# THE HOME STRETCH OF PREGNANCY

## PREPARING FOR DELIVERY

Dr. Christy Capet
Nurse Line: 512-533-4121
Emergency Line: 512-323-5465

# AM I IN LABOR?

- Follow the 5-1-1 Rule:
  - Contractions every 5 minutes
  - Lasting 1 minute in duration
  - For 1 hour
- If your water breaks call the nurse line and go to triage

# KICK COUNT REMINDERS

*Healthy babies move many times a day.*
*Active babies are healthy babies!*
*Start kick counts at 28 weeks.*

**How to do kick counts:**

- Try just after you eat. Your baby is most active then.
- Sit, or lie down on your left side.
- Check what time you start.
- Put your hands on your belly.
- Count how many times your baby moves.
- A "move" is any kick, wiggle, twist, turn, roll, or stretch.
- Count up to 10 movements
- If your baby moves 10 times in the first hour stop counting.

**If your baby doesn't move 10 times in the first hour, don't worry.**

- Your baby may be sleeping. Here's what you can do:
  - Eat or drink something.
  - Walk around for 5 minutes.
  - Repeat kick counts for another hour.

**Call your medical provider right away if:**

- You do not get **ANY** movements in the first hour.
- You do not feel 10 movements in the second hour.

# FMLA PAPERWORK

In order to have your FMLA paperwork filled out correctly and on time please ask at your appointment for the form to turn in with your HR paperwork.

We send all FMLA paperwork to a third party called HealthMark. The estimated turn around time will be 24-72 hours. There is a $25 processing fee paid directly to them. If you would like to inquire on the status of your forms please call (972) 895-2138 or e-mail fmla@healthmark-group.com

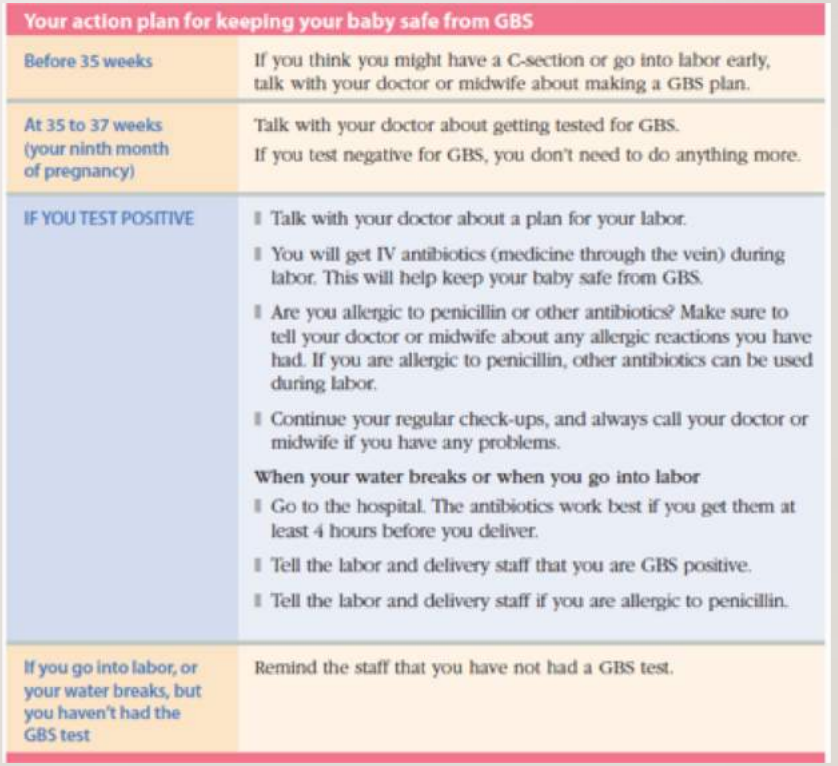
**** Please note: We cannot put you on short term disability prior to delivery without a complication. Your human resources will decline this leave and revoke your pay.

# 36 WEEKS: GROUP B STREP TESTING

GBS is a bacteria that can be found in the vagina. It is not concerning for your health, but it is the leading cause of meningitis in newborns. 4-6% of newborns who develop GBS disease will die.

We will test the presence of GBS with a swab at your 36 week appointment.

