DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY

PG SYMPOSIUM ON ANTENATAL CARE

Date : 23/10/25

"FROM BUMP TO BIRTH – LET CARE BEGIN"

SPEAKER – DR.SRAVANI TANJAVURU

MODERATOR – DR. REVATHY T G (PROFESSOR); DR. AFRAA (SR)

TOPIC – Antenatal care overview and history taking

Definition

A coordinated program of medical care, continuous risk assessment, and psychosocial support beginning pre-pregnancy and continuing through the postpartum period.

Goals & Objectives

Support and educate women for active participation in healthcare.

Improve maternal & neonatal outcomes, reduce stillbirths.

Screen for high-risk conditions and fetal wellbeing.

Promote family education & ensure immunization coverage.

Patient Education

Supplements: Folic acid, iron, calcium — essential for maternal and fetal health.

Nutrition: Balanced diet; include fruits, vegetables, proteins, grains, dairy.

Exercise: Brisk walk 30 min/day; pelvic floor & breathing exercises.

Lifestyle: Avoid smoking, alcohol, OTC drugs; safe travel (14–28 weeks).

Breastfeeding, contraception & labor preparation discussions essential.

Weight Gain

Normal gain: 10–12 kg

<6 kg → risk of LBW; >12 kg → risk of GDM, pre-eclampsia, macrosomia.

Nutrition Highlights

Nutrient	Requirement	Notes
Carbohydrates	175–210 g/day	45–60% total calories
Protein	1 g/kg/day	Fetal growth
Fats	15–20%	Limit saturated fats
Folic acid	300–600 µg/day	Start pre-conception
Calcium	1200 mg/day + 250 IU Vit D3	Split doses; avoid with iron
Iron	60 mg daily (120 mg if anemic)	With folic acid supplement

Drink 8–10 glasses of water daily

Rest & Sleep

Sleep 8–10 hours/day.

Prefer left lateral position.

Stretching helps prevent leg cramps.

Immunization

Td: 2 doses 4 weeks apart.

Tdap: 27–36 weeks GA.

Influenza, COVID-19, Hep B, Rabies (PEP) — safe in pregnancy.

Avoid live vaccines.

Mental & Oral Health

Encourage relaxation, positive environment.

Maintain oral hygiene to prevent gingivitis and preterm labor.

Antenatal History Taking

Patient ID, obstetric & gynecologic history, medical & surgical history, family & social background, and present pregnancy details.

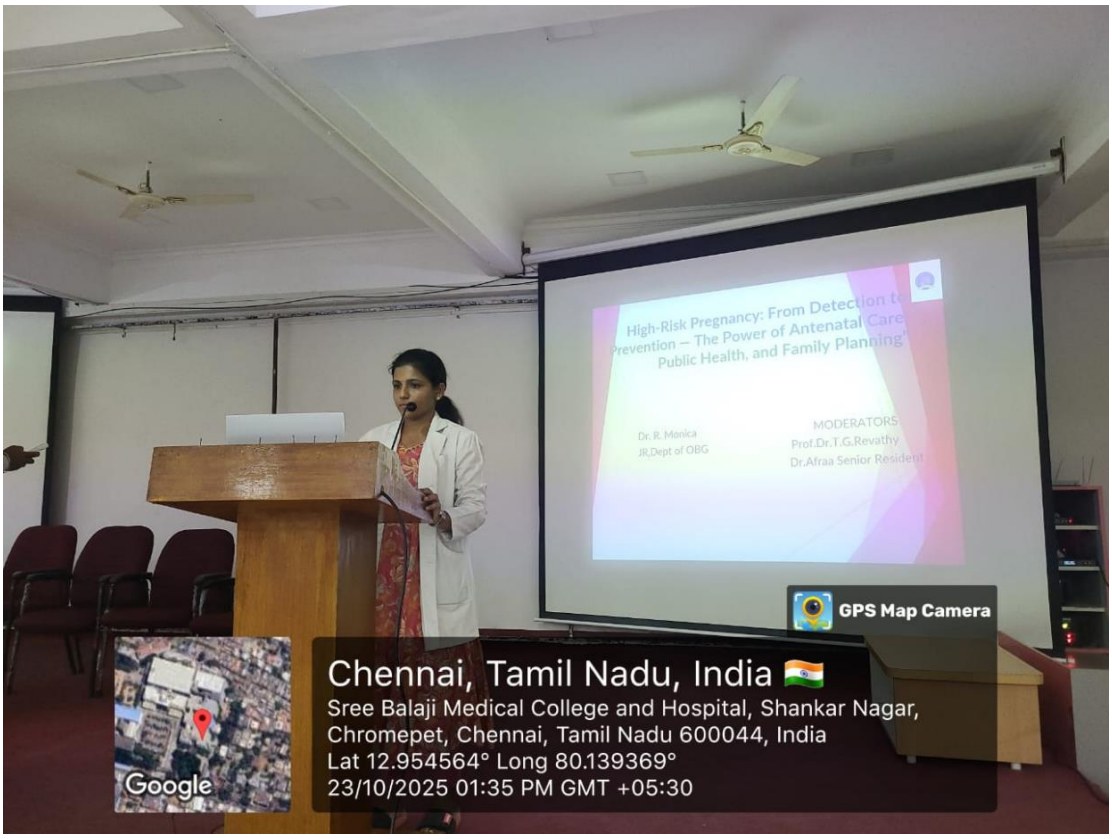
(Ref: Williams Obstetrics)

