulthood most people have been exposed to it, almost always without any symptoms. CMV is spread by person-to-person contact (kissing, sexual relations, bodily fluids). For example, it can spread if someone touches fluids from an infected individual, and then accidentally touches their own mouth. This is why hand-washing is so important. A common source of CMV is small children, so day-care workers and teachers are at increased risk for CMV exposure.

CMV is a concern because an infection during pregnancy can allow the virus to spread to the developing fetus, and can lead to birth defects such as deafness, blindness or mental retardation. One in 750 babies in this country is born with or later develops disabilities due to CMV infection passed from their mother during childbirth.

There is no vaccination and no treatment (except in severe cases). Precautions include: frequent hand washing, especially when around young children; avoid mouth-to-mouth kissing; do not share any cups or silverware. A blood test can be done to check for existing immunity. More than 50% of women are already immune to CMV.

4. **Parvovirus B-19 (Fifth Disease)**

Fifth Disease (also called erythema infectiosum) is caused by the virus parvovirus B-19. It is common in kids ages 4 to 14 and can lead to a flu-like illness often with joint pains and a characteristic facial rash sometimes called the “slapped cheek” rash. This is a contagious viral illness with an incubation period of about 1-3 weeks. About 1 in 5 adults can have this infection without any symptoms.

Parvovirus B-19 is a concern during pregnancy because the virus can lead to an infection in the fetus, particularly affecting the fetal bone marrow. This can lead to decreased production of fetal red blood cells, causing fetal anemia and possibly a serious condition called fetal hydrops. Frequent ultrasounds can be used to monitor the pregnancy for signs of hydrops, and in severe cases intrauterine blood transfusion can be done to treat the fetal anemia.

There is no vaccination and no treatment. Precautions include: frequent hand washing, avoid mouth-to-mouth kissing; do not share any cups or silverware. A blood test can be done to check for existing immunity. More than 50% of women are already immune to Parvovirus B-19.

G. **TERATOGEN INFORMATION**

MotherToBaby CA, formerly known as the California Teratogen Information Service (CTIS) Pregnancy Health Information Line and Clinical Research Program, is a statewide service. Our goal is to promote healthy pregnancies through education and research. Teratology is the study of birth defects caused by exposures during pregnancy.

Go to [www.mothertobabyca.org/](http://www.mothertobabyca.org/) or call Toll-FREE (866) 626-6847.
11) VACCINES DURING PREGNANCY

A. PERTUSSIS – FACTS ABOUT BOOSTER IMMUNIZATION DURING PREGNANCY

Pertussis (“whooping cough”), a once obscure disease, is a potentially lethal respiratory illness that is making a huge comeback. According to the L.A. Times (1/3/2011), in 2010, 10 infants were killed by pertussis and “more people were sickened than in any year since 1947.”

The age group hit the hardest by pertussis is children under 6 months of age, because they have not completed their infant series of vaccine shots and so they are more susceptible. This is why experts advise pregnant women, their spouses and other caretakers in the home to have a pertussis booster vaccine (called TDaP), to prevent exposure to the pertussis bacterium from the infant’s close contacts.

In the 1940’s, prior to the introduction of the vaccine, there were 250,000 cases per year of the illness in the U.S., and a significant number of infant deaths. In 1976, there were only 1,000 cases reported, but since 2003, that has increased to 10,000 cases annually. In California, only 700 people had pertussis in the year 2000 but in 2010 there were 7,800 cases reported!

The TDaP vaccine is safe and effective even during pregnancy. Pregnant women and their immediate family members are urged to have this booster immunity in order to prevent the transmission of deadly pertussis to their infants. The vaccine can be administered postpartum as well, and will take effect within a few weeks at most.

B. INFLUENZA (“A FLU SHOT”)

Should a pregnant woman get a flu shot? In short, the answer is almost always yes!

Influenza is normally not a serious illness. Typically the flu is a 5-10 day illness with fevers, chills, muscle aches, nausea and loss of appetite, weakness and upper respiratory symptoms. People feel pretty sick, but they do get better, and rarely does the flu lead to anything very serious. But, the key word is rarely! Although normal healthy adults rarely develop serious complications from the flu, the same cannot be said for pregnant women.

Here is what the CDC says about Influenza and Pregnancy:

1. The Flu Shot is the Best Protection Against Flu

Getting a flu shot is the first and most important step in protecting against flu. The flu shot given during pregnancy has been shown to protect both the mother and her baby (up to 6 months old) from flu. (The nasal spray vaccine should not be given to women who are pregnant.)

2. The Flu Shot is Safe for Pregnant Women

Flu shots are a safe way to protect the mother and her unborn child from serious illness and complications of flu. The flu shot has been given to millions of pregnant women over many years. Flu shots have not been shown to cause harm to pregnant women or their babies. It is very important for pregnant women to get the flu shot.

3. Early Treatment is Important for Pregnant Women

If you get sick with flu-like symptoms call your doctor right away. If needed, the doctor will prescribe an antiviral medicine that treats the flu. Having a high fever caused by flu infection or other infections early in pregnancy can lead to birth defects in an unborn child. Pregnant women who get a fever should treat their fever with Tylenol® (or store brand equivalent) and contact their doctor as soon as possible.

4. When to Seek Emergency Medical Care (If you have any of these signs, call 911 right away):
   - Difficulty breathing or shortness of breath
   - Pain or pressure in the chest or abdomen
   - Sudden dizziness
   - Confusion
   - Severe or persistent vomiting
   - High fever that is not responding to Tylenol® (or store brand equivalent)
   - Decreased or no movement of your baby
EXERCISE AND PHYSICAL ACTIVITIES DURING PREGNANCY

We encourage patients to be physically fit and active during pregnancy if they so desire. Many aerobic activities are safe and worthwhile during pregnancy. However, many sports activities pose a risk of falling, or a risk of collision with another participant. Listed below are activities we feel are safe, and those we feel should be avoided while pregnant.

A. ACTIVITIES GENERALLY SAFE DURING PREGNANCY

- Aerobic exercise such as walking, jogging, swimming, non-competitive tennis, etc. Health club equipment such as treadmills, stationary bikes, elliptical trainers.
- Aerobic classes designated as low-impact. The instructor should be made aware that you are pregnant. Avoid intense aerobic activities such as kickboxing, spinning, sprinting, etc.
- Weight lifting using upper and lower body, lower weights, higher reps. Later in pregnancy it might be better to avoid direct abdominal exercises such as sit-ups and crunches. Avoid heavy lifting requiring straining. Avoid lying flat on the back after the 5th month. Prenatal Yoga is an excellent exercise.
- Seat Belts: These should be worn at all times while in a moving vehicle. When the abdomen is enlarged, the waist belt should be worn below the abdomen, across the hips, and the shoulder strap should go across the shoulder above the abdomen.
- High Altitude: Airlines pressurize their cabins to the equivalent of about 6,000 to 8,000 feet elevation, so this altitude (whether in the air or on the ground) is generally safe while at rest. However, strenuous activities above this height can lead to altitude sickness (headache, fatigue, weakness, nausea). Please consider this issue when planning trips to any mountainous areas while pregnant.

B. ACTIVITIES TO AVOID DURING PREGNANCY

- RISK OF FALLS/COLLISION: avoid riding a bicycle, a horse, snow skiing, water skiing, skateboarding, rollerblading, racquetball, surfing, etc.
- ROUGH and BUMPY ACTIVITIES: avoid roller coasters, jet skis, high speed boating, off-road vehicles, etc.
- OVERHEATING: avoid hot tubs, dry sauna, steam rooms, Jacuzzis. Warm baths are fine.
- LYING FLAT ON YOUR BACK: Many patients are told that in the second half of pregnancy it is dangerous to lie flat on the back, and they have to lie on their left side. In my opinion, this warning is highly overemphasized and causes a great deal of anxiety in patients. If lying on your back feels fine, then GO AHEAD. Occasionally lying flat can cause lightheadedness or other discomforts, especially after the 5th month. If so, don’t do it. The “books” then advise lying on the left side, but lying on the right or left side is equally all right.

C. SEXUAL RELATIONS WHILE PREGNANT

For patients with normal low-risk pregnancies, there are no specific restrictions on traditional sexual intercourse. There may be slight discomfort requiring the use of different positions. Female on top and side-to-side positions are generally safer and more comfortable, and later in pregnancy, rear-entry might be the only position available if you are still interested in having sex.

There is occasional spotting after relations. If this occurs, please let us know. Libido can decrease, increase or remain the same while pregnant.

Male to female oral sex is not advised during pregnancy, as there have been rare reports that air entering the vagina can cause a serious condition called an embolism. Patients with high-risk pregnancies, such as twins, premature labor, high blood pressure, bleeding, etc., may need to abstain. Feel free to discuss any and all concerns with us at any time.
D. EXERCISE DURING PREGNANCY

There is a benefit from mild to moderate exercise during pregnancy, at least 30 minutes per session, at least 3 times per week. For cardiovascular exercise target heart rates goals are between 60% and 80% of an individual’s maximum heart rate. The maximum rate can be determined using the formula 220 minus your age. If you are 40, your maximum would be 180 and your target heart rate would be between 108 and 144. Untrained women should aim for the lower end of this range, whereas fit women can aim for the high end.

Many experts feel that swimming is the ideal exercise while pregnant. People stay cool, and the buoyancy effect can be a real relief in and of itself. Late in pregnancy, swimming on the back may allow for easier breathing (the opposite advice compared to lying on the back!).

Prenatal Yoga can be very beneficial. It can help with back pain, flexibility, strengthening and relaxation. We like the prenatal classes at Yoga House, 11 W. State St., Pasadena, CA, 91105, 626-403-3961.

Many women ask about Pilates and Yoga during pregnancy. A wonderful DVD is available, called “Pregnancy System” by Tracey Mallett. It covers Yoga, Sculpting, Pilates, Upper and Lower Body and Core Conditioning. Please see their web site: www.atptraining.com or call (626) 403-6545.

Warning: Any exercise during pregnancy should not be done to such an intense degree as to cause discomfort, shortness of breath or profuse sweating. The ability to speak in a normal manner without being short of breath is a desirable endpoint for exercise intensity. Exercise should be directed at fitness, not training for competition.

Precautions while exercising

- Avoid supine exercise after the first trimester, particularly resistance exercises such as bench press.
- Loss of balance can be a concern, particularly in the third trimester, so step aerobics may not be the best type of exercise at this time.
- Adequate hydration before, during and afterwards is important. Loose-fitting clothing appropriate to the environment can help prevent overheating.

E. DENTAL CARE DURING PREGNANCY

We encourage all of our patients to keep up their regular routine of preventive dental care. Routine dental exams are perfectly safe during pregnancy as are most minor dental procedures. The use of “novocaine” for dental procedures is considered safe, and taking penicillin if advised by the dentist is also safe. If dental X-Rays are needed, then the pregnant abdomen should be shielded with a lead apron. Some dentists will even “double-shield” which means using 2 aprons. This is okay, but probably more of a precaution than is absolutely necessary.

Studies show that women with poor dental hygiene are at risk for pregnancy complications, particularly premature labor and premature birth. One study showed that pregnant women with severe gum disease were 7 times more likely to deliver prematurely!

F. AIR TRAVEL DURING PREGNANCY

In November, 2009, the American College of Ob/Gyn issued an updated report on the safety of airplane travel while pregnant. They felt that low-risk patients could safely fly as late as 36 weeks of pregnancy (35 weeks for international flights). Traveling is discouraged if the patient has been diagnosed with pregnancy complications.

The airplane cabin is slightly depressurized, equal to being at an altitude of about 6,000 to 8,000 feet elevation. This will rarely cause symptoms such as thirst, nausea or headache, which can be relieved by breathing oxygen. It is advised to avoid carbonated beverages (or gas-producing foods) before flying as the gas can expand after take-off causing some abdominal cramping.

During long flights, it is important to be active periodically. Prolonged immobilization can increase the risk of a rare complication known as a deep vein thrombosis (DVT). This is when a blood clot forms in the lower leg. The clot can then travel to the lungs and rarely (extremely rarely) cause serious injury, even death. Prevention includes walking for a few minutes at least every 1-2 hours. Air turbulence can also occur, so pregnant women should always wear their seatbelts while sitting on the plane. ASK FOR AN AISLE SEAT.
It is good to get up every 1-2 hours and walk around, and use the restroom. This can also help prevent leg swelling, common from prolonged sitting. Stay well hydrated. Support stocking might be useful for a long flight. Loose clothing is advised as well.

G. SLEEPING

Many pregnant women have trouble sleeping. Typically, they are able to get to sleep okay, but then wake up in the middle of the night, often to use the restroom. Then, it can be difficult to get back to sleep. This is normal, but here are some helpful tips:

- Try to limit fluid intake after 6 pm if you are waking up to urinate
- Use extra pillows to try and get comfortable
- If your spouse snores, have him try the breath-right nasal strips
- consider the use of a nighttime sleep aid such as Tylenol PM
- Take a nap every day if you are able. Many studies show that a 30 minute “power nap” in the afternoon can actually help you to function better the rest of the day, and help your brain to enter the phase of deep sleep which is needed during the night to provide truly restful, rejuvenating sleep (sounds like a mattress commercial).

13) LOW BACK PAIN DURING PREGNANCY

(Include Hip pains, Sciatic and Lumbar area pains)

This is a nearly universal problem for pregnant women, due to multiple factors. High hormones soften the supportive ligaments of the low back, causing pain even early in pregnancy for some women. The growing weight of the uterus adds to the strain on the low back muscles.

A. PREVENTION

Avoid bending at the waist, try bending the knees. Avoid carrying anything heavy enough to cause low back discomfort while holding it. Be sure any chair used for prolonged periods of time is “ergonomic” (designed for extra low back support). Good posture while sitting and standing is very important. Avoid “slouching” as it can put severe strain on the low back over time. Special firm lumbar cushions for support can be very helpful. Chair height should allow both feet to rest flat on the floor. If a lot of time is spent sitting at a desk, then both arms should be even with the desktop.

Special stretches can be done daily to maintain spine flexibility. Low back strengthening exercises as outlined in most prenatal books can be helpful, but must be done for a few minutes each day to effective.

B. REMEDIES AND TREATMENTS

1. Prevention: Many “little” things done well can help prevent back pain. Good posture, limited weight gain, proper sitting positions, ergonomic chairs, low heels, proper bending and lifting, a firm mattress, minimize reaching above the head all can help.

2. Low back strengthening exercises

Many pregnancy books provide descriptions and images regarding exercises such as the pelvic tilt (and the dromedary droop) which can help reduce low back pain. Guess what? They work!...but they need to be done frequently.

