How common is it? Size is what matters most when it comes to shoulder dystocia, which occurs most frequently in very large babies. In fact, statistics show that fewer than 1 percent of babies weighing 6 pounds have shoulder dystocia, while the rate is considerably higher in babies weighing more than 9 pounds. For that reason, mothers who have uncontrolled diabetes (gestational diabetes or diabetes developed before pregnancy) are more likely to encounter this complication during delivery. The chances also rise if your pregnancy has gone past 40 weeks (since babies who arrive late are likely to be on the larger size) or if you've previously delivered a baby with shoulder dystocia. Still, many cases of shoulder dystocia occur during labors without any of these risk factors.

What are the signs and symptoms? Delivery stalls after the head emerges and before the shoulders are out. This can occur unexpectedly in a labor that has progressed normally up to that point.

What can you and your practitioner do? A variety of approaches may be used to deliver the baby whose shoulder is lodged in the pelvis, such as changing the mother's position by sharply pressing her thighs against her belly, applying pressure on her abdomen right above the pubic bone, or trying to turn the baby's shoulder while it is still inside. If the mom is mobile (for instance, hasn't had an epidural), rotating to an all-fours position might help. In some cases (such as when the estimated weight of the baby is over 9.9 pounds and the mom is diabetic, if the baby is estimated to weigh over 11 pounds in any pregnancy, or there was a shoulder dystocia in a prior pregnancy), the doctor might recommend a scheduled c-section to avoid the potential for vaginal delivery complications, including shoulder dystocia.

Can it be prevented? Keeping your weight gain within the recommended range may lower the chances of having a baby too big to easily maneuver through the birth canal, as can carefully controlling diabetes or GD.

Serious Perineal Tears

What is it? The pressure of your baby's large head pushing through the delicate tissues of your cervix and vagina can cause tears and lacerations in your perineum, the area between your vagina and your anus.

First-degree tears (when only the skin is torn) and second-degree tears (when skin and vaginal muscle are torn) are common. But severe tears—those that get close to the rectum and involve the vaginal skin, tissues, and muscles of the anal sphincter (third degree) or those that actually cut into the rectum (fourth degree)—cause pain and increase not only your postpartum recovery time, but your risk of incontinence, as well as other pelvic floor problems. Tears can also occur in the cervix.

How common is it? Anyone having a vaginal delivery is at risk for a tear, and as many as half of moms will have at least a small tear. Third- and fourth-degree tears are much less common.

What are the signs and symptoms? Bleeding is the immediate symptom. After the tear is repaired, you may also experience pain and tenderness at the site as it heals.

What can you and your practitioner do? Generally, all lacerations that are longer than 2 cm (about 1 inch) or that continue to bleed are stitched. A local anesthetic may be given first, if one wasn't administered during delivery or if you didn't have an epidural.

If you end up tearing or having an episiotomy, sitz baths, ice packs, witch hazel, anesthetic sprays, and simply exposing the area to air can help it heal more quickly and with less pain (see page 463).

Can it be prevented? Perineal massage and Kegel exercises (see pages 384 and 229), done during the month or so before your due date, may help make the perineal area more supple and better able to stretch over your baby's head as he or she emerges (though perineal massage before labor will only be helpful if you're a first-timer). Warm compresses on the perineum and perineal massage during labor may help avoid tearing. Allowing the delivery to slow down and be controlled (pushing only when you feel the urge, not on a specific timetable) will give your perineum more time to stretch so it'll be less likely to tear. Some practitioners suggest that delivering on all fours makes it less likely you'll tear, while squatting or lying flat on your back slightly increases the chances of tearing.

Uterine Rupture

What is it? A uterine rupture occurs when a weakened spot on your uterine wall—almost always the site of a previous uterine surgery, such as a c-section or fibroid removal—tears due to the strain put on it during labor and delivery. A uterine rupture can result in uncontrolled bleeding into your abdomen or, rarely, lead to part of the placenta or baby entering your abdomen.

How common is it? Fortunately, ruptures are rare in women who've never had a previous cesarean delivery or uterine surgery. Even women who labor after a previous c-section (have a VBAC) have only a 1 in 100 chance of rupture (and the risk is far lower when a woman undergoes a repeat c-section without labor). Women at greatest risk of uterine rupture are those attempting a VBAC who have been induced with prostaglandins—which is why VBACs are generally not done if the mom needs to be induced. Abnormalities related to the placenta (such as placental abruption or placenta accreta, or to the baby's position (such as a fetus lying crosswise) can also increase the risk of uterine rupture. Uterine rupture is more common in women who have already had 6 or more babies or have a very distended uterus (because of multiple fetuses or excess amniotic fluid).

What are the signs and symptoms? Searing abdominal pain (a sensation that something is "ripping") followed by diffuse pain and tenderness in the abdomen during labor (even in moms with epidurals) are the most common signs of uterine rupture. Most typically, the fetal monitor will show a significant drop in the baby's heart rate. The mother may develop signs of low blood volume, such as an increased heart rate, low blood pressure, dizziness, shortness of breath, or loss of consciousness.

What can you and your practitioner do? If you have had a previous c-section or uterine surgery in which the uterine wall was cut through completely and you'd like to attempt a vaginal birth, discuss with your practitioner whether you're a good candidate for VBAC (see page 357). Not being induced makes the extremely low risk of uterine rupture during VBAC even lower. If you do end up with a uterine rupture, an immediate c-section is necessary, followed by repair of the uterus. You may also be given antibiotics to prevent infection.

Can it be prevented? For women with increased risk (such as a previous c-section), fetal monitoring during labor

can alert your practitioner to an impending or occurring rupture. Women who are trying for a VBAC delivery should not be induced except in certain circumstances—discuss with your ob.

Uterine Inversion

What is it? Uterine inversion is a rare complication of childbirth that occurs when part of the uterine wall collapses and turns inside out (in effect, like a sock being pulled inside out), sometimes even protruding through the cervix and into the vagina. The full range of problems that can cause uterine inversion is not fully understood, but in many cases it includes the incomplete separation of the placenta from the uterine wall—the placenta then pulls the uterus with it when it emerges from the birth canal. Uterine inversion, when unnoticed and/or untreated, can result in hemorrhage and shock. But that's a remote possibility, since the condition is unlikely to go unnoticed and untreated.

How common is it? Uterine inversion is very rare—reported rates vary from 1 in 2,000 births to 1 in 50,000. You are at greatest risk for a uterine inversion if you've had an inversion during a previous delivery. Other factors that slightly increase the very remote risk include an extended labor (lasting more than 24 hours), several previous vaginal deliveries, or use of drugs like magnesium sulfate (given to halt preterm labor). The uterus also may be more likely to invert if it is overly relaxed or if the umbilical cord is short and is pulled too hard during delivery.