TOPIC- Antenatal care in High risk pregnancy

SPEAKER - Dr.MONICA .R

Second year postgraduate

Department of OBG



High-risk pregnancy is one in which the life or health of the mother, fetus, or both is at increased risk due to medical, obstetric, or socio-demographic factors. Globally, about 15–20% of pregnancies fall into this category, and in India, they contribute to over 70% of maternal morbidity and mortality. Major risk factors include pre-existing medical disorders such as hypertension, diabetes, cardiac or renal

disease; pregnancy-related complications like preeclampsia, multiple gestation, fetal growth restriction, and abnormal placentation; as well as historical and social factors like previous adverse outcomes, extreme maternal age, poor nutrition, and lack of access to antenatal care. Early detection through tools like the Gestosis score and Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) color-coded risk cards helps in timely risk stratification.

Effective management involves structured referral pathways to BEmONC and CEmONC facilities, depending on the severity, along with integration of national programmes such as RMNCH+A, Janani Suraksha Yojana, Janani Shishu Suraksha Karyakram, LaQshya, and Anemia Mukt Bharat. In Tamil Nadu, PICME enables digital tracking of pregnancies, while family planning counselling during ANC ensures postpartum contraception and birth spacing. Public health support through free ambulance services (102/104) further strengthens maternal and newborn outcomes. Early risk identification, structured referral, and linkage to health schemes together form the backbone of reducing maternal and perinatal mortality.

SPEAKER – DR.DIVYA CHRISTY

MODERATOR – DR. REVATHY T G (PROFESSOR); DR. AFRAA (SR)

TOPIC – Antenatal care – Visits, Investigations & Risk Identification

Summary:

Antenatal care aims to ensure the health of the mother and fetus through regular visits, systematic screening, and timely identification of risks. Adherence to updated national and international protocols ensures positive pregnancy outcomes

Antenatal Visits Guidelines

1. WHO (2016): Minimum 8 contacts starting before 12 weeks and continuing every few weeks until 40 weeks.
2. India (MoHFW): Minimum 4, ideally 8 visits, aligning with WHO recommendations.
3. NICE (UK, 2021): 10 visits for primigravida and 7 for multigravida.
4. ACOG (USA, 2020+): Every 4 weeks till 28 weeks, every 2 weeks till 36 weeks, then weekly.
5. FIGO: Endorses the WHO 8-contact model focusing on preconception to postpartum care.

Antenatal Investigations (FOGSI 2024 – Low-Risk Pregnancy)

• At Booking (≤12 weeks): CBC, Blood Group, HIV, HBsAg, HCV, VDRL, Urine routine, TSH, OGTT (DIPSI), Ultrasound.
• 16–20 weeks: Anomaly scan, Quadruple screen, CBC, Urine culture.
• 24–28 weeks: OGTT, CBC, Urine tests, ICT (if Rh-negative).
• 28–36 weeks: Growth scan, NST/Doppler (if high-risk), CBC, Urine protein.
• 35–37 weeks: Review Rh status, Anti-D prophylaxis if required.
• At Term: CBC, Blood grouping confirmation, and other indicated tests.

Serological Screening for STIs in Pregnancy (2025 Update)

• Syphilis: VDRL/RPR + TPHA at booking and 3rd trimester.
• HIV: 4th gen ELISA, repeat in 3rd trimester in high prevalence areas.
• Hepatitis B: HBsAg at booking; newborn prophylaxis with HBV vaccine + HBIG.
• Hepatitis C: Anti-HCV test for high-risk women.
• Rubella: IgG for immunity, postpartum vaccination if non-immune.

Trimester-Wise Risk Identification

• 1st Trimester: Identify pre-existing risks such as age, medical history, anemia, infections.
• 2nd Trimester: Detect GDM, hypertension, anemia, Rh incompatibility, FGR, and congenital anomalies.
• 3rd Trimester: Monitor for PIH, APH, preterm labor, malpresentation, and fetal growth abnormalities.

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