Chelsea Obstetrics

"The ethos of our practice is to put women and their families at the heart of our care and to promote choice in pregnancy and childbirth to provide the safest and most satisfying experience for you and your baby."

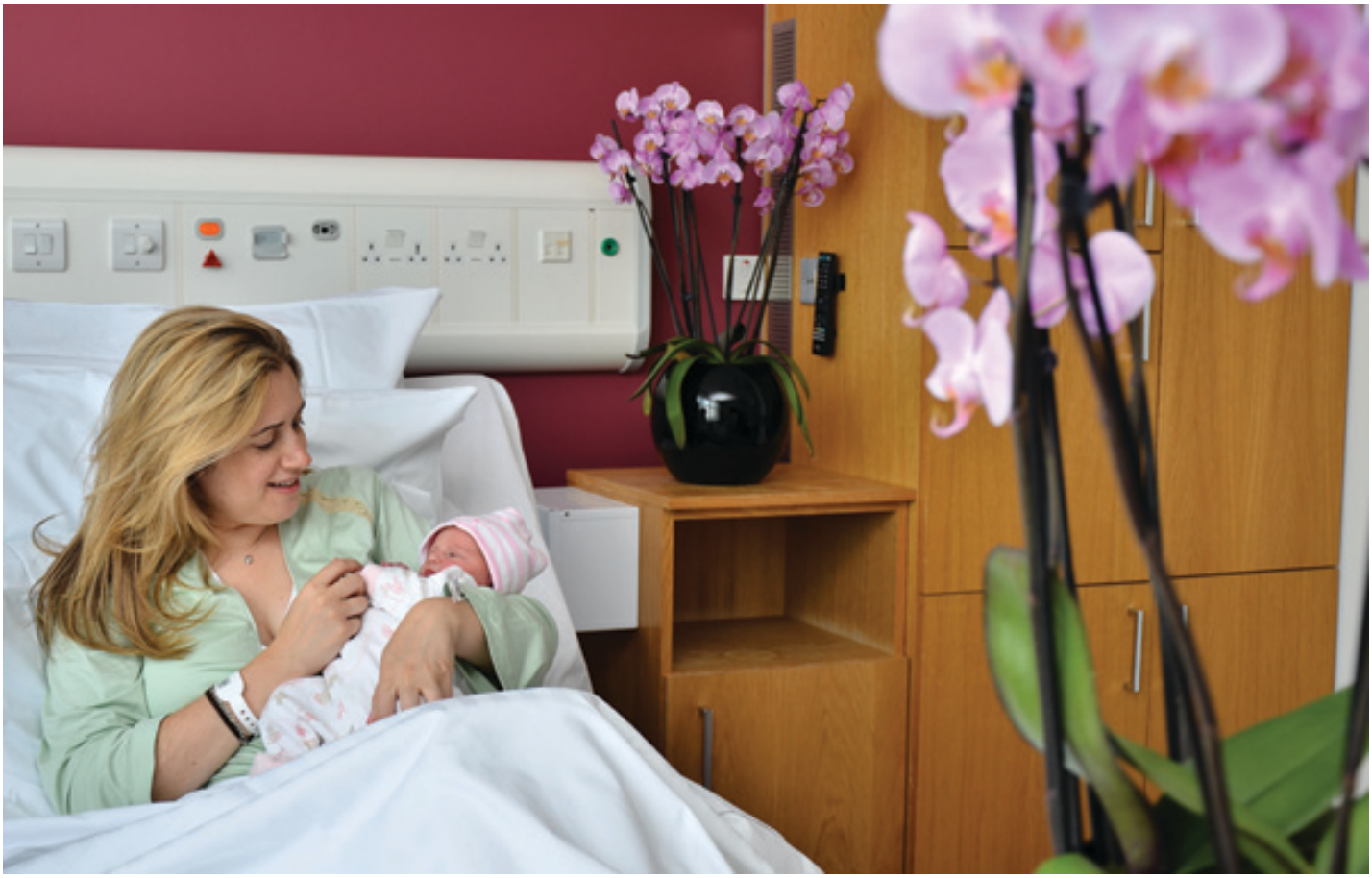

Photo Credit: Chelsea and Westminster Hospital NHS Foundation Trust

Mr Shane Duffy

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The Chelsea & Westminster Hospital

The Chelsea & Westminster Hospital (CWH) was opened in May 1993 and is one of London's newest hospitals. It is a wonderful building with a full range of medical, nursing and paramedical skills. It offers the highest standards of care and treatment and you will have all the backup services of an acute teaching hospital if needed – e.g. neonatal or maternal intensive care. A full team of staff is available around the clock providing first class cover and assistance in the event of an emergency.

