

FP Essentials

Call for Authors – October 2026

Common Issues in Pregnancy

We are seeking an author or author group to write a manuscript for this edition of *FP Essentials* on the topic of common issues in pregnancy. This edition will cover four topics:

- Updates in Routine Prenatal Care
- Evidence-Based Prenatal Recommendations for Healthy Pregnancy
- Common Symptoms and Concerning Presentations in Early Pregnancy
- Recognizing and Responding to Pregnancy Emergencies

The main text of the manuscript should be approximately 10,000 words in length, divided into four sections of approximately 2,500 words each, plus an abstract of approximately 200 words for each section. In addition, there should be key practice recommendations, a maximum of 15 tables/figures total, and up to 200 references to provide support for all recommendations and factual statements in the manuscript. References must be numbered sequentially by section, with each new section starting over at “1.”

This edition should focus on what is new in each topic and should answer the key questions listed for each section. Each section should begin with an illustrative case, similar to the examples provided, with modifications to emphasize key points; each case should have a conclusion that demonstrates resolution of the clinical situation. The references provided here include information that should be considered in preparation of this edition of *FP Essentials*. However, these should be used only as a starting point in identifying the most current guidelines and references to include in the edition.

Needs Assessment

Family physicians play an important role in early pregnancy evaluation, prenatal counseling, routine prenatal care, and recognition of urgent pregnancy-related complications. Although most pregnancies are uncomplicated, pregnancy-related symptoms and concerns frequently present first in primary care, urgent care, or through patient calls and portal messages. Maternal morbidity and mortality remain important public health concerns in the United States, with persistent disparities by race, ethnicity, geography, and access to care. Clinical recommendations for prenatal care have also evolved in recent years, including expanded use of cell-free DNA screening, tailored prenatal visit schedules and telemedicine, new immunization recommendations such as maternal respiratory syncytial virus (RSV) vaccination, ongoing discussion about aspirin prophylaxis, medication safety, and screening strategies. Family physicians need practical, evidence-based guidance to distinguish expected pregnancy symptoms from concerning presentations, provide effective counseling about healthy pregnancy behaviors and medication use, implement updated routine prenatal care recommendations, and recognize conditions that require urgent evaluation or referral. This edition of *FP Essentials* will review common symptoms and concerning presentations in early pregnancy, evidence-based prenatal recommendations for healthy pregnancy, updates in routine prenatal care, and recognition and initial response to pregnancy emergencies.

Section 1: Updates in Routine Prenatal Care

Example Case

A 34-year-old patient, gravida 2 para 1, presents at 8 weeks' gestation for an initial prenatal visit. Her first pregnancy was uncomplicated. She asks about genetic testing options, noting that a friend had a "blood test" that could detect Down syndrome early in pregnancy. She also wants to know whether the same number of prenatal visits is needed this time, given the prior uncomplicated pregnancy, and whether any new vaccines are recommended during pregnancy.

Key Questions to Consider

Prenatal Care Structure and Access

- What are the recommended components of the initial prenatal visit, including medical and obstetric history, physical examination, routine laboratory screening, pregnancy dating, risk assessment, and psychological screening? How should family physicians approach patients who present late to prenatal care or have had large gaps in care? *Consider a comprehensive table summarizing routine prenatal care by gestational age, including recommended visits, laboratory and risk-based screening, imaging, immunizations, genetic screening, and anticipatory guidance.*
- What is the current evidence regarding tailored or reduced prenatal visit schedules compared with the traditional 12–14 visit model? For which patients may reduced or hybrid visit schedules be appropriate, and what roles can telemedicine and remote monitoring play in prenatal care delivery? Which services are covered by insurers?

Ultrasonography and Genetic Screening

- What are the indications and optimal timing for obstetric ultrasonography during routine prenatal care, including first-trimester pregnancy dating, viability confirmation, multiple gestation, nuchal translucency measurement, and the second-trimester anatomy ultrasound? How should family physicians approach discordant dating, abnormal findings, soft markers, incidental findings, or need for referral?
- What prenatal genetic screening options should be discussed, including first-trimester combined screening, cell-free DNA screening/noninvasive prenatal testing (cfDNA/NIPT), second-trimester serum (quad) screening, carrier screening, and diagnostic testing with chorionic villus sampling or amniocentesis? How should family physicians counsel patients about timing, benefits, limitations, accuracy, cost, partner testing when indicated, and the difference between screening and diagnostic testing? *Consider a table comparing prenatal genetic screening and diagnostic testing options.*

Second- and Third-Trimester Screening

- What are the current USPSTF, ACOG, and ADA recommendations for gestational diabetes screening, including timing, one-step versus two-step approaches, diagnostic thresholds, indications for early screening, and limitations of early screening? *Consider a gestational diabetes diagnostic thresholds table.*
- Which vaccines are recommended during pregnancy, including Tdap, RSVpreF, influenza, and COVID-19, and what is the optimal timing for each? What vaccines are contraindicated during pregnancy? How should family physicians counsel patients about RSV prevention options, including the role of RSVpreF vaccination and the alternative strategy of infant nirsevimab?

