Southwest
CONTEMPORARY WOMEN'S CARE

Prenatal Education Curriculum

37 - 40 Weeks

Your Baby

37 Weeks
Your baby is approximately 19.1 inches long and 6.3 pounds. That's about the size of a pound puppy or a bunch of Swiss chard. Most babies are in a head down position by now.

39 Weeks
Your baby is approximately 19.9 inches long and 7.3 pounds. That's about the size of a Cabbage Patch Kid doll or a mini watermelon. Your baby's brain continues to develop to get them ready for the wild stimulation of the world.

Congratulations – you are now "full term!"

This means that your baby is fully developed and ready to be born. It's getting pretty tight in your uterus, so your baby's movements will be considerably less robust. However, your baby should still be moving at least 10 times every hour. If not, give our office a call or just go straight to OB triage for evaluation.

What happens when I go to the hospital for a labor check?

First off, as a reminder, you will go to Banner Desert Medical Center's Women's and Children's entrance for a labor check. This is what the entrance looks like…

When you arrive, you will be taken to a section of L&D called "OB triage" where you will be initially evaluated by a nurse.

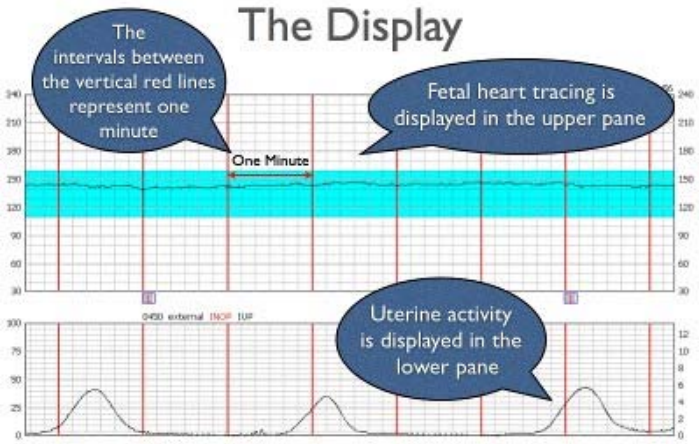
The labor and delivery nurse will first take your vitals (heart rate, blood pressure, weight, oxygen saturation) and then hook you up to a device that will monitor your baby's heart rate and the muscle tone of your uterus to see if you are contracting. We do this with several monitors that are strapped to your belly with stretchy belts. This is how it will look…

Once we have confirmed that your baby appears to be doing well on the monitor, your nurse will likely do a cervical exam to see if you are dilated. If your cervix is already very dilated, you might be admitted to the labor and delivery unit immediately. If your cervix is not very dilated, you may be asked to walk around and have your cervix checked again in an hour or two to see if your cervix has changed and thus indicative that you may be in labor.

If you are admitted to labor and delivery, your nurse will start an IV and begin giving you fluids through the IV as well as collect blood. We recheck your blood cell count and blood type as well as send a sample to the lab in case we need to give you blood emergently and need to match the donor blood to your blood. Finally, we may obtain a quick ultrasound to make sure that your little one is still head down!

What are you looking at when you monitor my baby?

There are 3 lines you will see on the screen when you are hooked up to the fetal monitor in L&D. The top panel will have a squiggly line that measures baby's heart rate and may have another squiggly line just beneath that a is a measure of your heart rate. The bottom panel will have line that correlates to your uterus's activity to see if you are contracting or not. Contractions will appear as small hills on the bottom panel.



A healthy baby will have a heart rate that falls between 110-160 bpm. Additionally, it is a good sign if the line that monitors your baby's heart is bumpy in appearance – we call this "variability." The doctors and nurses are able to read the monitoring strip to see if your baby is doing well in the uterus or stressed based off the patterns seen on the strip.

