

Antenatal Care - First Consult

[Disclaimer](#)

See also:

- [Antenatal – Second and Third Trimester Care](#)
- [Pregnancy-related Nausea and Vomiting.](#)
- [Prenatal Screening and Diagnosis of Fetal Anomalies](#)
- [Early Pregnancy Bleeding](#)

COVID-19 note

COVID-19 in Pregnancy:

- *While pregnant women are considered a vulnerable group, they do not appear to be more severely unwell if they develop the infection than the general population. Obstetric care providers have been advised by the [Royal Australian and New Zealand College of Obstetricians and Gynaecologists \(RANZCOG\)](#) to implement strategies to reduce the risk of exposure to infection. Face-to-face antenatal care will be reduced and telehealth consultations utilised for routine care.*
- *When referring women for obstetric care, clearly document any reasons that identify patients as high risk or in need of early obstetric assessment. Include baseline blood pressure measurement in referral to assist with triage.*
- *If a pregnant patient is confirmed or suspected COVID-19 positive, contact their obstetric provider for triage and management advice.*

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The first antenatal consult (within the first 10 weeks) requires a long appointment or may be completed over several visits. Note that [Statewide Referral Criteria](#) apply for some conditions for referral to a Level 6 Public Hospital Maternity Service.

1. Confirm pregnancy if not already done.
2. [Calculate estimated due date](#) using last normal menstrual period. Consider arranging a dating ultrasound between 8 weeks and 13 weeks plus 6 days of pregnancy, particularly if dates are uncertain.
3. Discuss the patient's plans for the pregnancy and:
 - how patient wishes to continue their pregnancy care e.g., public or private care, shared care if eligible. See Better Health Channel – [Having a Baby in Victoria](#).
 - if patient wishes to consider options, see [1800 my options](#) for information about counselling and woman-centred decision support, including termination of pregnancy referral options.
4. Ask about any symptoms of bleeding or pain. If so, consider the possibility of [miscarriage or ectopic pregnancy](#).
5. Assess **weight** and other **lifestyle aspects**.

Lifestyle aspects

- [Smoking](#) – patient and their partner
- [Alcohol and drug use](#).
- *Exposure to toxins e.g., through work or hobbies*
- *Hand hygiene*
- *Food hygiene and safety*
- *Healthy diet*

Weight in pregnancy¹

- *A BMI ≥ 35 (or ≤ 18.5) renders a pregnancy higher risk.*
 - *A high BMI increases the risk of maternal, fetal, and neonatal complications including:*
 - *gestational diabetes*
 - *pregnancy-induced hypertension or pre-eclampsia*
 - *thromboembolic disease*
 - *obstructed labour*
 - *caesarean section*
 - *preterm birth*
 - *stillbirth.*
 - *A low BMI increases the risk of complications including:*
 - *intrauterine growth restriction.*
 - *preterm birth.*
6. Take a detailed **history**. Identify **previous pregnancy outcomes** that require early obstetric review.

Previous pregnancy outcomes

- Discuss previous pregnancy experience as this may influence patient's choices.
- If the previous birth was by caesarean section, the appropriate management of the next birth can be discussed with the obstetric care provider.
- Identify previous pregnancy outcomes that require early obstetric review, such as:
 - Previous stillbirth or neonatal death
 - Recurrent or mid-trimester pregnancy loss
 - Cervical incompetence
 - Placental abruption
 - Previous delivery for severe fetal or maternal illness
 - Fetal abnormality
 - Gestational diabetes mellitus on insulin
 - Pre-eclampsia
 - Fetal growth restriction
 - Macrosomia > 4500 g
 - Shoulder dystocia
 - Pre-term labour or birth
 - Anal sphincter tear
 - Grandmultiparity
 - Rhesus iso-immunisation
 - Significant postpartum haemorrhage (> 1000 mL)

History

- Family history e.g. hypertension, diabetes, inheritable genetic conditions
- **Medical**
 - Take a medical history. Important pre-existing conditions include:
 - [diabetes](#) – type 1 or 2
 - cardiac or renal disease
 - hypertension
 - [thyroid disease](#)
 - [epilepsy](#)
 - [asthma](#)
 - Consider:
 - musculoskeletal symptoms – refer to [physiotherapist](#) to improve control.
 - [continence and prolapse](#).
 - possibility of [female genital mutilation/cutting \(FGM/C\)](#) – commonly performed in women from Somalia, Sudan, Ethiopia, and Egypt, and in some from the Middle East and Asia.
- **Mental health**
 - Take a mental health history, especially psychological disease e.g:
 - schizophrenia.
 - major mood changes.
 - previous or current trauma and abuse.
 - anxiety.
 - Consider the:
 - supports that will be available during pregnancy and post-partum.
 - possibility of [Family Violence](#).

