The Ottawa Hospital | L'Hôpital d'Ottawa

The Ottawa Hospital

Department of Obstetrics, Gynecology and Newborn Care

Attending Physician Policy Statement

Policy Statement:

The Department of Obstetrics, Gynecology and Newborn Care is dedicated to providing patient-centered care and ensuring a supportive partnership between you and the health care team throughout your pregnancy and birth.

While your primary physician will oversee your prenatal care, please note that due to the nature of physician on-call schedules, your doctor may not be present at the time of your delivery. During your hospital stay, you will be cared for by a skilled team of physicians and nurses.

We are unable to accommodate requests based on the gender, race, or religious background of the healthcare providers involved in your care. Please be assured that every member of the team is qualified and committed to providing high-quality care to you and your baby.

My signature confirms that I have read and fully understand the policy statement above and that I agree to receive care from the on-call team when indicated. I acknowledge that my questions have been answered to my satisfaction.

Patient's Signature: _____ **Date:** _____

ORIGYNS
OTTAWA OBSTETRICS REPRODUCTIVE INTEGRATED GYNECOLOGICAL SERVICES

Dr.Tammy LeRiche MD,FRCSC
205-1355 Bank Street
Ottawa, ON, K1H 8K7
Tele:613-721-2907
Fax:613-518-655
Email: Askus@origynsmedical.com
www.origynsmedical.com

Congratulations on your pregnancy! It is a privilege to be a part of this special time. Thank you for choosing our team.

Visits are typically:

- Every four weeks until 28 weeks
- Every two weeks 28- 36 weeks
- Weekly 36 weeks until delivery
- Your post-partum visit is typically six weeks after delivery
- Please book your follow-up appointment(s) before leaving the office
- My clinics are usually every Tuesday

The following are tests/investigations routinely offered in pregnancy in Ontario:

- 5 weeks and beyond: dating ultrasound
- 11+2 to 13+3 weeks: First trimester screening (FTS); this screens for genetic disorders such as Trisomy21 (Down Syndrome)
- 18-22 weeks: anatomy ultrasound
- 24-28 weeks: Diabetes and iron testing
- 28 weeks: Winrho will be provided if you have a negative blood type
- 32-34 weeks: an ultrasound may done to check for growth and position
- 35-37 weeks: a swab will be suggested to test for Group B streptococcus (GBS)
- 39-41 weeks: a pelvic exam is suggested to check for cervical dilation and possibly sweep
- 41+3: induction of labour will be offered if not delivered by then

Some reasons to get medical attention:

- Decreased fetal movements (< six movements in two hours after 24 weeks)
- Sudden gush of fluid
- Vaginal bleeding
- Regular contractions
- Severe headache, visual changes (flashes of light), chest pain
- Fevers/chills, severe vomiting or other serious health concerns

After 20 weeks you can go to triage at the Ottawa General Hospital or call there (613-737-8012). We are open 24/7. Before 20 weeks, you will have to go to ER.

Where will I deliver my baby?

Our team delivers at The Ottawa Hospital General Campus. Labour and delivery is on the 8th floor. I share call with a group of Obstetricians. The team at the hospital consists of nurses, medical students, residents, and anesthetists. An Obstetrician is available in hospital at all times.

The following immunizations are recommended during pregnancy:

- Whooping cough (Pertussis) vaccine: 21 to 32 weeks
- Influenza (seasonal)

The following medications can be used as needed and always sparingly during pregnancy:

- Pain: Acetaminophen (aka Tylenol); please use sparingly
- Cough and Cold: Robitussin DM
- Sore throat: Bradosol lozenges
- Constipation: Restorolax, Metamucil, Colace, Senna
- Hemorrhoids: Anusol, Proctosedyl
- Heartburn: Tums, Ranitidine (75 to 150mg twice daily) or Famotidine (20mg twice daily)
- Nausea and Vomiting: Gravol, Gravol Ginger, Diclectin

