

EMERALD COAST

Obstetrics and Gynecology



PRENATAL BOOK

EIGHTH EDITION

103 E. 23rd Street

Panama City, FL 32405

(850) 769-0338

www.emeraldcoastobgyn.com

Emerald Coast Providers



Michael Ingram, MD
FACOG



Henry Breland, MD
FACOG



George Ramie, DO
FACOG



Samuel Wolf, DO
FACOG



Toni Pennington, MD
FACOG



Kimberly W. Bain, MD
FACOG



Justo Maqueira, Jr., MD
FACOG



Debbie Ivey, ARNP



Michelle Lang, ARNP



Tammie Mott,
CNM/ARNP



Donna Thomson,
CNM/ARNP



Michelle Sims,
CNM/ARNP

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This book belongs to:

Name: _____

Phone: _____

Due Date: _____

EMERALD COAST OB/GYN OBSTETRIC PHILOSOPHY

We believe strongly that while we as obstetric providers will always work diligently to improve the lives of the families we serve, we cannot accomplish the most optimal pregnancy outcome without the constant and careful cooperation of the most important member of our team – the expectant mother, herself.

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Editor: Samuel Wolf, DO



Congratulations!



Welcome to our obstetric services! Emerald Coast OB/GYN has a long tradition of providing the very best of care to expectant families living in Bay County and surrounding counties in northwest Florida. We are pleased that you have chosen us to help you throughout this important time in your life.

We have prepared this booklet to introduce our practice to you and to provide you with important information and helpful answers to many questions that will come up during your pregnancy.

Be sure to slip our little book into your bag and carry it with you at all times. You will find that you will often refer to the information contained in this book throughout your pregnancy.

This book may also be found on our website www.ecobgyn.com. A complimentary copy will be given to you at your first visit. If you lose your book, you may acquire another book for \$8.

Register on the Patient Portal

Now you can update your patient information, check test results, pay your bill, request appointments, send and receive messages from our staff by accessing the Patient Portal. Please take time to activate your account.

First Time Registration:

Go to the website: www.ecobgyn.com and click Patient Portal. On the right of the screen click the blue link that says "Sign Up Today".

1. Find Your Patient Record: Enter your name, birth date, email and phone number, Click "continue". Note: Enter the phone number on file from your **first** visit. A confirmation code will be presented on screen. You will need that number to complete the activation.

2. Verify Your Identity: To ensure your privacy, we must verify your identity with a phone call, text, or email. Enter the phone number you would like to receive your call on and click "send code". When you receive the call, answer and follow the directions. Enter the confirmation code you were given on your call into the computer. When verification is complete you will continue the registration process on your computer screen.

3. Create Your Password: You will be prompted to create a password for future logins on the patient portal. Please keep this password somewhere safe.

CONTACTING US AFTER HOURS

We have a voicemail system that will pick up your call after hours and on the weekends. The system will direct your message to our on-call provider. If you ever call our office (769-0338) and no one returns your call, please keep in mind that your back-up option is Gulf Coast Hospital's Labor & Delivery Unit at (747-7700). **Our providers are on call for urgent problems. If you are calling for a prescription refill or a non-urgent matter please call the office during regular business hours or leave a message through the non-urgent voice mailbox.**

LOCATIONS

Our main office is located at 103 E. 23rd Street. See our website for map and directions.

CALLING US DURING BUSINESS HOURS

Triage Line: OPTION # 5. We believe we have the busiest and best obstetrical call center in Northwest Florida. If you are unable to find the answer to your question in your book, please have it available for reference during your call. If you call our office during business hours and need advice, prescription refills, or want a question answered, your call will be first taken by a member of our staff. If all staff are busy assisting others, your call will automatically go to the voice mail system, and a member of our staff will be back in-touch with you as soon as possible and will be triaged appropriately.

Other Office Calls: If you are calling our office for any other reason, please listen carefully for prompts to all departments. If you do not hear an option that best fits your needs, please press the operator option and your call will be directed to the person who can best help you.

APPOINTMENTS

We cannot guarantee which provider will be present at the time of your delivery.

When you are checking out with our scheduling department, you are welcome to indicate which provider you would like to see for your next visit. If you require, or would like a labor induction when appropriate, you are welcome to request a specific provider for delivery, and we will try our best to accommodate your choice.

OFFICE VISITS

Prenatal appointments will generally be scheduled at monthly intervals up to 28 weeks gestation, then every two weeks from 28 – 36 weeks gestation, and then weekly until delivery. Should you have complications or become high risk, more frequent visits may become necessary.

SIGNING-IN

Make sure you sign in at the front desk for all appointments. Please sign in 10-15 minutes prior to your appointment time so we can keep you on schedule. If at any time during your pregnancy you have a change in insurance, benefits, or contact information, please let us know immediately. ***Note, we check almost every patient's urine in our office. It is important that when you give a urine specimen that it is a "Clean Catch". In order to perform a clean catch, separate your labia, and urinate for a second or two in the toilet. Introduce the urine cup in mid stream without allowing the stream to touch the vagina or labia. This prevents false positive results on your urine results.

NICA

We are a NICA participating practice. The Florida Birth-Related Neurological Injury Compensation Association (NICA) was created by the Florida Legislature in 1988. NICA is a statutory organization that manages the Florida Birth Related Neurological Injury Compensation Plan used to pay for the care of infants born with certain neurological injuries. This plan is available to eligible families statewide without litigation. By eliminating costly legal proceedings, and through professional management of its disbursements, NICA ensures that birth-injured infants receive the care they need while reducing the financial burden on medical providers and families. There are restrictions to eligibility for NICA coverage.

FINANCIAL COUNSELOR

We are very proud to be able to offer our patients excellent financial counseling services. We have a full-time financial counselor who is very knowledgeable about health insurance reimbursement or will be of valuable help in arranging a self-pay payment plan if you will benefit from one. She can also help to identify your payment options that can be a huge relief to your budget during this important period of your life. Call to make an appointment with her to sit down and discuss your individual needs and concerns.

FMLA PAPERWORK

If you have FMLA paperwork that needs to be filled out for your maternity leave, please leave it with the front desk staff. Please allow 7-10 business days for this to be completed. We will call you when it is ready for pickup, or we are more than happy to fax it for you.

HEALTHY START SERVICES

We are happy to provide Healthy Start Services to our prenatal patients. These services include care coordination, smoking cessation, parenting and child development education, bereavement counseling, breastfeeding education, car seat safety education and community referral. There is no cost to the family and this program is not based on income. You will fill out a Healthy Start risk assessment questionnaire to determine eligibility or you can request a specific service. The goals of Healthy Start are to improve pregnancy outcomes, to reduce infant mortality rates and to promote healthy growth and development. For more information please see J. Lee Johnson when you are in our office or call her at 850-769-0338 ext. 178.

IMPORTANT UPDATES

To keep up to date with the latest information regarding pregnancy care, like us on Facebook.

We will periodically send out updates on important issues that may come up related to pregnancy.

www.facebook.com/emeraldcoastobgyn

Telephone Directory



Bay County Health Department 597 W. 11 th St. Panama City, FL	850-872-4720
Bay County Healthy Start and Lactation Support 836 Jenks Ave., Panama City, FL 32401	850-215-1320
Domestic Violence Hotline	850-763-0706
Emerald Coast Obstetrics and Gynecology	850-769-0338
Emergency Police / Fire / Ambulance	911
Gulf Coast Medical Center	850-769-8341
Admissions	850-747-7918
Financial Counselor	850-747-7914
Pre-admissions (surgical patients)	850-747-7920
Women's Center	850-747-7700
Medicaid Office - 2505 W. 15th Street Panama City, FL 32401	850-872-4185 Toll free 866-762-2237
Quest Diagnostic Laboratory	
Panama City	850-913-0006
Panama City Beach	850-233-6420
Marianna	850-482-4918
Port St. Joe	850-227-1030
WIC/Nutrition 597 W. 11 th St. Panama City, FL	850-872-4455



Community Services

Service	Agency (ies)	Address	Telephone Number
Adoption	1. Catholic Charities of Panama City 2. Children's Home Society 3. Adoption Center 4. Florida Baptist Children's Home	1. 3128 11 th St. Panama City, FL 2. 914 Harrison Avenue Panama City, FL 3. 3 Clifford Drive, Shalimar, FL 4. 8415 Buck Lake Road, Tallahassee, FL 32317	1. 850-763-0475 2. 850-747-5411 3. 850-785-0108 4. 850-878-1458
AIDS and HIV	1. BASIC 2. Bay County Health Department	1. 432 Magnolia Ave Panama City, FL 2. 597 W. 11 th St. Panama City, FL	1. 850-785-1088 2. 850-872-4455
Breastfeeding Support	1. Healthy Start Lactation Consultant		1. 850-215-1320
Child Medical Services/ Immunizations	1. Bay County Health Department 2. Children's Medical Society	1. 597 W. 11 th St. Panama City, FL 2. 914 Harrison Ave, Panama City, FL	1. 850-872-4455 2. 850-747-5411
Clothing/Baby items	1. Catholic Charities of Panama City 2. Children's Home Society 3. Family Service Agency 4. The Pregnancy Resource Center 5. A Sheltering Tree	1. 3128 11 th St. Panama City, FL 2. 914 Harrison Ave.. Panama City, FL 3. 114 E. 9 th St., Panama City, FL 4. 745 Grace Avenue, Panama City, FL 32401 5. 1616 Bayview Avenue, Panama City, FL 32401	1. 850-763-0475 2. 850-747-5411 3. 850-785-1721 4. 850-763-1100 5. 850-763-1433
Counseling Mental Health Services	1. Life Management 2. Mental Health Society 3. Florida Therapy	1. 525 E 15 th St., Panama City, FL 2. 1137 Harrison Ave. Panama City, FL 3. 2711 West 15th Street, Panama City, FL 32401	1. 850-522-4485 2. 850-769-5441 3. 850-769-6001
Drug Abuse Treatment	1. CARES 2. Life Management	1. 4000 E. 3 rd St. Panama City, FL 2. 525 E 15 th St. Panama City, FL	1. 850-872-7676 2. 850-522-4485

Community Services



Service	Agency (ies)	Address	Telephone Number
Early Child Development	1. Early Education and Day Care Referral.	1. 450 Jenks Ave. Panama City, FL	1. 850-872-7550
Food Assistance	1. Catholic Charities of Panama City 2. Beach Care Services	1. 3128 11 th St. Panama City, FL 2. 6816 Thomas Drive, Panama City Beach, FL 32408	1. 850-763-0475 2. 850-235-3002
Food Stamps/ AFDC/WIC	1. WIC Bay County Health Department 2. Florida Dept of Children's and Families	1. 597 W. 11 th St. Panama City, FL 2. 2505 West 15 th St. Panama City, FL 32401	1. 850-872-4666 2. 850-872-7600
Housing	1. Panama City Rescue Mission 2. Domestic Violence Program 3. Hidle House	1. 609 Allen Ave Panama City, FL 2. Unlisted.	1. 850-769-0783 2. 850-763-0706 3. 850-784-1020
Prescription Assistance	1. Bay County Health Department 2. Pancare	1. 597 W. 11th St. Panama City, FL 32401 2. 2309 E. 15th St. Panama City, FL 32401	1. 850-215-0616 2. 850-767-3454
Teen Services/ Pregnancy Prevention	1. Pregnancy Resource Center 2. Children's Home Society 3. Hannah's House Maternity Home 4. The Bridge Transitional Living Program	1. 745 Grace Ave. Panama City, FL 2. 914 Harrison Ave. Panama City, FL	1. 850-763-1100 2. 850-747-5411 3. 850-215-7710 4. 850-481-8501
Transportation	1. Medicaid Transport 2. Bay Town Trolley	1. TriCounty Community Counsel (schedule rides) (arrange return pickups) 2. Multiple locations	1. 850-785-0808 850-769-2140 2. 850-769-0557



Providers and Appointments

At Emerald Coast OB/GYN we provide specialized care to the pregnant woman and her family. Our providers practice as a team to give the very best of medical and nurse-midwifery care to the women we serve.

Michael Ingram, Henry Breland, George Ramie, Samuel Wolf, Toni Pennington, Kimberly Bain, and Justo Maqueira are our obstetrical physicians. Tammie Mott, Michelle Sims and Donna Thomson are our certified nurse-midwives. All are board certified by their professional certifying organization and all are licensed in their respective field by the state of Florida. Our combined experience in the field of obstetrics exceeds 175 years! Together, we provide continuous coverage of all obstetric services to all of our patients at every hour of every day - throughout the year.

Here is some brief information about our providers. For a more complete bio, please refer to the staff section of our website.

If you desire a midwife to deliver your baby, our practice will make every attempt to accommodate your request. Simply notify our check out staff at the end of your appointment and they will have you sign our "Request for Certified Nurse Midwife Care" form and your chart will be noted.

Michael Ingram, MD

Dr. Ingram grew up in Pike County Alabama and is the first physician in his family. He attended the University of Alabama (Roll Tide!) from 1976-1980 where he obtained his undergraduate degree in chemistry and English. While at the University of Alabama, he was elected to several honor societies including Phi Beta Kappa. He married his wife of now 27 years, Marian, between ending undergraduate and starting medical school. He then was fortunate to do his medical training at the University of Alabama in Birmingham from 1980-1984 where he graduated AOA (Alpha Omega Alpha) in the top 2% of his class. His specialty training was done at the University of Colorado from 1984-1988. There he delivered many babies, became proficient at gynecological surgery and even learned a little about snow skiing. After leaving his training program, he and Marian moved to Dothan Alabama where he practiced with Women's Medical Center from 1988-1995. While in Dothan he served as a Chairman of the Dept. of OB/GYN, as a liaison to the Alabama Board of Medicine regarding the practice of midwifery in the State of Alabama, and on the Board of the Wiregrass Children's Home. Most importantly, his daughter Ashley was born in 1992 bringing great joy to his and Marian's life.

His medical practice in Florida began in 1995 when he was able to join the well established practice of Dr. Mark Wolf. This practice has continued

to grow and add many new qualified and compassionate physicians, nurse practitioners, and certified nurse midwives with the support of our growing community. Since moving to Panama City Dr. Ingram has served as Chairman of the Department of Obstetrics and Gynecology at Gulf Coast Medical Center, served on the Board of Bay County Youth Soccer Association and Bay United Soccer Club, and has actively coached girls' soccer from ages 4 to 15. He has been active in the community, and his primary interest now is in making Emerald Coast OB/GYN the best option for prenatal care and gynecological services in Bay County. Outside of his busy work life, Dr. Ingram has directed and participated in numerous volunteer medical mission trips to poverty stricken nations.

Henry Breland, MD

Dr. Breland was born and raised in Marianna, Florida. He is the fourth of five children. His father, Jabe Breland, was a physician who practiced in Marianna for over forty years. His mother, formerly Betty Baker, was born and raised in Panama City. He attended Birmingham-Southern College for two and a half years and then transferred to Florida State University into the PIMS program, a forerunner to the medical school that is now there. In 1981 he received his Bachelor of Science degree in biology and transferred to the University of Florida to complete medical school, graduating in 1984. From there he did a year of internal medicine in New Orleans, Louisiana at Tulane University, and this was followed by a year of general surgery training in Huntington, West Virginia at Marshall University. For the next several years he worked in ambulatory care and emergency medicine in West Virginia until entering ob-gyn residency in 1993 in Charleston, West Virginia. After graduation in 1997 he remained in West Virginia for four years practicing ob-gyn. He then relocated to Panama City in 2001 to join the practice here at Emerald Coast OB-GYN. He is married to the former Nancy Holley, also of Marianna. Together they have five sons.

George B. Ramie, DO

Dr. Ramie is a 1996 graduate of Bay High School. He then graduated with a Bachelors in Science in Biology at Florida State University. He graduated with his Doctorate from Nova Southeastern University with Honors. While at Nova, Dr. Ramie was distinguished as an Anatomy Fellow, and was involved in Academic teaching. He went on to complete an Internship and Residency in Obstetrics and Gynecology in the Henry Ford Health System in Detroit, Michigan. While in Residency, he completed the requirements for the Consortium in graduate medical education offered through the Michigan State University. There he was a Chief Resident of his graduating class. Dr. Ramie is Board Certified in Obstetrics and Gynecology by the American Board Osteopathic Obstetrics and Gynecology.

Dr. Ramie has a special interest in the diagnosis and management of high risk conditions affecting pregnancy. In Gynecology, Dr. Ramie's scope of practice includes Well Women care through all stages of life. He has special interest in care for women in the perimenopausal and menopausal periods, particularly as it relates to aging. He embraces a holistic approach, utilizing Bio identical hormones to restore hormone levels. His scope of practice also include pelvic floor reconstructive surgery, vaginal surgery, advanced Laparoscopic surgery, daVinci Robotic surgery and the general management of most gynecologic conditions.

Dr. Ramie has three children and makes his home in Panama City, He is passionate about the delivery of a high quality health care experience in the office and at the hospital. Dr. Ramie is involved in medical staff leadership, serving on various panels and boards that assure safety and quality for patients. He strongly believes that care should be patient driven through a non-judgmental, empathetic, and caring relationship that puts the patient-physician relationship first.

Samuel Wolf, DO

Dr. Samuel Wolf is a native of Panama City. He received a B.S. in biology at Florida State University. He earned his doctorate (D.O.) at Nova Southeastern University College of Osteopathic Medicine. He completed a traditional rotating internship through the Michigan State University Health System, where he was awarded Intern of the year. He did his ob/gyn residency at the University of Florida Health Science Center / Shands Jacksonville. During his residency, Dr. Wolf served as administrative chief resident and was the recipient of many awards for teaching and research, including the prestigious Jelks Award for outstanding resident clinician of the year. He has had extensive experience in clinical gynecology and minimally invasive robotic gynecological surgery. He joined Emerald Coast OB/GYN in August of 2005 and received his board certification from the American Board of Obstetrics and Gynecology in December of 2007 and is a Fellow of the American College of Obstetricians and Gynecologists. He is a published author of peer reviewed research in Obstetrics and Gynecology and on the board of directors for Florida Woman Care, a group of over 300 OBGYN's in the state of Florida. He has also served as the President and Medical Education Chairman for the Emerald Coast Medical Association along with various positions in leadership at both the state and national level. He served as Chief of Staff for Gulf Coast Medical Center 2016-2017. He is also the author and editor of 8 editions of this book. In his off-time, Dr. Wolf enjoys spending time with his family and loves kitesurfing, snowboarding and hockey.

Toni Pennington, MD

Dr Pennington joined Emerald Coast Obstetrics & Gynecology in 2008. She was born and raised in Sykesville, Maryland. She received her Bachelor

of Science degree from Virginia Polytechnic Institute and State University and her medical degree from the Medical College of Virginia. She completed her internship and residency at the University of Florida Health Science Center/ Shands-Jacksonville where she received multiple teaching awards, including the Berlex Teaching Award. She is board certified by the American Board of Obstetrics and Gynecology and is also a fellow of the American College of Obstetricians and Gynecologists.