- **Family violence**

- Intimate partner violence may increase during pregnancy and postnatally.
- Studies show that women find it acceptable to ask about family violence.
- Explain to women that asking about family violence is a routine part of antenatal care.

See [Disclosure of Domestic and Family Violence](#).

- **Medication**

Medication history

- Review all current medications and check safety. To understand the categorisation system for medicines in pregnancy, see Australian Therapeutic Goods Administration – [Prescribing Medicines in Pregnancy Database](#).
- Look for **potential teratogenic effects** in prescription medication and:

Potential teratogenic effects

- Concerns about medication include:
 - miscarriage
 - teratogenesis
 - neonatal pulmonary hypertension
 - neonatal withdrawal
 - long-term behavioural or developmental effects.
- Stop any [category X drug](#).
- Change:
 - antihypertensives:
 - ACE inhibitors are contraindicated in pregnancy and should be ceased once pregnancy is confirmed.
 - Preference is for methyldopa or labetalol.

See also [Hypertension in Pregnancy and Postpartum](#).

- antidepressants:
 - Only cease or reduce the dose if clinically appropriate after careful discussion with the patient.
 - Consider using sertraline as it is currently the most widely used drug.
 - Paroxetine is contraindicated in pregnancy.
 - Risk of relapse is 50 to 70% if medication is withdrawn inappropriately.
- [antiepileptics](#) – avoid carbamazepine and valproate.
- [drugs for hyperthyroidism](#) – preference is for propylthiouracil in first trimester then switch to carbimazole in second trimester.
- [drugs for diabetes](#) – metformin is acceptable but [type 2 diabetics](#) usually switch to insulin during pregnancy.
 - non-prescription medications.
 - vitamins.
 - supplements.
 - complementary medications.
 - recreational drugs.

- **Vaccination**

- Check rubella and varicella immunity if not already known. Live vaccines should not be given in pregnancy.
- Seasonal influenza vaccine should be given before or during pregnancy.
- **Pertussis** is given in mid pregnancy.

- **Pertussis vaccination (dTpa) recommendations**

- Optimal time is 20 to 32 weeks, but can be given at any time in the third trimester.
- Give in each pregnancy, regardless of spacing between pregnancies. The pertussis antibody transferred to the infant is protective in the first 6 months of life.
- Give to the patient's partner (funded) if:
 - patient is ≥ 28 weeks pregnant, and
 - no dose was received in the last 10 years.
- If antenatal vaccination does not occur, vaccinate as soon as possible after delivery. The vaccine is free to parents of babies aged < 6 months if they have not received a pertussis booster in the last 10 years. This will reduce the likelihood of pertussis occurring in the parents, and thus, provides some indirect protection to the infant.
- See Department of Health and Human Services – [Parent's Whooping Cough Vaccine Program: For Health Professionals](#).

See [Immunisation – Pregnancy](#)

- Cervical screening

Cervical screening is safe in pregnant women

Offer cervical screening at any stage of a patient's antenatal care in accordance with national guidelines.

- Advise the patient that vaginal spotting may occur after the procedure, poses no risk to the pregnancy, and is self-limiting.
- Do not use the endocervical brush or combi-brush if the patient is pregnant.
- The cervix broom sampler is recommended for use in pregnant patients to collect a cervical screening specimen.
- Some patients may wish to defer their cervical screening – advise them that it will be recommended again at the postnatal visit.
- Colposcopy is safe during pregnancy.

Check patient's screening is up to date. See [Cervical Screening](#).

- **Genetic risk of fetal anomalies** (both parents if possible)

(List not exhaustive)

- Maternal diabetes, epilepsy
- Consanguinity
- Previous pregnancy, child with:
 - chromosomal anomaly
 - other significant physical or learning disability
- Family history of an inheritable genetic condition e.g. thalassaemia, cystic fibrosis, spinal muscular atrophy, fragile X syndrome
- Increased risk group e.g. Ashkenazi Jewish

