this & that

14

OBGYN QUICK GUIDES · IF THIS, THEN THAT

NO.

Antenatal Care

& the routine clinic visit

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Verified against ACOG · SMFM · CDC · RCOG/NICE · SOGC · WHO — October 2026

Antenatal care & the routine clinic visit

At a glance: the numbers to remember

≤10 wk	18–22 wk	24–28 wk	28 wk	36 wk
book; dating scan 11^{+2}–14^{+1} (NICE)	anomaly scan + placental site	glucose test	FBC, antibodies, anti-D if RhD-negative	presentation; GBS swab (ACOG)

Scope: the uncomplicated singleton pregnancy, with add-ons for common risk factors. Where societies disagree, each position carries the society name; follow your local protocol. Gestational diabetes (No. 07) and hypertension (No. 03) have their own volumes. Abbreviations are listed in Section 16.

01 The visit schedule

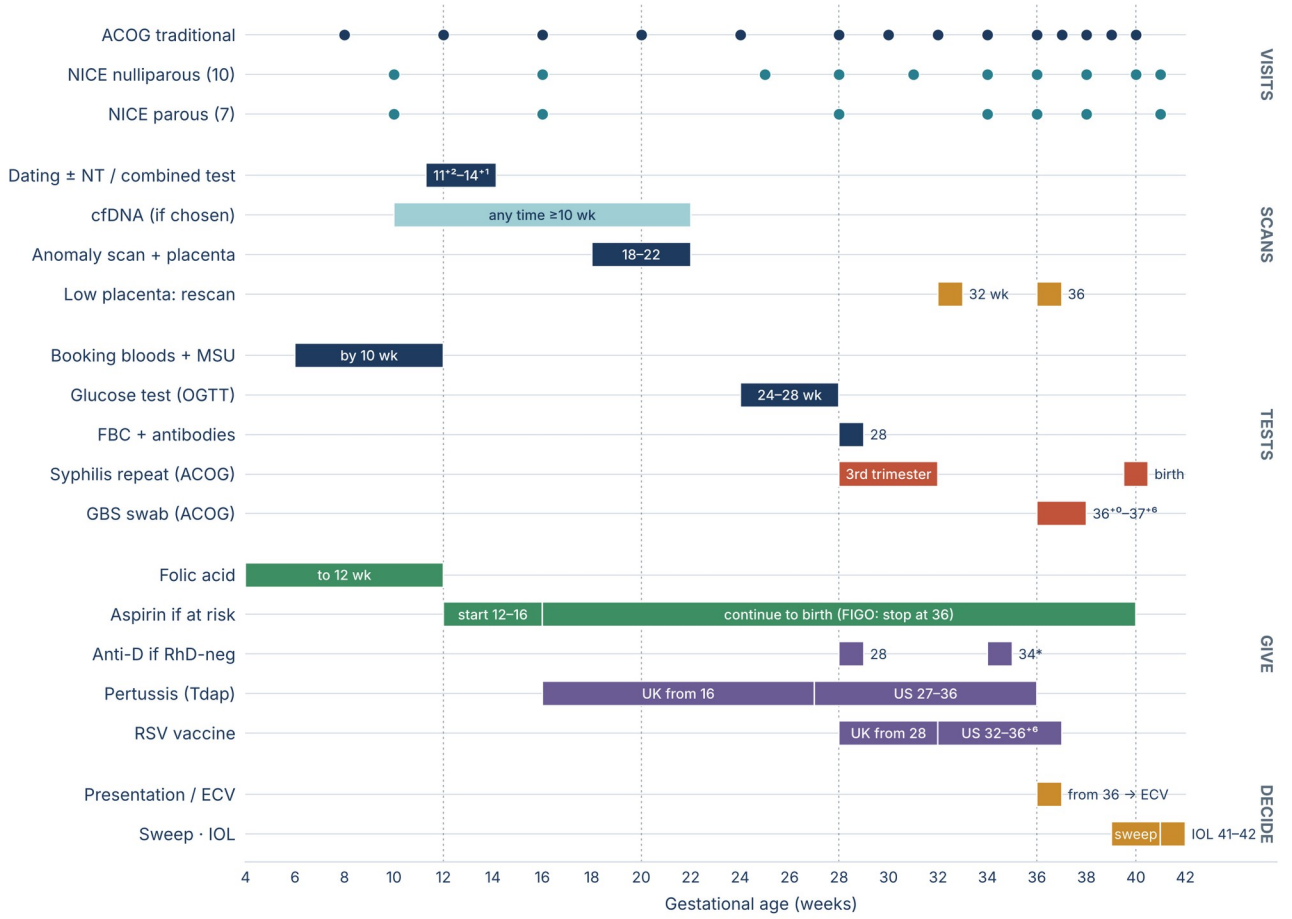


Figure 1. *What happens when: visits, scans, tests, prophylaxis and late-pregnancy decisions by gestational age. *Two-dose UK anti-D regimen.*

IF	THEN
How many visits?	• **ACOG (traditional):** every 4 wk to 28 wk, every 2 wk to 36 wk, then weekly (12–14 visits) • **ACOG Clinical Consensus 8 (2025):** tailored schedules with fewer in-person visits and telehealth for low-risk women are acceptable • **NICE NG201:** 10 appointments if nulliparous, 7 if parous • **WHO 2016:** at least 8 contacts (first <12 wk, then 20, 26, 30, 34, 36, 38, 40 wk)
Risk factor or complication found	Increase frequency, move to consultant-led care, and write the plan in the notes. Reassess risk at **every** visit, not only at booking.

IF	THEN
Did not attend	Contact the same day and rebook. Missed appointments are a recurring theme in maternal death enquiries; consider safeguarding.