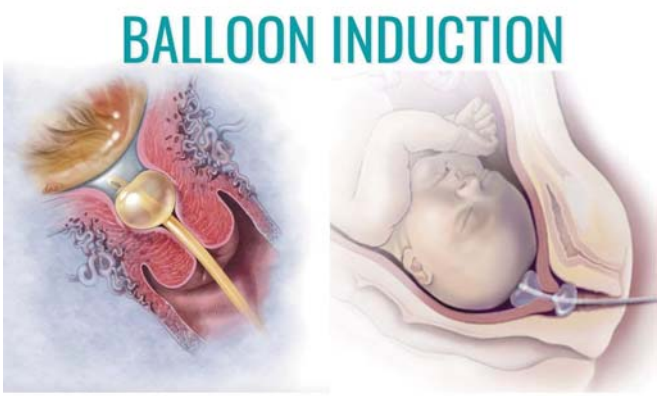
Give it to me straight doc – am I going to poop when I deliver?

Yes, you mostly likely will, and if you do this means that you are pushing correctly! Pooping when delivering is due to the baby's head pushing on your rectum and squeezing out any contents that may be present. We know this can be embarrassing but please take comfort in the fact that ALMOST EVERYONE POOPS WHEN THEY DELIVER. It's just something we don't talk about. We promise to sweep away the offending excrement as fast as possible. 😉

What will an induction of labor look like?

This all depends on how "favorable" your cervix is (i.e. is it dilated, soft, and thinning).

If your cervix is "unfavorable", meaning it does not appear ready for labor, we will start the induction process with a medication called Cytotec that is placed in the vagina or given orally to help begin to soften the cervix. Sometimes this medication can make your uterus irritable and start it contracting or cramping. Another option if your cervix is slightly open is to place what is called a "foley balloon," which is essentially a water balloon that sits just inside the uterus to put pressure on your cervix and thus mechanically open it



up. A special type of foley balloon catheter called a "cooks catheter" has an additional balloon that sits just outside the cervix to sandwich it between the two balloons. The balloon eventually gets expelled from the cervix and when this happens your cervix will be 3-5 cm dilated. Having a foley balloon placed is uncomfortable but relatively quick and an excellent means of kickstarting labor or making your cervix favorable (i.e. ready for labor).

Once your cervix is "favorable" (i.e. soft, beginning to thin out and dilate) we can start a medication that runs in your IV called Pitocin. Pitocin is a synthetic version of the hormone oxytocin which your body produces in labor to make your uterus contract.

Pitocin is slowly turned up to higher concentrations until your uterus starts contracting in a regular and strong pattern. This is the point where the labor and induction process begin to get more uncomfortable if they have not done so already.

Eventually when you have a regular contraction pattern and the baby's head is pushed up tightly against the cervix, we may recommend "amniotomy" where we manually break your bag of water with small hook called an "amnihook". This process is not painful, but it will make your contractions feel more intense once performed.

Operative Vaginal Delivery

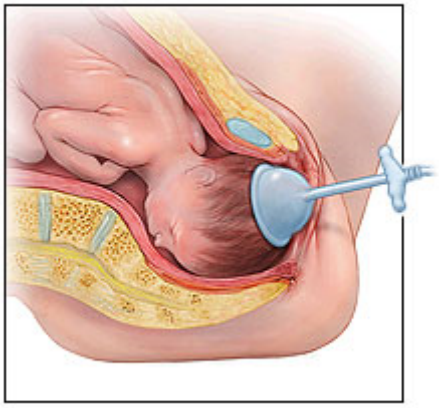
Operative deliveries are where we use instruments to assist in the vaginal birth of your baby. They are performed when you are completely dilated (10cm) and the baby's head is close to being fully delivered but a) your baby is showing signs of distress that they can't tolerate the remaining pushing needed to complete the delivery or b) you are exhausted from a long pushing stage and need a little extra help. Operative deliveries can be done in 2 different ways – with the aid of a vacuum or forceps, both of which require a physician to perform.

Vacuum Assisted Delivery

A vacuum device is an instrument with a small bell or cup shape that we apply suction to in order to apply it to your baby's head. Once applied to the head, we are able to help pull your baby out as you continue pushing.

The major risk of a vacuum delivery is that the blood vessels around the scalp and very rarely the brain can break from the vacuum pressure, leading to a bleed on the baby's scalp. While this is a rare complication, we do use measures to help prevent this by using a low pressure setting on the vacuum, only allowing the vacuum to "pop off" the baby's head a set number of times, and only performing this type of delivery on babies greater than 34 weeks. Additionally, we will have a team of baby doctors and nurses present at delivery just in case of any complications.