3. Relax the Back Store

There are a variety of items here that may be helpful. Full-length body pillows, footrests, lumbar support cushions and back support belts can help. The employees are quite knowledgeable about back pain but they also want to sell you the $2,000 gravity recliner (but it sure is comfortable).
4. **Supportive devices**

The most common is the maternity support belt sold at most maternity stores. This is a long elastic band with Velcro at each end that is worn below the pregnant belly in front, and across the low back.

Target sells a “Tummy Trainer” in the exercise section. This is wider and also less expensive than the maternity support belt, and it is very soft. A useful aid. Belly Bands are popular also.

For more discomfort full abdominal supports are available: Baby Hugger (1-888-770-0044 or www.babyhugger.com) Loving Comfort (call 800-344-0011 or www.maternitiesupport.com).

5. **Gel Foam (Memory Foam) Mattress Covers**

These come in different sizes and different thicknesses. A 4-inch thick memory foam or gel foam mattress pad provides extra comfort and padding, which can help sore backs and sore hips.

6. **Medical Care**

Heating pads to the low back are okay. Cool gel packs or ice packs can help if the pain is strong. Patients can be referred to specialists. Physical therapists can help low back pain. They can be seen independently or through the office of most orthopedists.

Physical Therapists or Chiropractors can be helpful, but some caution is needed. A chiropractor should have special expertise in pregnancy, use a special table for pregnant women, and use gentle techniques. Avoid the “holistic” chiropractors that claim to be able to cure cancer and diabetes and who promote Chinese herbs and other “non-traditional” therapies.

Physical Therapy groups:
- ATP Training in South Pasadena: 626-403-6545
- Evergreen Physical Therapy in Pasadena: 626.683.8536

14) **MULTIPLE GESTATION (TWINS AND TRIPLETS)**

The care of patients with multiple gestation is an important part of our practice. Since being in practice, we have had the privilege to participate in the care and delivery of over 200 patients carrying either twins or triplets (190 sets of twins, about 15-20 sets of triplets and 3 patients with quadruplets). Dr. Jick’s first years in practice were with Dr. Marc Lebed, an expert in high-risk pregnancy. Together, they delivered a lot of multiples!

We have special protocols for caring for patients with multiple gestation. We perform many more office visits and many ultrasounds. We use different nutritional supplements. We educate patients extensively about the early warning signs of preterm labor. We discuss activity levels and restrictions, curtailing of exercise, when to stop working and when to begin increased bed rest. We use fetal fibronectin testing (fnf) and cervical length ultrasound to assess for risks of premature labor.

15) **PREPARING FOR CHILDBIRTH**

A. **HUNTINGTON HOSPITAL CHILDBIRTH EDUCATION CLASSES (626-397-8768)**

1. **Childbirth Preparation Class – A 3-part class**

   Includes signs of labor, stages of labor, pain relief during labor; covers issues relating to the last month of the pregnancy. Start planning at 24 weeks and try and arrange for this series to begin about 32 weeks gestation (about 2 months before your due date). This class also includes medical information about hospital procedures such as fetal monitoring, induction of labor, Cesarean Section, epidurals and newborn procedures. Some Saturday classes with both sessions might be available, plan ahead!

2. **Infant Care – A 2-part class**

   Includes postpartum recovery for the mother, life with a newborn, baby’s behavior and basic newborn care. This is important stuff if you are about to deliver your first baby! Some Saturday classes with both sessions might be available, plan ahead!
3. **Breastfeeding Basics – 1 class**

Includes information about benefits of breastfeeding and various ways to help ensure a good breastfeeding outcome. Also covers nursing positions, latching on/off, milk supply and how to monitor the infant.

4. **Maternity Tour – Call 626-397-5037**

1st Sunday at 2:00 p.m. and 3rd Monday at 7:00 p.m. Braun Auditorium. No reservations needed, just show up!

For all of the above classes, it is a good idea to register well in advance, (ideally around week 24 of the pregnancy) since these classes are very popular and some time slots fill up quickly.

For more information, please call the Childbirth Education Office at 626-397-8768. Fax 626-397-2923. If you do not receive a return phone call or confirmation of your registration within a few days, please call again.

Online registration is available. Go to: [www.huntingtonhospital.com/childbirthclasses](http://www.huntingtonhospital.com/childbirthclasses)

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**B. THE FAMILY ROOM (626) 234-2106**

This is a new business located in San Marino, but the concept is long overdue for our community. The entire focus of The Family Room is on the expecting couple and their newborns and infants. The owner has assembled numerous experts, covering the fields of prenatal education, prenatal exercise, diet and nutrition (for pre-pregnancy, during pregnancy and during lactation), breastfeeding support and more. They have postpartum doulas who can come to your home after you deliver.

They teach a lot of classes, more than 20 different classes so far and they have been open only since 2014. Topics include classes on Grandparenting, preparing for twins (the owner has a set of twins and a singleton), getting pregnant, breastfeeding, infant care, infant CPR, mommy and me, pre- and post-natal exercise, and many more.

They are on the web at [www.familyroomcenter.com](http://www.familyroomcenter.com) and also on facebook

**C. THE CRADLE COMPANY**

The Cradle Company is located at 1359 N Hill Avenue, Pasadena, CA 91104. [www.thecradlecompany.com](http://www.thecradlecompany.com) phone: 323-662-0100. We are happy to promote their services to our expecting and postpartum families.

They provide:

- **Doula/Baby Nurse Services**: Postpartum caregivers assist parents during their transition home with newborn. Caregivers are available to assist with day/night care, bottle/breastfeeding, and infant care education.

- **Childbirth Education**: Real evidence based information to help you and your partner prepare for one of the most important days of your life.

- **Pediatric Sleep Services**: Sleep consultations are personally tailored to your child and provide families with detailed strategies to improve their infant/toddler's sleep habits.

- **Breastfeeding Services**: One-on-One consultations with Board Certified Lactation Consultants as well as support groups, drop-in services, and prenatal breastfeeding education.

- **Parent & Me Groups**: Interactive new parent groups offering an intimate, non-judgmental space to discuss child development and parenting.

**D. WHAT ABOUT BRADLEY?**

Bradley birthing classes are an alternative to traditional Prepared Childbirth Classes, and there are some differences worth mentioning here. Generally, the Bradley series is more comprehensive. There are more classes and more material is covered such as breast-feeding. There is also a strong emphasis on natural childbirth, drug-free deliveries and the active participation of the partner. For the most part, we support this type of birth preparation class, but we have some concerns as well.
The obstetrician’s job is to use medical knowledge, training, skills and judgment to do everything possible to ensure the health and safety of you and your unborn child. At times, this may interfere with a planned natural or low-intervention childbirth. In any situation that poses a potential risk to either the patient or the unborn baby, we will always explain what the concern is and what we think should be done about it and we will make the decisions together. This is where a trusting doctor-patient relationship is very important.

Through experience, we have learned that Bradley classes promote a strong anti-doctor and anti-hospital philosophy. Students are told “horror stories” about what happens during labor and childbirth. They are advised to be wary of what they are told by their medical caregivers, occasionally to the point of becoming adversarial. They are encouraged to refuse all manner of medical procedures and tests. The basic trust in the doctor-patient relationship becomes damaged which interferes with our ability to provide the best medical care possible.

If during pregnancy these issues become significant, rather than risk a possible conflict or confrontation at the time of your delivery, we will help arrange transfer of your care to another doctor more in agreement with your philosophy.

E. LAMAZE LAUGH AND LEARN

We learned from a patient about a great DVD-based childbirth preparation series:

“Hello, my name is Sheri Bayles, RN. I am an award winning Certified Lamaze Instructor and International Board Certified Lactation Consultant with 20 years of experience teaching at New York Presbyterian Hospital. I’ve taught over 5,000 couples, including many celebrities. My video 'Laugh and Learn About Childbirth' is the only complete childbirth course on the market. I cover all aspects of labor and delivery, including pain relieving options, as well as the entire Lamaze training - including one breathing technique and natural childbirth. My classes are taught in 6 easy to watch lessons.” [http://www.officialchildbirthclassdvd.com/](http://www.officialchildbirthclassdvd.com/)

F. BIRTH PLANS AND BIRTH PREFERENCES

The Birth Plan (we prefer the term Birth Preferences) refers to a patient’s (couple’s) preferences regarding her (their) labor and delivery. Sometimes it is a brief conversation with the OB doctor. Sometimes it is a piece of paper with a few general comments. Sometimes it is 2-3 pages or more of single-spaced sentences.

Many Birth Preferences are similar. Patients want to have mobility during labor, they want to minimize invasive procedures, they want their husband to cut the baby’s cord, they want the option of a drug-free birth, with the possibility of epidural if requested, and they would like to try to avoid episiotomy and avoid a Cesarean Section. We understand the need and desire to have the events of your birth proceed as closely as possible to your view of what is ideal, and we always try to help you achieve these goals.

However, it is important to understand that not all of the events of anyone's labor or delivery can be completely predicted. In general, the more aspects of the delivery that you feel need to be a certain way, and the more control that you feel you need to have, the more likely that actual events will deviate, and the more likely you may be disappointed after all is said and done.

Every labor is different. Every birth is different. Sometimes, no matter how healthy and prepared you are, the childbirth experience goes awry. This is why we deliver babies in the hospital, and this is why you go to an Obstetrician for your prenatal care and delivery.

Our preferred Birth Plan is a verbal conversation. However, if you have prepared written "Birth Preferences", they need to be reviewed by one of the doctors here so we can discuss them together. You may have requests or preferences that we feel are not safe medically, and which should be discussed prior to going into labor. We request that your “preferences” are kept to one page double-spaced, and avoid words such as "refuse", "must" or "won't". We also prefer that the title “Birth Preferences” be used as it indicates a sense of flexibility.

We strongly urge couples to have an open mind regarding the events of their upcoming childbirth. The last thing we want is for you to be disappointed after delivery because everything did not go exactly as hoped or planned.

Our goals are: first, a healthy baby and a healthy mom; and second, a safe vaginal delivery. We promise to do the utmost, to use all of our experience, skill and judgment to help you have a safe childbirth experience as close to that which you desire. That is our Birth Plan.

*Please see the appendix at the end for our common Birth Plan items.*
G. THE PEDIATRICIAN

After the baby is born, he/she immediately becomes the patient of the Pediatrician whom you have selected. Therefore, it is important to decide in advance of the delivery who this will be. We recommend that you choose your Pediatrician during the final 2 months of the pregnancy.

We provide a list of some local Pediatricians (at the back of this booklet). Some patients will have to choose doctors from amongst those who are on their insurance plan. If the Pediatrician is not located here in Pasadena, find out if he/she has admitting privileges at Huntington Hospital. If the doctor does not have admitting privileges, we can select a Pediatrician to be responsible for the baby from birth, until the baby is discharged home.

H. VAGINAL BIRTH INFORMATION SHEET

You will receive a copy of the Huntington Hospital Vaginal Birth Information Sheet. Every patient coming into the hospital who is planning on trying for a vaginal birth needs to read this sheet and sign a document that have read and understand the information. At any time during the pregnancy if you have any questions about the information on this document, please let us know.

16) CORD BLOOD BANKING

Cord Blood Banking (Stem Cell Preservation)

At the time of delivery, excess umbilical cord blood can be preserved. This blood is the baby’s, and it is rich in a type of cell called stem cells. These cord blood stem cells have the ability to become bone marrow cells, and they have been shown to save lives when used as donor cells for a bone marrow transplant. Bone marrow cells produce the red blood cells, the white blood cells (immune fighters) and the blood platelets (blood clotting cells). Over 75 different diseases have been cured using cord blood stem cells in this manner, and to date there have been over 20,000 cord blood transplants performed throughout the world.

Cord blood cells can be given back to the same individual if that person needs a bone marrow transplant in the future. This is the ideal situation because the cells are genetically identical. These cells also often match a brother or sister, and can be used if they ever need a bone marrow transplant. A genetically similar donor will greatly lower the risks of this high-risk procedure.

Regenerative Medicine

There is growing understanding that cord blood stem cells have additional potential. In the laboratory, these cells have shown the ability to help repair other damaged organs such as heart, brain or spinal cord. This field of study is called regenerative medicine. Some scientists are studying the use of cord blood cells to try and cure juvenile diabetes. Success stories are few so far, but there are over 200 research trials underway at the present time.

Three Options

There are 3 choices on what to do with cord blood at the time of delivery. One is to pay money to save it for your own use. This is called Family banking. Another choice is to donate the cord blood to a public bank. Currently there are no local banks doing this. The third is to throw away the blood. This is what happens 95% of the time.

The decision on whether or not to use Family banking of your baby’s extra cord blood depends on many factors. There is a significant cost for obtaining and preserving umbilical cord blood plus yearly storage fees, however many companies offer payment plans and discounts to try and help out.

Also, the chance that your own child will one day need a bone marrow transplant is low, but as genetic research advances, there may be new indications for this procedure that to date we are not aware of. This decision cannot be made in the delivery room. It should be made at least 2 months before the due date.

Which Company?

If you have decided to save the cord blood, you also need to decide which company to go with. There are many that advertise. One company we like is the Cord Blood Registry (www.cordblood.com). They were the first company to do this, and they are the largest service provider of this procedure. They have an excellent web site. For
more information, please call the Cord Blood Registry at 1-888-CORDBLOOD (1-888-267-3256). They also offer
the option of saving a segment of the umbilical cord itself.

Another excellent company is StemCyte (www.stemcyte.com). They, too have a very informative web site. Call
them at 626-646-2500. They are a local company and they offer tours of their facility. StemCyte also allows
you to save the cord segment in addition to the cord blood.

If you are researching the world of cord blood banking, public donations vs., private family banking, a good

17) CIRCUMCISION

Circumcision refers to the surgical removal of excess foreskin from the tip of the male newborn’s penis. It is
usually performed in the hospital on or after the day after the baby’s birth, and at Huntington Hospital usually by the
attending obstetrician. Local anesthesia is used routinely now for most circumcisions, although the baby still does
fuss and cry briefly. The procedure takes less than 2-3 minutes. We use the method known as the Gomco clamp.
(There is no plastic piece that needs 1-2 weeks to fall off.) The penis is wrapped in Vaseline gauze when we are
done.

1. Updated Guidelines for Newborn Circumcision

On August 27, 2012, the American Academy of Pediatrics (AAP) released an updated Policy on Circumcision
(1). According to this policy: “…the health benefits of newborn male circumcision outweigh the risks…” The
specific benefits identified included prevention of urinary tract infections, penile cancer, and transmission of some
sexually transmitted infections, including HIV.”

