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What's New in the First 12 Weeks?

Charting the Course through the Third Trimester Journey!

Dr Jenni Goold

The First Trimester

- Supplements

Folate, Vit D, iodine, others as needed- Iron, omega 3

- Booking investigations- routine bloods & urine

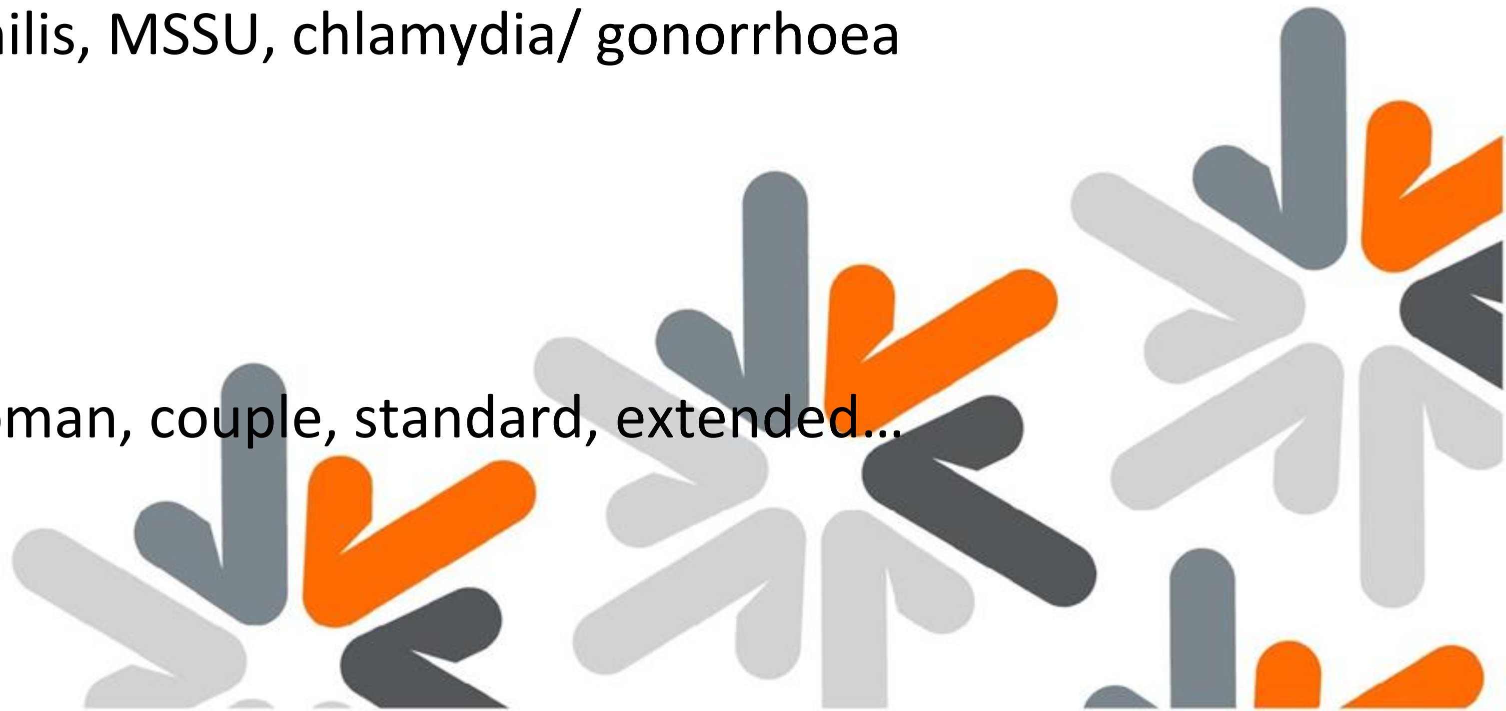
Bl Gr & Ab, CBP, Ferritin, Vit D, Syphilis, MSSU, chlamydia/ gonorrhoea

- Others relevant investigation ???