Visit by visit

Visit	Check and do	Order or give	Discuss
Booking (by 10^{+0} wk)	Full history and risk assessment (Section 3) · height, weight, BMI · BP · urine protein · mood, domestic abuse, FGM · smoking (NICE: CO test)	Booking bloods + urine culture (Section 4) · dating scan · start folic acid, vitamin D; aspirin if indicated	Screening options and consent · diet, food safety · vaccines · when to call
11–14 wk	Dating scan: CRL, viability, number, chorionicity	Combined test (NT + PAPP-A + hCG) or cfDNA if chosen	What a screen-positive result means
16 wk	BP · urine protein · review all results	Act on anaemia, bacteriuria, abnormal serology	Anomaly scan: what it can and cannot find
18–22 wk	Anomaly scan + placental site (NHS 18^{+0}–20^{+6})	Low-lying placenta → rescan ≈32 wk	Fetal movements leaflet by 24–28 wk
24–28 wk	BP · urine · SFH from 24 wk (NICE; ACOG from 20 wk) · FHR	Glucose test · Tdap from 27 wk (US)	Movements: report any reduction
28 wk	BP · urine · SFH · reassess pre-eclampsia and growth risk	FBC, group and antibodies · anti-D if RhD-negative · ACOG: syphilis rescreen · UK: RSV vaccine from 28 wk	Sleep on her side, not on her back (NICE)
31–34 wk	BP · urine · SFH	Rescan a low placenta ≈32 wk · US: RSV vaccine 32^{+0}–36^{+6} (Sept–Jan)	Birth preferences, analgesia, breastfeeding
36 wk	Presentation (scan if unsure) · BP · urine · SFH · NICE: CO test	GBS swab 36^{+0}–37^{+6} (ACOG) · breech → offer ECV	Labour signs, postnatal care, contraception · VBAC plan
38–40 wk	BP · urine · SFH · presentation	NICE: offer membrane sweep after 39^{+0}	Prolonged pregnancy; ACOG: elective IOL at 39 wk is reasonable for nulliparas
41 wk	BP · urine · SFH · presentation	Offer IOL (NICE from 41^{+0}; ACOG 41^{+0}–42^{+0}, by 42^{+6} at the latest)	If she declines IOL: monitoring plan from 42 wk

02 Every visit: the checklist

IF	THEN
Blood pressure	Every visit, seated, correct cuff. New ≥140/90 → same-day assessment; ≥160/110 → now (No. 03).
Urine dipstick for protein	• **NICE:** every face-to-face visit • **ACOG/Williams:** after booking only if hypertensive or symptomatic; dipsticks miss low-level proteinuria
Weight	• **ACOG/IOM:** weigh each visit and compare with BMI-based targets (Section 11) • **NICE NG247:** weigh at booking; do not reweigh routinely unless it changes management
Fundal height (SFH)	Measure in cm, plot on a chart, no more often than every 2 wk (NICE from 24^{+0}; SBL v3.2: first by 28^{+6}). Below the 10th centile, static or slowing growth → growth scan. Serial scans replace SFH if BMI ≥35, large fibroids or high FGR risk.

IF	THEN
Fetal heart and movements	Doppler auscultation once audible. Ask about movements from 24 wk at every visit; reduced movements → Section 13.
Symptoms	Headache, visual change, epigastric pain, bleeding, fluid, contractions, itching, dysuria, low mood (Section 10).
Results and plan	Review every result ordered since the last visit, act on it and document it. Update the risk assessment and book the next visit.

03 Booking visit: history, dating and risk

IF	THEN
Dating	• Use the first-trimester CRL (up to 84 mm); if CRL >84 mm use head circumference (NHS). IVF: date from transfer • Fix the EDD once; do not redate on later scans
LMP and scan disagree (ACOG CO 700)	• ≤8^{+6} wk: redate if >5 d · 9^{+0}–13^{+6}: >7 d • 14^{+0}–15^{+6}: >7 d · 16^{+0}–21^{+6}: >10 d • 22^{+0}–27^{+6}: >14 d · ≥28 wk: >21 d (suboptimally dated pregnancy)
Obstetric history	Every previous outcome: PTB, mid-trimester loss, pre-eclampsia, SGA, stillbirth, GDM, PPH, caesarean (number, indication, uterine incision), perineal injury, shoulder dystocia.
Medical and drug history	Stop teratogens (valproate, isotretinoin, warfarin, ACE inhibitors, methotrexate); switch rather than stop antiepileptics without advice. Levothyroxine: increase the dose by 20–30% when pregnancy is confirmed.
Family and social	Diabetes, pre-eclampsia, VTE, genetic disease, consanguinity (Section 9). Smoking and shisha, alcohol, drugs, occupation, support at home.
Mental health	• **NICE:** 2 Whooley questions + GAD-2 at booking; ask about past severe mental illness and family history of perinatal illness • **ACOG CPG 4:** a validated tool (EPDS, PHQ-9, GAD-7) at the first visit, later in pregnancy and postpartum
Domestic abuse	Ask at booking and at least once later, alone, without the partner or a family member interpreting.
Examination	BMI, BP, cardiorespiratory exam. Speculum or pelvic exam only if indicated or cervical screening is due; pelvic exam does not date the pregnancy.
End of booking	Risk score written down: aspirin? higher-dose folic acid? early diabetes test? VTE prophylaxis? growth scans? Name the lead professional.

04 Booking tests and what to do with them

Test	Who	Notes by society
FBC	All	Hb, MCV/MCH (thalassaemia clue), platelets. Repeat at 28 wk (all).
Blood group, RhD, antibodies	All	Repeat antibody screen at 28 wk: NICE all women; ACOG RhD-negative (Figure 2).
Haemoglobinopathy	All	UK: offer by 10 wk (family origin questionnaire + indices). ACOG: CBC indices for all; electrophoresis by ancestry or indices. Saudi: ask for the premarital certificate (Section 9).
HIV	All, opt-out	Retest in the 3rd trimester if at risk (CDC); rapid test in labour if unscreened.