Recommended resources:

Healthy Beginnings www.pregnancyinfo.ca
Online prenatal class https://www.ottawacea.com
https://www.themothersprogram.ca/
http://www.bcwomens.ca/
https://www.ottawapublichealth.ca/en/public-health-topics/pregnancy-and-parenting.aspx
Car Seat Safety https://www.ontario.ca/page/choosing-child-car-seat
TOH birth unit https://www.ottawahospital.on.ca/en/clinical-services/deptpgrmcs/departments/obstetrics-gynecology-and-newborn-care/having-a-baby/your-babys-birth-and-care/birthing-unit/
Prenatal screening https://www.prenatalscreeningontario.ca/en/pso/resources/Documents/Ontario-Prenatal-Screening-Leaflet-Aug2022.pdf

Pre-Admission Instructions for The Ottawa Hospital, General Campus

You can pre-register at the General Campus for the birth of your baby preferably after the 32nd week of pregnancy. Please call Admitting Monday to Friday 8-4 at 613-737-8200.

Please have the following information ready:

- Name, Address and your birth date
- Name of your Obstetrician (Dr. Tammy LeRiche) and name of your family doctor
- Next of kin or your chosen contact person's information
- Health Card number
- Any private insurance that may be used for a private or semi-private post-partum accommodation

Suggestions for Things to Bring for Labour:

- Footwear (eg slippers, slip on shoes, flipflops for shower)
- Bathrobe, warm socks, extra underwear, comfortable clothes
- Hair elastics and hair brush
- Lip chap
- Water bottle
- Heavy flow sanitary pads
- Personal toiletries (toothbrush, toothpaste, mouthwash, soap, shampoo, hand lotion)
- Extra pillows (for support person and laboring person)
- Camera
- Snacks (no peanut or nut products)
- Relaxing music +/- headphones

Baby

- Undershirts
- Socks
- Soft hat
- Receiving blankets
- Sleepers
- Car seat
- If winter, warmer blanket
- Soother (if you're planning to use)

INFORMATION FOR PATIENTS

Tdap Vaccination During Pregnancy

THE TDAP VACCINE IS RECOMMENDED IN EVERY PREGNANCY FROM 21 TO 32 WEEKS.

THIS PROTECTS YOUR BABY FROM A POTENTIALLY DANGEROUS INFECTION CALLED PERTUSSIS (WHOOPING COUGH).

TALK TO YOUR CARE PROVIDER TO FIND OUT HOW YOU CAN GET YOUR VACCINE.

WHAT IS THE TDAP VACCINE?

The Tdap vaccine is a combination vaccine that protects against **tetanus, diphtheria, and pertussis.** Vaccination in pregnancy **allows transfer of protective antibodies to your newborn** which provides protection until they can receive their first vaccines.

WHAT IS PERTUSSIS & HOW SERIOUS IS IT?

Pertussis, also called **whooping cough**, is a very contagious infection of the lungs and airways, caused by the bacteria *Bordetella pertussis.*

Your baby can experience symptoms such as:

- Coughing fits
- Difficulty breathing
- Vomiting

which can last for several weeks or even months.

Severe complications for babies can include:

- Pneumonia
- Seizures
- Brain damage
- Death

HOW COMMON IS PERTUSSIS?

The number of whooping cough cases in Canada have been declining since the pertussis vaccine became available.

Unfortunately, pertussis outbreaks are sporadic and difficult to predict. There have been recent increases in cases across Canada.

70% of hospital admissions for whooping cough occurred in infants younger than 4 months, and almost all deaths were in infants younger than 2 months.

Studies show that 9 out of 10 infants under 3 months old are protected after Tdap vaccination in pregnancy.

The most vulnerable babies are those who are too young to be vaccinated and don't have passive immunity from you receiving the Tdap vaccine in pregnancy.

IMPORTANT NOTE:
Everyone in contact with the baby should get the Tdap vaccine including partners, grandparents, siblings, and caregivers.