- What are the current recommendations for Group B Streptococcus (GBS) screening, including timing, specimen collection method, and indications for intrapartum antibiotic prophylaxis? What has changed in recent guideline updates?

Late Pregnancy and Postpartum Planning

- What third-trimester assessments and anticipatory guidance should family physicians provide, including fetal growth assessment, fetal movement awareness, fetal presentation, repeat laboratory screening when indicated, labor precautions, birth planning, postpartum care (“fourth trimester”) planning, breastfeeding education and support, and postpartum contraception?

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Section 2: Evidence-Based Prenatal Recommendations for Healthy Pregnancy

Example Case

A 32-year-old patient, gravida 1 para 0, presents at 10 weeks' gestation with questions about wellness strategies for a healthy pregnancy. Her prepregnancy BMI is 31 kg/m². She takes lisinopril for hypertension, drink 3 cups of coffee per day, and takes ibuprofen for occasional headaches. She recently started a prenatal vitamin but is unsure whether it contains enough folic acid. She asks whether it is safe to start an exercise program to lose weight. Her partner smokes marijuana in the home.

Key Questions to Consider

Physical Activity and Exercise

- What are the current recommendations (eg, type, frequency, intensity, duration) for physical activity and exercise during pregnancy and the postpartum period? What maternal and fetal benefits have been demonstrated? What are the risks of activities that are in excess of recommendations and how likely are adverse outcomes? What contraindications or warning signs should prompt modification or cessation of exercise?
- How should recommendations be individualized for patients who were sedentary before pregnancy, patients with obesity or medical comorbidities, and patients who were highly active before pregnancy?

Gestational Weight Gain and Nutrition

- What are the current National Academy of Medicine (formerly IOM) recommendations for gestational weight gain based on prepregnancy BMI? What are the maternal and neonatal risks of inadequate or excessive gestational weight gain, and what counseling interventions are effective for helping patients achieve healthy weight gain?
- What nutrition and supplementation counseling should family physicians provide during pregnancy, including folic acid, iron, iodine, calcium, vitamin D, omega-3 fatty acids, and prenatal vitamins? What dietary safety guidance should be provided regarding fish intake, mercury exposure, listeria risk, unpasteurized products, and other foodborne risks? *Consider a table summarizing recommended supplementation, typical doses, dietary sources, patients at increased risk for deficiency, and key safety considerations.*

Medication Safety in Pregnancy

- How should family physicians review and manage prescription medications when pregnancy is planned or confirmed, including use of the Pregnancy and Lactation Labeling Rule (PLLR)? Which commonly used medications should be reviewed urgently, substituted, or discontinued (eg, ACE inhibitors/ARBs, statins, retinoids, psychiatric medications, warfarin, NSAIDs, antiseizure medications)?
- What guidance should family physicians provide about over-the-counter medications for common symptoms during pregnancy, such as headache, heartburn, constipation, allergies, insomnia, and musculoskeletal pain? Is acetaminophen safe to use in pregnancy? *Consider a table summarizing the most common medications/classes that patients may take or may be taking, including PLLR, recommended options, and trimester-specific cautions.*

Caffeine, Substance Use, and Exposures

- What are the current recommendations regarding caffeine intake during pregnancy, and what is the evidence linking caffeine consumption to miscarriage, fetal growth restriction, low birth weight, or other adverse outcomes?
- What validated screening tools and brief interventions should family physicians use to identify and counsel patients about alcohol, tobacco/nicotine, cannabis, opioid, and other substance use during pregnancy? What are the key fetal and maternal risks, and what are the treatment or referral options? *Consider a concise table summarizing substance, screening approach, pregnancy risks, and recommended intervention or referral.*
- What environmental, occupational, and household exposures should family physicians counsel patients to avoid or reduce during pregnancy, and what practical risk-reduction strategies can be recommended?