Test	Who	Notes by society
Syphilis	All	ACOG 2024: universal rescreen in the 3rd trimester and at birth. CDC: rescreen at 28 wk and birth only if at risk or high prevalence.
Hepatitis B	All	UK: HBsAg. CDC: triple panel (HBsAg, anti-HBs, anti-HBc) if not documented before; vaccinate if non-immune (SMFM #69).
Hepatitis C	ACOG/CDC: all, every pregnancy	UK: not routine (UK NSC consultation 2026, no decision). RCOG: test women with FGM.
Rubella IgG	ACOG: all	England stopped screening in 2016. Non-immune → MMR after birth, never in pregnancy.
Urine culture (ASB)	ACOG, WHO: all	NICE and UK NSC: not recommended. Treat ≥10^5 CFU/mL for 5–7 days (ACOG CC 4).
Chlamydia ± gonorrhoea	<25 y or at risk	CDC: retest in the 3rd trimester if <25 or at risk; test of cure after treatment.
Early diabetes test	Risk factors only	ACOG 2024: HbA1c or OGTT for overt diabetes if BMI ≥25 (≥23 Asian) + another risk factor; routine early GDM screening not recommended. NICE: early OGTT only after previous GDM; do not use HbA1c.
TSH, vitamin D, ferritin	Selective	TSH if symptoms or thyroid history (ACOG PB 223). Ferritin if at risk of iron deficiency (BSH).
Cervical screening	If due	Do not delay; colposcopy is safe in pregnancy (No. 10).

Abnormal results

IF	THEN
Asymptomatic bacteriuria	Treat by sensitivity for 5–7 d (nitrofurantoin, cefalexin or amoxicillin; nitrofurantoin not at term). Repeat culture after treatment. GBS in urine at any count → IAP in labour; no swab needed.
MCV <80 or MCH <27 pg	Ferritin + haemoglobin electrophoresis. Trait → test the partner now; both carriers → refer for counselling and offer prenatal diagnosis.
HBsAg positive	• HBV DNA, LFT, HBeAg; hepatology referral; test the household • HBV DNA >200,000 IU/mL → **tenofovir** from 28–32 wk (SMFM #69) • Baby: HBIG + vaccine within 12 h. No caesarean for HBV alone; breastfeeding is fine
Syphilis serology positive	Confirm with a treponemal test, stage, treat with benzathine penicillin (desensitise if allergic), treat the partner, fetal scan ≥20 wk, refer to GUM or ID.
HIV positive	Same-week referral to the HIV MDT for ART; viral load plan for mode of birth and infant prophylaxis.
Overt diabetes early (HbA1c ≥6.5%, fasting ≥7.0 mmol/L)	Manage as pregestational diabetes: diabetes team, retinal and renal screen, fetal echo, aspirin (No. 07).
Antibody screen positive	Follow Figure 2: identify and quantify, refer to fetal medicine if clinically significant.

05 Ultrasound and aneuploidy screening

IF	THEN
Previous caesarean	Early scan (≈6–8 wk) to exclude a caesarean scar pregnancy; at the anomaly scan, map the placenta against the scar (PAS risk).

IF	THEN
Aneuploidy screening (offer to all, whatever her age)	• Combined test at 11^{+2}–14^{+1} (NHS; CRL 45–84 mm) or 11^{+0}–13^{+6} (ACOG/SOGC) • Quadruple test if she books late (UK 14^{+2}–20^{+0}) • cfDNA from 10 wk: first-line option (ACOG PB 226); UK and SOGC mainly contingent (NHS: chance ≥1 in 150) • Screen-positive → counsel; diagnosis needs CVS or amniocentesis
NT ≥3.5 mm	Offer CVS/amniocentesis with microarray and a fetal echo, even if cfDNA is low risk.
Anomaly scan	18–22 wk (ACOG, SOGC) / 18^{+0}–20^{+6} (NHS). Placental site, cord insertion, liquor.
Placenta <20 mm from the os at the anomaly scan	Transvaginal rescan at ≈32 wk; if still low, again at ≈36 wk (RCOG 2018; US Fetal Imaging Workshop 2014). Plan birth with No. 13. Check the 2026 RCOG GTG 27a for any change.
Cervical length at the anomaly scan	• **ACOG PB 234:** universal transvaginal CL in singletons is "reasonable" but not mandated • **NICE / SBL v3.2:** only if at risk of preterm birth (No. 01)
Uncomplicated singleton after 28 wk	No routine third-trimester scan (NICE; ACOG). Scan for SFH <10th centile, static growth, suspected malpresentation or liquor change.
High FGR risk (SBL v3.2)	Uterine artery Doppler at 18^{+0}–23^{+6} and growth scans every 3–4 wk from 28–32 wk.

06 Later tests: anaemia, RhD and GBS

Anaemia

IF	THEN
Thresholds	• **BSH 2020 (UK):** Hb <110 g/L 1st trimester, <105 g/L 2nd and 3rd, <100 g/L postpartum • **ACOG PB 233:** Hb <110 g/L 1st and 3rd trimester, <105 g/L 2nd
Anaemic, no known haemoglobinopathy	• Trial of **oral iron 40–80 mg elemental** every morning; alternate days if side effects (BSH) • Check haemoglobinopathy status at the same time • Recheck Hb at 2–3 wk
Hb rising	Continue for 3 months and for at least 6 wk after birth.
No rise, intolerant, late gestation or severe anaemia	Check adherence, ferritin, B12, folate; **IV iron** from the 2nd trimester; haematology if severe or not iron deficient.
Not anaemic but ferritin <30 µg/L	Treat with oral iron (BSH). Low stores at term means a PPH she cannot afford.
Routine iron for all?	• **WHO:** 30–60 mg elemental iron + 400 µg folic acid daily for every pregnant woman • **ACOG:** low-dose iron, as in prenatal vitamins • **NICE/Dewhurst:** not routine · **USPSTF 2024:** insufficient evidence