WHEN SHOULD I GET THE TDAP VACCINE?

All pregnant people should get the Tdap vaccine between 21 - 32 weeks gestational age.

Your body needs time to create protective antibodies and pass them to your baby before birth. Tdap antibodies decrease over time, so it is **recommended that you get the vaccine each time you are pregnant** and even if you were not vaccinated in a previous pregnancy.

WHAT ARE THE RISKS?

The Tdap vaccine is **very safe** and has been a recommended part of prenatal care for many years.

Side effects:

Most common
- Redness
- Swelling
- Pain
- Tenderness

Less common
- Body aches
- Fatigue
- Fever

CAN I STILL GET THE FLU AND COVID VACCINES?

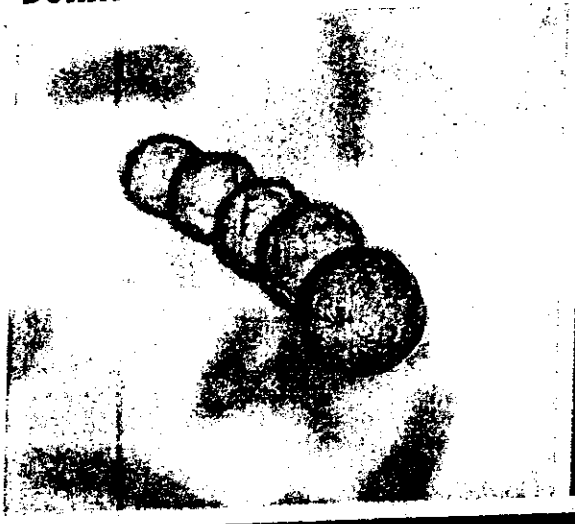
Yes! There is no required delay between Tdap and the COVID-19 or influenza vaccines.

Handout is based on recommendations by The Canadian National Advisory Committee on Immunization (NACI) and The Society of Obstetricians and Gynaecologists of Canada (SOGC).

v.01.11.2022

Thomas C, Reddeman L, Reed C, Alkhanbouli M, Clark I, Zhou GX, Shirreff L

GROUP B STREPTOCOCCUS (GBS) INFECTION
DURING PREGNANCY



THE SOCIETY OF OBSTETRICIANS AND GYNAECOLOGISTS OF CANADA

www.sogc.org

education

Screening for GBS, and having treatment if needed, is a common and routine part of pregnancy.

Group B streptococcus (GBS) are common bacteria which are often found in the vagina, rectum or urinary bladder of women. This is not the same bacteria which causes strep throat. Infections from GBS are usually not serious for a woman and are readily treated with antibiotics. However, when a woman becomes pregnant, the whole outlook changes. There is no sure way to prevent the GBS bacteria from being passed to a newborn at the time of birth and although it is very rare, and despite medical treatment, some babies still die as a result of complications from a GBS infection. Your doctor would like to help prevent this from happening. GBS usually does not cause infections in pregnant women, the concern is for the baby. Read this pamphlet to find out about group B streptococcus infections (GBS).

About group B streptococcus (GBS)

When GBS bacteria reach a woman's bladder, kidneys or uterus they can cause an infection. Infections can cause inflammation and pain. A woman can have these bacteria in her body and not know it. If a woman has these bacteria in her vagina and rectum without having any symptoms, she is said to be colonized (positive). It is estimated that 15 - 40% of all pregnant women are GBS colonized. Between 40 - 70% of colonized mothers pass the bacteria onto their babies during the birthing process. While most babies are not affected by the bacteria, a very small number (1- 2%) of these babies will go on to develop a GBS infection. Babies who are infected with GBS may have mild to severe problems which may affect their blood, brain, lungs and spinal cord. No one method of screening (testing) and treatment will prevent all GBS infant deaths.