Shane Duffy, Mark Johnson, Gubby Ayida, Mina Savvidou and Natasha Singh share their weekends on call. They have all worked closely together for the last six years running the High Risk pregnancy team at CWH. This enables them to provide comprehensive care to cover for annual leave, conferences and other professional duties. Occasionally if you make a call at this time you will be answered by the consultant who is on call for that weekend. If you do go into labour at the weekend, the consultant on call will deliver you.

The Kensington Wing: Private Maternity Unit

All private patients are accommodated in single rooms with en-suite facilities, a television, telephone and refrigerator in our purpose built Private Maternity Unit on the 3rd floor, Lift B. The private patients' kitchen supplies catering and an a la carte menu is provided, as well as menus for special needs. If you should need an operation then you may be nursed for the first day after this in the high dependency bay, where you can receive special monitoring and care. Our antenatal clinics are:

Monday evenings:
The Early Pregnancy Unit
3rd Floor, Lift Bank B

Thursday mornings:
The Westminster Wing
4th Floor, Lift D

Occasionally your appointment may have to be cancelled or rearranged at short notice if the consultant is involved in a delivery or an emergency. Your appointments can be booked by the secretaries and/or booked ahead when you come for your visits.

At your first visit you will be offered blood tests: Full blood count, blood group and antibody testing, testing for syphilis, rubella status, Hepatitis B serology, HIV testing, random blood glucose and a haemoglobin electrophoresis. Further blood tests for anaemia, blood group antibodies and screening for pregnancy diabetes may be offered at 26 and 34 weeks of pregnancy.

Plans for delivery are discussed at approximately 34 weeks, when your partner may like to come with you and take part. Please bring your white obstetric notes with you at each visit to the hospital and especially when you arrive for delivery and remember to take them with you when you travel.

Midwifery care

We have an experienced team of midwives on duty at all times on the Kensington Wing, Private Maternity Unit, who will care for you before, during and after labour. They are available 24 hrs.

If you have emergency queries you should contact the Midwives on the Kensington Wing, Private Maternity on: 020 3315 5945 / 5944 or for general enquiries contact the Patient Liaison Officers on 020 3315 8616 / 8618 (between 8am – 8pm). They will know if your consultant is away and who is providing cover.

Patient information: Nutrition before and during pregnancy

Will I need to change the way I eat when I am pregnant? — Probably. In fact, you will probably need to change the way you eat before you get pregnant. You will also need to start taking a multivitamin that has folic acid in it. If you want to get pregnant, see your doctor or nurse before you start trying. He or she will explain how your diet needs to change and outline the steps you can take to have the healthiest pregnancy possible.

Eating the right foods will help your baby's development. Your baby will need nutrients from these foods to form normally and grow. Eating the wrong foods could harm your baby. For example, if you eat cheese made from unpasteurized milk or raw or undercooked meat, you could get an infection that could lead to a miscarriage. Likewise, if you take too much vitamin A (more than 10,000 international units a day) in a vitamin supplement, your baby could be born with birth defects. Making healthy food choices is also important for your health as a mother. As your baby grows and changes inside you, it will take nutrients from your body. You will have to replace these nutrients to stay healthy and have all the energy you need.

Which foods should I eat? — The best diet for you and your baby will include lots of fresh fruits, vegetables, and whole grains, some low-fat dairy products, and a few sources of protein, such as meat, fish, eggs, or dried peas or beans. If you do not eat dairy foods, you will need to get calcium from other sources. If you are a vegetarian, speak to a nutritionist (food expert) about your food choices. Vegetarian diets can sometimes be missing nutrients that are important for a growing baby.

Should I prepare food differently? — Maybe. You need to be extra careful about avoiding germs in your food. Getting an infection while you are pregnant can cause serious problems. Here's what you should do to avoid germs in your food: Wash your hands well with soap and water before you handle food.

Make sure to fully cook fish, chicken, beef, eggs, and other meats. Rinse fresh fruits and vegetables well under running water before you eat them. After preparing food, wash your hands and anything that touched raw meat or deli meats with hot soapy water. This includes countertops, cutting boards, and cutlery.

To reduce the risk of germs in food, you should also avoid foods that can easily carry germs, including: raw sprouts (including alfalfa, clover, radish, and mung bean) milk, cheese, or unpasteurized juice.

Which foods should I avoid? — You should avoid certain types of fish and all forms of alcohol. You should also limit the amount of caffeine in your diet, and check with your doctor before taking herbal products.

