HERology Transcript—The Healthy Pregnancy

[00:00:00]

Sex and Pregnancy Myths

Anu Lala: Sex during pregnancy. Yes, no?

Joanne Stone: There's some people that just really are like s- I mean, it's either the patient or the partner who are really squeamish. Like, they, they think that the fetus is gonna know what they're doing

What Makes a Healthy Pregnancy

Anu Lala: Hello and welcome back to Herology, the Mount Sinai Health System's newest video podcast. I'm your co-host, Dr. Anu Lalla, and today we're talking about pregnancy. What makes a healthy pregnancy? What symptoms are the most serious? And what are the most common things people wish they'd known following their pregnancy?

To help answer these questions and more, I'm joined by our regular co-hosts, Dr. Joanne Stone and Dr. Ana Barbieri. Welcome. All right. Well, I'm so excited to be here with you both. We're gonna be talking about the healthy pregnancy. I have so many questions for you both. As a measly cardiologist, I don't, I can tell you I've been through two [00:01:00] pregnancies, but I have so many questions that I hope you can answer for both me and for our audience.

Maybe we'll start with you, okay if I call you Joanne? Um- Please

Joanne Stone: do.

Anu Lala: Why do we focus, when we talk about the healthy pregnancy, we talk, I mean, when I think about that, I think about the nine months What does a healthy pregnancy mean to you?

Joanne Stone: I mean, it's such a good question 'cause it's sort of like the polar opposite of what I get asked, which is, "What's a high-risk pregnancy?"

Anu Lala: Right.

Joanne Stone: Which is, you know, could be anything. Could be anything from, you know, somebody's 35 to somebody has terrible heart dise- you know, heart disease. But I think a healthy pregnancy most people would think about is having a good maternal outcome, where she stays healthy throughout the pregnancy and after delivery, and the baby also is h- is born healthy.

I think, I think that's sort of like the big picture. Mm. You know, when, when we talk about goals and talk about goals for, for mom, I mean, it... I'm like, "Listen, your [00:02:00] goal is healthy mom, healthy baby," right? That, that's sort of it. You know, anything can happen, right? Things can change. You could start off with not a single underlying medical disorder.

You're 28 years old, and this and that, but then things happen, and things change. But I think the bottom line really is just having a healthy outcome and staying healthy after delivery.

Anu Lala: Yeah. Yeah. I completely agree.

Why Preconception Care Matters

Anu Lala: To what extent do you feel, and then I'm gonna add, I'm gonna sh- point this to you, Anna, to what extent do you feel like there needs to be a shift in our thinking about healthy pregnancies to preconception?

Joanne Stone: It's so impor- it's so important, right? So everybody really should talk to their OBGYN prior to getting pregnant, right? Because you wanna see if there might be underlying conditions that you can make a, a pregnancy even healthier, right? So if you unmask somebody with some... You know, they change, and you know this be- even better than [00:03:00] I do, they change what the guidelines are for, like, stage one hypertension.

So you might, you know, identify somebody with that who was never diagnosed with high blood pressure before, or somebody who's pre-diabetic or- Mm-hmm ... somebody with polycystic ovarian syndrome, who really hasn't impacted on their life so much, but maybe that puts them at a higher risk for gestational diabetes later.

So the preconception visit is super important. You know, somebody who's obese and, you know, maybe they're thinking about getting pregnant in two

years from now and has the luxury of- Weight loss and maybe they'll go on a GLP-1 or something like that, you know, for some time before conceiving. Yeah. So I think that's, I think that's a lot of it.

Anu Lala: I'm gonna come back to that. But before that, Anna, now you, you are an OBGYN, but now much of your practice is in midlife and predominantly GYN. To what extent do you take a pregnancy history? Is... And is it because you're so trained to do so? Or to what extent [00:04:00] do you feel like it bears relevance to seeing women later on in life?

Anna Barbieri: I think, you know, it's a pregnancy history is essential to understand for a woman across all stages of her life. So I routinely ask about number of pregnancies, types of pregnancies, the outcomes in terms of what we call delivery mode. Mm. So vaginal delivery versus cesarean delivery, but also complications of pregnancy because we do understand now that those provide really an essential window-

Joanne Stone: Yeah

Anna Barbieri: into someone's current and future health. So things like a history of what Joanne said, high blood pressure disorders in pregnancy, pre-eclampsia, gestational hypertension, gestational diabetes. Even postpartum depression heightens the risk for certain, um, uh, sort of emotional states later in life, particularly across the perimenopausal transition.

So I'm a huge advocate for actually [00:05:00] including, um, thorough pregnancy history in any medical intake, and that's something we have a lot of work to do in.

Anu Lala: And when you're taking that history, now to get to that same question, do you sort of... I think you already touched on some of the details that you wish to gather, but what does a healthy pregnancy mean to you?