Vacuum extraction

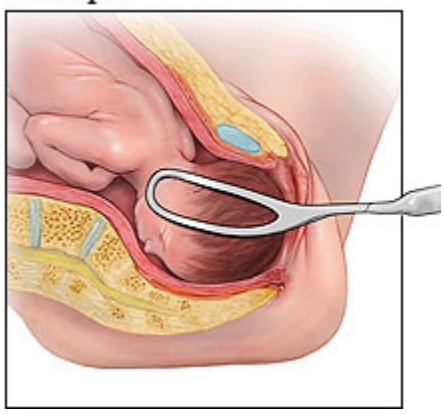


Forceps Assisted Delivery

Forceps are long metal instruments that look similar to salad tongs that are placed on either side of the baby's head to help pull the baby out as you push.

While a forceps delivery is more likely to result in a vaginal birth, they are also more likely to cause vaginal tearing, unfortunately. They are less likely than a vacuum to cause fetal bleeding on the head, but they do carry the risk of a cut to the baby's face and very rarely a nerve injury or scraping of the baby's eye. These are extremely rare complications but still possible. As such, we have the team of baby doctors and nurses present for forceps deliveries as well.

Forceps



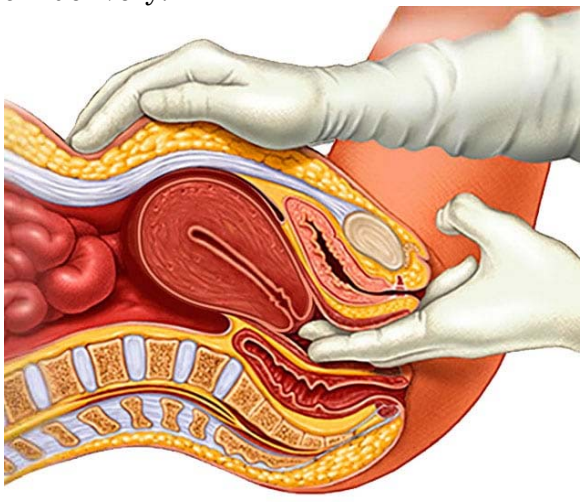
While operative deliveries can sound very scary, they actually have very low rates of complications and have the huge benefit of avoiding a c-section and thus the prolonged recovery and increased risk that occurs with a c-section. In the end, we will not perform any procedure that you are not comfortable with and if you do not want an operative vaginal delivery, we will respect that wish, but will need to move towards a c-section if that is the case.

What happens immediately after the baby is born?

As long your baby appears to be well and is crying with good color, he or she will be placed immediately on your chest. A nurse will vigorously wipe the baby's face and body to stimulate the baby to cry. This cry is important to help open up the baby's lungs and clear them of any amniotic fluid. We typically allow 30 seconds to 1 minute for the baby to remain attached to the umbilical cord to allow for one last burst of placental blood and nutrients, a practice known as "delayed cord clamping." After waiting the appropriate time, your OB will clamp the cord and then you or your partner/support person may have the honors of cutting the cord if you would like.

While you snuggle your little one, your OB will be working on delivering the placenta. You may feel some additional contractions at this point if you do not have an epidural as your uterus works to expel the placenta. During this phase, it is also perfectly normal to have a gush of bright red blood as the placenta separates from your uterus, so don't be alarmed if you see this! Once delivered you should feel a sense of relief but will continue to have some cramping as the uterus clamps down all of the blood vessels that supply the placenta.

Once the placenta is out, your OB may perform an exam called a "bimanual exam" where we use one hand to massage the uterus from the outside on your belly and another hand inside the vagina to massage the uterus from the inside. If you do not have an epidural, this will be uncomfortable but is thankfully short-lived and vital to reduce bleeding and ensure no parts of the placenta are left behind. Your nurse will continue to intermittently press on your belly to massage your uterus for several hours after delivery to help make sure that your uterus remains clamped down and thus preventing too much blood loss. After the bimanual, we will repair any tears acquired from delivery.



During this process, your nurse may offer to take your baby over to the warmer, weigh your baby, measure length, and take a set of vitals (heart rate, temperature, breathing rate). This is a quick process because we want the baby to be on your chest as much as possible for the next hour.