What are the signs and symptoms? Symptoms of uterine inversion include:

- Abdominal pain
- Excessive bleeding
- Signs of shock
- In a complete inversion, the uterus will be visible in the vagina

What can you and your practitioner do? Know your risk factors and tell your practitioner if you've had a uterine inversion in the past. If you do have one, your practitioner will try to push your uterus back up where it belongs, and then give you Pitocin (oxytocin) to encourage any floppy muscles to contract. In rare cases, where this does not work, surgery to reposition the uterus is an option. In either case, you might need a blood transfusion to make up for blood loss. Antibiotics may be given to prevent infection.

Can it be prevented? Because a woman who has had an inversion is at an increased risk for another, let your practitioner know if you've had one in the past.

Postpartum Hemorrhage

What is it? Bleeding after delivery, called lochia, is normal. But sometimes the uterus doesn't contract as it should after birth, leading to postpartum hemorrhage—excessive or uncontrolled bleeding from the site where the placenta was attached or from unrepaired vaginal or cervical lacerations. Hemorrhage can occur up to a week or two after delivery when fragments of the placenta are retained in, or adhere to, the uterus. Infection can also cause postpartum hemorrhage, right after delivery or weeks later.

How common is it? Postpartum hemorrhage occurs in 2 to 4 percent of deliveries. Excessive bleeding may be more likely to occur in these circumstances:

- The uterus is too relaxed and doesn't contract due to a long, exhausting labor.

- The uterus is overdistended because of multiple births, a large baby, or excess amniotic fluid.
- There was a traumatic delivery.
- Bits of the placenta were retained (unnoticed by the practitioner) after delivery.
- The placenta is oddly shaped or separates prematurely.
- Fibroids prevent symmetrical contraction of the uterus.
- The mother is very weak at the time of delivery (due to anemia, preeclampsia, or extreme fatigue, for example).
- The mother has been taking medication or supplements that interfere with blood clotting (such as aspirin, ibuprofen, ginkgo biloba, or large doses of vitamin E).
- There is an undiagnosed genetic bleeding disorder in the mother (which is very rare).

What are the signs and symptoms? The symptoms of postpartum hemorrhage include:

- Bleeding that soaks through more than 1 pad an hour for several hours in a row
- Heavy, bright red bleeding for more than just a few days
- Passing very large clots (lemon size or larger); smaller clots are normal
- Pain or swelling in the lower abdominal area beyond the first few days after delivery

The loss of large amounts of blood can make a woman feel faint, breathless, or dizzy, or cause her heart to speed up.

What can you and your practitioner do? You should expect bleeding following delivery, but alert your practitioner immediately if you notice abnormally heavy bleeding or any of the other symptoms listed above during the first postpartum week. If the bleeding is severe enough to be categorized as hemorrhage, you may need IV fluids or possibly even a blood transfusion.

Can it be prevented? After the placenta is delivered, your practitioner will examine it to make certain that it's complete—that no part of it might have remained in your uterus (which could lead to excessive bleeding or infection). He or she will probably give you Pitocin (oxytocin) or other medication and may massage your uterus to encourage it to contract to minimize bleeding. Breastfeeding (if you will be nursing) as soon as possible will also help your uterus contract, minimizing bleeding. Avoiding any supplement or medication that may interfere with blood clotting will also reduce the possibility of excessive postpartum bleeding.

Postpartum Infection

What is it? The vast majority of new moms recover from delivery without any problems at all, but childbirth can occasionally leave you open to infection. That's because it can leave you with a variety of open wounds—in your uterus (where the placenta was attached), in your cervix, vagina, or perineum (especially if you tore or had an episiotomy, even if it was repaired), or at the site of a c-section incision. Postpartum infections can also occur in your bladder or kidney if you were catheterized. A fragment of the placenta inadvertently left behind in the uterus can lead to infection, too. But the most common postpartum infection is endometritis, an infection of the lining of the uterus (the endometrium).

While some infections can be dangerous, especially if they go undetected or untreated, most often infections simply make your postpartum recovery slower and more difficult, and they take time and energy away from your most important priority: getting to know your baby. For that reason alone, it's important to get help for any suspected infection as quickly as possible.

How common is it? As many as 8 percent of deliveries result in an infection. Women who had a cesarean delivery or those who had premature rupture of the membranes are at greater risk.

What are the signs and symptoms? Symptoms of postpartum infection vary, depending on where the infection is, but there's almost always:

- Fever
- Pain or tenderness in the infected area
- Foul-smelling discharge (from the vagina in the case of a uterine infection, or from a wound)
- Chills

What can you and your practitioner do? Call your practitioner if you're running a postpartum fever of 100°F for more than a day; call right away if the fever is higher or if you notice any of the other symptoms above. If you have an infection, you'll probably receive a prescription for antibiotics (one that's breastfeeding-friendly if you're nursing). Take it as prescribed for the entire course, even if you begin to feel better. Taking probiotics when you're on the course of antibiotics (though spaced at least 2 hours apart) may prevent associated diarrhea, vaginal yeast infection, or thrush (in you or your baby, if you're breastfeeding). You should also try to get plenty of rest and drink lots of fluids.

Can it be prevented? Meticulous wound care and cleanliness after delivery can definitely help prevent infection (wash your hands before touching the perineal area, wipe from front to back, and use only maxipads—not tampons—for postpartum bleeding).

ALL ABOUT:

If You're Put on Bed Rest

Bed rest (a still-popular catchall phrase for a pregnancy prescription that's increasingly known as "activity restriction") can mean different things to different practitioners—and to the patients they prescribe it for. Maybe it's just getting off your feet every couple of hours, maybe it's that plus handing over the vacuum to your partner and turning in your gym membership for a while, maybe it's staying in bed for at least half the day, every day—and maybe it's a hospital stay for the last few weeks (or months) of your pregnancy. No matter what form it takes (or what it's called) it's estimated that bed rest is still being prescribed in about 20 percent of pregnancies in the U.S. That number may be waning, but probably not as quickly as many practitioners, many pregnant patients, and even ACOG would like.

So has this time-honored prescription for many problem pregnancies timed out? Probably not. There are still

a number of reasons why a practitioner might recommend a restriction of activities, but probably the simplest rationale is that practitioners often have no other treatment options open when trying to prevent complications like preterm birth—and yet, they feel compelled to "do something."

Certain moms-to-be are more likely to wind up on some kind of bed rest, including those who are over 35 (because they're generally more at risk of pregnancy complications), as well as those who are carrying multiples, have a history of miscarriage due to cervical insufficiency, who have pregnancy bleeding (such as in a threatened miscarriage), have particular pregnancy complications such as preeclampsia, have certain chronic conditions, or have threatened preterm labor.

What Kind of Rest?

If you've been put on bed rest, it's likely your marching (or in this case, no-marching) orders came with a list of very specific can-dos and definitely don't-dos. That's because bed rest comes in a variety of packages. Here's the basic lowdown on each type of bed rest. Be sure to talk over the options with your practitioner if you're being put on any form of bed rest—to make sure it's not stricter than it needs to be.

