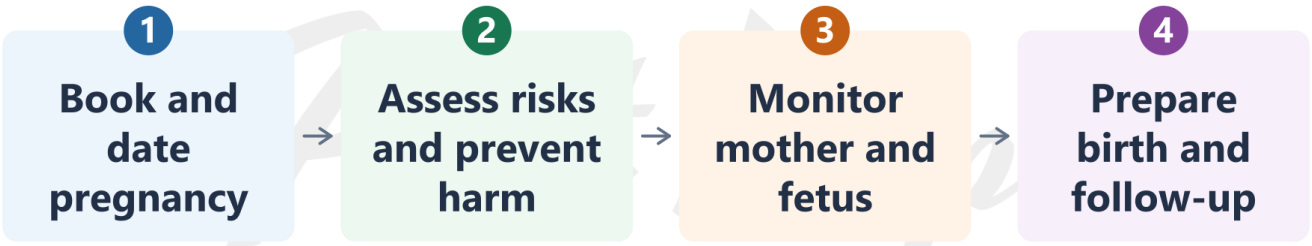
Obstetrics & Gynaecology - Topic 8 - Antenatal Care

Planning Antenatal Care

Objectives and Timing

- Antenatal care supports maternal health, follows fetal development and identifies problems early enough to improve the outcome.
- It also prepares the woman and family for birth, emergencies, feeding and care after delivery.
- Book early, preferably in the first trimester, so dating, baseline assessment and preventive measures are not delayed.
- The WHO contact model includes contacts before 12 weeks and at about 20, 26, 30, 34, 36, 38 and 40 weeks.
- Local programmes may organise visits differently, and symptoms or high-risk conditions require additional care between scheduled contacts.
- Every contact should include communication and useful assessment rather than simply recording attendance.



The Inverted Pyramid of Care

- The inverted-pyramid concept places substantial assessment and risk identification early in pregnancy.
- Early information is used to tailor prevention and later surveillance instead of waiting for complications to become obvious.
- This approach does not mean that later visits are unnecessary, because new problems can develop after a normal early assessment.

Methods of Estimating Gestational Age

1. Menstrual Dating

- Gestational age is counted from the first day of the last menstrual period when that date and cycle pattern are reliable.
- For a regular 28-day cycle, the estimated date of delivery is 280 days after the first day of the last period.
- Naegele's rule adds seven days, subtracts three months and adds one year, with adjustment for a consistently different cycle length.

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- For example, a last menstrual period beginning on 10 January gives an estimated date around 17 October in the same year.
- Irregular cycles, recent hormonal contraception, lactation or uncertain bleeding can make menstrual dating unreliable.

2. Ultrasound Dating

- Early ultrasound using crown–rump length provides a reliable estimate when performed and interpreted appropriately.
- Later fetal measurements are useful but become less precise for dating because individual growth differences increase.
- Use an established dating policy to reconcile menstrual and ultrasound estimates, and document the agreed estimated date clearly.
- Do not repeatedly change the due date to fit later small measurements, because this can conceal growth restriction.

History, Risk Assessment and Presentation

Components of the Obstetric History

1. Present Pregnancy

- Record the presenting concern, gestational age, booking status, previous tests and current medicines or supplements.
- Ask about bleeding, pain, vomiting, fever, urinary symptoms, headache, visual symptoms, swelling and fetal movements when appropriate.
- Ask about fluid leakage and contractions when membranes or preterm labour are a concern.

2. Previous Pregnancies

- For each pregnancy, record the year, gestation at its end, mode of birth, complications, baby's weight and outcome.
- Clarify miscarriage, ectopic pregnancy, stillbirth, neonatal death, congenital anomalies and any relevant investigation results.
- For previous caesarean birth, obtain the indication, uterine-incision details and operative complications if records are available.
- Gravidity includes the current pregnancy, while parity describes previous pregnancies reaching the locally used viability threshold.
- State the actual outcomes as well as shorthand because different recording systems can otherwise cause confusion.

