

CARTER HAYS POWERS & ASSOCIATES, LLP

OBSTETRICS GYNECOLOGY INFERTILITY

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LABOR PRECAUTIONS

Labor is different for every woman and it can be difficult to tell exactly what labor will feel like. This is a basic list of what to look for when you are in the third trimester. Please call the office at (214) 824-2563 during office hours or the After-Hours Emergency line in the evening or on weekends at (214) 360-5608. If you have questions, feel as though you are in labor, or are heading to the hospital - please call first to update the physicians.

Call your doctor for any of the following four:

1. **CONTRACTIONS** – It is normal for you to have contractions on and off in late pregnancy. They may occur high in the abdomen, low, or in the back. Braxton-Hicks contractions are typically short (30 seconds or less), irregular, and usually feel like “tightening” but not painful. To count your contractions, start from the beginning of the pain or tightening to the beginning of the next. If the contractions are **5 minutes apart or closer together** and stay that way **for at least an hour**, call your doctor. Also, if you have a continuous contraction that does not subside or any contractions that are too painful to wait, call your doctor.
2. **WATER BREAKING** – Most women have their water break after they are contracting, but sometimes the water breaks without any contractions. **Call us immediately** if you think your water has broken, regardless of whether or not you are having contractions. Water breaking is usually an obvious gush of clear fluid. Sometimes it is discolored or just a little trickle down the leg. If in doubt – call your doctor.
3. **BLEEDING** – You may have a small spot or streaks of blood if you lose your mucus plug or start contracting. You also may have a small amount of spotting after having your cervix checked or after intercourse. Any bleeding at any other time or any bleeding that is **bright red** or as **heavy or heavier than a period** should be reported to your doctor immediately.
4. **FETAL MOVEMENTS** – Your baby may be slowing down a little as you approach labor, but the baby should still be moving. Pay attention to the baby’s movements every day. The baby may have an hour or two of rest but then start moving again. If the baby is moving less than you normally perceive, then lay down and pay attention to the baby’s movements for an hour. If the baby moves less than 10 times in one hour, call your doctor.

A final word about the **mucous plug**: You may or may not see mucous come out of your vagina late in pregnancy. Some women see mucous several times and, sometimes, it is streaked with a small amount of blood. **Losing the mucous plug without any of the four signs noted above does not mean that you are in labor.** Do NOT let this alarm you!



The American College of
Obstetricians and Gynecologists



FREQUENTLY ASKED QUESTIONS
FAQ004
LABOR, DELIVERY, AND POSTPARTUM CARE

How to Tell When Labor Begins

- **What happens when labor begins?**
- **What is false labor?**
- **How can I tell the difference between true labor and false labor?**

What happens when labor begins?

As labor begins, the cervix opens (dilates). The uterus, which contains muscle, contracts at regular intervals. When it contracts, the abdomen becomes hard. Between the contractions, the uterus relaxes and becomes soft. Up to the start of labor and during early labor, the baby will continue to move.

Certain changes also may signal that labor is beginning. You may or may not notice some of them before labor begins:

Signs That You Are Approaching Labor

<i>Sign</i>	<i>What It Is</i>	<i>When It Happens</i>
Feeling as if the baby has dropped lower	Lightening. This is known as the "baby dropping." The baby's head has settled deep into your pelvis.	From a few weeks to a few hours before labor begins
Increase in vaginal discharge (clear, pink, or slightly bloody)	Show. A thick mucus plug has accumulated at the cervix during pregnancy. When the cervix begins to dilate, the plug is pushed into the vagina.	Several days before labor begins or at the onset of labor

What is false labor?

Your uterus may contract off and on before "true" labor begins. These irregular contractions are called false labor or Braxton Hicks contractions. They are normal but can be painful at times. You might notice them more at the end of the day.

How can I tell the difference between true labor and false labor?

Usually, false labor contractions are less regular and not as strong as true labor. Sometimes the only way to tell the difference is by having a vaginal exam to look for changes in your cervix that signal the onset of labor.