Parvo, TFT…

- Clinical Genetic Screening

Ideally pre-conception, options woman, couple, standard, extended…



The First Trimester

- First trimester screening & Omega 3

Timing 9-14 weeks

- NIPT

Cost $450, timing >10 weeks

- Early GTT

12-16 weeks

- Vaccinations

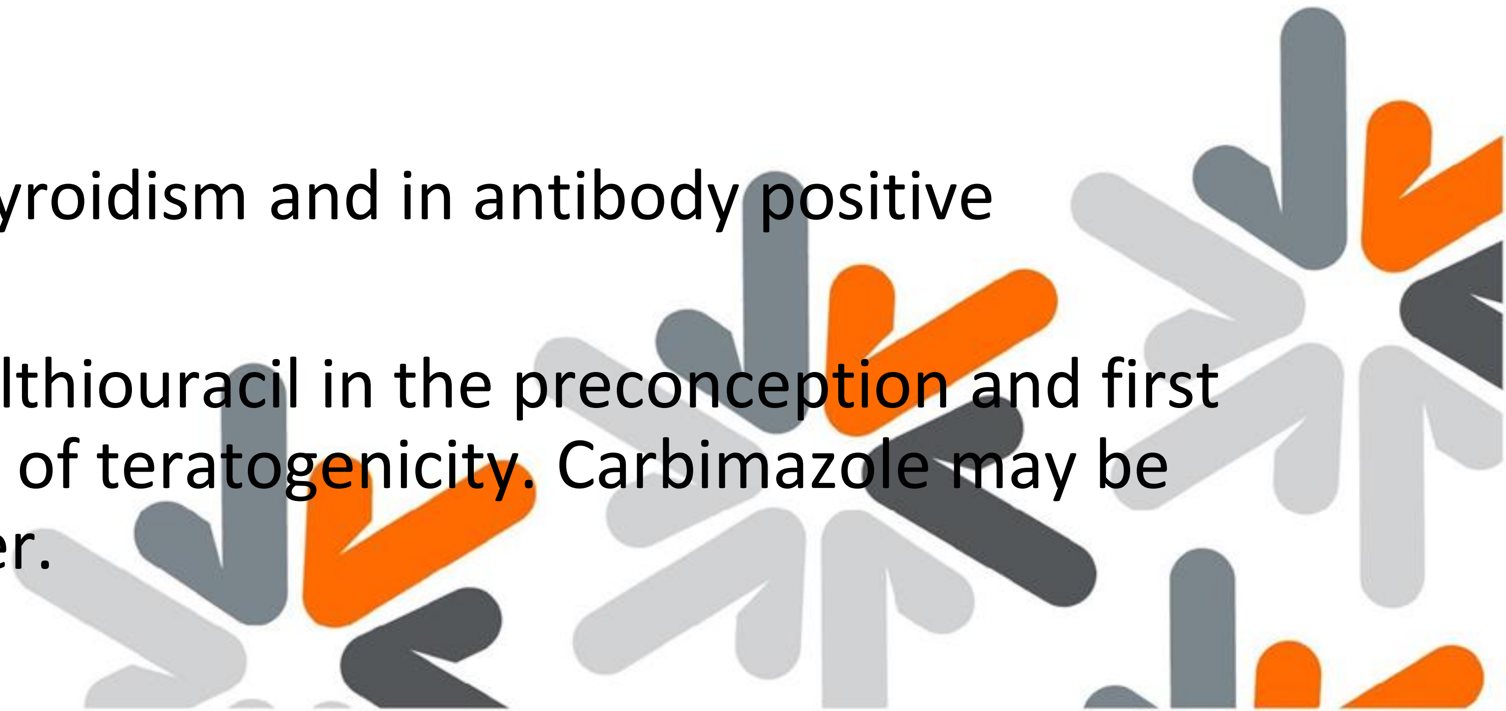
Influenza, COVID, Pertussis >20weeks

Thyroid function screening

- Thyroid dysfunction during pregnancy & postpartum is common.
- Universal thyroid function screening is currently not recommended! Check TSH* if: >30yrs, FH of thyroid disease, history of autoimmune disease
- WATCH THIS SPACE!

