

The Care Plans During Pregnancy

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Estimating the expected date of delivery is one of the first important tasks in prenatal care because gestational age influences screening, diagnosis, medication decisions, fetal-growth assessment, and the timing of delivery. The original case uses a last normal menstrual period beginning on December 1, 2012. Applying Naegele's rule—adding 280 days, or 40 weeks—gives an estimated due date of September 7, 2013. That calculation is correct if the menstrual date is reliable and the person has a regular 28-day cycle with ovulation near day 14. Modern obstetric care does not rely on the menstrual date alone. First-trimester ultrasound is generally the most accurate method for confirming or revising gestational age, and the final estimated due date should be documented early and changed only in defined circumstances. (American College of Obstetricians and Gynecologists, 2025)

Understanding the Estimated Due Date

An estimated due date is not a promise that birth will occur on one day. It is the date at which pregnancy reaches 40 weeks according to the best available information. Only a minority of births occur on the exact date. The estimate creates a common timeline for interpreting tests, fetal development, preterm labor, and post-term pregnancy. The patient should understand the expected range rather than viewing one calendar date as a deadline.

Naegele's Rule

Naegele's rule can be applied by adding seven days to the first day of the last menstrual period, subtracting three months, and adding one year. For December 1, 2012, adding seven days gives December 8, subtracting three months gives September 8, and adjusting for the calendar calculation produces approximately September 7–8, 2013. Direct addition of 280 days produces September 7. Small date differences can arise from the method used, leap years, and counting conventions. Electronic calculators reduce arithmetic error but do not determine whether the menstrual history is biologically reliable.

Assumptions Behind Menstrual Dating

Menstrual dating assumes a regular cycle of approximately 28 days and ovulation around 14 days after the first menstrual day. People with longer or shorter cycles may ovulate at different times. Irregular menstruation, recent hormonal contraception, breastfeeding, perimenopause, polycystic ovary syndrome, recent pregnancy, or uncertain recall can reduce accuracy. Light early-pregnancy bleeding may also be mistaken for menstruation. The clinician should ask how certain the date is and

whether the bleeding was normal in duration and flow.

Ultrasound Confirmation

First-trimester ultrasound measurement of crown-rump length provides the most accurate sonographic estimate of gestational age. Later ultrasound becomes less precise for dating because normal fetal-size variation increases. When the menstrual estimate and early ultrasound differ beyond accepted thresholds, clinical guidance indicates when the ultrasound date should replace the menstrual date. After a final due date is established, repeated changes based on later size measurements can misclassify growth problems as dating errors.

Suboptimally Dated Pregnancy

A pregnancy without an ultrasound that confirms or revises the estimated due date before 22 weeks is considered suboptimally dated under ACOG guidance. This does not mean the pregnancy is abnormal. It means uncertainty must be considered when planning antenatal testing or delivery. Elective delivery should not be scheduled using uncertain dating, and clinicians may need additional surveillance based on the best clinical estimate.

Preconception Care

Healthy pregnancy planning ideally begins before conception. Preconception care reviews chronic conditions, medication safety, immunization, nutrition, reproductive history, family history, substance exposure, occupational hazards, mental health, and social needs. The original essay suggests that preconception planning can avoid “disastrous genetic combinations.” This wording is inaccurate and stigmatizing. Genetic counseling can clarify inherited risks and reproductive options, but most conditions are not preventable through a simple compatibility test, and people with genetic conditions should not be described as undesirable combinations.

Folic Acid

Folic acid before conception and during early pregnancy reduces the risk of neural-tube defects. The appropriate dose depends on individual risk, prior pregnancy history, medication, and clinical guidance. Because the neural tube closes early, starting after pregnancy is recognized may miss part of the preventive window. Prenatal vitamins can support intake, but more is not always better. Supplements should be reviewed to avoid excessive doses or ingredients unsafe in pregnancy.

Medication Review

Prescription medicines, over-the-counter products, supplements, and herbal remedies should be reviewed. A patient should not stop a necessary medication abruptly without professional advice, because uncontrolled epilepsy, hypertension, diabetes, depression, or another condition may be more dangerous than the treatment. The clinician evaluates evidence, timing, dose, alternatives, and maternal-fetal benefit. “Natural” products are not automatically safe, and limited pregnancy data should be acknowledged.

First Prenatal Visit

The first visit usually includes confirmation of pregnancy, dating, full medical and obstetric history, physical assessment as appropriate, and discussion of the care plan. History includes prior pregnancies, cesarean birth, preterm birth, pregnancy loss, infertility, chronic illness, surgery, medication, allergies, family history, mental health, and social conditions. The clinician should ask about safety, housing, food, work, transportation, and support because these factors influence outcomes and access to care.

Sexual History

A sexual history may be clinically relevant for infection screening, pregnancy context, contraception, pain, coercion, and sexual wellbeing. The original essay suggests asking whether the patient had sexual contact “during the time” to confirm dating, but conception timing is not established reliably by interrogation about one encounter. Sperm can survive for several days, ovulation timing varies, and patients may not know exact dates. Questions should be explained, confidential, nonjudgmental, and limited to legitimate clinical purpose.