Since arriving in Panama City, she has served in various board positions and currently serves as president of the Emerald Coast Medical Association. She is also the current OB GYN department chair at Gulf Coast Regional Medical Center. She particularly enjoys working with expectant mothers, as well as teens and their unique health care needs. She is also trained in minimally invasive robotic surgery.

In her spare time, Dr Pennington enjoys spending time with her husband, Scott, and their two boys. She also enjoys painting, reading, scuba diving, fishing and hiking.

Kimberly W. Bain, MD

Dr. Bain was born in Anniston, AL and grew up in Atlanta, GA. She earned a B.S. in Biology from Indiana University in 1986, graduating Summa Cum Laude and Phi Beta Kappa. She attended Vanderbilt University School of Medicine in Nashville, Tennessee, receiving her M.D. in 1990. She completed an OB/GYN residency at the University of Tennessee in Memphis. After residency she remained on the faculty for 2 years as an Instructor, teaching residents and medical students as well as seeing patients in an office setting. Dr. Bain then moved to Anniston, Alabama, where she was in private practice for 10 years. From 2006 to 2010, she was in private practice in Lexington, Kentucky where she also served as an Instructor for the University of Kentucky Department of OB/GYN. In 2010, Dr. Bain and her family relocated to Panama City where she joined Emerald Coast OB/GYN. Dr. Bain has maintained Board Certification in Obstetrics and Gynecology since 1997 and is a fellow of the American Congress of Obstetricians and Gynecologists.

She and her husband, who is also a physician, met and married while they were at Vanderbilt Medical School. They have a son and a daughter.

Dr. Bain enjoys cooking, traveling, gardening, fishing, stand-up paddleboarding, SCUBA diving, and practicing her college French.

Dr. Bain has a special interest in fitness and nutrition. She has identified techniques and knowledge that will help women of all ages remain healthy and fit. She reached a point of frustration in her own fitness journey, which she successfully addressed using specific dietary and exercise routines. She understands the challenge of fitting a commitment to healthy lifestyle and fitness into a hectic schedule. But she is passionate about preventive medicine and the huge benefits that develop, and she truly enjoys working with her patients to help them feel good, look good, and be their healthy best!

Justo Maqueira, Jr., MD

Dr. Justo Maqueira, Jr. was the first physician trained and approved to perform daVinci Robotic Gynecologic procedures in the region. Since his first daVinci Robotic hysterectomy in February 2007 he has completed over 800 procedures using the daVinci Robotic Surgical System, making him the most experienced gynecologic daVinci surgeon in this region. Currently Dr. Maqueira is the only gynecologic surgeon in the region qualified to Proctor other surgeons with Intuitive Surgical on the daVinci Robotic Surgical System. Since proctoring his first case in July 2007 he has instructed over 100 Gynecologic Surgeons using the daVinci Robotic Surgical System around the country. He has a special interest in complex minimally invasive gynecologic surgery and is Board Certified by American Board of Obstetrics & Gynecology.

Debbie Ivey, ARNP-C, WHNP

Debbie began her career in nursing many years ago as an RN but realized her potential and attended the Women's Healthcare Nurse Practitioner program at Emory University in Atlanta, GA. After graduation, she attained her National Certification as an Advanced Registered Nurse Practitioner.

Debbie is well-trained in all aspects of women's health issues evidenced in the caring and knowledgeable way she relates to and cares for her patients. She has been with Emerald Coast OB/GYN since 1998 and has built a large patient base in her area of practice. When not working, Debbie enjoys boating, swimming, watching football and spending time with her family. She is active in protecting oceanic wildlife and is an avid lover of rescue animals, given that she has two dogs that are her joy. She has one son that graduated from Florida State University and now lives in Panama City.

Michelle Lang, ARNP-C, MSN

Michelle grew up in Jacksonville, Florida and moved to Panama City in 1995. She is a graduate of Gulf Coast Community College and Florida State University. She also received a Dual Master's Degree from the University of South Alabama as a Women's Health Nurse Practitioner and Women's Health Clinical nurse. She takes special interest in adolescent gynecology as well as traditional and bio-identical hormone replacement therapy. She has worked in the specialty of women's health since 1999. Michelle joined Emerald Coast OB/GYN in 2003. She holds National Certification as a Women's Health Nurse Practitioner.

Tammie Mott, CNM/ARNP, WHCNP, MSN

Tammie is an experienced clinician, who has been assisting childbearing women for many years. Prior to becoming a certified nurse midwife and women's health care nurse practitioner, she worked for over twelve years as a registered nurse in Labor and Delivery, nine years of which have been in

the Panama City area.

She became a Registered Nurse (RN) in 1993 after receiving her Associates of Science in Nursing from Columbus University, in Columbus, Georgia. She received her Bachelor of Science in Nursing from The University of South Alabama in 2003, and her Master of Science in Nursing, with clinical specialties in nurse-midwifery and women's health in 2006, from The Frontier School of Nurse Midwifery and Family Nursing.

Tammie is certified by the American College of Nurse Midwives and by the National Certification Center as a Women's Health Nurse Practitioner. She is certified by the National Certification Center in Inpatient Obstetrics since 2002. She is also certified in fetal heart monitoring and as an AWHONN Fetal Heart Monitoring Instructor. She is a Neonatal Resuscitation Provider Instructor.

Tammie believes in a personalized approach to health and pregnancy. She enjoys caring for women from their teen years on through the mysteries of menopause.

Donna Thomson, CNM/ARNP

Donna earned her Bachelors in Nursing at the University of Delaware. She spent her early career in the Army Nurse Corps. before moving to Florida where she has resided since 1978. Donna earned her Masters in Nursing at Florida Atlantic University. She received her midwifery training at the Frontier School of Midwifery and Family Nursing in 1997. She is certified by the American Midwifery Certification Board. Donna is also certified by the National Certification Corporation in In-patient Obstetrics. She has formal certification in fetal monitoring. She three grown children and four grandsons. Donna enjoys walking, hiking, weight lifting and reading. She is a die-hard Auburn fan..War Eagle!!

Michelle Sims, CNM/ARNP

Michelle has called Panama City home since 2002. She lives here with her husband and four children. Michelle first realized her desire to care for women when she served as an Emergency Medical Technician (EMT) in the Air National Guard and witnessed the miracle of childbirth. In 2005, Michelle completed her education as a Registered Nurse (RN) at Gulf Coast State College and began her journey in Women's Health as a labor and delivery nurse. That experience sparked a desire to be more involved in the care and empowerment of women. She decided to further her education in the area of Nurse-Midwifery. In 2012 she obtained a Master of Science in Nursing from Frontier Nursing University. She completed her midwifery certification in December of 2012. Michelle enjoys patient education and focuses on the importance of building a partnership with women and their families from puberty to the post-menopausal period.



Gulf Coast Medical Center

Emerald Coast OB/GYN chooses to use only Gulf Coast Medical Center for childbirth care. We think you will agree with us that GCMC is a very nice facility in which to give birth. * If you go to Bay Medical Center ER, you will NOT be able to be seen by your providers since they do not practice at that hospital. This obviously complicates continuity of your care so we encourage you to use the ER at Gulf Coast.

GULF COAST MEDICAL CENTER:

449 West 23rd Street. Panama City, FL 32405

Located off of 23rd Street near the intersection of State Avenue. The Women's Center is located on the 2nd Floor – closest to the main entrance.

Website: www.gcmc-pc.com/services/womens-center

Labor & Delivery:	747-7700
Accreditation:	Full
Average births per month:	200
Post Partum Rooms:	Private
Bathrooms:	Complete with soaking tub
Infant Rooming-In:	Yes
Well Baby Nursery:	Yes
Lactation Consultant:.....	Full-Time
Childbirth Classes:.....	Yes, call 747-7700
Anesthesia Services:	In-House 24 hours.
Pediatricians:	Most local doctors are on-staff
Obstetrical Operating Rooms:	2
Pediatric Surgical Subspecialties:	Yes



EMERGENCY CARE

Provided in the Emergency Room until the 20th week. After 20 weeks, stable patients will initially be evaluated in Labor & Delivery.

NEONATAL INTENSIVE CARE UNIT

A Level III neonatal unit is maintained at Gulf Coast Hospital and is available for babies requiring advanced care. The hospital contracts for the full-time services of a neonatologist. Occasionally, a baby is born with an unforeseen problem requiring very specialized care. At such times the situation is handled on an individual basis and the baby is transferred to the hospital where that particular special care is available.

PRE-REGISTRATION

You must pre-register with Gulf Coast Medical Center around the 28th week of your pregnancy. Please go to the following website to do this: <https://gcmc-pc.com/patients/registration.dot> or you can just Google "Gulf Coast Hospital Preregistration".

If you are paying for childbirth expenses "out-of-pocket", you will want to visit the Admission Office at the hospital in order to learn of special discounts they may offer for advanced payment.

LACTATION SUPPORT

Lactation consultants are on staff to help you initiate breast feeding during your postpartum stay. Also, Gulf Coast Medical Center has a breastfeeding support program to help you once you have gone home. This support group is called "Tea for Two" and meets in the hospital cafeteria at 2:00pm on the 2nd and 4th Tuesdays of each month. They also offer a prenatal breastfeeding class on select Saturdays. Please call 840-747-3600 or visit their website for more information and a class schedule.

HELPFUL BREASTFEEDING NUMBERS

Bay County Healthy Start — 850-215-1320

Franklin County Healthy Start — 850-653-2111

Gulf County Healthy Start — 850-227-1276

WIC Breastfeeding Hotline (24/7) — 850-747-5775

La Leche League — 850-525-3243

LOCK DOWN

If you need to go to Labor & Delivery between the hours of 9PM and 6AM you will find that the front entrance is locked for security purposes. In this situation, you will need to enter the hospital at the Emergency Room entrance located at the east side of the facility. Also, be sure to tell family and friends that incoming telephone service to patient care rooms is cut-off at 9PM to allow you to rest. You may still call out. The doors to the Women's Center are kept locked. All visitors need to be buzzed in and out of the unit by the receptionist. Also, visitors need to sign in at the front desk and wear a visitor sticker while in the Women's Center. The post partum unit is now located on the 3rd floor of the new tower at Gulf Coast Hospital. ***The Mother-baby unit is NOT accessible to visitors via the labor unit. Visitors must go down stairs and around the hall to the ICU elevators.

VISITORS

During labor, you will be expected to limit your visitors to no more than two at a time. During the time of delivery, you will be limited to keeping up to two people with you (no trading out) until you and baby are safe and sound during the recovery period. This is a hospital policy and exceptions can only be made by making special arrangements in advance with the nursing administrator responsible for the Labor & Delivery unit. The waiting room in the Labor & Delivery unit is small and usually crowded. Remember that there is a much larger waiting room located off the first floor lobby, next to the gift/snack shop. Visitors are also welcome to purchase food and beverages in the hospital cafeteria on the first floor. Once you have given birth and completed the immediate recovery period you may have visitors with more lenient limitations. Visitors will be expected to leave the building at 9 PM. One person may stay with you overnight. Consider bringing a twin sized air mattress with you for sleeping comfort, as the sleep chairs provided by the hospital may be a bit uncomfortable. That person must be old enough to offer assistance to you. Family and friends that are ill should not come to the hospital.

***If you would like a tour of Gulf Coast Medical Center's Women's Center, please call 747-7700.**



Laboratory Tests

Towards the beginning of your pregnancy care you need to review and understand the available lab tests. As technology offers more tests, counseling for these has become more complicated. This section of the booklet will attempt to break down the essential information in an easily understandable way. Testing guidelines and available tests change over time. This is not a comprehensive review and it is important to discuss any questions you have with your provider. We are the only practice to provide a full in-house blood collection service for the convenience of our patients.

Typically patients will have blood work performed early in the pregnancy, and then again at 26-28 weeks for some routine follow up tests. We are very happy that we now offer IN-OFFICE blood collection. These specimens are collected by us, and transferred to the lab preferred by your insurance or to the lab of your choice if you are uninsured. Most insurance companies in our region prefer to use QUEST Labs with the exception of United Health Insurance who uses Lab Corp. For patients without insurance please inquire about our reduced fees negotiated with Quest through Florida Woman Care.

There are certain labs that will need to be done through Gulf Coast Medical Center. This includes the GBS culture done at 35-37 weeks. This specimen will be collected in our office and sent to Gulf Coast Medical Center's laboratory for you. (see page 58 for more information on GBS).

Standard Tests

Routine initial tests include the following: a complete blood count, blood type, Rh, antibody screen, Rubella immunity screen, RPR (syphilis screen), Hepatitis B and C screening, HIV test, thyroid screen, a urinalysis with culture if necessary. An early diabetes screen will be ordered if you are overweight based on your height. A Pap smear will be performed if indicated at your first exam. Pap smears are generally not indicated for patients less than 21 years of age. Gonorrhea and chlamydia testing will be performed on all pregnant patients unless you specifically decline. If you have never had chicken pox or the vaccine, testing for immunity will be necessary with your prenatal labs. We do not routinely test for genital herpes so please let us know if you have ever been exposed or diagnosed with it.

Around 27-29 weeks, a repeat complete blood count, RPR (syphilis screen) and a 1 hour gestational diabetes screen will be ordered. Once again, this can be done in conjunction with your OB visit. You DO NOT need to be fasting for the gestational diabetes test, but if you eat foods high in carbohydrates just

before it, you increase the risk of having a false positive test. Examples of foods that will not usually alter the results are eggs, meats, and cheese. Water is always OK. You should plan to spend about 1 ½ hours at our office or at the lab to complete this test.

3 Hour Glucose test

This test will only be ordered if your one hour gestational diabetes screen is elevated. If this test is ordered, you will need to schedule it in advance at the lab of your choice. You should plan to budget about 4 ½ hours and are required to stay within the testing facility for the duration of the test. Bring a good book, an iPad or something else to do while waiting. Eat a balanced diet that contains at least 150 grams(g) of carbohydrates per day for 3 days before the test. Fruits, breads, cereals, grains, rice, crackers and starchy vegetables such as potatoes, beans and corn are good sources of carbohydrates.

Do not eat, drink (except water), smoke or exercise strenuously for at least 8 hours before your first blood sample is taken.

Tell your provider about all prescription and non-prescription medications you are taking. You may be instructed to stop taking certain medications before the test.

These instructions are from ACOG and the ADA.

Optional Testing

One of the most important things to understand about lab tests in any area of medicine is the difference between a “screening test” and a “diagnostic test”. A screening test is designed to be a low cost rapid test that looks for a specific problem in a large population of people. Screening tests have low “false-negative” results but they usually have a high rate of being “false-positive.” If a screening test is positive it means that a diagnostic test is now indicated. Diagnostic tests are usually more expensive but tell you with certainty whether the problem is actually there or not. This is especially important when it comes to testing your baby for genetic diseases and birth defects. For many years we have had a blood test called the **Quad screen** that will tell you the chances of your baby having Down syndrome, trisomy 18, and neural tube defects such as spina bifida. The test is limited by a high false positive rate and by the fact that it cannot be done until 15 weeks gestation. Nearly all insurance companies do cover the Quad screen as part of their standard pregnancy lab package.

Noninvasive Prenatal Testing (NPT) - with cell-free fetal DNA

Historically, if a patient had a Quad screen result that suggested a high risk for being abnormal, the mother would be offered a diagnostic test which involves using a needle to remove fluid around the fetus or tissue near the

placenta to confirm the results. There are 2 main procedures to accomplish this called amniocentesis and chorionic villus sampling (CVS). Both of these invasive tests carry a certain degree of risk that the mother could miscarry. Fortunately in 2013, cell free fetal DNA testing became available which allows us to test the baby's DNA extracted from blood taken from the mother. This test offers much higher accuracy than the Quad screen, and is non-invasive. Cell-free fetal DNA testing is usually referred to as "**noninvasive prenatal testing**" or "**NPT**". There are several companies that perform this test and use brand names such as the "*Harmony test*" and the "*Panorama test*". *Now that Cell-free Fetal DNA testing (NPT) is available, most patients will not need to undergo amniocentesis or CVS testing.* Furthermore, NPT can be done as early as 10 weeks and tests for several more problems than the original Quad screen. The false positive rate is less than 1% but since it is not zero, invasive testing will still be offered to patients with a positive **NPT**.

Why not just test everyone with NPT? This is becoming the standard, however, at this time most insurance companies will cover NPT for the following reasons:

- The mother is greater than 35 years of age.
- The patient had an abnormal Early Screen or Quad screen.
- There are abnormalities on the screening ultrasound that suggest a problem.

***Please note that any patient can opt in for NPT testing. The above requirements only refer to what the insurance companies will cover. If these do not apply to you and you still want NPT testing, you will undoubtedly have out of pocket cost for the test.

Optional testing for genetic diseases in the mother

Cystic fibrosis (CF) carrier testing

Cystic fibrosis is one of the most common genetic disorders in the United States. It is associated with breathing problems, recurrent lung infections, as well as problems with digestion. There are medications that can be given to help but even with treatment, this condition causes life-long illness and a shortened life expectancy. Cystic fibrosis does not affect intelligence or physical appearance.

Cystic fibrosis is a genetic disorder that results from mistakes or changes in a certain gene. All genes come in pairs, one from the mother and the other from the father. Cystic fibrosis is present only when an individual inherits two changed (abnormal) genes, one from each parent. When an individual has one changed gene and one normal gene, the person is a carrier. No significant health problems are caused from being a carrier of cystic fibrosis. Unless someone has

had testing, they will never know they are a carrier. The chance an individual is a carrier depends on their family history and ethnic background. You can be a carrier even if no one in your family has cystic fibrosis. Once you are tested for this you will never need this test again. All babies are tested for CF at birth.

Hemoglobin disease testing

This optional test will assess genetic problems with the mother's hemoglobin such as Sickle Cell Disease or Thalassemia. We strongly recommend that African American patients and patients with Mediterranean ancestry be tested for hemoglobin disease unless they have already been tested negative.

Unfortunately CF, SMA and Hemoglobin disease are not the only genetic problems carried. There are many more that we do not specifically list on our lab consent such as Fragile X disease and certain types of muscular dystrophy. It is for this reason that giving your provider a detailed and accurate family history is extremely important. If you know of a disease or condition that runs in your family, or even if you have a family member with an unexplained form of mental retardation, please let us know so that we can offer you additional testing.



Ultrasound

ROUTINE SCANS

We offer in-office ultrasound as a service to you. With our basic ultrasound we can determine due dates, number of babies, placental location, amniotic fluid volume, and basic anatomy. While our scans are not designed to detect specific fetal anomalies, if we suspect problems during the course of an ultrasound, we will offer referral to a perinatologist (MFM) where a higher level ultrasound designed to detect specific fetal anomalies will be performed. All patients have the option of being referred for a higher level ultrasound. Notify your provider if you want this and we will schedule it for you.

OPTIONAL AND NON-COVERED SCANS

We offer 4-D ultrasound and fetal sex determination scans. While medically indicated ultrasounds are generally covered by insurance with specific indications, sex determination and 4-D ultrasound for bonding with the fetus are not covered by insurers. We offer two options if you are interested in having ultrasound beyond those which are covered by insurance plans.