SUMMARY;

- Thyroxine –in overt hypothyroidism and in antibody positive subclinical hypothyroidism.
- For hyperthyroidism, propylthiouracil in the preconception and first trimester to reduce the risk of teratogenicity. Carbimazole may be used in the second trimester.



Physiology in pregnancy

- thyroid gland-hyperplasia and increased vascularity. Circulating iodine is reduced and thyroid-binding globulin increases.
- Rising beta-HCG in the first trimester can stimulate the TSH receptor as HCG has structural similarities to TSH, resulting in increased free triidothyronine (fT3) and free thyroxine (fT4), suppressing TSH secretion.
- A serum TSH below 0.1 mIU/L may be present in 5% of women by the 11th week of pregnancy.
- Normal TSH (mIU/L)in pregnancy:

  1st Trimester TSH 0.1-2.5

  2nd Trimester 0.2-3.0

  3rd Trimester 0.3-3.0

Thyroid function screening

Subclinical hypothyroidism-

- Test for Antithyroid Antibodies- no evidence to support treating if no antibodies
- Treat if antithyroid Ab +ve & TSH 2.5-4. Aim TSH < 2.5
- If initial TSH 4 or >, start thyroxine (50 mcg)
- check level 4-6 weekly & adjust dose

Navigating the Third Trimester

A Guide to the 28-Week Visit & Beyond, Let's Talk about a Birth Plan!

Dr Jenni Goold

Learning Outcomes

- What do women want (from GP OSC)
- Manage a pregnancy from 28 weeks & beyond
- Routine & ad hoc antenatal tests >28 weeks and managing results
- Managing issues that arise in 3rd trimester
- Lifestyle changes
- Medications/ vaccinations in last trimester - what to do?
- Advice re antenatal education- feeding options
- Talk about birth plan/preparedness

Tell me what you want, what you really, really want?

What women want if they were to have another baby:
the Australian Birth Experience Study (BESt) cross-sectional national survey

Keedle H, et al. *BMJ Open* 2023; 13:e071582

Obj: To explore if Australian women would do anything differently if having another baby

- Large survey (8804 responses) on women's birth experiences in the last 5 years (2016-2021) in Australia
- Responders tended to be of higher socioeconomic status, >30 years & university educated
- Lower rates of First Nations women & migrant women in the study of total population of women giving birth
- Covered all models of care - public & Private
- Survey available in seven languages

BESt Survey Results

- Continuity of Care (CoC)
- Self Blame (guilt) for 'not being prepared'/ assertive about what they want
- Vaginal Birth with min. intervention/ active in labour
- Equity in access- rural/ metro

What does this mean for GP OSC?

- CoC – Hospital models cost - effectiveness (fragmented care) vs GP model patient centred/holistic approach (CoC)
- Antenatal education - Formal/ opportunistic - ‘feel prepared’
- Lifestyle changes – Highly motivated time e.g. smoking, drugs, alcohol, weight etc
- Birth plans: Personalise but realistic expectations
- Early discharge - Importance for follow-up
- Explore options - Hypnobirthing, fitness, environment
- Explore feeding options – B/F education
- Unpack previous experience - Support? MH care plan?
- Dispel myths
- Advocacy

The model of GP OSC is invaluable in preparing supporting pregnant women, their partners & families through birth & beyond

28 weeks – Now What?

35 year old Emily, GP OSC, booked at WCH, G3P1, BMI > 30 (35 at booking), early GTT NAD & morph scan LLP

P Ob Hx:
Previous Elective LSCS for breech
Gestational HTN noted at 36 weeks

PMHx - Hypothyroidism
FHx - Father Type 2 DM

Medications - Folic acid, Elevit 1 daily,
Thyroxine 100micrgrams/daily

28 weeks – Now What?