We call this first hour of life the "golden hour" as research has shown that immediate skin-to-skin contact in the first hour has extraordinary benefits for you and your newborn. Studies have shown that the golden hour enhances bonding between the mother and newborn and helps the newborn adjust to life outside the womb. You may notice that your baby may crawl towards your breast and begin searching for your nipple in an attempt to feed. Your labor and delivery nurse can help you latch your baby on for his or her first feed when you notice this happen.

After the golden hour, your nurse will offer to take your baby over to the infant warming bed to administer a vitamin K shot, the first dose of the hepatitis B vaccine series, and antibiotic eye ointment.

Once you and baby appear stable, you both will be moved to your postpartum room where you and your baby will stay for the remainder of your stay until discharge.

What would a C-Section look like?

First off, many people ask if you will be awake during a c-section or put to sleep. Unless it is an emergency situation where we do not have time to place a spinal for anesthesia you will be able to be awake during the procedure and hold your baby shortly after delivery.

Planned C-Section

A planned c-section is when you have a scheduled date and time for your c-section delivery that we discuss and set up in the office beforehand. If this is the case, your surgery/delivery will proceed in a very calm manner. You will start off in OB triage where we will monitor your baby while we get you set up.

Your nurse will start an IV to give you fluids during the procedure and collect blood at the same time to confirm your blood type and check your blood cell count. Your nurse will then administer a few medications including a few things to help with nausea and antibiotics to help prevent infection. Your surgeon and your anesthesiologist will come and meet you before taking you back to the operating room to go through some consent forms and answer any last questions you might have. Once everything is set up, your nurse will walk you to the operating room where the anesthesiologist will be waiting for you. The anesthesiologist will then ask you to sit on the edge of the operating table where they will administer "spinal anesthesia" – similar to an epidural but a one-time shot injected into a slightly different space in your back with stronger numbing effects. Shortly after this is administered, your legs will begin to feel very heavy and tingly – similar to the sensation of your legs falling asleep. We will help you lie down flat on the bed and make sure you are comfortable. We will listen one more time to your baby to make sure that he or she is still doing well while we place a catheter into your bladder to help you pee during the procedure and monitor the urine you are producing as well. Once this step is complete, we will clean your belly with a special orange soap that sterilizes the area. This soap is then left to dry for 3 minutes – this is often the time we grab your partner or support person who will be able to sit next to your head for the entirety of the procedure. Once the soap has dried, we place a blue drape on your belly with a curtain obstructing your view of your belly. Finally, we will use a pair of sharp tweezers to pinch your belly to make sure that you are completely numb before starting. Once the baby is delivered, we will allow a short time for the baby to receive one last burst of umbilical cord blood before cutting the cord and handing your little one to the nursing staff to perform a quick look-over of your baby. Once it appears that your baby is adjusting well to life outside the uterus (usually just a couple of minutes), the nurses will bundle baby up and bring him or her to your chest to cuddle with you while we finish up the procedure and close you up.

We use absorbable sutures on the skin of your belly underneath the skin so you do not have to come back in to have them removed. Often times you will begin to feel sleepy at this stage due a rush of hormones and you may often drift to sleep at which point your partner or support person will take baby to a recovery room and wait for us to finish up. Finally, we will wheel you off to the recovery room where you will be reunited with your partner/support person and baby and be monitored for several hours. Once both you and baby appear to be stable and doing well, you will be taken to a postpartum room where you will spend at least 2 nights.

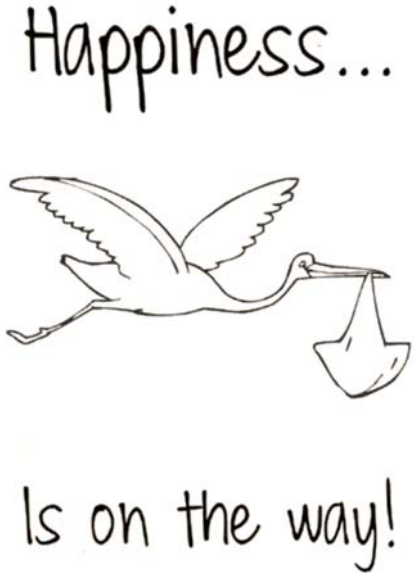
Unplanned Non-Emergent C-Section

This is a c-section that occurs after you have been laboring in L&D for a while attempting to have a vaginal birth but for some reason (whether you are not progressing or your baby is not tolerating labor well) we decide together that the safest option is to deliver via c-section. If this is the case, the procedure is very similar to a planned c-section except you will be made ready for the procedure in your labor room instead of OB triage. Additionally, if you have an epidural, the anesthesiologist has the ability to increase the dose of the medication in your epidural so you do not need a second poke to stay comfortable during the procedure. If you do not have an epidural in place, the anesthesiologist will place a spinal.