For more information visit: https://www.cdc.gov/groupbstrep/



| Your action plan for keeping your baby safe from GBS | |
|---|---|
| Before 35 weeks | If you think you might have a C-section or go into labor early, talk with your doctor or midwife about making a GBS plan. |
| At 35 to 37 weeks (your ninth month of pregnancy) | Talk with your doctor about getting tested for GBS.<br>If you test negative for GBS, you don't need to do anything more. |
| IF YOU TEST POSITIVE | ▮ Talk with your doctor about a plan for your labor.<br>▮ You will get IV antibiotics (medicine through the vein) during labor. This will help keep your baby safe from GBS.<br>▮ Are you allergic to penicillin or other antibiotics? Make sure to tell your doctor or midwife about any allergic reactions you have had. If you are allergic to penicillin, other antibiotics can be used during labor.<br>▮ Continue your regular check-ups, and always call your doctor or midwife if you have any problems.<br>**When your water breaks or when you go into labor**<br>▮ Go to the hospital. The antibiotics work best if you get them at least 4 hours before you deliver.<br>▮ Tell the labor and delivery staff that you are GBS positive.<br>▮ Tell the labor and delivery staff if you are allergic to penicillin. |
| If you go into labor, or your water breaks, but you haven't had the GBS test | Remind the staff that you have not had a GBS test. |

# GET VACCINATED AND GET OTHERS VACCINATED

- With every pregnancy women should get the Tdap vaccine to help pass pertussis antibodies to the fetus and to prevent themselves from getting sick and infecting their baby after delivery.
- Families and caregivers that may be in close contact with your baby before they can be fully vaccinated should also get the Tdap vaccine if they have not had it within the last 4 years.
- All patients should be vaccinated for FLU annually between October and March.
- The only vaccine babies get in the hospital is the Hepatitis B vaccine. You will be asked to sign a consent on admission to the hospital. Please talk to your pediatrician and know prior to admission if you do not desire the Hepatitis B series.

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Society for Maternal-Fetal Medicine

# Frequently Asked Questions for Pregnant Women 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 gasp for air. In newborns (birth to 1 month), pertussis can be life threatening. Recent outbreaks have shown that infants younger than 3 months are at very high risk of severe infection.

### What is Tdap?

The tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) vaccine is used to prevent three infections: 1) tetanus, 2) diphtheria, and 3) pertussis.

### I am pregnant. Should I get a Tdap shot?

Yes. All pregnant women should get a Tdap shot in the third trimester, preferably between 27 weeks and 36 weeks of pregnancy. The Tdap shot is an effective and safe way to protect you and your baby from serious illness and complications of pertussis. You should get a Tdap shot during each pregnancy.

### Is it safe to get 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 shot is safe when given to pregnant women.

### During which trimester is it safe to get a Tdap shot?

It is safe to get the Tdap shot during all three trimesters of pregnancy. Experts recommend that you get Tdap during the third trimester (preferably between 27 weeks and 36 weeks of pregnancy). This gives your newborn the most protection. The shot causes you to make antibodies against pertussis. These antibodies are passed to the fetus. They protect your newborn until he or she begins to get vaccines against pertussis at 2 months of age.

### Can newborns be vaccinated against pertussis?

No. Newborns cannot start their vaccine series against pertussis until they are 2 months of age because the vaccine does not work in the first few weeks of life. This is partly why newborns are at a higher risk of getting pertussis and becoming very ill.

### 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 also is important that all family members and caregivers are up-to-date with their vaccines. If they need the Tdap shot, they should get it at least 2 weeks before having contact with your newborn. This makes a safety "cocoon" of vaccinated caregivers around your baby.

*(see reverse)*

### I am breastfeeding my baby. Is it safe to get the Tdap vaccine?

Yes. The Tdap shot can safely be given to breastfeeding women if they did not get the Tdap shot during pregnancy and have never received the Tdap shot before.

### I did not get my Tdap shot during pregnancy. Do I still need to get the vaccine?

If you have never gotten the Tdap vaccine and you do not get the shot during pregnancy, be sure to get the vaccine right after you give birth, before you leave the hospital or birthing center. It will take about 2 weeks for your body to make protective antibodies in response to the vaccine. Once these antibodies are made, you are less likely to give pertussis to your newborn. But remember, your baby still will be at risk of catching whooping cough from others.

### I got a Tdap shot during a past pregnancy. Do I need to get the shot again during this pregnancy?

Yes. All pregnant women should get a Tdap shot during each pregnancy, preferably between 27 weeks and 36 weeks of pregnancy. This time frame is recommended because it gives the most protection to the pregnant woman and the fetus. It appears to maximize the antibodies present in the newborn at birth.

### I received a Tdap shot early in this pregnancy, before 27–36 weeks of pregnancy. Do I need to get another Tdap shot between 27 weeks and 36 weeks of pregnancy?

A pregnant woman does not need to get the Tdap shot later in the same pregnancy if she got the shot in the first or second trimester.

### Can I get the Tdap vaccine and flu vaccine at the same time?

Yes. You can get more than one vaccine in the same visit.

### What is the difference between Tdap, Td, and DTaP?

Children receive the diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. Teenagers and adults are given the Tdap vaccine as a booster to the DTaP they got as children. Adults receive the tetanus and diphtheria (Td) vaccine every 10 years to protect against tetanus and diphtheria. Td does not protect against pertussis.