Routine 28 weeks bloods

- Blood Group & Ab
- CBP
- Ferritin
- Vit D
- Syphilis
- GTT
- Others TFT, PE baseline

28 weeks – Now What?

Routine 28 weeks bloods

- Blood Group & Ab

O neg

- CBP

Hb 110

- Ferritin

17

- Vit D

48

- Syphilis

Neg

- GTT

5.2, 8.2, 9.5

- Others TFT, PE baseline
- TSH & T4 NAD, EUC/LFTs, ur prot, creat & ratio ok

Abnormal results – Now What?

Call the birthing hospital for advice

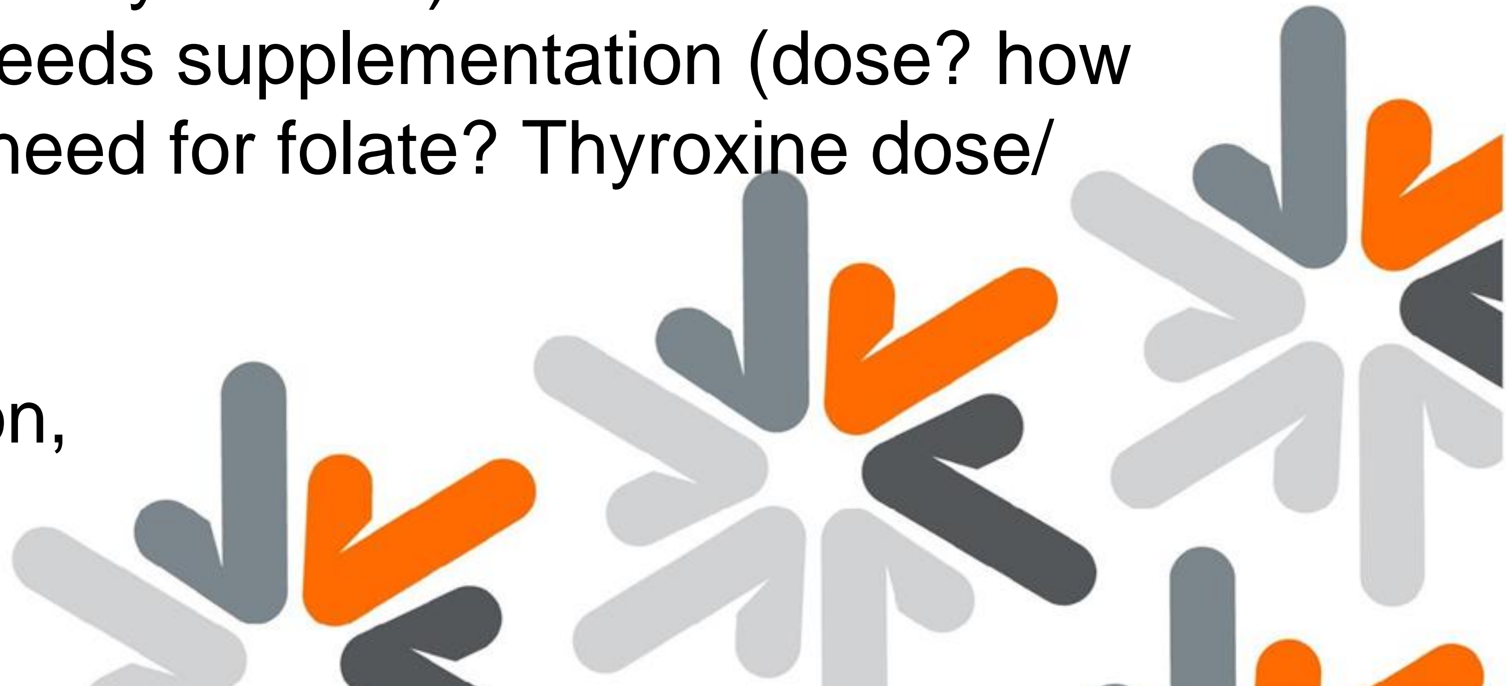
Can they still do OSC?

