

# Birth Preferences

## HOW DO I KNOW WHAT I WANT?

The members of the division of Gynecologic and Obstetric Specialists at Baylor College of Medicine want the exact same outcome as our patients: healthy, happy mothers and babies. There are many sources of information available to expectant parents, and some encourage parents-to-be to create Birth Plans. While we would like to be able to honor these wishes, we can all agree that when it comes to having babies, some things are hard to plan. Many of us have noticed common threads among birth plan requests which are no longer part of routine modern obstetric practice or are so common that a special request is not necessary. For example, the routine use of episiotomy (an incision to enlarge the vaginal opening during delivery) has been shown to increase the size of laceration or tearing. It's understood that women would rather avoid significant tearing, and most of those who create a Birth Plan request that the obstetrician avoid this procedure. Since the use of episiotomy is now restricted to rare, emergency cases, the request to avoid this procedure becomes unnecessary.

As a result, we have created this Birthing Preferences document to help expectant parents understand our rationale for certain recommendations based upon best evidence.

Our goal is to help women make informed decisions about their birth preferences. We encourage you to read this information early in your pregnancy and discuss it with your attending physician.

### Timing of Delivery:

- Health care professionals agree that unless there is a valid health reason, or labor starts on its own, delivery should not occur before 39 weeks (ACOG Committee Opinion 765: Avoidance of Nonmedically Indicated Early Term Deliveries and Associated Neonatal Morbidities. Feb 2019).
- Elective delivery (vaginal or cesarean) will not be performed prior to 39 weeks.

### Mode of Delivery:

- Cesarean delivery on maternal request is not recommended and should not be motivated by the lack of availability of effective pain management during labor.
- Evidence to consider for planned **vaginal** delivery:
  - Shorter hospital stays for the mother (usually <48 hours),
  - Decreased risk of respiratory problems for the newborn, compared to cesarean,
  - Fewer complications in subsequent pregnancies, such as uterine rupture, placental implantation problems, and the need for hysterectomy or blood transfusion:
    - Cesarean delivery increases the risk of subsequent placenta previa (placenta covers the cervix) or placenta accreta spectrum disorders (placenta grows into the uterine wall, requiring hysterectomy).
    - Risk of uterine rupture after previous cesarean: 1-2% for low transverse (horizontal) cesarean incision, 6% for classical (vertical) cesarean incision.
- Evidence to consider for planned **cesarean** delivery: Potential short-term benefit, compared to a planned vaginal delivery, includes a decreased risk of hemorrhage.

(ACOG Committee Opinion 761: Cesarean delivery on Maternal Request. Jan 2019).

### Trial of Labor after Cesarean (TOLAC)

- No type of delivery is risk free, however Vaginal Birth After Cesarean (VBAC) is associated with fewer complications than a scheduled repeat cesarean, but a failed TOLAC is associated with more complications than a scheduled 39+ week cesarean.
- Factors that *increase* the probability of success for TOLAC:
  - Prior vaginal delivery
  - Spontaneous labor

- Factors that *decrease* the probability of success for TOLAC:
  - Recurring indication for prior cesarean
  - Increased maternal age
  - Gestational age >40 weeks
  - Obesity
  - Preeclampsia (pregnancy complication characterized by high blood pressure and protein in the urine)
  - Short interpregnancy interval (time between pregnancies)
  - Increased newborn birth weight
- The Grobman Calculation using the above factors will give the predicted chance of vaginal birth after cesarean.
- Women with a less than 60% probability of VBAC have greater morbidity (increased risk of adverse outcome and complications) than women undergoing repeat cesarean delivery; see Grobman calculation at <https://mfmunetwork.bsc.gwu.edu/web/mfmunetwork/vaginal-birth-after-cesarean-calculator>.
- Individual factors must be considered in all cases of TOLAC, but most women with *one* prior cesarean delivery via a low-transverse (horizontal) uterine incision are a candidate for TOLAC.
- Women with *two* prior low-transverse cesarean deliveries may be considered a candidate for TOLAC after discussion with their attending physician but are not candidates for an induction of labor.
- TOLAC is not offered for women who have had a previous classical uterine incision (a vertical incision through the uterine muscle) or certain other surgeries involving the full thickness of the upper uterine walls. Skin incisions often do not correlate with uterine incisions. Other indications which may suggest that TOLAC will not be considered (ex. placenta previa).