One good way to tell the difference is to time the contractions. Note how long it is from the start of one contraction to the start of the next one. Keep a record for an hour. It may be hard to time labor pains accurately if the contractions are slight. Listed as follows are some differences between true labor and false labor:

Differences Between False Labor and True Labor

<i>Type of Change</i>	<i>False Labor</i>	<i>True Labor</i>
Timing of contractions	Often are irregular and do not get closer together (called Braxton Hicks contractions)	Come at regular intervals and, as time goes on, get closer together. Each lasts about 30–70 seconds.
Change with movement	Contractions may stop when you walk or rest, or may even stop with a change of position	Contractions continue, despite movement
Strength of contractions	Usually weak and do not get much stronger (may be strong and then weak)	Increase in strength steadily
Pain of contractions	Usually felt only in the front	Usually starts in the back and moves to the front

If you have further questions, contact your obstetrician–gynecologist.

FAQ004: Designed as an aid to patients, this document sets forth current information and opinions related to women's health. The information does not dictate an exclusive course of treatment or procedure to be followed and should not be construed as excluding other acceptable methods of practice. Variations, taking into account the needs of the individual patient, resources, and limitations unique to institution or type of practice, may be appropriate.

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How to Choose a Pediatrician

Selecting a pediatrician is one of the most important decisions you'll make. So be picky!

Many patients use the same pediatrician for years, but never feel satisfied with the level of care their children receive. Choose a pediatrician the same way you would hire someone to work for you. Interview several candidates and ask plenty of questions. Make your choice based on whom you feel most comfortable around and who meets your criteria.

Most people with have to choose a pediatrician based on which ones participate in their insurance plan. The Texas State Board of Medical Examiners, 800-821-3205, has records of complaints filed against every pediatrician in Texas. Most pediatricians say the best way to find a physician for your children is to ask friends, family, and co-workers.

Make sure you have an overall good feeling of trust and confidence in the pediatrician before making a commitment, if not, go see the next doctor on your list. Some pediatricians do not come to Baylor but a Baylor pediatrician will be happy to see your baby and give you all the information to take to your pediatrician.

The following are factors to consider and questions to ask when searching for a pediatrician:

- Are they certified by the American Board of Pediatrics and a member of the American Academy of Pediatrics?
- Ask about their training and medical background. Do they have sub-specialties?
- Check to see if the pediatrician is up to date on current medical issues.
- Discuss issues about care that is important to you such as breastfeeding, immunizations, nutrition, sleep patterns etc. Does the doctor share or will work with these beliefs?
- When the doctor cannot take your call, who will address your concerns? Do they charge a fee for calls? Is someone on call 24 hours a day? What are the procedures in the event of an emergency after hours?
- What are the office hours? Are there any hidden fees (like charges for no show appointments)?
- What types of insurance does the office accept?
- Is the office staff friendly, helpful, and responsive to your needs?
- When can you call if you are worried about your child's health?
- At what hospitals does the doctor have privileges? Is that one near you?
- How many patients does the doctor see in a day? How much time does he/she try to devote to each patient during visits?

Baylor Area

Baylor Scott & White
Pediatrics
214-823-2525
Dr. Marjorie Milici
Dr. Jenny Clifford

Carrollton

North Carrollton Pediatric
Associates
972-492-4242
Dr. William Coco
Dr. Lynn Coulter
Dr. Thomas Grubb
Dr. Deborah Wardell

Crandall

Kaleidoscope Kids
972-472-3800
Dr. Meredith Byington
Jennifer Clearman
Lindsey Newman

Duncanville

Pediatric Southwest
972-298-3888
Dr. Mark Towns
Dr. Tom Deacon
Dr. Louis Hunke
Dr. Jacquelynn Longshaw

East Dallas

Karam Pediatrics
972-341-9696
Dr. Albert Karam
Dr. Anne Marie Karam

Forney/Rockwall

Forney Pediatrics
469-728-7999
Dr. Louis Hunke
Laura Eddington

Pediatric & Adolescent
Specialist of Rockwall
214-939-8767
Dr. Greg Sonnen
Dr. Rana Pascoe

Garland/Murphy

Baylor Scott & White
Pediatric & Adolescent
469-800-2060
Dr. Shawn Abel
Dr. Paul Bassel
Dr. Robert Kotas
Dr. Johanna Limsenben
Dr. Myron Rosen

Irving

Clinical Pediatric Associates
of North Texas
972-331-7200
Dr. Elizabeth Dickey
Dr. Mary Askari-Brown
Dr. Trung Tran