Screening (testing) for GBS

Doctors agree that there are two acceptable options for screening, (testing) for GBS. A doctor may choose to routinely culture (test) all the pregnant women under his or her care between the 35th and 37th week of pregnancy, and treat the mothers who are GBS colonized (positive) with antibiotics when labour starts. Or a doctor may choose not to routinely test every woman, but rather to treat only those mothers who are at risk of passing the bacteria to their babies (Table 1) during the birth process. If cultures were not done around the time of the woman's 35th - 37th week of pregnancy, or if the test results are not available at the time of delivery, it is essential that women at risk are treated with antibiotics.

In addition, particularly if the woman has a history of bladder or kidney infections, a doctor may also test a woman's urine for the bacteria if the bacteria are found in the urine but not found in the vagina or rectum, the woman is still considered colonized (positive) and will still I be treated with antibiotics when she goes into labour.

Risk factors for GBS infections

Women are at high risk to pass GBS on to their babies if they:

1. Start labour before they reach 37 weeks gestation (with or without ruptured membranes).
2. Reach full term. but their membranes rupture (water breaks) and it seems as through the labour will last more than 18 hours.
3. If they have an unexplained, mild fever during labour.
4. If they have already had a baby who had a GBS infection.
5. If they have (or had) a bladder or kidney infection which was caused by the GBS bacteria.

This simple and painless test is done by inserting a Special Q-tip into a woman's vagina and rectum. The Q-tip is then placed in a special solution to see if the bacteria grow. This is called doing a Culture. If bacteria grow, the woman is said to be colonized (positive) If no bacteria grow, the test is negative.

Treatment for mother

Expectant mothers who tested positive for GBS bacteria will be treated with antibiotics when they go into labour or if their membranes rupture (water breaks) early. If a mother is not tested but is thought to be at high risk (Table 1) for passing the bacteria on to her baby during the birth process, she will also be treated with antibiotics to kill the bacteria during her labour and birth.Studies show that it is not beneficial to give antibiotics during pregnancy, as in more than 65% of cases, the bacteria have time to re-grow before labour begins.

Be sure to tell your doctor if you think you have had an allergic reaction to antibiotics in the past.

There are two types of GBS infections that can happen to newborn babies. The most common type is called early-onset disease. In this case, the babies are almost always infected during their journey down the birth canal because the bacteria were in their mother's vagina. The symptoms of early-onset infections show up before the baby is seven days old. Some babies show signs of this infection as early is six hours after birth. Early-onset disease can cause infections in a baby's lungs, brain, spinal cord or blood. This type of GBS infection can be very serious and frequently hard for a newborn baby to fight off. This is the infection that antibiotic treatment in labour is aimed at preventing.

The second type is called late-onset disease. In this case, the babies don't show signs of a GBS infection until after they are more than seven days old. About half of these babies were also infected during their birth. The other half became infected after the birth by being in contact with their GBS positive mother, or another person who is a carrier of the disease. Late-onset infections can also cause serious problems for the newborn. The most common problem is meningitis - an infection of the membranes which surround the brain and spinal cord. The risk of late-onset disease is not decreased by antibiotic treatment in labour but antibiotics are available for the baby once it is born. Babies with early-onset disease are more likely to die than those babies with late-onset disease.

Treatment for baby

All newborn infants are watched closely for symptoms of an infection, particularly when the mother was GBS positive at some point in her pregnancy, and no matter whether she was treated with antibiotics or not. While it is true that the chances are small that an expectant mother who was treated with antibiotics during pregnancy will pass the bacteria on to her baby - it can happen. Babies who show signs of a GBS infection after birth will also be treated with antibiotics. If available, a baby specialist (paediatrician) may be asked to help look after a baby with a GBS infection.

