The following summary addresses key aspects of the American College of Obstetricians and Gynecologists Guidelines for Preconception Care, Prenatal Care and Postpartum Care, as they apply in uncomplicated situations. However, it does not attempt to cover all details, and readers are encouraged to refer to the original source document for the comprehensive guidelines.

I. Preconception Care

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<th>Preconception Care</th>
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Preconception care aims to optimize a woman’s health, health behaviors, and knowledge prior to conception. Recommended care includes:

- **History**
  - Gynecologic, obstetrical, medical, surgical and psychiatric histories
  - Family history and genetic history
  - Assessment of socioeconomic, educational and cultural context
  - Immunization status
  - Medications (prescription and nonprescription)

- **Physical Exam**

- **Preconception counseling and interventions, including:**
  - Substance use (tobacco, alcohol, and drugs)
  - Family planning
  - Sexually transmitted diseases including HIV
  - Nutritional counseling and folic acid use
  - Safety and social supports
  - Immunizations, as indicated
  - Evaluation of medications
  - Consideration of preconception genetic screening

- **Management of medical conditions, including diabetes, hypertension, epilepsy, thyroid conditions, maternal phenylketonuria, asthma, history of bariatric surgery, hemoglobinopathies, inherited thrombophilias, obesity, and other chronic diseases**

II. Prenatal Care

Prenatal care involves an ongoing process of risk identification, assessment and management. Prenatal care visits should begin in the first trimester. A typical visit schedule is every 4 weeks for the first 28 weeks of gestation, every 2 weeks until 36 weeks of gestation, and weekly thereafter. The visit schedule may be altered for women requiring close surveillance, such as those with medical or obstetric problems or at the extremes of reproductive age.
### First Prenatal Visit

- **History**
  - Obstetrical and medical histories
  - Family history and genetic history
  - History of substance use and abuse, including tobacco, alcohol, drugs
  - Assessment of socioeconomic, educational and cultural context
  - Immunization status
  - Medications (prescription and nonprescription) and allergies
- **Physical exam including pelvic exam**
- **Education about the expected course of pregnancy, nausea and vomiting, signs and symptoms to report to the physician, laboratory tests to be done, costs, physician/midwife coverage for labor and delivery**
- **Education and counseling about safety practices (lap and shoulder belt use, infection prevention), counseling about substance use and abuse, psychosocial issues, nutrition, exercise, air travel**
- **Documentation of Last Menstrual Period (LMP) and assignment of Estimated Date of Delivery (EDD) / Estimated Date of Confinement (EDC)**
- **Recommend prenatal vitamins with folic acid and iron**

### Each Subsequent Prenatal Visit

- **Blood pressure**
  - Screen for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy
- **Weight**
- **Uterine size for progressive growth and consistency with EDD**
- **Presence of fetal heart activity at appropriate gestational ages**
- **Ask about fetal movement (at appropriate gestational ages), leakage of fluid, vaginal bleeding**
- **Urine dipstick, as clinically indicated**

### Initial Testing

- Blood type, D(Rh) type, Antibody screen
- Complete blood count
- Urinalysis
- Hepatitis B (HBsAg)
- Syphilis (VDRL/RDR)
- Rubella titer
- HIV
- Chlamydia
- For women at higher risk:
  - Gonorrhea
- Tuberculin skin test
- Ultrasound, as indicated to address specific clinical questions

## Antepartum Genetic Screening and Diagnosis

- Family history and ethnic background are key considerations in the need for genetic testing. There are a variety of ways to screen for fetal birth defects or genetic abnormalities. Obstetric providers should provide recommended screening or establish referral sources for screening. Patients should be educated about available options.
- Screening for aneuploidy should be offered to all women who seek prenatal care before 20 weeks gestation, regardless of maternal age, along with counseling to assist in informed decision-making.