Mesquite

Baylor Family Health Center
(Pediatrics)
469-800-2800
Dr. Julian Lacey
Dr. Wendy Lai

North Dallas

Preston Center Pediatrics
214-987-0777
Dr. Joe Peterman
Dr. Jennifer Wheeler

Dallas Pediatrics

Cambell Center
214-368-6341
Dr. William Moore
Dr. Chris Abel
Dr. Tana Roberts

Park Cities Pediatrics

214-361-7185
Dr. Matthew Simon
Dr. Tiffany Lieu

Pediatric Associates

of Dallas
214-369-7661
Dr. Christina Bourland
Dr. Michael Brown
Dr. Early Denison

North Dallas Cont.

Dr. Maribel Esquivel
Dr. Bich Do
Dr. Chris Dreiling
Dr. Lauren Gore
Dr. Lisa Gysen
Dr. Karen McClard
Dr. Muzzian Siddiqi
Dr. Melissa Waters
Dr. Samuel Wang
Dr. Kathryn Wray

Pediatricians of Dallas

214-691-3535
Dr. Somer Curtis
Dr. Karen Halsell
Dr. Hillary Lewis
Dr. Joe Neely
Dr. Jerald Mefferd
Dr. James Watkins
Dr. Matthew Yaeger

Oak Cliff

Oak Cliff Pediatrics
469-300-5437
Dr. Susan Bacsik
Dr. Beth Keyes
Dr. Christine Glasow
Hanna Slicker
Stephanie Garces

Plano

Pediatric Associates of
Dallas (Plano location)
214-369-7661
Dr. Charles Dunlap
Dr. Amy Hayes
Dr. Cynthia Webb
Dr. Nicole Corrigan-Garrett
Dr. Aya Embabi

Sunnyvale

Comprehensive
Pediatric Care
972-686-6400
Dr. Yasmin Tejani
Dr. Meenu Jindal
Dr. Shailaja Philip
Janett Galvin



Cord Blood Banking

- What is cord blood?
- What are hematopoietic stem cells?
- How can hematopoietic stem cells be used to treat disease?
- What are the advantages of using cord blood to treat disease?
- What are the disadvantages of using cord blood to treat disease?
- What is an autologous transplant?
- What is an allogenic transplant?
- How is cord blood stored?
- What are public cord blood banks?
- What are private cord blood banks?
- What steps need to be done before cord blood is collected?
- How is cord blood collected?
- What problems can occur during cord blood collection?
- What else should I think about when deciding whether to donate or store cord blood?
- Glossary

What is cord blood?

Cord blood is the blood from the baby that is left in the **umbilical cord** and **placenta** after birth. It contains special **cells** called **hematopoietic stem cells** that can be used to treat some types of diseases.

What are hematopoietic stem cells?

Most cells can make copies only of themselves. For example, a skin cell only can make another skin cell. Hematopoietic stem cells, however, can mature into different types of blood cells in the body. Hematopoietic stem cells also are found in blood and **bone marrow** in adults and children.

How can hematopoietic stem cells be used to treat disease?

Hematopoietic stem cells can be used to treat more than 70 types of diseases, including diseases of the **immune system**, **genetic disorders**, **neurologic disorders**, and some forms of cancer, including leukemia and lymphoma. For some of these diseases, stem cells are the primary treatment. For others, treatment with stem cells may be used when other treatments have not worked or in experimental research programs.

What are the advantages of using cord blood to treat disease?

Using the stem cells in cord blood to treat a disease has the following benefits compared with using those in bone marrow:

- Stem cells from cord blood can be given to more people than those from bone marrow. More matches are possible when a cord blood transplant is used than when a bone marrow transplant is used. In addition, the stem cells in cord blood are less likely to cause **rejection** than those in bone marrow.
- It is harder to collect bone marrow than it is to collect cord blood. Collecting bone marrow poses some risks and can be painful for the donor.

- Cord blood can be frozen and stored. It is ready for anyone who needs it. Bone marrow must be used soon after it is collected.
- Stem cells in cord blood can be used to strengthen the immune system during cancer treatments. Bone marrow stem cells do not have this capability.

What are the disadvantages of using cord blood to treat disease?

A disadvantage of cord blood is that it does not contain many stem cells. Units from several donors can be combined to increase the number of stem cells if a transplant is needed for an adult.