GENDER DETERMINATION (NON 4-D) (\$70.00)

This is performed in 2-D mode and is a very limited survey of your baby with specific focus on the genitalia. You are more than welcome to film a short video from your smart phone. You will also be given photo images at no additional cost. Regarding sex determination, we strive to be accurate and have a very good track record, but cannot offer a 100% guarantee!

4-D ULTRASOUND (\$145.00)

Our ultrasound machines have the latest 4D technology to allow real time 3 dimensional images of your baby. You are more than welcome to film a short video from your smart phone. The best time for 4-D ultrasound is between 30 and 34 weeks gestation. ***Please remember that not all babies cooperate during their ultrasounds and we can offer no guarantee that images and photos will be "picture perfect". In the event your 4-D ultrasound pictures are not as good as you hope, we will gladly repeat your ultrasound at the discounted price of \$72.50. Both, the gender determination and 4-D ultrasound must be scheduled in advance and can be arranged at the Check Out window. Please note that your 4-D scan will take longer than any of your other ultrasounds and as a result, will not be scheduled on the same day as a visit with your provider. They will only be scheduled when you are between 30 and 34 weeks gestation.

Approved Medications



While most medications now carry "pregnancy warnings" the medications listed on these two pages are "over-the-counter" and are those we are very comfortable using during pregnancy. **We believe the medications on this list will not cause harm to your unborn baby.**

CONSTIPATION

- Surfak, Colace, Metamucil, Fibercon, magnesium oxide, or any over-the-counter stool softener may be helpful if used according to package directions. Avoid use of laxatives.

COUGH & CONGESTION

- Dimetapp, Mucinex, or Robitussin – use according to package directions.

DIARRHEA

- Imodium AD. Use according to package label.

GAS PAIN OR FLATULENCE

- Mylicon or simethicone products – use according to package directions. Also, avoid drinking through a straw. You may also use Beano before meals.

HEARTBURN, ACID INDIGESTION, OR GASTRIC REFLUX

- Gaviscon, Tums, Roloids, Mylanta, Zantac, Pepcid AC, Prilosec OTC etc. Use according to package directions.

HEMORRHOIDS

- Anusol products, Preparation H products, Tucks – use according to package directions.

APPROVED VACCINES

- The influenza (flu) shot and Tdap (tetanus, diphtheria, and pertussis) shot are safe to take during pregnancy and are highly recommended. See page (32) for details about these two vaccines. Be sure to get both of these shots to protect you and your baby!

INSOMNIA (SLEEP AIDS)

- You may use Tylenol PM, Unisom or plain Benadryl according to the package directions to occasionally help you get to sleep.

MILD DISCOMFORTS (HEADACHES, BACKACHES, “AROUND LIGAMENT” PAIN, ETC.)

- Tylenol – use according to package directions. We recommend that you avoid the use of ibuprofen, Motrin, Advil, or aspirin products **unless** specifically recommended by us. 400 mg of over-the-counter magnesium oxide works well to prevent migraine type headaches.

NAUSEA

- Emetrol. Use according to package label.
- Ginger capsules, 250mg. Take by mouth, every 6 to 8 hours on a regular basis. Peppermint can also help.
- Vitamin B-6 (25 mg tablet form). Take one tablet by mouth, every 6-8 hours on a regular basis.
- Unisom (doxylamine) 25mg tablets. Break them in half and take ½ tablet by mouth, every 6 to 8 hours on a regular basis. At this dose the remedy does not often increase sleepiness.
- Dramamine (dimenhydrinate). Take 50 to 100mg by mouth every 4 to 6 hours. Do not take more than 200mg a day if you are also taking Unisom.

SINUS CONGESTION (COLD OR ALLERGY SYMPTOMS)

- Chlortrimeton, Claritin, Zyrtec, or any Tylenol products, like Tylenol Cold, Tylenol Sinus, etc. Use according to package directions.
- You may use nasal saline spray as often as you desire.
- If you are running a fever (100.5) or have yellow/green drainage, call for an appointment.

SORE THROAT

- Throat sprays, lozenges – use according to package directions. Warm saline gargles are very helpful and can be used as often as you desire. If you have a fever of 100.5 or more, or exposure to someone with “strep throat”, you need to call our office.”

SUNBURN PROTECTION

- Be very careful about sun exposure during your pregnancy. Pregnancy hormones make it much more likely that you will burn very quickly. Use clothing, hats, umbrellas and UVB/UVA sun block to protect yourself. Also, remember to drink lots more water while outdoors in the heat. You will become dehydrated much faster while pregnant. This will cause uterine cramps.

VAGINAL ITCHING

- Monistat, Mycelex, or Gyne-Lotrimin. Use according to package directions.

***** Questions about any of the above medications or about any medications that are not listed should be discussed at an appointment or by calling our office and talking to a member of our staff on telephone duty at 769-0338, ext. #2.**

Prenatal Education



Perhaps at no other time in your life will education about your condition become more important to you and to those you love. Pregnancy is a brief but physically and emotionally challenging time in any woman's life. It's a great time to get yourself and your family prepared for the immediate future. Fortunately, many options and offerings are available to you!

For beginners, we recommend the book, **Your Pregnancy Week by Week** by Dr. Glade Curtis. You will find this book in most bookstores or at the public library. It can easily be purchased on-line at Amazon.com. Other helpful resources are listed at the end of this book.

Please note if you watch labor or birth shows on television, remember that the producers of these shows are generally filming the most sensational stories they can find and usually don't have patient education in mind during their production. SCARY!

CLASSES

Lamaze Class: Knowing that pregnancy and birth can be demanding on your body and mind, Lamaze seeks to help build your confidence and ensure that you have the education and support you need during pregnancy and birth. You have likely received a lot of information from many resources, and it's easy to feel overwhelmed. We will help you evaluate these resources to make safe and healthy choices that are best for you and your baby. Our Lamaze classes are led by Tammie Mott, CNM, LCCE. Tammie is a Lamaze Certified Childbirth Educator and has years of experience as both a labor nurse and certified nurse midwife. Please pick up one of our brochures the next time you are in the office! For more information on our Lamaze program and an updated class schedule you may call our office at 850-769-0338 or speak with a member of our staff at your next visit.

Community Pregnancy Information Classes: First Baptist Church – Downtown, Panama City (The Pregnancy Resource Center) offers a variety of prenatal and child rearing classes. The classes are provided at no charge and have the added benefit of special coupons that can be redeemed for a variety of essential supplies and equipment that expectant mothers might need. To find out more about these classes please call: 763-1100.

Gulf Coast Medical Classes: Call the Women's Center at 747-7700 to inquire about any additional childbirth education classes that may be available at the hospital.

Healthy Start offers a series of four free Childbirth Education Classes. For more information and to register, call 850-215-1320.



Morning Sickness

Nausea and vomiting with pregnancy, often referred to as “morning sickness” affects 70 to 85% of all women. It is caused by an increase in hormones released by the developing placenta early in the pregnancy. Many women experience only a queasy stomach or loss of appetite. Some women find it to be a debilitating condition. “Morning sickness” may occur at any time during the day or night, with symptoms usually starting between the 4th to 7th weeks of pregnancy and ending by the 16th week for the vast majority (90%) of women. On rare occasions, nausea and vomiting may persist throughout the pregnancy.

WHAT CAN I DO?

No one remedy will be effective at all times. It usually takes a combination of many strategies to keep problems to a minimum. Here are some helpful tips.



- Use a vitamin that contains only folic acid, B6 & B12. Take it in the late afternoon or before bed with a small meal.
- Eat small amounts of appealing food every 2 hours. Be sure to eat proteins such as nuts, eggs, yogurt, cheese, meat, & fish.
- Use aroma & taste therapy. Use lemon drops, peppermint, pickled sushi ginger, etc.
- Sip iced beverages such as lemonade, water, or ginger ale.
- Nibble crackers, toast, or gingersnaps just before getting out of bed.
- Wear seasick prevention wrist bands around-the-clock. They cost less than \$10.00 and can be found in many drug or boat supply stores.

HERBS & MEDICINES

Studies have shown the following medications and herbal remedies to be helpful. If taken on a regular basis they may prevent nausea & vomiting – rather than to immediately relieve a current episode. All are available without a prescription.

- Ginger capsules, 250mg. Take by mouth, every 6 to 8 hours on a regular basis.
- Vitamin B-50 Complex (tablet form). Break them in half and take ½ tablet by mouth, every 6 to 8 hours on a regular basis.
- Unisom (doxylamine) 25mg tablets. Break them in half and take ½ tablet by mouth, every 6 to 8 hours on a regular basis. At this dose the remedy does not often increase sleepiness.
- Dramamine (dimenhydrinate). Take 50 to 100mg by mouth every 4 to 6 hours. Do not take more than 200mg a day if you are also taking Unisom.

PRESCRIPTION MEDICATIONS

If these suggestions do not help you - please give us a call. We can prescribe other medicines that are not available over-the-counter. Some of these medications are very expensive and some cause significant sleepiness which can disrupt your normal activities.

DIET AND DEHYDRATION

If you are having difficulty tolerating a regular diet, try a BRATT diet (bananas, rice, applesauce, toast, and tea). This diet is easy on your stomach and will help provide essential nutrients. If you cannot tolerate any solid food, Gatorade is helpful by providing calories and potassium.

If you are vomiting frequently and cannot keep clear liquids down for a prolonged period of time, please give us a call. On rare occasions patients require intravenous re-hydration in the emergency room or in the infusion center at Gulf Coast Medical Center.



Warning Signs During Pregnancy

The following list of symptoms can be associated with a serious problem with your pregnancy. If you experience any of the following, notify us by telephone immediately. We are on-call 24/7, 365 days per year to cover pregnancy related emergencies. Notifying us early, can allow us to prepare the hospital staff accordingly and help to avoid problems with delay in care.

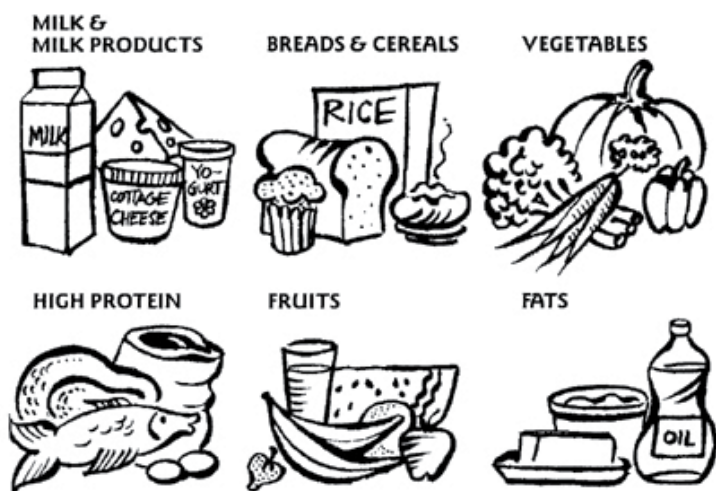
- After 24 weeks, decreased fetal movement during any 12-hour period, especially when you are resting or during the evening hours.
- Fever of 100.5 degrees or higher.
- Vaginal bleeding.
- Persistent dizziness or fainting spells that occur even though you are well hydrated and well nourished.
- Persistent headaches that occur even though you are well hydrated, well nourished, and continue after taking Tylenol and resting.
- Sudden swelling of the hands and/or face.
- Blurred, ‘sparkly’, flashy, or strange vision. Little white floaters that occur occasionally and after rubbing your eyes are nothing to worry about.
- Pain or burning associated with urination.
- Sharp abdominal pain that persists after resting.
- Persistent vomiting and/or diarrhea despite using our recommendations in this booklets section on Morning Sickness (pg. 26) and Approved Medications. (pg. 23)
- More than 4 painful contractions per hour that do not respond to hydration and rest if you are less than 36 weeks. (see Pre-term Labor pg. 51)
- Rupture of the bag of waters or leaking of amniotic fluid. Please review our booklet section on ruptured membranes. (pg. 64)
- Persistent rash, such as redness or irritation of the skin.
- Pain under your incision if you have previously delivered by c-section.
- Any other symptoms that have recent onset and are concerning to you.



Nutrition During Pregnancy



Eating right during your pregnancy is one of the very best things you can do for yourself and your baby. Pregnant women are sometimes concerned about gaining weight during pregnancy. How much weight you plan to gain during pregnancy depends on your weight before becoming pregnant. Use our weight gain graph to keep up with the amount you gain as you progress through your pregnancy. Plotting your weight on this graph will help you keep your weight gain in perspective. Only weigh yourself 1 time per day in the morning after you void.



The Six Food Groups

Where Does Your Weight Go???

- Blood -- 3.0 pounds
- Breasts -- 2.0 pounds
- Uterus -- 2.0 pounds
- Baby -- 7.5 pounds
- Placenta -- 1.5 pounds
- Amniotic fluid -- 2.0 pounds
- Retained tissue fluid -- 4.0 pounds
- Stored fat/protein -- 7.0 pounds

Total: 29 pounds

EMERALD COAST DIETARY RECOMMENDATIONS

We recommend eating 3 meals and 3 small snacks throughout the day. The *South Beach Diet* can be used as an excellent guide for your diet. When using the *South Beach Diet* be sure to select foods from both Phase I and Phase II food groups. Avoid eating more than one starch or simple carbohydrate food at any one meal or snack. The majority of your carbs should come from fruits and vegetables. Remember that juices are mainly sugar, so try to dilute them with water or diet ginger ale for instance to decrease your carb intake.

Avoid all empty calorie and fast foods - as much as humanly possible! Other tips: Don't eat chips out of the bag, don't watch TV while you eat, try to have a small appetizer 30 minutes before meals, and try to make dinner the smallest rather than the largest meal of the day. **Sweet-tea and soft drinks are absolutely horrible for you during pregnancy. Please avoid them completely.**

Remember the most important foods for your developing baby are fats and protein.

*** Ideas for snacks: Nuts, avocado, cheese on whole grain crackers, yogurt, trail mix, protein bars, sunflower seeds, dried fruits, boiled eggs, raisins, pickles, and Edamame (soy beans) which can be found in the organic frozen food section.

EMERALD COAST RECOMMENDED FOOD SERVINGS

- Whole grain Breads, Cereals, Pastas, Brown Rice, Sweet Potato 4/day
- Vegetables 4/day
- Fruit (best to eat the flesh and avoid sweetened juices)..... 3/day
- Poultry, Fish, Dry Beans, Meat, Eggs, Nuts 4/day
- Milk, Yogurt, and Cheese (low-fat) 3/day

PREGNANCY FOOD PRECAUTIONS

- Moderate fried foods, and sugar intake. It's fine to use artificial sweeteners.
- Limit your use of caffeinated beverages to 2 servings a day.
- If you have lactose sensitivity it is fine to use lactose free products.
- Do not eat unpasteurized soft or hard cheeses. Check the labels.
- Seafood known to have high mercury content includes Shark, Swordfish, King Mackerel, Tuna and Tilefish. Canned light Tuna has less than Albacore. Limit these fish to one serving a week.
- Reheat prepared meats, such as hot dogs and deli meats - reheat until steaming.
- Do not eat raw meats or seafood. Cooked oysters and sushi are fine.
- Excessive alcohol intake during pregnancy has been associated with numerous birth defects.

A healthy target weight gain for the average woman (BMI between 20 and 26) is between 25 and 35 pounds. If you were overweight at the start of your pregnancy (BMI above 26) your target should be to gain between 15 and 25 pounds. For thin women (BMI below 20) it is recommended that you gain

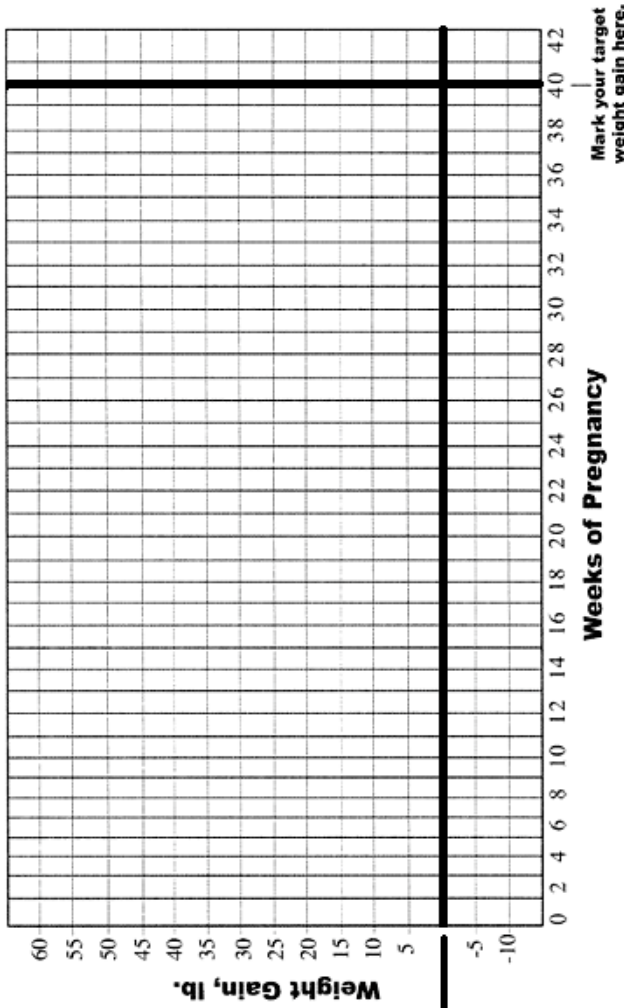
between 28 and 40 pounds. Use the weight gain graph below above to keep up with the amount you gain (or lose) as you progress through your pregnancy.

Start by writing down your starting pregnancy weight on the bold line at the far left of the chart. Record your recommended target weight gain goal range along the bold line at the far right of the chart. As you continue through your pregnancy record any gains (or losses) that have occurred since you last weighed. Try to weigh on the same scale whenever possible and try to weigh with your shoes off, whenever possible.

Plotting your weight on this chart will help you keep your weight gain in perspective.

Your Weight Gain Chart

Your BMI: _____ (Ask your nurse for this number)



Smoking



Smoking is very common in our community. In fact, 25% of all Americans smoke cigarettes. Nicotine can be as addictive as crank, heroin, or cocaine. It is always hard to quit, but the good news is that it's often easier to quit smoking during pregnancy. During pregnancy cigarettes often don't taste as good and pregnant women are more motivated to quit for their baby's sake! Cigarettes are particularly harmful to the developing fetus. Mothers who smoke are more likely than average to have the following problems:

- Miscarriage
- Small birth weight babies
- Stillborn babies
- Abruption (when the placenta separates from your uterus)

These problems arise because cigarette smoke causes premature aging of the placenta which is your baby's lifeline for oxygen and nutrition.

Problems with smoking are not limited to the pregnancy. Babies born to tobacco addicted mothers can have irritable symptoms from nicotine withdrawal. Babies living in homes where there is cigarette smoke are more prone to chronic lung problems such as asthma. Furthermore, these babies are at greater risk for sudden-infant-death syndrome. Finally, children are less likely to start smoking if their parents do not smoke. For all of these reasons (as well as for your own good health) it is extremely important to quit smoking. We will work with you and help you succeed! Our Health Care Navigator can assist you with the SCRIPT program that is designed to help you quit smoking within 7 days — ask your provider for more information.