Initial Laboratory Evaluation

Initial prenatal testing commonly includes blood type and Rh status, antibody screening, complete blood count, and screening for selected infections according to current guidelines and individual risk. Testing may include HIV, syphilis, hepatitis B, hepatitis C, and other infections. Urine testing can identify asymptomatic bacteriuria. Rubella and varicella immunity may be assessed because live vaccines are not given during pregnancy but can be offered afterward when indicated. Exact panels vary by jurisdiction and patient. (American College of Obstetricians and Gynecologists, 2026)

Syphilis Screening

Syphilis can cause severe fetal and neonatal harm and is treatable during pregnancy. Modern testing commonly uses treponemal and nontreponemal assays according to laboratory algorithms rather than relying on the historical VDRL test alone. Screening is recommended early, with repeat testing later for people or communities at increased risk and according to law or guidance. A positive screening result requires confirmation and timely treatment, usually with penicillin when syphilis is diagnosed in pregnancy.

HIV and Hepatitis

Early HIV testing allows treatment that protects the patient's health and greatly reduces perinatal transmission. Hepatitis B screening identifies the need for newborn prophylaxis and maternal management, while hepatitis C screening can identify infection requiring follow-up and infant testing. Consent and counseling should be respectful. A diagnosis should never be used as a reason to deny prenatal care.

Genetic Screening and Diagnostic Testing

Prenatal genetic screening estimates the chance of selected chromosomal conditions; diagnostic testing such as chorionic villus sampling or amniocentesis can provide more definitive information but carries procedure considerations. Screening is not a diagnosis, and a positive result requires counseling and follow-up. Options should be offered without coercion and should reflect the patient's values. Carrier screening may be considered before or during pregnancy.

First-Trimester Care

Early visits address nausea, vomiting, nutrition, bleeding, medication, and warning signs. Severe vomiting with dehydration or weight loss needs evaluation. Vaginal bleeding can have several causes and does not always indicate pregnancy loss, but heavy bleeding, severe pain, dizziness, or fainting requires urgent assessment. Ectopic pregnancy must be considered when symptoms and dating are concerning. Early care also establishes a schedule for ongoing visits.

Nutrition

Pregnancy increases nutritional needs, but the advice to "eat for two" can be misleading. A balanced pattern includes protein, vegetables, fruit, whole grains, dairy or alternatives, healthy fats, and sufficient fluids. Iron, folate, iodine, calcium, vitamin D, and other nutrients may need attention.

Weight-gain recommendations depend on prepregnancy body mass index and individual health. Counseling should avoid stigma and recognize food access, nausea, culture, allergies, and eating disorders. (World Health Organization, 2016)

Food Safety

Pregnant patients should avoid unpasteurized milk and unsafe products, raw or undercooked meat and eggs, high-risk refrigerated foods according to public-health guidance, and fish with high mercury levels. Produce should be washed, raw and ready-to-eat foods separated, and leftovers refrigerated promptly. Fish also provides valuable nutrients, so guidance should identify safer choices rather than recommend avoiding all seafood. Listeria, toxoplasmosis, and other infections can have serious pregnancy effects.

Alcohol, Tobacco, and Other Substances

No known safe amount or timing of alcohol use in pregnancy has been established. Tobacco and nicotine exposure increase risks, while cannabis, cocaine, opioids, and other substances can affect pregnancy and care. Screening should be confidential and nonpunitive so patients are willing to disclose use. Treatment and harm-reduction services should be offered. Abrupt withdrawal from some substances, especially alcohol or benzodiazepines, can be medically dangerous and requires professional management.

Physical Activity

Most healthy pregnant people can continue or begin appropriate moderate physical activity, adjusted for fitness, symptoms, and obstetric conditions. Exercise can support cardiovascular health, mood, sleep, and function. Activities with high fall, collision, heat, or decompression risk may be unsuitable. Warning signs such as bleeding, fluid leakage, chest pain, severe shortness of breath, or painful contractions require stopping and seeking advice.

Vaccination

Vaccines protect the pregnant patient and infant. Recommendations commonly include inactivated influenza vaccine during influenza season and Tdap during each pregnancy at the advised gestational period to improve newborn pertussis protection. COVID-19 and other vaccine guidance should follow current recommendations and individual circumstances. Live vaccines are generally avoided during pregnancy and may be given before conception or postpartum. Vaccine questions deserve evidence-based discussion rather than dismissal. (Centers for Disease Control and Prevention, 2026)

Blood Pressure and Preeclampsia

Blood pressure is measured throughout pregnancy. Preeclampsia can involve hypertension and signs of organ dysfunction and may occur with symptoms such as severe headache, visual changes, upper abdominal pain, sudden swelling, or shortness of breath. Some patients have few symptoms, making routine measurement important. Low-dose aspirin may be recommended for defined high-risk individuals, but it should not be started without clinical guidance.

