

4. Episiotomy: Not routine, but performed when indicated.
5. Enemas, shaves--never used.
6. C-Sections: Indications include: baby's head too big to fit ("cephalopelvic disproportion"), breech presentation, placenta previa and fetal distress.
7. Circumcisions: Usually done the day after delivery. Circumcision is not medically necessary. Risks of the procedure are small, but include infection, excessive bleeding, scarring and the possibility of requiring a future procedure to take off more foreskin or correct scarring. If you do not have it done, there is less than a 10% chance it will ever need to be done for medical reasons. Some insurance companies do not pay for circumcision as it is an elective procedure.
8. Hospital stay: 1-2 nights for a vaginal delivery, 3-4 nights for a C-Section. Your insurance company may have rules about your length of stay, and unless there is a medical reason, such as heavy bleeding or fever, we cannot extend your stay in the hospital without risking a big bill for you.

After you have the baby, you will be given a postpartum instruction sheet in the hospital.

THE WOMEN'S OB-GYN GROUP
410-997-8444

 THE LAST MONTH 

The last month is from 35-36 weeks to delivery. Full term is anywhere between 37 and 42 weeks.

Prenatal Care: You will be seen every week from 36 weeks until delivery. Beginning at 36 weeks, we will check your cervix every visit for signs of impending labor. At 36 weeks we will obtain a vaginal culture for Group B streptococcus screening.

Fetal position: By now, the baby should be in head-first or "vertex" presentation. If your baby is still breech at 36 weeks, we will discuss your options with you.

With the first baby, the head usually starts to engage ("drop") by 37-38 weeks; then the cervix starts to efface or thin-out, and finally starts to dilate. With your first baby, your cervix may or may not begin to dilate before labor starts.

With the second (or later) baby, the head may or may not engage before labor. The cervix usually begins to dilate, then efface, and then the head descends. Not infrequently, your cervix may dilate to 3 or even 4 centimeters before labor begins.

Post-Dates: If you go beyond your due date, we use the term "Post-Dates". At your due date, we perform a biophysical profile (ultrasound to look at the placenta, fetal tone & movement, and amniotic fluid volume, and fetal monitor strip).

We induce labor between 40 and 42 weeks, depending on many factors, including fetal well-being, fetal size, and readiness of the cervix for labor.

Labor: When to Call: Unless we instruct you otherwise, call us when:

1. ...You are having strong contractions every 5 minutes for at least one hour. The contractions may at first feel like back pains, menstrual cramps or gas pains, and then get stronger. You may have slight bleeding ("bloody show") or a heavy mucous discharge. You do not need to call us when you pass your mucous plug, unless you are in labor as defined here. Passage of the mucous plug means your cervix is getting ready for labor, but your labor may not start for a few days, or even a week or more.

2. ...Your water breaks, even if you are not having any contractions. We want to be called when it happens. If your membranes have ruptured, but you are not in labor, we may instruct you to stay at home for up to six hours to wait for labor only if all of the following are true: Your pregnancy has been normal, the amniotic fluid is clear (not green), the baby's head was down against the cervix at your last appointment, you have felt the baby kick after your membranes ruptured, your group B strep culture is negative, and you do not have a history of rapid labors. Depending upon individual circumstances, if you are not in labor on your own after your water breaks, we begin Pitocin induction of labor between four and six hours after your water has broken. Our goal is to deliver the baby within 24 hours of when your membranes rupture.



3. ...You have any bleeding like a period or more. If you have spotting on the toilet tissue, or blood-streaked mucous discharge, this is normal, and you shouldn't worry. But if you have bleeding that actually wets a pad, you need to call us.

Who to Call: During office hours, we can be reached by dialing our office number at 410-997-8444. When the office is closed, call 410-368-8877. If you get no answer, you can call Labor & Delivery at the hospital at 410-368-2610. If you call us during the daytime when the office is open, we will have you come to the office for a labor check. If the office is closed, your call will be forwarded to the answering service at St. Agnes Hospital, who will take your name and number. Whichever doctor that is on call will return your call as quickly as possible. If you have not heard from anyone in twenty minutes, call again.

What to Do: On nights and weekends, we will send you to the hospital for a labor check. Go to the front entrance of the hospital, and proceed to the Admissions desk. They will direct you to Labor & Delivery. In Labor & Delivery, a nurse will have you change clothes and give her a urine specimen. She will also check your blood pressure, place you on the fetal monitor and check your cervix. She will then call us and inform us of your condition.

With the first baby, labor is usually between 12 and 24 hours. It takes a variable amount of time to progress from 0 to 4 centimeters; after that, your cervix will usually dilate one centimeter per hour. When you get to 10 cm, you begin the second stage, or "pushing". This stage may take from one to three hours. You can expect us to be there by the time you are 5 cm, or earlier if you desire an epidural or have any problems.

With the second baby, labor is usually half the length of the first labor.

Pain Medications: If you are not planning "to go natural," and you need something for pain in early labor, we would administer narcotics through an I.V. Later in labor, we cannot give narcotics, because there would not be enough time for the baby to clear the drugs from its circulation before birth. Later in labor, if you need medication for pain we would recommend an epidural, placed by the anesthesiologist. Typically, we try to avoid giving an epidural before labor is well established. Ideally, you should be at least 2-3 centimeters dilated, or have a strong contraction pattern.

Answers to frequent questions:

1. IVs: Fairly typical, indicated for abnormal fetal heart pattern, maternal dehydration, VBAC's or epidurals, or IV pain control.
2. Fetal monitoring: Routine, at least for twenty minutes every two hours. If all is going well, and you wish to walk around the rest of the time, you do not have to stay on the monitor. If you need Pitocin or the amniotic fluid has meconium, you must be monitored continuously.
3. Group B streptococcus (GBS): Approximately 20% of women carry the GBS bacteria as part of the normal vaginal flora. It does not usually cause any problems to the woman. However, if a newborn comes into contact with the GBS bacteria, the baby may develop a severe infection. We therefore screen all Ob patients at 36-37 weeks for presence of this bacteria. If it is present, we treat with antibiotics in labor to avoid transmission of the bacteria to the baby during delivery