TIPS FOR QUITTING

GET READY

Set a quit date. Reduce the number of cigarettes you smoke. Get rid of ALL cigarettes and ashtrays in your home, car, and workplace. Don't let anyone smoke in your environment. Review your past attempts to quit (what worked and what didn't). Once you quit, do not smoke – not even one puff.

GET SUPPORT & ENCOURAGEMENT

Tell your family, friends, and coworkers that you are quitting and that you want their support. Ask them to not smoke in front of you or leave cigarettes out. Get individual, group, or telephone counseling. Avoid people who secretly want you to fail!!! Talk to us – we can help!!!

LEARN NEW SKILLS & BEHAVIORS

Distract yourself from urges to smoke. Talk to someone, take a walk, or get busy with a task. When you first quit, change your routines. Take a different route to work. Drink decaffeinated tea instead of coffee. Eat lunch outdoors. Do things to reduce your stress. Take a hot bath, exercise, read a good book. Take deep and relaxing breaths of clean air. Drink lots of water. Plan something enjoyable to do every day! Buy a yoyo, paddle ball, or something to occupy your hands.

GET MEDICATION & USE IT CORRECTLY

Medications can help you stop smoking and lessen the urge to smoke. Using one of these medications will practically double your chance of quitting! Ask us for advice about the use of these medications during pregnancy. While we do not prescribe nicotine patches during pregnancy, there are other effective medications that we can prescribe.

PREPARE FOR RELAPSE OR DIFFICULT SITUATIONS

Most relapses occur within the first 3 months after quitting. Use a relapse as a learning tool and move forward. Be aware of triggers like alcohol and being around other smokers who will often encourage you to smoke with them.

ADDITIONAL SMOKING CESSATION RESOURCES:

“I Quit for You, Baby!” Free
classes.

Call Healthy Start @ 872-4130.

Quitline @ 877-822-6669



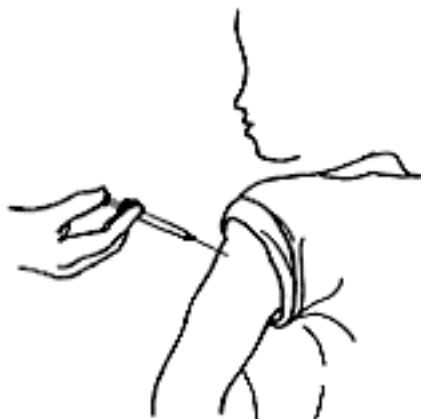
"Vaping" is not safe during pregnancy. The contents of "vapor smoking" or "E-cigarette" products are unknown. Many of the products are imported from other countries and not tightly regulated by the FDA for safety.

Important Immunizations During Pregnancy



INFLUENZA (FLU) SHOTS

Pregnant women and their babies are at increased risk of catching influenza (the flu). This is because your immune system is slightly diminished during pregnancy, which increases your risk of infections. While influenza generally causes mild illness, pregnant women are more likely to suffer more severe symptoms and the flu can even trigger premature labor. Also at higher risk are newborns and any child under age 5. You need to take this very seriously. Flu (combined season & H1N1) shots are especially recommended during pregnancy. You and your other household members should be vaccinated just as soon as vaccine becomes available. Anyone who will be in close contact with your baby should be vaccinated before your baby is born. *This is especially important because your new baby cannot receive influenza vaccine protection until she or he reaches 6 months of age.* There is evidence suggesting that vaccinated mothers can pass protection to the fetus and later to newborns through breast-feeding.



TDAP (tetanus, diphtheria, and pertussis) BOOSTER

America is experiencing a serious increase of Pertussis (whooping cough) illness in infants. Most infections are occurring in babies too young to have their own protection developed as they complete their DPT baby shots. Whooping cough illness can be life threatening to infants. Most deaths have occurred in infants younger than 2 months of age. The American Advisory Committee on Immunization Practices recommends that every pregnant woman be immunized with the Tdap vaccine between the 27th and 36th weeks of her pregnancy. Giving the vaccine late in pregnancy allows passive antibody protection to pass from the mother to her fetus. Optimal antibody protection begins occurring 2 weeks after the woman receives her immunization. Our office is able to administer the Tdap vaccine to our patients with commercial insurance. TriCare patients will need to receive their vaccinations at the base clinic. Our patients with Medicaid and those without insurance can receive their vaccine at the health department or walk-in clinics that carry the vaccine. Other household members and any other people expected to have close contact with the baby should also receive this vaccine before the baby is born.



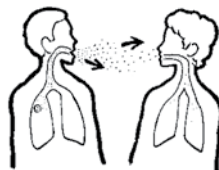
Influenza (flu) Infection & Pregnancy

SYMPTOMS

Fever (usually high) with chills, headache, extreme fatigue, dry cough, runny or stuffy nose, muscle aches, sore throat, vomiting, and occasionally, diarrhea.

WHAT IF I GET SICK?

- Stay at home and limit contact with others.
- Get lots of rest.
- Treat any fever right away (use Tylenol.)
- Aggressively increase your fluid intake.
- Call our office as soon as you believe you have the flu symptoms listed above. We will review your situation and advise you if we think testing or anti-viral medication (i.e. Tamiflu) are needed. These medications work best if started within 48 hours of becoming ill. There is little information about the effect of these medications when used during pregnancy, but no serious side effects have been reported.



HOW IS INFLUENZA SPREAD?

Influenza is spread from person-to-person by exposure to airborne viral particles and by touching surfaces that have been contaminated with secretions. It is not spread by eating pork! Here are some everyday preventive actions that can offer you protection:

- Avoid close contact with sick people.
- Cover your nose and mouth with a tissue, or your sleeve, whenever you cough or sneeze. Throw your used tissues into the trash - and wash your hands.
- Wash your hands often with soap and water, especially after you cough or sneeze. Try to wash for 20 seconds (sing Happy Birthday for good timing!) If soap and water is unavailable, alcohol-based hand cleaners are also effective. They should be rubbed in until dry.
- Avoid touching your eyes, nose or mouth. Germs enter your body through these pathways.
- Make a plan for how to care for sick family members.
- Stock up on household, health, and emergency supplies, such as Tylenol, tissues, soap and alcohol-based hand cleaners, canned goods such as soups and other non-perishable foods, etc.
- Call us if you have been exposed to someone with a flu-like illness. Antiviral medicines (i.e. Tamiflu) can be prescribed to attempt to prevent symptoms of both types of influenza after an exposure.

BREAST-FEEDING WHILE ILL

Breast-feeding is strongly recommended for infants during the flu season. Infants who are not breast-feeding are more vulnerable to infection and hospitalization for severe respiratory illness than infants who are breast-feeding. If you become ill with influenza it will be very



important to continue to provide your baby with your breast milk either by nursing or by pumping to feed. While you are ill, it is best to have healthy family members or friends care for your baby. If you are ill and do not have anyone available to help with infant care, it is advisable for you to wear a mask, if possible, when caring for your baby. Antiviral medication (i.e. Tamiflu) is acceptable for use when breast-feeding. As always, contact your pediatrician for additional information.

ZIKA VIRUS – WHAT YOU NEED TO KNOW

1. **Zika primarily spreads through infected mosquitos.** You can also get Zika through sex. Many areas in the United States have the type of mosquitoes that can spread Zika virus. These mosquitos bite during the day and night. Zika can also be passed through sex from a person who has Zika to his or her sex partners, even if the person doesn't have symptoms.

2. **The best way to prevent Zika is to prevent mosquito bites.**

- Use EPA-registered insect repellent – it works!
- Wear long-sleeved shirts and long pants.
- Stay in places with air conditioning or window and door screens.
- Remove standing water around your home.

3. **Zika is linked to birth defects.**

Zika infection during pregnancy can cause a serious birth defect called microcephaly that is a sign of incomplete brain development. Doctors have also found other problems in pregnancies and among fetuses and infants infected with Zika virus before birth. If you are pregnant and have a partner who lives in or has traveled to an area with risk of Zika, use condoms or do not have sex during your pregnancy. To be effective, condoms should be used from start to finish, every time during vaginal, anal, and oral sex.

4. **Pregnant women should not travel to areas with risk of Zika.**

If you must travel to one of these areas, talk to your healthcare provider first and strictly follow steps to prevent mosquito bites and sexual transmission during your trip. See CDC's guidance for the US for information on travel within the continental US and Hawaii.

5. **Returning travelers infected with Zika can spread the virus through mosquito bites and sex.**

Even if they do not feel sick, travelers returning from an area with risk of Zika should take steps to prevent mosquito bites for 3 weeks so they do not spread Zika to uninfected mosquitoes. If a mosquito bites a person while he or she has Zika virus in his or her blood, the mosquito can become infected and then infect other people.

Couples with a partner who lives in or has traveled to an area with risk of Zika, especially those who are pregnant or planning to become pregnant, should take steps to protect during sex. Zika can stay in semen for months after infection (even without symptoms), and can be spread to partners during that time.

Zika virus updates and information can be found at www.cdc.gov/pregnancy/zika.



Herpes Infections & Pregnancy

Oral and genital herpes infections can be problematic in pregnancy. The biggest concern with genital herpes is transmission to the baby at the time of birth. Newborn herpes infection is rare but can be devastating to the baby. Transmission occurs by “shedding” of virus particles from an active herpes lesion. The risk of transmission is high if the mother has her first infection during the pregnancy (Primary infection). On rare occasions the mother can transmit a primary infection to her baby through the placenta during the first or early second trimester. This can cause serious fetal malformations and also lead to a miscarriage. Transmission to the infant with recurrent herpes infections is much rarer because the mother has usually passed antibodies to the baby through the placenta during the pregnancy.

Patients with an active genital herpes infection need to be delivered by c-section. If you have a history of herpes infection and present to the hospital in labor, it is important to notify your nurse and/or provider if you think you have symptoms of an outbreak. The virus is transmissible to the baby even in the first couple of days before a blister starts. It is recommended that patients with a history of herpes be started on an antiviral medication between 35-37 weeks gestation. Recent studies have shown that this significantly reduces the risk of an outbreak at the time of delivery. This medication is usually continued several weeks into the postpartum period.

About 5% of newborn herpes infections are contracted after birth. Make sure people always wash their hands before touching your baby, and never let anyone with a cold sore kiss, nuzzle, or hold your baby. Any herpes infection can be dangerous to a newborn, including the kind that causes cold sores. If you have an outbreak anywhere on your body cover it and minimize baby contact with that area. Wash your hands frequently. If you develop a herpes sore in or on your mouth avoid kissing your baby until it is completely gone. Wear a mask until the sore has crusted and dried.

It is safe to breast-feed while you have a herpes outbreak as long as there are no lesions on the breasts. Once again, hand washing in this case is imperative.

Headache in Pregnancy



Occasionally, a woman with chronic headaches prior to pregnancy will experience a reduction in headache frequency. However, due to increased estrogen levels during pregnancy some women who suffer from migraines may have an increase in the frequency and severity of their headaches. Unfortunately, most women with problem headaches will continue to live with headaches during their pregnancy. Due to hormonal changes, blood sugar fluctuations, and sometimes, dehydration, women with no history of migraines may develop headaches during pregnancy.

TIPS FOR LIVING WITH HEADACHES

- If you are under the care of a neurologist, chiropractor, or pain management specialist, please continue your care while pregnant.
- If you need medication for your headaches be sure to talk with us about it. Some headache medications should not be used during certain periods of your pregnancy.
- Avoid headache triggers. Some food triggers include; MSG, chocolate, nuts, peanut butter, bananas, onions, avocado, NutraSweet (Equal), pickled foods, yogurt, sour cream, aged cheese, processed meats, pizza, and caffeine.
- Eat frequent small meals that contain some protein. Examples of protein include dairy products, eggs, meats, and beans. These foods help you avoid low blood sugar which is a common cause of headaches during pregnancy.
- Drink plenty of liquids. Dehydration is a common problem during pregnancy and can contribute to headaches. Water is your best source of hydration. Remember that small amounts of caffeine have not been shown to be harmful during pregnancy; however, it is a diuretic and can cause dehydration. Furthermore, it is not uncommon for patients to experience headaches secondary to caffeine withdrawal.
- 400 mg of Magnesium Oxide taken twice daily, has been shown to significantly decrease incident of migraine headaches.
- If you think your headache may be related to sinus congestion try using a decongestant (see page 24). You can also place warm compresses on your face just above and below the eyes. Saline nasal sprays and breathing steam can also help reduce the pressure of sinus congestion.
- It is OK to take Tylenol alone - or with Benadryl (Tylenol PM) to treat your headache. Do not take Benadryl or Tylenol PM unless you can rest for a while in a darkened and quiet room. Benadryl causes sleepiness and is unsafe to use if you are doing anything that requires you to remain alert. If you need to remain alert, take plain Tylenol – regular or extra strength as directed on the bottle.

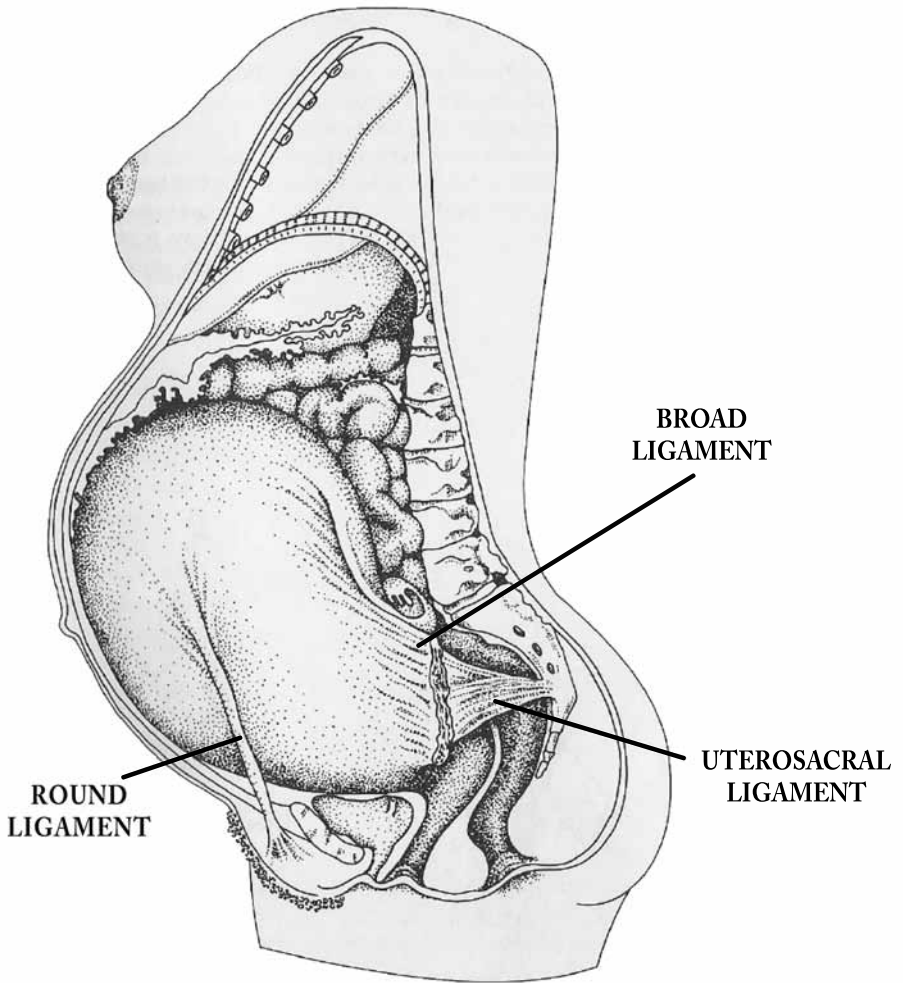
***If you are having a severe headache accompanied by visual changes, weakness, or numbness, contact us immediately even if it occurs after your delivery.



Ligament Pain

There are 3 main sets of ligaments that support the uterus. 1) The round ligaments attach the front sides of the uterus to the pubic bone. 2) The broad ligaments support the far sides of the uterus to the pelvic bone sidewalls. 3) The uterosacral ligaments support the back of the uterus to the lower part of the vertebrae just above the buttocks. As the uterus begins to grow out of the pelvis, the ligaments stretch like thick rubber bands and can cause cramping and sharp pains.

- During the first three months of pregnancy many women report that they feel crampy just like they do before or during a menstrual period. This may be due to the stretching of all 6 of the ligaments.
- During the second and third trimester the round ligaments can cause pain in the lower abdomen, in the pubic region, and on either or both sides. This is a normal but uncomfortable occurrence and usually resolves once the uterus grows to full-term size. When round ligament pain occurs, there is a sharp, stabbing kind of pain, that fortunately is brief. Round ligament pain frequently occurs with a sudden movement, coughing or sneezing, stretching, heavy lifting, standing, or a twisting of the upper body (like beginning to roll over in bed without first bending the knees.) When round ligament pain occurs it can be resolved by lying on the side that hurts - with the legs curled up against the abdomen. A heating pad, warm bath, and/or Tylenol frequently help relieve the discomfort. An elastic maternity belt is also helpful and can be worn over or under your clothes. If the pain is prolonged without improvement, or is accompanied by vaginal bleeding, fever, upper/mid back pain, nausea, vomiting, diarrhea, or burning with urination you should contact us or report to Labor and Delivery.
- Low back pain is usually caused from stretching of the uterosacral ligaments. This can frequently be eased with a heating pad, warm bath (remember that prolonged soaking in hot tubs is not recommended during pregnancy), massage, and Tylenol. We also recommend the “Cat & Cow” Yoga exercise to relieve this discomfort. Please review recommendations found in the back pain section of this book on page 42.



**ROUND
LIGAMENT**

**BROAD
LIGAMENT**

**UTEROSACRAL
LIGAMENT**

UTERUS



Back Pain During Pregnancy

Back pain is a very common complaint during pregnancy. As your baby grows there will be strain and stretching of the back muscles, ligaments, and joints. Additionally, hormonal changes of pregnancy will cause some relaxation of your abdominal muscles. Furthermore, pregnancy changes your center of gravity and causes you to walk differently making you use muscles you are not used to using.

To help prevent or ease low back pain, try our suggestions listed below:

- Be aware of how you sit, stand and move. Check your posture. Tuck your tummy in and keep your back straight, as if your hair is being pulled straight up.
- Wear low heeled shoes with good arch support.
- When standing for long periods, move in place or put one foot up on a stool.
- If your bed is soft, have someone place a board between the box spring and mattress.
- Try to not bend from the waist to pick things up, squat down, bend your knees and keep your back straight.
- Sit in chairs that have good back support. Try placing a small pillow behind your low back when sitting.