Diabetes

Preexisting diabetes requires preconception and prenatal management because glucose levels affect maternal and fetal outcomes. Gestational-diabetes screening commonly occurs during the second trimester, with earlier evaluation for selected high-risk patients. Treatment may include nutrition, activity, monitoring, and medication. A random glucose measurement alone does not provide a complete prenatal diabetes assessment. Diagnostic methods should follow established protocols.

Second-Trimester Anatomy Ultrasound

A detailed ultrasound is commonly performed around the middle of pregnancy to evaluate fetal anatomy, placenta, fluid, and growth. It can identify many conditions but cannot detect every abnormality or predict every outcome. Findings may require repeat imaging, maternal-fetal medicine consultation, or diagnostic testing. Counseling should explain uncertainty and avoid describing ultrasound as a guarantee of a “normal” child.

Fetal Growth

Clinicians monitor uterine size and may use ultrasound when growth is uncertain or risk factors exist. A fetus measuring smaller or larger than expected can reflect growth conditions, fluid differences, parental characteristics, or dating error. Once reliable early dating is established, later size should not automatically change the due date. Growth assessment looks at trends and clinical context.

Rh Incompatibility

Rh-negative patients are evaluated for antibodies. Rh immune globulin may be given during pregnancy and after delivery or certain bleeding events when indicated to reduce sensitization. The care plan depends on blood type, antibody status, fetal or newborn type, and previous history. This is one example of how early laboratory information guides later preventive care.

Mental Health

Pregnancy can involve depression, anxiety, trauma symptoms, obsessive fears, substance concerns, or bipolar illness. Screening should occur with a system for referral and treatment. Untreated illness can affect functioning and safety, while treatment decisions require balancing benefits and risks. Asking about thoughts of self-harm or harm to the baby is necessary when warning signs occur. Emergency symptoms require immediate care.

Intimate Partner Violence

Private, respectful screening for coercion or violence can identify serious risk. The patient should be interviewed without a partner or family member present when possible. Disclosure should lead to safety-focused support, not pressure to confront or leave immediately. Documentation must protect confidentiality and follow local law. Pregnancy can be a period of increased vulnerability for some patients.

Third-Trimester Care

Later care monitors fetal growth, movement, maternal symptoms, blood pressure, and preparation for labor and newborn care. Screening for group B streptococcus is performed according to current guidance, with antibiotics during labor when indicated. Discussions include signs of labor, rupture of membranes, pain options, breastfeeding or feeding plans, contraception, transport, and support. A birth plan is a communication tool, not a contract guaranteeing one course.

Fetal Movement

Patients should learn their baby's usual movement pattern and contact the care team if movement is noticeably reduced. Formal counting methods vary. Reduced movement can be benign or a sign requiring evaluation. The patient should not delay because of fear of appearing anxious. Clear instructions improve timely care.

Urgent Warning Signs

Urgent evaluation may be needed for heavy bleeding, severe abdominal pain, fluid leakage, severe headache, vision change, chest pain, difficulty breathing, seizure, fever, persistent vomiting, painful regular contractions before term, reduced fetal movement, or thoughts of self-harm. The exact action depends on gestational age and local services. Written instructions and a contact number should be provided.

Visit Schedule and Individualization

Traditional prenatal schedules increase visit frequency as pregnancy advances, but care can be individualized according to risk, access, telehealth capability, and patient preference. High-risk pregnancies may require more visits and specialist care. Fewer routine visits should not reduce access to urgent assessment. Transportation, employment, childcare, disability, and language support affect whether a plan is realistic.

Shared Decision-Making

Prenatal care should not treat the patient as a passive container for fetal development. The pregnant person is the patient and has rights to information, consent, refusal, privacy, and respectful care. Clinicians should explain benefits, harms, alternatives, and uncertainty. Cultural values and reproductive goals matter, but emergency risk should also be communicated clearly. Trust improves adherence more effectively than shame.

Postpartum Planning

Pregnancy care should anticipate the postpartum period, including bleeding, blood pressure, wound care, mood, sleep, feeding, contraception, chronic conditions, and social support. Severe headache, breathing difficulty, chest pain, heavy bleeding, fever, or suicidal thoughts after birth require urgent attention. Follow-up should not be limited to a single visit weeks later when earlier contact is indicated.

Conclusion

Using the last normal menstrual period of December 1, 2012 produces an estimated due date of September 7, 2013 through the 280-day rule. The calculation is useful but depends on menstrual reliability and should be confirmed with early ultrasound. A strong pregnancy care plan begins with preconception health where possible and continues through individualized screening, nutrition, infection prevention, medication review, mental-health care, chronic-disease management, fetal assessment, vaccination, warning-sign education, and postpartum planning. The aim is not only to avoid congenital anomalies but to support the health, autonomy, and safety of the pregnant patient and developing fetus through evidence-based, respectful care.

References

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