Further resources from the Society of Obstetricians and Gynaecologists of Canada

- Guideline available at **www.sogc.org**:
  - The Prevention of Early-Onset Neonatal Group B Streptococcal Disease
- The book, "Healthy Beginnings: Giving your baby the best start from preconception to birth", available at **www.sogc.org/healthybeginnings**

TRAVEL IN PREGNANCY

https://www.acog.org/womens-health/faqs/travel-during-pregnancy

- Is travel safe during pregnancy?

In most cases, pregnant women can travel safely until close to their due dates. But travel may not be recommended if you have pregnancy complications. If you are planning a trip, talk with your obstetrician–gynecologist (ob-gyn). And no matter how you choose to travel, think ahead about your comfort and safety.

- When is the best time to travel during pregnancy?

The best time to travel is mid-pregnancy (14 to 28 weeks). During these weeks, your energy has returned, morning sickness is improved or gone, and you are still able to get around easily. After 28 weeks, it may be harder to move around or sit for a long time.

- What should I know about deep vein thrombosis and preventing blood clots?

DVT is a condition in which a blood clot forms in the veins, usually in the leg. DVT can lead to a dangerous condition called pulmonary embolism. This is when a blood clot travels to the lungs. Research shows that any type of travel lasting 4 hours or more—whether by car, train, bus, or plane—doubles the risk of DVT. Being pregnant is an extra risk factor for DVT.

If you are planning a long trip, take the following steps to reduce your risk of DVT:

- Drink lots of fluids without caffeine.
- Wear loose-fitting clothing.
- Walk and stretch at regular intervals.

Special stockings that compress the legs, either below the knee or full length, can be worn to help prevent blood clots from forming. Talk with your ob-gyn before you try these stockings. Some people should not wear them (for example, those with diabetes mellitus and other circulation problems). Also, compression stockings can increase the risk of DVT if they are too tight or worn incorrectly.

- How should I prepare for international travel?

Visit your ob-gyn at least 4 to 6 weeks before a trip outside Canada. At this visit you can go over your travel plans, get advice about specific health issues, and discuss vaccines that are recommended for the area you will be visiting.

This also gives you time to call your health insurance. Ask if you are covered outside the Canada. If not, you may be able to buy travel health insurance.

Carry a copy of your health record with you outside the country. Also, before leaving home, locate the nearest hospital or medical clinic in the place you are visiting.

You should also check with the airlines to see about flying later in pregnancy (sometimes a note is required or flights are not permitted beyond 36 weeks pregnant).

NAUSEA AND VOMITING OF PREGNANCY

https://www.acog.org/womens-health/faqs/morning-sickness-nausea-and-vomiting-of-pregnancy

- Is nausea and vomiting normal during pregnancy?

Nausea and vomiting of pregnancy is a common condition. It can occur any time during the day, even though it's often called "morning sickness." Nausea and vomiting of pregnancy usually doesn't harm the fetus, but it can affect your life, including your ability to work or go about your normal everyday activities. There are safe treatment options that can make you feel better and keep your symptoms from getting worse.

- When does nausea and vomiting of pregnancy start?

Nausea and vomiting of pregnancy usually starts before 9 weeks of pregnancy. For most women, it goes away by 14 weeks of pregnancy. For some women, it lasts for several weeks or months. For a few women, it lasts throughout the pregnancy.

- When is hyperemesis gravidarum diagnosed?

This condition may be diagnosed when a woman has lost 5 percent of her prepregnancy weight and has other problems related to dehydration, or loss of body fluids (see below). Women with hyperemesis gravidarum need treatment, sometimes in a hospital, to stop the vomiting and restore body fluids.

- What are the signs of dehydration?

Nausea and vomiting can cause you to lose fluids. If fluids are not replaced, it can lead to dehydration. You should call your ob-gyn or other obstetric care provider if you have the following signs and symptoms of dehydration:

- You have a small amount of urine that is dark in color.
- You are unable to urinate.
- You cannot keep down liquids.
- You are dizzy or faint when standing up.
- You have a racing or pounding heartbeat.

- When can nausea and vomiting of pregnancy become a problem?