What is an autologous transplant?

In an **autologous transplant**, the cord blood collected at birth is used by that same child. This type of transplant is rare for the following reasons:

- A child's stem cells cannot be used to treat genetic diseases in that child. All of the stem cells have the same **genes** that cause the disease.
- A child's own stem cells cannot be used to treat that child's leukemia, a cancer of the blood.

What is an allogenic transplant?

In an **allogenic transplant**, another person's stem cells are used to treat a child's disease. This kind of transplant is more likely to be done than an autologous transplant. In an allogenic transplant, the donor can be a relative or be unrelated to the child. For an allogenic transplant to work, there has to be a good match between donor and recipient. A donor is a good match when certain things about his or her cells and the recipient's cells are alike. If the match is not good, the recipient's immune system may reject the donated cells. If the cells are rejected, the transplant does not work.

How is cord blood stored?

Cord blood is kept in one of two types of banks: public or private. They differ in important ways that may affect your choice.

What are public cord blood banks?

Public cord blood banks store cord blood for allogenic transplants. They do not charge to store cord blood. The stem cells in the donated cord blood can be used by anyone who matches. Some public banks will store cord blood for **directed donation** if you have a family member who has a disease that could potentially be treated with stem cells.

Donors to public banks must be screened for blood or immune system disorders or other problems. With a cord blood donation, the mother's blood is tested for genetic disorders and infections, and the cord blood also is tested after it is collected. Once it arrives at the blood bank, the cord blood is "typed." It is tracked by a computer so that it can be found quickly for any person who matches when needed.

What are private cord blood banks?

Private or family banks store cord blood for autologous use or directed donation for a family member. Private banks charge a yearly fee for storage. Blood stored in a private bank must meet the same standards as blood stored in a public bank. If you have a family member with a disorder that may potentially be treated with stem cells, some private banks will store the cord blood free of charge.

What steps need to be done before cord blood is collected?

Certain steps must be done beforehand:

- The bank must be notified and a collection kit must be obtained in advance (usually 6 weeks or more) of your due date. Some hospitals have collection kits on hand, whereas others do not.
- A family medical history must be provided and the mother's blood must be tested.
- Consent must be given before labor begins.

If you choose a private bank, you will sign a contract and pay a fee before the baby is born.

How is cord blood collected?

Cord blood is collected by your obstetrician or the staff at the hospital where you give birth. Not all hospitals offer this service. Some charge a separate fee that may or may not be covered by insurance.

The process used to collect cord blood is simple and painless. After the baby is born, the umbilical cord is cut and clamped. Blood is drawn from the cord with a needle that has a bag attached. The process takes about 10 minutes.

What problems can occur during cord blood collection?

Sometimes, not enough cord blood can be collected. This problem can occur if the baby is preterm or if it is decided to delay clamping of the umbilical cord. It also can happen for no apparent reason. If an emergency occurs during delivery, priority is given to caring for you and your baby over collecting cord blood.

What else should I think about when deciding whether to donate or store cord blood?

Think about the following points when making your choice:

- Donating cord blood to a public bank adds to the supply and can potentially help others. Donating to a public bank is especially important for ethnic minorities, who are not well represented in cord blood banks. Public cord blood donation increases the chance of all groups finding a match.
- Only certain hospitals collect cord blood for storage in public banks.
- Storing a child's stem cells in a private bank as "insurance" against future disease is not recommended.
- If you already have a child with a medical condition that may be helped by a cord blood transplant, donating a biological sibling's cord blood for directed donation is encouraged.
- If you decide to store cord blood in a private bank, you should find out the total cost, including charges for collecting and processing the cord blood and the annual storage fees.

Glossary

Allogenic Transplant: A transplant in which the donated tissue, organ, or cells come from another person. The donor may be a family member or unrelated to the recipient.

Autologous Transplant: A transplant in which the recipient uses his or her own cells or tissue (such as bone marrow).

Bone Marrow: The spongy tissue in bone cavities that produces new blood cells.

Cells: The smallest units of a structure in the body; the building blocks for all parts of the body.

Directed Donation: A donation of an organ or cells that is directed to a specific individual or group, such as a family member.

Genes: Segments of DNA that contain instructions for the development of a person's physical traits and control of the processes in the body. They are the basic units of heredity and can be passed down from parent to offspring.