Unplanned Emergency C-Section

This is a c-section that has to be done very quickly because you or the baby are in immediate danger and need to be delivered immediately. This can be a scary situation as all of the medical staff will be rushing around you to get you ready as quickly as possible making it a very stressful environment. You will be quickly unplugged from all of your monitors in the labor room and quickly wheeled into the operating room. If you have an epidural, the anesthesiologist will quickly dose your epidural to make you numb so you can stay awake. If you do not have an epidural, you will need to be put to sleep with general anesthesia as we do not have time to place a spinal anesthetic in a true emergency.

Once anesthesia has been administered, we will splash iodine on your belly to help cleanse the area. This is not quite as effective as the special soap described earlier, so you will need additional IV antibiotics to help prevent infection that will be given during the procedure. In an emergency situation, your partner/support person is not able to be in the room for safety reasons. After the baby is born, the after care will look very similar to the above-described c-sections.



What will postpartum look like at the hospital?

If you had an uncomplicated vaginal delivery, you can expect to stay in the hospital for 24 to 48 hours. If you had a c-section, you can expect to stay for 2-4 days. Our hospital practices "rooming in," where your baby stays in your postpartum room with you in a bassinet that can be wheeled next to your bed.

The first few hours on the postpartum floor, you and your baby will have your vital signs checked fairly frequently to ensure that you are both doing well after delivery and not showing any signs of infection or excessive bleeding. You may feel slightly unsteady on your feet, so don't be afraid to ask your nurse for help.

You may also notice that it may be difficult to pee if you had an epidural. This is perfectly normal. Some patients need a temporary catheter to help them pee, but most are able to pee on their own given some time.

Expect to feel cramping similar to menstrual cramps for the first few days after delivery. This is your uterus shrinking back down into your pelvis and will continue this process over the next couple of weeks until it is back to its pre-pregnancy size. This cramping is very responsive to Tylenol and Ibuprofen, so don't be afraid to ask for some during your hospital stay. If you had a c-section, your pain may be more intense, and you may require a short course of opioid pain medications (such as Oxycodone or Percocet). These are addicting medications, so use these sparingly. Additionally, opioid medications are infamous for causing constipation, so don't be afraid to ask for stool softeners if they are not offered to you.

Your nurse will be an excellent resource in helping you take care of your vaginal area if you had a vaginal delivery ("peri care") or your incision if you had a c-section. Your nurse is also an excellent resource for learning how to take care of your new infant, including changing diapers, feeds, and safe sleeping practices. Postpartum nurses are truly the unsung heroes of the delivery process!

Our hospital has several lactation specialists that will check on you during your postpartum stay to see if they can help troubleshoot any issues with breastfeeding you may have. You can see them as many times as you like. They are an amazing resource that you should take advantage of!

During your stay, your newborn will need to have several things happen before they can be discharged. They will undergo a "newborn screening" where a small amount of blood is collected by pricking their heel to test for several rare genetic and metabolic disorders. They will have their hearing tested to screen for deafness. They will have a head-to-toe examination by a pediatrician.

If you desire, your baby boy can be circumcised (this can also be done in your pediatrician's office if you prefer). You will need to fill out paperwork with the birth recorder to begin the process of applying for your baby's social security card and birth certificate. Finally, you will need a car seat to take your baby home in prior to leaving.

What will postpartum look like at home?

The next few weeks will be a huge adjustment for you, your partner, and your baby. There are going to be many times when you feel lost and unsure of how to care for your newborn. This is normal and every new parent feels this regardless of how rosy they make it look on social media. Thankfully, you will have many visits with your pediatrician immediately after birth that will help answer many of these questions for you and make sure your baby is adjusting well and growing appropriately.