Anna Barbieri: So it's a great question. Uh, and I would even go a little bit further with that. I think, think of healthy pregnancy the same way I think about health.

Anu Lala: Mm.

Anna Barbieri: And there are different ways to think of that, right? Health can be absence of disease or a complication. This is what a lot of our medical system is geared towards.

Even in a preconceptional visit, let's make sure, check you don't have thyroid disorders. Check you don't carry, uh, some abnormal, uh, gene. Check your immunity to varicella is good. Mm. You know, it's really kind of ruling out the presence of certain abnormalities. I [00:06:00] think a healthy pregnancy and health is really the presence of a more optimized state Knowing that none of us are ever in kind of this perfect health, right?

So healthy pregnancy to me means for sure one where a woman is supported before that pregnancy, during pregnancy, after pregnancy, in many different ways. When she is supported socially, when she's supported emotionally, when she's supported medically certainly, um, and when she's aware of the changes in her body too.

And a lot of that falls under medical care and prevention and treatment of complications. Um, but there are aspects to a healthy pregnancy that are much more, um, sort of centered on social support and emotional support too.

Joanne Stone: I, you know, I, I love that, and I, and I think, you know, in a prior conversation that we had, we talked about [00:07:00] some questions that we should be asking patients.

We may think e- that everything's going fine or healthy, but maybe we need to ask, like, "Is everything going okay? Are you facing any challenges?" Like, some of these things that we need to elicit because maybe that's going to bring up certain things- Right ... that we've never thought about. We think everything is perfectly fine, but in fact, they're having stress about certain issues.

You know, I just had a patient today whose father was diagnosed with a, a unfortunate brain tumor, and, um, she's moving and this, you know, like, so, so that, you know, that stress sort of has come out just by sort of asking some questions about, like, what's going on in your life, right? Right. So-

Anu Lala: Being curious.

Joanne Stone: Yeah, being curious. Boy,

Anu Lala: I think I love that. What ex- to, to what extent do you think that women are actually making these preconception appointments? Is it more that- A- and is it that we're self-selecting or they are self-selecting themselves because they're [00:08:00] worried about XYZ? Do you think it should be something that we mandate or we encourage more so?

Uh, or are you finding more so that people are like, "Hey, look, I'm pregnant, and now I need to see an OBGYN"?

Joanne Stone: I think, I think it's probably more common that they find themselves pregnant and then go for their first visit, right? But I think the more we can get out the awareness of the importance of that preconceptional visit, you know, is- would- we'd be doing such a service to patients.

Yeah. Because, you know, it's a, it's a half hour, 45-minute con- uh, maybe sometimes an hour-long conversation, but it can cha- really dramatically change the outcomes. And, you know, people have questions about maybe medications that they're on or what vitamins they should take. Or we talk a lot about, you know, if you're on Instagram or TikTok and you see everything about all the different supplements, you know, like should you be on this and that.

So I- it's, it's, it's really would be wonderful for it to be mandated.

Anna Barbieri: Yeah.

Joanne Stone: But, [00:09:00] um, I think we can at least encourage it and maybe through this podcast get the word out how important it is.

Anna Barbieri: I agree. I, you know, I think that is an essential visit. Yeah. Just as essential as, you know, seeing a teenager before she goes off to college.

Like, I think that should be a really important visit to help prepare her for kind of more, um, education and making certain decisions and handling certain things that she's going to need to handle. But, uh, that's another story for another podcast. But a preconceptional visit can be extremely useful to somebody in terms of understanding their own health, modifying, um, certain risk factors, optimizing that pregnancy outcome, but also reducing anxiety.

You know, people have access to a lot of information these days, and a lot of information can be confusing and conflicting. Um, and that visit can be used to allay some of that anxiety. And then the other side of that coin is [00:10:00] also that that visit can highlight certain things that may be more urgent. I cannot tell you how often I've seen patients who may be forty-two and they say, "You know what?

I'm going to try to get pregnant next year. It's not time yet." And we do need to address certain really biological realities there that are really important, and that

visit may be the one that actually changes that person trajectory and the success of her plan.

Anu Lala: I think that's such a paradigm shift. I mean, when we've got it in our heads that we've got to get mammograms and we've got to get colonoscopies at forty-five now, why isn't it that we really kind of- advocate for that preconception visit.

I, I think that that's a, a shift in our thinking that would be beneficial to so many for all of the reasons that you all mentioned.

Common Symptoms vs Red Flags

Anu Lala: So now moving into the actual pregnancy. Um, I can see you smiling, Joy. And she's like, "Yes." So what, [00:11:00] w- at what level, we all know, oh, you're pregnant and you're going to have pain, back pain.

You're going to be exhausted. You're going to be moody. You're going to need more sleep. What are some of the thresholds around those specific symptoms where You feel like it's important to normalize for a patient, but then you also want them to understand the boundaries of what might feel excessive.