Scheduled resting (or activity restriction). In the hopes of preventing full bed rest later, some practitioners ask moms-to-be with certain risk factors (such as multiples or a previous preterm delivery) to rest for a prescribed amount of time every day. The recommendation may be to sit with your feet up or lie down for 2 hours at the end of every workday or rest for an hour, lying down on your side (left preferably, but either side is fine), for every 4 hours that you're awake. Some practitioners may ask you to simply shorten your workday in your third trimester and restrict activities such as exercise, stair-climbing, and walking or standing for extended lengths of time.

Modified bed rest. With modified bed rest, you're generally prohibited from working in the office (though working from the comfort of home is probably okay), driving, and doing household chores (now, that's something to celebrate!). Sitting up (possibly with your feet up) is probably fine, as is standing just long enough to make yourself a sandwich or take a shower. You may even be granted one outing per week, as long as it doesn't involve a long walk or any stairs. You'll also be able to go to your monthly (or even weekly, if necessary) practitioner appointment. Moms-to-be on modified bed rest may split their day between the couch or recliner and the bed, but going up or down stairs will be kept to a minimum. Light physical therapy may be prescribed.

Strict bed rest. This usually means you need to be horizontal all day except for bathroom trips and a brief shower (using a shower chair if possible). If there are stairs in your house, you're going to have to pick a floor and stay there. (Some women will be allowed to make a round-trip between floors once a day, for others it might be just once a week.) Strict bed rest means no kitchen privileges, so unless you'll have someone around to serve up meals and snacks, you'll need a minifridge or cooler by your bed. Light physical therapy may also be prescribed at home.

Hospital bed rest. Some moms-to-be require constant monitoring, which means hospital admission. And just by the nature of being in the hospital,

Before You Head to Bed

Been sent to bed? Check this list before you crawl under the covers.

- Check in with your health insurance company. Let your health plan know you've been put on bed rest (and submit the right medical forms from your practitioner if necessary). Ask what home care, if any, will be covered. Ask, too, if you might be covered for physical therapy, medical supply rental, or even massage. You can also inquire about your coverage in case your baby is born prematurely.
- File for disability insurance. Bed rest can have enormous financial impact on a family that's about to expand (another reason to be sure it's truly necessary as prescribed). If you won't be able to work, speak to someone in the HR department (if there is one) at your workplace to see if you qualify for short term disability coverage (you should, though you and your practitioner will have to document the reasons why)—and whether your bed rest "time off" from work will cut into your FMLA coverage (see page 200), if you are entitled to any.
- Explore work-at-home options. If your job and your employer are flexible, you may be able to continue working at least part-time while on bed rest. Or if your job doesn't allow this, perhaps you can look into opportunities that do.
- Load up your phone. Make sure you've updated your contact info with numbers you may need while you're stuck in bed (your practitioner, the pharmacy, the hospital, neighbors and friends who can help you in a hurry).
- Create online or app accounts for restaurant delivery, grocery and drugstore delivery, online concierge services, dog walker services, laundry services, and so on, and let the deliveries begin—finances permitting.
- Hire help, if possible. Or enlist help from family, friends, and neighbors who have offered. You'll need a hand with light cleaning, errands, babysitting (if you have other children at home), carpooling (if you have older kids who need to get to school, activities, and play dates), meal prep, and laundry. If your friends and neighbors have offered to help, suggest they use online tools to keep things organized, such as lotsahelpinghands.com, carecalendar.org, or mealbaby.com.
- Give people who you'll want visiting access to your keys (or leave a key with a neighbor, the apartment manager, or doorman) so you don't have to get out of bed each time the doorbell rings. If possible, arrange to have a neighbor accept deliveries.
- Purchase or borrow a mini fridge that can be placed next to your bed (or couch) and stocked with drinks, cut up veggies, cheese, yogurt, and other snacks that need to stay chilled. Or consider a cooler lined with ice packs and restocked daily.
- Set up a charging station for your laptop, phone, tablet, and anything else that'll need to be recharged. All the wires should be within easy reach.

you'll be spending a lot more time in bed. However, given concerns about prolonged inactivity, if you're prescribed hospitalization, you may also be prescribed light physical therapy during your stay—a good thing, since it'll keep your muscles working in a way that's safe for you and your baby. If you've

been admitted to the hospital because preterm labor has already begun, you'll likely need constant monitoring as well as IV meds. Your bed may even be positioned at a slight angle (feet higher than head) so that gravity can help keep your baby (or babies) growing in your womb for as long as possible.

Pelvic rest. Yes . . . this means exactly what it sounds like: no sex. But what "no sex" means is up for interpretation, so be sure to ask exactly what it means in your circumstance. It might mean nothing inserted into the vagina (no penis, fingers, dildos, vibrators, and so on), it might mean no oral or anal sex either, or it might just mean no orgasm for you. You might be put on pelvic rest if you've been bleeding (such as with a threatened miscarriage in the first trimester or later in pregnancy because of placenta previa), or because you have a history of preterm delivery, or if you're having premature contractions in this pregnancy, or because you have cervical insufficiency.

The Downsides of Resting

Staying off your feet (whether it's being sent to bed, your sofa, or the hospital) for weeks or even months definitely can take a physical toll. Prolonged inactivity can lead to hip and back pain, muscle loss (which can make it harder to bounce back once you deliver), skin irritation (aka bed sores), bone loss, and even blood clots in the legs. It may also aggravate many of the normal symptoms of pregnancy, such as heartburn, constipation, and leg swelling, as well as increase your risk for GD, since your body isn't breaking down glucose at its usual rate. Bed rest may decrease your appetite, which might keep you from eating enough to nourish your baby (or babies). On the flip side, endless hours in bed can invite mindless eating—especially if you're out of your mind with boredom—and that can lead to excess weight gain, especially since you're not burning calories through regular activity and exercise.

But there can be a psychological cost to bed rest, too. Prolonged inactivity is linked to pregnancy depression and anxiety, especially if you're stuck indoors, cut off from activities that typically keep your mind and body busy, deprived of social interaction, exercise (and the natural-high hormones it releases), sex (ditto), the stimulation of work, even exposure to sunlight (which boosts mood and regulates sleep). There's a loss, too, of the "normal" pregnancy experience (the one where everyone around you becomes extra-attentive, solicitous, respectful—where that bump makes you feel extra-special wherever you go). The emotional impact (like the physical impact) may linger after delivery, and is associated with a higher risk of postpartum depression and anxiety disorders.

Staying Up When You're Lying Down

The thought of lying in bed or lounging around the house with the TV remote may sound pretty appealing—until it's prescribed in the form of bed rest. Bed rest, unfortunately, is no pajama party. Once reality sets in, taking it easy can suddenly seem like hard work. That's why it's important not to lose sight of the big picture (healthy pregnancy, healthy baby) and to remind yourself that your practitioner probably has good reason for keeping you off your feet—or at least off your regularly scheduled high-activity lifestyle.