Fish – You should not eat types of fish that could have a lot of mercury in them. These include shark, swordfish, king mackerel, and tilefish. Mercury is a metal that can keep the baby's brain from developing normally. You can eat types of fish that do not have a lot of mercury, but not more than 2 times a week. The types of fish and other seafood that are safe to eat 1 or 2 times a week include shrimp, canned light tuna, salmon, pollock, and catfish. Tuna steaks are also OK to eat, but you should have that only once a week. Check with your doctor or nurse about the safety of fish caught in local rivers and lakes.

Alcohol – You should avoid alcohol completely. Even small amounts of alcohol could harm a baby.

Caffeine – Limit the amount of caffeine in your diet by not drinking more than 1 or 2 cups of coffee each day. Tea and cola also have caffeine, but not as much as coffee.

Herbal products – Check with your doctor or nurse before using herbal products. Some herbal teas might not be safe.

What are prenatal vitamins? — Prenatal vitamins are vitamin supplements that you take the month before and all through your pregnancy. These vitamins, which also contain minerals (iron, calcium), help make sure that your baby has all the building blocks he or she needs to form healthy organs. Prenatal vitamins help lower the risk of birth defects and other problems.

What should I look for in prenatal vitamins? — Choose a multivitamin that's labeled "prenatal" and that has at least 400 micrograms of folic acid. Folic acid is especially important in preventing certain birth defects. Show your doctor or nurse the vitamins you plan to take to make sure the doses are right for you and your baby. Too much of some vitamins can be harmful.

How much weight should I gain? — That will depend on how much you weigh to begin with. Your doctor or nurse will tell you how much weight gain is right for you. In general, a woman who is a healthy weight should gain 25 to 35 pounds during her pregnancy. A woman who is overweight or obese should gain less weight. If you start to lose weight, for example, because you have severe morning sickness, call your doctor or nurse.

Patient information: Activity during pregnancy (The Basics)

What do I need to do differently while I am pregnant? — During pregnancy, most women can be as active as they were before they got pregnant. This includes travelling, working, exercising, and having sex. If you have any questions about doing an activity during pregnancy, be sure to ask your doctor or midwife. Women with certain conditions might need to limit their activity. If your doctor or midwife thinks you should limit your activity, he or she will let you know.

Travel — Women can drive and travel by car throughout their pregnancy. But when travelling by car, it's important to: Always wear your seat belt. The shoulder belt should go between your breasts and to the side of your belly. The lap belt should go under your belly. Take plenty of breaks during long trips. Be sure to stop often so that you can walk and stretch your legs. Keep the car's air bags turned on.

Women can also travel by plane during pregnancy. But if you are planning to fly toward the end of your pregnancy, check with the airline. Most airlines don't allow women to fly during their last month of pregnancy. During long flights, be sure to shift your position while seated, and move your legs and feet often. You should also stand up and move around when it is safe to do so. This can prevent blood clots from forming in your legs.

If you are planning to travel to another country, let your doctor or midwife know. In some countries, infection is a concern. Ask your doctor or midwife whether you can safely go there. For example, many health care providers recommend that pregnant women not travel to places in the world where malaria is common.

Exercise — Doctors recommend that all adults, including pregnant women, get at least 30 minutes of exercise on all or most days of the week. Exercise has many benefits during pregnancy. It can help with your mood, energy level, and sleep. It can also help with pregnancy symptoms such as constipation, bloating, swelling, and back pain.

The type of exercise that is right for you depends on your current pregnancy, past pregnancies, and how active you were before you got pregnant. In general, doctors usually recommend walking and swimming as good types of exercise for pregnant women. Pregnant women should avoid activities in which they could easily fall or hurt their belly. These include hockey, soccer, basketball, horseback riding, downhill skiing, and gymnastics.

To exercise safely, you should:

- Avoid lying flat on your back
- Slowly increase your level of activity
- Avoid exercising in hot or humid weather
- Drink plenty of water
- Wear a support bra
- Stop exercising if you get out of breath

You should stop exercising if you have any of the following symptoms:

- Vaginal bleeding
- Feeling light-headed or dizzy
- Headache or chest pain
- Muscle weakness
- Contractions
- Vaginal fluid loss
- Leg swelling, pain, redness, or warmth
- Reduced baby movements

Work — Whether or not you should stop working depends on your health, your baby's health, and what your work involves. Women who have no problems during pregnancy can usually work up until they go into labour. But it depends on your job and what it involves. Every employer has a Material Safety Data Sheet that contains information on the chemical properties and health effects of the substances used in the workplace. If you work with or near chemicals or other toxic substances, you should read this worksheet and discuss with your doctor.

