



The prenatal pediatric visit

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ABSTRACT

In Mexico, the prenatal pediatric visit is uncommon despite the advantages for the doctor, the family, and the child. It provides an opportunity to begin the doctor- family relationship, obtain medical information to identify potential risks in the mother and in the newborn, share information with the family on the care the infant will receive, and in case of special risks establish a plan of action where the parents participate in the medical decisions. It is also an opportunity to provide emotional support for the family and begin educating the parents in neonatal care.

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In Mexico, pediatric prenatal consultation is uncommon, especially in government healthcare services. Not all newborns in Mexico will be attended to by a pediatrician because the physician of first contact, if we consider the nationwide population, is a general physician, and for users of public healthcare services a specialist in general family medicine. In 1966 the American Academy of Pediatrics started to recommend prenatal pediatric visits, with four specific objectives.¹

In Cuba, childcare is part of parental education for future mothers in relation to pregnancy, nutrition, breast feeding, and monitoring children's growth and development. Participants in the program include obstetricians, pediatricians, general physicians, and psychologists.² In Switzerland, midwives discuss issues of parenting and parent-child relations as part of prenatal consultation, in addition to medical subjects.³

Contact between pediatricians and future parents is desirable for different reasons. The family of the future infant and the physician can exchange information prenatal pediatric consultation, with multiple advantages for them all.

Objectives of prenatal pediatric consultation are: 1) Begin forming a relationship of trust between the family and the doctor. 2) Obtain medical information on the family. 3) Identify perinatal risks. 4) Provide information on neonatal care. 5) Establish a neonatal prognosis in cases where risks are identified. 6) Involve the parents in therapeutic decisions on ill infants and, if possible, anticipate. 7) Create a supportive emotional environment for the parents. 8) Educate the family on infant care.^{4,5}

Prenatal pediatric consultation is of special interest in cases of first pregnancy, with adolescent parents, in case of antecedents of birth defects, abortions, or stillbirths, in high-risk pregnancies,

and in all cases where the future parents experience anxiety for any reason.⁵

Obstetricians/Gynecologists should be alert to parents' concerns regarding their children's future and recommend a prenatal pediatric visit to ensure that they have up-to-date and reliable information, to avoid inappropriate advice from third parties. When prenatal pediatric consultation proves impossible, much of the information that should be provided will have to be made available at the first visit after childbirth, although the mother is usually exhausted and distracted and it may not have the same impact. The first pediatric visit is an excellent opportunity to establish the doctor-patient relationship.

The parents must be comfortable. The doctor should be seated, make eye contact, and avoid technical language during the conversation.⁴ After introducing himself/herself, the pediatrician should allow the parents to speak, to express their reasons for requesting prenatal pediatric consultation, to identify any possible cause for concern or anxiety. The pediatrician should give both parents the necessary time and full attention, also observing the attitude, posture, and non-verbal language of all members of the family that attend the visit. The pediatrician will learn the family's hopes and concerns regarding their future child and fears about possible birth defects or hereditary problems that are detected from the first phase of the conversation. Cohen mentions that if the grandparents are available and interested in the process, rules should be established so that the future parents feel supported, but not controlled, by their own parents.⁵ Such emotional support is especially important for adolescent parents.

Later, the pediatrician will request information on the mother's clinical history, including illnesses, prior pregnancies (if any), and their outcome, and should inquire about the current pregnancy

in greater detail. This information will allow the pediatrician to establish an up-to-date diagnosis and identify risks to the future infant.

In the case of a low-risk pregnancy, the pediatrician should give the parents an overview of delivery room care for a vigorous newborn: Apgar and Silverman Andersen evaluations, physical examination, and hospital routine (rooming-in, transitional nursery, visiting hours, feeding, etc.) depending on hospital guidelines and the family's preferences. Needless to say, it is an excellent time to discuss the benefits and advantages of early and exclusive breast feeding when successful lactation is established. There is documented proof that providing prenatal information on breast feeding, with postnatal reinforcement and home visits or telephone calls by support personnel is successful in increasing the duration and continuity of breast feeding.^{2,6} It is also advisable to advance information on neonatal screening, in blood and auditory and ophthalmologic. The parents should know what vaccines are applied before leaving the hospital and when the next vaccines will be applied afterwards.

In some cases, pediatric consultation is in response to learning of a fetal malformation detected by ultrasound. In such cases, the parents usually arrive with anxiety and anguish due to the finding. The medical consultation centers on the prognosis of the malformation. In this kind of situations in particular it is necessary to offer up-to-date information on risks, confirming tests (when necessary), and treatments and an overview of the chances of having a healthy child, a fatal outcome, or a child with sequelae.

