Staying Well When You're Expecting

In pregnancy, when you need to stay well for two, the proverbial ounce of prevention is worth far more than a pound of cure. The following suggestions will increase your chances of staying well when you're expecting (and when you're not):

Keep your resistance up. Eat the best diet possible, get enough sleep and exercise, and don't run yourself down by running yourself ragged. Reducing stress in your life as much as you can also helps keep your immune system in tip-top shape.

Avoid sick people like the plague. As best as you can, try to stay away from anyone who has a cold, flu, stomach virus, or anything else noticeably contagious. Keep your distance from coughers on the bus, avoid hugging a friend who's complaining of a sore throat, and evade the handshake of a colleague with a runny nose (handshakes spread germs, not just greetings). Also avoid crowded or cramped indoor spaces when you can.

Wash your hands. Hands are the major spreader of infections, so wash them often and thoroughly with soap and warm water (about 20 seconds does the trick), particularly after exposure to someone you know is sick and after spending time in public places or riding on public transit. Hand washing is especially important before eating. Keep a hand sanitizer or hand sanitizing wipes in your glove compartment, in your desk drawer, and in your handbag or briefcase so you can wash up when there's no sink in sight.

Don't share the germs. At home, try to limit germ-spreading contact with sick kids or a sick spouse as much as possible. Avoiding finishing up their sandwich scraps and drinking from their cups. And while every sick child needs a dose of kiss-and-hug therapy from mom now and then, be sure to wash your hands and face (or wipe them down with hand sanitizer) after those comforting cuddles. Wash up with soap and water or wipe down with hand sanitizer, too, after touching germy sheets, towels, and used tissues, especially before touching your own eyes, nose, and mouth. See that little patients wash their hands frequently, also, and try to get them to cough and sneeze into their elbows instead of their hands (a good tip for adults, too). Use disinfectant spray or wipes on phones, tablets, keyboards, remotes, and other surfaces they handle.

If your own child or a child you care for or regularly spend time with develops a rash of any kind, avoid close contact and call your doctor as soon as you can unless you already know that you are immune to chicken pox, fifth disease, and measles.

Be pet smart. Keep pets in good health, updating their immunizations as necessary. And be sure to wash your hands after handling pet food or bowls (they sometimes harbor bacteria). If you have a cat, take the precautions to avoid toxoplasmosis (page 72).

Look out for ticks and mosquitoes. Avoid areas where Lyme disease or the Zika or West Nile virus are prevalent, or be sure to protect yourself adequately (see pages 537 and the box on page 536).

To each their own. Maintain a no-sharing policy when it comes to toothbrushes and other personal items (and don't let those toothbrushes mingle bristle-to-bristle). Use disposable cups for rinsing in the bathroom.

Eat safe. To avoid food-borne illnesses, practice safe food preparation and storage habits (see page 117).

up (a powder may go and stay down easier). Don't worry, however, if you just can't handle your prenatal for a few days or so—no harm done.

If you can't get anything down, talk to your practitioner. Dehydration is a problem for anyone suffering with a stomach bug, but it's especially problematic if you're pregnant. You might be advised to take some rehydration fluid (like Pedialyte, which also comes in a soothing freezable form) or electrolyte water. Coconut water may be helpful, too. If you can't keep even that down, your doctor might want you to come in for IV fluids. Also call in if you're running a fever with those tummy troubles (see page 527).

Check with your practitioner before you open up your medicine cabinet looking for relief. Antacids like Tums and Rolaids are considered safe to take during pregnancy, and some practitioners may okay gas relievers, but ask first. Your practitioner may also okay certain antidiarrheal medicines, but probably only after your first trimester is safely behind you.

And sick tummies, take heart: Most stomach bugs clear up by themselves within a day or so.

CMV

"I'm a preschool teacher, and we've had an outbreak of CMV at our school. Is this something I should worry about catching during pregnancy?"