(ACOG Practice Bulletin 205: Vaginal Birth After Cesarean Delivery. Feb 2019)

### **Should I hire someone to help me cope with labor?**

- The continuous presence of a support person or persons during labor, including nurses, midwives (Certified Nurse Midwife), or lay individuals (Doula, Lay Midwife, or Certified Professional Midwife), has a number of benefits for women and may reduce the likelihood of the need for medication for pain relief, reduce operative deliveries, and improve satisfaction with their birth experience.
- Lay support individuals should not influence a patient's right to her own pain management choices by making her feel pain medications are wrong or harmful. Decisions regarding pain management are to be made by the patient. If you desire the experience of unmedicated labor, we support you. If in pain, uncomfortable, or tired, deciding to have pain medication is not a sign of weakness nor does it show a lack of concern for the baby's well-being.
- Lay support individuals should not make medical management decisions but can help support pregnant women when making these shared decisions with their physician.
- Your nurse is a trained professional and will check on you frequently. He or she is an integral part of the team to help ensure patient safety. They will assist you with positioning and coach you in labor, if desired. The nurses at the Pavilion for Women have assisted thousands of women through the birth process and are experienced with a wide array of birthing preferences.

(ACOG Practice Bulletin 209: Obstetric Analgesia and Anesthesia. Mar 2019)

### **Who else might be involved in my care? What happens during labor?**

Our OB/GYN group is part of Baylor College of Medicine, a renowned teaching institution, which means we work with both medical students and residents. However, all medical management decisions are made ultimately by the attending physician in conjunction with the patient.

- Medical students may be present to help care for you in clinic and in the hospital. They often have more time to spend with patients. They will never do a cervical examination or examine any part of your body without supervision or consent.
- Residents are doctors that have finished medical school and are training to become specialists in obstetrics and gynecology. They help us take the best possible care of you during any hospitalization. They are supervised by your attending physician and/or covering physician.

- The Baylor Gynecologic & Obstetric Specialists Division has both male and female physicians. There are situations that may arise in which even though you are routinely seen by a female physician you may be taken care of or delivered by a male physician when you are in labor.
- While attending physicians try to attend to their patient's delivery, if your personal physician is not able to be at the delivery, another member of our group will be present. An on-call physician is physically located in the hospital 24/7/365.
- We will attempt to maintain your comfort with interruptions only as clinically necessary, usually about every 2-4 hours.
- There are times when your partner cannot be present, for example, at the initial assessment, during administration of anesthesia, or during a cesarean under general anesthesia. Visitors are not allowed in the room during these procedures.
- We support your desire to listen to your own music, keep lights dimmed, have a quiet room, and have ice chips or popsicles. You can ask about clear liquids or possible other foods depending on your individual situation.
- If you use corrective lenses, during labor there are no restrictions on wearing conventional rigid contact lenses, rigid gas permeable contact lenses, hydrophilic soft contact lenses, extended wear soft contact lenses, or glasses. Should you need surgical delivery with regional anesthesia, glasses or soft contacts are allowed but not rigid contacts. With general anesthesia, there is no need for glasses or contacts and any type of contact lens can risk injury to your cornea, therefore no corrective lenses are allowed if undergoing general anesthesia.
- Still photographs may be taken; however, video of any kind is not allowed during vaginal or cesarean delivery. Please respect physicians and all staff members and ask if they are agreeable to having pictures taken before any type of photography, even if they may only appear in the background.

## **THE FIRST STAGE OF LABOR: PAINFUL CONTRACTIONS AND CERVICAL DILATION UNTIL COMPLETELY DILATED AND READY TO PUSH**

### **Maternal Position:**

- With normal labor, a healthy woman with a fetus with a normal heart rate pattern may assume a position that is most comfortable to them.
- Lateral positioning (lying on your side) is sometimes suggested because this position is associated with the most efficient maternal cardiac output. This means that when a pregnant woman is in this position, she is pumping as much well-oxygenated blood to the placenta and baby as possible. Your nurse or other providers may ask you to lay on one side or the other if, from his or her review of the baby's heart rate, the provider determines that the baby may benefit from a position change.
- Walking has not been shown to enhance or impair progress in labor  
(ACOG Committee Opinion 766: Approaches to Limit Intervention During Labor and Birth. Feb 2019).