Preventive Interventions

- What are the current USPSTF and ACOG recommendations for low-dose aspirin prophylaxis to prevent preeclampsia, including risk stratification, timing of initiation, dose, and contraindications? What evidence is emerging regarding optimal aspirin dosing? (*Note: Diagnosis and management of hypertensive disorders of pregnancy will be covered in Section 4.*)
- Do doulas or community health workers have an impact on pregnancy outcomes when utilized during the prenatal period?

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Section 3: Common Symptoms and Concerning Presentations in Early Pregnancy

Example Case

A 28-year-old patient, gravida 2 para 1, presents to your office at approximately 7 weeks' gestation by last menstrual period with persistent nausea, occasional vomiting, fatigue, and mild lower abdominal cramping. She reports light vaginal spotting over the past 2 days. A home pregnancy test was positive 10 days ago, but prenatal care has not yet been established. She is anxious and asks whether these symptoms are normal, whether the spotting means a miscarriage is occurring, and what to expect next. The clinic does not have on-site ultrasound.

Key Questions to Consider

Normal Early Pregnancy Symptoms

- What are the most common symptoms experienced in the first trimester (eg, nausea/vomiting, fatigue, breast tenderness, urinary frequency, constipation, mild pelvic cramping, mood changes, dizziness), what is the underlying physiology, when do these symptoms typically begin, peak, and resolve, and what counseling can family physicians provide to reassure patients while identifying features that should prompt further evaluation? *Consider a table summarizing common first-trimester symptoms, expected timing, reassuring features, warning signs, initial evaluation, and management.*

Nausea and Vomiting of Pregnancy

- What is the current evidence-based stepwise approach to managing nausea and vomiting of pregnancy (NVP), including nonpharmacologic interventions (eg, dietary modifications, ginger, acupuncture) and pharmacologic therapy (eg, pyridoxine, doxylamine-pyridoxine, ondansetron, metoclopramide, promethazine)? What new evidence exists regarding the pathophysiology of NVP, including the role of GDF15, and what potential implications does it have for risk stratification, prevention, or future treatment?
- How should family physicians distinguish NVP from hyperemesis gravidarum? What validated tools (eg, PUQE score) are available to assess severity? What are the criteria for outpatient versus inpatient management, and what complications should be monitored (eg, dehydration, electrolyte abnormalities, Wernicke encephalopathy)?

First-Trimester Bleeding

- How common is first-trimester vaginal bleeding, and what is the differential diagnosis (eg, threatened miscarriage, early pregnancy loss, ectopic pregnancy, subchorionic hemorrhage, cervical or vaginal causes)? *Consider a table summarizing causes of first-trimester bleeding, associated clinical features, recommended initial evaluation, and criteria for urgent referral.*
- What is the recommended initial evaluation for a patient presenting with first-trimester bleeding, including clinical assessment, quantitative β -hCG, transvaginal ultrasonography, Rh status, and other tests when indicated? What is the prognostic value of confirming fetal heart rate by Doppler or ultrasound in a patient with threatened abortion? How should family physicians approach this evaluation in settings without immediate access to ultrasound?
- What are the current ultrasound criteria for diagnosing early pregnancy loss versus findings that are suspicious but not yet diagnostic? How should family physicians counsel

patients during this period of diagnostic uncertainty, and when is expectant management with repeat testing or imaging appropriate?

- What is the current evidence for progesterone therapy in patients with first-trimester bleeding, particularly those with a history of prior miscarriage? Which patients, if any, may benefit, and what counseling should family physicians provide about expected benefits, limitations, and uncertainty?

Pregnancy of Unknown Location and Ectopic Pregnancy Recognition

- When transvaginal ultrasonography does not identify either an intrauterine or ectopic pregnancy, the patient is classified as having a pregnancy of unknown location — a transient state that may represent a normal early intrauterine pregnancy, an early pregnancy loss, or an ectopic pregnancy. How should family physicians evaluate and follow a pregnancy of unknown location using serial β -hCG measurements and repeat imaging? What β -hCG trends help distinguish these possibilities, and how should this diagnostic uncertainty be communicated to patients, particularly in settings without immediate access to ultrasound?
- What are the key risk factors (eg, prior ectopic pregnancy, pelvic inflammatory disease, tubal surgery, smoking, infertility) and clinical features (eg, vaginal bleeding, pelvic or abdominal pain, adnexal tenderness) that should raise suspicion for ectopic pregnancy in a patient with a positive pregnancy test? What red flags (eg, hemodynamic instability, peritoneal signs, shoulder pain) indicate possible rupture and require emergent referral? *Avoid detailed discussion of the management of ectopic pregnancy.*