In the 1980’s, newborn circumcision was performed on more than 80% of all newborns. Now the rate is down
to about 55%. One major reason for the large drop was the widely distributed and publicized policy released in
March, 1999 from the American Academy of Pediatrics. At the time, according to the AAP, the risks of
circumcision did not justify the benefits.

Thus, even in 1999, the AAP acknowledged that there were benefits to newborn circumcision, but they felt that
the decision was not really a medical one since there were also minor risks. This took the medical profession out of
the decision-making process. Parents were told that they had to choose or not choose the procedure based on other
factors such as cultural, religious or personal preference.

2. What are the benefits of newborn circumcision?

Recent studies (2) have now scientifically proven that circumcised newborn males are less prone to urinary
tract infections (UTI’s) infections during their first year of life. A UTI occurs in 1% of all uncircumcised male
children under age 1 and the reduction of UTI was from 3-10 fold in circumcised males (from 14 in 1000 to 2 in
1000).

Circumcision protects males from three different sexually transmitted diseases (STD’s)! It turns out that
uncircumcised males have twice the risk of acquiring HIV, herpes (HSV) and human papillomavirus (HPV) as
adults compared to circumcised males.

3. What about the risks of the procedure?

One of the most common reasons not to perform a circumcision was concern about future diminished sexual
sensation in circumcised males. This is not easy to study, but in a review of the literature (according to the NEW
AAP policy: “There is fair evidence that no significant difference exists between circumcised and uncircumcised
men in terms of sexual function.”

The rate of complications of this minor procedure is quite low, on the order of 1 in 500 procedures. Bleeding,
the most common complication, is usually very minor and easily treated. The rate of serious complications, such as
penile injury, was less than 1 in 2,500 cases.

The AAP did not go so far as to advocate that all newborn males should have a routine newborn circumcision.
But, the new policy is a significant change in direction for the organization and thus for the medical profession as
well.
What about pain medication?

For many years, the policy has been to use some type of injectable pain medication such as lidocaine during newborn circumcision. The NEW policy supports this as well.

Summary

Newborn circumcision is a safe procedure. It can be performed quickly and nearly painlessly, normally taking place in the hospital soon after birth. There are true, proven benefits to newborn circumcision and compared to the rare risks, we feel that these benefits outweigh the risks. We therefore advise our patients to strongly consider having their newborn males circumcised.

1. AAP CIRC Policy Statement
   http://pediatrics.aappublications.org/content/early/2012/08/22/peds.2012-1989

2. AAP CIRC Technical Report
   http://pediatrics.aappublications.org/content/early/2012/08/22/peds.2012-1990

All of the physicians here perform newborn circumcisions. There is a separate fee for these which is your responsibility to pay. We never know which insurance the newborn will be covered by, so we have to bill the patient for the procedure. In turn, we provide you the paperwork that allows you to bill your insurance company and be reimbursed by them.

For Care after circumcision: see postpartum instructions.

18) NEWBORN SCREENING TESTS

The California Newborn Screening Program screens all newborns for dozens of conditions, including PKU, disorders of hemoglobin, thyroid disorders, adrenal disorders and fatty acid metabolism disorders. The test is done by drawing a few drops of blood from the baby’s heel (about 18-24 hours after birth) and sending it to a state laboratory. The results are then sent to your Pediatrician. All babies have this testing done automatically.

The value in performing newborn screening is that there are rare conditions which can be identified immediately at birth, long before any harm or damage has occurred to the baby. After making the diagnosis, treatment can be implemented immediately, either completely preventing or at least minimizing the extent of harm that can be caused by the condition identified. For more information, you may contact the Genetic Disease Branch of the California Dept. of Health Services at 510-412-1502.

19) FETAL TESTING – NON STRESS TESTS (NST’S)

We provide routine NST testing for many reasons, which include not delivering by the due date, babies that seem to be too large or too small, cord around the baby’s neck on ultrasound, multiple gestation, decreased fetal movement, high-risk pregnancy or patients with medical conditions such as high blood pressure, diabetes, premature labor and for other reasons as well.

A non-stress test is an office visit that takes from 30 to 60 minutes. You are placed on an external fetal monitor, similar to what is used during labor, and then you lie down and rest. There is no discomfort. The monitor creates a paper printout (called the tracing) showing the fetal heart rate changes and uterine contractions. We read the tracing and determine if the baby is getting enough oxygen and blood flow, which is the case the great majority of the time. Abnormal NST’s can be managed many ways such as by repeating the test the next day, or sometimes by sending the patient to Labor and Delivery for additional testing.
20) OVERDUE

We do not consider a pregnancy overdue one day past the due date. The textbook definition of a full-term pregnancy is 37 to 41 weeks, therefore 41 weeks is considered to be overdue.

1. **Being overdue is associated with the following possible problems:**
   - increased size of the baby leading to increased chance for a C/S
   - increased chance that the baby will pass meconium (have a bowel movement) during labor. This material can sometimes get in the baby’s lungs before the birth which might lead to breathing problems after delivery
   - increased chance that the placenta will lose some function because it is “aging.” This is gradual and rarely a problem, but placental aging can lead to decreased placental blood flow to the baby. This in turn can lead to decreased oxygen to the baby and this is what we call fetal “stress.” Fetal stress is often worse during labor due to the contractions which briefly reduce blood flow even more. Therefore babies under stress also are at higher chance of being born by C/S.

2. **We begin twice a week non-stress testing starting at the due date, and we also examine the cervix. Sometimes we will advise inducing labor due to being overdue. When the baby is doing well on the testing, sometimes we will continue to watch and wait, knowing (and hoping!) that the patient can go into labor at any time (hopefully soon).**

21) HUNTINGTON HOSPITAL

A. LABOR AND DELIVERY

We perform all of our deliveries at Huntington Hospital. The Main Building contains the Labor and Delivery Unit, Postpartum (Maternity), the Newborn Nursery and the Neonatal Intensive Care Nursery (NICU) on the same floor. Deliveries occur in LDR (Labor, Delivery and Recovery) rooms. In this room you may have your entire labor, a vaginal delivery and about a 1-2 hour recovery time all without changing beds. Afterwards you transfer to the postpartum (Maternity) area, where nearly all rooms are private. There are also 3 operating rooms that can be used for either Cesarean birth or vaginal birth. Rooming-in with the baby is available in the maternity department.

B. SKIN TO SKIN

Skin to skin is a practice that involves placing the newborn baby on the mother’s skin very soon after the delivery, perhaps within 5-10 minutes. A newer variation of this is to deliver the baby right onto the mother’s abdomen and leave him/her there for a while. Just be aware that right out of the womb the baby is normally covered with fluid, blood and often the baby voids or defecates as well. If you don’t mind having all this mess, then go for it!

This helps to promote mother-infant bonding and is a very special time. It also helps to promote breastfeeding. Once you are transferred to the Maternity Unit, we encourage moms and dads to try skin to skin contact. It feels great and babies love it too!

C. SPECIAL SERVICES

Huntington offers a comprehensive range of services designed to provide you with the maximum amount of safety and security should the need arise. There is an excellent Neonatal Intensive Care Unit should the newborn have any problems, with 24-hour availability of a Neonatologist (newborn care specialist). There is 24-hour availability of an OB Anesthesiologist solely responsible for Labor and Delivery patients. There is 24-hour-a-day availability of Operating Room personnel should an emergency arise requiring immediate surgery. There is also a 24-hour-a-day “emergency” Obstetrician who is in the Labor and Delivery Unit should an emergency arise and the doctor has not yet arrived.

D. NEONATAL INTENSIVE CARE UNIT (NICU)

Huntington Hospital has one of the biggest, busiest and best NICU’s in Southern California. There is a NICU physician in the hospital 24-hours-a-day. During delivery, there may be circumstances where we need to have the neonatal team at the birth. Some reasons for this are meconium-stained amniotic fluid, fetal distress or premature
birth, to name a few. When the “team” is present, right after delivery the baby is placed in the warming bed and they begin their evaluation. Afterwards, they may decide that the baby needs to be admitted directly to the NICU, but usually they determine that the baby is fine and can proceed to the normal newborn nursery.

If your baby is admitted to the NICU, be sure to take advantage of emotional support offered by The Parent Connection. Composed of a group of parents who have had babies hospitalized in the NICU, they have regular meetings and provide one-on-one support. For more information, call 626-398-8509.

E. THE LABORIST PROGRAM AT HUNTINGTON HOSPITAL

There is a program at Huntington Hospital called the Ob Hospitalist Service, but many of us use the term laborist. This means that a Board-Certified Ob/Gyn doctor is physically present in the hospital 24 hours a day. This doctor works for the hospital and provides services to patients in the labor and delivery unit depending on the situation.

The most important reason for the presence of the laborist is in case of emergency. We know that sometimes an incident can occur at any time of the day or night where the immediate presence of an experienced obstetrician can be vital. Private doctors are on-call but they are not always physically present in the hospital, especially at night, weekends and holidays. This is the main function of the laborist, to be available in case of a true emergency, when your own private obstetrician is not present in the hospital.

Laborists are also willing to step in to provide OB services for our patients in non-emergency situations. Your private obstetrician may request the assistance of a laborist from time to time as the need arises.

F. RONALD MCDONALD HOUSE

If your baby is admitted to the NICU, sometimes he/she may need to remain in the hospital even after you have been discharged. If you would like to be close to the hospital 24/7, you may want to contact Ronald McDonald House. Located across the street from Huntington, they offer a lovely bed and breakfast-like atmosphere at a very low cost and are open to any family whose child is in the Hospital. Please call them at 626-585-1588.

G. HOSPITAL FOOD – AFTER DELIVERY – CALL EXT 3663

Huntington has a Room Service program for all meals. You are provided a menu. Nobody comes to take your order, you have to call ahead. It can take 30 to 45 minutes for your food to arrive. There are set windows for meal times, for example dinner is only served from 4 pm to 7 pm. Please be aware of this. If you are hungry at off-times and are on a normal diet (called a regular diet), you can eat whatever you like, so someone can bring food to you. Just ask them. No one says no to a new mom!

The hospital cafeteria in the West Tower is wonderful. At the north end is an outdoor patio and fountain. It is very pleasant. The cafeteria is open about 20 hours out of 24 and pretty decent food can be obtained there, plus they sell lots of snacks and juices. Also, there is no restriction on food brought in from outside, so you may want to pack some non-perishable snacks for after delivery, or have someone bring you something to eat or drink after you arrive in the postpartum Maternity Unit.

H. HOSPITAL STAY

Discharge from the hospital after delivery is flexible. After vaginal delivery the length of stay is up to 48 hours. The day after a vaginal delivery, a patient may go home if she feels fine and wishes to leave. After cesarean section the usual stay is 3-4 days. Discharge time is about 12:00 noon, and there is a 10:30 a.m. class most new mothers (and dads/significant others are welcome to come also!) take on the morning of discharge.

I. THE HOSPITAL IS “LOCKED DOWN” AFTER 8 P.M.

Every night at 8:00 p.m., after visiting hours end, all doorways into the hospital are locked except for one, the Emergency Dept. (E.D.) After 8 p.m., all labor patients must enter the hospital using this entrance only. Someone will be there to escort you to Labor and Delivery. There is valet parking and hospital security outside the E.D. entrance.
J. VISITING HOURS AND RESTRICTIONS

Normal visiting hours for the Hospital are from 11:00 a.m. until 8:00 p.m. However, in the Maternity Area only, there is Nesting Time from 2:00 p.m. until 4:00 p.m. During Nesting Time visitation is further limited.

All visitors need to obtain a visitor’s pass. These can be obtained at the information desk in the main lobby and also in the Emergency Room waiting area after 8 p.m. No more than 3 visitors are allowed in a patient’s room at a time, and one of them has to be the spouse or designated support person. Passes have to be returned when the visitor leaves.

K. HOSPITAL REGISTRATION

We provide this form to you on the OB thumb drive or you can download it from the Huntington Hospital website. Please complete it and mail it (or fax it) to the Hospital by your 7th month of pregnancy. You should expect some mail from the Hospital after sending in the registration, usually about 1 month before the due date. If you have not yet selected a pediatrician, it is okay to mail the form anyway. Then, just let the hospital know who the Pediatrician will be when you are admitted for your delivery.

L. HOSPITAL LABOR AND DELIVERY TOUR

There is a program that includes a presentation and Labor and Delivery tour designed for the new maternity patient and their guest. Refreshments are served. These are held twice a month (1st Sunday at 2 p.m. and 3rd Monday at 7 p.m., holidays excluded) at the Braun Auditorium at Huntington Hospital. No reservations are necessary. For more information, call 626-397-5037. We recommend arriving early enabling you to get into the first tour groups.

M. VIDEORECORDING AND PHOTOGRAPHY DURING LABOR AND DELIVERY

Huntington Hospital has Restrictions on video recording (including cell phones or camcorders) and photographing childbirth. They do not allow direct filming/recording of any medical procedure, including the actual moments of birth and any newborn medical care. Tripods are not allowed either. Video recording and photography of the patient before and after the delivery, and of the baby after the delivery is allowed provided that the mother and/or the baby are considered medically stable.

This policy reflects a trend that we are seeing across the country, which is a concern that routine gestures, procedures and comments can be scrutinized, reinterpreted and replayed to such an extent that those viewing the images will believe that something improper has taken place.

22) LABOR AND DELIVERY

A. WHAT TO TAKE TO THE HOSPITAL

From your first arrival in the hospital until your discharge home, your stay may include between 3 and 6 different rooms. Light packing is the key and bring a minimal amount of stuff to the labor suite. Do not bring expensive items such as watches or jewelry and do not bring large amounts of cash.

- Cord Blood Donation kit, if you are doing this. Keep the kit in the open so we know that it’s there. Be sure the nurse draws extra blood for use in the Cord Blood Kit (avoids a 2nd blood draw later).
- Listening to music during labor is nice. Many people bring an ipod, iPad, iWhatever.
- Labor support items such as tennis ball and other back rubbing devices, small fans, special photos
- Any prescription medication you are taking. All prescription drugs must be in their original container with the medical label attached.
- Chap stick is a good idea.
- Slippers or warm socks (older ones are better in case they get soiled).
• Perhaps a favorite pillow.
• If you wear contact lenses, bring glasses as a back-up.
• Camera (charged), extra batteries, video camera and charging cord. Cell phone and charger, plus a list of phone numbers to call from the birthing suite. Don’t forget the charging cords – for your cell phones, iPads, cameras, laptops, etc.
• Bottled water or clear juice. Perhaps some snacks for afterwards or for guests or dad.
• If epidural is planned, you may have “free time” during labor. Reading materials, playing cards, DVD’s and laptop PC’s may come in handy (don’t laugh).
• All items needed postpartum, such as overnight toiletries and clothing should be kept in a separate case, maybe even in the car, to be retrieved after your arrival in the postpartum area.