Joanne Stone: Yeah. Um, great question. I mean, one thing is, yes, these things are normal, but you don't want to normalize and dismiss.

Anu Lala: Hmm.

Joanne Stone: Right? Like round ligament pain, that's something where people feel it in the groin. It's typically around 20 weeks. It's a ligament that's, it goes from the labia to the top of the uterus.

It gets stretched, and people say, "Oh, I'm having this groin discomfort." Ah, it's just round ligament pain. Well, you know, it freaking hurts. It hurts like hell. You know, it hurts. So it does, right? I've

Anu Lala: heard. [00:12:00]

Joanne Stone: You know, and like, oh, hemorrhoids, those are, you know, that's common symptom. You know, just take some Me- Metamucil and, you know, whatever, and use Preparation H or whatever.

But, like, it's really uncomfortable, and so I think we can't, we shouldn't be dismissive. We can say it's normal, but not be dismissive. Hmm. And also, give them good advice of, like, what to do. You know, like, if you, if you are constipated and you want to prevent hemorrhoids from occurring, give them really good advice about high fiber diet and increasing your, you know, being hydrated, uh, taking, uh, stool softeners, all, all that stuff.

So I think we need to acknowledge, yes, it's normal, but, but don't, don't dismiss it. On the other hand, what you, you know, you asked about certain pain, you know, that's-- certain things that maybe are more than normal. I think we have to take that seriously, right? So, um, some things that need to be treated, like people get swelling in their wrist later on in pregnancy.

It's carpal [00:13:00] tunnel syndrome. I mean, sometimes that can be so severe that they really need treatment. Hmm. So we need to sort of know when it's at that severity where they may need to see a hand specialist and maybe get steroid injections or something, you know, something like that when traditional therapy hasn't worked.

Anna Barbieri: Right. I think that's- I also think, you know, there's a difference between normal and common. Right. I think we often say just because something is common, we call it normal, right?

Anu Lala: Great point.

Anna Barbieri: But that doesn't mean that something that's common doesn't cause suffering or is not an issue. And I think in pregnancy, you know, there are some things-- I'm gonna draw back on my memories of being-

an obstetrician many years ago. You know, we used to kind of divide up these things into two different categories. One was sort of- Issues and abnormalities that would potentially could be very worrisome. Let's say brighter vaginal bleeding, right? Or if you have started [00:14:00] to feel your baby move, something like decreased fetal movement.

And then you have a whole host, Joanne, like you said, of things that are common, so people often dismiss them. Mm. "Oh, everybody's got that. Oh, you're, well, you're pregnant."

Anu Lala: Right. "

Anna Barbieri: Of course. Just, just put up with it" I mean, that's what it feels like. Right?

Anu Lala: Right.

Anna Barbieri: But there are solutions. There are ways that m- you know, we can prevent some of these things from feeling worse.

So I, I would be very careful about, like, drawing that line between normal and common.

Anu Lala: And common.

Anna Barbieri: Yeah.

Anu Lala: I like that a lot. Do you feel like a lot of that is contingent on you, or you as the practitioner, to ask those questions? Especially ones around, like, round ligament pain, groin pain, or hemorrhoids, for example, which is not exactly something that you think, you know, you're proud to disclose at parties, right?

Yeah. There's so much, you know-

Joanne Stone: It's not t- not cocktail party

Anu Lala: conversation. It depends. You know? Uh, it depends, right.

Anna Barbieri: But- At [00:15:00] mom night out- ... you are. That is what you disclose

Joanne Stone: then. A little urinary

Anu Lala: incontinence when you cough, you know? Ri- but- There is, depending also on your upbringing, cultural backgrounds, there can be a lot of shame around talking about some of these symptoms and some of these occurrences that are common in pregnancy.

To what extent do we need to raise awareness about this for our patients and for each other? And to what extent do you feel like it's, you know, really just the onus is on you as, as the doctor seeing that patient to ask those specific questions?

Joanne Stone: You know, I think, I think at a first visit you can sort of outline some of the things that you may feel.

Mm. You know, we go through things like medication use, lifestyle, you know, the fact that, yes, you can color your hair. I mean, I learned that lesson, you know, my very first year of being an attending when I had a patient whose hair, gray hair was down to here in the third tri- You know, like, she was, like, [00:16:00] due in a week.

I'm like, "You know, you could dye your hair." And she's like, "Why didn't you tell me that sooner?" Thank you. Right? So, so we go through a lot of these things, you know, early on and, like, what are the medications that you can take that are over the counter? Travel. Travel, right?

Anna Barbieri: Travel. Sushi, yes.

Joanne Stone: Sushi. Hot

Anna Barbieri: tubs.

Medications. Exactly.