- Sleep on your side with pillows between your legs for support. Try a small pillow under your tummy.
- A hot or cold pack applied to the area may help. Try a warm shower or bath
- Book a massage, or get your partner or a friend to help. If you want to book a massage, most licensed therapists require a prescription before they will work on pregnant patients, so let us know and we will refer you.
- Use a maternity support belt to help support the growing uterus and your low back muscles.
- Do the “Cat & Cow” Stretch exercise for low back pain
 - ▶ Get on your hands and knees and curl your back up like an angry cat, holding the position for the count of 5 while blowing out all of your air.
 - ▶ Then, flex your back down toward the floor letting your back sway like a cow. Look up to the ceiling and breathe in deeply.
 - ▶ Breathe in when flexing to the floor and breathe out when arching up.
 - ▶ Let your baby dangle and concentrate on relaxing your spine muscles.
 - ▶ Repeat these stretches 15 to 20 times at each session and do them several times a day.

Cat & Cow Stretch





- Do the Pigeon Stretch exercise for sciatic and low back discomfort
 - ▶ Start on your hands and knees with your hands shoulder length apart.
 - ▶ Bring your left leg in front of you with the knee bent. Bring the left knee to the outside of the left and allow the right leg to straighten and release to the floor.
 - ▶ Square the hips towards the floor.
 - ▶ Add padding under the left side of the buttock as necessary to bring the hips square.
 - ▶ You can then extend your right foot backward and deepen the stretch while keeping your hips straight.
 - ▶ Hold the stretch for several minutes then switch sides.

There is a link to a short instructional video in the FAQ section of our website. www.ecobgyn.com

Remember, sometimes back pain can be the first sign of a serious problem. If you find that these measures are not helpful for your back discomfort or if you are becoming worse rather than improving please call to discuss your symptoms.

Exercise During Pregnancy



In the absence of medical or pregnancy complications, 30 minutes or more of moderate exercise a day is recommended. In general, pregnant women engaging in regular, moderately intense physical activity continue to derive the same health benefits during pregnancy as they did prior to becoming pregnant. Some women are very physically active and are used to regular exercise. With a few modifications these women may continue their program as long as their pregnancy is uncomplicated. Women who are not used to regular exercise but want to begin an appropriate program may do so to gain the health benefits that exercise can offer during pregnancy. Exercise increases your energy level, helps mobilize fluids to decrease swelling, and may be helpful in the prevention and management of gestational diabetes. As always, if you have any questions or concerns regarding a specific exercise program or any problems you encounter during exercise, please talk with us.

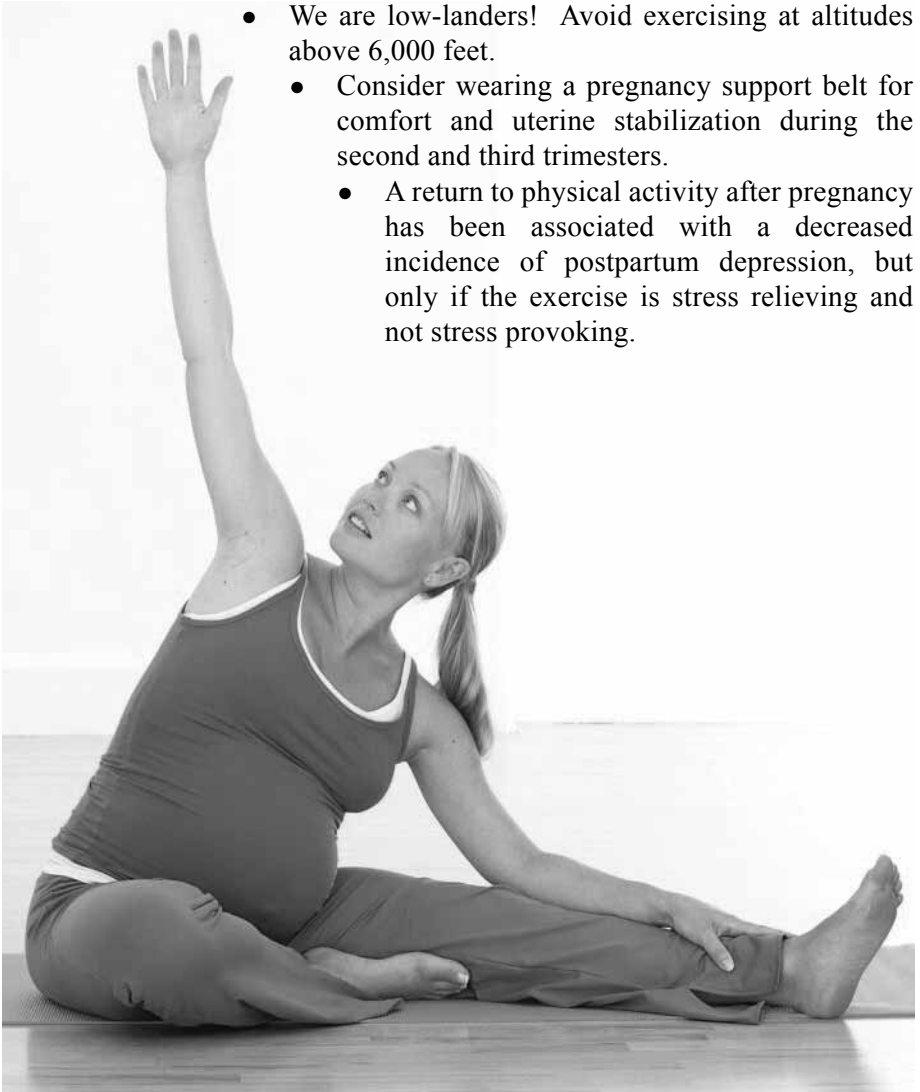
CONSIDERATIONS AND GUIDELINES

- Remember that your center of gravity changes as the pregnancy advances which can make you clumsier and more prone to falling. Plan accordingly and try to exercise with a buddy or at least carry a cellphone.
- Whenever you exercise remember that you need to increase your fluid intake so that you avoid dehydration, dizziness and muscle cramps (remember, that the uterus is a muscle!).
- Be sure to wear shoes and clothing appropriate for your exercise routine.
- Stop the activity, or slow down and rest if you become extremely short of breath, develop pain in your chest, notice dizziness, or develop frequent uterine contractions. If these symptoms continue, speak with us about the problem.
- Many women find that walking, dancing, swimming, and Yoga offer excellent benefits and are ideal exercises during pregnancy and the postpartum period. After the first trimester, try not to exercise while lying flat on your back except for brief moments. We recommend the Gaiam Prenatal Yoga DVD/Video available at Target. You may also purchase the DVD at www.gaiam.com for \$15.
- Avoid sports with a high potential for contact injuries such as basketball, football, and soccer. Also avoid exercise with a high potential for falling such as horseback riding, mountain climbing, gymnastics, downhill skiing, and cycling. This is especially important in the second half of

pregnancy when the baby loses the protection of the pelvic bones.

- Scuba diving below 32 feet during pregnancy is not recommended. Your fetus can get the bends even if you do not. Skin diving and snorkeling are fine, but remember to use the buddy system. You will fatigue easier during pregnancy.
- Avoid bouncy or bumpy rides such as jet skiing or boating in choppy water, and off-road riding in all-terrain vehicles.
- When participating in aerobic exercise be certain to slow down whenever you notice that you cannot talk comfortably during your workout.
- Always wear protective clothing and sun screen while exercising outdoors.

- We are low-landers! Avoid exercising at altitudes above 6,000 feet.
- Consider wearing a pregnancy support belt for comfort and uterine stabilization during the second and third trimesters.
- A return to physical activity after pregnancy has been associated with a decreased incidence of postpartum depression, but only if the exercise is stress relieving and not stress provoking.



Travel During Pregnancy



Normal pregnancy should not put a damper on travel plans but some precautions are necessary. The best time to travel is between weeks 14 and 32. During this time you are usually less queasy and are not as likely to experience some of the common discomforts of late pregnancy. **If you do plan to travel, it is recommended that you carry a copy of your prenatal records with you in the event you need to be seen in a hospital during your trip.** Please arrange to see us shortly before you leave and a copy of your records will be given to you on request.

If you are traveling by plane, most airlines will allow you to fly up to a month before your due date. Try to get an aisle seat towards the front of the plane. Don't worry about the metal detectors at the airport. They will not harm your baby. If you are traveling to a foreign country please discuss this with your provider. Women who are pregnant should not travel to areas with active Zika virus infections reported. Please go to <http://www.cdc.gov/pregnancy/zika/> for the most up to date information regarding the Zika virus.

TRAVEL TIPS

- Always wear your seatbelt snugly across your pubic bone and below your growing uterus when in an automobile. Do not disable your air-bags.
- Before your trip, ask your family or friends for the name & phone number of an obstetric provider, or a hospital with obstetric services.
- Keep your travel plans flexible. Problems can come up at any time. Buy travel insurance to cover tickets and deposits that can't be refunded.
- While traveling, plan to walk about every hour. Stretch your legs often to lessen the risk of developing a blood clot and make you more comfortable. This will also decrease the amount of swelling in your ankles and feet. Don't cross your legs while sitting. Don't sit in the same position for long periods of time.
- If you are traveling longer than 4 hours, one 'baby aspirin' (81mg) taken the day before your trip and on the day of travel may help prevent blood clots.
- Wear comfortable clothing & shoes. Consider wearing support stockings.
- Carry light snacks and water with you.
- Take time to eat. A balanced and healthy diet during your trip will boost your energy and keep you feeling good. Be sure to get plenty of fiber to ease constipation, a common travel problem.
- Drink plenty of fluids to help prevent dehydration, uterine cramping, and urinary tract infection. Empty your bladder at least every two hours.
- Get plenty of sleep, and rest often.
- Stretch your back and neck muscles from time to time.
- Don't do too much. It's tempting to squeeze in as many sights as you can, but it is important to adjust your pace when you are traveling during pregnancy.



Fetal Kick Counts

Most pregnant women begin to feel the baby move sometime between the 16th and 20th weeks of pregnancy. Women who have had babies in the past will frequently feel this movement earlier than those having their first baby. We call this early movement “Quickening”, a term that comes from the Bible - meaning “life”. Babies are usually the most active between the hours of 10:00 PM and 2:00 AM. They may sleep for up to 40 minutes with the sleep cycle lengthening as the pregnancy progresses. Also, during late pregnancy your baby may decrease the big kicks and huge flips simply because of running out of playground space. Movements may become softer but should continue to be frequent and reassuring. After the 24th week of pregnancy keeping track of your baby’s movement habits becomes an increasingly important way for you to monitor your baby’s health. If, after the 24th week of your pregnancy you feel that your baby is not moving normally, please do a *Fetal Kick Count*. Simply follow the guidelines listed below.

FETAL KICK COUNT GUIDELINES

- Before beginning, be certain that you have recently nourished yourself. If not, eat a healthy snack with a glass of water, milk or juice.
- In a quiet place, lie down on your side - or sit in a comfortable chair. Avoid the distractions of work, television, conversations, and interruptions.
- Pay close attention to the movements of your baby. Check the time. Count every kick or movement until your baby has moved at least 10 times. Healthy babies can sleep for up to 40 minutes out of an hour! For this reason, it is important to give your baby up to 2 hours to complete the test. Once you count 10 fetal movements you can go about your day with reassurance. Remember that your baby’s sleep cycles may lengthen as your pregnancy progresses.
- As your baby grows larger, the movements usually become softer and gentler. All of your baby’s movements count, even if the activity is not as prominent as you may have noticed before.
- If you have completed 1-4, above, and your baby has still not moved at least 10 times within 2 hours you should come to our office for electronic fetal monitoring. If we are closed, you should go to Labor & Delivery at Gulf Coast Hospital. Call us first so we can let the nursing staff know you are coming. This will give us reassurance that all is well with your baby.

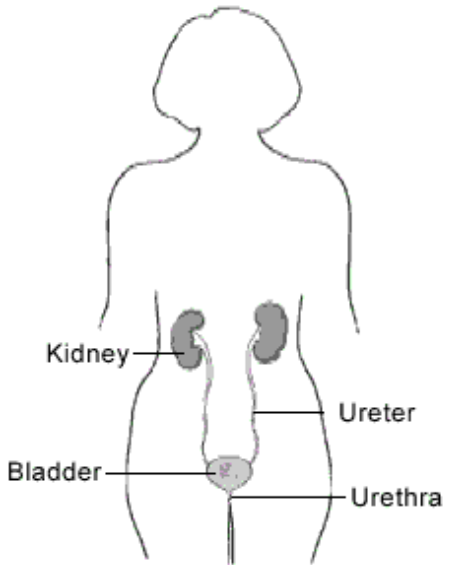
Urinary Tract Infection



Urinary tract infections can be serious during pregnancy. Bodily changes are taking place that increase your risk of urinary tract infection. Pregnancy hormones relax the muscles and valves in the urinary system, which can cause urine to move more slowly through the urinary tract. Furthermore, pressure from the growing uterus can squeeze or pinch the small tubes (ureters) that carry urine from the kidneys to the bladder. Bacteria, once in the bladder can travel upwards toward the kidneys, and can cause a very serious infection.

In addition to making you very ill, a kidney infection can trigger pre-term

labor. Pregnant women with kidney infection usually require hospitalization with intravenous antibiotics, as well as low dose antibiotic throughout the remainder of the pregnancy to prevent recurrence.



- **SYMPTOMS OF A BLADDER INFECTION:** Pain and/or burning before, during, or after urinating. Feeling more than the usual urge to urinate or increased frequency of urination. Sometimes blood can be seen in the urine or on the toilet tissue. The urine may or may not have a foul odor. Please report these symptoms to us.
- **SYMPTOMS OF A KIDNEY INFECTION:** Frequently the symptoms are the same as for a bladder infection but are often accompanied by fever, chills, generalized aches and pains, and pain in the mid-back or side. Women with a kidney infection sometimes feel like they are coming down with the flu.
- **SYMPTOMS OF A KIDNEY STONE:** This can occur with or without an infection. The most frequent symptoms are severe colic-like or spasmodic pain that does not improve with movement or time. The pain can be located in the back, side, lower abdomen, or the pubic area. Sometimes there is bloody urine or blood on toilet tissue. Please report these symptoms to us.

HOW YOU CAN HELP PREVENT URINARY TRACT INFECTIONS?

- Always wipe from front-to-back instead of wiping germs from the anal and vaginal region toward the urethral opening.
- Drink plenty of liquids daily so that you need to empty your bladder about every 2 hours. Avoid caffeinated liquids because they can cause dehydration. Cranberry juice has been reported to reduce your risk of a bladder infection.
- Always empty your bladder after sexual intercourse. This helps flush the urethra of germs.
- When lying down, remember to lie on your side. This will help release pressure off of the kidneys and the ureters.
- Rest in the knee-chest position, especially if your mid-back region is hurting.
- Make sure you are getting plenty of vitamin C.
- If antibiotics are prescribed, be certain to take all of them, and take them at the times prescribed. Never quit taking the antibiotics because you feel better! The surviving bacteria will become resistant to that antibiotic.



Pre-term Labor



Pre-term labor is defined as the onset of consistent uterine contractions that are every 5-8 minutes in a woman who is between 20 – 36 weeks pregnant, who in addition, has either spontaneous rupture of the membranes or progressive cervical dilation. **Most women who have pre-term contractions do not go into pre-term labor.**

Premature birth occurs in about one of every ten pregnancies. Prematurity can cause health problems for the baby because their lungs and other organs have not had time to fully develop. The earlier a baby is born, the more likely he or she will have health problems related to pre-term birth. Some of these problems can be immediately life-threatening as well as cause problems that affect the infant throughout his or her life.

WOMEN ARE AT INCREASED RISK OF DELIVERING PRE-TERM IF THEY:

- Have delivered a premature baby in the past.
- Are habitual users of alcohol, tobacco, or street drugs.
- Have had infections that are not treated.
- Have a multiple gestation pregnancy (i.e. twins.).
- Weighed less than 100 pounds before becoming pregnant.
- Are younger than 18 or older than 40.
- Have poor nutrition, poor dental hygiene, or obesity.
- Had bleeding problems during the pregnancy.

NOTE: Just because you don't have any of the above risk factors DOES NOT mean you can't have pre-term labor.

PRE-TERM LABOR SIGNS AND SYMPTOMS

- Irregular or regular contractions (like menstrual cramps).
- Low backache.
- Increased vaginal discharge, spotting, or fluid leaking from the vagina.
- Feelings of pressure in the pelvis.
- Fever (oral temp greater than 100.5)

IF YOUR SYMPTOMS ARE MILD AND YOU HAVE NO FLUID LEAKING OR BLEEDING YOU MAY TRY THE FOLLOWING:

- Stop what you are doing and find a place to relax.
- Drink two or three glasses of caffeine free liquid (water, juice, Gatorade).

- Empty your bladder.
- Sit or lie down and take note of the frequency of your contractions for one hour.

If your symptoms go away, you can go about your regular activities but continue to monitor for contractions. If the symptoms do not go away and you notice more than 4 painful contractions per hour call the office. During business hours we may have you come to the office for evaluation. If the office is closed we will direct you to Labor & Delivery. **Once again it is very important for you to call our office (769-0338) and let the on-call provider know you are on your way.**

► During an evaluation of pre-term labor we will monitor your contractions using the electronic fetal monitor and may perform a vaginal ultrasound to measure the length of your cervix. A short cervix can be a risk factor for pre-term birth. We sometimes also order a test call Fetal fibronectin to determine your risk of delivering prematurely within the next few weeks. Each of these tests is a non-invasive method of evaluating your risk for premature labor. These tests are helpful but not definitive. They frequently will give false positive results. Pre-term labor has many causes and often can be a difficult problem to diagnose.

► Patients who have a history of pre-term birth are at increased risk of pre-term labor in subsequent pregnancies. Weekly progesterone injections starting at 16-18 weeks have been shown to decrease the risk of pre-term delivery in this high-risk group of patients. If you feel you may be at risk for pre-term labor, please discuss this with your provider.



Blood Pressure Problems



Blood pressure (BP) refers to the amount of pressure exerted on the walls of your arteries during both the contraction and relaxation phases of your heart-beat. A blood pressure reading has 2 numbers. You may hear it referred to as “120 over 80”. The first number is called the *systolic* pressure, and the second number is the *diastolic* pressure. Blood pressure changes often throughout the day. When a person’s blood pressure stays high for some reason, it may signal a problem.

If you are pregnant and your BP is 140/90 on several readings, this is too high. When a pregnant patient has high blood pressure it can cause blood flow problems to the fetus which can compromise growth or cause other problems with the placenta.

CATEGORIES OF HIGH BLOOD PRESSURE

CHRONIC HYPERTENSION:

This condition occurs when a mother is diagnosed with high blood pressure before pregnancy. Often medications have to be changed to drugs that are safer in pregnancy. Due to cardiovascular changes throughout the pregnancy, patients with chronic hypertension have to be monitored very closely.

GESTATIONAL HYPERTENSION:

When patients who do not have chronic hypertension, develop high blood pressure during the second half of pregnancy it is referred to as gestational hypertension. This condition requires careful monitoring and can lead to pre-eclampsia (see below).