Uppercase letters in these abbreviations mean full-strength doses of diphtheria (D) and tetanus (T) toxoids and pertussis (P) are used in the vaccine. Lowercase "d" and "p" mean reduced doses of diphtheria and pertussis are used in the vaccines for teenagers and adults. The "a" in DTaP and Tdap stands for "acellular," meaning that the pertussis component contains only a part of the pertussis organism.

### RESOURCES

American College of Obstetricians and Gynecologists
www.acog.org

Immunization for Women
www.immunizationforwomen.org

Centers for Disease Control and Prevention
http://www.cdc.gov/vaccines/vpd-vac/tetanus/default.htm

Society for Maternal–Fetal Medicine
www.smfm.org



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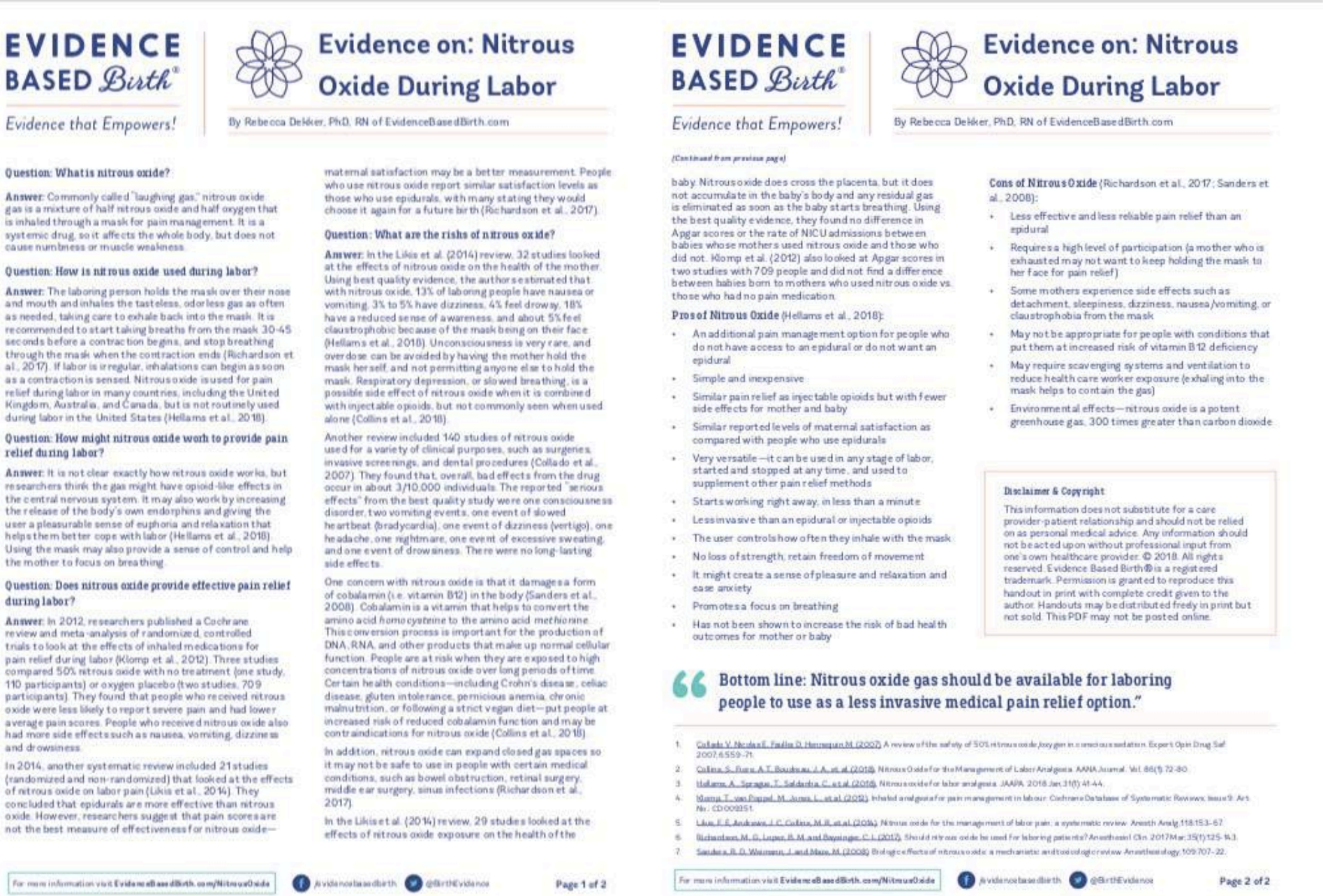
# EPIDURALS FOR PAIN RELIEF IN LABOR

- Epidural anesthesia is *regional anesthesia* that blocks pain in a particular region of the body. The goal of an epidural is to provide *analgesia*, or pain *relief*, rather than *anesthesia,* which leads to a total lack of feeling. Epidurals block the nerve impulses from the lower spinal segments. This results in decreased sensation in the lower half of the body.

| Risks | Benefits |
|---|---|
| May cause drop in blood pressure | Allows rest and relaxation |
| <1% experience severe headache | Alert, active participant in birth |
| May slow labor progression | Pain relief with minimal side effects |

# NITROUS FOR PAIN RELIEF

ST. DAVID'S NORTH AUSTIN NOW OFFERS NITROUS OXIDE FOR PAIN RELIEF IN LABOR.