### Recommended Subsequent Testing

#### Testing recommended for all pregnant women
- Hematocrit or hemoglobin – early in third trimester
- Diabetes screening – usually at 24-28 weeks with a plasma glucose one hour after a 50-g oral glucose challenge. A 3-hour oral glucose tolerance test should be performed for those with an abnormal screening test.
- Screening for Group B streptococcal disease at 35-37 weeks
  - Women with group B streptococcal bacteriuria during the current pregnancy and those who have previously given birth to a neonate with early-onset group B streptococcal disease do not need to be screened but should be treated with intrapartum prophylactic antibiotics.

#### Testing recommended when indicated
- Ultrasound
  - The timing and type of ultrasound should be based on the clinical question being asked. The optimal timing for a single ultrasound examination in the absence of specific indications for a first trimester exam is 18-20 weeks of gestation.
- Antepartum tests of fetal well-being are indicated when there is increased risk of fetal demise.
  - The type of test, when to start testing, and frequency of testing are dependent upon the clinical situation.

#### Testing recommended only for women at increased risk
- Antibody tests in unsensitized D-negative patients at 28-29 weeks
- Third trimester HIV, chlamydia, syphilis, gonorrhea
- Testing at time of hospital admission: Hepatitis B

### Education and Counseling (After Initial Prenatal Visit)
- Working
- Childbirth education classes
- Newborn care provider
- Anticipating labor
- Preterm labor
- Trial of labor after Cesarean delivery
- Elective deliveries are not recommended prior to 39 weeks of gestation without medical indication and documentation of term gestation
- Breastfeeding
- Postpartum contraception/sterilization/tubal ligation
- Psychosocial issues, including substance use or abuse, depression, intimate partner violence

**Treatment**
- Anti-D immune globulin for unsensitized D-negative patients at 28-29 weeks and at the time of ectopic gestation, abortion, procedures associated with possible fetal-to-maternal bleeding, conditions associated with fetal-maternal hemorrhage, unexplained vaginal bleeding, delivery of a newborn who is D-positive.
- Immunizations:
  - Influenza vaccine for women who will be pregnant during the influenza season, using inactivated influenza vaccine.
  - Tdap – Administer one dose of Tdap during each pregnancy, preferably between 27 and 36 weeks gestation, regardless of the interval since prior Td or Tdap vaccination.
- Other vaccines when specifically indicated: Hepatitis A, Hepatitis B, pneumococcal, meningococcal
- Use low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.

**III. Postpartum Care**

For women with a Cesarean section or complicated pregnancy, 7-14 days after delivery may be recommended. A postpartum visit is recommended for all women approximately 4-6 weeks after delivery. Services at that visit should include:

<table>
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<tr>
<th>Postpartum Visit</th>
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<tbody>
<tr>
<td><strong>Interval History</strong></td>
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<td><strong>Physical Exam</strong></td>
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<td>- Weight, blood pressure, breasts, abdomen, pelvic exam (including examination of episiotomy repair and evaluation of uterine involution)</td>
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<td>- Pap test if needed</td>
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<tr>
<td><strong>Testing</strong></td>
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<td>- Women with gestational diabetes should be screened for diabetes 6-12 weeks postpartum</td>
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<tr>
<td><strong>Counseling</strong></td>
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<td>- Breastfeeding</td>
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<tr>
<td>- Screen for postpartum depression, postpartum blues</td>
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<tr>
<td>- Discuss contraception and plans for future pregnancies</td>
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<tr>
<td>- Discuss implication of any pregnancy complications on future pregnancies</td>
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<td>- Review immunizations and administer Tdap, rubella and/or varicella vaccines if indicated</td>
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<td>- Counseling regarding behaviors, such as tobacco, alcohol, and other substance use, with referrals for follow up care if appropriate</td>
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73. ACO Committee Opinion. Available at: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Postpartum-Care. A recent update to the ACOG recommendation on Postpartum care. Accessed June 06, 2019. It is recommended that all women have contact with their obstetrician–gynecologists or other obstetric care providers within the first 3 weeks postpartum. This initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth. The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being, including the following domains: mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance. Women with chronic medical conditions such as hypertensive disorders, obesity, diabetes, thyroid disorders, renal disease, and mood disorders should be counseled regarding the importance of timely follow-up with their obstetrician–gynecologists or primary care providers for ongoing coordination of care (it was decided not to make this update until 2019).