### **Water immersion:**

- Water immersion is *not* associated with a reduced rate of perineal trauma or tears (tears to the area between vagina and anus during delivery), operative vaginal delivery, nor cesarean delivery.
- Water immersion *may* be associated with decreased use of epidural, spinal, or paracervical analgesia (pain medication).
- Immersion should not prevent or inhibit other aspects of care, including monitoring of both mother and fetus.
- No immersion is recommended or allowed after rupture of membranes or during second stage of labor.  
(ACOG Committee Opinion 679: Immersion in Water During Labor and Delivery. Nov 2016)

### **Fetal Monitoring:**

- Fetal monitoring is the process of watching the baby's heart rate. It can be done via external or internal monitoring.
  - External monitoring uses a doppler ultrasound device to record the fetal heart rate to create an ongoing electronic recording of the baby's heartbeat.
  - Internal monitoring is accomplished with a small electrode receiver placed directly on the fetal head or the part of the baby closest to the cervix. Internal monitoring is not more accurate than external monitoring if external monitoring is capturing and displaying the fetal heart rate signal.

- External fetal monitoring can be performed two ways: continuously or intermittently. Generally, intermittent monitoring is performed every 15 minutes in the active phase of the first stage of labor and every 5 minutes in the second stage (pushing) of labor.
- Intermittent monitoring may not be appropriate for all pregnancies.
- Labor of women with high-risk conditions should be monitored with continuous fetal heart rate (FHR) monitoring. (ACOG Practice Bulletin 106: Intrapartum Fetal Heart Rate Monitoring: Nomenclature, Interpretation, and General Management Principles. July 2009).

#### **IV Fluids and Oral Intake:**

- Intravenous (IV) access is required, as a precaution, for all women admitted to the Pavilion for Women. While your hospital course may be uncomplicated, the risks associated with a pregnant woman requiring inpatient hospitalization (before, during, or after labor) necessitate, at a minimum, the establishment and maintenance of IV access in the form of a saline lock (a small port in the arm or hand with a cap).
- Studies have shown that laboring women receiving IV fluids at high rates have shorter labors as compared to women who receive IV fluids at slower rates. Most studies have not found a significant difference among cesarean rates among women with oral versus IV hydration. These data are not considered to be strong enough to base firm recommendations because of variation in study design. Two studies have shown a decreased length of labor in women receiving IV hydration as compared to women who hydrated orally. The group receiving IV hydration experienced shorter labors by 29 minutes. (Dawood F [Dowswell T](#), [Quenby S](#) Intravenous fluids for reducing the duration of labour in low risk nulliparous women. *Cochrane Database Syst Rev*. 2013 Jun 18;6:CD007715. doi: 10.1002/14651858.CD007715.pub2).

#### **Labor Induction – A procedure performed to purposefully begin labor with the intention of delivery:**

- Indications for induction of labor may include:
  - Premature rupture of the membranes of the amniotic sac (bag of water broken with no contractions),
  - Maternal conditions (examples: diabetic and high blood pressure disorders, kidney or liver disease, advanced maternal age, etc.),
  - Multiple gestation (two or more fetuses),
  - Fetal compromise (examples: growth restriction, too little or too much amniotic fluid, isoimmunization [condition in which mother's and baby's blood are incompatible]),
  - Chorioamnionitis (infection in the membranes surrounding the fetus and the amniotic fluid),
  - Post-term pregnancy (near or at 41 completed weeks),
  - Placental abruption (placenta peels away from the inner wall of the uterus).
- At this time, there is not a consensus as to whether elective induction of labor after 39 weeks (in the absence of a medical indication) in women who are going to deliver their first baby is associated with an increase or decrease in their cesarean delivery risk. At our institution and in our practice, elective induction of labor after 39 weeks has limited availability and is not routinely performed due to logistical factors that impact its feasibility and practicality as a standard practice. ([Vrouenraets FP<sup>1</sup>](#), [Roumen FJ](#), [Dehing CJ](#), [van den Akker ES](#), [Aarts MJ](#), [Scheve EJ](#). Bishop score and risk of cesarean delivery after induction of labor in nulliparous women. *Obstet Gynecol*. 2005 Apr;105(4):690-7. [Vahratian A<sup>1</sup>](#), [Zhang J](#), [Troendle JF](#), [Sciscione AC](#), [Hoffman MK](#). Labor progression and risk of cesarean delivery in electively induced nulliparas. *Obstet Gynecol*. 2005 Apr;105(4):698-704. Grobman WA, Rice MM, Reddy UM, Tita ATN, Silver RM, Mallett G, Hill K, Thom EA, El-Sayed YY, Perez-Delboy A, Rouse DJ, Saade GR, Boggess KA, Chauhan SP, Iams JD, Chien EK, Casey BM, Gibbs RS, Srinivas SK, Swamy GK, Simhan HN, Macones GA; Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Labor Induction versus Expectant Management in Low-Risk Nulliparous Women. *N Engl J Med*. 2018 Aug 9;379(6):513-523. doi: 10.1056/NEJMoa1800566. PMID: 30089070; PMCID: PMC6186292).