Nausea and vomiting can become more of a problem if you cannot keep down food or fluids and begin to lose weight. When this happens, it sometimes can affect the fetus's weight at birth.

- Can weight loss cause other issues?

Weight loss can lead to problems with your thyroid, liver, and fluid balance. Because hyperemesis gravidarum is difficult to treat and can cause health problems, experts recommend early treatment so that it does not become severe.

- How can I manage nausea and vomiting of pregnancy?

Changes to your diet and lifestyle might help you feel better. These change can include:

- Taking vitamins
- Adjusting meal times
- Changing the types of foods you eat

- Should I take vitamins?

Yes, take a prenatal vitamin. Studies show that taking a vitamin supplement before and during pregnancy reduces the risk of having severe nausea and vomiting of pregnancy.

- What can I do to help with nausea?

- Eat dry toast or crackers in the morning before you get out of bed to avoid moving around on an empty stomach.
- Eat five or six "mini meals" a day to ensure that your stomach is never empty.
- Eat frequent bites of foods like nuts, fruits, or crackers.

- What kinds of foods might help?

Try bland foods. The BRATT diet (bananas, rice, applesauce, toast, and tea) is low in fat and easy to digest. If these foods don't appeal to you, try others. The goal is to find foods that you can eat and that stay down.

- Can protein help?

Yes, try adding protein to each meal. Good nonmeat sources of protein include:

- Dairy foods, such as milk, ice cream, and yogurt
- Nuts and seeds, including butters like almond butter and peanut butter
- Protein powders and shakes

- Are any supplements worth trying?

Ginger can help settle your stomach. You can try:

- Ginger capsules
- Ginger candies
- Ginger ale made with real ginger
- Ginger tea made from fresh-grated ginger

- Do I need to drink a lot of fluids during pregnancy?

Yes, your body needs more water during pregnancy. Drink throughout the day, not just when you are thirsty. Aim for 8 to 12 cups of water a day during pregnancy.

Not drinking fluids can lead to dehydration, which can make nausea worse. If a bad taste in your mouth makes it hard to drink water, chew gum or eat hard candy.

- What can I do if some smells make nausea worse?

Foods or odors that might never have bothered you before might now trigger nausea. Do your best to stay away from them. Use a fan when cooking. Have someone else empty the trash.

- How can I protect my teeth from frequent vomiting?

Frequent vomiting can cause some of your tooth enamel to wear away, due to the acid in your stomach. Rinse your mouth with a teaspoon of baking soda dissolved in a cup of water to help neutralize the acid and protect your teeth.

- What medications may be used to treat nausea and vomiting of pregnancy?

If diet and lifestyle changes don't help, or if you have severe nausea and vomiting of pregnancy, you might need medical treatment. Your ob-gyn or other obstetric care provider will first want to know whether your symptoms are due to nausea and vomiting of pregnancy or another medical cause. If other causes are ruled out, you may be able to take certain medications:

- Vitamin B6 is a safe, over-the-counter treatment that may be tried first for nausea and vomiting of pregnancy.
- A prescription drug that combines vitamin B6 and doxylamine is available (Diclectin). It has been found to be safe to take during pregnancy and has no harmful effects on the fetus.

- Are antiemetic drugs safe during pregnancy?

Many antiemetic drugs have been shown to be safe to use during pregnancy. But others have conflicting or limited safety information. For example, a drug called ondansetron is highly effective in preventing nausea and vomiting, but studies are not clear about its safety for the fetus. Ondansetron also has been linked to heart-rhythm problems in people taking the drug, especially in those who have certain underlying conditions.