Once you find out from your practitioner exactly which activities are allowed (and which aren't), use these tips to minimize some of the side effects.

Physically. You may be surprised at the things you can still do when you're being asked to do less. A few suggestions:

- Move what you can. Your practitioner may allow—and in fact prescribe—some low-impact exercise (walks, light weights for your upper body, resistance bands for your lower body) to minimize muscle loss and maintain your strength.
- Stretch what you can. As much as you can under your practitioner's guidelines, stretch your legs, circle your ankles, and flex your feet to help prevent blood clots and keep your muscles strong. Raise and lower your arms, do shoulder rolls, do chest expansions (lace your fingers behind your back and open your chest), and so on to keep up your strength in your upper body. And don't forget those Kegels, which you can do even if you're sent to bed.
- Monitor what you eat. A significant dip in a mom's appetite can lead to weight loss for her and a lower birthweight for her baby—so if you find yours slacking, fight back by grazing on nutritious snacks. Of course, if you find yourself eating too much (out of boredom or depression), excessive weight gain might also become an issue—so keep an eye on nonstop nibbling, and make sure you have healthy snacks handy.
- Stay hydrated. It's easy to remember to drink water when you're active (say, after a run), but it's hard to work up a thirst in bed. Getting enough fluids helps minimize swelling and constipation, which are both compounded by moving less.
- Keep comfortable. If you are confined to bed for most or part of the day, maximize blood flow to your uterus by lying on your side, not your back, and change sides every hour or so to lessen body aches and prevent bed sores. Put a pillow under your head, a body pillow under your belly and between your knees, and perhaps a pillow behind you (a regular one or a specially designed one for propping), if that helps you to balance. Staying propped up in bed (especially after eating) also helps ease heartburn.

Mentally. Living with limitations on your activity can be hard to handle—especially if you're normally a very active person. Sometimes keeping yourself busy can provide a welcome distraction. Try to:

- Stay connected. Of course, you'll want to stay in touch with family and friends via phone, text messaging, videochatting, and social media—if only so you can vent to those who love you most. But you may find the most empathy and support from those who are also sitting out pregnancy—your fellow bed-resters. You can find them on WhatToExpect.com (and don't forget to go app happy with the What To Expect app). Or check out the box on page 581 for a list of other online resources for women going through high-risk pregnancies.
- Structure the day. Try to establish a routine—even if the highlight is a short (approved) walk down the block and a shower.
- Work from home. If your job allows it, go for it. But first, get clearance from your practitioner so you're clear what your limits are (for instance, on how much stress you can be under).

FOR FATHERS

Handling Bed Rest

Having her activity restricted is clearly no picnic for your partner (especially if she's actually banished to bed)—and it's certainly no vacation for you, either. In fact, you'll be working overtime trying to keep up with the household chores and errands that you may have previously shared—adding a variety of new job descriptions to your previously existing ones, from executive assistant to butler, chef (and water bottle filler), chauffeur, housekeeper, pillow fluffer, amateur (or make that "pop") psychologist, and verbal punching bag (a girl's got to vent), all juggled with your regular job. Have other children at home? Their care and feeding will be your job, too, for the most part. Her bed rest will be exhausting for you, for sure, but if you keep your eyes on the prize (a healthy mom and a healthy baby), you'll soldier through this rough patch. Here are some ways to help you (and your partner) handle the ups and downs of being put on bed rest:

Set up a steady stream of visitors. Sure, she only has eyes for you—but after many long, boring days of staying home (or mostly home), your spouse may crave a change of pace, and a change of faces. So work with your friends and family to put together a rotating schedule of visitors who will hang out with your honey. It'll be good for her, and you'll get the break you need (and deserve).

Bring on the entertainment. You'd be bored silly (or cranky), too, if you were stuck at home. Stock up on games, choose a TV series to download and binge watch together, and learn the best takeout places in the neighborhood (then order from them online). Surprise her with a mix of her favorite music.

Exercise together. She might only be able to walk around the block, but with you by her side, that walk will be a lot more fun. She's been allowed to use light weights for some upper body moves? Grab your weights and do some chest flies while she does her light bicep curls. Encourage her to bicycle her legs (if that's allowed) or do foot flexes while you do some spinning on the stationary bike next to her. Do sit-ups in bed next to her while she's doing her neck rolls.

Ask her "in" for a date. She may not be able to get out to a dinner and a movie, but you can bring the date night home (or to the hospital room). Dress up (even if it's just your best pj's), put on some dinner music, bring out the candles and the nice dishes, and have her favorite restaurant deliver (or cook her favorite meal). It may not have the same ambience she remembers from your nights out, but it'll be a welcome respite from the daily waiting game.

Treat her. If it's in your price range, or is covered by insurance, bring in a massage therapist for a prenatal rub down

- Prepare for baby. Register for your layette, order the gear, and scout for a doula, a lactation consultant, a pediatrician, even childcare options—all online.
- Create a baby playlist. Start playing the songs now, and your little one will likely be soothed by them later. Plus, music may soothe you when you need it the most (like now, when you're feeling a little savage-beast-like).

(just make sure it's cleared by her practitioner). See if a local nail salon will agree to a house call and (finances permitting) book her a mani-pedi. If that's out of your financial league or not up her alley, give her a back rub, do facials together at home (find an online recipe for one that's made from ingredients you probably have at home, like oatmeal or avocado), or offer to paint the toes she can no longer reach.

Talk her up. Just about every expectant mom could use an extra boost for her confidence, but mamas-on-bed-rest can benefit from even more sweet talking. Yes, you always think she's beautiful and sexy, even when she hasn't washed her hair in days or put on makeup in weeks, but does she know you think that? Let her know . . . as often as you can.

Lend your shoulder and your ear. Sometimes, she'll need to vent, and most times, you'll be on the receiving end of her frustrations. For best results (and because she deserves it), respond with patience, understanding, and empathy. Talk her up (or talk her down when she's feeling on the ledge)—remind her she's beautiful, strong, and your own personal hero, and that this too shall pass (leaving you both with a cuddly prize package for her efforts)—but also let her unload as much as she needs to. As you attend to her emotional needs, however, try not to ignore your own entirely. Be sure to take a break yourself now and then (that's what the rotating schedule of visitors is for) and lean on your buddies for support, too. Being on bed rest is hard—but so is being the care provider for someone on bed rest.

Watch her mood. Being stuck on bed rest is linked to an increased risk of pregnancy depression and anxiety disorder. Be alert to the signs (see page 174) and if you notice them, take the steps necessary to get her the help she needs. Be alert, too, to the signs of postpartum depression (see page 498), since pregnancy bed rest increases that risk as well. Is your mood worrying you? Depression can hit expectant and new dads, too. Check in with your doctor and make sure you get the help you need.