Your body has a lot of healing to do in the next few weeks. Support it by resting when you can, eating a nutritious diet, and asking for help when you need it. Here are a couple of changes to your body to expect.

Postpartum Belly

Right after you give birth you will still have a bit of belly due to the uterus still being quite enlarged, water retention, stretched skin, and weight gain from the pregnancy. Your belly will flatten out to pre-pregnancy state over the next few weeks to months

Lochia

Lochia is the brownish red discharge that persists for several weeks after your initial bleeding stops. This is a normal discharge, but if you notice that it switches back to heavy bright red, this can be a sign of a delayed postpartum bleed, and you should contact our office right away.

Breast Engorgement

In the first few days after delivery, your milk will come in and cause your breasts to become swollen and painful and can even lead to a low-grade fever. If you notice that only one breast is swollen or painful, your fever spikes higher than 100.4°F, or you develop flu like symptoms (body ache, fatigue, headache), this may be a sign of mastitis (an infection in the breast) and you should call our office to be seen and started on antibiotics.

Mood Swings

Your body is going to be riding a roller coaster of rapid swings of emotions fueled by hormones! Please see the earlier handout on postpartum mood disorders.

A Note on Bonding

Some women experience a rush of emotion and love for their newborn upon delivery, but for a lot of women it takes time to get to know your new tiny human before you feel bonded to it, and that is a perfectly normal reaction! Continue to cuddle, interact, and care for your baby and your bond will form and strengthen with time.

Postpartum Visit

At this visit we will assess how you are healing from your delivery. We will be asking questions about vaginal bleeding, pain, issues with using the bathroom, how your mood is adjusting, how infant feeding is going, and initiating contraception. Your OB may perform a quick pelvic exam to ensure that all vaginal tears and your uterus have healed. If everything looks good, you will have the release to begin having sex again if you wish.

Feel free to bring your new bundle! We know how hard it can be to secure childcare for a newborn, so we would like to extend the offer to bring your baby along to your visit – plus, we love getting to see this critter we have been listening to and watching for the past 9 months! Also please feel free to bring a photo of your newborn so we can add it to our baby wall of fame!

What is your birth plan?

Who do you want present?

Do you want it to be just you and your partner? Or are you the type of person that wants your entire support team present? The choice is yours!

What do you want for pain control?

Unmedicated Birth

The benefits of an unmedicated birth include increased mobility during the labor process as well as immediately after. Studies have shown that the pushing phase of labor is slightly shorter for unmedicated births as well.

IV Pain Medications

Typically, these are narcotic medications such as Stadol, Morphine, or Dilaudid. These medications will help dull the pain, but will cause you to feel dizzy, sleepy, and decrease inhibitions – similar to what a few cocktails might feel like. Additionally, some women experience mild nausea with administration of these medications.

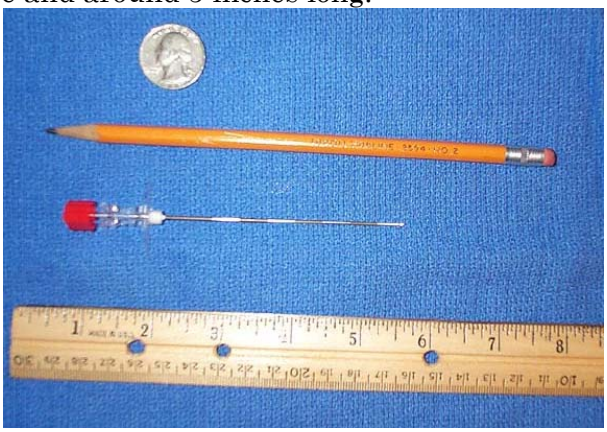
Narcotic medications do cross the placenta and thus have an effect on the baby. However, the effect is transient. IV pain medications can cause changes in your baby's heart rate as well as make the baby sleepy. Because we want your baby to be alert and vigorous at the time of delivery, we typically do not administer these medications once you are 6cm dilated or greater. This will allow your baby enough time to metabolize these medications and thus decrease their effect at the time of birth.

Epidural

An epidural is a type of pain management that is administered by an anesthesiologist. It is done by inserting a needle to thread a small catheter into the epidural space, a space that is immediately outside of the spinal cord and nerves. This catheter then slowly infuses a pain medication that greatly reduces pain from the waist down and has very minimal absorption across the placenta. It is turned off after delivery and typically takes a few hours to fully wear off.