RhD-negative women

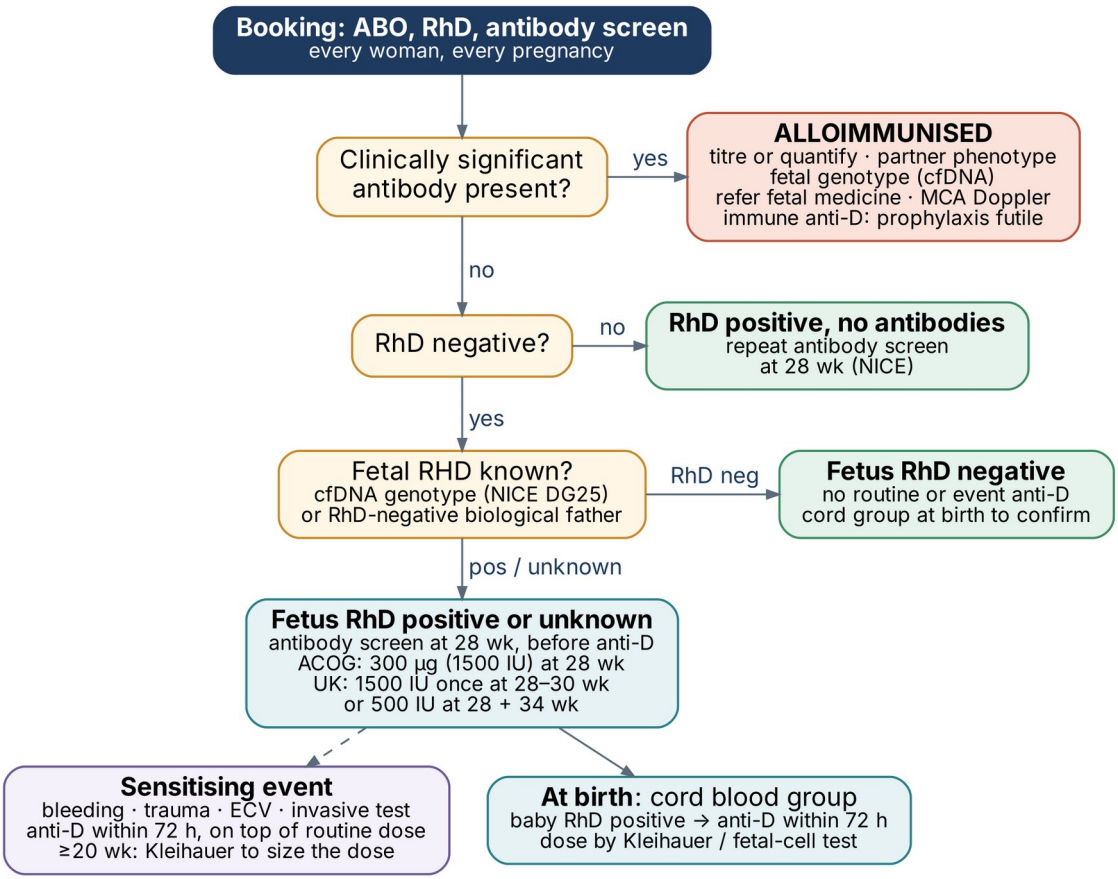


Figure 2. *Antibodies, anti-D prophylaxis and fetal RHD genotyping.*

IF	THEN
Fetal RHD genotyping (cfDNA)	• **NICE DG25 / HTG420:** offer from 11 wk; skip anti-D if the fetus is RhD-negative • **SMFM 2026:** not routinely in non-alloimmunised women while anti-D is available; consider in shortages
Loss or abortion <12^{+0} wk	ACOG 2024: routine anti-D may be forgone. NICE NG126 has its own rules (No. 05).

Group B streptococcus

IF	THEN
ACOG CO 797 / SOGC	Universal rectovaginal culture at 36^{+0}–37^{+6} wk; positive → IAP in labour or with rupture of membranes.
RCOG GTG 36 (UK)	No universal screening; IAP for risk factors. GBS3 trial results are pending.
IAP without a swab (all societies)	GBS bacteriuria this pregnancy · previous baby with GBS disease · unknown status with labour <37 wk, ROM ≥18 h or fever ≥38 °C.
Penicillin allergy	Clarify the reaction now: low-risk history → cefazolin; refer for allergy testing where available (ACOG).

07 Supplements and vaccines

Item	Dose and timing	Society notes
Folic acid	400 µg daily, ideally from 3 months before conception to 12 wk	USPSTF 0.4–0.8 mg.

Item	Dose and timing	Society notes
High-dose folic acid	5 mg daily (UK) / 4 mg (ACOG) to 12 wk	Previous NTD (personal, partner or family), diabetes, sickle cell or thalassaemia, antiepileptics (NICE NG247 adds HIV medicines). **BMI ≥30:** RCOG GTG 72 yes; NICE NG247 no (400 µg enough).
Vitamin D	10 µg (400 IU) daily (NICE); IOM 600 IU	No routine testing (ACOG CO 495). Saudi adult consensus 2026: 1000–2000 IU daily maintenance; no Saudi pregnancy-specific dose found.
Iron	See Section 6	Policies differ by society.
Iodine	150 µg daily supplement (ACOG)	Use iodised salt.
Calcium	1.5–2 g daily if dietary intake is low (WHO); FIGO: if <800 mg/day	Lowers pre-eclampsia risk in low-intake women.
Aspirin	ACOG 81 mg; NICE 75–150 mg; FIGO ≈150 mg at night	Start 12–16 wk (by 28 wk at the latest); continue to birth (FIGO: to 36 wk). Indications in Section 8.
Pertussis (Tdap)	Every pregnancy. US 27–36 wk (early in the window); UK from 16 wk, ideally ≈20 wk (ADACEL)	Protects the newborn through maternal antibody.
Influenza (inactivated)	Any trimester, in season	Saudi MOH lists pregnant women for annual flu vaccine.
RSV (Abrysvo)	US: 32^{+0}–36^{+6} wk, Sept–Jan; UK: from 28 wk year-round	Not repeated in later pregnancies (US). Alternative: infant nirsevimab.
COVID-19	ACOG: recommended at any gestation	UK: no longer offered to pregnant women unless immunosuppressed (2025). US federal guidance contested in court.
Hepatitis B	Non-immune women (SMFM #69)	Safe in pregnancy.
Live vaccines	MMR, varicella, LAIV, BCG: **contraindicated**	Give MMR or varicella after birth; inadvertent vaccination is not an indication for termination.