Fortunately, it's not likely that you can pick up CMV from one of your students and pass it on to your baby. That's because most adults were infected with CMV during childhood. If you're among that majority or if you've had CMV as an adult—and as someone who spends a lot of time with little ones, that's definitely possible—you can't catch it now (though the CMV could be "reactivated"). Even if you do come down with a new CMV infection during pregnancy, the risks to your baby are low. Though half of expectant moms infected with CMV give birth to infected infants, only a small percentage of them show ill effects. The risks are lower still in a baby whose mom had a reactivated infection during pregnancy.

Still, because there is the potential for serious birth defects with CMV infection, it's smart to play it as safe as possible. Unless you know for sure that you're immune to CMV because you've had the infection before or because you were tested preconception, your best defense is a good offense (as it would be with any viral infection you're trying to avoid). As someone who works with little ones (and their germs), you probably know the hygiene drill. Be especially meticulous in practicing standard protocol for preventing the spread of any type of infection, such as washing your hands often and carefully, especially after changing diapers or helping children out at the potty—and of course, resist nibbling on leftovers.

Though CMV often comes and goes without any obvious symptoms, it's occasionally marked by fever, fatigue, swollen glands, and sore throat. If you notice any of these symptoms, check with your doctor. No matter if these symptoms signal CMV or another illness (such as flu or strep throat), you'll need some sort of treatment.

Fifth Disease

"I was told that a disease I had never even heard of before—fifth disease—could cause problems in pregnancy."

Fifth disease, caused by the parvovirus B19 (not to be confused with the parvovirus that affects dogs and

cats), is the 5th of a group of 6 diseases that cause fever and rash in children. But unlike its sister diseases (such as measles and chicken pox, the ones that get all the attention), fifth disease isn't widely known because its symptoms are mild and can go unnoticed—or may even be totally absent. Fever is present in only 15 to 30 percent of cases. For the first few days, the rash gives the cheeks the appearance of having been slapped, then spreads in a lacy pattern to trunk, buttocks, and thighs, recurring on and off (usually in response to heat from the sun or a warm bath) for 1 to 3 weeks. It can be confused with the rash of other childhood illnesses or even a sun- or windburn. Adults don't typically show the "slapped cheek" rash.

Concentrated exposure from caring for a child sick with fifth disease or from teaching at a school where it is epidemic somewhat increases that very small risk of contracting the illness. But half of all women of childbearing age had fifth disease during childhood and are already immune, so infection, happily, isn't common among pregnant women. In the unlikely event that a mom-to-be catches fifth disease and her fetus does become infected, the virus can disrupt the developing baby's ability to produce red blood cells, leading to a form of anemia or other complications. If testing reveals you've contracted fifth disease, your practitioner will follow you for signs of fetal anemia with weekly ultrasounds for 8 to 10 weeks. If the baby is infected during the first half of pregnancy, the risk of miscarriage increases.

Again, the odds that fifth disease will affect you, your pregnancy, or your baby are very remote. Still, as always, it makes sense to take the appropriate steps to avoid any infection while you're expecting (see page 532).

Chicken Pox (Varicella)

"My toddler was exposed to chicken pox at her childcare center. If she comes down with it, could the baby I'm now carrying be hurt?

Not likely. Well insulated from the rest of the world, your baby can't catch chicken pox from a third party—only from you. Which means you would have to catch it first, something that's unlikely. First of all, your child probably won't catch it and bring it home if she was immunized with the varicella vaccine (it's recommended that all tots get their first dose of the varicella vaccine at age 1 year—hopefully yours did). Second of all, it's very likely you had the infection as a child (85 to 95 percent of the U.S. adult population has had it) or had the vaccine, and are already immune. Ask your parents or check your health records to find out whether you have had chicken pox or received the vaccine (which became available in 1995). If you can't find out for sure, ask your practitioner to run a test now to see if you are immune.