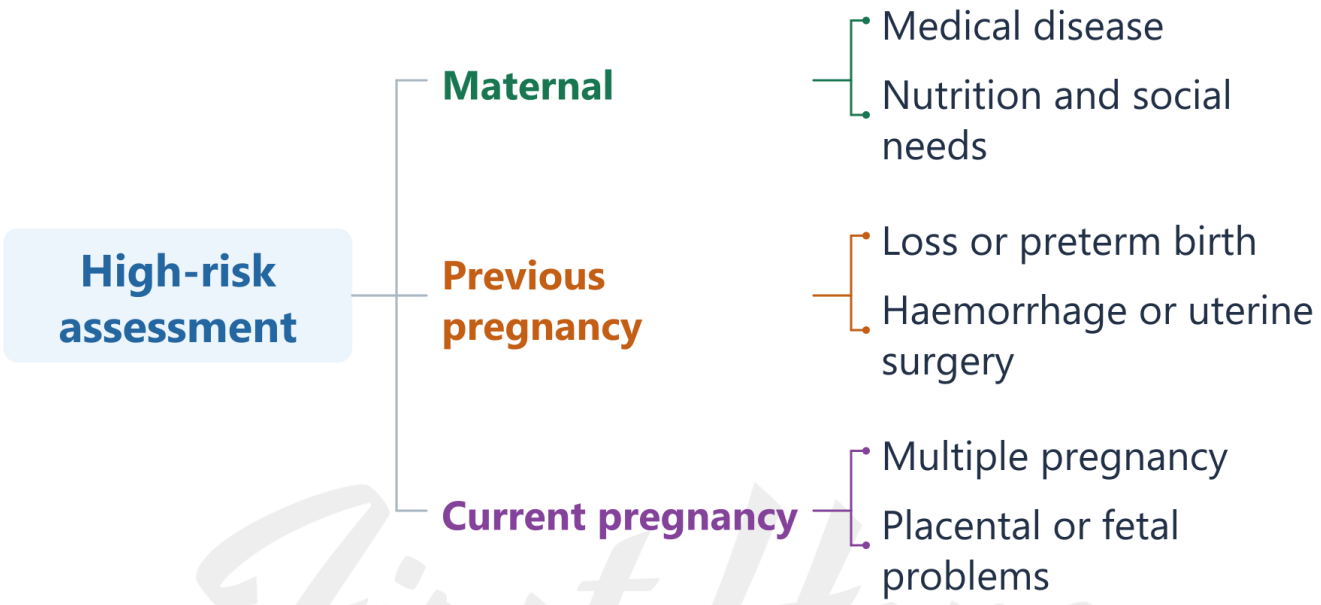
3. Medical, Surgical and Social History

- Ask about diabetes, hypertension, epilepsy, cardiac or renal disease, thrombosis, transfusions and mental-health conditions.

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- Record previous uterine or cervical procedures, other operations and anaesthetic problems.
- Explore allergies, family genetic disease, consanguinity where relevant, diet, tobacco, alcohol and occupational exposures.
- Assess support, financial or transport difficulties and safety at home through a private and respectful discussion.

Identifying High-Risk Pregnancy



- Risk factors include important maternal disease, previous adverse pregnancy outcomes, multiple pregnancy and current fetal or placental problems.
- Assess the severity and combinations of risks rather than assigning the same plan to everyone with one risk label.
- Document a specific response, such as specialist referral, aspirin assessment, growth surveillance or delivery in a better-equipped centre.
- A woman without an early risk factor can still develop an emergency, so universal danger-sign advice remains necessary.

Presenting the Case

- Begin with age, gravidity, relevant previous outcomes, gestational age and the reason for review.
- Present the important history, examination and investigation findings in a logical sequence.
- End with the maternal and fetal assessment, unresolved questions and a practical care plan.
- Avoid a long recital of normal findings that hides the main clinical problem.

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General and Abdominal Examination

Preparation and General Assessment

- Introduce yourself, confirm identity, explain the examination and obtain consent with appropriate privacy and chaperone support.
- Ask the woman to empty her bladder and position her comfortably, avoiding prolonged flat supine positioning in advanced pregnancy.
- Measure weight and blood pressure using suitable equipment, including an appropriately sized blood-pressure cuff.
- Assess pulse, temperature when indicated, pallor, hydration, oedema and signs of cardiac, respiratory or thyroid disease.
- Examine for disease suggested by the history rather than treating antenatal examination as an isolated abdominal procedure.

Inspecting and Palpating the Abdomen

1. Inspection

- Expose only the area needed and observe abdominal size, shape, scars, striae and visible fetal movement.
- Note tenderness before deeper palpation and ask the woman to report discomfort.

2. Fundal Grip

- Palpate the uterine fundus to estimate its level and identify the fetal pole within it.
- A head usually feels firm and rounded, while the breech is generally softer and less regular.

