36-week Antenatal Visit

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“It's a milestone visit recommended for pregnant women in all settings. ”

Transcribed directly from MOGCAST Episode 24. Listen here:
https://open.spotify.com/show/6dtXQ6jLjAIi7lHtP71cYe?si=7671224caacc4f4a

Hello, my name is Dr Elizabeth McCarthy, known as Liz, and I'm an obstetrician, subspecialist in maternal fetal medicine and heavily involved in teaching women's and newborn health at the University of Melbourne. This podcast is about what happens in antenatal clinic for women around 36 weeks.

It's a milestone visit recommended for pregnant women in all settings, both high-income countries like Australia and in low-resource or resource-constrained settings where a four-visit FANC, or Focused Antenatal Care Program, helps improve outcomes for women and babies.

So the standard tasks in 2022 Australian maternity practice at 36 weeks are fourfold. One, to assess maternal health. Two, to assess fetal health. Three, tests for haemoglobin, platelets, blood group, antibodies, and rectovaginal group B strep carriage. And four, to make plans for what next, especially considering birthplace, timing, and mode.

So first, concerning maternal health; check for pregnancy complications, including preeclampsia, which becomes progressively more common with advancing gestation. If the woman has GDM, she's probably been monitoring this for six to eight weeks now. So have a look at her home blood glucose monitoring records, which are usually in a handwritten booklet, sometimes with authentic bloodstains and comments about special occasion foods like pavlova.

Check on what medications and supplements the woman's been taking. If she has been taking low-dose aspirin to prevent preeclampsia, this can usually be ceased around 36 weeks. And as always, assess any symptoms she is bothered by with a careful history and target and examination.

Concerning fetal health, maternal perceptions of fetal movements are still very important. Determining fetal presentation is particularly timely at 36 weeks because presentation is relatively stable from there and cephalic presentation is the best. It's the lowest risk for labour to start and continue with.

The routine examination focuses on blood pressure in the seated position, abdominal examination and urinalysis. With abdominal examination, the fundal height is usually 36 centimetres at 36 weeks, give or take a couple of centimetres. It is really important to determine fetal presentation precisely.

Be aware that normal BMI and really good abdominal tone sometimes makes this assessment challenging clinically. In fact, the only recognised obstetric complication for women with a normal rather than a high BMI is late diagnosis of breech presentation, probably because such patients often don't have other complications which would have prompted an obstetric ultrasound. So on abdominal palpation, remember the fetal breech can feel roundish and fairly bony, but the head is more definitely round because of the neck and the fetal skull is smoother than other fetal bony parts. If in doubt, ask a senior obstetrician or midwife to repeat the palpation and clarify with them whether they think an ultrasound is needed to absolutely confirm fetal presentation.

So in the few percent where you do confirm a breech presentation at 36 weeks, the woman can be offered an external cephalic version. This is a manipulation aimed at encouraging the fetus to somersault into a cephalic presentation. It's usually done between 36 and 38 weeks, sometimes later. The practitioner uses their hands to apply deep directed palpation. That accounts for the description external or the E of ECV. And the aim is to

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bring the fetal head close to the cervix. Hence the C or cephalic for head and the V or turning for version. That's what ECV means.

If a woman does not wish an ECV or she tries it and it doesn't work, as occurs in about 50% of attempts, then a caesarean birth is a safe birth mode for the baby, usually planned close to 39 weeks if the fetus persists in the breech presentation. A few women prefer to plan for vaginal breech birth and some babies are in a hurry and are born by vaginal breech birth anyway, even if there was a preplanned caesarean. So you can practice delivering a baby as a breech in simulation tutorials.

If you are involved with a real case where vaginal breech birth looks likely, always escalate to the most experienced obstetrician and midwife to be present for this to make it as safe as possible and have paediatrics on hand too. Okay.