Sex — Women can keep having sex during a normal pregnancy.

Patient information: How to tell when your labour starts

What is labour? — Labour is the way a woman's body prepares to give birth. Labour usually starts on its own between 37 and 42 weeks of pregnancy. A woman's "due date" is at 40 weeks. A pregnancy that lasts 37 to 42 weeks is called a "term" pregnancy. When labour starts before 37 weeks, doctors call it "preterm" labour.

What are the signs that labour is starting? — The different signs that labour is starting can include the following:

- The baby moves lower (or "drops") in your belly.
- You have increased vaginal discharge that is thick, mucus-like, or slightly bloody. (Vaginal discharge is the term doctors use to describe the fluid that comes out of the vagina.) The increased vaginal discharge is sometimes called a "mucus plug" or a "bloody show."
- Your water breaks. During pregnancy, your baby is in a sac in your uterus and surrounded by a fluid called "amniotic fluid." This sac will break open sometime before your baby is born. When it breaks open, the fluid inside comes out of your vagina. This can feel like a gush or trickle of fluid. You have low back pain or belly cramps.
- You start having contractions. During a contraction, the uterus tightens. This can be painful and make your belly feel hard. After a contraction, the uterus relaxes and the pain goes away. Some women have "Braxton Hicks contractions" or "false labour contractions." These feel like contractions, but they are not true contractions. They do not mean that you are in labour.

How can I tell if I'm having true contractions? — It can be hard to tell if you are having true contractions or Braxton Hicks contractions. But here are some ways to help tell the difference:

- True contractions come every few minutes and get more frequent over time. Braxton Hicks contractions can come every few minutes, but they don't get more frequent over time.
- True contractions don't go away, even when you rest. Braxton Hicks contractions usually go away when you rest.
- True contractions will get stronger and more painful over time. Braxton Hicks contractions usually don't get stronger or more painful over time. If you are still not sure whether you are having true contractions, call your doctor or midwife.

What should I do if I start having contractions? — If you start having contractions, you should time them to see how far apart they are. That way, you can tell if they get more frequent. You can time your contractions by writing down the time when each contraction starts. If you have a clock with a second hand, you can also time how long each contraction lasts. Your doctor or midwife will want to know how far apart your contractions are and how long they last.

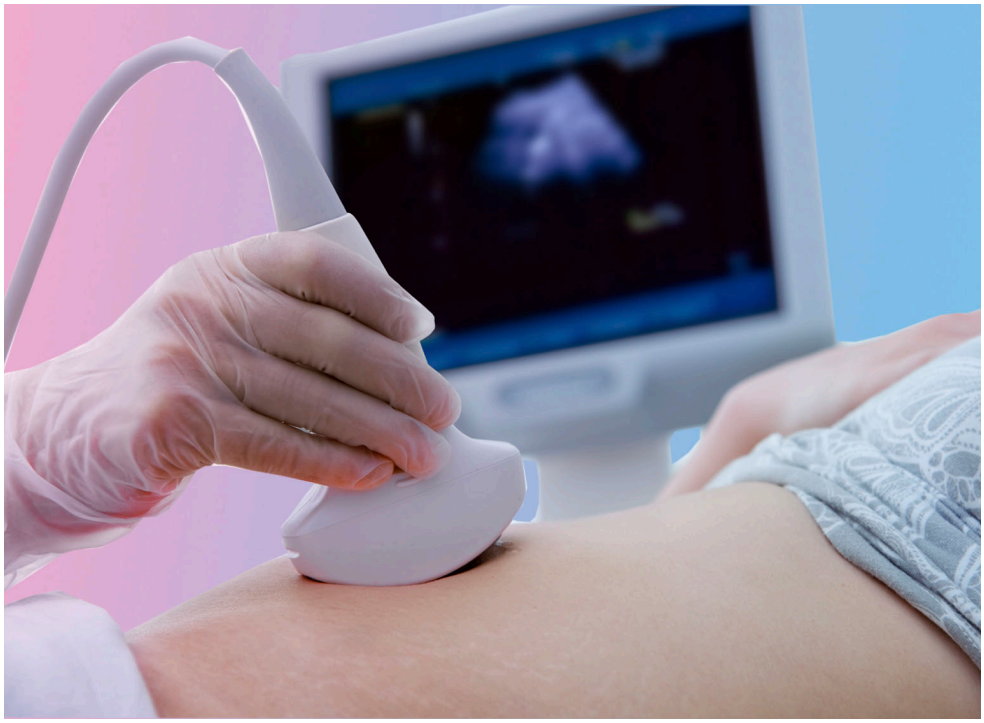
When should I call my doctor or midwife? — Call the Kensington Wing (020 3315 8616) if you think you are in labour or if ANY of the following things happen:

- You have blood, mucus, or fluid leaking from your vagina.
- You have 6 or more contractions in 1 hour. (That means your contractions are 10 minutes apart or less.)
- Your contractions are getting stronger and are painful.
- Your doctor or midwife will probably want to see you to do an exam. To tell if you are in labour, he or she will check your cervix to see if it is opening ("dilated") and thinning out. He or she will see how frequent your contractions are. He or she might also do other tests.

What if my labour starts too soon? — If you start having any symptoms of labour before 37 weeks, call your doctor right away. He or she might want to give you medicine to try to stop your labour.

What if my labour doesn't start on its own? — If your labour doesn't start on its own, your doctor will talk to you about your options. He or she might try to start your labour with medicines. This is called "inducing labour."

How long will my labour last? — If it's your first baby, your labour will probably last for many hours. If it's not your first baby, your labour will probably be shorter.



Patient information: C-section (caesarean delivery)

Introduction — A caesarean delivery (also called a surgical birth) is a surgical procedure used to deliver an infant. It requires regional (or rarely general) anesthetic to prevent pain, and then a vertical or horizontal ('bikini line') incision in the lower abdomen to expose the uterus (womb). Another incision is made in the uterus to allow removal of the baby and placenta.

Caesarean deliveries may be performed because of maternal or fetal problems that arise during labour, or they may be planned before the mother goes into labour. More than 28 percent of births in the UK occur by caesarean delivery.

Reasons for Caesarean section — Some women who intend to deliver vaginally will eventually require caesarean delivery. The following list describes some reasons caesarean might be needed:

- Labour is not progressing as it should. This may occur if the contractions are too weak, the baby is too big, the pelvis is too small, or the baby is in an abnormal position. If a woman's labour does not progress normally, in many cases, the woman will be given a medication (Pitocin/oxytocin) to be sure that contractions are adequate for several hours. If labour still does not progress after several hours, a caesarean delivery may be recommended.
- The baby's heart rate suggests that it is not tolerating labour well.
- The baby is in a transverse (sideways) or breech position (buttocks first) when labour begins.
- Heavy vaginal bleeding. This can occur if the placenta separates from the uterus before the baby is delivered (called a placental abruption).
- A medical emergency threatens the life of the mother or infant.

Planning Caesarean delivery — A planned caesarean delivery is one that is recommended because of the increased risk(s) of a vaginal delivery to the mother or her infant. Caesarean deliveries that are done because the woman wants, but does not require, a caesarean delivery are called "maternal request caesarean deliveries".

There are a number of medical and obstetric circumstances that a healthcare provider would recommend scheduling a caesarean delivery in advance. Some of these circumstances are listed below:

- The mother has had a previous caesarean delivery or other surgery in which the uterus was cut open. A vaginal delivery is possible after caesarean delivery in some, but not all cases.
- There is some mechanical obstruction that prevents or complicates vaginal delivery, such as large fibroids or a pelvic fracture.
- The infant is unusually large, especially if the mother has diabetes.
- The mother has an active infection, such as herpes or HIV, that could be transmitted to the infant during vaginal delivery.
- The birth involves multiple gestation (twins, triplets, or more).
- The woman has cervical cancer.
- The infant has an increased risk of bleeding.
- The placenta is covering the cervix (called placenta previa).

There is some controversy about the preferred method of delivery in certain situations. These include some birth defects, such as spina bifida and fetal abdominal wall defects, and some maternal medical problems. One of the most important factors in scheduling a caesarean delivery is making certain that the baby is ready to be delivered. In general, caesarean deliveries are not scheduled before the 39th week of pregnancy.

All women will meet with an anesthestist on the morning of the operation to discuss the various types of anesthesia available and the risks and benefits of each. Instructions about how to prepare for surgery will also be given, including the need to avoid all food and drinks for 10 to 12 hours before the surgery.