When the problem detected requires a more specialized intervention or treatment by a medical team, prenatal consultation with other specialists, such as a geneticist, neonatologist, pediatric cardiologist, pediatric neurologist,

pediatric surgeon, pediatric neurosurgeon, pediatric oncological surgeon, and others, is advisable.^{7,8} Crombleholme et al.⁹ noted that obstetric care changed following consultation with a surgeon among 221 fetuses with malformations: the pregnancy was interrupted in 9.5% of the cases due to chromosomal malformations. The birthing hospital changed in 37% to facilitate immediate postnatal care. The time for terminating pregnancy was moved forward in 4.5% to avoid greater harm to the fetus, and 5% received treatment *in utero*.

A studio by Respondek-Liberska, which compared costs of travel to a referral site, found that transportation *in utero* is five times less costly than transporting a newborn in an ambulance, 28 times less than transport by helicopter, and 42 times less than transport by airplane.¹⁰

In case of an imminent preterm birth, the pediatrician should know the gestational age as accurately as possible and discuss with the parents the chances of survival, maneuvers the neonatologist will perform in resuscitation and on arrival at neonatal care: intubation, surfactant, catheters, drugs, laboratory and examining room studies, risk of concomitant diseases, complications from treatment, and probable short-and omg-term sequelae.⁴ In such cases, consulting with the neonatologist is highly useful due to the information he/she will provide the future parents.⁷

Paul et al. conducted a survey of mothers who attended prenatal consultation with a neonatologist due to risk of preterm birth and 84% reported that the visit was useful and 71% felt more calm and comfortable after the visit.¹¹ Griswold suggests, even, a visit to the Neonatal Intensive Care Unit.⁴

A study by Friedman et al.¹² compared the incidence and duration of breast feeding in



premature infants whose mothers received a prenatal consultation with a neonatologist, and found that it was prolonged significantly in hospital and after release, compared with the control group. It is important to discuss the advantages of breast feeding in the premature group, to foment extraction of milk because many of them cannot be fed with human milk.

If gestational age is at the limit of viability with survival and prognosis uncertain, there should be an extensive discussion of the risks and advantages with the active participation of the parents, covering treatment options, observing “the best interests of the infant”.^{4,13} Needless to say, these decisions should be based on up-to-date data, preferably from the place where the birth will take place. If the gestational age is below the limit of viability or there are malformations with early mortality and high morbidity (less than 23 weeks, less than 400 g, anencephaly), not reanimating and providing only comfort care should be considered.¹⁴

A survey applied to neonatologists by Bastek et al.¹³ in New England, United States, found that 75% of them think that the decision to discontinue resuscitation maneuvers should be made jointly between parents and neonatologist, but only 40% acknowledged that decisions were made in practice by both parties and 50% reported making the decision on their own.

Offering emotional support and making the future mother feel that we can advise her and make recommendations for the care of her future infant will increase her peace of mind and prevent her from seeking advice from family and friends, who will always be willing to give it, although their recommendations may not always be the most appropriate. If there are other children in the family, their feelings, concerns, and expectations, as well as rivalry with the new sibling, must be considered and a plan of action must be prepared.⁵

In some cases the pediatrician’s emotional support for the mother must be very explicit, for example with adolescent parents, single mothers, when there are family members with chronic physical or mental illnesses, in cases of prenatal diagnosis of birth defects, and when expecting a preterm birth.

One of the pediatrician’s activities, somewhat complex but gratifying, is to help parents become more competent in caring for their children.⁵ Although in a single prenatal visit it can be difficult to cover many issues, it is necessary at the prenatal or postnatal visit, but before the infant goes home, to discuss matters of nutrition, bathing, diaper changing, nocturnal care, sleeping position, use of pacifiers, hand washing, domestic hygiene, and others of shared responsibility between parents.⁵

Pisacane et al.¹⁵ trained the spouses of mothers who wanted to breast feed in helping them with some of the common problems with breast feeding and observed greater duration of breast feeding compared with a control group, confirming that fathers should be included even in matters of breast feeding.

From the prenatal visit, the pediatrician should establish his/her office hours and form of communication in case of non-urgent but important questions, and develop a plan of action for emergencies with the infant. The American Academy of Pediatrics recommends that residents in pediatrics learn the contents and importance of prenatal consultation.⁵

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