PRE-ECLAMPSIA (previously referred to as Toxemia)

This is a serious medical condition that can affect all organs of the body. We do not completely understand why pre-eclampsia occurs, but it is a potentially life threatening disease that occurs in the presence of high blood pressure usually in the third trimester. It is usually diagnosed by the presence of protein in the urine representing stress on the kidneys. Other clinical features of pre-eclampsia include:

- Headaches
- Rapid weight gain

- Severe swelling of hands and face
- Visual disturbances
- Abdominal pain around the liver
- Seizures – if seizures develop, the disease is referred to as Eclampsia

Patients with pre-eclampsia may need to be hospitalized. Patients that develop severe pre-eclampsia may require early delivery.

If you develop any blood pressure problems in pregnancy, you can expect more frequent office visits and increased antenatal surveillance (see the section of the booklet regarding fetal testing).

Gestational Diabetes Mellitus



Diabetes is a disease that causes high blood sugar. Diabetes can occur in both pregnant and non-pregnant women. When it occurs in pregnancy, it is called gestational diabetes and if a patient is diabetic before pregnancy it is referred to as pre-gestational diabetes. There are serious health problems and complications that are associated with diabetes in pregnancy. Gestational diabetes usually resolves with the birth of the baby; however, it may persist or return later in life. This is more likely to occur in women who do not maintain a healthy diet and normal body weight as they mature.

To screen for diabetes your provider will order a 1 hour glucose tolerance test (GTT). This is usually ordered between 24 and 28 weeks. Your provider may decide to do an “early glucose tolerance test” if you have certain risk factors. If you have an early GTT, you will still need the regularly scheduled GTT in the second trimester. If your 1 hour GTT is abnormal, you will need to undergo a 3 hour GTT to make a definite diagnosis of diabetes. You do not need to be fasting for the 1 hour test but follow our eating directions found in the laboratory testing section on page 18. For the 3 hour GTT, you must be fasting! Nothing to eat or drink after midnight except water until your test is completed. We encourage water. Not drinking enough water makes multiple blood draws difficult. Otherwise, no gum, no anything!

If you are diagnosed with gestational diabetes, you will be scheduled to our Gestational Diabetes Class taught by an experienced member of our clinical team. Emerald Coast OB/GYN is the only obstetric office in the area to offer this type of specialized teaching session! Be sure to attend, if scheduled.

The ultimate goal in the treatment of pregnancy associated diabetes is overall control of the mother’s blood sugar. Optimal blood sugar control has been shown to significantly reduce the risk of inherent pregnancy and delivery complications.

After your baby is born, you will need to be tested again. This is to screen for non-gestational diabetes





Abdominal Trauma

Pregnancy provides no immunity against accidents and injury. In fact, pregnant women are more prone to falls due to changes in the center of gravity and weight gain. It is natural to worry more about any injury sustained during pregnancy because of fear of harm to your fetus. Most injuries do not damage the baby or cause the onset of miscarriage or labor. However, there are particular types of injuries or accidents that do cause us concern and must be carefully evaluated. Often the concern is related to the stage in pregnancy which the injury occurs. For example, during the first 12 weeks of your pregnancy, the developing embryo is quite well protected due to the thickness of the uterine muscle and the structure of your pelvic bones. As your pregnancy develops, the uterus becomes an abdominal organ and the uterine muscle becomes progressively thinner. Therefore, the farther along you are, the more serious the injury can be, especially when abdominal trauma and falls are involved. Here is our advice:

FIRST TRIMESTER:

If you have a motor vehicle accident or take a fall during the first 12 weeks of pregnancy you will most likely not have injured your baby. Remember that during this period of time it is normal to experience crampy pelvic and low back pain similar to those many women have with their menstrual periods. If you end up in the Emergency Room, they will check your fetal heart tones before they release you. If you have a minor injury and don't need to go to the Emergency Room, use common first aid measures such as 'RICE', (Rest, Ice, Compression, and Elevation). You may take Tylenol for minor aches and pains. Notify us if you experience vaginal bleeding.

SECOND AND THIRD TRIMESTERS

(After 13 weeks gestation):

If you have a significant fall, abdominal trauma, or an auto accident that is more than a fender-bender (i.e. you were traveling at more than 20mph, your air bags deployed, or you were compressed against the steering column or dash), we will want to evaluate both you and your baby at GCMC. While most severe obstetric complications are diagnosed within the first 4 hours following abdominal trauma, some can develop over a longer period of time. For this reason we may want to evaluate you for several hours immediately after the injury. If you are out of town at the time of the accident or injury, you should report to the nearest hospital that has an obstetric department. If you sustained a serious injury to another part of your body, such as a head or neck injury, severe laceration, fracture, or other significant bodily injury, you should receive a triage assessment in the Emergency Room prior to being released to Labor & Delivery for evaluation of your baby.

Additional Fetal Surveillance



Sometimes we need to increase the level of fetal wellbeing assessments over-and-above routine monitoring with fetal kick counts by additional testing. These tests are non-invasive in nature and are used to detect problems that may arise. There are many reasons why your provider might order additional fetal surveillance. The following list contains examples of some reasons these tests might be ordered.

PRE-EXISTING MATERNAL PROBLEMS

- Chronic hypertensive disorders
- Severe heart disease
- Chronic renal disease
- Poorly controlled hyperthyroidism
- Maternal age above 40 years
- Clotting disorders
- Type 1 diabetes mellitus
- Lupus and other systemic diseases
- Hemoglobinopathies, such as Sickle Cell Anemia

PREGNANCY RELATED DISORDERS

- Pregnancy induced hypertensive disorders
- Too much or too little amniotic fluid
- Gestational diabetes
- Previous stillbirth
- Overdue baby
- Decreased fetal movement (see our page on fetal kick counts)
- Fetal growth problems
- Multiple gestation
- Placental problems

TYPES OF TESTING

NON-STRESS TEST (NST)

This is an assessment of a baby's well-being. By changes in the fetal heart rate pattern, your provider can verify with a large degree of certainty that your baby is OK.

AMNIOTIC FLUID INDEX (AFI)

This is an ultrasound test to measure the amount of fluid around your baby.

BIOPHYSICAL PROFILE (BPP)

This is an ultrasound test to evaluate the baby's movement, muscle tone, breathing motion, and amniotic fluid volume. This test helps us determine the baby's overall well-being.



Group B Strep Testing

Group B Streptococcus (GBS) is a common bacterium that lives within the human body without causing harm to healthy people. GBS can be found in the intestine and vagina in about 3 of every 10 women. It is not a sexually transmitted disease, and it does not usually cause discharge, itching, odor, or other symptoms. It will not harm you or your sexual partner. However, in rare circumstances GBS can seriously harm a newborn baby. At the time of birth, babies are exposed to the GBS bacteria if it is present in the vagina. This can result in pneumonia, meningitis, or a blood infection. Full-term babies who are born to mothers who carry GBS in the vagina at the time of labor and childbirth have a 1 in 200 chances of getting sick from GBS during the first few days of life. Premature babies have an increased chance of becoming ill from GBS if it is present.

We can discover most people at risk for GBS transmission by culturing every pregnant woman shortly before the expected due date. We recommend culturing between the 35th and 37th week of pregnancy or earlier if there is a risk of pre-term labor (twins, etc.) For those patients anticipating a Cesarean section, we still advise the GBS test because this information will be helpful in treating any baby who becomes ill - regardless of the route of birth. We obtain the culture at the office during a regular prenatal visit. Your results will be available to us and to the nurses in Labor & Delivery after 48 hours. Occasionally, GBS can cause a urinary tract infection during pregnancy. GBS urinary tract infections are treated at the time of diagnosis.

If your culture is positive, we will recommend that you receive antibiotics during labor. If you carry GBS at the time of birth and you are given intravenous antibiotics during labor, the risk of your baby getting sick from GBS is 1 in 4000. If a baby becomes sick with GBS, it usually occurs within the first 24 hours after birth.

If you go into labor before you are cultured for GBS we will consider your GBS status 'unknown' and will recommend that you receive antibiotics during labor. In some circumstances, GBS positive patients may not have adequate time to get sufficient doses of antibiotics. In these cases, your baby may be admitted to the NICU for an observational workup for infection.

Vaginal Birth After Cesarean (VBAC)



If you have had a C-section in the past, it is imperative that you discuss the topic of VBAC with your provider. This term refers to the process of giving birth vaginally when you have previously had a Cesarean delivery in the past. Approximately 70% of women who attempt a VBAC will successfully deliver vaginally. The remainder will ultimately require a repeat C-section. Depending on your specific medical condition, there may be additional risks, benefits, and/or alternatives to VBAC. It is important to discuss your individual risks, options, and concerns with your clinician. Women with a history of having a vaginal birth prior to their previous cesarean are better candidates for VBAC.

Benefits of VBAC:

VBAC has a smaller risk of complications such as hemorrhage and infection, for the mother, when compared to repeat C-section. Recovery time is shorter and usually associated with less pain.

Risks of VBAC:

The greatest risk associated with VBAC is the increased risk of uterine scar separation, or rupture, at the site of the previous Cesarean incision. Such a separation may be minor or catastrophic requiring emergency Cesarean delivery. Most studies report the risk of uterine rupture to between 1%-3%. More recent studies place this risk as low as 0.3%-0.4% if the previous cesarean was not a vertical incision on the uterus. Emergency Cesarean delivery becomes a lifesaving procedure in cases of uterine rupture. The emergency nature of the operation adds greater risk to the mother and baby more than a planned repeat Cesarean birth.

VBAC is associated with a higher risk of harm to the baby than to the mother. If the uterus ruptures during a VBAC attempt, there may not be enough time to operate to prevent death or permanent brain injury to the baby.

Consequences to the woman who experiences a uterine rupture can include hemorrhage, damage to the uterus, bladder, ureters, bowel, and possibly death. In such an emergency there is an increased risk for the need for a blood transfusion and the risk of post-operative infection is also higher.



Selecting a Pediatrician

Choosing a pediatrician is generally a matter of personal preference and insurance restrictions. Like providers in other specialties, pediatricians may participate in some insurance plans but not others. We are very fortunate here in Panama City to have many skillful, kind and respected pediatricians in practice. Check the telephone book's Yellow Pages or ask other family members and friends for their recommendations. In addition, you may call the Gulf Coast Medical Center's, "Consult-a-Nurse Health Care Referral Line" at 747-3600 for suggestions and answers to common questions that you may have about locating a pediatrician in our community.

If you know which pediatrician you want to have care for your baby, you should call their office by your 32nd week of pregnancy to make sure they will be able to accept your new baby into their practice. You may want to request an office visit to sit down and talk about office policy and other subjects important to you - so that you get a chance to become acquainted before your baby is born.

Rather than make this type of advance arrangement, many expectant parents choose to use the services of the "on-call" pediatrician for their baby's immediate newborn care. All pediatricians practicing at Gulf Coast Medical Center take turns being the "on-call" pediatrician and provide care to all babies born during that time. Most parents find they like the "on-call" pediatrician so much that they continue care in that pediatrician's office long after their newborn baby is discharged from the hospital's nursery. Tricare families find that this option seems to work out for the best because most military families will transfer care to a physician on-base for follow-up pediatric care.



*We would like to thank the pediatric offices who have helped sponsor this educational booklet by placing an advertisement in the back of our book. We appreciate their commitment to patient education!

Induction of Labor



Inducing labor means starting or bringing on labor through medications or other methods before labor begins on its own. Labor may be induced for a variety of reasons. A primary risk of inducing labor is that it may be unsuccessful. If an induction is unsuccessful, a Cesarean section becomes necessary. When compared to a vaginal birth, a Cesarean carries higher risks of postpartum complications and a significantly longer recovery period. Generally, inductions are separated into those that are medically necessary and those that are elective.

MEDICALLY INDICATED INDUCTION:

This type of induction is recommended when the health of the woman or baby is at risk. The following are examples of why a medical induction might be needed: Overdue baby, blood pressure problems, infection, placental problem, ruptured membranes. Sometimes, an induction may be recommended due to concern that you may not make it to the hospital in time once you go into labor.

ELECTIVE INDUCTION:

This type of induction is one chosen by the woman for convenience or other non-medical reasons. It is important to understand that if you opt for elective induction, there are some associated risks. This is an important decision that you should discuss extensively with your doctor or midwife. Ideally, elective inductions are scheduled at about 39 – 41 weeks of pregnancy (by our best estimate) and when the cervix is determined to be favorable. We can evaluate your cervix when performing a pelvic exam during late pregnancy. Induction initiated when the cervix is not ‘favorable’ or ‘ripe’ carries an increased risk of the need for a cesarean section. In order for you to be a candidate for elective induction, your provider must be sure of your due date. Patients who present for initiation of prenatal care late in pregnancy often are not ideal candidates for elective induction.

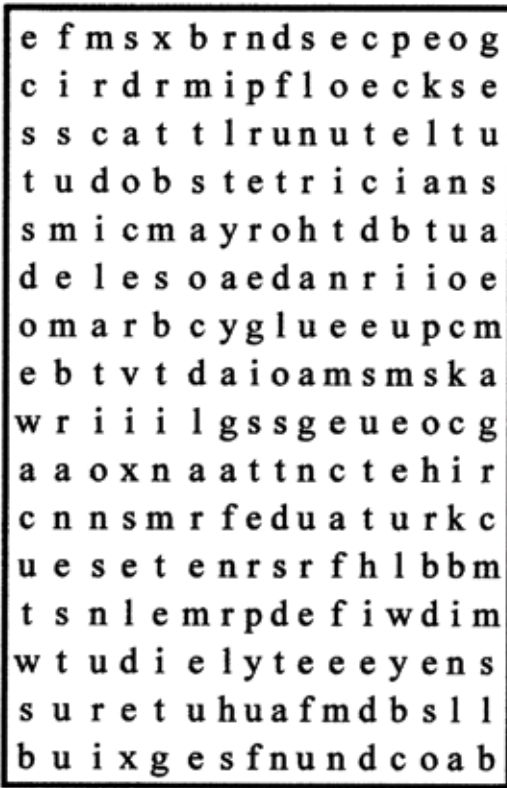
Inducing labor before the cervix is ready requires use of cervical ripening medication and necessitates hospital admission for the ripening - before the actual induction can begin. This adds expense to the childbirth process. Perhaps the best way to be certain that your baby is ready to live outside your body is to wait for the baby to initiate its own labor (within a reasonable time-frame). Inducing labor a bit too early can place the baby at increased risk for immaturity problems such as transient breathing difficulty, transient temperature control problems, newborn jaundice, and problems coordinating

suck and swallow. These problems can cause separation if your baby needs to remain in the nursery or the NICU for close observation. It can also complicate the initiation of breast-feeding, and sometimes contributes to a longer hospitalization for baby or readmission to treat for jaundice.

INDUCTION SCHEDULING

When we schedule a labor induction, there is no guarantee that Labor & Delivery will have space for you! Unlike reserving a hotel room, the Labor & Delivery unit cannot “hold” a room for us. Women who present in natural labor or require admission for medical necessity will have first priority, just as you would in the same situation. Sometimes elective inductions get “bumped”! This can be frustrating for us and especially for you and your family. For this reason, it is important that the Labor & Delivery staff has a working emergency telephone number where you can be reached if changes become necessary. Also, it is recommended that you call Labor & Delivery to be certain a room is available before you drive to the hospital. The phone number for Labor & Delivery is 747-7700. If your induction has been postponed, contact our office the next morning after 8:00

Questions: Please ask us any questions you may have about possible induction of labor. We consider the advisability of induction on an individual basis and will be happy to answer any questions you may have in this regard.



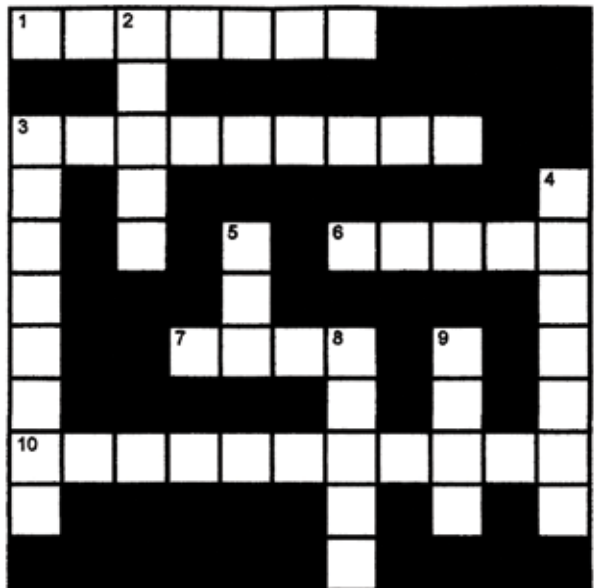
ultrasound
emeraldcoast
hospital
kickcounts
cervix
uterus
girl
boy
ligaments
mucusplug
membranes
fetus
hydrate
contraction
midwife
breastfeed
birth
dilation
effacement
preregister
obstetrician

Across

1. Drink lots of these to stay healthy!
3. What usually lasts 280 days?
6. Our "Phone ____" can answer most questions.
7. We use ____ Coast hospital.
10. ____ schedulers can schedule your visits.

Down

2. The lab we prefer.
3. ____ vitamins are important to take.
4. www.ecobgyn.com is our ____ address
5. Pregnant women need their ____ shots!
8. Your unborn baby is called a ____.
9. We recommend the South Beach ____.





Broken Water?

About 10% of the time your water will leak or break before labor begins. If your water breaks (rupture of membranes), labor usually begins soon after. Usually rupture of membranes is obvious, however, on occasion the signs can be subtle. Sometimes, an examination is needed for confirmation. Here are some tips to help you decide what to do if you suspect your water has broken or is leaking.

- The first thing to remember is that leaking urine can seem like leaking amniotic fluid. The baby can head-butt your bladder and cause some urine to leak out.
- Importantly, when your bag of water is leaking it will **not** stop. If it is urine leaking, it will stop once you have completely emptied your bladder.
- Before coming to the office or to Labor & Delivery you can always take a few minutes to do the “Panty Test” to help you decide.

THE PANTY TEST

- Completely empty your bladder.
- Cleanse the vaginal region with soapy water, rinse off and dry completely with a clean towel (you may want to use a hair dryer to dry all your pubic hair completely).
- Put on the clean panties or a fresh panty liner and walk about your home for about 15 minutes.
- Return to the bathroom and check your panties or liner.
- If you remain wet after taking the above steps you will need to report to the office or Labor & Delivery for more specific testing.
- If you remain dry, go about your regular activities but keep alert for continuing signs of leakage. Sometimes the symptoms may be subtle. If you are ever in doubt, err on the side of caution and see your care provider.



True Labor?



Our recommendations outlined in this section are specific to labor at term. If you are experiencing these symptoms before your 36th week of pregnancy, please refer to our section on “Pre-term Labor”. ([pg. 51](#)) If you are still in-doubt, please give us a call.

Sometimes it can be difficult to determine if the symptoms you are experiencing are caused by ‘pre-labor’ or the real thing! Here are a few points of advice. If ever in-doubt you may certainly call us at 769-0338 or report to Labor & Delivery for a complete assessment.