B. WHEN TO COME TO THE HOSPITAL FOR NORMAL DELIVERY

After you have reached 37 weeks, you are considered full-term. Only at this point in pregnancy do the following guidelines apply:

• If this is your first baby, for routine labor pains you should try to wait, and call us once the contractions are regular, about every 5 minutes, lasting 45 to 60 seconds, and are strong and uncomfortable (it is difficult to talk through the contraction) and this has been continuing for about 1-2 hours.
• The “5-1-1” rule: contractions every 5 minutes, 1 minute long, for 1 hour (and strong).
• If this is a subsequent pregnancy, call when the contractions are regular, about every 6-8 minutes and uncomfortable (not yet painful). Basically, when you feel like you are in labor, you probably are.
• Also, if there has been any leakage of fluid per vagina that could be amniotic fluid, you should call us.
• *In the middle of the night (usually 10 p.m. to 6:00 a.m.), if the above occurs, you should go directly to Labor and Delivery without calling the doctor. You will be checked after your arrival and they will contact the doctor and report to us how you are doing.
• Please DO NOT CALL for bloody show or for signs of early labor. The idea is to call us when it is likely that it is time to come to the hospital to deliver. Bloody show and early labor mean that it is too soon to come to the hospital. As always, do not hesitate to call us if you are concerned, or if you are not sure what to do.
• Note that after 8:00 p.m., every entrance to the Hospital is locked except for one. The only open entrance after 8:00 p.m. is the Emergency Department (ED) entrance located at the West end of Congress Street, 1 block west of Fair Oaks, 1 block south of California Blvd.

C. THE OB EMERGENCY DEPARTMENT (OB ED)

Effective in 2015, Huntington Hospital has opened up their OB ED (Obstetrical Emergency Department). This is a special area located in the Labor and Delivery Unit. ALL Ob patients, who are 20 weeks pregnant or beyond, coming to Huntington Hospital for urgent problems or emergencies, are directed to the OB ED.

This includes conditions such as:

• possible labor or preterm labor
• possible rupture of membranes
• vaginal bleeding or spotting
• decreased fetal movement
• major illness after 20 weeks of pregnancy
• evaluation after a fall or accident
• and more
**Medical Screening Exam**

The purpose of the OB ED is for you to be evaluated as soon as possible after your arrival. In order for this to consistently occur, there is an Ob/Gyn physician assigned to the OB ED 24 hours a day. His or her job is to perform a Medical Screening Exam (MSE) on every patient presenting to the OB ED, in order to determine if your condition is stable, or urgent, or rarely a life-or-death emergency.

A MSE is usually a brief exam, for the purpose of collecting enough information to determine the urgency of the situation. It is not designed to be a full and complete evaluation, which is why it is called a screening exam.

Once the MSE has been performed, your regular Ob/Gyn physician (or the physician on-call for our group) is notified of the results of this exam. That doctor then assumes all subsequent care and responsibility for you. After the OB ED physician performs their brief MSE and speaks to your physician (or on-call colleague), their role in your care has been completed.

The OB ED Ob/Gyn physician might be the on-duty Laborist, might be an assigned Ob/Gyn community physician, and may or may not be one of the doctors in our On-Call group. Their job is just to perform a medical screening exam. After that, your regular Ob/Gyn (or on-call colleague) takes over your care.

**D. LABOR MANAGEMENT (SEE APPENDIX FOR BIRTH PLAN COMMENTS)**

Assuming that you have no complications of pregnancy, we do not subject you to very many “routine” procedures during labor and delivery. We do not request perineal (vaginal) shaving. We do recommend an IV (intravenous) line during labor, although a saline lock is an option (this is a short IV catheter filled with saline so you do not have to be connected to the full IV line and bag of fluid).

Episiotomy is an incision made in the area between the vagina and the rectum at the time of the delivery of the baby’s head. It is done to try to prevent spontaneous lacerations or tears of the vulva, vagina, urethra or clitoris. Many patients wish to avoid an episiotomy. We believe that patients truly wish to avoid or minimize any damage to that part of the body, and that is our goal. However, at times there may be a medical indication for episiotomy, such as fetal distress, or to prevent a potentially large tear. Our goal is for you to go home with the fewest stitches possible!

We do believe in the use of external electronic fetal monitoring. This need not be continuous and we offer intermittent monitoring at your request. Internal fetal monitoring is performed for medical indications. You are not “strapped down” in bed during labor. Patients may ambulate during labor, go to the restroom, even shower if they wish to (and if there is no medical contraindication).

It is important to understand that an obstetrician is responsible for two patients, the mother and the baby. If a situation presents itself that appears to put the fetus at risk, then the doctor is obligated to suggest and encourage interventions designed to minimize and/or prevent a possible adverse outcome. This may mean completely disregarding a “Birth Plan” and implementing various degrees of medical care including the possibility of Cesarean Section.

Some patients want to have an entirely natural delivery. No medications, no fetal monitoring, no intravenous, and essentially little or no medical intervention, almost like a home birth. Our advice is that you would be much better off finding another obstetrician who would be more accommodating to these preferences.

**E. DOULAS**

The use of a doula as a support person during labor can be quite helpful. Their role is to provide emotional support and comfort for the laboring patient, which they can do quite well. The reason most people hire a Labor Doula is that they want a fully natural childbirth without any pain medication. If an epidural is planned, the role of the Doula becomes diminished and might not be as valuable to you.

Doulas have limited medical training, and they are should inform you that they are not medical care providers. Most doulas have been certified by an organization called DONA (Doulas of North America). Please see the DONA website for more information: [http://www.dona.org](http://www.dona.org). We have worked with many different doulas and overall have found their assistance encouraging and positive.
Unfortunately, there are some doulas that have a negative attitude toward traditional medical care, hospitals and doctors. Although childbirth is a natural process, we feel that it is best done in a hospital due to the occasional serious and unexpected problems that can arise. When this occurs, a doula that tends to distrust hospital personnel can sometimes interfere with the delivery of proper medical care, and this will not be allowed.

There are also doulas that specialize in postpartum care for mother and baby after they arrive home from the hospital. (See Cradle Company). Please see the phone number section at the end of this booklet.

F. EPIDURAL ANESTHESIA

Anesthesia (pain relief) is available 24 hours a day. Huntington Hospital is one of the very few Los Angeles hospitals to offer around-the-clock dedicated obstetrical anesthesia coverage. There is a different anesthesiologist on-call for emergency room and trauma patients. Therefore, an anesthesiologist is always in or near the labor area. Epidural anesthesia is available at all times, upon your request. You do not have to “make a reservation.”

1. Epidural Myths

Myth: Epidurals can make you paralyzed.

We have seen thousands of patients who have received labor epidurals, but have not yet seen someone permanently injured by one, but it is theoretically possible. (We also drive on the freeway and travel by airplane knowing that there is a remote risk of death or severe injury with these activities as well.) Dr. Jick has rarely seen a nerve stretch injury which took weeks to months to resolve, but it did resolve. For example, sometimes the legs are stretched way back during the pushing phase of labor. The epidural masks the pain that would normally result if the leg stretching is excessive. Thus a nerve stretch injury in the groin or buttock area can occur.

Myth: Epidurals lead to a high risk of Cesarean.

There is some data to suggest that giving an epidural too early in labor increases the chance for a C/S. The practice now is to wait until the patient is at least 4 centimeters dilated (signaling the onset of the active phase of labor) before allowing an epidural. So far, this does not seem to increase the C/S rate. In fact, in many cases epidurals can prevent a C/S, by relaxing an otherwise anxious and suffering labor patient.

Myth: Epidurals will stop labor.

If given too early, epidurals can slow down labor. By waiting until 4 cm. dilatation before placing the epidural, this rarely happens. If the labor does slow down, we can use Pitocin to carefully and gradually bring the labor back to a "normal" pattern, or we can allow the epidural to wear off (most patients do NOT want this option).

Myth: "I won't be able to push."

There are times where the patient is so numb that she cannot push, but this happens rarely. Typically, the patient doesn't FEEL the urge to push, but with good coaching she can still push quite effectively. We have delivered LOTS of babies to moms with great epidurals who pushed REALLY WELL, and yet didn't feel severe pain when the baby delivered. Some doctors routinely turn off epidural pumps when it's time for the patient to push, but this is rarely necessary.

Myth: REAL WOMEN DON'T NEED EPIDURALS.

No comment.

2. Epidural Truths

TRUTH: Labor can be fun!

We have seen patients actually enjoy their labor and have fun because of the epidural. Patients can take naps, watch TV, send texts, update their FB, enjoy music, play cards or socialize, all while their body is in booming labor! The birth itself can be nearly painless, and many patients actually sit up to watch the baby as it emerges from their birth canal.
TRUTH: Natural childbirth is just not possible for all women.

Many patients experience so much pain during labor that they actually lose themselves. They can be in so much pain that they scare themselves or their loved ones. For these individuals, the epidural is nothing short of a miracle. To make these women feel guilty, to imply that they are bad mothers, or that they are wimps because they didn't go natural is upsetting. Nobody can feel another person's pain, and the choice of having an epidural should not be stigmatized or somehow interpreted as a “failure.”

TRUTH: There is a "price" to be paid for the epidural.

With natural childbirth, during the pushing, there is an incredible intensity in the room. The coachers are counting loudly, the patient is working hard, sweating, grimacing, moaning and maybe screaming and usually really hurting! Then comes the actual moment of birth. There is a prolonged sharp pain, a final, big push -- accompanied at times by a drawn out intense gasp, followed by a loud and lusty newborn baby cry, whereupon the patient's wail is transformed in the same breath into a tearful shout of pain, joy and relief all at the same moment! The experience is unbelievable, and we understand why many women are determined to have a natural childbirth. The “price to be paid” with epidural is that your birth will likely not be as intense as the above description.

We support your freedom to choose how you will deal with your labor pains. We will support you if you desire drug-free natural childbirth, and we will support you if you want your epidural as soon as you check in to the hospital! Epidurals have proven themselves to be a safe and effective means of having excellent pain relief during labor, however there are some risks and side effects to having epidurals as well. We can further discuss epidural anesthesia to any level of detail that you wish.

G. TAKING HOME THE PLACENTA

It is okay to take home your placenta after delivery. The only exception might be if there was some type of infection or some other unusual birth-related issue where we would need to send the placenta to the lab. The Hospital will prepare it for you to take home. Just make sure to mention this to the Labor nurse before you deliver. There is a minimum 48 hour hold on all placentas from routine deliveries.

There is a service called placental encapsulation. This means trimming off and saving just the meaty portion of the placenta, which is then heated up, sterilized, freeze-dried, ground into powder and placed in small gelatin capsules, enough to last for months. EVERYONE who knows about this will tell you the same thing, they believe that eating these capsules can help prevent postpartum depression. This is a good example of how the public believes something even though there is no medical data or scientific proof of any kind.

(If a movie star does it, then it must be a good idea, right?)

According to a June 2015 CBS news report: “… after reviewing the existing scientific literature on the subject, Dr. Crystal Clark, a psychiatrist specializing in reproduction-related mood disorders at Northwestern University, found that there is no data to support these claims. What's more concerning, she says, is that there are no studies examining the potential risks of eating the placenta, which filters out toxins and pollutants during pregnancy to protect the developing fetus.

"Bacteria and elements such as mercury and lead have been identified in the post-term placenta," Clark told CBS News. "So if the theory is that we retain nutrients and hormones such as estrogen and iron that could be beneficial, then the question becomes what harmful substances can also be retained that could harm the mother or the baby if she is breastfeeding."

Clark and her research team reviewed 10 published studies on the topic, covering both the attitudes and motivations for eating the placenta and the consumption of animal and human placenta by nonhuman mammals. There are no studies of scientific rigor available on placentophagy in humans. The results were published in Archives of Women's Mental Health. (http://www.cbsnews.com/news/no-proven-health-benefits-unknown-risks-of-eating-placenta/).

If you still wish to do this, call Joni Lucarelli at 626-390-0085.

H. INDUCTION OF LABOR

Induction of labor is a procedure where medication is used to either initiate the onset of labor, or to maintain or strengthen labor. Intravenous Pitocin is most commonly used for this. Pitocin causes uterine contractions, and is given in very low doses using a computer-controlled continuous intravenous pump. The first setting is at the lowest
dose, and then the dose is gradually increased until satisfactory contractions have been obtained. We can also induce labor using a medication called Cytotec. This is a hormone inserted vaginally and studies have shown it to be a safe and effective method for inducing labor and/or for helping the cervix soften up.

There are many different reasons why labor may need to be induced. The most common medical indications are overdue babies, elevated blood pressure, history of rapid labor, and suspected big babies (we can induce a bit before the due date, before the baby reached its largest size). Sometimes we induce labor because patients live far away, or have other ‘situational’ reasons, which are referred to as “logistical” indications.

Many patients wonder if there is way to “make themselves” go into labor. Ob/Gyn’s usually advise vigorous physical activity, dancing, walking a lot, having intercourse. All might help. One interesting approach is the famous “Maternity Salad.” This is available at a restaurant called Caioti, in Studio City (818-761-3588). Good luck! (p.s. we are NOT big fans of castor oil. It can work, but can also lead to diarrhea, gas pains, and abnormally strong contractions).

I. VAGINAL BIRTH AFTER CESAREAN (VBAC)

If you have had one previous Cesarean, you may be a candidate for a chance at vaginal birth. There are risks associated with attempting VBAC, such as the possible risk of uterine rupture (tearing of the uterus in the area of the prior C/S scar). Uterine rupture can have serious consequences, including hemorrhage, blood transfusion, hysterectomy, placental separation and/or oxygen deprivation to the baby, rarely leading to fetal brain injury and/or death. Recent data suggests that these risks are higher than previously believed. Patients who have had two or more previous Cesarean sections are not candidates for VBAC.

Based on literature regarding the high risks of attempting VBAC, we rarely offer this option to our patients.