Your anesthesiologist will inject a numbing medication prior to placing the epidural. Most women say that this is the most uncomfortable part of the procedure and say it is like a bee sting. Occasionally during the actual placement of the catheter, you may feel a quick electric shock that radiates down your leg that lasts less than a second but can be uncomfortable. Once the epidural catheter is placed, the needle is removed and the catheter does not cause you any discomfort.

A lot of women ask how large the needle used for an epidural is. It's about as thin as a small wire and around 5 inches long.



There are a lot of pros to an epidural. This is by far the most effective form of pain control during labor. It has minimal effect on your baby during your labor and is generally regarded as a very safe procedure. Having superior pain control during your labor can help you to be more present during the delivery and have an overall more enjoyable experience. Relief from the pain of labor may allow you to sneak a quick nap in before the big moment!

There is no evidence that an epidural will increase the chance of c-section or cause more interventions to occur during your labor. The decision for c-section (or any intervention for that matter) is based on the well-being of your baby or yourself.

If you do end up requiring an emergency c-section, an anesthesiologist can administer anesthesia for the surgery more quickly and safely if an epidural is already in place.

Additionally, the epidural will help with pain control if you need a vaginal repair from any tears that occur during the delivery as well as an uncomfortable exam called a "bimanual exam" where your delivering provider checks for any left-over placenta in your uterus.

In terms of cons, you will not be able to walk once the epidural is placed and thus will be confined to a bed until the epidural wears off after delivery.

The medication also makes it so you cannot pee on your own. This means that during the labor process, your nurse will have to place a catheter into your bladder to empty it of urine and that it may be challenging to pee in the immediate postpartum period. Very rarely, some women need to have a catheter placed for a day or so after delivery to help this pee but this is definitely not the norm.

Very rarely you can develop a severe headache as a result of the epidural called a "spinal headache" that can be treated by an anesthesiologist very effectively.

You may feel like your back is a little bruised after the delivery, but this is TRANSIENT. Numerous studies have shown that an epidural does NOT cause long term back pain. That being said, carrying a small human for several months and the weight of it pulling on your back can cause some back pain after pregnancy – sorry!

Many ask if an epidural will slow your labor down. Studies have shown that an epidural will NOT prolong the first stage of labor (i.e. when your cervix is opening up). It can increase the second stage of labor (i.e. the pushing phase) by 30-50 minutes.

One other question women ask is when is it too late to get an epidural? The short answer is when the baby has already delivered! That being said, if you are completely dilated and the baby is moving down well, we may encourage you just try and push the baby out naturally.

Alternative Pain Control Methods

We are super flexible with any method you have researched and would like to try. We have had some patients have great success with labor ball exercises, water immersion, "hypno-births", acupressure, aromatherapy… the list goes on and on! As long as the method is safe for both you and your baby, we are open to discussing and trying anything.

Also know that you can change your mind at any time! You are in control during your labor and do not have to stay married to one pain management option just because it was your initial choice!

How do you want your atmosphere?

Some patients like to play some soft music in the background while other prefer a more silent environment. Bring any personal items, such as a blanket or pillow, that will make your experience more comfortable.

Do you want the baby directly on you after delivery or would you prefer that we clean the baby first?

Placing your newborn on your chest has a lot of benefits including initiating bonding, helping to regulate baby's breathing, heart rate, and temperature, and encourages the baby to feed. That being said, if you would prefer that we clean your baby before your baby is placed skin to skin with you, that is perfectly okay!

When the baby first comes out, he or she will be covered in a creamy white substance called "vernix." Vernix acts as a moisturizer for the baby's sensitive skin.

Are you ok with the nurse giving routine medications to your newborn?

Immediately after birth, we recommend that the baby receive a vitamin K shot to help prevent life threatening bleeding, their first hepatitis B shot, and administration of an antibiotic ointment to help prevent neonatal conjunctivitis that can lead to blindness.

The CDC highly recommends administration of all three of these medications immediately postpartum or prior to discharge. However, this is your baby, and we respect your decision if you choose not to have these medications administered.

The foundation of these educational materials has been created by Dr. Beienburg.