- Cervical ripening is sometimes required prior to induction of labor when the cervix is minimally dilated (not yet open at all or not open very much), uneffaced (has not started thinning), or firm. Induction methods – multiple methods of cervical ripening have been studied and have been proven to be effective and safe:
  - Membrane stripping or sweeping (where the physician inserts their finger through the cervix to gently separate the amniotic sac (bag of water) from the cervix & walls of the uterus) increases the likelihood of spontaneous labor within 48h;
  - Medications, including prostaglandins (like misoprostol or dinoprostone) and oxytocin;
  - Foley or Cook balloon catheters, to help mechanically open the cervix;
  - Amniotomy (purposefully breaking the bag of water in the hospital);
  - Nipple stimulation (has only been studied in low-risk pregnancies & only successful in women with a favorable cervix); and
  - Combinations of all the above are often used to help shorten the length of labor and decrease the risks of complications without increasing the risks of cesarean section.
- Your attending physician and/or their partners will determine which is the best option based on the clinical situation in a shared decision-making model to consider your desires and to address your concerns.

**Augmentation of Labor – The use of Pitocin or rupture of membranes (your bag of water) to improve the strength of uterine contractions:**

- Augmentation should be considered if:
  - Cervical dilation ceases over a period of hours (usually 2-4);
  - The frequency of contractions is less than 3 per 10 minutes; or
  - The intensity is insufficient.
- For labor augmentation, amniotomy (purposely breaking the bag of water) compared with no amniotomy is associated with a decreased need for oxytocin (Pitocin) augmentation and a shorter active phase of labor (after 6 centimeters). Both methods have been shown to have no negative impact on fetal heart rate (FHR) patterns or need for cesarean deliveries compared to expectant management (watchful waiting without augmenting labor).  
(ACOG Clinical Practice Guideline 8: First and Second Stage Labor Management. Jan 2024).

**Pain Management in Labor:**

- The decision about the timing and method of pain relief in labor is personal and will be made by the patient.
- In the absence of a medical contraindication, maternal request is sufficient medical indication for pain relief during labor. The fear of unnecessary cesarean delivery should not influence the method(s) of pain relief chosen during labor.
- There are several options to consider:
  - No medication.
  - IV medication: narcotics such as Nubain and Fentanyl -- Opioid agonists and opioid agonist-antagonists (also known as narcotics) are available for IV administration either upon request or with the use of a patient-controlled analgesia (PCA) pump. Recent studies show analgesic effect in labor is limited and the primary mechanism is heavy sedation. The half-life (duration of the presence) in infants varies depending on medication given. Some women are satisfied with the level of pain relief provided by narcotics when large enough doses are used. Women who desire pain medicine, but who are not candidates for regional anesthesia, may opt for PCA narcotic.
  - Inhaled nitrous oxide (also commonly called “laughing gas”) -- Nitrous oxide is a very quick-acting gas that a woman can breathe in labor to help decrease pain and anxiety. It is a very safe medication with minimal risks and has been used safely for many decades world-wide. There are no known long term side effects, but it could cause mild dizziness, nausea, headache, or feeling strange. There are no known effects on the baby. Gas is delivered using a handheld mask by the patient herself. After the mask is pulled away from the face or discontinued, the effects will quickly fade as the patient continues to breathe room air or pure oxygen. The mask may not be held in place by anyone besides the patient or used by anyone besides the patient. It is administered about 30 seconds before a contraction is expected to begin and is breathed continuously until the contraction ends.

