Examine patients for fitness for pregnancy?

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THE traditional first antenatal examination performed about the tenth week of pregnancy is 20 weeks too late. Any abnormalities which are found have to be considered in the light of the pregnancy itself. They may be trivial or they may require urgent investigation. They may even be such that termination should be considered. How sad that sometimes a pregnancy which has only just begun should have to end! Need this be so? Why do we place ourselves in a position where necessary investigations are hampered or constrained by the knowledge that they may be harmful to the fetus?

Must women become pregnant only when they are emotionally ready for it? Why do we not help women to prepare for her pregnancy physically as well? Why do we not say: "Come and see me when you are ready to start a pregnancy and give me the opportunity to examine you to see that all is well before you start. Then if I find anything wrong we can put it right, and if I do not find anything wrong you will know that you are in good shape to make a start"? The response to this approach is immediate. It makes sense to the patient and it is much easier for us.

The examination should be conducted like a first antenatal examination in which full particulars and a good history should be taken. The personal history may reveal previous illness which may require full evaluation in the light of the prospective pregnancy. The family history may reveal some skeletons in the cupboard where a little genetic counselling may be in order; or a previous fetal abnormality may suggest the same. The previous obstetric history may throw light upon other weaknesses revealed at that time.

The physical examination may suggest the need to seek a further opinion about a heart or chest condition or whether a renal investigation is required. Radiological examination is now available without restraint. Surgery may still be undertaken and a tumor of the breast irradiated without any qualms. Glycosuria can be properly assessed and if diabetes is confirmed, treatment begun and proper advice offered. Gynaecological abnormalities such as an ovarian cyst or fibroids can be noted and the required action taken uninhibited by further problems of pregnancy. Blood disorders may be discovered that can be corrected. The patient's immunity to rubella can be established and vaccine given if necessary, thereby avoiding the need for a subsequent termination. The report on the WR and the rhesus antibodies may need some action. An evaluation of the blood urea and electrolyte levels may be of help should toxaemia develop subsequently.

Lastly the prevention of toxaemia can be started by determining that there is no obesity present, for obesity with pregnancy will ultimately lead to some degree of toxaemia. If the weight in pounds is much more than twice the height in inches the patient must be advised to slim. For example, someone who is 64 inches (1·63 m) in height should weigh 128 lbs (58·1 kg) or not much more than 130 lbs (59 kg). This will allow a healthy rise in weight of 20 lbs (0·91 kg) during a normal pregnancy and avoid the sequelae of toxaemia. Finding that a patient is overweight at the first antenatal examination is exasperating because the options then are to advise slimming during the pregnancy, which cannot be fair to the fetus, or to let her continue and try to cope with the toxaemia as and when it arises (Taylor, 1969).

Having performed a proper 'fit-for-pregnancy' examination and made whatever corrections were thought to be necessary, then the subsequent first antenatal examination becomes a simple matter of confirming the pregnancy and making suitable arrangements for it. The spadework has already been done. Both general practitioner and mother will feel happily confident that all that can be done has been done and hopefully the subsequent pregnancy should be uneventful.

This is basic general practitioner work. To prepare a woman for her pregnancy is just as rewarding as looking after her during the normal pregnancy which should follow. It only remains to propagate this idea among our patients and happier pregnancies with healthier babies should be the result.

Reference

Taylor, J. B. (1969). On predicting the onset of toxaemia of pregnancy. *Journal of the Royal College of General Practitioners*, **18**, 156-165.