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## Evidence on: Nitrous Oxide During Labor

By Rebecca Dekker, PhD, RN of EvidenceBasedBirth.com

**Question: What is nitrous oxide?**

**Answer:** Commonly called "laughing gas," nitrous oxide gas is a mixture of half nitrous oxide and half oxygen that is inhaled through a mask for pain management. It is a systemic drug, so it affects the whole body, but does not cause numbness or muscle weakness.

**Question: How is nitrous oxide used during labor?**

**Answer:** The laboring person holds the mask over their nose and mouth and inhales the tasteless, odorless gas as often as needed, taking care to exhale back into the mask. It is recommended to start taking breaths from the mask 30-45 seconds before a contraction begins, and stop breathing through the mask when the contraction ends (Richardson et al., 2017). If labor is irregular, inhalations can begin as soon as a contraction is sensed. Nitrous oxide is used for pain relief during labor in many countries, including the United Kingdom, Australia, and Canada, but is not routinely used during labor in the United States (Hellams et al., 2018).

**Question: How might nitrous oxide work to provide pain relief during labor?**

**Answer:** It is not clear exactly how nitrous oxide works, but researchers think the gas might have opioid-like effects in the central nervous system. It may also work by increasing the release of the body's own endorphins and giving the user a pleasurable sense of euphoria and relaxation that helps them better cope with labor (Hellams et al., 2018). Using the mask may also provide a sense of control and help the mother to focus on breathing.

**Question: Does nitrous oxide provide effective pain relief during labor?**

**Answer:** In 2012, researchers published a Cochrane review and meta-analysis of randomized, controlled trials to look at the effects of inhaled medications for pain relief during labor (Klomp et al., 2012). Three studies compared 50% nitrous oxide with no treatment (one study, 110 participants) or oxygen placebo (two studies, 709 participants). They found that people who received nitrous oxide were less likely to report severe pain and had lower average pain scores. People who received nitrous oxide also had more side effects such as nausea, vomiting, dizziness and drowsiness.

In 2014, another systematic review included 21 studies (randomized and non-randomized) that looked at the effects of nitrous oxide on labor pain (Likis et al., 2014). They concluded that epidurals are more effective than nitrous oxide. However, researchers suggest that pain scores are not the best measure of effectiveness for nitrous oxide—maternal satisfaction may be a better measurement. People who use nitrous oxide report similar satisfaction levels as those who use epidurals, with many stating they would choose it again for a future birth (Richardson et al., 2017).

**Question: What are the risks of nitrous oxide?**

**Answer:** In the Likis et al. (2014) review, 32 studies looked at the effects of nitrous oxide on the health of the mother. Using best quality evidence, the authors estimated that with nitrous oxide, 13% of laboring people have nausea or vomiting, 3% to 5% have dizziness, 4% feel drowsy, 18% have a reduced sense of awareness, and about 5% feel claustrophobic because of the mask being on their face (Hellams et al., 2018). Unconsciousness is very rare, and overdose can be avoided by having the mother hold the mask herself and not permitting anyone else to hold the mask. Respiratory depression, or slowed breathing, is a possible side effect of nitrous oxide when it is combined with injectable opioids, but not commonly seen when used alone (Collins et al., 2018).

Another review included 140 studies of nitrous oxide used for a variety of clinical purposes, such as surgeries, invasive screenings, and dental procedures (Collado et al., 2007). They found that, overall, bad effects from the drug occur in about 3/10,000 individuals. The reported "serious effects" from the best quality study were one consciousness disorder, two vomiting events, one event of slowed heartbeat (bradycardia), one event of dizziness (vertigo), one headache, one nightmare, one event of excessive sweating, and one event of drowsiness. There were no long-lasting side effects.

One concern with nitrous oxide is that it damages a form of cobalamin (i.e. vitamin B12) in the body (Sanders et al., 2008). Cobalamin is a vitamin that helps to convert the amino acid *homocysteine* to the amino acid *methionine*. This conversion process is important for the production of DNA, RNA, and other products that make up normal cellular function. People are at risk when they are exposed to high concentrations of nitrous oxide over long periods of time. Certain health conditions—including Crohn's disease, celiac disease, gluten intolerance, pernicious anemia, chronic malnutrition, or following a strict vegan diet—put people at increased risk of reduced cobalamin function and may be contraindications for nitrous oxide (Collins et al., 2018).