23) CESAREAN SECTION

Many patients ask us about this and we can talk about this subject at length. About one-fourth to one-third of all babies are delivered by Cesarean section, and there are many reasons for this. Medical indications include, but are not limited to: failure of the cervix to fully dilate, fetal distress, twins, breech, herpes, placenta previa, pre-eclampsia (toxemia), previous cesarean section, babies suffering from intrauterine growth restriction (IUGR) or babies that are disproportionately too large to fit through the pelvis.

Our Cesarean birth rate (as many people ask us) is not the lowest in town, and it is not the highest. We feel that every Cesarean Delivery that we do is for appropriate medical reasons. At the time that this decision is made, we thoroughly explain the reasons for the choice so that it is felt by both the parents and the physicians to be the safest and best decision given their particular situation.

Cesarean By Request: The American College of Ob/Gyn supports the concept of a Cesarean Section based on the patient’s request. In this case, the patient would not have to go through labor, and the Cesarean Section would be scheduled about one week before the due date. Our job is to inform you of the potential risks and benefits of this approach when compared with the standard approach of trying for normal vaginal delivery. Some experts believe that Cesarean Section can prevent certain vaginal and pelvic problems that some women experience later in life such as urinary incontinence and pelvic organ prolapse.

If you choose to have your baby by a planned Cesarean, we can arrange this for you.

Cesarean Pre-Op

If we know that your delivery is going to be a planned C/S, we arrange a pre-op visit about 1-3 days before the actual delivery. During this visit, we perform a physical exam and then review the C/S paperwork and procedures. After this visit, you will usually proceed right to the Hospital Admitting Dept. There is more paperwork and you will also meet an L&D nurse who does some pre-op teaching and arranges for a blood draw. This is also a good time to modify your diet by trying to eliminate gassy-type foods such as broccoli, beans or other green veggies, to help minimize post-op discomfort from gas pains (typically the day after the C/S).

24) TUBAL LIGATION (STERILIZATION)

Tubal Ligation (a “tubal”) is an operation to perform permanent sterilization on a woman. The fallopian tubes allow the sperm and egg to meet, and this is where conception occurs. When the tubes are “tied” a small piece of each tube is surgically removed. The other internal female organs (uterus, cervix and ovaries) are not involved in the
procedure, so there should not be any changes in sensation or function of any female organs after a tubal ligation has been performed.

Tubal Ligation can be done at the same time as a Cesarean Section or it can be done shortly after vaginal birth, referred to as a postpartum tubal ligation. When done at the time of a C/S, there is very little additional risk, additional pain or change in the post-operative recovery. It also adds only a few minutes to the overall length of the operation.

As a postpartum procedure, it is performed about an hour after the delivery; however, emergencies in the Labor and Delivery Unit take precedence, and there is a chance that the tubal may be delayed or cancelled. A small incision is made just below the belly button, and the procedure usually takes about 15 to 30 minutes. Discomfort is moderate initially, but is minimal by the second postpartum day making this form of sterilization a very appealing option.

Tubal ligation is considered permanent and not reversible. Although the tubes can be surgically reconnected, the operation to do so involves microsurgery, is time-consuming, very expensive, and often doesn’t work. Many women turn to in-vitro fertilization to attempt conception if they later decide to have another baby. Thus, it is important to be 100 percent sure before having a tubal ligation done. In other words, ‘maybe’ means ‘no’.

25) BLOOD TRANSFUSION AND BLOOD SAFETY

There is always going to be some blood loss with the delivery of a baby. Normally, by the end of pregnancy, the woman’s body has been able to produce about 500 cc extra blood (equivalent to a 1 unit blood donation). This is one reason why taking extra iron and folic acid is important during pregnancy.

Sometimes the blood loss is higher than average. This can occur with a Cesarean Section or if there is a delivery complication such as placenta previa, retained placenta, or postpartum hemorrhage. Most of the time, the body can sustain a great deal of blood loss without a transfusion being necessary. However, in the event of excessive blood loss, a blood transfusion may become necessary to preserve the life and/or health of the patient.

If a blood transfusion becomes necessary, the need is immediate and therefore volunteer donor blood bank blood must be used. It takes days to prepare blood from a relative before it is ready to be transfused. All donor blood is stringently tested per Red Cross and FDA regulations; however, despite thorough testing, there is still a remote chance of acquiring an infectious disease from blood such as HIV (odds are 1 in a million) or Hepatitis C (odds about 1 in 250,000).

If you would not accept blood under any circumstances, even those deemed to be life threatening, it is important that you inform us of this situation. Otherwise, we will assume that you agree to a blood transfusion if it becomes necessary.

26) DISABILITY

A. DEFINITIONS

The law states that a physician can place a patient on disability only if the patient has a medical condition that prevents her from performing her regular job. Patients with high-risk pregnancies can be placed on disability at any time during the pregnancy continuing until 6-8 weeks postpartum. Normal pregnant women can go on disability 4 weeks before their due date (at 36 weeks) and can remain on disability until 6 weeks after a vaginal delivery (or up to 8 weeks after a Cesarean Section). However, a normal, healthy pregnant woman may choose to continue working past 36 weeks gestation if she wishes to.
B. DISABILITY INSURANCE

Once a doctor declares that a patient is medically disabled, the patient may be eligible for benefits provided she has disability insurance coverage. This coverage may be a private policy, an employer-provided benefit or may be through the State of California, which is called the SDI program.

C. CALIFORNIA SDI

The State of California pays disability benefits to employed pregnant women, provided that they are covered under SDI, which is a payroll deduction. Not every employee qualifies for this benefit, and if you are eligible, you still need to file a claim form. We can provide you with the proper claim form, or you can contact any branch of the E.D.D. (Employment Development Dept.). The form is on our web site also. You fill out a brief section, and we do the rest. SDI benefits do not begin until the 8th day after the onset of your disability and they extend until 6 weeks after the due date (or up to 8 weeks if a Cesarean Section). If you are still disabled at that time, you will receive a disability extension form from the State that we need to fill out.

If your disability policy is other than SDI, there likely will be different forms, different guidelines and possibly different terms of coverage. You will need to clarify these with whoever is providing the coverage. We will provide you with a physician’s certificate of disability, and we will be glad to help you fill out your disability coverage forms.

Please note: Wait until AFTER you have stopped working before you fill out the SDI form and submit it to us. Give us the form filled out with your last day of work entered. Do not submit it prior to this date.

How to File an Online Claim with SDI

1. Go to edd.ca.gov
2. Click on File and Manage a claim
3. They will get you set up with an account give you a username and password
4. You will then need to fill out SDI forms (supplemental Disability form)
5. Once you fill out your portion of the form it will give you a receipt number (example: R1000000452139)
6. Call OUR office with receipt number
7. Our office will then do our part online.
8. It usually takes about 5-7 days for them to process after we put our part in the system.

D. DMV HANDICAPPED PARKING PERMITS

Some high-risk patients might benefit from being able to park in handicapped spaces. This can be arranged, so please let us know if you feel that you need this service. It is a temporary permit only.

E. PREGNANCY LEAVE

Disability Leave

If you are disabled and work for an employer with 5 or more employees, you have the right to take unpaid pregnancy disability leave for up to 4 months.

Family Medical Leave Act (workplace more than 50 employees) (FMLA)

Under the federal Family and Medical Leave Act and the California Family Rights Act, female employees are entitled to up to 12 weeks of unpaid leave for the birth of a child (and for other reasons not mentioned here). This leave is unrelated to pregnancy disability leave and may be taken in addition to any disability leave the pregnant employee is entitled to under the Fair Employment and Housing Act. HealthCare insurance coverage must be maintained during this leave.

F. CALIFORNIA PAID FAMILY LEAVE PROGRAM (PFLA)

Starting July 1, 2004 California became the first state in the U.S. to offer paid family leave. Workers can get up to 6 weeks of partial pay per year (within a 12-month time period) while taking time off from work to care for a new baby. Most people get about 55% of their usual pay. The program is funded by an SDI payroll deduction from your paycheck and the payments come from the EDD, a state agency, not the employer. Any worker who currently
pays into the SDI program is automatically eligible for this paid family leave. New mothers who are eligible for 6 weeks of postpartum SDI are also eligible for this paid family leave to bond with the new baby.

For more information, call the EDD at 1-800-480-3287 or go to their web site: http://www.edd.ca.gov. Also see http://www.paidfamilyleave.org/law.html.

G. PREGNANCY DISCRIMINATION

1. Discrimination or harassment against an employee based upon their pregnancy is prohibited by California State Law (the California Fair Employment and Housing Act applies to employers with 5 or more employees) and by Federal Law (the Pregnancy Discrimination Act of 1978 applies to employers with 15 or more employees).

2. Employers must treat pregnant employees who are unable to do certain tasks the same as other temporarily disabled employees.

3. An employer cannot force a pregnant employee to take mandatory leave if she can still perform her essential job functions.

4. California law requires that employers must provide you with any reasonable accommodation for pregnancy that they are capable of providing (such as more frequent breaks for trips to the restroom, or a transfer to a less strenuous or dangerous position while pregnant).

5. Harassing or unwelcome conduct relating to pregnancy, childbirth or related medical conditions is a form of sexual harassment and is prohibited under California and Federal law. An employer is responsible even if the harassment is by a fellow employee or supervisor, if the employer knew or should have known about it and did not take immediate steps to correct it.

6. If you believe that you have been discriminated against:
   • You should begin keeping a paper trail as detailed as possible listing names, dates and content of conversations, keeping copies of all correspondence.
   • Try to work at the least official levels first such as with your direct supervisor. Then proceed up the chain of command. Include your company’s Human Resources Dept. (if there is one). If you are in a union, talk to them. If there is a grievance mechanism, use it.
   • Be aware of deadlines if you decide to file a complaint with a government agency.
   • You need to file a complaint with the Dept. of Fair Employment and Housing less than one year from the date of the discriminating act, and with the Equal Employment Opportunity Commission less than 300 days from the earliest act.


8. EDD has downloadable publications: http://www.edd.ca.gov/pdf_pub_ctr/de8714c.pdf is a fact sheet on disability.

27) BREAST FEEDING

A. BENEFITS OF BREAST-FEEDING

We believe that breast-feeding offers many advantages over bottle-feeding. Breast milk provides maternal antibodies and white blood cells that help boost the newborn’s immune system. This is particularly beneficial for the first 4-6 weeks after birth. Additionally, breast milk fed babies have been shown to have fewer problems with food allergies when they are older. Breast-feeding can be more convenient than bottle-feeding since the milk is always warm, fresh, clean and readily available. Lastly, the emotional bond between mother and child is quite intense and satisfying during feedings.

Exclusive Breast-Feeding: Experts are starting to acknowledge that for breast-feeding to be successful, the goal should be for the baby to be breast-fed 100%, starting right from birth. This can be a challenge, yet the benefits are well documented.
B. ENGORGEMENT

The milk “comes in” between the second and fifth day postpartum. The breasts swell, and can become hard, sore and tender. Proper nursing techniques, along with some hot packs (hot, wet, wrung-out hand towels) should help the let-down. This phase lasts only a few days.

C. SCHEDULING OF FEEDINGS

There has been a recent movement to put the newborn on an exact 3-hour breast-feeding schedule. We are opposed to this for newborn infants. For the first 2-3 months of life, as much as possible, breast-feeding should be done “on-demand.” When the baby is hungry, he/she should be fed! The baby needs to develop trust, to know instinctively that his/her needs will be met.

Most newborn babies are not biologically capable of following a schedule. They may sleep 4-6 hours straight, or get hungry an hour after eating. You must learn to trust your parental instincts. Don’t let your newborn baby cry and suffer in order to satisfy some expert who says that you should “train” the baby to feed exactly every 3 hours.

D. BREAST-FEEDING IN THE HOSPITAL

For many new moms it may come as a surprise that breastfeeding can actually be quite a challenge initially! The baby is sleepy, won’t latch on, sucks for a minute and then stops, or sucks too long causing pain. Furthermore, despite the best intentions of the nurses, new moms often get conflicting advice. What follows are a few breastfeeding tips based on my own experience: (this advice applies mainly to the first few days when initiating nursing)

- Most important: The breast is NOT a pacifier. Do not let the baby suck too long. 5-10 minutes per nipple should be enough. Many new moms think the baby will stop sucking when he/she is satisfied. Not true. Sucking is an instinct and babies LOVE to suck. Sucking is not HUNGER. Sucking too long may damage the nipple, causing cuts, bruising, pain, bleeding and increased risk of breast infection. After breast-feeding is well established, longer times on the breast are fine as long as the nipple is not being harmed.

- Repeat: Sucking is not Hunger. There are early hunger cues such as rooting, sticking out the tongue and fussing. The baby may feed well if these signs are present. If these signs are not noticed, then the baby may begin to cry and be difficult to console other than by feeding. Ideally, the baby goes to the breast when the hunger signs are strong but crying has not yet begun. Crying which can be easily relieved by hugging, holding, playing, diaper-changing, etc. suggests that hunger is not the issue, and perhaps it is not yet time to nurse.

- When babies are hungry, they will latch on readily and suck vigorously. Strong sucking will also help stimulate more milk production for next time. It is better to feed a real hungry baby every 2-3 hours than a barely hungry baby every hour.

- Huntington Hospital is considered a breast-feeding friendly hospital. They really want all new moms to nurse exclusively. The nurses will not suggest a bottle or formula for your baby, unless you ask. During the first few days, there may be little milk production. There is colostrum, which is healthy for the baby, but only a small amount is produced. If no formula is given, the baby will not starve, but will likely lose some weight before leaving the hospital. One of the reasons babies sleep so much the first day or two is Mother Nature’s way of minimizing their hunger and need for food while breast milk production is minimal.

- If you nurse both breasts at one feeding, remember which side was second. Start on that side next time. This way the same breast is not fed from first each time, which over time can cause that breast to become larger than the other one.

- When the baby comes off the breast, the areola is very wet. Let it air dry a few minutes before covering up. Then lanolin (or a few drops of breast milk) can be used to moisturize the areola.

- Lactation Support: If you are having problems nursing, we can recommend the services of a lactation specialist. Electric breast pumps are also available for rental. We recommend the Medela brand.
E. BREAST PUMPS: THE GOOD AND THE BAD

Many women start to use breast pumps immediately postpartum. Pumping can help with milk letdown and can stimulate production. Alternatively, milk can be pumped and then fed to the baby in a bottle, allowing for others to feed the baby, and also allowing the quantity of milk consumed to be monitored. Some women “pump ahead” and purposefully try to produce more milk than the baby needs so the extra can be stored. This is often done in preparation for returning to work. This is the good part, but there is also a negative aspect to using breast pumps.