Joanne Stone: Exercise. But, but we, we-- I think it's a great idea to go over some of the common symptoms that you may- Yeah ... experience in each trimester, right? You know, we talk about the nausea and the fatigue, overwhelming fatigue in the first trimester. You know, some of the other symptoms like we talked about, around ligament pain or, or just lots of pelvic pressure, sciatica.

If think if we give them some of that information ahead of time, at least they'll be a little bit alerted to it, and then, you know, ask them open que- open-ended questions. How are you feeling? Is anything bothering you? Are you in any pain? And-

Anna Barbieri: Right ... knock on wood. I think it also opens the door for people to not be worried about bringing something up, especially if [00:17:00] something has really moved beyond that common and, and to the really sort of pathologic or abnormal state.

And nausea in the first trimester is a perfect example for that, of, of that. There are some women who are somehow lucky and don't ever feel it. I don't know, I,

I was throwing up multiple times a day, every day- ... for 20 weeks. So I was on the other end of the spectrum, but plenty of people are in the middle.

Do they need medications or do they need a little bit of ginger and adjustment in how they eat? That's that group, but they should also know the tools they have. But just opening the door to this will allow the women that are experiences those s- those severe symptoms to get treatment and, and not be afraid to speak up.

Anu Lala: Right. I, I think that that distinction between it being common but not dismissed- Yes ... is so, so important. And going back to that preconception visit, that's also a way for you to develop this rapport with this [00:18:00] practice individual who's- hopefully going to carry you through for the next nine months and beyond, right?

Anna Barbieri: You know what? You must have read my mind, because I was just going to say that's a great opportunity to kind of, you know, test drive that practice. Yeah.

Anu Lala: Connect

Anna Barbieri: or not. What's, what's your connection? What is the vibe? What is the approach? Is that ... You know, a lot of people in pregnancy, I'm sure Joanne, you see that, have certain philosophies and approaches to how they want to be taken care of, the beliefs around the use of pain medication in, in their labor and so on.

This is a good opportunity to see if the practice aligns with your own personal medical philosophy. Also understanding that we can't control How pregnancy goes and yeah Right.

Joanne Stone: No, you, you both are bringing up a great, great, um, point, and I think as obstetricians sometimes we don't address, like, the birthing plan until the third trimester.

Right. Well, you know, it could, you [00:19:00] know, it could be something completely different. Like, there are some practices that might not want to, um, have somebody who had a prior cesarean delivery attempt a, a vaginal delivery. Mm. Well, you're going to wait till the third trimester to ask that question, and then you've been in with the wrong, with the wrong doctor or practice, you know, for the whole time or, or expressing some people that might be, maybe they're better off with a midwife, right?

Yeah. You know, there are goals. And

Anna Barbieri: I think that, you know, that pregnancy, the pregnant, um, person-obstetrician relationship is, is one of those very special- Very special ... relationships in life. Yeah. Um, it's special on both sides, so yeah, I think it's a great opportunity for a little blind date right there. I

Anu Lala: like it.

I like that. Yeah.

C-Section Then Vaginal Birth

Anu Lala: Speaking, well, you bro- before I go into my next question, you actually brought this up, and I don't know the answer to this, and you hear so many different things. So once you have had a delivery via [00:20:00] cesarean, uh, section, can you have a vaginal delivery? What is the consensus around that, or is it really practice, provider, practitioner dependent?

Joanne Stone: I mean, part of it depends on the kind of cesarean, right? So if you had a cesarean, maybe you were 26 weeks pregnant, and you had what we call a classical cesarean, which is a vertical incision on the uterus, not on the skin, but on the uterus, that's a contraindication- Mm ... to having a vaginal delivery, right?

So that is, like, one absolute, right? Um, there are other things that's a, that's a discussion with the patient, so if you had a s- cesarean because you got to fully dilated, you pushed for four hours, and you didn't deliver, your chance of success is not zero, but it's not as high as somebody who had the first section because the baby was in the breech presentation- Right

which has a much higher success rate. So it's that conversation. It also is, like, how many children do you want, right? Because we know with each [00:21:00] cesarean section, there's more scar tissue. There's greater chance for abnormal placen- pl- uh, placentation. So it's a lot of these factors that we need to talk to patients about what are their desires.

You know, some people are like, "Ah, you know, I had a section. I don't want to ruin another part of my body, so let me just do a repeat section," right? Yeah. So, you know, because-

Anna Barbieri: And I think, you know, it's a, it's, it's a big discussion actually because it has to take into account all of those past, um, sort of history details, but also future plans, so it's kind of looking, like, into a crystal ball of like, ah, how many times are we going to do this, right?

Right.

Anu Lala: Yeah.

Anna Barbieri: Um, it also has to take into account just this- Kind of a personal philosophy. No- somebody who could have had a cesarean section after prolonged labor and the baby's heartbeat went down, was this massive emergency, caused so much stress and anxiety. They could be like, "You know what? I, I don't wanna go there."