- Regional anesthesia (epidural, spinal, pudendal block);
  - Regional anesthesia diminishes pain by creating a partial to complete loss of pain sensation below the belly button with varying degrees of impaired movement. This means that pain is markedly reduced, and women may or may not be able to move their legs. However, because of the regional effects of the anesthesia, the muscles in the legs are not strong enough to stand or walk safely, for example if patients want to walk to the bathroom or around the room. Use of regional anesthesia may not be possible with refractory maternal hypotension (abnormally low blood pressure), coagulopathy (clotting disorder), use of some blood thinners, untreated maternal bacteremia (bacteria in the blood), skin infection over site of needle placement, and increased intracranial pressure caused by a mass lesion.
  - **Epidural** offers the most effective form of pain relief for labor, and is used by most women in the U.S. An advantage of this method is the ability to continuously measure and adjust the medication over the course of labor as needed. The epidural can then also be used for cesarean delivery or postpartum tubal ligation, if needed. Epidurals work well for longer procedures and typically take about 10-20 minutes to take effect.
    - In patients with increased risk of undergoing urgent cesarean delivery, early use of a regional analgesia during labor may have the benefit of reducing the need for emergent general anesthesia.
    - Epidural analgesia may prolong labor by 40-90 minutes and may result in an approximately two-fold increased need for oxytocin augmentation.
    - Neuraxial analgesia techniques (when drugs are administered into a specific region) are the most effective and least depressant treatments for labor pain.
    - It is almost never too late to receive an epidural – epidurals are often successfully placed in women with cervical dilations of 8-10 cm, if she can remain still for the procedure.
  - **Spinal analgesia** provides excellent pain relief for procedures of shorter duration, such as a cesarean, the second stage of labor, rapidly progressing labor, or postpartum tubal ligation. In contrast to an epidural, the medicine begins to take effect immediately.
  - **Combined Spinal Epidural (CSE)** offers the rapid onset of spinal analgesia combined with the ability to use the epidural catheter to prolong the duration of analgesia.
  - Side effects of epidural or spinal anesthesia may include hypotension (low blood pressure), transient (temporary) fetal heart rate decelerations, post-dural puncture headache (caused by puncture of membranes surrounding the spinal cord), transient neurologic symptoms (itching), fever, maternal paralysis (very rare, occurring in women who cannot clot their blood normally).
- Local Anesthesia (direct injection into perineum at the time of delivery and/or laceration repair); or
  - Direct injection: local anesthetic injected directly into the perineum, vagina, and/or vulva before episiotomy and during repair of lacerations.
  - Pudendal block: local anesthetic injected into the pudendal nerves on each side of the pelvis immediately prior to vaginal delivery. This causes numbness of the perineum (area between vulva and anus) during delivery. A pudendal block can be used for operative vaginal delivery and can help decrease the pain of laceration and repair in a patient who does not have an epidural.
  - Transversus abdominal plane (TAP) or quadratus lumborum (QL) block
    - A special kind of long-acting local anesthetic that is injected between the abdominal muscle layers (“Abs”) during surgery while still anesthetized from the procedure. It helps to numb the incisional (“sharp”) pain from surgery for 24-72 hours. This allows for a faster recovery and possible earlier discharge from the hospital. This can usually be given after a spinal block, but not usually after a higher dose epidural block.

- General anesthesia
  - Reserved for cesarean patients who cannot use regional analgesia or in some emergency situations.
  - All inhaled anesthetic agents readily cross the placenta and have been associated with neonatal depression. Induction of anesthesia should be as close as possible to actual delivery.

(ACOG Practice Bulletin 209: Obstetric Analgesia and Anesthesia. Mar 2019. ACOG Clinical Practice Guideline 8: First and Second Stage Labor Management. Jan 2024)

## **THE SECOND STAGE OF LABOR: PUSHING**

### **Pushing:**

- It is best to push during contractions as they provide additional force. Some women may benefit from direction while pushing; others may push effectively with minimal instruction.
- Using a mirror or touching the head is a personal preference. A mirror may help encourage or show a woman how she is pushing. Touching the head lets you know that you are almost done!
- Having a stronger block from regional anesthesia (ex. an epidural) may result in the pushing process taking longer, possibly 1-2 hours longer. The amount of medication given by the epidural can be increased if pain control is poor or lessened to help improve the sensation of pressure and ability to push effectively.