Relying on breast pumps, even partly, can lead to breast milk overproduction and to lack of synchronization with the baby. What is synchronization? This is when a breast-feeding woman’s milk production and timing is closely related to the baby’s feeding cycles. Not every nursing mom achieves this but many come close. When the baby is breastfed exclusively on demand, and no pump is used, it is possible for the mother’s milk production to exactly match the baby’s needs. When the baby is hungry, the breasts are hard and full about the same time. At night, the mother might wake up because her breasts become hard and tender, and within moments may hear that the baby is waking up and is hungry.

If the pump is used too often, milk overproduction disrupts this timing. The breasts may become hard and full while the baby is asleep. Pumping will empty them, but then an hour later when the baby gets hungry, he/she will be fed with breast milk in a bottle, and this can keep on happening. It can be very tiring to pump the breasts 6–8 times a day (about 10–20 minutes per session), and to bottle feed the baby 6–8 times per day as well.

F. MENSTRUATION AND CONTRACEPTION

It is normal for nursing mothers not to have their menstrual periods while breastfeeding. This is due to a low estrogen state. Other consequences of low estrogen are vaginal dryness, decreased sex drive and some degree of contraceptive benefit. The first menstrual period usually occurs about 4–8 weeks after weaning, but some women develop regular monthly cycles while continuing to nurse.

G. MEDICATIONS WHILE BREAST-FEEDING

There is a general fear of taking any medication while breast-feeding, however, many medications can be taken with minimal risk. There is a great deal of information available on this subject. Of course you should discuss the particular details with your Pediatrician, but doing some homework in advance may be helpful.

The following substances and/or medications are felt to be safe to take while breastfeeding: alcohol in small amounts, B-Vitamins, Birth Control Pills, caffeine in small amounts, Codeine, Inderal, Motrin or Advil, Penicillin, Prednisone, Procardia, Progesterone or similar drugs like Micronor or levonorgestrel, Tylenol, Zovirax and many others.

H. SEX WHILE BREAST-FEEDING

After the six-week postpartum check-up, the patient is usually given the “green light” to resume sexual activity. Many husbands are anxiously awaiting their partner’s answer to the question, “Honey, what did the doctor say?”

However, just because you have the ‘green light’ does not obligate you to put the car into drive! Many women are not ready for sexual activity at 6 weeks. You may be exhausted and sleep deprived. Additionally, there are physical changes in your body due to breast-feeding that may result in diminished desire for sex. For example, estrogen levels are naturally very low while breastfeeding. This is why breastfeeding women usually do not get their periods and why they are less fertile. But it also may lead to diminished or absent libido (sex drive). Furthermore, the low estrogen levels can persist for as long as the woman breastfeeds.

Another consequence of low estrogen levels is vaginal dryness. This condition is also common in women after menopause for the same reason...low estrogen levels. However, it is fully reversible once the patient has weaned. Vaginal dryness may make sex uncomfortable. This can be greatly improved through the use of vaginal lubricants such as K-Y liquid or Astro-Glide. Some women may benefit from the use of a low-dose vaginal estrogen cream. Lastly, some form of birth control is still advisable. Please see the discussion ahead.
I. **MASTITIS**

If you develop redness, hardness and pain in one breast, especially with a fever above 101°F, this could be a breast infection (mastitis). If left untreated, it can progress to an abscess. Please call the office right away if you develop any of these symptoms.

J. **SUPPRESSION OF MILK PRODUCTION**

In August 1994, the only remaining medication that could be prescribed to suppress lactation (Parlodel) was decertified by the manufacturer for that indication. There were case reports of maternal seizures and a few deaths. Consequently, there is no longer any medication which is FDA-approved for the purpose of lactation suppression.

If you do not wish to breast-feed, you can help prevent the development of painful engorgement by doing the following: Wear a tight-fitting bra up to 24 hours per day for about 2 weeks. For breast soreness apply an ice pack to the breasts for 15-30 minutes, 3-4 times per day; take two Advil (or its equivalent) every 4 hours; avoid breast stimulation or hot water on the breasts; and, avoid any hand expression of milk. Call us if you have problems with engorgement.

K. **INCREASING MILK PRODUCTION**

Sometimes there is not enough breast milk to completely feed the baby. Many different things have been tried to increase milk production. Breast pumps can be useful. Certain herbs such as fenugreek and milk thistle have been recommended with varying degrees of success. A prescription medication called Reglan can be tried, but side effects such as dry mouth and restlessness are common. Lastly, a medication from Canada called domperidone has been shown to help, but this drug is illegal in the U.S.

L. **CHOOSING NOT TO BREAST FEED**

There are many reasons for deciding not to breast feed. These include having to take medication that is not safe for the baby, prior history of severe difficulties nursing, or personal preference. Furthermore, some women try very hard in the beginning and things just don’t work out. There might be severe pain, or insufficient milk supply, or just too much frustration. We believe that bottle-feeding a newborn can be safe and nutritious and for some women this might be the best option. Deciding not to breast feed is the right of every new mother, and if this is the best choice for you, we support it.

M. **ADDITIONAL RESOURCES:**

- Huntington Hospital Breastfeeding Center: 626-397-3172. They have a Support Group that meets every Thursday from 10 a.m. to 11:30 a.m. Bring your baby (after 6 weeks of age)!
- [http://www.thebump.com/t/breastfeeding](http://www.thebump.com/t/breastfeeding)

28) **POSTPARTUM INSTRUCTIONS**

A. **GENERAL ACTIVITY**

Your amount of activity can gradually increase, but try to avoid getting overly tired. Household activities should be resumed gradually, beginning with the easiest, and later adding the more difficult tasks. You should expect to be able to do almost all of your activities within 3-4 weeks. Try to rest as much as possible, for example take a daily nap the first few days. Try to sleep when the baby sleeps.

*Avoid driving for about 1-2 weeks, and do not drive if you are still taking narcotic-type pain medication. Being a passenger is okay. Do not begin driving until you feel that your reflexes are normal, and you can make fast or sudden movements without hesitation.*

**AFTER A CESAREAN BIRTH:** You should be doing most light activities by 2-3 weeks, but a full recovery may take 6-8 weeks. **Avoid driving for the first 2 weeks.**

**IN THE HOSPITAL:** You will generally spend 3-4 nights in the hospital. We urge you to have someone who can sleep over in your room with you, especially the first night or two. This person can be very helpful in case
the nurses are too busy. Just having someone close by to hand you something, get you some water, help you up to the restroom or to call the nurse for you can make a big difference in your recovery.

B. DIET AND VITAMINS

In general, you may eat whatever you wish. Breastfeeding mothers tend to avoid spicy or odorous food such as garlic, onion, pepper, etc. You still need 3-4 servings per day of dairy or calcium supplementation. High fiber is helpful to maintain bowel regularity. Prenatal vitamins and DHA or Omega-3 supplements should be taken daily.

C. PAIN RELIEF

Prescription pain medication will be written for you at the time of discharge home. Pain in the episiotomy area gets better quickly, usually within one week. Warm sitz baths (shallow warm bath), Tucks pads and Dermoplast spray (topical anesthetic available non-prescription) and Tylenol or Motrin may help.

AFTER A CESAREAN BIRTH: You will be given prescription pain medication at discharge. Tylenol or Motrin may also be taken for pain relief. By 1-2 weeks, you may no longer need it. There will be discomfort in the area of the incision for a while but usually of a mild degree by the third or fourth week after surgery. Occasionally, numbness around the incision may persist for many months.

D. HYGIENE

You may wash your hair, shower, or take warm hot sitz baths as you wish. Full tub bathing is okay as long as the tub has been carefully cleaned in advance. Continue perineal care as you have been instructed in the hospital, but do not douche, use tampons or resume intercourse before your SIX-WEEK postpartum visit.

AFTER A CESAREAN BIRTH: Keep the wound dry after bathing by blow-drying it, or by air-drying. Call the office if you notice drainage, separation or redness around or from the incision.

E. VAGINAL BLEEDING/DISCHARGE

Some vaginal discharge or bleeding (“lochia”-initially red, later on pink to brown) will usually last for 3-5 weeks after giving birth, and occasionally longer. There is usually less lochia after cesarean birth than after vaginal. Use pads only, not tampons. With excessive activity the lochia may return to a redder color for a few days. The return of menses is variable. If you are nursing, you may not have any menses throughout the nursing period, or you may have random spotting. The 1st period may be from 6-12 weeks after cessation of nursing. On the other hand, you can have regular menses even while still breast-feeding.

If you are not nursing, the first period may be from 6-12 weeks after delivery. The first period can be unusually heavy with clots, and it may take a few months for regular menses to resume.

F. HEMORRHOIDS AND CONSTIPATION

Constipation is common postpartum, particularly while nursing (due to fluid losses). Please follow the same advice given during pregnancy. Prevention is the key. Drink plenty of water throughout the day. Have a good daily intake of fiber (fruits, vegetables and bran). For constipation, you can try prune juice, Metamucil or Citrucel (adds bulk), Colace (a mild stool softener), or MOM (Milk of Magnesia). For hemorrhoids, we recommend fiber and bulk supplements to help produce soft stools (bran, bran and more bran), sitz baths at home, Preparation H or Anusol (with or without hydrocortison), or Tucks pads.

G. EXERCISE

We recommend taking it easy the first week or two. Walking is good exercise initially. By 3-4 weeks you may be able to begin some stretching and mild exercises.

AFTER A CESAREAN BIRTH: Don’t expect to begin regular exercise for 6-8 weeks. Walking is good for you, but be careful not to overdo it. Some stretching and exercises that avoid the abdominal area may be initiated 2-4 weeks after the operation. Actual sit-ups or other direct abdominal exercises should wait until at least 2 months after C/S.
H. CARE AFTER CIRCUMCISION

Your baby’s circumcision is performed using a method called the Gomco technique. Immediately after the procedure, the penis is wrapped in Vaseline gauze. There will be a small amount of dark blood on the gauze – this is normal and expected. The gauze might fall off on its own. If it does, leave it off. If it does not fall off, then it should be removed in 24-48 hours. If you are still in the hospital, you can ask a nurse to remove it if you wish. To remove the gauze, apply a little Vaseline or A&D ointment first, and the gauze will easily slide right off.

After the gauze is removed, the circumcised area of the penis usually looks red and swollen. The healing phase takes about 2 weeks. During this time, the redness gradually fades to pink and the swelling resolves. The pink area becomes the new skin. The red area you see initially is new skin, like you might see after a blister pops or after a bad sunburn peels. It is very tender. As it heals, secretions are normal. These can be white or yellow. New skin will come in and may look glistening white. Don’t touch this area. Once you see normal, pink-looking skin, the healing phase is complete.

During the 2 weeks of healing, there is not much to do. The most important thing is to keep the end of the penis covered with Vaseline or A&D ointment as often as you can. Every time you place a new diaper, cover the area with more ointment, or place the ointment on the diaper so when you close the diaper, it covers the circumcised area. You can gently clean the area by running lukewarm water over it. Then, very gently pat it dry with a soft cotton pad or gauze, apply the ointment and you are done. Do not be alarmed if there is a small amount of blood when you dry it.

IMPORTANT – READ THIS

One problem that you have to look for is when the new skin sticks to the edge of the exposed tip of the penis (called the glans). You should check more than once a day for this, especially the first few days.

After a circumcision, the skin on the shaft of the penis is supposed to end below the glans. Sometimes the skin slides up and over the edge of the glans, and starts to attach itself. Since this is new skin, it has to be pulled back down or else it will heal this way and remain there permanently. The result will be a cosmetic issue only, not a functional issue.

Sometime, you will see swollen tissue that is visually blocking the edge of the glans. This is normal. But, if you see penile skin covering the edge of the exposed glans, you will have to pull it down gently to prevent it from sticking there permanently. Here is what you do:

1. Get your supplies. q-tips, small cotton gauze pads or the equivalent, Vaseline (or A&D).
2. Two people are needed. One will hold the baby’s legs apart. Be firm, they are very strong!
3. Carefully inspect the area. Is the penile skin attached and covering the edge of the glans? Pull down a little on the skin below the glans to make sure. If it is, then…
4. The other person uses a moist q-tip or a q-tip covered with Vaseline. Use the q-tip to press down on the glans of the penis and push the sticky skin down and away, beneath the edge of the glans. It just takes a few seconds. The goal is for the entire edge of the glans to be visible with no skin attached to it.
5. A few drops of blood might appear when you do this. Apply pressure with a Vaseline covered cotton gauze or pad for about a minute. Done.

If you have any questions (and if one of our doctors performed the circumcision), call our office and make an appointment for one of the doctors to see your baby. Call 626-304-2626.

I. AFTER DISCHARGE FROM THE HOSPITAL

Please call the office (626-304-2626) to schedule your postpartum check-ups. We like to see you at 6 weeks postpartum after vaginal delivery, and about 1-2 weeks and then 6 weeks postpartum for cesarean birth. Please bring us a new baby picture, better yet, bring the baby to your check-ups also!

J. CALL THE OFFICE RIGHT AWAY IF YOU HAVE ANY OF THE FOLLOWING:

- Severe or worsening pain anywhere, especially in the abdominal or the perineal areas
- Shaking chills or fever (temperature greater than 101°F)
- Frequency and/or burning with urination or any difficulty with urination
• Significant increase in vaginal bleeding, especially heavy, bright red bleeding
• Feeling faint, lightheaded or weak and dizzy
• Swelling, tenderness, or redness in either breast, or the episiotomy site
• (If C/S): redness around the wound or drainage of any kind from it

K. POSTPARTUM BLUES AND POSTPARTUM DEPRESSION

Postpartum Blues refers to a mild and brief episode of distress occurring in up to 80% of new mothers within the first few weeks after childbirth. A woman can feel weepy, exhausted, anxious or tense, but these feelings generally resolve after the first few weeks. If not, then it is possible that the condition is actually postpartum depression.

Postpartum Depression is more than the “baby blues.” It may occur immediately after birth or many months later. It can happen after any birth, not just the first time. Up to 15% of new mothers can develop postpartum depression. The symptoms can develop gradually or have a sudden onset, and they include:

- feelings of hopelessness, loneliness, isolation
- crying for no obvious reason
- anxiety
- sleeping problems, insomnia or excessive sleepiness
- eating problems such as loss of appetite or binge eating
- frightening thoughts or fantasies
- the feeling that something is “not right”

Postpartum Depression is different from the normal stress and exhaustion most parents experience when adjusting to a new baby. It can be a serious health condition that can interfere with a woman’s ability to take proper care of herself, her new baby and/or her family. It is also quite treatable, but only if the person asks for help. There are safe medications that can be taken while breastfeeding which are very effective at treating this condition.