Help her bounce back. Think that after all that rest, she'll be ready to run new-baby marathons when it's over? Actually, the opposite will be true. The longer she has spent on restricted activity, the more deconditioned she'll become—and the less energy and stamina she'll have. Which means she'll actually be more tired than the average new mom, not more refreshed, and that she'll likely need more help during her postpartum recovery, not less. Give her that help, as well as the time she needs to get back her strength—but remember that both of you can expect to feel pretty drained for a while, thanks to your new parent positions.

- Stream some shows. Two words: binge watch.
- Get crafty. Knit, crochet, scrapbook, or quilt (if you don't know how, turn to a YouTube tutorial or a crafty friend). You'll keep busy while creating keepsakes for your little one.
- Organize. Clean up your laptop and your phone once and for all, catch up on software and app updates, upload

photos into a digital frame. Create a baby announcement list, and design your e-card or paper birth announcement. Make sure you have all the addresses (or email addresses) ready to roll. You can even print out address labels in advance, if you're pretty sure you won't want to handwrite them. Order stamps while you're at it.

- Socialize. Throw a pajama party—order in pizza or have your friends bring over a potluck. And if you can't go out for your baby shower, ask your friends to throw it at your house.
- Primp and polish. Try not to fall into the "nobody's going to see me anyway" trap. Looking good makes you feel good, whether anyone sees you or not. So brush your hair, put on makeup, slather your tummy in yummy-smelling lotion (your skin might be itchy and dry anyway), treat yourself to a DIY facial or mani. If you can afford it, consider having a mobile hairstylist or manicurist make a house call. (Drop the hint to your friends that this would make a great shower gift.)
- Start a journal. Now's a great time to begin recording your thoughts in an online journal or in the *What to Expect Pregnancy Journal and Organizer.* Or consider writing a few letters to your baby, to preserve pregnancy moments you can share with your child years later. Have some feelings about bed rest you'd like to vent? You can journal those, too.
- Be a mommy-to-be blogger. Always wanted to write? Now's your chance.
- Keep your eyes on the prize. Frame one of your ultrasound pictures, and keep it by your side or put it on your phone or tablet as your wallpaper—so when the going gets tough, you can remind yourself that you have the best reason in the world not to go anywhere at all.

Bed Rest and the Rest of Your Family

Wondering how bed rest will affect the rest of your family, from your partner to other children (including your furry ones)? It will probably affect them in more ways than you'd imagine:

Your partner. When you're sent to bed, your partner may be sent to work—overtime. Depending on your restrictions, he may become responsible for most of the household cleaning and laundry, errands, grocery shopping, and meal prep—all in addition to his regular job. Sex might be taken off the table, too, so try to be gentle and patient with each other as you both power through this dry spell. And though you're probably aching for company after long days alone, encourage your partner to go out with friends occasionally—it'll do him good (and that will do you both good).

Have other children? He'll clearly have even more on his hands (and in his arms . . . and on his back . . . and in his backseat). Since he's shouldering the load, try to be especially respectful of his parenting style and techniques, which might be different from yours.

Your children. If you already have other children—especially age-appropriately clingy little ones who just want to be picked up and carted around on mom's hip—activity restriction can be an added challenge. You'll probably be looking at fewer tickle-fests and hide-and-seek marathons—and more tea parties, books, puzzles, coloring, and board (okay, bored) games. You can also spend time together looking at pictures

Moms Helping Moms

Every pregnancy comes with some challenges, but a pregnancy that's high risk (or one that's been complicated) can come with a whole lot more. Facing those challenges is always easier when you've got company—other moms who know exactly what you're going through because they're going through it, too (or have already gone through it themselves). You're likely to find that support online—check out WhatToExpect.com, sidelines.org, betterbedrest.org, and keepemcookin.com.

of your older child as a baby, helping him or her acclimate to the idea of the newborn soon to arrive. Try not to pin the blame for your bed rest on the baby-to-be, however, since that could set the stage for sibling rivalry. Instead say the doctor's orders were to rest so that the baby can grow strong and healthy. If at all possible, have someone else take your toddler for a run around outside every day, since burning off some of that energy may facilitate quieter playtime with you.

Feeling guilty about not "being there" for your older ones? That's understandable (guilt sort of comes with the mom territory), but try to let it go. Remember, your little ones cherish every mama moment, even those spent snuggling in bed together.

Your pets. For some dogs and most cats, it doesn't get better than lying in bed or on the sofa with mommy all day. But for the frisky few who need interactive playtime, mom's activity restriction can cramp their style. Ditto those who need long walks. Of course your partner can take over the pet care (and if necessary, you can try to find a dog walker), but if your fur baby is extra mommy-dependent, you'll also have to do some extra reassuring (and petting).

When the Rest Is Over

It might seem counterintuitive, but the more you rest, the more tired you can become—and that's definitely true when you've been on bed rest for any length of time. Even the littlest efforts can seem monumental when you've lost muscle tone and strength and when decreased aerobic capacity can leave you out of breath just climbing a few stairs. Add labor, delivery, and recovery to that debilitating equation, along with normal new parent sleep deprivation, and you can expect to drag physically, even more than the average mom (who's plenty tired herself).

So keep your expectations realistic after delivery. Cut yourself some postpartum slack, factoring in all your body has been through and what it's still going through now. Plan on building back up to your former fitness level slowly but surely. Start off gradually, modifying the postpartum exercises on page 520 if even those are difficult, and then building up as your stamina (and muscle mass) increases. Walking, yoga, and swimming are good activities to get back into the game. With consistent effort on your part and help from your practitioner, family, and friends, don't worry. You'll get there!

CHAPTER 20

Pregnancy Loss

Pregnancy is supposed to be the happiest of times, filled with excitement, anticipation, and pink-and-blue daydreams about life with your baby-to-be. And usually, it is all of those things, but not always. Sometimes a pregnancy ends unexpectedly and tragically. Even if you only saw your baby on ultrasound, you bonded with your son or your daughter each day he or she was growing inside of you. And having those dreams and hopes of a future shattered is understandably heartbreaking. If you've experienced the loss of a pregnancy or if you've had a stillborn baby, you know firsthand that the depth of your pain can be beyond words. This chapter is dedicated to helping you and your partner understand what happened, handle the pain, and cope with one of life's most difficult losses.

Types of Pregnancy Loss

Early Miscarriage

What is it? A miscarriage is the loss of an embryo or fetus before it is able to live outside the uterus, resulting in the unplanned end of a pregnancy. When such a loss happens in the first trimester, as it does 80 percent of the time, it's called an early miscarriage. (A miscarriage that occurs between the end of the first trimester and week 20 is considered a late miscarriage; see page 589.)

