Pregnancy Milestones

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"The booking visit provides a unique opportunity to set up pregnancy care"

Transcribed directly from MOGCAST Episode 7. Listen here:
https://open.spotify.com/show/6dtXQ6jLjAIi7lHtP71cYe?si=7671224caacc4f4a

"Hi, my name is Dr. Julia Francis. I'm one of the Obstetricians at The Mercy and I'm going to talk you through the pregnancy journey and milestones for pregnancy care.

The booking visit provides a unique opportunity to set up pregnancy care, to review any maternal medical conditions which may impact on pregnancy, and to particularly screen for women at risk in pregnancy who may require special or additional care in pregnancy.

The first visit should involve confirmation of the pregnancy, either via urine or serum beta HcG, and calculation of the best estimate of the date of delivery. A comprehensive clinical and psychosocial history should then be undertaken, particularly screening for women at risk of pre-eclampsia, fetal growth restriction, preterm birth, gestational diabetes. or any maternal medical conditions that may require extra or special care in the pregnancy. The pregnancy history will be covered in a separate podcast.

Your clinical assessment then should involve an assessment of BMI, so maternal height and weight, recording of the booking blood pressure, a cardiovascular, respiratory and thyroid examination, discussion with the woman about importance of breast self-examination and attention to any breast changes, and target examination of the breasts in women at risk of malignancy, those with a previous history, strong family history, or any clinical concerns.

You should then perform an abdominal palpation and confirm the fetal heart with a Doppler or ultrasound depending on the gestation. Review of the routine antenatal investigation should be undertaken. These include an FBE with particular attention to the haemoglobin to exclude underlying anemia. The MCV is a screening test for thalassemia, noting that an MCV less than 80 at booking is a prompt for both maternal and paternal haemoglobin electrophoresis and DNA studies, review of the platelets to exclude any underlying thrombocytopenia, which may indicate ITP or another maternal medical condition.

You should review the blood group and antibody screen, in particular discussing rhesus negative status and importance of anti-d prophylaxis if this applies. Review of the infectious screenings, so rubella, syphilis, hepatitis B, C, HIV, and targeted varicella serology for those women without a clinical history of chickenpox. Review of the urine MCS to exclude asymptomatic bacteruria and review of the cervical screening test history and performance of this test at the booking visit if it is overdue. We also then recommend review of and consideration of CMV and Parvo virus screening for women at risk, particularly those who work in childcare or early school settings and a TSH for women at risk of thyroid disease. You should then discuss with the patient and her support person the options for reproductive carrier screening and aneuploidy screening.

In terms of general advice in the pregnancy, it's important to discuss avoidance of teratogens. They are things like high dose x ray, alcohol, cigarette smoke.

Important to discuss lifestyle measures such as smoking, alcohol, gestational weight gain according to BMI and then exercise, work and travel precautions as required. Particularly in this climate, important to recommend both the flu and the COVID vaccination to the pregnant woman and offer written information about both of these.

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Also touch on the importance of the pertussis vaccination in the third trimester. It's important to review vitamin and mineral supplementation and make sure that the woman's on an appropriate pregnancy multivitamin supplement and discuss prevention of infections, both CMV and those transmitted by food such as toxoplasmosis and listeria.

Depending on your initial assessment in terms of the woman's risks for pre-eclampsia, it may well be appropriate to commence her on low dose aspirin and calcium at the booking visit. If she's at risk of preterm birth, at this point in time, you could discuss the role of progesterone and potential consideration for additional cervical length surveillance, and if at risk of gestational diabetes, perform an early oral glucose tolerance test.

From there, we would generally discuss antenatal care options with the woman. These would depend very much on the individual patient context and the location in which you're working. But these may well be shared care, a midwifery led model of care or a medical model of care, or some combination of the three.
From there, the routine tests that are then offered in pregnancy are an ultrasound at 12 to 13 weeks to look at the nuchal translucency and early anatomy. A 20-week ultrasound looking for fetal structural anomalies, placental location, and cervical length.

At 28 weeks, the oral glucose tolerance test is then performed along with an FBE and antibody screen. At this point, you can also perform a targeted repeat of syphilis screening, hepatitis B, C, HIV, and chlamydia as required.

At 36 weeks, we would generally recommend screening for group B strep and a repeat FBE prior to the onset of labour. The schedule of visits very much depends on the individual patient and their pregnancy context, but in general would be a booking visit around 12 to 14 weeks, review at 20, 24 and 28 weeks. A fortnightly review from 28 through to 36 weeks, and then weekly review from 36 weeks onwards.

Each of these visits should involve review of both maternal and fetal well-being. These are discussion of fetal movements and a recognition of normal fetal movement pattern and when to present. Excluding abdominal pain, tightening's or vaginal loss. Review of any preeclampsia symptoms, particularly in primiparous women or those at increased risk. Clinical assessment should then be undertaken performing blood pressure, symphysis fundal height, fetal heart rate, and review of the fetal lie and station.

Important to remember that the 36-week visit is a unique time to confirm a longitudinal lie, and if a breech presentation is diagnosed, an ultrasound can be undertaken, and discussion can be had about options for ECV or elective caesarean section. From this point, along with the weekly visits from 36 weeks, we would recommend tests of fetal wellbeing from 41 weeks, consideration of induction of labour from 41 to 41 plus 3 weeks."