### **Operative Vaginal Delivery:**

- Forceps or vacuum may be necessary for cases involving: maternal exhaustion, to shorten or avoid pushing, or in the case of fetal heart rate patterns which indicate that the baby should be delivered rapidly to prevent neonatal depression (baby not breathing or otherwise transitioning well on their own).
- Both forceps and vacuum are acceptable and safe instruments for operative vaginal delivery. The physician will determine which instrument to use in a particular situation and obtain your consent.
- Neonatal injuries are rare after operative vaginal delivery and may be the result of abnormal labor forces and not the instruments.

(ACOG Practice Bulletin 219: Operative Vaginal Birth. Apr 2020.)

### **Delivery Positions:**

- Delivery on your back in a semi-reclined position is the most commonly used position and allows a provider maximum space for applying delivery maneuvers which is most important in emergent situations.
- The bed, footrests, leg-rests, birthing handles, and birthing bar can be positioned in a variety of ways to help keep you comfortable while ensuring space for the physician and safe delivery for the infant.

### **Episiotomy:**

- Restricted use of episiotomy whenever possible reduces the likelihood of perineal lacerations (tears in tissue between vagina and anus), and it is recommended by ACOG to avoid the use of episiotomy.
- There is no evidence supporting episiotomy in preventing pelvic floor damage.
- Formerly suggested fetal benefits of episiotomy including cranial protection, reduced perinatal asphyxia (deprivation of oxygen), less fetal distress, better APGAR scores (evaluation of newborn's health), reduced complications from shoulder dystocia (baby's shoulder stuck during delivery); these are not supported by data.

(ACOG Practice Bulletin 198: Prevention and Management of Obstetric Laceration at Vaginal Delivery. Sept 2018.)

**Indication for Cesarean Delivery:**

- Indications for scheduled cesarean delivery include: placenta previa (placenta covers the cervix), prior uterine surgery affecting active segment, malpresentation (abnormal fetal position), multiples, or maternal request.
- Labor indications for cesarean delivery include: labor arrest (no cervical change over multiple exams or baby's head not coming down with pushing) or baby's heart rate not responding well to labor despite efforts for improvement.
- Majority of cesareans are done using spinal or epidural anesthesia. This allows you to stay awake. Emergency cesareans, when a patient does not already have an epidural, necessitates general anesthesia.
- If general anesthesia is required, no family is allowed in the room during delivery.

**After Vaginal Delivery:**

- Delayed cord clamping is a routine practice in modern obstetrics for up to 60 seconds. It results in improved transitioning to early neonatal life for both preterm and term pregnancies but may also increase the risk for neonatal phototherapy (light therapy for the treatment of jaundice).
- The evidence for delayed cord clamping in preterm infants is the most robust. Delaying clamping 30-60 seconds after birth has neonatal benefits including improved transitional circulation, better establishment of red blood cell volume, and decreased need for transfusion. The greatest benefit is the possibility for a nearly 50% reduction in bleeding in the brain.
- Delayed cord clamping will be stopped prior to 60 seconds if it is clear the infant needs to be resuscitated immediately.
- Timing of umbilical cord clamping should not be altered for the purpose of collecting umbilical cord blood for banking.  
(ACOG Committee Opinion 814: Delayed Umbilical Cord Clamping After Birth. Dec 2020)

**Umbilical Cord Blood Banking:** public (donation) or private (personal "insurance" policy)

- The blood left in the newborn's umbilical cord after it is cut contains potentially beneficial cells called stem cells. The blood can be collected and stored (banked) for future medical use.
- Public banking promotes donation to someone related or unrelated to the donor. Publicly banked blood must meet donor screening standards and infectious disease testing as outlined by the FDA. Public banking is not typically offered at the Pavilion for Women.
- Private banking was developed for use by the donor family later in life if a disease is present in a sibling or develops in the infant over time. There is an initial processing cost and an annual storage fee. There is no accurate estimate of the likelihood of the individual needing or using their cord blood; some estimate approximately 1 in 2,700 individuals will use the umbilical cord blood for a child or a family member.

(ACOG Committee Opinion 771: Umbilical Cord Blood Banking. Mar 2019)

(Updated May 2024)

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**Baylor College of Medicine – Gynecologic and Obstetric Specialists**

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6620 Main St., Suite 1220, Houston, TX 77030  
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