PRECONCEPTIONAL COUNSELING

The average likelihood of conception in any given cycles is in the order of 20% to 25%. In a cohort of 100 normal couples attempting to achieve conception, it is likely that 85 of the 100 will conceive in the first year with another 10 conceiving in the second year for an aggregate of 95 normal couples in 100 achieving conception within 24 cycles of unprotected intercourse. Just because a couple attempts to initiate conception in any given month it is unlikely that it will happen in the short term and persistence and patience likely will be required.

The use of drugs, alcohol, and tobacco in the periconceptional period must be eliminated. Enhanced lifestyle is important to a healthy pregnancy. Various problems are associated with illicit drug use. Intra-uterine growth restriction or failure to grow at the expected rate is associated with use of many drugs and tobacco. Placental abruption leading to preterm delivery or intra-uterine fetal death is associated with other drugs. Finally, the potential to increase likelihood of birth defects with some drugs is demonstrated. Finally, Fetal Alcohol Syndrome is discussed. Because there is “no safe dose” of alcohol in pregnancy, its use should be avoided in the goal of achieving the healthiest pregnancy possible. Living a healthy lifestyle in the periconceptional period and during a planned pregnancy are critical when attempting to avoid problems.

DWC urges pregnant patients and those attempting pregnancy to use appropriately selected over the counter medications when the need arises during pregnancy. The below listed medications are safe in pregnancy at published doses. Do not suffer. When the need arises feel free to treat these symptoms as suggested below.

**Cold:**
Chlortrimeton
Sudafed

**Cough:**
Robitussin DM

**Sore Throat:**
Cepestat
Cepecol

**Heart Burn:**
Maalox
Mylanta
Tums

**Constipation:**
Metamucil
Dulcolax
Pericolace
Diarrhea:  
Immodium  

Fever:  
Tylenol  (avoid Aspirin or Motrin products)  

MATERNAL CONDITIONS  

Women with pre-existing health conditions should be evaluated carefully prior to initiating pregnancy. As a general rule any chronic health condition should be brought under the tightest control possible before pregnancy.  

A general rule of thumb is that if a condition requires treatment prior to pregnancy, treatment should probably not be discontinued just because a woman is pregnant.  

DWC recommends patients consult the PDR (Physician’s Desk Reference) or Epocrates.com to review every drug they are taking. Drugs have been separated based on ability to cause demonstrated birth defects or significant problems when used in pregnancy.  

In general, DWC believes drugs in Class A, Class B and Class C can be continued during pregnancy. We believe this because these drugs have never been shown to elevate the risk of a birth defect above the baseline risk in the population. Class D and above drugs should be discontinued and changed out for drugs with demonstrated safety during pregnancy (Class A – C). That is because these drugs have been shown to increased the likelihood of having a baby with a birth defect above that in the general population. Ideally, Class D and above drugs are discontinued before pregnancy is established at the time of a pre-conceptional consultation.  

If pregnancy has already been diagnosed, Class D and above drugs should be halted immediately and substitution discussed with your DWC physician or Certified Nurse Midwife.  

WEIGHT GAIN  

Appropriate weight gain in pregnancy is important. New recommendations for weight gain in pregnancy have been developed based on patient’s pre-pregnancy BMI and are set forth:  

<table>
<thead>
<tr>
<th>Pre-Pregnancy BMI</th>
<th>BMI</th>
<th>Total Weight Gain</th>
<th>Rate of gain 2nd &amp; 3rd Trimesters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>&lt; 18.5</td>
<td>28 – 40</td>
<td>1 lb (1 – 1.3)</td>
</tr>
<tr>
<td>Normal weight</td>
<td>18.5 – 24.9</td>
<td>25 – 25</td>
<td>1 lb (0.8 – 1)</td>
</tr>
<tr>
<td>Overweight</td>
<td>25.0 – 29.9</td>
<td>15 – 25</td>
<td>0.8 lb (0.5 – 0.7)</td>
</tr>
<tr>
<td>Obese</td>
<td>≥ 30</td>
<td>11 – 20</td>
<td>0.5 lb (0.4 – 0.6)</td>
</tr>
</tbody>
</table>
You can calculate your BMI at WebMD using your height and weight. It is now well known that excessive weight gain in pregnancy is dangerous and should be discouraged. Maternal weight is determined at each office visit and goals are discussed with your care giver.