In addition, nitrous oxide can expand closed gas spaces so it may not be safe to use in people with certain medical conditions, such as bowel obstruction, retinal surgery, middle ear surgery, sinus infections (Richardson et al., 2017).

In the Likis et al. (2014) review, 29 studies looked at the effects of nitrous oxide exposure on the health of the



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*(Continued from previous page)*

baby. Nitrous oxide does cross the placenta, but it does not accumulate in the baby's body and any residual gas is eliminated as soon as the baby starts breathing. Using the best quality evidence, they found no difference in Apgar scores or the rate of NICU admissions between babies whose mothers used nitrous oxide and those who did not. Klomp et al. (2012) also looked at Apgar scores in two studies with 709 people and did not find a difference between babies born to mothers who used nitrous oxide vs. those who had no pain medication.

**Pros of Nitrous Oxide** (Hellams et al., 2018):

- An additional pain management option for people who do not have access to an epidural or do not want an epidural
- Simple and inexpensive
- Similar pain relief as injectable opioids but with fewer side effects for mother and baby
- Similar reported levels of maternal satisfaction as compared with people who use epidurals
- Very versatile—it can be used in any stage of labor, started and stopped at any time, and used to supplement other pain relief methods
- Starts working right away, in less than a minute
- Less invasive than an epidural or injectable opioids
- The user controls how often they inhale with the mask
- No loss of strength, retain freedom of movement
- It might create a sense of pleasure and relaxation and ease anxiety
- Promotes a focus on breathing
- Has not been shown to increase the risk of bad health outcomes for mother or baby

**Cons of Nitrous Oxide** (Richardson et al., 2017; Sanders et al., 2008):

- Less effective and less reliable pain relief than an epidural
- Requires a high level of participation (a mother who is exhausted may not want to keep holding the mask to her face for pain relief)
- Some mothers experience side effects such as detachment, sleepiness, dizziness, nausea/vomiting, or claustrophobia from the mask
- May not be appropriate for people with conditions that put them at increased risk of vitamin B12 deficiency
- May require scavenging systems and ventilation to reduce health care worker exposure (exhaling into the mask helps to contain the gas)
- Environmental effects—nitrous oxide is a potent greenhouse gas, 300 times greater than carbon dioxide



> **"Bottom line: Nitrous oxide gas should be available for laboring people to use as a less invasive medical pain relief option."**

1. Collado V, Nicolas E, Faulim D, Hennequin M. (2007) A review of the safety of 50% nitrous oxide/oxygen in conscious sedation. Expert Opin Drug Saf. 2007;6:559-71.
2. Collins S, Fiore A T, Boudreau J A, et al. (2018) Nitrous Oxide for the Management of Labor Analgesia. AANA Journal. Vol. 86(1): 32-80.
3. Hellams, A., Sprague, T., Saldanha, C., et al. (2018). Nitrous oxide for labor analgesia. JAAPA. 2018 Jan;31(1):41-44.
4. Klomp T, van Poppel, M, Jones, L, et al. (2012). Inhaled analgesia for pain management in labour. Cochrane Database of Systematic Reviews, Issue 9. Art. No.: CD009351.
5. Likis, F. E, Andrews, J. C, Collins, M. R, et al. (2014). Nitrous oxide for the management of labor pain: a systematic review. Anesth Analg. 118:153-67.
6. Richardson, M. G, Lopez, B. M, and Baysinger, C. L. (2017). Should nitrous oxide be used for laboring patients? Anesthesiol Clin. 2017 Mar;35(1):125-143.
7. Sanders, R. D, Weimann, J, and Maze, M. (2008). Biologic effects of nitrous oxide: a mechanistic and toxicologic review. Anesthesiology. 109:707-22.

# INDUCTION: *HOW SHOULD I PREPARE FOR MY LABOR INDUCTION?*

- Schedule your pre-admissions appointment by calling (512) 901-1542
- Eat breakfast, lunch and a light dinner on the day of the induction and keep yourself well hydrated throughout the day. You will only be allowed to drink water and have ice chips after midnight. If your induction begins in the morning you CAN eat breakfast before you arrive.
- Take a shower with an antibacterial soap such as Dial and wear freshly laundered clothes.
- Remove all jewelry and body piercings prior to admission
- Pack a small bag with comfort/essential items: toiletries, robe, camera, chargers, baby book, cord blood banking kit, Photo ID, and health insurance card.
- Your labor partner may bring other items such as, the car seat, baby and mom's going home clothes, and other things when you are on the Postpartum Unit