So I've discussed history and examination for assessing maternal and fetal health. And these procedures are essentially the same wherever you're practicing, whether it's at Echuca or Parkville, Dili in Timor, or an outlying health post in a Pacific island. It's just the process of escalation to hospital or obstetric care might be variably complicated by geography. But generally history and examination are the same in high resource settings or in FANC, focused antenatal care. The documentation variably might be as an electronic record or a paper record. You as medical students can help with these records and confirm that the woman is involved in record keeping about her pregnancy.

So the third task is about tests. Now these vary more according to the local health priorities and available resources. But what you're likely to see in Australia practice at the time or closer to the time when I'm recording this is that women at 36 weeks usually have three tests. They have an FBE to assess for anemia and thrombocytopenia. They have a blood group antibody screen in preparation for Rh-D negative women having a second anti-D injection. Their first would have been about 28 weeks and their second 36, sometimes a bit earlier, weeks. The third test is a low vaginal or rectovaginal swab for group B streptococcus known as GBS.

GBS is part of normal bowel flora for about 20% of women, and it's not a pathogen there. But if it colonises the baby during labour, the baby can develop early onset pneumonia or GBS sepsis. Knowing about GBS carriage before birth allows a procedure called intrapartum chemoprophylaxis. That's a technical shorthand, admittedly using long words, saying that the procedure is to give the woman targeted penicillin-based intravenous antibiotics when she's in labour. Because this is known to be effective in reducing GBS colonisation of the infant, it's the most important time to do that in order to reduce early onset GBS sepsis.
In the FANC setting, these tests might be a bit different. They'd be modified depending on the local disease burden and available resources. And even in Australian settings, this can also be a good time, 36 weeks, to retest syphilis.

The fourth task concerns planning for what next. So the woman's usually quite aware the pregnancy's coming to an end and most are happily focused on the future, becoming a parent again or for the first time. Meeting their baby and they're busy planning. Many women have already started maternity leave a week or two before, so they've got a bit more time for planning. Others will still be working. Not all women are relaxed and happy though, so assess everyone's psychosocial wellbeing without assumptions and assist or refer as needed to

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optimise wellbeing.

All women need to know what to do if they think they're in labour or have concerns about their own health or their fetal health. So in Australian hospital practice, which is what you'll mainly see, women would have a phone line, a telephone number to put in their phone so they can ring a midwife in the birth suite. And the midwife will be very happy to chat with them, record the conversation in a progress note and record the advice given.

So some common reasons for women to ring the birth suite midwife are first, if they think they're in labour, so women are advised to call if contractions at term are five minutely or closer together, or if they just don't like the pain and would like a bit more help. Second, if they think they could have ruptured their membranes, so women are advised to call if they feel that amniotic fluid or any unusual discharge is coming out of the vagina. And third, there are some red flag symptoms that women should ring the midwife about, reduced fetal movements, vaginal bleeding, abdominal pain other than contractions, headaches, sudden increase in oedema or visual changes.

So in the FANC setting or in other settings, perhaps home birth, planned home birth, the same symptoms still need skilled and timely assessment by a midwife or doctor, but the communication systems might be different. They might ring their private midwife directly or they might visit a health post if they don't have a mobile phone.

In the high-resource settings where you will do placement in women's and newborn health, women usually have a few more non-milestone visits after the 36-week visit, so typically they will still come back for more appointments every one to two weeks, and these visits focus, again, on serial, maternal and fetal wellbeing and any additional education.

So many women will go into spontaneous labour in the month after the 36-week milestone visit. Others will have a planned birth during that month because the risks of continuing pregnancy outweigh the risks of either labour induction, so about a third of pregnant women in current practice would go through induction, or an elective caesarean section.

So I refer you and recommend you listen to podcasts on labour induction by Dr Julia Francis and on caesarean section by Dr Hannah Skrzypek because even at the 36-week visit sometimes these are issues the woman is wanting to discuss even though the procedures may not happen for a couple of weeks. The remaining milestone antenatal visit is for the 10% of women who haven't given birth by 41 weeks, and this will be the subject of a separate podcast.

So I hope you enjoy antenatal clinic. I might see you around there. Bye for now.