Right. "Sk- I want a scheduled, you know, 8:00 [00:22:00] AM." Yeah. "I'm showing up that day. I don't want the drama. It was terrible." And then there are other people in that position who really, really want to try, and they have a good chance of success for a vaginal delivery. So I think being, again, nuanced conversation and being on the same page while practicing safe medicine and not doing something harmful for either mom or baby is, is...

it's all goes together there. It's

Anu Lala: so amazing how these are, like, constant reminders of how not protocolized aspects of medicine, particularly in this case of a healthy pregnancy are. So I thank you for that little detour. So what about individuals who are on medications prior to conceiving and now show up at your door saying, "Listen, I'm pregnant.

I'm on semaglutide," or Wegovy or Ozempic or Mounjaro or whatever they happen to be on, a GLP-1.

Joanne Stone: Yeah.

Anu Lala: What do you tell them?

Joanne Stone: Yeah, so I [00:23:00] mean, that's the ideal candidate, and certainly also depends on which medication they were on, 'cause some have longer half-lives that stay in their body. Um, but that's the ideal patient who should come for preconceptional consultation, right?

Right. Right. Right. Because-

Anna Barbieri: So true.

Joanne Stone: Right. So true. We, we don't have any really good human safety data on GLP-1 use during pregnancy. They're told to stop the medication, right? And you- Mm ... ideally you wanna stop it preconceptually. We do know that there are some benefits in terms of achieving a pregnancy. So patients who have, have lost weight, maybe they had p- um, polycystic ovarian syndrome and, you know, are, are better able to conceive, right?

Right. We see that.

Anu Lala: Right. That's the irony,

Joanne Stone: right?

Anu Lala: That's the irony, right. You're like, "Well, that's how I got here."

Joanne Stone: Exactly. "

Anu Lala: And now you're telling me to stop it."

Joanne Stone: That's right. But that's what we have to tell people now because we don't have the safety data- Yeah ... and we don't know the, you know, the long-term effects on the fetal brain and things like that.

And it's a struggle because people lose w- you know, if they, if they were [00:24:00] on it for weight loss-

Stopping GLP-1s in Pregnancy

Anu Lala: It's a-

Joanne Stone: Then you have to, you know, they're gonna, they're gonna gain more weight, you know, after we... There are studies that show that. If they're on it because they, you know, because they were diabetic, then you have to switch them over to safe, you know, me- medicine, insulin or metformin or things like that.

Right.

Anu Lala: That's been studied. I mean, as, as a cardiologist, you know this. I just, I've been dealing with this just happened ironically in the past two weeks, where I've had patients who have needed, uh, the GLP-1 for cardiometabolic health. It may or may not have played a role in increased fertility, and they show up, and now I'm having to peel back on a medication- Mm-hmm

that I know offered and conferred benefits from a cardiovascular perspective.

Anna Barbieri: It's such a, you know, it, it's a perfect example of how complicated things can get in medicine so quickly. Because on one hand, with, especially with GLP-1s and pre-pregnancy [00:25:00] weight loss, especially in something like PCOS, which is such a common endocrine disorder, and using a GLP-1 can lead to significant weight loss and correction of certain metabolic parameters and processes that then will subsequently result in greater ovulation rates or greater pregnancy rates.

Plus, we know that being overweight and carrying too much weight prior to pregnancy, right, it gives you all the-

Anu Lala: Carries so much risk, yeah ...

Anna Barbieri: all the heightened risks of everything from hypertensive disorders to, uh, delivery complications, and so on.

Unknown Fetal Risks Ahead

Anna Barbieri: But yet, we really don't know how a GLP-1 will affect that fetus and subsequently that person, and whether it will have any long-term effects on their metabolic system later in life.

Yeah. So it's a really, like, we're kind of out on the open ocean here without knowing, and it's, it's really difficult, I imagine, to have this conversation.

Joanne Stone: Yeah, I mean, I think that the data that will first come out will be [00:26:00] on, um, fetal anomalies because people will have conceived, right? Right. And then they'll stop at some time, maybe in the first trimester if they get i- into prenatal care early.

So there'll be registries and, you know, and, and there's currently no, um, known, although not enough studies out there, there's no known, um, impact on fetal anomalies right now or teratogenicity. But everybody's stopping it early, so

we're not gonna know, like- Right ... the long-term outcomes. I'm not sure. I had to honest, I did too.

Yeah.

Anu Lala: You know?

Anna Barbieri: Yeah. It wouldn't be... I mean, it would be so interesting, right? If some people continued it for whatever reason, the practice is now to stop it. Is it impacting childhood obesity rates? Right. There's continued risks. Is it, you know, like, we just don't, don't re- It's, and it's impossible to weigh those, right?