Advantages of planned caesarean — The advantages of a planned caesarean delivery include:

- It allows parents to know exactly when the baby will be born, which makes issues related to work, childcare, and help at home easier to address.
- It avoids some of the possible complications and risks to the baby.
- It avoids the possibility of postterm pregnancy, in which the baby is born two or more weeks after its due date.
- It helps ensure that a pregnant woman's obstetrician will be available for the delivery.
- It may offer a more controlled and relaxed atmosphere, with fewer unknowns such as how long labour and delivery will last.
- It may minimize injury to the pelvic muscles and tissues and the anal sphincters. These injuries sometimes occur during vaginal delivery, which may increase the risk of urinary or anal incontinence.

The benefits of planned caesarean delivery must be weighed against the risks. Caesarean delivery is a major surgery, and has associated risks.

Risks — Because caesarean delivery involves major surgery and anesthesia, there are some disadvantages compared to vaginal delivery.

- Caesarean delivery is associated with a higher rate of injury to abdominal organs (bladder, bowel, blood vessels), infections (wound, uterus, urinary tract), and thromboembolic (blood clotting) complications than vaginal delivery.
- Caesarean delivery is associated with a higher risk that the placenta will attach to the uterus abnormally in subsequent pregnancies, which can lead to serious complications.
- Cutting the uterus to deliver the baby weakens the uterus, increasing the risk of uterine rupture in future pregnancy if you decide to have a vaginal birth. This risk is small and depends upon the type of uterine incision.

Infant risks — The overall risks to the infant are lower with C Sections however there are few risks of caesarean delivery for the infant. Temporary respiratory problems are more common after caesarean birth because the baby is not squeezed through the mother's birth canal. This reduces the reabsorption of fluid in the infant's lungs.

Potential complications — The most common complications related to caesarean delivery include infection, hemorrhage (excessive bleeding), injury to pelvic organs, and blood clots.

Infection — The risk of postoperative uterine infection (endometritis) varies according to several factors, such as whether labour had started and whether the water was broken. Endometritis is treated with antibiotics. Wound infection, if it occurs, usually develops four to seven days after surgery, but sometimes appears during the first day or two. In addition to antibiotics, wound infections are sometimes treated by opening the wound to allow drainage, cleansing with fluids, and removing infected tissue if needed.

Hemorrhage — One to two percent of all women having caesarean deliveries require a blood transfusion because of hemorrhage (excessive bleeding). Hemorrhage usually responds to medications that cause the uterus to contract or procedures to stop the bleeding. In rare cases, when all other measures fail to stop bleeding, a hysterectomy (surgical removal of the uterus) may be required.

Injury to pelvic organs — Injuries to the bladder or intestinal tract occur in approximately one percent of caesarean deliveries.

Blood clots — Women are at increased risk of developing blood clots in the legs (deep vein thrombosis or DVT) or the lungs (pulmonary embolus) during pregnancy and the postpartum period. This risk is further increased after caesarean delivery. The risk can be reduced by using a device that gently squeezes the legs during and after surgery, called an intermittent compression device. Women at high risk of DVT may be given an anticoagulant (blood thinning) medication to reduce the risk of blood clots.

Maternal request for caesarean delivery — The concept of requesting a caesarean delivery is relatively recent. In most Western countries, pregnant women have the right to make choices regarding treatment, including how they will deliver their child. A woman who wants to request a caesarean delivery should discuss this decision with her healthcare provider. He or she can provide information about each method of delivery and can help to relieve common fears about pain, the expected process of labour, as well as the woman's right to determine how she will deliver. The woman should also discuss the risks and benefits of maternal request caesarean delivery; in general, the risks are the same as those of a planned caesarean delivery. The woman should also discuss the possible need for a caesarean delivery with future pregnancies. Regardless of a woman's decision, it is possible to reconsider the decision at any time based upon a change in circumstances.

Emergency caesarean delivery — In some cases, caesarean delivery is performed as an emergency surgery, after attempting a vaginal delivery. Time may be of the essence, depending upon the situation. Caesarean deliveries performed due to concerns about the mother's or infant's health is started as quickly as possible. In contrast, if a caesarean is performed because labour has not progressed normally or for other, less serious concerns about the baby's wellbeing, the surgery is usually begun within 30 to 60 minutes.

If an epidural was placed before the attempted vaginal delivery, it can be used to administer anesthesia for the caesarean delivery (a larger dose is necessary for caesarean delivery versus vaginal delivery). Otherwise, spinal anesthesia (or rarely general anesthesia) is given.

Procedure — A woman may be given an oral dose of an antacid to reduce the acidity of the stomach contents. An intravenous line will be placed into the hand or arm, and an electrolyte solution will be infused. Monitors will be placed to keep track of blood pressure, heart rate, and blood oxygen levels.