Though the chances of your becoming infected are slim if you aren't immune, an injection of varicella-zoster immune globulin (VZIG) within 96 hours of a documented personal exposure (in other words, direct contact with someone who has been diagnosed with chicken pox) may be recommended. It isn't clear whether or not this will protect the baby if you do end up with chicken pox anyway, but it should minimize complications for you—a significant plus, since this mild childhood disease can be quite severe in adults. If you should be hit with a severe case, you may be given an antiviral drug to further reduce the risk of complications.

Measles, Mumps, and Rubella

Chances are good that you're already immune to measles, mumps, and rubella. That's because you (like most women of reproductive age) probably received the MMR vaccine, which protects against all 3 diseases, when you were a child—or less likely, that you had the diseases and can't catch them again. But with rising lapses in vaccination rates resulting in new outbreaks of these potentially dangerous diseases, you might be wondering if there's any risk to your pregnancy or your baby. Here's what you need to know:

Measles. In the very unlikely scenario that you're directly exposed to someone with measles and are certain you're not immune, your doctor may administer gamma globulin (antibodies) during the incubation period—between exposure and the start of symptoms—to decrease the severity of the illness should you come down with it. Measles does not appear to cause birth defects, though it may be linked to an increased risk of miscarriage or premature labor. If you were to contract measles near your due date, there is a risk that your newborn might catch the infection from you.

Mumps. It's not that easy to get mumps these days. It isn't highly contagious through casual contact, and only a few hundred Americans contract mumps each year, thanks to routine childhood immunization. However, because the disease appears to trigger uterine contractions and is associated with an increased risk of miscarriage in the first trimester or preterm labor later, pregnant women who aren't immune should be alert for early symptoms of mumps (possibly vague pain, fever, and loss of appetite, followed by the salivary glands becoming swollen, then ear pain and pain while chewing or with acidic or sour food or drink). Notify your practitioner of such symptoms immediately, because prompt treatment can reduce the chance of problems.

If you become infected during the first half of your pregnancy, the chances are very low (around 2 percent) that your baby could develop a condition called congenital varicella syndrome, which can cause some birth defects. If you come down with chicken pox later in your pregnancy, there's almost zero danger to the baby. The exception is if you get chicken pox just before (within a week of) giving birth or just after delivery. In that extremely unlikely scenario, there's a small chance your newborn will arrive infected and would develop the characteristic rash within a week or so. To prevent neonatal infection, your baby would be given an infusion of chicken pox antibodies immediately after delivery (or as soon as it becomes apparent that you've been infected postpartum).

Shingles, or herpes zoster, which is a reactivation of the chicken pox virus in someone who had the disease earlier (and happens only rarely in pregnant women), does not appear to be harmful to a fetus, probably because the mom—and so her baby—already has antibodies to the virus.

If you are not immune and escape infection this time, ask your doctor about getting immunized after delivery, to protect any future pregnancies. Immunization with the 2 doses taken between 4 and 8 weeks apart should be finished at least a month before any new conception.

Rubella. Because rubella can be very dangerous during pregnancy, your practitioner will perform a simple test—a rubella antibody titer—that measures the level of antibodies to the virus in your blood at the first prenatal visit to be absolutely certain you're immune. In the unlikely event you turn out not to be immune (or if the antibody levels in your blood are low, meaning that your immunity is waning), there's still no reason to worry. Happily, the CDC considers rubella to be eradicated in the U.S., making it nearly impossible for you to catch it here (and for the virus to be harmful you'd actually have to come down with the illness). The symptoms, which show up 2 or 3 weeks after exposure, are usually mild (malaise, slight fever, and swollen glands, followed by a slight rash a day or so later) and may sometimes pass unnoticed. If you did come down with rubella during pregnancy (and, again, the odds are extremely remote), whether your baby would be at risk would depend on when you contracted it. During the 1st month of pregnancy, the chance of a baby developing a serious birth defect is pretty high. By the 3rd month, the risk is significantly lower. After that, the risk is lower still.