08 Risk add-ons at booking

IF	THEN
Pre-eclampsia risk	• **ACOG/USPSTF (81 mg):** 1 high factor (previous pre-eclampsia, multiple pregnancy, chronic hypertension, type 1/2 diabetes, renal disease, SLE/APS) or ≥2 moderate (nulliparity, BMI >30, family history, age ≥35, IVF, previous SGA or adverse outcome, interval >10 y, low income or Black race as social risk markers) • **NICE (75–150 mg):** 1 high (hypertension in a previous pregnancy, CKD, SLE/APS, diabetes, chronic hypertension) or ≥2 moderate (first pregnancy, age ≥40, interval ≥10 y, BMI ≥35, family history, multiple pregnancy) • Details and monitoring: No. 03
Previous GDM or diabetes risk	Early test (Section 4); repeat at 24–28 wk if normal (No. 07).
BMI ≥30	• Folic acid dose: RCOG 5 mg vs NICE 400 µg (Section 7) • Pre-eclampsia, diabetes and VTE risk scores; serial growth scans if SFH unreliable • BMI >40: anaesthetic review and specialist referral (NICE NG247)
Previous caesarean	Early scan for scar pregnancy, placental mapping at 20 wk, VBAC vs repeat caesarean decision documented by 36 wk.
Previous spontaneous PTB or mid-trimester loss	Cervical length surveillance from 16 wk ± progesterone or cerclage (No. 01).

IF	THEN
Previous SGA or stillbirth	Uterine artery Doppler at 18^{+0}–23^{+6}, serial growth scans (SBL v3.2); consultant care; discuss timing of birth.
Twins	• Chorionicity at the 11^{+2}–14^{+1} scan (lambda or T sign) • Scans: DCDA every 4 wk from 20 wk; MCDA every 2 wk from 16 wk (NICE NG137) • Birth: DCDA 37^{+0}, MCDA 36^{+0}, MCMA 32^{+0}–33^{+6} wk • Aspirin: high-risk factor (ACOG), moderate (NICE)
VTE risk (RCOG GTG 37a)	Score at booking, on every admission and after birth. RCOG interim statement (Sept 2026): revised score, weight-based LMWH, BMI ≥50 as a new threshold; full update due 2027.
Epilepsy, cardiac, renal, thyroid or autoimmune disease	Joint obstetric–medical clinic; detailed anomaly scan ± fetal echo where indicated.
Smoker (cigarettes or shisha)	Opt-out referral to stop-smoking support; CO test at booking and 36 wk (NICE NG209); serial growth scans (SBL v3.2).

09 Saudi-specific points

IF	THEN
Premarital screening certificate	• Mandatory since 2004 for sickle cell and β-thalassaemia; HBV, HCV and HIV added in 2008 (MOH) • Ask to see the result: an at-risk couple may have married anyway • Both carriers → genetic counselling, offer CVS or amniocentesis; partner testing if not done
Consanguineous couple	Ask at booking. Take a three-generation family history for recessive disease, previous affected children and unexplained deaths; refer to genetics when positive; offer a detailed anomaly scan.
Vitamin D	Deficiency is common (covered dress, indoor life). Give at least the NICE 10 µg daily; no Saudi pregnancy-specific dose found. Test only if symptomatic or high risk.
Ramadan fasting	• Pregnancy is a recognised exemption; no ACOG, RCOG or NICE guideline covers fasting in pregnancy • MOH: consult before fasting; do not skip suhoor; ≈10 cups of water between iftar and suhoor • Advise against fasting: GDM or pregestational diabetes (IDF-DAR 2021 high risk); by expert opinion also hyperemesis, pre-eclampsia, FGR, threatened PTL, significant anaemia • Stop the fast and come in: reduced movements, dizziness or fainting, contractions, vomiting, dark urine, headache
Hajj or Umrah	• MOH Hajj 1447H rules: last 3 months of pregnancy or a high-risk pregnancy at any stage do not meet the Hajj health capability criteria • Meningococcal ACWY (conjugate within 5 y or polysaccharide within 3 y), ≥10 d before arrival; pregnancy does not preclude it (CDC) • Heat: hydration, shade, and the travel advice in Section 11
Food habits	Unpasteurised milk, including fresh camel milk, and soft cheeses carry **Brucella** and **Listeria**. Advise pasteurised or boiled only.