Anesthesia — The woman is usually accompanied to an operating room before anesthesia is administered. A spouse or partner can usually stay with the woman in the operating room. There are two types of anesthesia used during caesarean delivery: regional and less commonly, general. For a planned caesarean delivery, regional anesthesia is usually performed. Meeting with the anesthetist allows the woman to ask specific questions about anesthesia, and allows the anesthesist to identify any medical problems that might affect the type of anesthesia that is recommended.

With epidural and spinal anesthesia, the anesthetic is injected near the spine, which numbs the abdomen and legs to allow the surgery to be pain-free while allowing the mother to be awake. General anesthesia induces unconsciousness. This means that the mother will not be awake or aware during the procedure. After the anesthesia is given, the woman will fall asleep within 10 to 20 seconds and a tube will be placed in the throat to assist with breathing. General anesthesia carries a greater risk of complications than epidural or regional anesthesia because of the need for an endotracheal (breathing) tube and because drugs given to the mother affect the infant.

Women who have general anesthesia will not be awake during the caesarean delivery. Regional anesthesia is generally preferred because it allows the mother to remain awake during the procedure, enjoy support from staff and a family member, experience the birth, and have immediate contact with the infant. It is usually safer than general anesthesia. After the anesthesia is given, a catheter is placed in the bladder to allow urine to drain out during the surgery and reduce the chance of injury to the bladder. The catheter is usually removed within 24 hours after the procedure.

Skin incision — There are two basic types of incision: horizontal (transverse or "bikini line") and vertical (midline). Most women have a transverse skin incision, which is made 1 to 2 inches above the pubic hair line. The advantages of this type of incision include less postoperative pain, more rapid healing, and a lower chance that the wound will separate during healing.

Less commonly, the woman will have a vertical ("up and down") skin incision in the midline of the abdomen. The advantages of this type of incision include rapid access to the uterus (eg, if the baby is in distress or if the woman is bleeding excessively).

Uterine incision — The uterine incision can also be either transverse or vertical. The type of incision depends upon several factors, including the position and size of the fetus, the location of the placenta, and the presence of fibroids. The main consideration is that the incision must be large enough to allow delivery of the fetus without causing trauma. The most common uterine incision is transverse. However, a vertical incision may be required if the baby is breech or sideways, if the placenta is in the lower front of the uterus, or if there are other abnormalities of the uterus. After opening the uterus, the baby is usually removed within seconds. After the baby is delivered, the umbilical cord is clamped and cut and the placenta is removed. The uterus is then closed. The abdominal skin is closed with either metal staples or re-absorbable sutures. After the mother and baby are stable, she or her partner may hold the baby.

Postoperative care — After surgery is completed, the woman will be monitored in a recovery area. Pain medication is given, initially through the IV line, and later with oral medications. When the effects of anesthesia have worn off, generally within one to three hours after surgery, the woman is transferred to a postpartum room and encouraged to move around and begin to drink fluids and eat food. Breastfeeding can usually begin anytime after the birth. A pediatrician will examine the baby within the first 24 hours of the delivery. Most women are able to go home within three to four days after delivery.

Skin sutures are usually removed within five to seven days of delivery, while re-absorbable sutures are absorbed by the body and do not need to be removed. The abdominal incision will heal over the next few weeks. During this time, there may be mild cramping, light bleeding or vaginal discharge, incisional pain, and numbness in the skin around the incision site. Most women will feel well by six weeks postpartum, but numbness around the incision and occasional aches and pains can last for several months.

Future deliveries — Previously, obstetricians recommended that all women who had a caesarean delivery have the same for all future deliveries. However, this is no longer the case. Most women in the United Kingdom who have had one low transverse caesarean delivery choose to have a repeat caesarean delivery, although these women could try to have a vaginal delivery with the next pregnancy. Between 60 and 80 percent of women who try to deliver vaginally after a c-section are successful in delivering vaginally. However, women who have a vaginal birth after caesarean (VBAC) have a less than 1 percent chance that the uterus will rupture during delivery, which could affect the baby's health.

When to call me:

It is useful to set up a protocol for emergency with me before an emergency strikes. If we have not made a plan and you are experiencing a symptom that requires immediate medical attention, try: If it is out of daytime hours first call the midwife on the Kensington Wing (020 8746 5945/5944). If she is not available and does not call back within a few minutes, call again and leave a message explaining your problem is. If you are less than 20 weeks gestation then go directly to the nearest casualty department or dial 999.

When you report any of the following, be sure to mention any other symptoms you may be experiencing, no matter how unrelated they may seem to the immediate problem. Also be specific, mentioning when you first noticed each symptom, how frequently it recurs, what seems to relieve or exacerbate it and how severe it is.