7. Assess **risk of pre-eclampsia**.

Risk of pre-eclampsia

- High risk:
 - History of pre-eclampsia, especially if early onset (before 34 weeks)
 - Systemic lupus erythematosus or antiphospholipid syndrome
 - Chronic kidney disease
 - Hypertension
 - Type 1 or type 2 diabetes
- Moderate risk if > 1 of:
 - Aged ≥ 40 years
 - BMI of ≥ 35 at first visit
 - Family history of pre-eclampsia in first-degree relative
 - First pregnancy
 - Multiple pregnancy
 - > 10 years since previous pregnancy

Some [specialist obstetric imaging groups](#) and genetic services offer [screening for early onset pre-eclampsia](#), a condition that affects 0.3% of women and requires delivery before 34 weeks. This can be performed at the same time as combined first trimester screening and is estimated to detect up to 8 out of 10 pregnancies at risk of early pre-eclampsia.

8. Discuss [prenatal screening and diagnosis of fetal anomalies](#).

9. Perform a **clinical examination**.

Clinical examination

- Check for **pre-existing medical conditions**.

Pre-existing medical conditions

Examples include:

- Cardiovascular e.g. [hypertension](#), cardiac disease
 - Endocrine e.g. [diabetes Type 1 and 2](#)
 - Neurological e.g. [epilepsy](#)
 - Psychiatric
 - Renal
 - Respiratory e.g. [asthma](#)
 - Musculoskeletal e.g. SLE
 - Thyroid (goitre)
- Record weight, BMI, and blood pressure.
 - Consider if there is [female genital mutilation/cutting \(FGM/C\)](#).
 - Offer breast examination, particularly if concerns regarding breastfeeding or any recent changes.
 - Perform **cervical screening test** if due.

Ask about oral health as poor maternal oral health can affect pregnancy outcomes and dental health of offspring.

10. Investigate in all patients:

- Blood group and **antibodies**

Blood group antibodies

Antibodies detected on screening can be classified as:

- High risk: Anti-D; Anti-c; Anti-K (Kell)
- Intermediate risk: M, Duffy, Rh other than D and c, S, s, U, Lutheran, Kidd, H, Diego, Scianna, Colton, Gerbich, and Vel
- Low risk: Lewis (Lea, Leb), HLA/Bg, N, p1, Yt, Xg, Dombrock, LW, Chido/Rogers, Cromer, Knops, Indian, JMH, I, and HI

Management:

- In general, pregnancies with low risk antibodies can be managed as usual
- If intermediate or high-risk antibodies are detected during pregnancy testing, the pregnancy is managed as higher risk.

See also: [Anti-D Prophylaxis in Pregnancy](#)

- FBE
- Rubella serology unless confirmed by recent test
- HIV, Hepatitis B and C serology
- Syphilis serology/Treponema pallidum particle agglutination assay (TPHA)
- MSU – microscopy, culture, and sensitivity (MCS)

11. Arrange **further investigations** as appropriate.

Further investigations

- Varicella immunity
- Chlamydia, gonorrhoea if aged < 29 years or risk factors
- Ferritin (if risk factors for anaemia, low MCV or haemoglobinopathy)
- **Haemoglobinopathy (thalassaemia) screen** – if not performed previously

Screening for thalassaemia

- Haemoglobinopathies are the most common genetic defect worldwide.
- Perform FBE, ferritin, haemoglobin electrophoresis – with DNA analysis to follow, if indicated.
- If performed previously, testing does not need to be repeated.
- Consider testing partner at the same time, particularly if they are from Southern Europe, Middle East, Africa, South-East Asia, Indian subcontinent, or Pacific Islands. Write partner details on each request slip to link at the laboratory.

- [Cervical screening](#)
- B12 if vegan
- TSH only *when indicated*
- Screen for [gestational diabetes](#) in patients at **high risk**.

High risk factors for hyperglycaemia in pregnancy

- Previous hyperglycaemia in pregnancy
- Maternal age ≥ 40 years
- Family history of diabetes mellitus (first degree relative with diabetes, including sister with gestational diabetes mellitus (GDM))

- Ethnicity:
 - Asian
 - Indian subcontinent
 - Aboriginal and Torres Strait Islander
 - Pacific Islander
 - Maori
 - Middle Eastern
 - Non-white African
- Pre-pregnancy BMI > 35
- Previous macrosomia (baby with birth weight > 4500 g or > 90th centile)
- Polycystic ovarian syndrome
- Medications:
 - Corticosteroids
 - Antipsychotics

Management

Practice Point

Commence aspirin if at risk of pre-eclampsia

In patients at risk of pre-eclampsia, commence low dose aspirin between 12 and 16 weeks gestation, unless contraindicated.