10 When she should come in

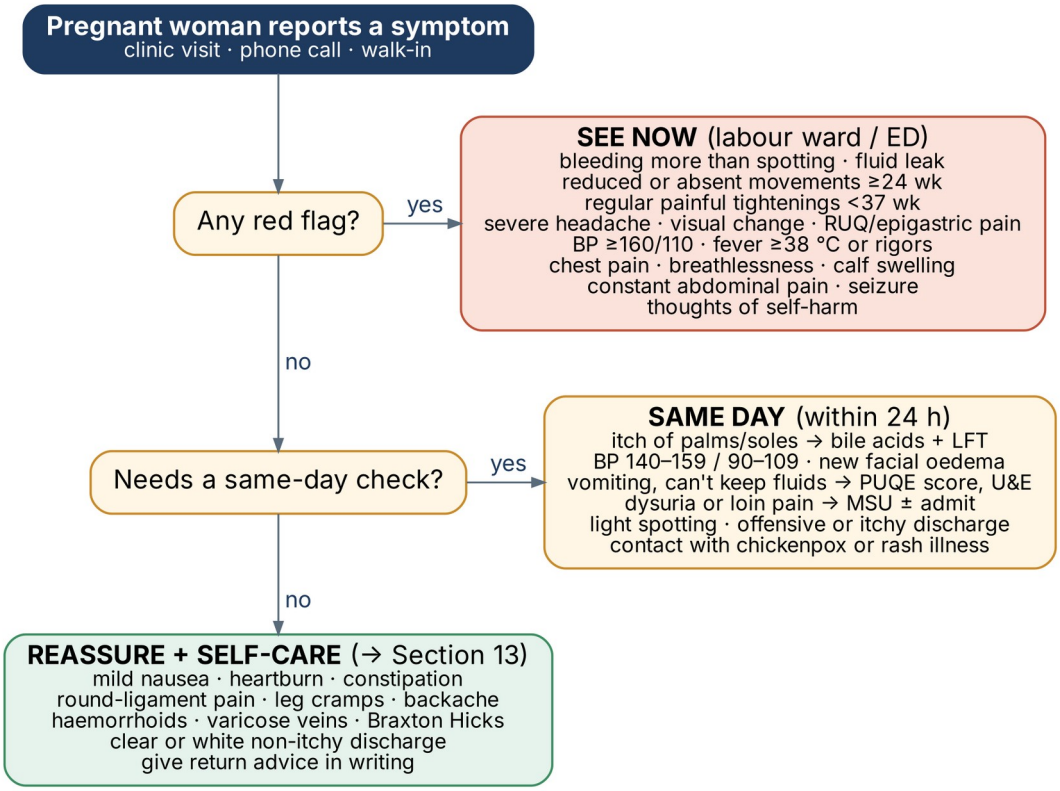


Figure 3. *Symptom triage for the clinic, the phone and the walk-in.*

Give every woman this list in writing at booking, with the labour-ward number. Reduced movements are never handled by phone advice to wait until the morning.

11 Common questions: lifestyle

IF	THEN
"How much coffee or tea?"	Caffeine <200 mg/day (ACOG CO 462; UK FSA): about 2 mugs of instant coffee or 1 café coffee. Count tea, cola, energy drinks and chocolate.
"Can I eat fish?"	Yes: 2–3 servings a week of low-mercury fish (FDA/EPA). Avoid shark, swordfish, king mackerel, marlin, tilefish, bigeye tuna and orange roughy. No raw or smoked fish.
"What foods should I avoid?"	• Unpasteurised milk (including camel milk), soft or blue-veined unpasteurised cheese, pâté, cold deli meats unless reheated until steaming (Listeria) • Undercooked meat, unwashed vegetables, cat litter (toxoplasma) • Liver and vitamin A (retinol) supplements
"How much weight should I gain?" (IOM 2009)	• BMI <18.5: 12.5–18 kg · 18.5–24.9: 11.5–16 kg • 25–29.9: 7–11.5 kg · ≥30: 5–9 kg • NICE sets no targets and advises against dieting to lose weight in pregnancy
"Can I exercise?"	Yes: ≥150 min/week of moderate activity (ACOG CO 804); walking, swimming, cycling on a static bike, pregnancy yoga. Avoid contact sports, fall risk, scuba diving, hot yoga and lying flat for long after 20 wk. Stop if bleeding, fluid, pain, dizziness or chest pain.
"Is intercourse safe?"	Yes, in an uncomplicated pregnancy. Avoid with placenta praevia, unexplained bleeding, ruptured membranes, or a short or open cervix.

IF	THEN
"Can I fly?"	• **ACOG:** up to 36 wk in an uncomplicated pregnancy • **RCOG:** risk rises after 37 wk (singleton) or 32 wk (twins); airlines often want a letter after 28 wk • Flights >4 h: aisle seat, walk, fluids, graduated compression stockings; LMWH only if high VTE risk • Check travel insurance; avoid Zika-affected areas
"Car travel?"	Three-point belt: lap strap under the bump across the thighs, shoulder strap between the breasts. Keep airbags on. Any collision → assessment (abruption).
"Sauna, hot tub, hammam?"	Avoid core temperature >39 °C, especially in the first trimester (NTD risk). Short, warm, not hot.
"Which side should I sleep on?"	After 28 wk, go to sleep on her side, not on her back (NICE; MiNESS). ACOG has no statement. Waking on her back is not a reason for alarm.
"Hair dye, nails, skin care?"	Hair dye: minimal absorption, no proven harm; ventilated room. Avoid oral isotretinoin (and topical retinoids). Sunscreen is fine.
"Can I keep working?"	Usually until labour. Reduce heavy lifting, long standing (>3 h a day), night shifts and chemical exposure where possible; provide a work-adjustment letter.
"Smoking, shisha, alcohol?"	Stop all; no safe amount of alcohol. E-cigarettes are less harmful than smoking but not risk-free.
"Perineal massage?"	From 34 wk, 5–10 min daily, more intact perineums in nulliparous women (Obstetric EBG).

12 Common questions: medicines and exposures

IF	THEN
Pain or fever	• **Paracetamol** is first choice, at the lowest effective dose for the shortest time (MHRA 2025; ACOG/SMFM) • FDA (Sept 2025) began a label change citing an autism association; it states causation is not established. ACOG and SMFM call paracetamol safe; untreated fever carries its own risk
NSAIDs (ibuprofen, diclofenac)	Avoid from 20 wk (FDA 2020: oligohydramnios, fetal renal injury); contraindicated after 28 wk (MHRA 2023: ductal closure). Low-dose aspirin is exempt.
Opioids (codeine, tramadol)	Short courses only; warn about neonatal withdrawal with use near term.
Antibiotics	• Penicillins and cephalosporins: safe • Macrolides: use if benefit outweighs risk, e.g. penicillin allergy (MHRA 2021) • Nitrofurantoin: avoid at term; in the 1st trimester only if no alternative (ACOG) • Trimethoprim: avoid in the 1st trimester (folate antagonist) • Tetracyclines and fluoroquinolones: avoid
Cold and allergy	Loratadine, cetirizine, chlorphenamine, saline sprays, steroid nasal sprays are acceptable. Avoid oral decongestants (pseudoephedrine, phenylephrine), especially in the 1st trimester.
Nausea and reflux medicines	Section 13.
Herbal and "natural" products	Unregulated; avoid unless the ingredients are known and safe. Ginger is acceptable for nausea.