3. Lateral Grip

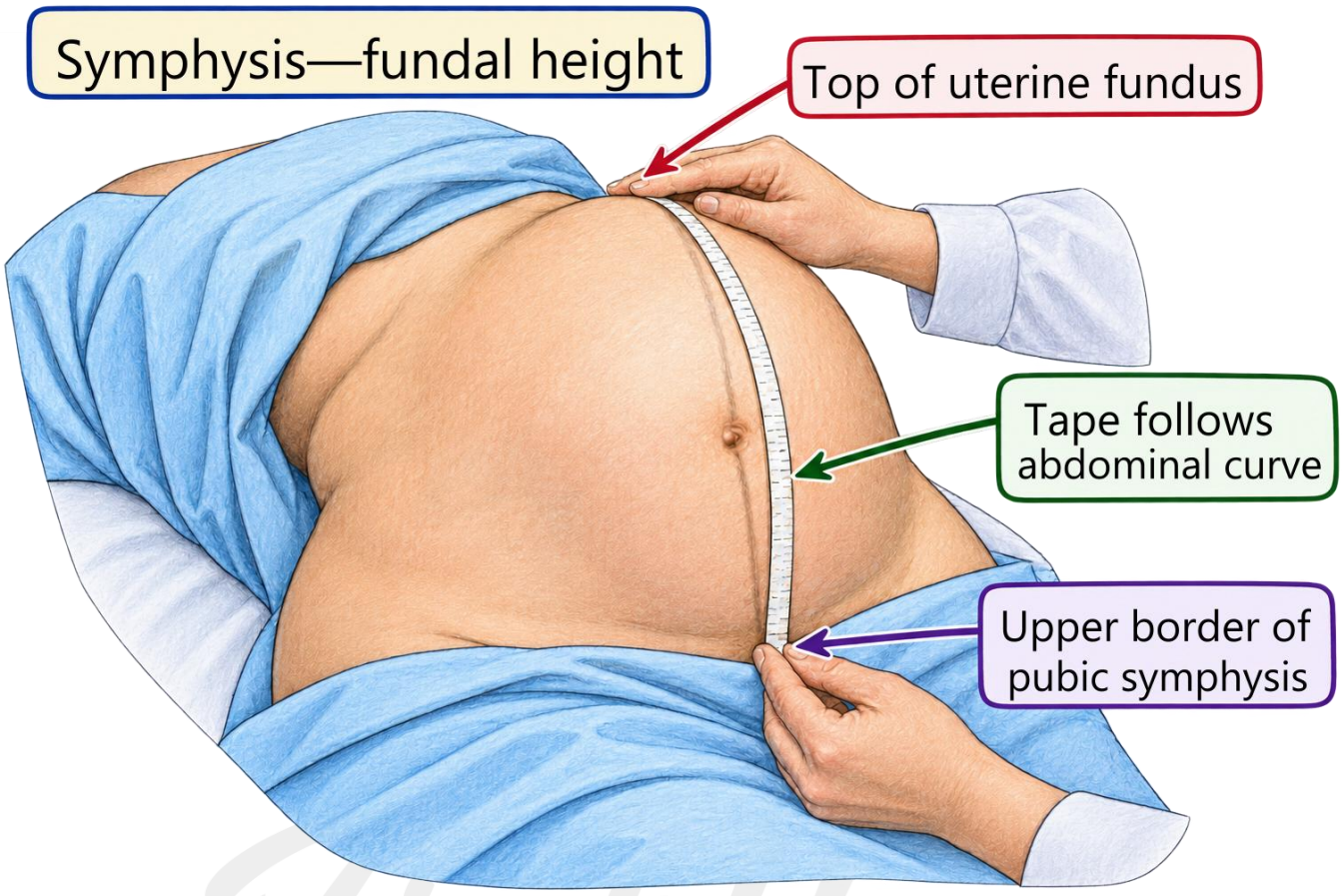
- Palpate each side to identify the smoother fetal back and the smaller irregular limbs.
- These findings help determine fetal lie and guide the site for listening to the fetal heart.

4. Pelvic Grips

- Assess the presenting part above the pelvic inlet and whether it remains mobile or has descended.
- The lower grip can help assess head attitude and the amount of head palpable above the brim.
- Document lie, presentation and engagement separately because they describe different features.
- Confirm an uncertain or clinically important presentation with ultrasound rather than relying on forceful palpation.

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Measuring Symphysis–Fundal Height



The tape follows the abdominal curve from the upper pubic border to the palpated uterine fundus

Measurement Technique and Serial Charting

- Identify the upper border of the pubic symphysis and the top of the uterine fundus by gentle palpation.
- Use a non-stretch measuring tape along the longitudinal abdominal curve between these landmarks.
- Record the measurement in centimetres and plot it on the appropriate chart rather than estimating it from finger breadths alone.
- In a singleton pregnancy without regular growth scans, serial measurements after about 24 weeks help screen for altered growth.
- Measure consistently and avoid excessively frequent measurements because short-interval variation can be misleading.

Interpreting Discrepancy and Arranging Ultrasound

- A measurement smaller or larger than expected needs interpretation with dates, maternal habitus, fetal number, fluid volume and growth.
    - A small measurement may reflect incorrect dates, growth restriction, reduced fluid or a head that has descended.
    - A large measurement may reflect multiple pregnancy, excess fluid, a large fetus, fibroids or incorrect dates.

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