Call immediately for any of the following:

- Severe lower abdominal pain, on one or both sides, that doesn't subside and is accompanied by bleeding or nausea and vomiting.
- Severe upper mid-abdominal pain, with/without nausea, and swelling of hands and face.
- Heavy vaginal bleeding (especially when combined with abdominal or back pain).
- Coughing up of blood.
- Pain on breathing/ chest pain.
- A gush or steady leaking of fluid from the vagina.
- A sudden increase in thirst, accompanied by reduced or no urination at all for an entire day.
- Painful or burning urination, if accompanied by chills and fever over 38.9°C and/or backache.
- Very sudden and severe swelling or puffiness of hands, face, and eyes, accompanied by headache vision difficulties or sudden significant weight gain (more than 900g) not related to overeating.
- Vision disturbances (blurring, dimming, double vision) that persists to two hours or more.
- Extremely severe vomiting accompanied by pain and/or fever.
- Frequent diarrhoea (more than three times/ day), particularly if bloody or mucousy.
- Fewer than two fetal movements per hour after 28 weeks.

Call the same day (or next morning, if in the middle of the night) for the following:

- Severe lower abdominal pain, on one or both sides, that doesn't subside.
- Vaginal spotting (though slight staining a week to ten days after conception or light pink spotting after intercourse in late pregnancy is not usually a cause for concern).
- Bleeding from nipples or rectum, or blood in your urine.
- Swelling or puffiness of hands, face and eyes.
- Severe headache that persists for more than two or three hours.
- Sudden weight gain of more than 900g not related to overeating.
- Painful or burning urination.
- Fainting or dizziness.
- Chills and fever over 37.8°C (in the absence of cold or flu symptoms), call the same day; fever over 38.9°C, call right away. (Either way, start bringing down any fever over 37.8°C promptly by taking Paracetamol).
- Severe nausea and vomiting; vomiting more often than two or three times a day in the first trimester; vomiting later in pregnancy when you didn't earlier.
- All over itching, with or without dark urine, pale stools or jaundice (yellowing of skin and whites of eyes).
- Absence of fetal movements for more than twenty four hours after the 20 weeks.

Mr. Shane Duffy

MB BS DTM&H MSc MRCOG

Shane is a Consultant Obstetrician and Gynaecologist at Chelsea and Westminster Hospital in London. His specialist areas are advanced labour ward practice, female pelvic floor dysfunction and postgraduate education in obstetrics and gynaecology. He provides a continuum of care for uncomplicated pregnancies and pregnancies that develop complications early on or in labour.

In addition to his responsibilities at Chelsea and Westminster Hospital, Shane is involved in a variety of education and charitable initiatives:

- Shane is a faculty lead for surgical and emergency obstetric workshops both nationally and internationally. He runs a bi-annual training course for the College of Surgeons and the Royal College of Obstetricians and Gynaecologists (RCOG) for all UK Med Registered Trauma Doctors which helps doctors operate more effectively in austere environments.

- Shane is the Clinical Director of New Futures, a life-saving initiative created by Chelsea and Westminster's maternity team and the hospital's charity, CW+. New Futures aims to make childbirth safe for women and babies regardless of where they live. New Futures delivers training courses in Africa to help healthcare workers manage obstetric emergencies more effectively, and treats women in Uganda who suffer from obstetric fistula, a hole in the birth canal caused by obstructed childbirth which results in constant incontinence and social segregation. More information about Shane's work with New Futures is available at http://www.cwplus.org.uk/newfutures

- Shane is an independent advisor to the Secretary of State for Health in the U.K. through the Independent Reconfiguration Panel.

Shane was previously Chair of the RCOG Global Collaboration Committee and the RCOG Global Project Implementation Committee. He founded Maternity Worldwide, a charity dedicated to preventing death in childbirth.

Shane qualified with a Bachelor of Medicine, Bachelor of Surgery (distinction) from Guys and St Thomas Hospitals, University of London. He went on to gain two diplomas (2001, 2002), Master of Science (2001), and is a Fellow of the Royal College of Obstetricians and Gynaecologists (2013).

Shane believes that women and families should be at the heart of maternity care and promotes choice in pregnancy and childbirth to provide the safest and most satisfying experience for you and your baby. Shane is currently accepting private patients and also undertakes women's wellness check-ups. For further information, please contact Shane's Secretary, Marlene, on 07774 272441 or at secretary@chelseagynaecology.co.uk