IF	THEN
X-ray or CT	Fetal dose <50 mGy carries no measurable risk of anomaly or loss (ACOG CO 723). Chest X-ray ≈0.0005–0.01 mGy; CT pelvis ≈10–50 mGy. Never withhold a needed scan; iodinated contrast is acceptable.
MRI	Safe in any trimester without gadolinium; gadolinium only if it changes management.
Dental care	Treatment, local anaesthesia and dental X-rays are safe; encourage a check-up (ACOG CO 569).
Medicine taken before she knew	Check a teratology source (UKTIS, MotherToBaby). Few drugs warrant more than a detailed anomaly scan.

13 Common questions: symptoms

IF	THEN
Nausea and vomiting	• Small frequent meals, ginger, P6 acupressure • First line: doxylamine–pyridoxine (ACOG; FDA-approved), antihistamines (cyclizine, promethazine) or phenothiazines (prochlorperazine) (RCOG GTG 69, 2024) • Second line: ondansetron (≈3 extra oral clefts per 10,000 if 1st trimester; RCOG: should not be discouraged) or metoclopramide • Score with PUQE; ketonuria does not measure severity. Cannot keep fluids, weight loss or AKI → admit; thiamine for every admission
Heartburn	Small meals, avoid lying down for 3 h after eating, raise the bed head. Antacids or alginates, then H2 blockers or PPIs (all acceptable). Epigastric pain with high BP is pre-eclampsia until proven otherwise.
Constipation	Fluids, fibre, bran; then bulk-forming laxatives, lactulose or senna (stimulants work better but cause cramps).
Leg cramps	Calf stretching; magnesium lactate or citrate 5 mmol morning + 10 mmol evening for 3 wk (Obstetric EBG). Calcium does not help.
Back and pelvic girdle pain	Water exercise, physiotherapy, support belt, paracetamol. Severe or neurological pain → examine properly.
Round-ligament or groin pain	Sharp, brief, on movement; reassure once uterine tenderness, contractions and UTI are excluded.
Haemorrhoids and varicose veins	Treat constipation; topical agents for piles; compression stockings ease leg symptoms but do not prevent veins.
Itching	Palms and soles, worse at night, no rash → bile acids + LFT (cholestasis); repeat if normal and itching persists. Rash → dermatoses of pregnancy.
Headache	Paracetamol, fluids, rest. From 20 wk: check BP and urine. Severe, sudden, or with visual change → now.
Vaginal discharge	White, non-itchy, non-odorous is physiological. Itch → candida (topical azole, 7 days). Odour → BV. Watery → exclude ROM.
Breathlessness	Mild exertional breathlessness is physiological. At rest, sudden, with chest pain, tachycardia or low SpO_2 → now (PE, cardiomyopathy).
Fatigue	Common in the 1st and 3rd trimesters; check Hb, and TSH if other features.

IF	THEN
Reduced fetal movements (RCOG GTG 57, 2026)	• <24 wk: movements not yet reliable; auscultate if concerned • 24^{+0}–28^{+0}: Doppler heartbeat + history for stillbirth and FGR risk • From 26^{+0}: computerised CTG • >28 wk: ultrasound if RFM persists, risk factors, or no scan in the last 2 wk • Birth only with evidence of compromise; bringing birth forward is acceptable after 39^{+0}

14 Do not

- Redate a pregnancy that already has a first-trimester scan.
- Use a fundal height alone when BMI ≥35 or fibroids make it unreliable; book serial scans.
- Give MMR or varicella vaccine in pregnancy, or advise termination after one was given by mistake.
- Prescribe NSAIDs after 20 wk, or let a woman switch from paracetamol to ibuprofen because of the autism headlines.
- Give 5 mg folic acid on BMI alone without knowing which guideline your unit follows (RCOG and NICE now differ).
- Use HbA1c or a glucose challenge to diagnose GDM in a UK-protocol unit (NICE), or screen for GDM before 24 wk without risk factors (ACOG 2024).
- Offer routine third-trimester growth scans in an uncomplicated singleton, or a CTG in clinic for reassurance alone.
- Leave an abnormal result unactioned: every result needs a named person, an action and a date.
- Send home a woman with reduced movements after 26 wk without a CTG.
- Advise a pregnant woman to fast in Ramadan when she has diabetes, hyperemesis, FGR or threatened preterm labour.

15 Where the guidelines differ

Topic	ACOG / SMFM / CDC (USA)	RCOG / NICE (UK)	WHO / SOGC / Saudi
Visits	Every 4 → 2 → 1 wk (12–14); tailored schedules acceptable (CC 8, 2025)	10 nulliparous, 7 parous; book by 10 wk	WHO ≥8 contacts
Weight and urine	Weigh each visit; urine protein not routine after booking	Weigh at booking only; urine protein every visit	—
Urine culture (ASB)	All at booking	Not recommended	WHO: all
HCV · rubella	Both universal	Neither routine (rubella stopped 2016)	Saudi: HCV on premarital screen
Syphilis rescreen	ACOG: all, 3rd trimester + birth; CDC: at risk	Booking only	—
GDM	Two-step (50 g then 100 g) preferred for all at 24–28 wk, one-step allowed; early test for overt DM if risk	Risk-based 75 g OGTT (5.6 / 7.8 mmol/L)	WHO/IADPSG and Saudi MOH 2014: 75 g OGTT (5.1 / 10.0 / 8.5)
GBS	Universal swab 36^{+0}–37^{+6}	Risk-based IAP	SOGC: universal
Anti-D	300 µg at 28 wk; cfDNA RHD not routine (SMFM 2026)	1500 IU at 28–30 wk or 500 IU at 28 + 34; cfDNA RHD offered	—
Aspirin	81 mg; 1 high or ≥2 moderate (age ≥35, BMI >30)	75–150 mg; moderate = age ≥40, BMI ≥35	FIGO: ≈150 mg at night, 11–14^{+6} wk to 36 wk
Folic acid, BMI ≥30	400 µg (no BMI rule)	RCOG 5 mg; NICE NG247 400 µg	—
Routine iron	Low-dose in prenatal vitamins; USPSTF: insufficient	Not routine; treat ferritin <30	WHO: 30–60 mg for all