An early pregnancy loss is often related to a chromosomal or other genetic defect in the embryo, but it can also be caused by hormonal and other factors. Most often, the cause can't be identified. Miscarriage is not caused by exercise, sex, working hard, lifting heavy objects, a sudden scare, emotional stress, a fall, or a minor blow to the abdomen, and it isn't triggered by even the most severe morning sickness.

How common is it? Early miscarriage is far more common than most women realize. Though it's hard to know for sure, researchers have estimated that over 40 percent of conceptions end in miscarriages. But since well over half of

You'll Want to Know . . .

Happily, the vast majority of women who experience a miscarriage go on to have a perfectly normal and healthy pregnancy in the future.

miscarriages occur so early that a woman doesn't even know she's pregnant yet, they often go unnoticed, passing for a normal or sometimes heavier period. See the box on page 584 for more on the different types of early miscarriage.

Signs and symptoms. The symptoms of a miscarriage can include some or all of the following:

- Cramping or pain (sometimes severe) in the center of the lower abdomen or back
- Heavy vaginal bleeding (possibly with clots and/or tissue) similar to a period
- Light staining continuing for more than 3 days
- A sudden pronounced decrease in or loss of the usual signs of early pregnancy, such as breast tenderness and nausea (not the normal, gradual diminishing as the first trimester comes to a close)
- A cervix that appears open (dilated) when examined by the practitioner
- No embryo visible on ultrasound (the sac is empty)
- No heartbeat detected on ultrasound

What can you and your practitioner do? If your practitioner finds that your cervix is dilated and/or no fetal heartbeat is detected on ultrasound (and your dates are correct), it means that you are having a miscarriage or have already had one. Sadly, nothing can be done to prevent the loss at this stage.

If you're in a lot of pain from the cramping, your practitioner may recommend or prescribe a pain reliever. Don't hesitate to ask for relief from the pain if you need it.

Many miscarriages are complete, meaning all the contents of the uterus are expelled from the vagina (that's why there is often so much bleeding). But sometimes—especially the later in the first trimester you are—a miscarriage isn't complete, and parts of the pregnancy remain in the uterus (known as an incomplete miscarriage; see box, page 585). Or a heartbeat isn't detected on ultrasound, which means the embryo or fetus has died, but no bleeding has occurred yet (this is

Are You Spotting?

Seeing red (or pink or brown) on your panties or toilet paper is definitely scary when you're expecting. But not all spotting or bleeding means you're miscarrying or losing your baby. Some women spot on and off for their entire pregnancies. Read about the many reasons for spotting that aren't related to miscarriage on page 143.

Sometimes spotting, heavy bleeding, and/or cramping indicate a threatened miscarriage. That, too, doesn't mean you're definitely losing your baby. See page 546 for more on threatened miscarriage.

If you're not sure when to call your practitioner for spotting or bleeding, see the box on page 545. If you've experienced or are experiencing a loss, this chapter can help you cope.

Types of Early Miscarriage

If you're experiencing an early pregnancy loss, the sadness you're feeling is the same no matter the cause or the official medical name. Still, it's helpful to know about the different types of miscarriage so you're familiar with the terms your practitioner might be using.

Chemical pregnancy. A chemical pregnancy occurs when an egg is fertilized but fails to develop successfully or implant fully in the uterus. A woman may miss her period and suspect she is pregnant—she may even have a positive pregnancy test because her body has produced some low (but detectable) levels of the pregnancy hormone hCG. But in a chemical pregnancy, there will be no gestational sac or placenta, and the pregnancy ends in what seems like a period. Experts estimate that up to 70 percent of all conceptions are chemical, and many women who experience one don't even realize they've conceived. Often, a very early positive pregnancy test and then a late period (a few days to a week late) are the only signs of a chemical pregnancy.

Blighted ovum. A blighted ovum (or anembryonic pregnancy) refers to a fertilized egg that attaches to the wall of the uterus and begins to develop a placenta (which produces hCG), but then fails to develop into an embryo. What is left behind is an empty gestational sac (which can be seen on an ultrasound). Experts believe that up to half of all early miscarriages are blighted ovums. Most blighted ovum miscarriages occur very early in the first trimester. Some even occur before a woman realizes she's conceived, and end in what seems like a late period. Others are only noticed during a routine early ultrasound, when (after weeks 5 or 6) a gestational sac is visible but there is no embryo inside it.

called a missed miscarriage). In either of those cases, your uterus will eventually be—or need to be—emptied so that you can recover and your normal menstrual cycle can resume (and you can try to get pregnant again, if you choose to). There are several ways that this can happen:

- Expectant management. You and your practitioner may choose to let nature take its course and wait until the pregnancy is naturally expelled. Waiting out a missed or incomplete miscarriage can take anywhere from a few days to, in some cases, 3 to 4 weeks.
- Medication. Medication—usually a misoprostol pill taken orally, or vaginally as a suppository—can prompt your body to expel the fetal tissue and placenta, and can be used in a missed or incomplete miscarriage, as well as a blighted ovum—a fertilized egg that implants but doesn't develop (see box, above). Just how long this takes varies, but typically, it's only a matter of days at the most before the miscarriage is completely expelled (though bleeding can continue for a few days longer). Side effects of the medication can include nausea, vomiting, cramping, and diarrhea.
- Surgery. Another option is to undergo a minor surgical procedure called dilation and vacuum curettage (D&C). During this procedure, the doctor gently dilates your cervix and removes (by suction) the fetal tissue and placenta

Missed miscarriage. A missed miscarriage is when the embryo or fetus dies but isn't expelled, at least not right away. Often there are no signs initially (no bleeding, for instance), and in some cases the placenta continues to produce hormones, which makes your body think you're still pregnant. A missed miscarriage is usually discovered during a routine first trimester ultrasound when there is no heartbeat detected, or later on in the first trimester when the heartbeat can't be heard with Doppler. The fact that there are no warning signs—you come to your appointment expecting to see or hear the heartbeat and there isn't one—can make the realization all the more painful. Some women notice the loss of all existing pregnancy symptoms (though that in and of itself doesn't mean that the pregnancy is lost), and less commonly, experience a brownish discharge.

Complete miscarriage. A complete miscarriage is when all the pregnancy tissue (embryo and placenta) passes from the uterus through the vagina. The woman experiences bleeding and cramping, and the miscarriage completely empties the uterus without any medical intervention. On examination, the practitioner finds that the cervix has reclosed, and there is no sign of a pregnancy sac in the uterus on ultrasound. The earlier the miscarriage occurs (usually those earlier than 12 weeks), the more likely it is to be a complete one.

Incomplete miscarriage. An incomplete miscarriage is when the embryo or fetus is no longer viable and passes through the vagina via bleeding along with some of the tissue from the placenta, but some pregnancy tissue stays inside the uterus. With an incomplete miscarriage, a woman continues to cramp and bleed (sometimes heavily) and her cervix remains dilated. Because there is some remaining placental tissue in the uterus, it continues to produce hCG, which is detectable in blood tests and doesn't fall as expected. The remaining tissue in the uterus is also still visible on an ultrasound.

from your uterus. Bleeding following the procedure usually lasts no more than a week. Though side effects are rare, there is a slight risk of infection following a D&C.