The following strategies have been shown to help prevent postpartum depression:

- The responsibilities of motherhood are learned, so try to prepare in advance
- Get help from husband, dependable friends, and relatives
- Make friends with other couples who are experienced with child-bearing
- Don't overload yourself with unimportant tasks
- Don't move to a new home soon after the baby arrives
- Don't be overly concerned with keeping up appearances of either yourself or your surroundings
- Get plenty of rest and sleep!
- Don't be a nurse or social hostess to relatives and others at this time
- Confer and consult with husband, family and experienced friends, and discuss your feelings and concerns
- Arrange for babysitters, you need some down time

For more information, contact:

- Huntington Hospital has a postpartum depression program. Call 626-397-2330. [www.huntingtonhospital.com/Main/PostpartumDepression.aspx](http://www.huntingtonhospital.com/Main/PostpartumDepression.aspx)
- We have an article on our website: [http://library.fowh.com/postpartdepr.html](http://library.fowh.com/postpartdepr.html)
- Postpartum Net ([www.postpartum.net](http://www.postpartum.net)) home of Postpartum Support International.
L. POSTPARTUM THYROID PROBLEMS

Not all postpartum fatigue is due to sleep deprivation. About 5% of women can experience postpartum thyroiditis, an inflammation of the thyroid gland that can cause thyroid dysfunction. The thyroid gland regulates the body’s metabolism. Both underactive and overactive thyroid can cause serious problems and both conditions can occur with postpartum thyroid dysfunction.

Underactive thyroid can cause fatigue, weakness, intolerance to cold, swelling, hair loss and weight gain. Overactive thyroid can cause insomnia, palpitations, anxiety, intolerance to heat and weight loss. If you experience more than 2-3 of any of these symptoms, please contact our office right away. These conditions are easy to diagnose and easy to treat, but only if you let us know!

M. BIRTH CONTROL OPTIONS POSTPARTUM

Whether you are breast-feeding or not, and whether you are having any periods or not, you can still conceive. Birth Control will be discussed at your 6-week postpartum visit. If you are breast-feeding, your options include condoms, the diaphragm, the IUD, and the mini-pill (a progesterone-only hormonal contraceptive which is FDA approved for nursing mothers). If you are not breast-feeding, then the Birth Control Pill is also an option.

One of the best contraceptive methods for breast-feeding women is the Mini-Pill, also called Micronor, which contains a low-dose progesterone derivative. Taken daily, it provides 98% contraception to nursing mothers, and is FDA approved for this situation. The side effects are minimal, including lack of regular periods, possible spotting, and possible mild bloating. This is different than the regular birth control pill as there is no estrogen in the Mini-Pill.

The Copper-T IUD (called Paragard) is FDA approved for up to 10 years continual use and the Mirena IUD is effective for 5-years with fewer side effects than the Copper-T. These current IUD’s have NONE of the problems associated long ago with the Dalkon Shield, and they are becoming a popular birth control option.

The above is a partial list of the major options in birth control at this time. There are others not mentioned, and new developments continue to occur, but it is helpful before the visit to have an idea of what is available so that you can be prepared.

N. WEIGHT LOSS POSTPARTUM

It is likely that you will weigh more at your 6-week check-up than you did prior to becoming pregnancy. Typically, a patient loses 15 to 20 pounds comparing their weight just before delivery with their weight at the 6-week check-up. DO NOT DESPAIR!

The most important thing is to accept that this is normal, it is going to happen, but with a bit of work and a commitment, it will be a temporary situation. Please do not immediately start trying to diet and exercise right after delivering. Your body needs energy (food) and rest to properly heal and recover.

1. AFTER THE 6-WEEK CHECK

After the 6-week check-up, we usually give patients the “green light.” This means we allow you to resume intercourse and to resume or begin exercise and/or dieting. If you are breast-feeding, it is still possible to lose weight, but the timing needs to be gradual, maybe aiming for one pound per week of loss. Weight Watchers has a program for weight loss while lactating.

Exercise – We prefer that you start off slowly, maybe 30 minutes, 2-3 times a week for the first 1-2 weeks, then gradually increase to the level that you would like to attain. Initially, we advise focusing on cardiovascular (‘CARDIO’) type exercises, as this is how that body develops stamina. Treadmill, walking, stationery biking, dance or aerobics classes, swimming are all excellent forms of ‘cardio.’ One fun type of cardio that is becoming very popular is the “stroller strides” type of class which combines walking the baby in the stroller with various types of cardiovascular and strengthening exercises.

2. The Tupler Technique

Julie Tupler, RN has developed abdominal exercises to help reduce the “mummy tummy” after childbirth.

- Go to https://diastasisrehab.com/
- see the article on our web site at: http://library.fowh.com/resources/Tupler+Technique.pdf
O. WEIGHT LOSS AND NUTRITION EXPERTS

- Wendy Crump, RD, (good with kids also), 626-403-6000, wjcrump@earthlink.net (RD means Registered Dietician).
- Carina Weston at ProFitness - just 2 blocks from our office. “It was the best thing I did for postpartum weight loss”. www.profitnessnetwork.com, (626) 799-7243

P. RESOURCES FOR POSTPARTUM HELP

- AccentCare, 2270 Huntington Drive, San Marino, CA 91109, 626-458-1400, Cell: 626-399-7084, Fax: 800-457-3309, www.accentcare.com
- Brio Home Health Agency, 888-914-2746 or 909-680-0059, www.briohomecare.com
- The Family Room (626-234-2106) provides postpartum doula services. In their own words, “We are a family resource center providing information and support before and after baby, and in the early years of parenthood. Located in San Marino, The Family Room combines all the essential resources for parents to thrive before and after baby, under one roof — for example, childbirth prep, breastfeeding support, mommy and me classes, safe and effective exercise for all stages and much more. Plus, a community to share the adventure.” www.familyroomcenter.com (626-234-2106).
- The Cradle Company (323-662-0100) offer Doula/Baby Nurse Services. Postpartum caregivers assist parents during their transition home with newborn. Caregivers are available to assist with day/night care, bottle/breastfeeding, and infant care education.
- Some Doula agencies will provide postpartum doula services.
PATIENT’S BILL OF RIGHTS  
AND RESPONSIBILITIES

The medical practice of Fair Oaks Women’s Health recognizes and respects the rights of each patient as an individual with unique health care needs and we are committed to providing considerate, respectful, confidential and high quality personalized medical care to each and every patient. In turn, we believe that our patients have specific responsibilities to our practice.

The following outlines these rights and responsibilities.

PATIENT RIGHTS

1. I have the right to receive appropriate informed consent in advance of any treatment (test, prescription, procedure or surgery) being performed on me. This means that I will be informed of the reasons for the treatment, the alternatives, the risks and benefits of the treatment, and the risks if I choose not to have this treatment.

2. I have the right to privacy. This means that all information about my health and in my medical record is absolutely confidential, and cannot be disclosed to any other individual or organization (including my spouse or life partner), except when I give my written permission, or when disclosure is mandated by law.

3. I have the right to receive a complete copy of my medical record in a timely fashion upon my written request, and I agree to pay a reasonable fee for the work involved in providing me this copy.

4. I have the right to be seen in a timely manner. I will be informed of any delay and have the right to reschedule if the delay is too lengthy.

5. I have the right to be informed in a timely manner of all test results.

6. If I have an urgent medical condition, I have the right to speak to someone immediately when I call and to be seen as soon as possible based on my condition.

PATIENT RESPONSIBILITIES

1. I have the responsibility to understand my insurance plan and benefits.

2. I have the responsibility to take prescribed medications as directed, and if I do not understand the directions, I will call the office for clarifications.

3. In order to insure my good health, I have the responsibility to follow through on all of the doctor’s recommendations, including having tests performed, seeing other physicians I have been referred to and returning for follow-up appointments.

4. I have the responsibility to be on time for all scheduled appointments and to notify the office at least 24 hours in advance when I need to cancel or reschedule an appointment.

5. I have the responsibility to pay my co-payment at the time of service.

6. I have the responsibility to pay a $25 charge for any check returned by my bank.

7. If I fail to pay for services rendered and my account is assigned to collections, I have the responsibility to pay all of the costs of collections including reasonable attorney’s fees.

8. If I am pregnant, I have the responsibility to notify this office (in advance if possible) of any change in health insurance. I understand that failure to do this may result in my maternity coverage being denied by my new health insurance plan.

9. I understand and agree that this office can only submit a bill for a diagnosis or medical condition documented in my medical record, and that to do otherwise could be considered fraudulent.
We would like to thank you for choosing Fair Oaks Women’s Health as your women’s health care provider. This section explains our current office and financial policies. It is important that you read and agree to these policies.

**Late Arrivals:** You are expected to arrive on time for your scheduled appointments. New patients should plan to arrive 30 minutes early to allow for completing forms and updating your electronic medical record in the computer. If you are more than 15 minutes late, we may have to reschedule your appointment.

**Fair Oaks Women’s Health accepts Cash, Personal Checks, Travelers Checks, MasterCard, Visa, American Express Cards and ATM debit cards as payment for services rendered.**

**Financial Responsibility:** Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. For minors, the parent who accompanies the minor for their first visit will be financially responsible for all charges incurred.

**The Obstetrical Fee (OB Fee) includes:** The OB Physician Consultation, all routine prenatal visits, labor management and vaginal delivery, all postpartum care in the hospital and all routine postpartum office visits.

**The OB Fee Does Not include:** amniocentesis; Cesarean Section and assistant surgeon for C/S; cord blood collection; high risk pregnancy; Hospital Services including epidural anesthesia, Labor and Delivery, C/S Operating Room; injectable medications given in the office; intravenous therapy in the office; Lab costs – blood, urine, cultures, etc.; newborn care by the Pediatrician; newborn circumcision; Non-Stress Tests (NST’s), Nuchal Translucency (NT) and afp lab fee (California Prenatal Screening); Counsyl Genetic Test, MaterniT21 test, office visits not pregnancy-related; physician hospital visits for non-delivery related hospital stays; pregnancy confirmation office visit; prenatal education classes; Rhogam injections; sex-check and 3-D ultrasounds (these are not billable to insurance); tubal ligation; and all ultrasound (sonogram) exams.

**Insured Patients:** Please bring your insurance card with you to your first appointment. If your insurance plan requires an office visit co-pay, this will be collected at the time of service. The co-pay cannot be waived by our office; it is a requirement placed on us by your insurance carrier. You are financially responsible for any co-insurance, deductible or non-covered service. If you are a member of a health plan that Fair Oaks Women’s Health participates with, we will submit a claim to your insurance company on your behalf.

**Balance Due:** Once we have received payment along with an Explanation Of Benefits (EOB) from your insurance plan, you will receive a statement from our office indicating what your insurance has paid. Any remaining balance will then be due and payable. Patients with large deductibles will be asked to pre-pay a portion of their known medical expenses (for example, pregnant or gyn surgery patients)

**Non Insured Patients:** Payment in full will be due at the time of service. If you are unable to pay your balance in full, you will need to make arrangements with our Office Manager.

**Returned Checks:** A $25 fee will be assessed for any check returned for insufficient funds. After that, only cash or credit cards will be accepted for payment.

**Disability Forms:** A $20 fee will be charged for processing and mailing each disability form. These forms have become longer and more complicated and require a lot of administrative time to handle.

**Medical Records Request:** There is a $25 fee for a medical records request. Payment for these records will be collected prior to records being released. A complimentary copy of your records will be sent to the physician of your choice.

**Collection Accounts:** Fair Oaks Women’s Health reserves the right to turn an account over to collections if it is deemed that the account is in default of payment or compliance with this policy. In the event you breach this agreement, you agree to pay all collections fees, including court costs, collections agency fees and attorney’s fees incurred by us in enforcing the terms hereof, whether or not formal legal proceedings are commenced.

**Financial Hardship:** We understand that sometimes it is a hardship to pay your medical bills timely. Please meet with our Office Manager so we can work out a payment plan. Ignoring medical bills is not advisable. Let us know your situation so we can work with you.
### USEFUL TELEPHONE NUMBERS

<table>
<thead>
<tr>
<th>Description</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfeeding: Huntington Hospital Breastfeeding Center</td>
<td>626-397-3172</td>
</tr>
<tr>
<td>Caioti – “The Salad”</td>
<td>818-761-3588</td>
</tr>
<tr>
<td>Childbirth Education Huntington Hospital</td>
<td>626-397-8768</td>
</tr>
<tr>
<td>Cradle Company</td>
<td>323-662-0100</td>
</tr>
<tr>
<td>Cord Blood Registry</td>
<td>1-888-CORDBLOOD (1-888-267-3256)</td>
</tr>
<tr>
<td>CVS Experts</td>
<td></td>
</tr>
<tr>
<td>Joseph Ouzounian, M.D.</td>
<td>626-796-2700</td>
</tr>
<tr>
<td>John Williams, M.D. (Cedars-Sinai)</td>
<td>310-423-9999 appts.</td>
</tr>
<tr>
<td>Doulas: Tracy Hartley (<a href="http://www.bestdoulas.com">www.bestdoulas.com</a>)</td>
<td>877-436-8528</td>
</tr>
<tr>
<td>Fair Oaks Women’s Health</td>
<td>867-568-8550</td>
</tr>
<tr>
<td>Answering Service (emergency only)</td>
<td></td>
</tr>
<tr>
<td>Fair Oaks Women’s Health Office and Fax Numbers</td>
<td>626-304-2626 main</td>
</tr>
<tr>
<td>Fair Oaks Women’s Health after-hours message line</td>
<td>626-696-2688</td>
</tr>
<tr>
<td>The Family Room (childbirth classes and more)</td>
<td>626-234-2106</td>
</tr>
<tr>
<td>Huntington Hospital: Main Number</td>
<td>626-397-5000</td>
</tr>
<tr>
<td>L&amp;D Tour Information: Huntington Hospital</td>
<td>626-397-5037</td>
</tr>
<tr>
<td>Labor and Delivery: Direct Line, Huntington Hospital</td>
<td>626-397-5069</td>
</tr>
<tr>
<td>Lactation Support: Huntington Hospital</td>
<td>626-397-3172</td>
</tr>
<tr>
<td>Marina’s Oasis (in Fair Oaks Women’s Health office)</td>
<td>626-MY OASIS (696-2747)</td>
</tr>
<tr>
<td>Professional Skin and Body Care</td>
<td></td>
</tr>
<tr>
<td>Maternal Fetal Medicine – USC Group (in Pasadena)</td>
<td>626-796-2700</td>
</tr>
<tr>
<td>Maternity: Huntington Hospital</td>
<td>626-397-5078</td>
</tr>
<tr>
<td>Postpartum Depression – Huntington Hospital</td>
<td>626-397-2330</td>
</tr>
<tr>
<td>Ronald McDonald House (for parents of NICU babies)</td>
<td>626-585-1588</td>
</tr>
<tr>
<td>Parent Connection – NICU Support</td>
<td>626-397-8509</td>
</tr>
<tr>
<td>Teratogen Information (Mother to Baby CA)</td>
<td>(866) 626-6847</td>
</tr>
<tr>
<td>Yoga House Prenatal Yoga</td>
<td>626-403-3961</td>
</tr>
</tbody>
</table>
31) PEDIATRICIAN NAMES AND PHONE NUMBERS

Note: Everyone delivering at Huntington Hospital needs a Pediatrician for their newborn baby who is ON STAFF at the Hospital. All of the physicians below (except Glendora) are on staff at Huntington.