# INDUCTION: *METHODS USED TO INDUCE LABOR*

- Cervical ripening medications – These medications are given to soften and dilate your cervix.
  - **Cervidil®** is inserted into your vagina where it is left in place for up to 12 hours and then removed.
  - **Cytotec** is a tablet you can take orally or is placed in your vagina behind your cervix. Cervical ripening medications are typically started in the evening with Pitocin to start the next day.
- You will be encouraged to rest throughout the night as active labor will be more likely to occur the following day. There is a slight chance the cervical ripening medication may put you into active labor.
- Pitocin® – Pitocin is a man-made form of the hormone oxytocin–a natural hormone found in your body. This medicine causes your uterus to contract. It is given through an IV and the dose is slowly increased until a satisfactory labor pattern occurs. Typically, Pitocin is started the next morning after the cervical ripening medications have made your cervix soft and dilated.
- Rupture of membranes (breaking your water) – If your water has not already broken, your doctor may do this for you. Breaking your bag of water will also help start contractions. This is done with a small hook that makes a hole in the amniotic sac. Your cervix must be dilated enough to safely insert the hook, and the baby's head well applied to the cervix before this is considered and done.

# INDUCTION: *WHAT SHOULD I EXPECT UPON ADMISSION?*

- When you arrive at the hospital you will need to check in with the unit clerk on the 2nd floor. You will be brought to your room and asked to change into a gown. After you are in bed fetal monitors will be applied. You will then have your blood work drawn and an IV started in your hand or arm to administer emergency medications and intravenous hydration fluids. Delivery consents will be reviewed and signed. Your nurse will perform a cervical examination before starting any induction medications.
- You will be monitored continuously; this means you must be in bed or sitting in a chair most of the time. You will be encouraged to change positions frequently and will be allowed to get up to go to the bathroom.
- Occasionally, despite medication used for your induction, you may not go into labor. If this occurs your doctor will discuss with you options such as Cesarean section or inducing labor at a later time.

# INDUCTION: *WHAT TO EXPECT IF YOU NEED TO RESCHEDULE MY INDUCTION?*

- The hospital is not able to predict how many spontaneous labor patients or births are going to happen on any given day. Although it is rare, there may be days when they do not have enough hospital beds or staff available for patients who are scheduled for a procedure like a labor induction. Patient safety is their priority, your induction will never be delayed without your safety and your baby's safety considered first. Medically indicated inductions do take precedence over elective inductions.
- When they need to delay or cancel your induction a charge nurse and your doctor will decide on another date for your induction. We appreciate your understanding in this situation since we all want you to have a safe and healthy childbirth experience with us.

# CESAREAN SECTION PRE-OP INSTRUCTIONS

- It is **MANDATORY** that you have nothing to eat or drink at least 8 hours prior to your procedure.
- Call the hospital pre-admission nurse at (512) 901-1542 at least one week before your C/S to schedule an appointment 24-48 hours before your scheduled procedure.
  - You will check in at the desk on the ground floor in the Women's Center
  - You will sign your consent forms, answer admission questions to complete your registration in the EMR, get your admission bands, and have your admission blood work drawn.
- You should PLAN to arrive at least 2 hours prior to your scheduled surgical time as instructed.

# CESAREAN SECTION CONT.

- **The Day of Your Cesarean Section**
  - On the day of your surgery, you should:
    - Bring a case for your eyeglasses. Remove contacts prior to surgery.
    - Leave your jewelry and valuables at home, including all body piercings.
    - Bring needed items for discharge including a "going home" outfit for baby and yourself, an infant car seat and baby blankets.
    - One support person may accompany you in the Operating Room for your Cesarean Section. The nurse will provide your support person with the appropriate attire.

# FAMILY FRIENDLY CESAREAN SECTIONS

Watch your baby be born through a clear drape that still protects the sterile field for your surgery.

After delivery, a blue drape will be put up so you do not have to watch the remainder of the procedure and can have some privacy with your baby.

Breastfeed and bond with your baby in the operating room.

# DOULAS

We welcome the continuous physical and emotional support provided by doulas during labor. This article provides information for you to decide if a doula is right for you.

Popular Doula groups in Austin include ATX Doulas, Austin Doula Care, Austin Born, Austin Childbirth, and Austin Doula Collective.

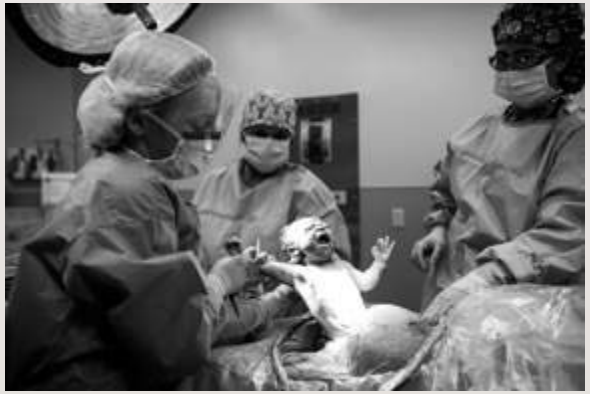
For those who have little to no support GALS and Mama Sana Vibrant Woman offer free doula services.