How should you and your practitioner decide which route to take? Some factors you both can take into account include:

- How far along the miscarriage is. If bleeding and cramping are already heavy, the miscarriage is probably already well under way. In that case, allowing it to progress naturally may be preferable to a D&C. But if there is no bleeding yet (as in a missed miscarriage), misoprostol or a D&C might be better alternatives.
- How far along the pregnancy is. The farther along the pregnancy is, the more fetal tissue there will be, and the more likely a D&C will be necessary to empty your uterus completely.
- Your emotional and physical state. Waiting for a natural miscarriage to occur after an embryo or fetus has died in utero can be psychologically debilitating. It's likely that you won't be able to begin coming to terms with—and grieving for—your loss while the pregnancy is still inside you. Completing the process faster will also allow you to resume your menstrual cycles soon, and when and if the time is right, to try to conceive again.

Age and Miscarriage

More and more older moms are getting pregnant and having healthy babies at the time in their lives that's right for them and their partners—who are often older, too. But on average, with increasing age comes an increased risk of miscarriage. That's because the older eggs of older moms (and possibly their older partner's sperm) are more likely to contain a genetic defect that results in an embryo that isn't viable—that is, one that can't survive. These embryos are most often miscarried. So while a 20-year-old's odds of losing a pregnancy are 10 to 15 percent, a 35-year-old has a 20 percent chance of miscarrying, a 40-year-old has a 40 percent chance, and a 45-year-old's risk of pregnancy loss is over 80 percent.

When a woman conceives through advanced reproductive techniques like IVF (which women over 40 are more likely to do), the risks of miscarriage can be lowered (though not eliminated) through preimplantation screening, which stacks the odds of a healthy pregnancy by implanting only those embryos that appear healthy and viable.

- Risks and benefits. Because a D&C is invasive, it carries a slightly higher (though still very low) risk of infection. The benefit of having the miscarriage complete sooner, however, may greatly outweigh that small risk for some women. With a naturally occurring miscarriage, there is also the risk that it won't completely empty the uterus, in which case a D&C may be necessary to finish what nature has started.
- Evaluation of the miscarriage. When a D&C is performed, evaluating the cause of the miscarriage through an examination of the fetal tissue will be easier. If this isn't your first miscarriage, genetic testing can be performed on the tissue as well, which can help predict the likelihood of recurrence, as well as provide some measure of closure.

  If you miscarry naturally and feel able (physically and emotionally, and both might be extremely difficult) to save the expelled pregnancy, you can do this in a sterile cup or small storage container, so that it can be tested later.

No matter what course is taken, and whether the ordeal is over sooner or later, the loss will likely be difficult for you. See page 592 for help in coping.

Molar Pregnancy

What is it? A molar pregnancy starts when an egg is fertilized, but instead of a normal pregnancy resulting, the placenta develops into an abnormal mass of cysts (also called a hydatidiform mole), and there is no accompanying fetus. In some cases, identifiable—but not viable—embryonic or fetal tissue is present. This is called a partial molar pregnancy.

The cause of a molar pregnancy is an abnormality during fertilization, in which 2 sets of chromosomes from the father become mixed in with either 1 set of chromosomes from the mother (partial mole)—or none of her chromosomes at all (complete mole). Most molar pregnancies are discovered within weeks of conception.

How common is it? Molar pregnancies are relatively rare, occurring in only 1 out of 1,000 pregnancies. Women under the age of 20 or over the age of

Choriocarcinoma

Choriocarcinoma is an extremely rare pregnancy-related cancer (occurring in only 1 out of every 40,000 pregnancies) that grows from the cells of the placenta. This malignancy most often occurs after a molar pregnancy, miscarriage, abortion, or ectopic pregnancy, when any left-behind placental tissues continue to grow despite the absence of a fetus. Only 15 percent of choriocarcinomas occur after a normal pregnancy.

The condition is usually diagnosed when there has been intermittent bleeding following a miscarriage, a pregnancy, or the removal of a molar pregnancy, as well as abnormal tissue discharge, elevated hCG levels that do not return to normal after a pregnancy has ended, a tumor in the vagina, uterus, or lungs, and/or abdominal pain.

If you are diagnosed, the news is very reassuring. While any type of cancer carries with it some risk, choriocarcinoma responds extremely well to chemotherapy and radiation treatments and has a cure rate of more than 90 percent. Hysterectomy is almost never necessary because of this type of tumor's excellent response to chemotherapy drugs.

And happily, with early diagnosis and treatment of choriocarcinoma, fertility is unaffected, though it's usually recommended that trying for another pregnancy be postponed for 1 year after treatment for choriocarcinoma is complete and there is no remaining evidence of disease.

35, as well as women who have had multiple miscarriages, are at a slightly increased risk for a molar pregnancy.

What are the signs and symptoms? A molar pregnancy seems like a normal pregnancy in the beginning, but then the expectant mother may notice:

- Dark brown to bright red vaginal bleeding during the first trimester
- Severe nausea and vomiting
- Sometimes, uncomfortable cramping

The practitioner may notice other signs, including:

- High blood pressure
- A uterus that is larger than expected
- A uterus that is doughy (rather than firm)
- An absence of embryonic or fetal tissue, or presence of tissue that isn't viable (as seen on ultrasound)
- Excessive levels of thyroid hormone in the mother's system

What can you and your practitioner do? If an ultrasound shows you do have a molar pregnancy, the abnormal tissue must be removed via a D&C (remember, even if there is embryonic or fetal tissue, it's not viable—that is, it can't

You'll Want to Know . . .

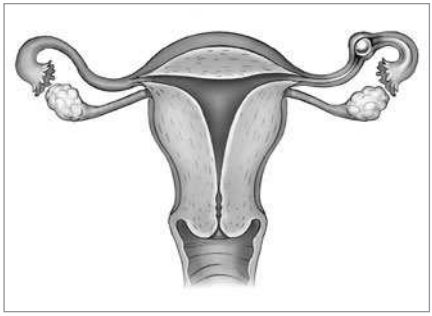
Having had a molar pregnancy doesn't put you at much higher risk for having another one. In fact, only 1 to 2 percent of women who have had a molar pregnancy go on to experience a second.

develop into a baby). Followup is crucial to make sure it doesn't develop into a malignancy, like choriocarcinoma (see box, page 587), though luckily, the chances of this happening in a treated molar pregnancy are very low.

Ectopic Pregnancy

What is it? An ectopic pregnancy (also known as a tubal pregnancy) is a nonviable pregnancy that implants outside the uterus, most commonly in a fallopian tube, usually because something (such as scarring in the fallopian tube) obstructs or slows the movement of the fertilized egg into the uterus. An ectopic pregnancy can also occur in the cervix, on the ovary, or in the abdomen. Unfortunately, there is no way for an ectopic pregnancy to continue normally.