Don't remember if you were ever vaccinated with the MMR, or if you ever had measles, mumps, or rubella? Check your medical records (or with your parents, who would most likely know whether they chose to opt out of routine vaccines like the MMR). If you're definitely not immune (or if titers show your immunity is low), you won't receive the MMR (or a booster) during pregnancy. Though there has never been a problem reported among babies of women who were inadvertently vaccinated before they knew they were pregnant, experts advise not taking the theoretical risk. But you can be vaccinated with the MMR (or if your titers are low for only one of the diseases, with just that individual vaccine) right after delivery. This will not only help protect your little one until he or she is fully immunized, but will protect your future pregnancies as well.

Hepatitis A

"I just heard about a recall of packaged fruit because of possible hepatitis A contamination—after I had already bought and eaten some. If I get hepatitis A, could it affect my pregnancy?"

Hepatitis A infection is rare these days in the U.S. (it's more prevalent in countries with poor sanitation) and is usually passed along through the fecal-oral route (by ingesting something that has been contaminated with the feces of an infected person). Most infections result from close personal contact, but the virus can also be spread by an infected food worker—likely the reason the food you purchased was recalled (and another good case for safe hygiene practices while cooking and preparing food). The infection is often mild, with no noticeable symptoms (especially in young children). Older children and adults typically experience muscle aches, headache, abdominal discomfort, loss of appetite, fever, and malaise, and in some cases jaundice (a yellowing of the skin and eyes). In rare cases the symptoms become severe enough to require hospitalization. Symptoms usually last no longer than 2 months, and those infected with hepatitis A recover completely (usually without any treatment needed) and end up immune to the infection for the future. (You're also immune if you were ever vaccinated against hep A.)

Protecting Against Zika Virus

Zika virus is an infection spread by mosquitoes (and in some cases through sex). Though it isn't normally risky for the general population, usually causing mild symptoms (or sometimes no noticeable symptoms at all), the virus has been linked both to miscarriage and serious birth defects—such as microcephaly (a small head) and brain damage—in babies of moms infected during pregnancy. If you live in or must travel to a region where Zika is prevalent (the CDC recommends that you don't travel to these areas), protect yourself against mosquito bites (see box, page 269). If your partner has traveled to a Zika-affected region, the CDC advises that you abstain from sex or use a condom during sex for the rest of your pregnancy. If you do become infected with the Zika virus during pregnancy (or if you think you might have been infected with it), you'll get a blood test and ultrasound and your pregnancy will be monitored more closely. For the latest information, visit cdc.gov/zika.

Happily, the infection is rarely passed on to a fetus or newborn. That's because the antibodies your body produces after exposure pass right away through the placenta, completely protecting the baby from the infection. So even if you did catch it, it's unlikely to affect your pregnancy. Still, your practitioner may suggest you get a shot of immunoglobulins within 2 weeks of exposure, just to be on the extra-safe side (the shot itself is safe, too).

If you are planning to travel to an area with high rates of infection, or if you have hepatitis B or C, ask your physician about immunization against hepatitis A, which can be given during pregnancy.

Hepatitis B

"I'm a carrier of hepatitis B and just found out that I'm pregnant. Will my being a carrier hurt my baby?"

Knowing that you're a carrier for hepatitis B is the first step in making sure your condition won't hurt your baby. Luckily it's unlikely the infection will be passed on to your baby while in utero. But because this liver infection can be passed on to baby during delivery, prompt steps will be taken at your baby's birth to make sure that doesn't happen. Your newborn will be treated within 12 hours with both hepatitis B immune globulin (HBIG) and the hepatitis B vaccine (which is routine at birth anyway). This treatment can almost always prevent the infection from developing. Your baby will also be vaccinated at 1 or 2 months and then again at 6 months (this, too, is routine for all babies), and may be tested at 12 to 15 months to be sure the therapy has been effective.