Genetic Disorders: Disorders caused by a change in genes or chromosomes.

Hematopoietic Stem Cells: A type of blood cell that can mature into other types of blood cells.

Immune System: The body's natural defense system against foreign substances and invading organisms, such as bacteria that cause disease.

Neurologic Disorders: Diseases that affect the brain, spinal cord, or nerves.

Placenta: Tissue that provides nourishment to and takes waste away from the fetus.

Rejection: An immune response in which the body recognizes transplanted cells or tissues as foreign and attacks them.

Umbilical Cord: A cordlike structure containing blood vessels that connects the fetus to the placenta.

If you have further questions, contact your obstetrician–gynecologist.

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PRE-REGISTRATION WITH BAYLOR

We advise you to pre-register to the hospital for your delivery. This will expedite the care in which you receive.

There are three different methods in which you can register:

1. ONLINE

- a. Go to: www.baylorhealth.com/dallaschildbirth
- b. Look for the link to the “Pre-Register for Your Delivery”
- c. Create a new account with password and security question
- d. Log on after account is created and choose “Manage my account/pre-registrations”
- e. Be certain to select the hospital in which you will be delivering as “Baylor University Medical Center at Dallas”
- f. Complete the form in its entirety and press “Submit” (please verify that you have the correct hospital selected)

2. IN PERSON

- a. Complete the “Maternity Pre-Admission Information” sheet
- b. Bring completed form to Baylor University Medical Center at Dallas: 3500 Gaston Avenue, 1st floor of the Jonsson Hospital, Patient Registration
- c. Please have your driver’s license and insurance card with you

3. BY MAIL

- a. Complete the “Maternity Pre-Admission Information” sheet
- b. Make a copy of your driver’s license and insurance card
- c. Mail all three items (Pre-admission form, copy of driver’s license and copy of insurance care) to:

Jonsson Admitting
Baylor University Medical Center at Dallas
3500 Gaston Avenue
Dallas, TX 75246



Online pre-registration

Your time is important to us. We advise you to pre-register with the hospital for your delivery. There are three different methods you can use to register:

1. Online

- Go to: [BSWHealth.com/DallasChildbirth](https://www.bswhealth.com/DallasChildbirth)
- Select “Pre-Register for Your Delivery” link
- Create a new account with a password and security question
- Log on after creating your account and choose “Manage my account/pre-registrations”
- Be certain to select the location where you will be delivering
- Complete the form in its entirety and press “Submit” (please verify that you have the correct hospital selected)

2. In person

- Complete the “Maternity Pre-Admission Information” sheet
- Bring the completed form to Baylor University Medical Center, part of Baylor Scott & White Health in Dallas: 3500 Gaston Avenue, 1st floor of the Jonsson Hospital, Patient Registration
- Please bring your driver’s license and insurance card with you

3. By mail

- Complete the “Maternity Pre-Admission Information” sheet
- Make a copy of your driver’s license and insurance card
- Mail all three items (Pre-admission form, copy of driver’s license and copy of insurance card) to:

Baylor University Medical Center
Jonsson Admitting
3500 Gaston Avenue | Dallas, TX 75246



Questions?
Call **877.810.0372**

SHAKEN BABY SYNDROME

DEFINITION

Shaken baby syndrome is a type of inflicted traumatic brain injury that happens when a baby is violently shaken. A baby has weak neck muscles and a large, heavy head. Shaking makes the fragile brain bounce back and forth inside the skull and causes bruising, swelling, and bleeding, which can lead to permanent, severe brain damage or death. The characteristic injuries of shaken baby syndrome are subdural hemorrhages (bleeding in the brain), retinal hemorrhages (bleeding in the retina), damage to the spinal cord and neck, and fractures of the ribs and bones. These injuries may not be immediately noticeable. Symptoms of shaken baby syndrome include extreme irritability, lethargy, poor feeding, breathing problems, convulsions, vomiting, and pale or bluish skin. Shaken baby injuries usually occur in children younger than 2 years old, but may be seen in children up to the age of 5.

TREATMENT

Emergency treatment for a baby who has been shaken usually includes life-sustaining measures such as respiratory support and surgery to stop internal bleeding and bleeding in the brain. Doctors may use brain scans, such as MRI and CT, to make a more definite diagnosis.