# BIO VIDEO

*Bio video is a hospital based photography service to capture your birth with pictures. They are only guaranteed to make your delivery if you pre-register online.*

https://www.biovideo.com/home

# BIRTH PHOTOGRAPHERS



Sarah Siller Photography

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# BIRTH PHOTOGRAPHERS


Paige Wilks Photography

http://www.paigewilks.com

# IN HOSPITAL NEWBORN PROCEDURES

*AAP News* Parent Plus

INFORMATION FROM YOUR PEDIATRICIAN

## Why you should say yes to the test: newborn procedures explained

You did everything possible to take care of your baby during pregnancy. After your delivery, routine procedures can ensure a healthy start for your newborn.

The following screenings and tests are recommended by the American Academy of Pediatrics (AAP) for all newborns. If your baby needs to be retested or rescreened after leaving the hospital, be sure to follow up promptly.

- **Vitamin K injection**: Because most babies are low in vitamin K after birth, an injection is given. The AAP has supported this routine hospital procedure since 1961 to prevent unexpected bleeding in the first week of life.
- **Eye drops**: Erythromycin drops prevent an eye infection that can lead to blindness. The infection can be spread from mother to baby in the birth canal. The drops are given to every newborn, even if the mother tested negative for a birth canal infection.
- **Heel stick**: All babies are required by their state to get tested for metabolic disorders before they leave the hospital. This is done by drawing a few drops of blood from the baby's heel. The blood is sent to a laboratory for testing that can identify babies who need medical care, sometimes before they show signs of a problem. To see what disorders are tested for in your state, visit bit.ly/1FCUqsq.
- **Pulse oximetry test**: Critical congenital heart disease affects eight of every 1,000 newborns annually. It can be detected by placing a sensor on the baby's skin to measure oxygen in the blood and heart rate. Early detection can prevent disability or death, but not all heart defects are found through screening. For more information, visit http://1.usa.gov/1BOpEHh.
- **Hepatitis B vaccine**: All newborns should get the first dose of this vaccine before they leave the hospital. It protects against a contagious liver disease that can cause lifelong illness. Mothers can spread the virus to babies at birth. Thanks to the vaccine, the number of people with chronic disease has decreased by 82% since 1991.
- **Hearing screening**: Two to three children out of every 1,000 are born deaf or hard of hearing. The hospital can test your baby's hearing using one of two methods. Otoacoustic emissions testing involves placing a small probe in the ear to measure how the auditory inner ear responds to the sounds. Auditory brainstem response testing involves putting probes on the baby's scalp to measure brain waves' response to sounds. Getting help early for hearing-impaired children is important.

  Find resources at http://bit.ly/1lzoghz.

*— Trisha Korioth*

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# Evidence and Ethics on: Circumcision

By Rebecca Dekker, PhD, RN of EvidenceBasedBirth.com

**Question: What is circumcision?**

**Answer:** Male circumcision is the surgical removal of the foreskin (also called *prepuce*), which is specialized tissue that covers the head (or *glans*) of the penis.

**Question: How common is circumcision?**

**Answer:** About 30-33% of the world's males 15 years or older are circumcised. Of these circumcised males, about 69% are Muslim, 1% are Jewish, and 30% are circumcised for non-religious reasons.[1] The U.S., where 71% of men are circumcised, is unusual in its preference for non-religious circumcision. However, the rate of newborn circumcision is going down. When last reported in 2010, 58% of male newborns were circumcised before hospital discharge, and 42% were not.[2] The Western states have the lowest rate of circumcision, with a low of 31% in 2003.

**Question: How does the penis develop?**

**Answer:** Newborn males are normally born with their prepuce fused to their glans by a membrane, making it so that the prepuce cannot be *retracted*, or pulled back from the glans. Babies who are left intact (uncircumcised) should never have their prepuce retracted or pulled back toward their abdomen by force (e.g., during a bath or medical check-up). Forced retraction can cause pain, tearing and bleeding. In normal penis development, the prepuce usually becomes less attached and more retractable over childhood and adolescence.

**Question: Is circumcision cleaner?**

**Answer:** Both circumcised and intact males can maintain genital hygiene with regular washing. With an intact penis, there is no need to wash beneath the prepuce until it is easily retractable. The white substance called *smegma* that builds up in folds of genital tissue is normal for males and females (where it can build up between the labia and around the female prepuce, i.e. hood of the clitoris) and can be wiped away with washing. Once males discover (on their own) that the prepuce can be pulled back, they can be taught to clean the glans with water as part of a regular bathing or showering routine.