PRENATAL GENETIC SCREENING

Information for Your Pregnancy

KEY FACTS

- Prenatal genetic screening is a way for you to find out the chance that your baby has or does not have trisomy 21 or trisomy 18.
- This screening poses no risk to the pregnancy since it involves ultrasound and blood work.
- Prenatal genetic screening is not diagnostic. Only diagnostic testing, such as chorionic villus sampling (CVS) or amniocentesis, can give you a "yes" or "no" answer about trisomy 21 and trisomy 18 during the pregnancy.
- Prenatal genetic screening is available to all pregnant individuals in Ontario, and is optional. The routine pregnancy care you receive from your health-care provider will not be affected whether or not you choose to have this screening.

WHAT DO WE SCREEN FOR?

Prenatal genetic screening involves screening for at least two common chromosome differences:

- trisomy 21 (Down syndrome)
- trisomy 18 (Edwards syndrome)

Anyone may have a baby with trisomy 21 or trisomy 18, regardless of their family history. This chance increases with the age of the pregnant person (or the age of egg donor).

IS PRENATAL GENETIC SCREENING RIGHT FOR ME?

Would knowing whether there is a higher or lower chance to have a baby with trisomy 21 or trisomy 18 be helpful to you during the pregnancy? Some people would prefer to wait for this information until the baby is born. Others would want to know if there is a chromosome difference to help them prepare for having a child that may require special care. When there is a chromosome difference, the health-care provider may recommend changes to how the pregnancy is looked after, or the birth plan. Some individuals would consider interrupting the pregnancy if the result is confirmed by further diagnostic testing.

You may wish to discuss the decision with your health-care provider if you have further questions. The choice whether to have prenatal genetic screening is personal. If you decide you do not want these tests, you can still have ultrasounds in the pregnancy.

HOW DO WE SCREEN?

If you have not yet done a prenatal genetic screen, you can choose one of the following tests available in Ontario:

enhanced First Trimester Screening (eFTS) / Second Trimester Screening (STS)

Both tests are covered by Ontario Health Insurance Plan (OHIP). How far along you are in the pregnancy and ultrasound availability in your area will determine which of these two tests is possible for you.

Non-Invasive Prenatal Testing (NIPT)

NIPT is the most accurate prenatal genetic screening test, and is OHIP-funded in certain situations. You can choose to pay for NIPT out-of-pocket (private-pay) if you do not meet any of the funding criteria on our website.

LEARN MORE Visit our website to read more about chromosome differences and available tests. Reach out to one of our Genetic Counsellors by phone or email.

PRENATAL SCREENING
DÉPISTAGE PRÉNATAL
ONTARIO

Address: —
www.prenatalscreeningontario.ca

Phone: —
1-833-351-6490

Email: —
pso@bornontario.ca

V5 08/2022

What is the Nuchal Translucency (NT) Ultrasound?

- Typically done as part of eFTS, from 11 weeks and 2 days to 13 weeks and 3 days of pregnancy.
- Measures the fluid-filled pocket at the back of the neck of the developing baby.
- Offers valuable information about the pregnancy, beyond screening for trisomy 21 and trisomy 18.
- You can consider this ultrasound even if you are choosing NIPT or you do not wish to have prenatal genetic screening.

Below are questions that you and your health-care provider can consider when choosing a test.

QUESTIONS TO CONSIDER	eFTS	STS	NIPT
When in pregnancy is it done?	11 weeks and 2 days to 13 weeks and 3 days	14 weeks and 0 days to 20 weeks and 6 days	9-10 weeks or later
What does it include?	· blood work · NT ultrasound	· blood work	· blood work
What does it screen for?	· trisomy 21 · trisomy 18	· trisomy 21 · trisomy 18	· trisomy 21 · trisomy 18 · trisomy 13 · sex chromosome differences · microdeletion syndromes[1]
Can it be done if pregnant with more than one baby?	No	No	Yes, it can be done if you are pregnant with one baby or twins
What is the detection rate for trisomy 21?[2]	89%	87%	More than 99%
What is the false positive rate for trisomy 21?	6%	8%	Less than 0.1%
What is the detection rate for trisomy 18?	85%	39-89%	96%
What is the false positive rate for trisomy 18?	Less than 1%	Less than 1%	Less than 0.1%

Meaning, how many pregnancies where the baby really does have trisomy 21 will be flagged as "screen positive" (or "high risk") by this test?