28 weeks – Now What?

BP large cuff seated 132/80
SFH 34cm, FHH 138
FMF

Issues to consider?
Reliability of SFH - (due to body habitus)
Results- Iron & Vit D def, needs supplementation (dose? how long?, if/when to recheck) need for folate? Thyroxine dose/ monitoring?
GTT?

- lifestyle, mood, education, BF, concerns, myths



28 weeks – Issues

35 year old Emily:

Elevated BMI
PH LSCS & late onset gestational HTN
Hypothyroidism
Iron deficiency
Vit D deficiency
GDM
Rhesus negative
LLP

- lifestyle, mood, education, B/F, concerns, myths

28 weeks – BMI

Bariatric Guidelines:

BMI>35, liaise with hospital re special requirements

BP - cuff size
Monitor with growth scans: growth parameters, AFI & dopplers
28, 32-34 weeks & consider 36 weeks
Increased risk for GDM- early GTT and repeat 28 weeks
GDM screening- what if PHx bariatric surgery ?
Profiles 5 consecutives days
Monitor for other co-morbidities e.g. HTN, PE

28 weeks – Hypothyroidism

Who to screen?
Early TFT results??
Known Hypothyroidism:
Monitor 6 weekly, if stable min each trimester - Adjust dose accordingly
Post birth dosing?

28 weeks – Supplements

Iron:

- Diet
- Ferrograd & maltofer
- Infusion?

Vit D:

- 400 IU daily but in deficiency 1000 IU daily (increase to 2 if still low at 28 weeks)
- How long?

Reminder re dietary requirements in pregnancy

Lifestyle education - smoking, alcohol etc

What supplements? Is it enough?

Vit D Routine & Deficient Dosing

Vitamin D - some products:

- Blackmores Preg & BF Gold (500u per capsule)
- Elevit (200 u per tablet)
- Swisse preg & Ultivite 600u per capsule)
- 0.5ml Ostelin Vit D liquid (1000units/0.5mls)
- OsteVit-D (1000u)
- Ostelin Vit D (1000u)

Medications?

As a general rule do not stop any pre-existing medication without seeking advice & consider safety profile of any medication added…….

Women's and Children's Hospital Drug Information in Pregnancy and Breastfeeding **8161 7222**

Hospital Midwife Coordinator – GP Obstetric Shared Care

GP Partners Australia – GP Obstetric Shared Care Program

OTIS – www.teratology.org/OTIS_fact_Sheets.asp

Anyone have any other favourite sources? …...drugs.com

28 weeks – Vaccinations?

Vaccinations:

Fluvax anytime
Pertussis from 20-32 weeks
Covid

Anti D- 28 & 34 weeks (& sensitising events), birth

28 weeks – GDM

Diagnosis F>5, 1 hour >10 hours >8.5
Explanation/importance of control
Impact pregnancy & life long
Refer Diabetes Education
Monitoring: profiles- F, 2 hr post-prandial
Range: F <5.1,Post prandial <6.7 red flags?
Mx diet, metformin, insulin

Other Considerations:
High risk, risk of co-morbidities (HTN, PE),
growth monitoring- scans, weight gain
Timing of birth
F/U - 6 weeks & annually

>28 weeks Birth Plan (Item 16591)

Previous LSCS; Options:

- Repeat LSCS - what does this mean?
- VBAC – risks?

Timing?

- Depends on GDM control:

Diet - term

Treatment good control - >38-39 weeks

Treatment – poor control/ LGA >37 weeks

IOL/VBAC

Item 16591- Pregnancy planning >28weeks
includes MH screen / DV screen

Scans?

Growth scan - Growth parameters, AFI, dopplers
Monitoring growth:
Elevated BMI (growth 28,32,36)
GDM (32,36)
LLP (32-34) & later if remains LL

When else?
Discrepancy from SFH & weeks
Other issues for F/U e.g. renal dilation, echogenic focus, dopplers, AFI, marginal cord, fibroids,
atypical uterus

32 weeks – Now What?