PRE-LABOR SYMPTOMS

The nature of pre-labor or “false labor” symptoms are that they generally come and go. It can be uncomfortable but you will not see a progression in strength, intensity, regularity, or frequency over a period of time. Your contractions will usually be somewhat irregular in timing and strength – no real or predictable pattern. Another clue is that pre-labor or false labor contractions change in nature when you change your activity level. Test it by resting or walking. True labor will continue despite any actions you may take, whereas pre-labor or false labor symptoms will usually subside with activity change and hydration.

THE WATER TEST

To help you rule-out pre-labor or false labor, you can try this test. Drink 3-4 glasses of clear liquid and lie on your side for about one hour. If you are in pre-labor or false labor, your contractions will begin to fade or taper off. If you are in true labor, no amount of liquids or rest will change your symptoms or stop your contractions! As always, if you are unsure, you may always call us or report to Labor & Delivery. If you go to Labor & Delivery for assessment and end up being sent home, do not be embarrassed or angry! This happens frequently. Sometimes differentiating labor from false labor can be difficult, especially for first time mothers.

TRUE LABOR

The definition of true labor is regular and painful uterine contractions that cause the cervix to dilate - over time. The nature of true labor is that it is not influenced by anything you do. It will not matter if you remain still or active – true labor will continue. Real labor contractions may begin as mild

or irregular but over time become predictable, organized, and increasingly uncomfortable. If your water remains intact, time the contractions for at least one hour before deciding to come to the hospital. We want you to come to Labor & Delivery once your contractions are every 5 minutes and progressively getting stronger. As always, if your water breaks you need to go to the hospital without delay.

5-1-1

Remember the 5-1-1 rule! When contractions are no more than 5 minutes apart, lasting for at least one minute for a duration of one hour – you should start making arrangements to get to the hospital.

If you are in early labor and your water has not broken, you may want to walk, shop, take in a movie, catch up on household chores, or do some other activity to help you relax. A warm bath might be your perfect choice!

THE EXCEPTIONS

If you have a history of rapid labor (less than 3 hours), if you live more than one hour from the hospital, or if your Group B Strep Culture was positive, you will want to leave for the hospital once contractions are between 5 and 10 minutes apart. Mild bloody discharge can be normal up to two weeks before -- or with the onset of labor. This is sometimes referred to as “passing the mucus plug”. However, if you have bleeding enough to saturate a pad or the blood continues to be bright red in color, this should be considered serious and you should report to labor and delivery.

Labor Epidurals



LABOR EPIDURALS: What are they and what can I expect? **by Brian Kradel, MD**

Epidural Analgesia- sometimes called an epidural block causes some loss of feeling in the lower area of your body, yet you will remain awake and alert.

An epidural block is given in the lower back into a small space (epidural space) below the spinal cord. You will be asked to sit or lie on your side with your back curved outward until the procedure is completed. You can move when it is done, but you will not be allowed to get out of bed or walk around.

Before the block is performed, your skin will be cleaned and local anesthesia will be used to numb an area of your lower back. After the epidural needle is placed through this numb area into the epidural space, a small tube (catheter) is inserted through the needle, and the needle removed. Small doses of medication will be given continuously through the catheter to reduce (may not completely eliminate) the discomfort of labor. In some cases, the catheter may touch a nerve during insertion and this may cause a “tingling” or “jerking” sensation down one leg.

Because the medication needs to be absorbed into several nerves, it may take a short while for the epidural to take effect. Pain relief will begin within 10-20 minutes after the medication has been injected.

Although an epidural block will make you more comfortable, you still may be aware of your contractions. You may also feel vaginal exams as labor progresses, but they should not hurt. Your anesthesiologist or nurse anesthetist will adjust the degree of numbness for your comfort and to assist labor and delivery. You might notice temporary heaviness or weakness in your legs. This will disappear after the catheter is removed.

It is important to understand that an epidural may not completely eliminate the discomfort related to labor and delivery. The goal of any epidural placement is to reduce, not eliminate your discomfort.

Although rare, complications or side effects, such as decreased blood pressure, headaches, infection, nerve injury, paralysis and even allergic reaction or death can occur with any procedure. These risks must be accepted and consent signed by you before an epidural is performed.

A woman can decrease some of these risks by holding as still as possible while the procedure is performed. If a headache occurs (risk is 1 in 100), it

often subsides within a few days. If the headache does not stop or it becomes severe, a simple treatment (epidural blood patch) may be needed to help the headache go away. After delivery, your back may be sore from the injection for a few days. However, an epidural should not cause long-term back pain.

The veins located in the epidural space become swollen during pregnancy. Because of this, there is a risk that the anesthetic medication could be injected into one of them. Just like the IV catheter in your hand or arm. If this occurs, you may notice dizziness, rapid heartbeat, a funny taste or numbness around the mouth. If this happens, let your anesthesiologist/nurse anesthetist know right away.

If you require a cesarean delivery, the epidural catheter will be injected with a much stronger drug to increase your pain relief. This will numb your entire abdomen for the surgery. Although there is no pain, there may be feelings of pressure.

The use of an epidural for pain relief during labor and delivery does NOT slow your labor down or increase the chance of you having a cesarean delivery.

No two labors are the same and no two women have the same amount of pain. Some women need little or no pain relief, and others find that pain relief gives them better control over their labor and delivery. Talk to your doctor and your anesthesia expert about your options. Don't be afraid to ask questions and don't be afraid to ask for pain relief if you need it.

Epidurals for labor and delivery are safe procedures if performed by properly trained anesthesia providers (anesthesiologists or nurse anesthetists). Despite the safety of the procedure, it remains an "elective" procedure and not a requirement. It is important that you read and understand the anesthesia consent before the procedure is performed. You must understand and accept the risks.

Hospital Packing List



You may want to pack two bags for the hospital: one for items you'll need during labor and another for everything else you'll need during your stay. Here are some ideas!

FOR LABOR:

- Your insurance card, photo ID, birth plan if you have one, and any hospital paperwork you might need.
- Eyeglasses, if you need them. If you use contacts, you should bring 'backup' glasses just in-case.
- Cell phone, charger, backup battery, tablet, and headphones.
- Diversions for early labor such as a book, magazines, or tablet.
- Robe, nightgown, non-skid socks/slippers, and laboring clothes that you don't mind getting ruined.
- Basic toiletries including hair ties and headbands.
- Pillows for you and for your labor support partner (use colorful pillowcases so yours don't get mixed up with the hospital linen).
- Fragrant oils or lotions for massage. Favorite photos or other focal point. Something to play music on. A hand fan.
- Hard candy, breath mints or strips, lollipops.
- Lip balm or moisturizer.
- A bathing suit for your labor support partner(if you need assistance in the tub or shower.)
- Snacks and a reusable water bottle for you and your labor support person (you may want to pack a small cooler). Change for vending machines.
- Baby book for those tiny footprints!

FOR POSTPARTUM:

- Fresh clothing for you and your labor support person. You may want gowns and sweats. If you are breast feeding, try to find gowns that open or button in the front.
- Cosmetics and perhaps your hair dryer.
- Bring nursing bras and breast pads, lanolin cream and nursing pillow if you plan to breast feed. The hospital will provide sanitary pads and net panties during your stay.
- A going-home outfit. Bring something roomy, comfortable, and easy to get into. Most women still look about 6 months pregnant in that first postpartum week! Plan to wear comfortable flat heeled shoes.

FOR BABY:

- An infant car seat. You can't drive your baby home without one!

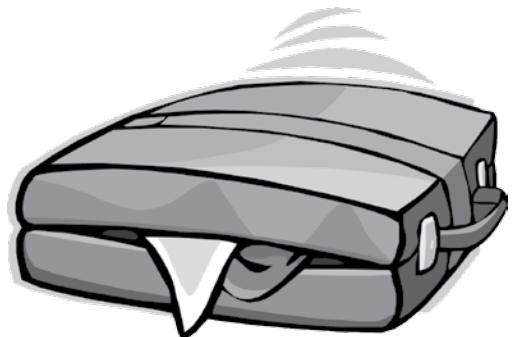
- A cute going home outfit (one-piece stretch outfits are easiest).
- A “photo opportunity” outfit - if you plan to have any commercial baby photos taken before you go home.
- Comfy newborn clothing if you wish to dress your new baby in anything other than diapers, tee-shirts, and receiving blankets provided by the hospital.
- Receiving blankets – 2.
- Mittens, caps, and socks or booties.

FOR SIBLINGS:

- A few favorite books and toys.
- Age appropriate snacks.
- A surprise gift from the new baby.
- A gift for the new baby (chosen by the sibling and wrapped prior to the new baby’s arrival).
- A disposable camera just for big brother or sister’s photos of the new baby.
- Drawing paper and crayons or markers.
- An adult that you and your children trust, just in case your child needs to leave the hospital - for any reason.
- Do not allow sick siblings to come to the hospital. While sibling visitors are encouraged but they tire easily so it is recommended to limit the time of their visits.

WHAT NOT TO BRING:

- Cash in excess of that needed for snacks
- Work materials
- Pets
- Valuables
- Credit cards or jewelry



Circumcision



If you are expecting a baby boy you will need to decide whether or not you want to have him circumcised after birth. Circumcision is a minor surgical procedure done to remove the foreskin from the penis. Most baby boys in our culture are circumcised for reasons of personal preference or for religious beliefs. The American Academy of Pediatrics has gone on the record to state that circumcision is **not medically necessary** and should be performed only for reasons of personal preference. In years past, we believed circumcision was medically necessary to prevent disease. It is now known that this is not the case. However, there is some evidence that HIV and other sexually transmitted diseases are more easily transferred in uncircumcised males. Circumcision carries a small risk of bleeding and infection. There is also a small risk of re-epithelialization in which the foreskin grows back.

WHAT SHOULD I DO RIGHT NOW?

The most important thing to do while you are still expecting is to think it over. Check out a library book, visit web sites for more information, and ask us questions. Try to have your decision made before you deliver. Since many insurers consider circumcision medically unnecessary they do not cover the cost of the procedure. Some Medicaid plans now pay for circumcision. Speak with our Front Desk staff - **now** - for more information regarding your insurance situation, our fees and our payment requirements.

WHAT IF I DECIDE TO HAVE MY BABY CIRCUMCISED?

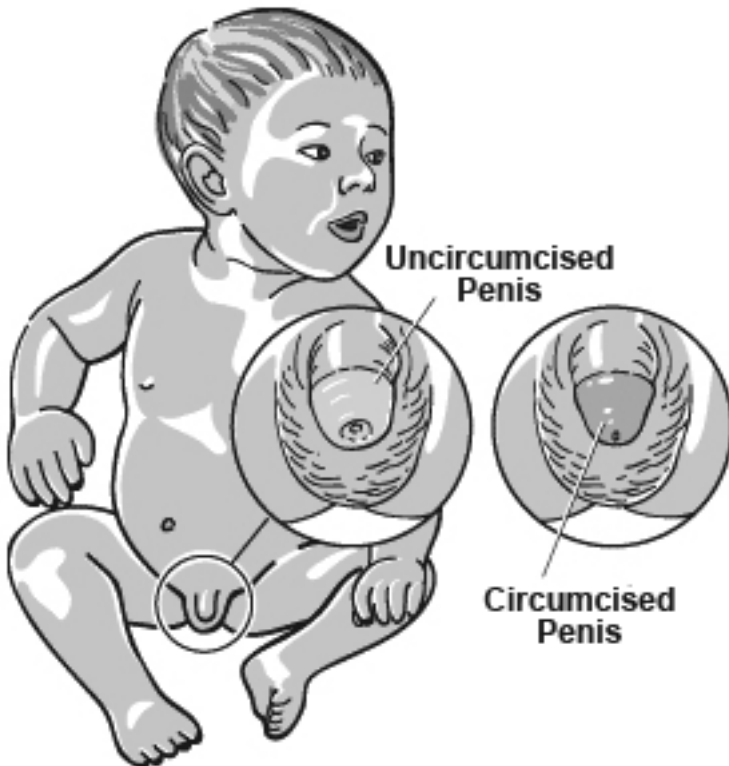
If we determine that your insurance will not cover circumcision - we ask that you pre-pay our fee before the surgery is performed. We will accept cash, check, money order, MasterCard, VISA or Amex if your insurance doesn't cover it. We charge \$200.00 if you prepay at the office during the prenatal period and \$400.00 if you do not. Our providers use the Gomco instrument to perform circumcision. **As with any cosmetic surgery, complications can arise that might require additional surgery which may result in additional expense to you.** It is best to have circumcisions performed while the baby is in the hospital. If your baby is not circumcised in the hospital, this will need to be performed by a urologist or pediatric surgeon. They will usually not perform the procedure until the infant is 1 year of age.

BASIC CIRCUMCISION CARE

Circumcision care includes being sure to keep your baby's newly circumcised penis clean. If you notice stool on the penis, clean it with warm soapy water. Regular applications of Vaseline will keep healing skin from sticking to the diaper and allows quicker healing. It is important to keep the skin pulled back behind the tip portion of the penis with each diaper change to insure correct healing, especially in the first 3-4 days.

WHAT IF I DECIDE NOT TO HAVE MY BABY CIRCUMCISED?

Your baby will do just fine. You will need to be responsible for teaching your little boy to carefully clean his penis and foreskin every day while bathing. Your pediatrician and the nursery nurses will help you learn how to do this (it is not hard to do). Sometimes little boys become negligent about cleaning (just like trying to avoid brushing their teeth!) and it will be up to you to be sure they develop the habit of cleaning themselves as a part of their daily routine. The risk you face with neglected cleansing of the foreskin is chronic inflammation and a potential for infection. Sometimes this results in a decision to have circumcision done later in life. Late circumcision generally requires hospitalization and can be much more traumatic and painful.



Postpartum Information



After you leave the hospital, please do not hesitate to call our office if you have questions or problems.

POSTPARTUM OFFICE VISIT

Call the office at (850) 769-0338 to schedule your postpartum appointment. You should be seen in the office in about five to six weeks after your delivery.

You should, however, contact us promptly if any of the following occur:

- Heavy sustained bleeding greater than or equal to one pad per hour.
- Flu-like feeling, fever greater than 100.5, or chills.
- Localized redness or tenderness on your breasts associated with fever.
- Redness, drainage, bleeding at the site of the cesarean incision.
- Foul smelling discharge from the vagina.
- Extreme tenderness of pubic bone, accompanied by frequency, urgency, or burning on urination
- Extreme tenderness in abdomen accompanied by a temperature greater than 100.5.
- Pain that seems to be getting worse, rather than better.

NORMAL CHANGES

In the 4-6 weeks following delivery, the changes of pregnancy are gradually reversed as the body begins to return to its non-pregnant state. The amount of time required for this process varies, depending on the type of delivery you had and other associated medical conditions. The first 6 weeks following the birth of your baby is called the postpartum period.

THE UTERUS

The normal changes of the pregnant uterus to accommodate a growing baby are not reversed overnight. During pregnancy, the uterus increases approximately 11 times its non-pregnant weight, weighing more than 2 pounds immediately after delivery and is about the size of a grapefruit. It can be felt just below the navel. By 8 weeks postpartum the uterus has usually returned to normal size.

AFTERBIRTH PAINS

As the uterus shrinks, its muscle fibers contract, causing afterbirth pains. These contractions are much less painful than labor contractions because there is no associated pain from the cervical dilation. Afterbirth pains are most noticeable the first 3 to 4 days following delivery, particularly for women who have had previous deliveries. These contractions are also pronounced during breast-feeding. Advil, Motrin, or Ibuprofen taken as directed can significantly reduce this pain.

LOCHIA

The drainage from the birth canal following delivery is called lochia. During the immediate few days after the birth, the discharge is like a menstrual flow. In 3-4 days, the discharge becomes more watery and pale. By the second week, lochia is thicker and more yellow in color. Finally, after 4 weeks, the discharge decreases to a minimum as the uterine lining heals. The odor of lochia is usually described a “fleshy, musty, or earthy.” The odor should not be bad or offensive. You may have a day of heavier bright red bleeding as the body rids itself of the placenta scar. You may experience occasional cramping and with that, the passing of a clot and brief bleeding. This is normal. Lochia is often heavier when the mother gets out of bed. However, it is important to notify our office if you experience heavy, profuse and persistent bleeding (more than one pad per hour) or if there is a foul odor to the discharge. Please use pads instead of tampons, do not douche, and please abstain from intercourse until the bleeding stops.

BIRTH CANAL

The vagina stretches to accommodate delivery and gradually returns to its previous condition by the end of the third week. The supporting structures and muscles of the pelvic floor may not completely return to normal for 6-7 weeks. Episiotomies and lacerations usually require 4 or more weeks to heal. It is important to resume Kegel exercises in the first few postpartum days. These pelvic floor exercises may help speed healing and help muscles return to normal.

It is very common to feel sore and bruised in the vaginal, perineal and rectal areas after delivery. If you have had stitches, these will dissolve gradually and do not need to be removed. It is important to keep the perineal area as clean as possible. After either urination or bowel movement, the area should be rinsed with warm water and gently dried. You may use sitz baths for relief from discomfort (sit in a bath of 6-8 inches of warm water for 15-20 minutes, may repeat 2-3 times a day, may add antibacterial soap to the water). You may use a topical anesthetic spray such as Dermoplast for additional relief. You may take ibuprofen or Tylenol®, two tablets every three to four hours for discomfort.

INCISION CARE FOLLOWING CESAREAN SECTION

Generally, incisions are closed with staples. These are usually removed 5-7 days after the c-section. Call our office shortly after your discharge and set up an appointment for staple removal. The two most important instructions regarding wound care are to keep the incision clean and dry. You should wash the incision daily with soapy water and allow it to completely dry once you are finished bathing. If one or two staples fall out on their own, this is usually not concerning. Sometimes Steri-strips are placed after the staples are removed. It is OK to shower with Steri-strips, if they have not fallen off by 4 days, manually remove them. It is important to notify our office immediately if you notice active

bleeding or drainage from the incision. Once again, if the wound is reddening or if you are experiencing pain not controlled by your pain medications, you need to contact us.

MENSTRUAL CYCLE

The first menstrual period following delivery is usually delayed by breast-feeding. Most bottle feeding patients will experience their first period within 7-9 weeks after delivery. Nursing mothers frequently resume menstrual periods by 12 weeks, however, some do not menstruate until they have completed breast-feeding. Warning: Ovulation will return before the first menstrual period which may result in pregnancy.

INTERCOURSE

It is important to abstain from intercourse until you are cleared by your provider at your postpartum visit. Lubrication may be needed for comfort when you first resume sexual activity. Don't be alarmed if there is discomfort the first few times you have intercourse. Breast-feeding mothers are more likely to have vaginal dryness and some discomfort during intercourse for 4-6 months after delivery. This is caused by diminished estrogen production due to lactation.

CONSTIPATION AND GAS PAIN

If you experience constipation and/or gas pain, try increasing your fluid intake and your intake of fresh fruits and vegetables. Metamucil, Surfak, or Colace may be taken as directed. For gas, you may take Gas-X (simethicone 40 - 80 mg) three to four times daily with meals and at bedtime. Try eating natural foods like prunes, prune juice, apple juice, apple cider, bran flakes or raisin bran. Increase your fluids, especially water. Avoid caffeine (colas, tea, coffee and chocolate). If a laxative is needed, magnesium citrate, Dulcolax, Peri-colace, or milk of magnesia as directed.