PROGNOSIS

In comparison with accidental traumatic brain injury in infants, shaken baby injuries have a much worse prognosis. Damage to the retina of the eye can cause blindness. The majority of infants who survive severe shaking will have some form of neurological or mental disability, such as cerebral palsy or cognitive impairment, which may not be fully apparent before 6 years of age. Children with shaken baby syndrome may require lifelong medical care.

Breast and Nipple Care

Prevention and Treatment of Sore Nipples



Breastfeeding is meant to be a comfortable and pleasant experience. When you are first getting started with breastfeeding, you may feel awkward – that is common. It will take some practice and patience to get relaxed. Remember, both you and your baby are learning a new skill.

Breastfeeding is not supposed to hurt, but many new mothers find that in the first week or two of nursing, they may experience nipple tenderness and soreness. This is normal and will improve as the baby gets better at nursing.

The key to comfortable breastfeeding is getting the baby attached (or latched) to the breast correctly with your nipple deep into his mouth. The way your baby latches and the positions in which you nurse can help prevent sore nipples. If your nipples are already sore, a proper latch and good positioning will help them heal a little bit faster. It is also helpful to contact a lactation consultant or healthcare professional to assist you in comfortable breastfeeding techniques.

Positioning and Latch Technique

- You and your baby should be in a comfortable position.
- You may find it helpful to use some pillows to support your arm.
- Hold your baby so he is facing you and your breast. His ear, shoulder and neck should be in a straight line.

- Hold your breast with your thumb on top of your breast and fingers below, well away from the areola (darker part surrounding the nipple).



- Pointing the nipple upward, tickle his lip until he opens his mouth **wide**. Be patient, sometimes this takes a minute or two.



- Bring baby's chin into your breast and pull him close so he takes in a big mouthful of breast.



- Keep baby's body pressed close to yours. This allows the nipple to stay deep in the baby's mouth. It's OK if baby's nose touches the breast.



- After the first few sucks, you should feel a tug at the breast, but no pain. (In the first few days the latch itself may hurt a bit, but the discomfort should ease over time.)

Signs of a Good Latch

- Baby sucks actively at the breast.
- Mouth is opened wide.
- Lips are flanged outward (like a rosebud).
- You may hear swallowing.
- Baby's chin is touching your breast (nose may also be touching).
- Baby's ear, shoulder and hip are in a straight line and baby's body is facing you.
- You should feel a tugging at the breast but no "toe-curling" pain after the first few sucks.

Breast and Nipple Care

Prevention and Treatment of Sore Nipples



If your Nipples are Already Sore

- You may want to begin the feeding on the side that hurts less.
- Massage your breast for a minute or two before breastfeeding to stimulate the milk flow before baby latches on.
- If your breasts are full or firm, express some milk to soften the breast and make it easier for the baby to get the breast and nipple far back into his mouth.
- Make sure the baby is positioned properly with a wide open mouth and has hold of a large mouthful of breast. If baby is sucking on the nipple only, this can be extremely painful and your nipple may become damaged.
- For pain relief, you can apply Tender Care™ lanolin on your nipples and areola after feeding to soothe the tender skin.
- If your nipples are very sore or there is a break in the skin, a moist environment is recommended for optimal healing. Tender Care Hydrogel pads provide immediate cool and soothing pain relief and promote tissue healing. The pads are placed over the nipple and worn inside the bra between feedings. Tender Care lanolin can also be used with the Hydrogel pads if needed.
- SoftShells™ for sore nipples can be worn inside your bra between feedings to allow air to circulate and protect the tender nipples from rubbing on the fabric.
- If you have tried these comfort measures for a few days and nipple pain increases or you see bleeding or cracks, call a lactation consultant or healthcare professional for assistance.

Helpful Hints

- When removing baby from the breast, remember to first break the suction by inserting a clean finger into the baby's mouth between the gums and holding it there while pulling him away.
- Breastfeed frequently (8-12 times in 24 hours). Watch for early feeding cues such as gentle stirring, being awake and alert, putting his hand to his mouth, etc. It is a good idea to try to breastfeed when baby is calm and alert, before he is crying and upset.
- Wait until breastfeeding is well established before introducing bottles and pacifiers.
- Keep bras and bra pads clean and dry.