BP 130/80, SFH 40, FHH 142, FMF, Weight, presentation breech, lie oblique, Not engaged 5/5

Others:

Scan for growth & placental position,

BSL monitoring, (emailing Diabetes Ed?)

Antenatal education classes (QR code)

Birth planning

Check CBP & Iron 32 or 36 weeks)

Prepare for 36 week hospital visit – LVS, birth plan, B/F Ed, questions

- lifestyle, mood, education, B/F, concerns, myths

34 weeks?

BP 130/80, SFH 40, FHH 142, FMF, Weight, Presentation Cephalic, lie long 5/5

what else?

- Anti D x2
- Check-in
- Work plans?/ maternity leave?
- Diabetes control?
- Education - birth plan

She mentions she has an itchy rash on trunk….

Consider cholestasis - BA (<8), PUPPP (pruritic urticarial papules and plaques of pregnancy)

Settles with soap free, moisturisers etc.

- ❖ Lifestyle, mood, education, BF, concerns, myths

She says she is going to celebrate finishing work with a glass of champagne.

What do you do?

NHMRC guidelines 2009

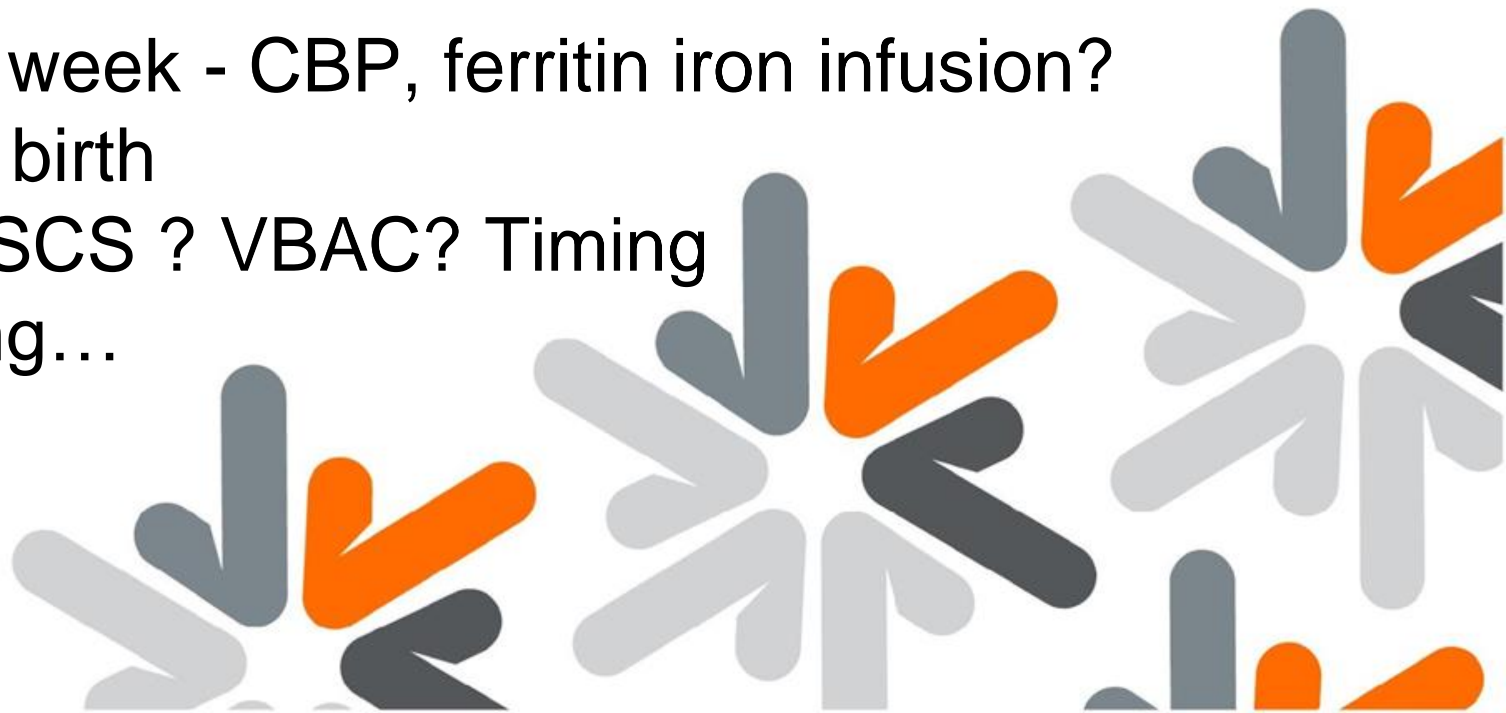
There is no lower limit that can be guaranteed completely safe and so the safest thing is to **STOP**