1. Arrange [pregnancy booking](#) early to circumvent difficulty in accessing services with capacity limitations.
2. If any bleeding or pain, manage as per [Early Pregnancy Bleeding](#).
3. If history or examination reveals a **pre-existing medical condition**, arrange review by treating specialist or appropriate [specialist referral](#) as soon as pregnancy is confirmed.
4. Cease **medications** with potential teratogenic effects.
5. Offer [influenza vaccination](#) to all pregnant patients.
6. Offer low dose aspirin for **prevention of pre-eclampsia** in patients at **moderate or high risk of pre-eclampsia**.

Prevention of early pre-eclampsia

- Commence low dose aspirin 150 mg at night from 12 weeks and before 16 weeks of pregnancy, unless contraindicated (e.g., allergy, active peptic ulcer disease, or gastrointestinal bleeding).
- If risk is recognised after 16 weeks, aspirin can be commenced, however current evidence suggests this may be less effective compared to commencement prior to 16 weeks.
- Aspirin should be ceased at 36 weeks.

- *Recommend adequate dietary calcium intake. Calcium supplement can be considered if dietary calcium does not meet RDI of 1000 mg per day.*

7. Provide **smoking cessation advice** if relevant.

Smoking in pregnancy

- *Smoking in pregnancy increases risks of miscarriage, premature birth, low birth-weight babies and perinatal health problems.*
- *Smoking in pregnancy is more common in women who:*
 - *are socioeconomically disadvantaged.*
 - *experience mental health conditions.*
 - *have a substance use disorder.*
 - *have fewer social supports.*
- *Successful smoking cessation counselling needs to consider these factors.*

Offer support and advice:

- Offer cessation interventions to pregnant women who smoke as soon as possible in the pregnancy, throughout the pregnancy, and beyond.
- Offer intense support and proactive telephone counselling, e.g. [QuitCoach](#).
- Offer **self-help material** to supplement advice and support.

Self-help material

Quitline:

- [Pregnancy and Smoking](#) (brochure)
- [Smoking and pregnancy](#)
- If these interventions are not successful, consider [nicotine replacement therapy](#) after clearly explaining the risks involved.
- Inform pregnant women and new mothers of the dangers of passive smoking to newborn babies and young children.
- Recommend phone app Quit for You – Quit for Two. See Clinical Resources (below).
- Higher dose of NRT is needed in women who are pregnant or on oral contraceptive pills (OCP).

8. Provide mental health support as appropriate. Advise patient of online resources, e.g. [Centre of Perinatal Excellence \(COPE\)](#), [Gidget Foundation](#), [PANDA](#).

9. Provide [general nutritional advice](#).

- Recommend supplements:
 - **Folic acid**
 - *Advise folic acid supplementation of 0.4 to 0.5 mg per day for at least 1 month prior to pregnancy, and for the first 3 months after conception.*
 - *Some patients will need **higher doses of folate**.*

Higher doses of folate

A 5 mg daily dose is recommended where there is a known increased risk of neural tube defect (NTD):

- *BMI > 30*
- *Previous child or family history of NTD*
- *Patients taking anticonvulsant medication*
- *Pre-pregnancy diabetes mellitus*

- Malabsorption
- 5-methyltetrahydrofolate deficiency
- **Iodine**
Women who are pregnant, breastfeeding, or considering pregnancy should have an iodine supplement of 150 micrograms each day.
- **Vitamin D**
Advise all women to take 400 IU Vitamin D daily as part of a pregnancy multivitamin supplement. Note that RANZCOG no longer recommends testing of Vitamin D levels in pregnancy, regardless of maternal risk factors.
- Routine iron supplementation is not necessary
- B12 if vegan/vegetarian diet
- If overweight or obese discuss **gestational weight gain goal ranges** and the goals of **weight management during pregnancy**.

Weight management during pregnancy

- Counsel patients sensitively regarding obesity in pregnancy.
- Explain that limiting weight gain can reduce the risk of adverse outcomes.
- Advise not to restrict dietary intake below the recommended food group requirements for pregnancy.
- Stop prescription and over-the-counter weight loss medications.

Gestational weight gain goal ranges.

Pre-pregnancy BMI	Rate of gain 2nd and 3rd trimester (kg/week)	Recommended total gain range (kg)
< 18.5	0.45	12.5 to 18
18.5 to 24.9	0.45	11.5 to 16
25 to 29	0.28	6.8 to 11.3
≥ 30	0.22	5 to 9.1

Source: [Victorian Maternity eHandbook: Obesity](#)

- If underweight or obese, consider [dietetic referral](#) to assist achievement of gestational weight gain goals.