Ultrasound can detect an ectopic pregnancy, often as early as 5 weeks. But without early diagnosis and treatment of an ectopic pregnancy, the fertilized egg might continue to grow in the fallopian tube, leading to a rupture of the tube. If the tube bursts, its ability in the future to carry a fertilized egg to the uterus is destroyed, and if the rupture is not cared for, it can result in severe, even life-threatening, internal bleeding and shock for the mother. Luckily, quick treatment (usually surgery or medication) can help avoid such a rupture and removes most of the risk for the mother while greatly improving the chances of preserving her fertility.



In an ectopic pregnancy, the fertilized egg implants in an area other than the uterus. Here, the egg has implanted in the fallopian tube.

You'll Want to Know . . .

More than half of the women who are treated for ectopic pregnancies conceive and have a normal pregnancy within a year.

How common is it? About 2 percent of all pregnancies are ectopic. Women at risk of having an ectopic pregnancy include those with a history of endometriosis, pelvic inflammatory disease, a prior ectopic pregnancy or tubal surgery, and women who smoke, have an STD, or conceived while using progesterone-only birth control pills. An IUD doesn't increase the risk of an ectopic pregnancy, but when pregnancies occur with an IUD, they are more commonly ectopic.

What are the signs and symptoms? Like many miscarriages, abnormal bleeding is an early sign. But with an ectopic pregnancy, there will sharp, crampy pain with tenderness, usually in the lower abdomen (it often begins as a dull ache that progresses to spasms and cramps) as well. Pain may worsen on straining of bowels, coughing, or moving. If the fallopian tube ruptures, there will be heavy bleeding inside the abdomen and you may experience:

- Severe sharp abdominal pain

If You've Had an Early Pregnancy Loss

Though it can be hard for parents to accept it at the time, when an early pregnancy loss occurs, it's usually because the condition of the embryo or fetus wasn't compatible with life. Early miscarriage is generally a natural selection process in which an abnormal embryo or fetus (defective because of genetic abnormality, poor implantation in the uterus, maternal infection, random accident, or other, unknown reasons) is lost because it is incapable of survival.

That said, losing a baby, even at the earliest stages of life—even when the loss was inevitable from the start—can be traumatic. So allow yourself to grieve as much as you need to—it's a necessary part of the healing process. But also remember that there's no one way you should feel, since everyone experiences this kind of grief differently. You may feel far sadder than you might have expected to, or you may feel ready to move on far sooner than you thought you might, or you may feel all over the map emotionally. Grieve and heal your way, in your own time. Sharing your feelings with your partner will be essential, and finding support from others (especially those who have also experienced a pregnancy loss) may be enormously helpful, too. But again, do what feels right to you. Just try not to let guilt compound your pain—miscarriage is not your fault.

For more on coping with your loss, see page 592. For help for fathers coping with such a loss, see the box on page 600.

- Rectal pressure
- Shoulder pain (due to blood accumulating under the diaphragm)
- Heavier vaginal bleeding
- Lightheadedness, fainting, and shock

What can you and your practitioner do? If it is determined that you have an ectopic pregnancy (usually diagnosed through ultrasound and blood tests), there is, unfortunately, no way to save the pregnancy. You'll most likely have to undergo surgery (laparoscopically) to remove the tubal pregnancy or be given drugs (methotrexate), which will end the abnormally occurring pregnancy. In some rare cases, it can be determined that the ectopic pregnancy is no longer developing and can be expected to disappear over time on its own, which would also eliminate the need for surgery.

Because residual material from a pregnancy left in the tube could damage it, a follow-up test of hCG levels is performed to be sure the entire tubal pregnancy was removed or has been reabsorbed.

Late Miscarriage

What is it? The loss of a baby between the end of the first trimester and the 20th week is called a late miscarriage. Though the medical term is "miscarriage," and though the baby is still considered pre-viable (unable to live outside the womb), the loss can feel more palpable because the pregnancy felt more palpable—especially if you've watched your belly swell, felt the first kicks, and wondered at those beautiful little features developing before your eyes on ultrasound. For help coping with this kind of devastating loss, see page 594.

You'll Want to Know . . .

When the cause of a late miscarriage can be determined, it may be possible to prevent a repeat of the tragedy. If a previously undiagnosed cervical insufficiency (an incompetent cervix) was responsible, future miscarriages can be prevented by cerclage early in pregnancy, before the cervix begins to dilate (see page 34). If chronic disease, such as diabetes, hypertension, or obesity is responsible, the condition can be brought under control prior to any future pregnancy. An abnormally shaped uterus or one that is distorted by the growth of fibroids, polyps, or a septum (a piece of tissue that divides all or part of the uterine cavity in two) in some instances can be corrected by surgery. The presence of antibodies that trigger placental inflammation and/or clotting may be treated with low-dose aspirin and heparin injections in a subsequent pregnancy. Some causes of late miscarriage, such as acute infection, are very unlikely to recur.

How common is it? Late miscarriages occur in about 6 in 1,000 pregnancies. A late miscarriage is usually related to the mother's health (a chronic condition such as antiphospholipid antibody syndrome or, rarely, poorly controlled diabetes), the condition of her uterus, cervical insufficiency (see page 34), an untreated bacterial infection, or problems of the placenta. Sometimes a late miscarriage is due to chromosomal or other genetic abnormalities in the fetus.

What are the signs and symptoms? The signs and symptoms of a late miscarriage include:

- Heavy bleeding (possibly including blood clots), accompanied by strong cramping and abdominal pain
- A dilated cervix (found during examination)
- No fetal heartbeat detected on ultrasound or with Doppler
- A complete cessation of baby's movements (if the mother has already begun feeling movement consistently)

What can you and your practitioner do? If you're experiencing the type of heavy bleeding and painful cramping that signal a miscarriage, there's usually nothing, unfortunately, that can be done to stop the inevitable. The miscarriage may be complete, or your practitioner may need to perform a D&C to remove any remnants of the pregnancy. If the miscarriage hasn't begun on its own, yet it's clear during a routine office visit or on ultrasound that there is no fetal heartbeat, your practitioner might bring you into the hospital to induce labor using misoprostol or for a procedure similar to a D&C called a D&E—dilation and evacuation—in which surgical methods are used to deliver the fetus and placenta. A D&E is considered safer than induction because of decreased risk of infection and bleeding, but talk to your practitioner about the relative risks and benefits of both options. If induction is chosen, depending on how far along in the pregnancy you are, you may have the opportunity to hold your baby, and doing so may help in the grieving process (see page 595 for more).

A late miscarriage will be emotionally painful and it is also likely to be physically painful, so be sure to ask for medication if you need it.