Meaning, how many pregnancies will this test flag as "screen positive" (or "high risk") but the baby does not really have trisomy 21?

Meaning, how many pregnancies where the baby really does have trisomy 18 will be flagged as "screen positive" (or "high risk") by this test?

Meaning, how many pregnancies will this test flag as "screen positive" (or "high risk") but the baby does not really have trisomy 18?

1 The current Canadian guidelines do not currently recommend the use of NIPT to screen for microdeletion syndromes.
2 Detection rates and false positive rates were obtained from Ontario pregnancie (except twins) with a due date between Sept. 2016 and March 2021.

LEARN MORE
- Visit our website to read more about chromosome differences and available tests.
- Reach out to one of our Genetic Counsellors by phone or email.

PRENATAL SCREENING
DÉPISTAGE PRÉNATAL
ONTARIO

Address: —
www.prenatalscreeningontario.ca

Phone: —
1-833-351-6490

Email: —
pso@bornontario

NUTRITION IN PREGNANCY

For full document https://www.acog.org/womens-health/faqs/nutrition-during-pregnancy

- Why is nutrition during pregnancy important?

Eating well is one of the best things you can do during pregnancy. Good nutrition helps you handle the extra demands on your body as your pregnancy progresses. The goal is to balance getting enough nutrients to support the growth of your fetus and maintaining a healthy weight.

- How much should I eat during pregnancy?

If you are pregnant with one fetus, you need an extra 340 calories per day starting in the second trimester (and a bit more in the third trimester). That's roughly the calorie count of a glass of skim milk and half a sandwich. If you are carrying twins, you should get about 600 extra calories a day. If you are carrying triplets, you should take in 900 extra calories a day.

- What vitamins and minerals do I need during pregnancy?

During pregnancy you need folic acid, iron, calcium, vitamin D, choline, omega-3 fatty acids, B vitamins, and vitamin C. See the below table for recommended amounts.

Key Vitamins and Minerals During Pregnancy

Nutrient (Daily Recommended Amount)	Why You and Your Fetus Need It	Best Sources
Calcium (1,300 milligrams for ages 14 to 18; 1,000 milligrams for ages 19 to 50)	Builds strong bones and teeth	Milk, cheese, yogurt, sardines, dark green leafy vegetables
Iron (27 milligrams)	Helps red blood cells deliver oxygen to your fetus	Lean red meat, poultry, fish, dried beans and peas, iron-fortified cereals, prune juice
Iodine (220 micrograms)	Essential for healthy brain development	Iodized table salt, dairy products, seafood, meat, some breads, eggs

Nutrient (Daily Recommended Amount)	Why You and Your Fetus Need It	Best Sources
Choline (450 milligrams)	Important for development of your fetus's brain and spinal cord	Milk, beef liver, eggs, peanuts, soy products
Vitamin A (750 micrograms for ages 14 to 18; 770 micrograms for ages 19 to 50)	Forms healthy skin and eyesight Helps with bone growth	Carrots, green leafy vegetables, sweet potatoes
Vitamin C (80 milligrams for ages 14 to 18; 85 milligrams for ages 19 to 50)	Promotes healthy gums, teeth, and bones	Citrus fruit, broccoli, tomatoes, strawberries
Vitamin D (600 international units)	Builds your fetus's bones and teeth Helps promote healthy eyesight and skin	Sunlight, fortified milk, fatty fish such as salmon and sardines
Vitamin B6 (1.9 milligrams)	Helps form red blood cells Helps body use protein, fat, and carbohydrates	Beef, liver, pork, ham, whole-grain cereals, bananas
Vitamin B12 (2.6 micrograms)	Maintains nervous system Helps form red blood cells	Meat, fish, poultry, milk (vegetarians should take a supplement)