Why Pregnancy Data Lags

Anu Lala: It also speaks to, this is a passion of mine, you know, as a clinical trialist. Forget the underrepresentation of women broadly, but- How little we [00:27:00] know about what is safe and what is not safe in pregnancy. Do you find that to be a struggle? I mean, you've been president of MFM societies nationally, internationally.

Where do you feel like we are with our understanding with what is, quote-unquote, "safe and not safe during pregnancy"?

Joanne Stone: It's such a, it's such a huge thing because, you know, pregnant individuals were considered, you know, vulnerable populations, and really pharmaceutical companies don't want to include them- Yeah

in studies because- Yeah ... of, you know, the, the risks of, you know, the legal risks, right? And, um, so it's really problematic as so many of these medications have never been studied in pregnancy. So we really don't have enough information to give to patients on, on the safety. So it's p- it's problematic, you know, and, and ethical.

And then there's ethical discussions, you know? Right. Right. You want to do randomized trial. Do you want to randomize people to stopping the GLP-1s or continuing? Right. Yes. And who's going to do that? You know, who's going to do that study? And so it's, it's, uh, it's [00:28:00] really problematic. It's one population.

Well, that and children also, the lot of, you know, lot of studies that have not been done in children- In children ... on

Anna Barbieri: medications. It's really, you know, it's such an ethical conundrum, right? Because we tend to always, not always, we tend to operate from the assumption of healthier mom, healthier baby. I

Anu Lala: was just going to get at that.

Yeah.

Anna Barbieri: And most of the time, that t- actually turns out to be true, right? We're even seeing that with certain, you know, let's take depression, right? It's not healthy for a mom to be severely depressed in pregnancy. Mm-hmm. And because of that, we u- do use, um, antidepressants. It may improve bonding and therefore even, um, neonatal and infant outcomes.

But some drugs are not like that, so maybe healthier mom through the use of certain pharmaceuticals doesn't mean healthier baby. And we've gone down this road before, like the whole thalidomide story and all of that. It's very, you know, with- [00:29:00] We, we just don't know.

Anu Lala: Yeah.

Anna Barbieri: So I leave it up to the smarter people

Joanne Stone: in the room.

Like, like Joanne. Well, let's get- Or the one that least does deliveries.

Late Night Pregnancy Googles

Anu Lala: What are some of the, the most common things that you hear people googling at 2:00 AM during their pregnancy? Mm. Is it that they're, you know, saying that they're super horny, and they're looking up why they're having sex dreams? Is it the round ligament pain?

What are some of the common things where you're like, "Don't worry"-

Joanne Stone: Yeah ...

Anu Lala: you're not alone."

Joanne Stone: Yeah. Um, I, you know, I think, uh, sometimes it's, you know, just waking up at night and not getting ... Be able to get back to sleep. Mm. I think that's one of them. Um, yeah, the sex dreams is a, is a thing. I mean, people do have very, very vivid, you know, sex dreams.

Which, good for you, if you ... Is it okay though? It's pretty fun. It's okay. Yeah, exactly. Could be fun. Yeah. Um, so those are, like, some of the sort of easy ones that [00:30:00] people do, you know. Anything to worry

Anna Barbieri: about- Food is definitely, like, top of mind. Mm. Can I eat this? Can I eat that? Um, one of the questions I once had was-

Anu Lala: I'm laughing preemptively.

Yeah. I don't know why.

Anna Barbieri: I had a bite of a poppy seed bagel. And I'm worried about potential opium dependency or addiction or something like that. I'm like, okay, that's not gonna come from a poppy seed bagel, but, you know. So, um, and I think people, you know- People don't know- Yeah ... and get anxious, and, you know, pregnancy's also a ti- time where a lot of women try to be perfect because they are, and they're hypervigilant because they think every single little thing will affect that baby.

And I just want to say, that's how you think on your first baby. Your second baby, you're like, "I'm having my third cup of coffee." "And where is my salmon roll?"

Anu Lala: Right. Right, right, right. And we've gone through some myths in a, in a [00:31:00] prior conversation.

Rapid Fire Pregnancy Myths

Anu Lala: Quick yes, nos. Sushi- Yes ... yes or no?

Joanne Stone: Yes. Mm. But li- limit the tuna, and no raw shellfish.

Anu Lala: Okay. I like it. We've got the expert here. Yeah. Wine. Yes, no?

Joanne Stone: Well- Tricky ... the, the, the societal recommendations are to avoid a- all alcohol. Um, studies really show more than a certain amount of

alcohol per day is, puts you at an increased risk for fetal alcohol syndrome. Mm. So, so I think I tell people once in a while, you know, once in a while, it's okay.

Yeah. A lot of people really are just like, "Absolutely not. I would never." You know, like, there, there, there's so much out there, and, and again, the recommendation is to avoid all alcohol, but in all likelihood, once in a while is okay.