Topic	ACOG / SMFM / CDC (USA)	RCOG / NICE (UK)	WHO / SOGC / Saudi
Cervical length	Universal TVUS "reasonable"	Risk-based only	—
Pertussis · RSV	Tdap 27–36 wk · RSV 32^{+0}–36^{+6} wk, seasonal	From 16 wk · RSV from 28 wk, year-round	—
COVID-19 vaccine	ACOG: recommended	Not offered unless immunosuppressed	—
Mental health screen	Validated tool (EPDS, PHQ-9, GAD-7) at intake, later and postpartum	Whooley + GAD-2 at booking	—
Sleep position	No statement	Side-sleeping after 28 wk	—
Flying	Up to 36 wk	Caution after 37 wk (32 wk twins)	Saudi Hajj: not in the last 3 months
Post-dates	IOL 41^{+0}–42^{+0}; elective 39 wk reasonable (nullipara)	Sweep after 39^{+0}; offer IOL from 41^{+0}	—

16 Abbreviations

Abbr.	Meaning	Abbr.	Meaning	Abbr.	Meaning
ACE	angiotensin-converting enzyme	GAD-2/-7	anxiety screening tools	NT	nuchal translucency
ACOG	American Coll. of Obstetricians & Gynecologists	GBS	group B streptococcus	NTD	neural tube defect
AKI	acute kidney injury	GDM	gestational diabetes mellitus	NVP	nausea and vomiting of pregnancy
APS	antiphospholipid syndrome	GTG	Green-top Guideline (RCOG)	OGTT	oral glucose tolerance test
ART	antiretroviral therapy	GUM	genitourinary medicine	PAPP-A	pregnancy-associated plasma protein A
ASB	asymptomatic bacteriuria	Hb	haemoglobin	PAS	placenta accreta spectrum
BCG	bacille Calmette–Guérin vaccine	HbA1c	glycated haemoglobin	PB	Practice Bulletin (ACOG)
BMI	body mass index	HBIG	hepatitis B immunoglobulin	PE	pulmonary embolism
BP	blood pressure	HBsAg	hepatitis B surface antigen	PHQ-9	Patient Health Questionnaire-9
BSH	British Society for Haematology	HBV	hepatitis B virus	PPH	postpartum haemorrhage
BV	bacterial vaginosis	hCG	human chorionic gonadotrophin	PPI	proton pump inhibitor
CBC	complete blood count	HCV	hepatitis C virus	PTB	preterm birth
CC	Clinical Consensus (ACOG)	HIV	human immunodeficiency virus	PTL	preterm labour
CDC	Centers for Disease Control & Prevention	IADPSG	Intl Diabetes & Pregnancy Study Groups	PUQE	Pregnancy-Unique Quantification of Emesis
cfDNA	cell-free DNA screening	IAP	intrapartum antibiotic prophylaxis	RCOG	Royal Coll. of Obstetricians & Gynaecologists
CFU	colony-forming units	ID	infectious diseases	RFM	reduced fetal movements
CKD	chronic kidney disease	IDF-DAR	Diabetes and Ramadan Alliance (IDF)	RhIG	Rh immunoglobulin (anti-D)
CL	cervical length	IOL	induction of labour	ROM	rupture of membranes
CO	Committee Opinion; carbon monoxide	IOM	Institute of Medicine (now NAM)	RSV	respiratory syncytial virus
CPG	Clinical Practice Guideline (ACOG)	IU	international units	RUQ	right upper quadrant
CPU	Clinical Practice Update (ACOG)	IV	intravenous	SBL	Saving Babies' Lives (NHS England)
CRL	crown–rump length	IVF	in vitro fertilisation	SFH	symphysis–fundal height
CT	computed tomography	LAIV	live attenuated influenza vaccine	SGA	small for gestational age
CTG	cardiotocography	LFT	liver function tests	SIP	Scientific Impact Paper (RCOG)
CVS	chorionic villus sampling	LMP	last menstrual period	SLE	systemic lupus erythematosus
DCDA	dichorionic diamniotic	LMWH	low-molecular-weight heparin	SMFM	Society for Maternal-Fetal Medicine
DM	diabetes mellitus	MCA	middle cerebral artery	SOGC	Soc. of Obstetricians & Gynaecologists of Canada
EBG	Evidence Based Guidelines (Berghella)	MCDA	monochorionic diamniotic	SpO_2	oxygen saturation
ECV	external cephalic version	MCH	mean corpuscular haemoglobin	STI	sexually transmitted infection
ED	emergency department	MCMA	monochorionic monoamniotic	Tdap	tetanus, diphtheria, acellular pertussis
EDD	estimated date of delivery	MCV	mean corpuscular volume	TSH	thyroid-stimulating hormone
EPA	Environmental Protection Agency	MDT	multidisciplinary team	TVUS	transvaginal ultrasound
EPDS	Edinburgh Postnatal Depression Scale	MHRA	UK medicines regulator	U&E	urea and electrolytes
FASP	NHS Fetal Anomaly Screening Programme	MMR	measles, mumps, rubella	UKHSA	UK Health Security Agency
FBC	full blood count	MOH	Ministry of Health (Saudi)	UKTIS	UK Teratology Information Service
FDA	US Food and Drug Administration	MRI	magnetic resonance imaging	USPSTF	US Preventive Services Task Force
FGM	female genital mutilation	MSU	midstream urine	UTI	urinary tract infection
FGR	fetal growth restriction	NG	NICE guideline	VBAC	vaginal birth after caesarean
FHR	fetal heart rate	NICE	Natl Institute for Health & Care Excellence	VTE	venous thromboembolism
FIGO	Intl Federation of Gynecology & Obstetrics	NSAID	non-steroidal anti-inflammatory drug	WHO	World Health Organization
FSA	Food Standards Agency (UK)	NSC	National Screening Committee (UK)		

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Decision aid only: it does not replace clinical judgement or local protocols. Verify drug doses against your formulary.