Resources and References

Got to www.medela.com for products and information available for you and your baby.

To locate Medela products or a breastfeeding specialist in your area, go to www.medela.com or call 1-800-TELL YOU, 24 hours a day, 7 days a week.

Some other excellent resources:

- International Lactation Consultant Association – www.ilca.org
- La Leche League International – www.llli.org
- United States Lactation Consultant Association – www.uslcaonline.org

medela

Medela, Inc., P.O. Box 660, 1101 Corporate Drive, McHenry, IL 60051-0660
Medela Canada, Inc., 4160 Sladeview, Crescent Unit #8, Mississauga, ON L5L 0A1
Phone: (800) 435-8316 or (815) 363-1166 Fax: (815) 363-1246
Email: customer.service@medela.com
www.medela.com

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Frequently Asked Questions for Patients Concerning Tdap Vaccination

What is pertussis (whooping cough)?

Pertussis (also called whooping cough) is a highly contagious disease that causes severe coughing. People with pertussis may make a “whooping” sound when they try to breathe and are gasping for air. In newborns (birth to 1 month), pertussis can be a life-threatening illness. Multiple recent outbreaks have demonstrated that infants who are younger than 3 months are at a very high risk of severe infection.

What is Tdap?

Tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) vaccine is used to prevent three infections: tetanus, diphtheria, and pertussis.

I am pregnant. Should I get a Tdap shot?

Yes. All pregnant women should receive a Tdap vaccine preferably between 27 weeks and 36 weeks of gestation. The Tdap vaccine is an effective and safe way to protect you and your baby from serious illness and complications of pertussis. The Tdap vaccine should be administered during each pregnancy.

Is it safe to receive the Tdap shot during pregnancy?

Yes. There are no theoretical or proven concerns about the safety of the Tdap vaccine (or other inactivated vaccines like Tdap) during pregnancy. The available data demonstrate that the vaccine is safe when given to pregnant women or women in the postpartum period.

During which trimester is it safe to receive a Tdap shot?

It is safe to get the Tdap vaccine during all trimesters of pregnancy. Experts recommend that Tdap be administered to you during the third trimester of your pregnancy (ideally between 27 weeks and 36 weeks of gestation) to maximize the protection of your newborn. The newborn protection occurs because the protective antibodies you make after being vaccinated are transferred to the fetus and protect your newborn until he or she begins to receive the vaccines against pertussis (at 2 months of age).

Can newborns be vaccinated against pertussis?

No. Newborns cannot begin their vaccine series against pertussis until 2 months of age

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OBSTETRICS GYNECOLOGY INFERTILITY

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because the vaccine does not work in the first few weeks of life. That is partly why infants are at a higher risk of getting pertussis and getting very ill early in life.

What else can I do to protect my baby against pertussis?

Getting your Tdap shot is the most important step in protecting yourself and your baby against pertussis. It is also important to make sure all family members and caregivers are up to date with their vaccines and, if necessary, that they receive the Tdap vaccination at least 2 weeks before having contact with your baby. This creates a safety "cocoon" of vaccinated caregivers around your baby.

I am breastfeeding my baby. Is it safe to get vaccinated with Tdap?

Yes. The Tdap vaccine can safely be given to breastfeeding mothers if they have not been previously vaccinated with Tdap.

I did not receive my Tdap shot during pregnancy. Do I still need to be vaccinated?

For women not previously vaccinated with Tdap, if Tdap was not administered during pregnancy, it should be administered immediately postpartum.

I got my Tdap shot with my previous pregnancy. Do I need to be vaccinated with Tdap again in this pregnancy?

Yes. All pregnant women should be vaccinated with Tdap during each pregnancy preferably between 27 weeks and 36 weeks of gestation. This time frame is recommended in order to generate the most protection for the mother and fetus because this appears to maximize the antibodies in the newborn at birth.

I received a Tdap shot early in this pregnancy before 27-36 weeks of gestation. Do I need to get another Tdap shot during 27-36 weeks of gestation?

A pregnant woman should not be re-vaccinated later in the same pregnancy if she received the vaccine in the first or second trimester.

RESOURCES

The American College of Obstetricians and Gynecologists
Immunization for Women
www.immunizationforwomen.org
Society for Maternal-Fetal Medicine