Anu Lala: Sex during pregnancy. Yes, no?

Anna Barbieri: Yes. Yeah, I mean, there are some, a rare exceptions.

Someone with a [00:32:00] placenta previa, for example, after a certain time, I think. Yeah. Or somebody with again, I haven't delivered a baby in seven years, but- No, you're right.

Joanne Stone: After like 20

Anna Barbieri: weeks. Yeah, after 20 weeks. Yeah, yeah. Um, somebody, again, with complications, premature rupture of membranes- Mm ... let's say, otherwise, go for it.

Joanne Stone: But it's, it's- Is that

Anna Barbieri: what you say?

Joanne Stone: Yeah. No, I do. But it's interesting 'cause, like, there's some people that just really are like s- I mean, it's either the patient or the partner who are really squeamish. Like, they, they think- ... that the fetus is gonna know what they're doing, and are like gonna be horrified or embarrassed or something like that, so- The

Anna Barbieri: fetus is not gonna know.

Joanne Stone: Yeah, I know. Like, but, like, it's, you know, for some people, it's like, yeah, you know? Mm. I told my husband, yeah, no, there's noth- you're not allowed to have intercourse after like 12 weeks. That's the

Anu Lala: data. That's

Joanne Stone: it. Yeah, exactly.

Anu Lala: Um, masturbation during pregnancy. Yes, no?

Joanne Stone: Yeah, so the, it's a really good question.

So people ask that a lot if [00:33:00] they had a history of a prior premature birth. Mm-hmm. There's no data that having an orgasm is gonna cause you to go into preterm labor, so it really is totally safe, and why the heck not?

Anu Lala: I like this. Old wives' tales- Mm ... that refuse to die.

Anna Barbieri: Mm.

Anu Lala: Okay. Yes. Pedicure, yes, no?

Anna Barbieri: Oh, because of- Allowed, not allowed

a reflexology on the feet-

Anu Lala: Yeah,

Anna Barbieri: potentially

Anu Lala: leading to- Allowed.

Anna Barbieri: Allowed ...

Anu Lala: allowed. Yeah. Allowed. Even third trimester, second tri, you don't care. You

Joanne Stone: can get your pedicures. Well, you want the... Listen, your, your legs are gonna be in the footrest, and, you know- ... you're not having socks on- You want your toes ... so you want your nice toes.

Exactly. Beautiful. And you're not gonna have time after the baby's born to

Anu Lala: go ahead and- Totally ... get a pedicure. Coffee, yes, no?

Joanne Stone: Yeah, up to 150 millig- No ... 150 to 200 milligrams.

Anu Lala: Okay.

Travel and Babymoon Safety

Anu Lala: Travel, yes, no?

Anna Barbieri: Yes. Um, it also depen- it depends on how your pregnancy has been going. Mm. Again, if [00:34:00] you have certain pregnancy, um, conditions where you may end up in the hospital, you know, at any given point, that's something unpredictable.

Do you really want to be out, I don't know, zip-lining in Costa Rica? Like, probably not, right? So I think in those circumstances, no, and probably when it gets closer to your delivery, you probably want to deliver with the people you've met that have been taking care of you, so, like, probably limit travel then, but-

Anu Lala: I imagine you'd get that question a lot, right, around babymoons.

All the time. Oh, yeah. Like, what-

Anna Barbieri: All the time ...

Anu Lala: what island is okay for me to go to? Can I fly to Paris? I mean, this is uncertain. You know,

Anna Barbieri: some people- It rained for- ... they have that luxury ... seven days straight on my babymoon.

Anu Lala: Oh. Oh, brutal.

Anna Barbieri: And I didn't have any alcohol, and then I got salmonella poisoning, so- Oh

also be careful.

Joanne Stone: Yeah. Yeah. Yeah. No, it's true. I mean, especially when Zika was really prevalent. Mm. Mm. We had lots of questions- I remember that ... about Zika pre- I remember ... travel. But I, but I think, you know, what you said is really important. It's like, [00:35:00] when is it? Where are you going? If it's a quick trip to, you know, Florida or visit parents in, you know, Maine or something like that, and you're 34 weeks, it's probably okay.

You know, if you're really gonna go to some remote island where it's really hard to, you know-

Anu Lala: Get

Joanne Stone: back ... get, get back, that's more of an issue.

Anu Lala: Yeah, so it's not entirely straightforward. No. I think this is why these questions- Yeah ... keep coming up, right? Yeah.

Partners and Support Systems

Anu Lala: L- one thing I want to end on, we have talked a lot about what a healthy pregnancy means, mom, baby.

We have all kinds of families, all kinds of ways of getting pregnant. To what extent do you feel like a partner, and that can come in many different forms, even if it's not nec- necessarily a, a, a lover of a partner, plays a role in the healthy pregnancy for a woman?