36 weeks – Now What?

Hospital Visit:

Ensure GP has set up expectations:

- B/F education – encourage attendance (GDM- EBM prior to birth)
- LVS - GBS
- Review results 32 or 36 week - CBP, ferritin iron infusion?
- GDM control – timing of birth
- Birth planning- repeat LSCS ? VBAC? Timing
- Identify WAS, car parking…



38 weeks – Now What?

BP, SFH, FHH, FMF, presentation lie

- Diabetes control?
- Unpack hospital visit: GBS result & explanation
- Check CBP, Ferritin from 32 or 36/40, TFT
- Birth Plan- early discharge, newborn screening/hearing, feeding options
- prolonged pregnancy planning: >40 fetal wellbeing check, IOL 41/40- GDM birth by term
- Plan 2 & 6 review for both mother & baby

* lifestyle, mood, education, B/F,
  concerns, myths

Term – Now What?

Hospital: BP 130/80, SFH 40, FHH 142, FMF, Weight, presentation, lie

Birth Plan - prolonged pregnancy, fetal wellbeing (CTG, scan etc.)
VE - Bishops score, stretch & sweep

IOL booked

Birth - Now What?

Early discharge….

How did it go?

Domiciliary MW? CAFHS?

2 & 6 week review but PRN

Monitor MH, supports, CAFHS - EPNDS

Feeding, lochia, wound - LSCS scar, episiotomy, perineum

Contraception

Feeding

Diabetes Mx - screening 6 weeks & annual

Baby – Blue Book checks, monitor growth parameters, vaccinations

Why Obstetric Shared Care?

WE ARE SIMPLY THE BEST

- Continuity of care & holistic care
- Patients generally happy, healthy and well
- Great support from Hospitals, Midwife Coordinators, GP OSC Program & GP Partners Australia
- CPD Activities, resources and networking opportunities
- Financial incentives; item numbers 16500 & 16591
- Excellent option of care for low risk women
- Keeps GP patient population young!

So tell me what you want, What you really really want ?

Women want:
Continuity of Care

Who better than their GP!

What do Women Want?

ANSWER: **GP OSC**

GP Partners Australia Website

PREGNANCY SURVEY | OSC GPs BY POSTCODE | OSC PRACTICE LOCATOR

HOME | EVENTS | GP NEWS | GP OBSTETRIC SHARED CARE | COVID-19 | CONTACT US

Pregnant – Now What?

Need Help?

- SA GP Obstetric Shared Care Protocols – April 2020 (New Version Coming!)
- SA Perinatal Practice Guidelines
  - www.health.sa.gov.au/ppg
- GP OSC Program;
  Manager/Midwife- Leanne March
  Program Event Support- Naomi Pointon
- GP Advisor Jenni Goold E:Jenni.Goold@sa.gov.au
  - Contact via Leanne - GP OSC Program SA
- OSC Midwife Coordinators
  - Contact details in GP OSC Brochure or via GP Partners or Hospital

Questions?

GP Shared Care
Obstetric

Thank you

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www.gppaustralia.org.au