HEMORRHOIDS

If you experience hemorrhoids you may relieve discomfort by avoiding standing or sitting for long periods of time, take rest periods whenever possible during the day, lying on your left side with legs elevated on two pillows. Knee/chest position is also pain relieving. Do not allow yourself to become constipated. Drink plenty of liquids, especially water! Sitz baths will help. You may also use Preparation H, Annusol HC, Dermoplast, and Tucks pads (witch hazel), which are available over-the-counter.

DIET

A well-balanced diet is necessary for the healing process. For a breast-feeding mother, the normal caloric requirement is about 2,000 calories per day. Your diet should include foods high in protein and non-saturated fats.

Breast-feeding mothers should increase their fluid intake to 10-12 glasses of

water per day to help facilitate adequate milk production. Foods that you eat will end up in the breast milk usually within two to four hours. Keep track of foods in your diet that may affect either the taste of your breast milk or make your baby colicky. Foods that tend to give you gas will frequently do the same to your baby. We recommend you continue the prenatal vitamins while nursing.

BREAST CARE IN BOTTLE FEEDING MOTHERS

If you are not breast-feeding, we recommend wearing a tight bra and avoiding breast stimulation. Ace wraps and ice packs may also be helpful. You may try applying cabbage leaves to the breast in order to dry the milk supply. Apply the cabbage leaves two to three times daily for about 15 minutes. Call us if you have localized tenderness, redness, or fever.

BREAST CARE FOR BREAST FEEDING MOTHERS

Discuss with your pediatrician issues such as adequacy of the newborn's intake, supplementing with formula, or use of medications while breast-feeding. A firm supportive nursing bra should be worn day and night. Avoid using soap directly on your nipples. Following a breast-feeding session, allow your nipple to air dry. The natural oil glands around the areola will keep the nipples soft and supple. Breast pads should be free of plastic liners to allow air flow. Breast colostrum or milk is an excellent moisturizer for the nipples to prevent cracking and blistering. Breast creams are not advised. Frequent feedings of 8 to 12 times in 24 hours help to prevent engorgement. Nipple soreness is expected for the first one to two weeks. If you experience cracking or bleeding of the nipples, fever, or severe pain, please call the office. Also, consider speaking with a lactations consultant.

***Most insurance plans may cover an electric breast pump under the Affordable Care Act that was passed. Check with your insurance provider about coverage and we can provide you with a prescription if needed.

PLACENTAL INGESTION

Eating the placenta is a trendy practice touted by some who believe there are health benefits for mothers. However, there is no valid research supporting these claims. Most research showing benefit has been funded by the companies that sell placental encapsulation services. The placenta is the temporary organ that grows in the uterus to provide the fetus with nutrients and oxygen. Researchers at Northwestern University School of Medicine reviewed 10 published research studies on the practice. They found no data to support the common claims that eating the placenta either raw, cooked or encapsulated offers protection against postpartum depression, reduces post-delivery pain, boosts energy, helps with lactation, promotes skin elasticity, enhances maternal bonding, or replenishes

iron in the body. The researchers also noted that there have been no studies conducted on whether eating the placenta has any potential risks. Emerald Coast OBGYN does not recommend this practice, nor do we offer placenta processing services. The hospital does allow mothers to take their placenta home after the appropriate consents are signed. If you plan on taking your placenta home, you will need to bring a cooler or waterproof container.

POSTPARTUM BLUES

Regardless of whether you are a first time mother or not, having a newborn is a major life change. Your entire time schedule and priorities will change. In the beginning, at least, your whole world will center on your baby. It is normal on occasion to feel overwhelmed. It sometimes takes 2 to 3 months to establish a routine with your newborn. “Postpartum Blues” are associated with occasional crying, mood swings, and fatigue. These symptoms are very common early on and are usually attributed to sleep deprivation. Don’t hesitate asking for help during this time period from friends and family so you can catch up on sleep.

POSTPARTUM DEPRESSION

Less commonly, patients may develop persistent severe emotional symptoms later on in the post partum period. Post partum depression is characterized by:

- Excessive crying
- Inability to sleep or excessive sleeping
- Loss of appetite
- Fear and anxiety
- Feelings of hopelessness or loss of control
- Hostility or self-blame
- Difficulty concentrating or making decisions

These symptoms are not signs of weakness or inadequacy. You should seek professional help (our office or a therapist) if you are experiencing these symptoms. Treatment may include medication, counseling, and in severe cases hospitalization. With proper treatment, most women recover fully. Above all, remember that postpartum depression is a real condition and help is available.



Family Planning

In today's world we are very fortunate to have many contraceptive options available to us! Perhaps never before have so many choices been within our reach. We divide them into temporary and permanent. The temporary methods are further divided into hormonal, mechanical, and barrier. Be sure to talk with us about your plans. We can help you sort out the best option for you.

PERMANENT METHODS

For permanent contraception we are generally speaking about sterilization procedures such as tubal ligation for women and vasectomy for men. **Remember, no sterilization procedure has a 0 % failure rate.** The failure rate generally quoted to patients undergoing tubal ligation is about 1 in 100. The failure rate is age dependent with younger patients having a higher rate of unintended pregnancy after sterilization.

TUBAL LIGATION

Tubal Ligation procedures are done surgically by interrupting the tubes between the ovary and the uterus. This interruption prevents the meeting of the woman's egg and the man's sperm. Tubal ligation will make you sterile and should never be seen as a temporary or easily reversed procedure. At Emerald Coast the primary method used is placement of small metal surgical clamps placed on the fallopian tubes to seal them. Tubal ligation is always a surgical procedure and must be done at the hospital or at one of the outpatient surgical centers. The procedure is done on an outpatient basis unless you have it scheduled as part of a planned Cesarean section or as a postpartum procedure done shortly after delivery. If not done at the time of c-section, patients will usually undergo general anesthesia (you are put to sleep). Postpartum tubal ligation is done through an incision under your navel. The incision is slightly larger for an immediate postpartum tubal ligation, so if the cosmetic appearance of your belly button is important to you, a laparoscopic procedure done 8 weeks postpartum will probably be a better choice for you.

Some insurance providers, such as Medicaid, require that initial paperwork be started at least 30 days before you plan to have the tubal ligation performed. For this reason, we strongly recommend that you initiate the paperwork at about 28 – 32 pregnancy weeks if you believe you are seeking a permanent procedure. Be sure to let us know so that we can help you make plans. Remember, you can begin the required paperwork and still change your mind at any time before the tubal ligation is done.

Another method of tubal interruption is the ESSURE procedure which has been FDA approved for over 10 years. With this method there is no incision and these procedures can be performed safely in our office with essentially no down-time. Please see the website www.essure.com for more information on this procedure. Most insurances including Prestige Medicaid cover the Essure procedure.

VASECTOMY

Vasectomy is a minor but permanent outpatient office procedure for men and is available through a urologist. If your partner is considering a vasectomy, please ask us for referral information.

TEMPORARY METHODS

Temporary methods: Of course, any of the temporary methods will provide contraception but only if used correctly and consistently!

HORMONAL

- Oral contraceptive pills
- Depo Provera injections – given every 3 months
- The vaginal ring – inserted monthly
- The patch – applied weekly to skin.
- The hormonal intrauterine device – good for up to 5 years
- The single rod implant/Nexplanon – good for up to 3 years.

We can provide you with information about each of these methods and discuss with you which method may suit your individual situation best. These methods are all very effective - when used as intended. Each option carries its own risks. We are happy to discuss the advantages, risks, and limitations of any of these methods with you.

NON-HORMONAL

These will generally include barrier methods such as diaphragms and condoms, spermicidals, the non-hormonal intrauterine device, and natural family planning methods such as ovulation charting. Be aware that breastfeeding and penis withdrawal will provide uncertain results and cannot always be counted on to prevent pregnancy. We are happy to discuss the advantages and limitations of any of these methods.

INTRAUTERINE DEVICES (IUD's)

These are small “T” shaped devices that are placed into the uterus by your provider in the office. The procedure is usually quick and associated with only mild cramping. There are several now available. Two types are:

- **Paragard:** This IUD has no hormones. The device has a copper coating and primarily works by incapacitating sperm and may be used for up to 10 years.

- **Mirena/Liletta:** These IUD's have a progestin (hormonal) coating that works by disrupting sperm, thinning your uterine lining, and thickening cervical mucus. One beneficial side effect of this device is lighter periods. It can take 4-6 months until patients see a decrease in their periods, and often during this time they are irregular. These devices may be used for up to 4 or 5 years.
Skyla: This IUD is good for up to 3 years and is an estrogen free device. It also works by thickening cervical mucus, inhibiting sperm movement, reducing sperm survival, and thinning the lining of your uterus.
- **Emergency Contraception:** Any of us can run into this type of emergency. What if the condom breaks, or you have not consistently taken your contraceptive? What if you suddenly remember the antibiotics your dentist prescribed? The Plan B emergency contraceptive is now available over-the-counter (without prescription) for all women. Emergency contraception is not as certain as the non-emergency or continuous methods of birth control. However, when taken properly within 72 hours of unprotected sex, Plan B emergency contraception will be effective about 80% of the time. Plan to spend \$40 to \$45 for Plan B. Most pharmacies carry this product.

Interesting Websites



INTERESTING WEBSITES YOU MAY WANT TO VISIT**

www.emeraldcoastobgyn.com or www.ecobgyn.com

Our website will have clickable links if you want to use it as a starting point.

PREGNANCY

www.4women.gov/pregnancy

www.marchofdimes.com

www.childbirthconnection.org

www.cdc.gov

www.lamaze.org

www.acog.org/publications/patient_education

www.mymidwife.org

www.osteopathic.org

www.spinningbabies.com

PLACENTA DONATION

www.donorcare.org

CIRCUMCISION

www.nlm.nih.gov/medlineplus/circumcision.html

www.mayoclinic.com/health/circumcision/PR00040

BREASTFEEDING

www.la lecheleague.org

www.kellymom.com

BIRTH CONTROL

www.KnowMyCycle.com

www.gynob.emory.edu/familyplanning/contraception.cfm

FDA website:

www.fda.gov/womens/healthinformation/birthcontrolguide.pdf

**** Emerald Coast OB/GYN is not responsible for content or advice found on any internet website other than our own. If you have concerns or questions about advice found on an internet website, please discuss it with us.**



Pregnancy Myths

1.) **Have a baby - lose a tooth.** Not true. A pregnant woman should never lose a tooth due to her baby! Preventive and emergency dental care is important during pregnancy. Diligent dental care is important in pregnancy. You should strive to have 1800mg calcium from foods or supplements daily during pregnancy.

2.) **Taking iron while pregnant will cause your baby to have dark skin.** Not true. Baby's skin color is caused by family genes, not what you eat.

3.) **Sex during pregnancy will harm your baby.** Not true. Sex is safe during all trimesters unless otherwise specified by your care provider.

4.) **Raising your arms above your head will cause your baby to become tangled in the umbilical cord.** Not true. All babies swim, twist, and turn within their sac of amniotic fluid. A mother's activity will not cause an umbilical cord problem. Approximately 25% of all healthy babies will be born with their umbilical cord wrapped about their shoulders or necks. Sometimes the cord may even form a knot. There is a gel like substance in the cord that protects it from compression.

5.) **Having your hair dyed or permed during pregnancy will harm your baby.** Not true. Chemicals used in today's hair products are generally not harmful to your baby.

6.) **Eating for two means eating twice as much.** Not true. While you and your baby do need a healthy diet this does not mean eating twice as many calories! You actually should only eat a total of 300 calories/day more during your pregnancy.

7.) **Painting the nursery can harm your baby.** Maybe - or maybe not... It is certain that scraping old lead based paint off your woodwork can cause harm so let others do the prep work if the old paint was applied before 1977 (when lead paints were taken off the market.) When painting, be sure to have good ventilation and use fans. Avoid oil-based paints and products containing mercury. Avoid solvents. Use latex paints that do not contain ethylene glycol ethers or biocides. Better yet – get others to do the painting for you!

8.) **If you have lots of heartburn, your baby will have a full head of hair.** Not true. There is no evidence that heartburn in the mother is related to hair growth in the baby.

9.) **Sex determination myths.** All false!!! We cannot determine gender by fetal heart rate, the Drano test, the pencil test, maternal acne, carrying high, carrying wide, carrying low, or severity of nausea & vomiting. Ultrasound is the most accurate method for sex determination.

10.) **Immersion in water will harm my baby.** Not true. Warm baths are soothing and can help relieve muscle aches and pains. Bath water will not enter

your vagina and cause infection in your baby. It is best to avoid overheating by keeping bath temperature no higher than 100 degrees. Also, it is best to avoid bathing when at home alone during the later weeks of your pregnancy so that someone can help you out of the tub to reduce the chance of a slip or fall.

11.) **You will harm your baby if you sleep on your back.** Relax! It is true that you will have improved circulation to your kidneys and uterus if you avoid sleeping on your back after the 20th week of pregnancy. When your uterus becomes large it can squeeze the blood flow trying to return to your heart and this can also cause you to feel dizzy or nauseated. After your 20th week try to rest and sleep on your side. If you wake up and find yourself on your back, don't worry – just reposition yourself to the side.

12.) **Touching kitty litter will harm your baby.** Not true. It is not the litter we worry about. It is the feces of outdoor cats that eat birds. Their feces can contain toxoplasmosis which is a rare but dangerous parasite. Indoor cats that eat packaged cat food will rarely have this organism. There are several solutions to this concern. Your vet can check your pet for toxoplasmosis to see if there is any threat to you and your baby or simply have someone else change the litter box. If the pregnant woman must clean the litter box she should wear gloves and a mask. As always, hand washing is important when handling any pets or after outdoor gardening work.

13.) **You are more likely to go into labor on the night of a full moon or during a storm.** Labor is triggered by a complex series of hormonal/biochemical signals that have no known connection to moon phases, atmospheric conditions, or the position of the stars.

14.) **Water birth will make my baby's birth transition easier.** Once the baby is out, the placenta starts to separate which means less oxygen through the umbilical cord. Babies need air! This being said, soaking in water is usually very comforting during labor. Just be sure to get out of the bathtub before you deliver.





Cord Blood Banking

Cord blood refers to the few ounces of blood remaining in the umbilical cord and placenta which has traditionally been discarded as medical waste following the birth of a child. Physicians and scientists discovered that cord blood contains stem cells (similar to that in bone marrow) that have the ability to replicate or develop into additional cells which can be used to treat life-threatening diseases.

Cord blood banking refers to storing the cord blood which remains in the umbilical cord and placenta after your baby is delivered and safely in your or the pediatric teams' care. The collection of cord blood does not harm the mother or the baby.

The cord blood banking process consists of collection, shipment to the lab, processing, and cryopreservation of the cord blood. Cord blood transplantation is the process where the stored cord blood is thawed and subsequently infused in patients for treatment of more than 70 life threatening diseases.

Additionally, there are many promising clinical trials being performed using cord blood to treat diseases and conditions such as diabetes (types 1 & 2), cerebral palsy, cartilage defects and spinal cord injuries, to name a few. The existence of these trials does not guarantee that they will become clinical therapies. Currently, the chances of a child or family member being treated with a unit of cord blood are about 1 in 2,700. This number is expected to change as technology for its use continues to improve. Parents should also be aware that if a child were to develop leukemia that cord blood would not be able to be used since the stem cells will have the same genetic markers of leukemia.

Patients considering private cord blood banking should be informed of the following issues:

1. The indications for cord blood transplant are limited to certain genetic, hematologic, and malignant disorders. For a complete list go to www.nmdp.org
2. Routine storage of umbilical cord blood as “biologic insurance” against future diseases is not recommended by the *American Congress of Obstetricians and Gynecologists* nor the *American Academy of Pediatrics*.

3. Cord blood banked by families is much more likely to be used by the donors' siblings than the donors.
4. Private storage of umbilical cord blood should be considered if there is a family member with a current or probable future need for transplantation.
5. Cord blood stored in a private cord blood bank is saved for that family. Cord blood has approximately a 30% probability of being an exact match or very close match for each brother or sister. A family that chooses to store their baby's cord blood pays a fee for the collection, cryopreservation, and annual storage of the umbilical cord blood. Selection of a private cord blood bank is an important decision. Parents should read all contracts thoroughly and inquire about quality measures. *Florida Woman Care* has selected *Cord Use* as the preferred cord banking company based on the quality of the transportation, cryopreservation techniques, and customer service. www.corduse.com
6. Parents do have the option to donate cord blood to a public cord blood bank. Cord blood donated to a public cord blood bank is available for any patients who need a transplant. The donation process is free to the parents donating the umbilical cord blood. Today, however, only certain hospitals are able to collect umbilical cord blood for possible storage in public cord blood banks. Cord blood donated to public banks but does not meet criteria for the public inventory can be used for ethical research to improve transplantation or develop new therapies using cord blood.

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Dawn Hancock is the owner of Simply You Mastectomy Boutique and has a passion for helping women look good and feel better about themselves by fitting them with breast prosthesis and bras. Dawn has 20 years of experience in the medical field. She is a local to Panama City, Florida and enjoys volunteering for local non-profit organizations.

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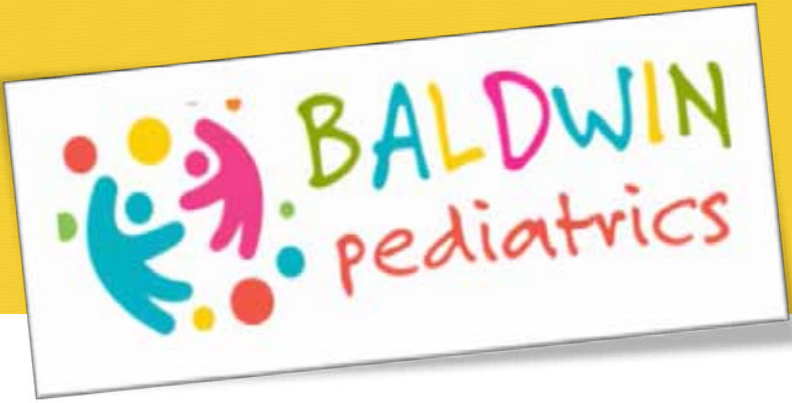
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“My name is Suzanna Haynes, born and raised right here in Panama City. I was born at Gulf Coast Regional Medical Center 23 years ago on November 10, 1994. When I found out I was expecting my daughter, I knew I wanted to give birth in the same location. Child birth was always one of my biggest fears, but while giving birth to my precious baby girl at Gulf Coast on February 21, 2018, those fears were greatly subsided by the staff and nurses there. I always felt important and that the nurses genuinely cared for me. I am most thankful for my team of physicians. On top of the staff at Gulf Coast, they also have new rooms for recovery and they make you feel so fresh and comfortable after having your baby. I feel so lucky to have a medical facility with this kind of care so close to home!”

Suzanna Haynes (1994) and her daughter, Eleanor (2018), both born at Gulf Coast Regional Medical Center.



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