Joanne Stone: I think the, you know, having somebody that's like an emotional support- Mm-hmm

is really important. [00:36:00] Um, I mean, people do this on their own without a partner, but they can bring their mom- Right ... their sister.

Anu Lala: Yeah, that partner doesn't have to be- Mm-hmm ... a partner, partner.

Joanne Stone: Exactly. Exactly. But, you know, it is going through something, especially if it's a first time, going through something that's, you know, y- unknown to you and, you know, unexpected.

So having somebody that you can rely on to be there for you, I think is super helpful.

Anna Barbieri: I think that support also shows up, can show up in so many different ways. That support can show up at a prenatal appointment. Mm-hmm. Somebody who can ask follow-up questions or maybe can ask something from a different perspective and can remember something differently.

That support can show up as like a cup of tea at night. You know, that's great, nice, versus having to deal with the evening alone. That support shows up in labor, and that support can show up later as just help in many, many different ways. So I think, you know, and, and I think we've talked about it in our [00:37:00] other podcasts, just having support, period, is healthy for us.

Anu Lala: Do you advocate for that kind of support, or do you ask about a, a woman's support system around pregnancy? Do you feel like it's, uh, you know, sort of incumbent upon us to do so for those reasons?

Anna Barbieri: I would, you know, again, I will, I will defer to the maternal and fetal medicine expert here. I think it's hugely important.

I mean, there are programs built around this because we know that lack of support during pregnancy and after pregnancy is linked to worse outcomes. So having, you know, sort of, um, almost baked in ways of asking about that during prenatal care and in the hospital around the time of delivery is hugely important.

And prov- and being able to rely on certain, um, support networks, including social support networks, is important, important to [00:38:00] identify the patients that will benefit from that.

Joanne Stone: Yeah, I, I think you're right, and, you know, if you think more broadly across, you know, across the country, even, you know, internationally, there are areas where there are maternity deserts where it's really hard to get to an appointment or takes two hours- Right

to get to, you know. Those, especially in those areas, you know, people need, I think, a support system that can help get them there or help, you know, make the, make, make them to their appointments or be there during, you know, pregnancies that might end up being, you know- They're starting off healthy, but they may be at higher

Anu Lala: risk after Right.

You just don't know exactly how it's gonna go You don't know. Yeah So I, I think that's hugely important.

One Takeaway for Moms

Anu Lala: So we're gonna close. I wanna give you both the opportunity for a last word. If there was one thing that you wanted women to know about

A healthy pregnancy. What would that be? If there was one takeaway from this episode that you want people to leave with, what would it be? We'll start with Anna, and then we'll end with [00:39:00] Joanne.

Anna Barbieri: Okay. Um, I would say this. I would say this as an, um, OBGYN, but also as a mother. You start being a parent when the f- the second you find out you're pregnant, maybe even before.

Mm. And part of parenthood is releasing control over certain things and acknowledging the fact that we can't control everything. So while it's important to know and read, inform yourself, not be dismissed, bring up issues, and be very active in your own health, there is a degree of lack of control over the process, and we need to be okay with that.

Anu Lala: Mm.

Joanne Stone: I love that.

Flexibility and Resilience

Joanne Stone: Yeah, I was thinking sort of on a similar-

Anna Barbieri: Well, that sounds depressing, so-

Joanne Stone: No, no, no. No, I hope not. Yeah. Because I, I think the, the flexibility's super important- Yes ... right? Resilience.

Anna Barbieri: Yes.

Joanne Stone: It's a res- resilience. And, and things [00:40:00] may start off, you know, without a hitch, but things can change, you know?

And, and complications can occur. And so we have to be open and, um, and, you know, well-informed, but also, you know, understanding that, that things can, you know, can change. I mean, you hope for the best and, and all that, but, you know... And I, I don't wanna, I really don't wanna end on a depressing note at all.

Most pregnancies- Yeah ... end beautifully with, like, this beautiful bundle of joy in your arms. But, but, but, you know, like you said, be flexible, be open for, for things to come up. Yeah. And, and, and, and know that, you know, you can ask questions, and hopefully you, you know that you're with a good practitioner who's gonna get you through it safely.

Anu Lala: Yeah. There's an element of surrender.

Joanne Stone: Yeah.

Anu Lala: Yeah. Right?

Anna Barbieri: Yeah,

Anu Lala: that's beautifully said. And I think, I think that's also so beautiful for an OBGYN, and this is actually what I wanted to do originally before I went into internal medicine and cardiology. I think there's this- There [00:41:00] is time. Will you take

Anna Barbieri: me,

Anu Lala: Jo?

I feel like there's this beautiful responsibility and opportunity in this. So I thank you so much, both of you. I always learn so much from you. And, uh, looking forward to our next episode.

Anna Barbieri: Us too. Thank you.

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