10. Advise patients about safe **exercise in pregnancy**.

Exercise in pregnancy

- Effective exercise can reduce the incidence of gestational diabetes and weight gain in pregnancy.
- In the absence of complications, advise patients to undertake 30 to 60 minutes of moderate activity at least 3 to 4 times per week.
- Heart rate should usually not exceed 140 beats per minute.

- *Safe exercise options include walking, stationary cycling, aerobic exercises, dancing, resistance (e.g., weights), stretching exercises, water aerobics (this list is not exhaustive).*

11. Provide information about **hand hygiene** and [food safety](#) to prevent infections such as listeriosis, salmonellosis, and toxoplasmosis.

Hand hygiene

Advise wearing gloves and washing hands well after gardening/touching soil and to avoid touching cat litter, to reduce risk of toxoplasmosis.

12. Advise that there is no safe limit of alcohol consumption in pregnancy.

13. Provide information about **prevention of cytomegalovirus (CMV) and parvovirus.**

Prevention of cytomegalovirus (CMV) and parvovirus

The specific recommended hygiene measures to prevent CMV are:

- *Do not share food, drinks, or utensils used by young children (less than 3 years of age).*
- *Do not put a child's dummy in your mouth.*
- *Avoid contact with saliva when kissing a child.*
- *Attention to hand hygiene, when changing nappies or when in contact with urine. Thoroughly wash hands with soap and water for 15 to 20 seconds, especially after changing nappies, feeding a young child, or wiping a young child's nose or saliva.*
- *Clean toys, countertops, and other surfaces that come into contact with children's urine or saliva, and not sharing a toothbrush with a young child.*

14. If concerns about [female genital mutilation/cutting \(FGM/C\)](#), arrange [referral](#).

15. Encourage good dental care and if oral health concerns, arrange [dental referral](#). Pregnant women with a current concession card are eligible for priority public dental care.

16. If travel is planned, consider if there will be exposure of the patient or their partner to the [Zika virus](#). Ensure patient is informed of risks and strategies to avoid infection.

17. Arrange a follow up appointment in 1 to 2 weeks to discuss investigation results and provide women with a copy to take to their obstetric provider.

Referral

- Arrange [pregnancy booking](#) as soon as pregnancy is confirmed. Clearly document any reasons that identify patient as high risk or in need of early obstetric assessment.
- If **pre-existing medical condition**, arrange review by treating specialist or appropriate <https://www.semphn.org.au/resources/pathways/statewide-referral-criteria.html>
- If underweight or obese, consider [dietetic referral](#).
- If concerns about FGM/C, arrange [referral](#).
- If oral health concerns, arrange [dental referral](#).

Note that [Statewide Referral Criteria](#) apply for some conditions for referral to a Level 6 Public Hospital Maternity Service.

Information

For health professionals

Further information

- Safer Care Victoria – [Maternity and Newborn Services User Guide](#)
- Australian Government Therapeutic Goods Administration – [Prescribing Medicines in Pregnancy Database](#)
- Obstetrics and Gynecology – [Inactivated Influenza Vaccine During Pregnancy and Risks for Adverse Obstetric Events](#)
- Royal Australia and New Zealand College of Obstetricians and Gynaecologists (RANZCOG):
 - [Exercise During Pregnancy](#)
 - [Female Genital Mutilation \(FGM\)](#)
 - [Management of Obesity in Pregnancy](#)
 - [Vitamin and Mineral Supplementation and Pregnancy](#)
- The Royal Women's Hospital – [Guidelines for Shared Maternity Care Affiliates 2015](#)

For patients

- Better Health Channel:
 - [Having a Baby in Victoria](#)
 - [Pregnancy and Diet](#)
 - [Pregnancy Tests: Ultrasound](#)
- Centre of Perinatal Excellence (COPE):
 - [Am I at Risk?](#) [emotional and mental health problems]
 - [Preparing for Birth](#)
 - [Preparing for Pregnancy](#)
 - [Types of Support](#) (counselling and psychological support)
 - Department of Health - [Information You Might Not Know About Pregnancy and Alcohol](#)
- Monash Women's – [Monash Women's Fact Sheets](#)
- Pregnancy, Birth and Baby – [Home Page](#)
- Women's Ultrasound Melbourne – [Ultrasound in Pregnancy](#)

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