**Question: What is the evidence on circumcision?**

**Answer:** The research on newborn circumcision is extremely limited. Any research involving routine newborn circumcision comes from observational studies, not from randomized, controlled trials. Also, much of the research on circumcision comes from studies on males who were circumcised as adults, sometimes in Sub-Saharan African locations where there is a higher risk for certain infections.

There are serious concerns about how relevant this research is to newborns in other countries. Most of the evidence on newborn circumcision is highly disputed and any recommendations for practice are mostly weak.

Circumcised newborns may experience fewer urinary tract infections (UTIs). A review found that under 1 year of age, 1.38% of intact males had a UTI versus 0.14% of circumcised males.[3] About 111 circumcisions would be needed to prevent a single (treatable) UTI in infancy. Overall, UTIs occur more often in females. About 8% of girls and 2% of intact boys have had a UTI before age 7.

The rate of early complications after newborn circumcision is around 2%.[4] The most common complications are bleeding, swelling, and cosmetic concerns following the procedure that may lead to reoperation. Circumcision is also a very painful procedure that requires pain treatment.

**Question: What is the ethical debate around routine male infant circumcision?**

**Answer:** The debate centers on whether the practice respects or violates the principle of *autonomy*, or bodily integrity, of the male infant. For more info on the ethical debate, see page 2 of this handout.



> **"There is no compelling evidence to justify routine male infant circumcision on medical grounds."**

1. WHO and Joint UN Programme on HIV/AIDS (2007). Male circumcision: global trends and determinants of prevalence, safety and acceptability.
2. Owings, M., Uddin, S. and Williams, S. (2013). Trends in circumcision for male newborns in U.S. hospitals: 1979-2010.
3. Singh-Grewal, D., Macdessi, J. and Craig, J. (2005). Circumcision for the prevention of urinary tract infection in boys: a systematic review of randomised trials and observational studies. Arch Dis Child, 90(8), 853-858.
4. Weiss, H.A., Larke, N., Halperin, D., et al. (2010). Complications of circumcision in male neonates, infants and children: a systematic review. BMC Urol, 10, 2.



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Evidence and Ethics on: Circumcision

By Rebecca Dekker, PhD, RN of EvidenceBasedBirth.com

**Ethical Debate:**

In addition to the medical evidence on circumcision, we also examined the research on 'Circumcision' and 'Ethics' published within the last 10 years.

We found 21 articles that discussed routine male infant circumcision, and we grouped them according to whether the author's viewpoint suggested they found the practice to be unethical or ethically justified. Of these, 13 papers portrayed routine male infant circumcision as unethical, 5 papers made the case that it is ethically justified, and 3 papers discussed both viewpoints.

We summarize the main points from these papers below to show their diverse views on circumcision and ethics:

| View That Routine Male Infant Circumcision Is Not Ethical | View That Routine Male Infant Circumcision Is Ethical |
|---|---|
| • It is irreversible surgery on healthy minors who cannot give consent<br>• It causes pain and trauma during the surgery and suffering as the wound heals<br>• There are both immediate post-surgical risks, as well as unknown risks beyond the immediate post-surgical period, which together may outweigh the benefits<br>• It deprives the male of tissue that protects the glans and urinary opening<br>• It reduces the sensitivity of the penis by removing sensitive tissue<br>• There are less invasive and more effective preventions and treatments for many conditions it addresses (for example, condoms for HIV prevention and oral antibiotics to treat UTIs)<br>• New proposals to remove tissue from healthy infants would never get approval<br>• There is a *double standard* — a rule that is unfairly applied to one group but not another<br>  ○ Society would likely consider it unethical to remove healthy tissue from female infants' genitals even if there was evidence of health benefits<br>  ○ Every type of female genital cutting is recognized internationally as a violation, even when it does not remove any tissue (i.e. a ritual "prick")<br>  ○ We should "protect all non-consenting persons, regardless of sex or gender, from medically unnecessary genital cutting" | • This view argues that it leads to significant medical and public health benefits over a lifetime<br>• Its (known) benefits outweigh its (known) harms<br>• Injection of local anesthetic to the base of the penis is safe and effective at reducing pain<br>• Autonomy is respected by allowing parents to decide in the best interests of their child<br>• Parents should be allowed to decide in the best interests of their child<br>• We live in a diverse society that must be tolerant of families who elect the procedure for cosmetic preference or family tradition/belonging<br>• Delaying the option until the age of consent misses some of the benefits of circumcision in early life (e.g., reduction in UTIs) and results in a higher rate of complications than when done in infancy<br>• The risk of immediate complications is low (about 2% for newborns in prospective studies and 2-4% for adult males in African RCTs) |

For more information visit EvidenceBasedBirth.com/circumcision /evidencebasedbirth @ebbirth 

Circumcision is a very personal decision. If you elect to have this procedure, once cleared by the pediatrician your doctor will perform the circumcision in hospital before you go home.


# WHAT TO PACK FOR THE HOSPITAL