Rose City Pediatrics
www.rosecitypediatrics.com
Drs. Powell, Schlundt, Gokey and Lai
800 S. Fairmount, #415
Pasadena, CA 91105
626-449-8440

Pasadena Pediatrics (Hunt Health Physicians)
www.huntingtonhealthphysicians.org
Drs. Legault, Legault, Kim, Salamon,
McCormick, Mackanic and others
55 E. California Blvd. Suite 200
Pasadena, CA 91105
626-449-7350

Kindercare Pediatrics
www.kindercarepediatrics.com
Dr. Holly Wang
Dr. Kiandra Kang
50 Alessandro Pl #200
Pasadena, CA 91105
626-696-1234

Dr. Irma Gonzalez
960 E Green Street. Suite L12
Pasadena, CA 91106
626-795-8811

Huntington Plaza Peds
www.huntingtonplazapediatrics.com
Drs. Reid, Batin, Cohen, Rivera and others
800 S. Fairmount, 1st floor
Pasadena, CA
626-795-7051

San Marino Pediatric
Dr. Allison Yim, Cindy Collo, and others
375 Huntington Dr Suite F
San Marino, CA 91108
(626) 270-1580

Dr. Isaac Haddad
2990 E. Colorado Blvd #105C
Pasadena, CA 91107
626-793-3700
He also speaks Arabic, Armenian and French

Glendale Pediatrics
www.glendalepediatrics.com
Drs. Feuille, Hartstein, Henry, Bursch,
Fabris-Carral, Iyer, Fan and others
1500 E. Chevy Chase Dr, Suite 250
Glendale, CA
818-246-7260

Descanso Pediatrics
Drs. Smith, Rodarte, Mazmanian,
Chou, Anderson and others
1346 Foothill Blvd., La Canada
They have “walk-in hour” from 8-9 a.m. M-F
818-790-5583

Arcadia Pediatrics (Hunt Health Physicians)
www.huntingtonhealthphysicians.org
Drs. Arya, Chiriboga, Dimen, Fanselau,
Hu, Lee, Mechoso, Jacobs-Kleisli, Jee
301 W. Huntington Dr., Suite 305 & 320
Arcadia, CA
626-447-3516

Glendora Area
Glendora Pediatric Medical Group
www.glendorapediatricsmedicalgroup.com
Janet Fermin, M.D.
Amjad Mahfoud, M.D.
210 S. Grand Ave #202
Glendora, CA 91741-4269
626-335-0211
Note: these doctors are NOT on staff at Huntington, but they come highly recommended.
<table>
<thead>
<tr>
<th>Birth Plan Items</th>
<th>Physician Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermittent Fetal Monitoring</td>
<td>This is fine as long as the fetal heart tracing is reassuring. We require reassuring electronic fetal monitoring as part of the routine management of labor.</td>
</tr>
<tr>
<td>Walking during labor</td>
<td>If your fetal heart tracing is reassuring, you are free to walk during labor. We do not “strap you down” and for the last 20 years we never have.</td>
</tr>
<tr>
<td>Saline lock instead of IV</td>
<td>This is fine but you need to stay well hydrated during labor. A patient in labor at least needs a saline lock in place because IV access might be needed in an emergency. A clear liquid diet allowing up to 6-8 ounces of liquids per hour is advised. The saline lock can be very important if a sudden emergency happens such as uncontrollable bleeding or sudden fetal distress.</td>
</tr>
<tr>
<td>Explain all tests and procedures to me</td>
<td>We always do this. Patients make the final decisions whenever a medical test or procedure might be indicated. We explain everything to help you decide.</td>
</tr>
<tr>
<td>Use of Pitocin</td>
<td>This is not done automatically or for no reason, but there are situations where Pitocin usage is very important, such as when the contractions are too weak, or after the placenta is delivered. This might occur after an epidural, for example. If Pitocin is used to help your labor, the goal is for your contractions to be effective enough for your labor to progress towards a normal vaginal birth and help prevent a C/S.</td>
</tr>
<tr>
<td>Epidural – timing and indications</td>
<td>It is almost never too late for an epidural. This procedure is your choice. Some women feel guilty about choosing an epidural, and this should not be the case. If this is a first labor, there is no way to know in advance how strong the pain will be.</td>
</tr>
<tr>
<td>Different positions for pushing</td>
<td>This is fine if you do not have an epidural. You can squat (we have a squat bar), or you can push while lying on the side. Epidurals cause your legs to be too weak to support you, so pushing is usually done in a semi-reclining position, which is actually a very good position for pushing!</td>
</tr>
<tr>
<td>Try to avoid episiotomy</td>
<td>Some people begin perineal and vaginal massage weeks before the delivery to try and stretch the vaginal opening to help avoid episiotomy. This might work, but also might cause the vagina to remain somewhat stretched in the future. We try to avoid episiotomy when possible, but sometimes a bad tear can be more painful and result in more stitches than an episiotomy. <strong>Our goal is for you to go home with the fewest stitches possible.</strong> We do not perform episiotomy routinely, but in some situations this surgical cut can prevent a worse vaginal tear.</td>
</tr>
<tr>
<td>Baby on mother’s chest, skin-to-skin</td>
<td>As soon as the baby emerges from the birth canal, we try to place the baby on the mother’s chest for skin-to-skin contact. This keeps them warm, and moms really like it! Then, the nurse needs to perform a brief newborn assessment, check vitals and breathing, and then hopefully bring the baby back to mom as soon as possible.</td>
</tr>
<tr>
<td>Clamp cord after it stops pulsing</td>
<td>Despite the widespread support for this on the Internet, delayed cord clamping can be risky. The baby could pump its own blood back into the placenta resulting in blood loss for the baby. Or, the baby could end up with too much blood which can cause the baby’s blood to become too thick, not flow well and increase the risk for newborn jaundice. Dr. Jick suggests an alternative, called milking the cord. After the baby is born, extra blood inside the cord can be physically milked into the baby just prior to clamping the cord. This saves time and ensures that the blood goes into the baby and not the reverse!</td>
</tr>
<tr>
<td>Taking Home the Placenta</td>
<td>It is okay to take home your placenta after delivery. The only exception might be if there was a birth-related issue where we need to send the placenta to the lab. Just make sure to mention this to the Labor nurse before you deliver. Again, despite what Dr. Google says, there is no evidence that eating placental capsules can prevent postpartum depression.</td>
</tr>
</tbody>
</table>
33) PREGNANCY CHECKLIST

☐ Take prenatal vitamins once a day. We also advise a daily DHA supplement (but many PN Vitamins now include DHA). We also advise a daily Calcium Supplement with Vitamin D.

☐ Have your first prenatal lab panel done. Most labs can be drawn in our office, unless your insurance plan requires you to go to an outside lab. If you transfer care to us, we NEED those lab results.

☐ Decide if you would like non-invasive prenatal testing (called NIPT). This is a test to detect fetal DNA in the mother’s blood and can be done after 10 weeks. It is very accurate but also can be very expensive.

☐ You will receive information from the State of California about Prenatal Integrated Screening. Please review this information prior to your first OB consultation with the doctor.

☐ If you are interested in CVS, done at about 11 weeks, please tell us right away. You will need some tests done beforehand.

☐ Decide if you are interested in the nuchal translucency test (the NT test) which is done at 12 weeks gestation here in our office. This is the first part of the 2-part prenatal screening program.

☐ At 16 weeks, the second part of the 2-part prenatal screening test is done. This is the afp blood test.

☐ All patients are tested for possible gestational diabetes about 26-28 weeks. (twins-sooner). In addition, if you are Rh Negative, you will need a Rhogam injection after the 28-week blood draw.

☐ By the 7th month, decide about childbirth preparation classes. First-time patients may want to take the Huntington prepared childbirth classes, breast-feeding, infant care or others.

☐ By the 7th month, send in your Labor and Delivery pre-registration form to Huntington Hospital. If you do not yet have a Pediatrician, you may leave that section blank.

☐ Huntington Hospital’s Birthing Center offers free tours. Call 626-397-5037. Check the hospital web site.

☐ Select a Pediatrician for the baby’s care while in the hospital. We can recommend one, but many patients wish to ask around and pick someone of their own choosing. Verify that your selected Pediatrician is on your child’s medical insurance plan and is on staff at Huntington.

☐ If you are planning on having a tubal ligation (tying the tubes), please be sure that you have signed the California State Sterilization Consent Form.

☐ Any balance due should be paid by the 28th week. Please discuss all financial issues with our billing dept.

☐ Make a decision about umbilical cord blood banking. See the section in our booklet for more information.

☐ If you work, once you have determined your last day of work, we can help you submit a disability claim. You may also be eligible for the California Paid Family Leave program. See the section in this booklet.

☐ Contact your insurance carrier about 1 month before your due date to be sure that they are aware that you are pregnant, and that there have been no unexpected problems with your coverage. If you are planning on having a Cesarean, or a tubal ligation, or both, be sure they know about these issues as well.

AFTER DELIVERY

☐ After you deliver, we will bill your insurance. If you are billing them, you will need a “SUPERBILL” from us. Write the baby’s birthday on the superbill before sending it to the insurance company.

☐ Read the Postpartum section in your OB Guidebook. There is good information on breastfeeding.

☐ After delivery, call to schedule your postpartum appointment. We would like to see you 6 weeks after having a vaginal delivery, and 1-2 weeks after having a Cesarean delivery.

Congratulations!
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Credits: all black and white drawings in this publication are from Mr. Kevin Jick ([www.kevinjickdesign.com](http://www.kevinjickdesign.com))
Welcome to Huntington Hospital. Our Labor and Delivery unit is designed to provide a safe environment for you to deliver your child. The labor experience varies from person to person. Ideally your labor will progress without need for medications or procedures. However, sometimes your obstetrician may recommend treatments designed to improve the chance of a successful vaginal birth. This information sheet explains some of the treatments and interventions which may be used during your labor, starting with those that are more common.

- **Pitocin** is an intravenous medication containing the drug oxytocin, which is the natural hormone that stimulates contractions. We use this if your contractions are not strong enough or frequent enough to lead to birth. Your obstetrician might use this to induce or start labor, or to improve your contractions if they are too weak or too far apart.

- **Artificial rupture of membranes** is a quick and safe procedure performed by your obstetrician to break the “bag of water” in the womb. This may help the labor to progress faster.

- **A labor epidural** is used to relieve the pain of labor and is administered by an anesthesiologist. Sometimes the relaxation provided by the epidural can help labor progress or allow more effective pushing. Your anesthesiologist will explain the details of this procedure to you.

- **An episiotomy** is an incision made at the lower vaginal opening. For many women the vaginal opening is not large enough to allow birth, even with use of mineral oil and perineal massage. A natural tear may occur during birth requiring stitches, or the obstetrician may recommend an episiotomy which will also require stitches.

- **Misoprostol** and **Cervidil** are intravaginal medications that help soften the cervix in preparation for labor. They are used if your obstetrician recommends to induce labor but your cervix is not ready (we say “not ripe”) for labor.

- **The vacuum** is a hand-held device that is applied to the baby’s scalp which allows your obstetrician to assist and help your baby deliver vaginally. It might be used if you are unable to push the baby out yourself after several hours of pushing. It may also be used to deliver the baby faster if the baby is not tolerating the last stages of labor. There are some risks with using this device. The most common risk is a temporary bruised swelling on the baby’s scalp. Sometimes even with the vacuum, the baby will not deliver vaginally. In those cases, a Cesarean birth might be necessary. Your obstetrician will discuss this with you if a vacuum is being considered.

- **Forceps** are shaped like a pair of long spoons, and like the vacuum can be applied to the baby’s head to help direct the baby outwards. Forceps can leave marks on the baby’s face or head, although these are usually temporary. Like the vacuum, forceps do not always result in a vaginal delivery and thus a Cesarean birth may be done instead. Your obstetrician will discuss this further with you if a forceps procedure is being considered.

All vaginal births involve some degree of pain and bleeding. Sometimes labor does not result in a vaginal birth, and a Cesarean birth might be necessary. Rarely more serious complications can occur, such as excessive bleeding, intrauterine infection, tears affecting the cervix, uterus, bladder or rectum, or shoulder dystocia where the baby gets wedged in the birth canal, after the head is out. Your obstetrician and nurses are trained to manage these complications. Our goal is the safe delivery of your baby, while maximizing your safety as well. If you have further questions regarding the information above, please discuss them with your obstetrician.
Pre-Post Natal Water Fitness at the

Rose Bowl Aquatics Center

360 N ARROYO BOULEVARD, PASADENA, CA 91103 • PHONE 626.564.0330 • FAX 626.356.7572

This class is perfect for mothers-to-be who are challenged by their changing body and new moms who would like to get back in shape! Mothers-to-be are supported by the buoyancy of the water and flotation belts and can often do exercises that would not be possible on land.

The water decreases the effects of gravity on the body decreasing the stress on joints and muscles. The gentle exercise helps reduce swelling that can be caused by decreased venous return. After giving birth, moms often benefit from the exercises that help to gradually rebuild stamina and restore normal body weight.

Class Schedule
Monday, Wednesday & Friday - 12:30 pm-1:30 pm

Class Fees
One Class - $10
Monthly - $60
3D and 4D Ultrasound

Congratulations!

Did you know Fair Oaks Women’s Health offers 3D and 4D ultrasounds

3D and 4D package includes:

• 15 minutes session
• CD of color pictures
• DVD of entire session
• 4 b/w & 2 color printed pictures

$150 (for existing patients)
$250 (for outside patients)
payable at time of service

Best timing is between
26 and 30 weeks