MATERNAL OBESITY

Obesity is a modifiable risk factor for pregnancy. Risks in pregnancy include gestational diabetes, hypertension in pregnancy and risk of having a fetus with congenital malformations. Risk of Cesarean Section increases with increasing BMI. Women with NIH Class 2 Obesity (BMI of 35-40) have a three times higher chance of Cesarean Section than women with normal weight. Women with elevated BMI also have significantly elevated risk of wound infection and wound disruption compared with normal weight women. Induction of labor is also harder in Obese women. Risk of failed induction increases in correspondence to increasing level of obesity. Risk of failed induction reaches 80% in NIH Class 3 Obesity.

Because of these factors, women are urged to lose as much weight as appropriate prior to pregnancy in order to reach a normal weight (normal BMI).

Bariatric Surgery is appropriate for women with NIH Class 3 Obesity (BMI > 40) or NIH Class 2 Obesity (BMI 35-40) who have associated medical disorders such as diabetes or hypertension. If surgery is contemplated, contraceptive measures should not be discontinued. The best recommendation is to allow one to one and a half years to pass after surgery prior to conception so pregnancy does not occur at the time of maximum weight loss. Studies have demonstrated no difference in outcome for women conceiving prior to or after one year.

Testing including blood pressure, diabetes screening, TSH, free T3, free T4 and Vitamin D level are reasonable prior to pregnancy for obese women.

LAB TESTING

Routine laboratory testing includes Rubella Titer, Varicella Titer, HIV, Hepatitis B Surface Antigen and CBC. Testing appropriate to any pre-existing maternal condition should also be performed along with genetic testing if appropriate. Glucose screening is indicated for women suspected to have diabetes. CMV screening is appropriate for women who work in child care facilities. Gonorrhea and Chlamydia testing for women with multiple partners or prior history of infection. Hepatitis C and toxoplasmosis may also be warranted.

GENERAL ISSUES

Patients can maintain normal exercise and activities in the peri-conceptional period. Once pregnancy is established it is usually recognized that a woman can maintain at least 70 –80% of the exertion level she is used to. Maintaining pre-pregnancy exercise schedule is encouraged in
most women but they are instructed to avoid any potential for abdominal trauma, falls or serious injury in pregnancy.

Maternal vitamin pills are recommended in the pre-conceptional period. Folic Acid, an ingredient in Maternal Vitamins, is well known to decrease the incidence of open neural tube defect when used before pregnancy is established. In fact, the benefit peaks only after a year of use so Vitamins with Folic Acid are encouraged as soon as a couple begins thinking about pregnancy. Recommended Folic Acid supplementation is 0.4 to 1 mg daily. This amount is found in Maternal Vitamins.

For women with higher likelihood of having a baby with Open Neural Tube Defect (ONTD) 5 mg of Folic Acid is recommended.

Certain infections in susceptible women during the early part of pregnancy are known to cause birth defects and increase rate of pregnancy loss. Women contemplating pregnancy should know their Rubella (German Measels) status and get immunized should they not be immune several months before entertaining pregnancy. Women should avoid changing kitty litter during pregnancy as well. Fifth’s Disease is another condition to be avoided during the first trimester so contact must be avoided with infected individuals whenever possible.

An early start to prenatal care is always encouraged. Thorough laboratory evaluation and ultrasound assessment should be conducted. Questions for your DWC Physician or CNM should be prepared in order to make the first visit as productive as possible.

We thank you for your confidence in us and hope you return to start prenatal care in the near future.
References