Early Pregnancy Loss: Initial Recognition and Counseling

- What warning signs suggest early pregnancy loss, and what initial workup and counseling should family physicians provide while diagnosis is being confirmed? What are the diagnostic criteria for nonviable pregnancy in the first trimester? What resources and approaches are effective for supporting patients experiencing pregnancy loss or diagnostic uncertainty, including attention to grief, mental health, return precautions, and follow-up? *Avoid detailed discussion of the management of early pregnancy loss.*

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Section 4: Recognizing and Responding to Pregnancy Emergencies

Example Case

A 32-year-old patient, gravida 3 para 2, at 34 weeks' gestation calls the clinic reporting a sudden onset of severe headache, visual "spots," and upper abdominal pain. She had a normal prenatal visit 2 weeks ago with a blood pressure of 118/72 mmHg. The medical assistant obtains a blood pressure of 168/104 mmHg on patient arrival. The patient's prenatal records show no prior hypertension during this pregnancy.

Key Questions to Consider

General Approach to Pregnancy Emergencies

- What warning symptoms during pregnancy should prompt urgent evaluation, and what initial steps should family physicians take before transfer or referral (eg, maternal vital signs, gestational age confirmation, fetal heart tones if feasible, IV access, laboratory studies)? What examinations or interventions should be avoided until certain diagnoses are excluded (eg, digital cervical examination before placenta previa is ruled out)? *Consider a comprehensive triage table organized by chief symptom, with columns for key differential diagnoses, initial evaluation, immediate actions, and disposition or referral criteria.*

Bleeding in the Second Half of Pregnancy

- What are the key causes of vaginal bleeding after 20 weeks' gestation (eg, placenta previa, placental abruption, vasa previa, cervical causes, bloody show/labor, trauma)? How do clinical features help distinguish these conditions (eg, painful versus painless bleeding, uterine tenderness or rigidity, fetal heart rate abnormalities, signs of coagulopathy)? What initial evaluation and stabilization should family physicians perform? When is emergent transfer to labor and delivery required?

Hypertensive Disorders of Pregnancy

- How are hypertensive disorders of pregnancy classified (gestational hypertension, preeclampsia without severe features, preeclampsia with severe features, HELLP syndrome, eclampsia), and what are the current diagnostic criteria and blood pressure thresholds for each? What has changed in recent guideline updates regarding diagnosis and management thresholds? *Consider a table summarizing the diagnostic criteria, severe features, initial actions, and referral thresholds.*
- What symptoms and clinical findings constitute severe features of preeclampsia (eg, systolic blood pressure ≥ 160 mmHg or diastolic ≥ 110 mmHg, headache unresponsive to treatment, visual disturbances, right upper quadrant or epigastric pain, pulmonary edema, thrombocytopenia, elevated liver enzymes, renal insufficiency), and what immediate actions should family physicians take when these are identified (eg, antihypertensive therapy, magnesium sulfate initiation if available, coordinate urgent transfer)? What is the current recommended threshold and timeline for treating acute-onset severe hypertension?
- How should family physicians recognize and counsel patients about postpartum preeclampsia, including the timeline of risk, warning signs that should prompt emergency evaluation, and the importance of postpartum blood pressure monitoring? What institutional processes, clinical pathways, or safety bundles can help systematically

identify and respond to antepartum or postpartum hypertensive disorders in various clinical settings?

Preterm Labor and Preterm Premature Rupture of Membranes

- How should family physicians evaluate a patient presenting with regular contractions, pelvic pressure, low back pain, or vaginal bleeding before 37 weeks' gestation? How can preterm labor be distinguished from Braxton Hicks contractions? What is the role of cervical length measurement and fetal fibronectin testing in risk stratification, and when should patients be transferred for further evaluation?
- How should family physicians recognize and initially evaluate suspected preterm premature rupture of membranes (eg, history of fluid leakage, sterile speculum examination, avoidance of digital cervical examination, confirmatory testing)? What are the key management principles and referral indications that family physicians should understand, including the rationale for antenatal corticosteroids, magnesium sulfate for neuroprotection, GBS prophylaxis, and latency antibiotics?

Other Urgent Pregnancy Conditions

- What additional urgent pregnancy conditions should family physicians recognize, including intrahepatic cholestasis of pregnancy, decreased fetal movement, venous thromboembolism, peripartum cardiomyopathy, pyelonephritis, sepsis, and severe dyspnea or chest pain? For each, what are the key presenting features, initial evaluation, and disposition or referral criteria? *Consider addressing these conditions in the comprehensive triage table or a complementary table rather than as separate detailed narratives.*

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