Hepatitis C

"Should I be worried about hepatitis C during pregnancy?"

Because hep C is usually transmitted via blood (for instance, through past transfusions or illegal drug injections), unless you've had a transfusion or are in a high-risk category, it's unlikely you'd be infected. Hepatitis C can be transmitted from infected mother to child during delivery, with a transmission rate of about 4 to 7 percent. The infection, if diagnosed, can potentially be treated, but not during pregnancy.

Lyme Disease

"I live in an area that's high risk for Lyme disease. Do I need to take any extra precautions now that I'm pregnant?"

As you probably already know, Lyme disease is most common among those who spend time in wooded areas where deer ticks hide out—but those ticks can occasionally hitch a ride into the suburbs and city, too, via greenery brought in from the country.

The best way to protect yourself is by taking preventive measures. If you are out in woodsy or grassy areas, or if you are handling greenery grown in such areas, wear long pants, tucked into boots or socks, and long sleeves, and use an insect repellent effective for deer ticks (such as one containing DEET) on exposed skin and treat clothing with permethrin. When you return home, check your skin carefully for ticks (if you can't easily see certain parts of your body now that you're pregnant, have your partner or someone else screen those areas of skin). If you find a tick, remove it right away by pulling straight up on it with tweezers (removing a tick within 24 hours almost entirely eliminates the possibility of infection). There is no need to save the tick for testing.

If you find a tick and notice the characteristic blotchy, bull's eye rash at the bite site, see your doctor—a blood test may be able to determine whether you are infected. Early symptoms of Lyme may include fatigue, headache, stiff neck, fever and chills, generalized achiness, and swollen glands near the site of the bite. Later symptoms may include arthritis-like pain and memory loss.

Fortunately, studies have shown that prompt treatment with antibiotics completely protects a baby whose mother is infected with Lyme—and keeps mom from becoming seriously ill.

Bell's Palsy

"I woke up this morning with pain behind my ear, and my tongue felt numb. When I looked in the mirror, the whole side of my face looked droopy. What's going on?"

It sounds like you may have Bell's palsy, a temporary condition caused by damage to the facial nerve, resulting in weakness or paralysis on one side of the face. Though it's quite uncommon in general, Bell's palsy strikes pregnant women 3 times more often than it does women who are not pregnant, and occurs most often in the third trimester or early postpartum. Its onset is sudden, and most people with the condition wake up without warning to find their face drooping.

The cause of this temporary facial paralysis is unknown, though experts suspect that certain viral or bacterial infections may cause swelling and inflammation of the facial nerve, triggering the condition. Other symptoms sometimes accompanying the paralysis include pain behind the ear or in the back of the head, dizziness, drooling (because of the weak muscles), dry mouth, inability to blink, impaired sense of taste, tongue numbness, and even impaired speaking.

The good news is that Bell's palsy will not spread beyond your face and won't get worse. More good news: Most cases completely resolve within 3 weeks to 3 months without treatment (though for some it can take as long as 6 months to go away completely). And the best news of all: The condition poses no threat to your pregnancy or your baby and needs no treatment. But since the signs of a stroke (which is slightly more common during pregnancy even in young and healthy women) can mimic those of Bell's palsy, it's critical that you call your practitioner right away if you notice a sudden onset of a facial droop.

ALL ABOUT:

Medications During Pregnancy

What do just about all prescription and over-the-counter medications have in common? Check out the fine print on those labels and package inserts and you'll see: Virtually all warn pregnant women against using them without a doctor's advice. Still, if you're like the average expectant mom, you'll wind up taking at least one prescription drug during your pregnancy and even more over-the-counter medications. How will you know which are safe and which aren't?

Fortunately, only a few drugs are definitively known to be harmful during pregnancy, and many drugs can be used safely. Still, no drug—prescription or over-the-counter, traditional or herbal—is 100 percent safe for 100 percent of the people, 100 percent of the time. And when you're pregnant, there's the health and wellbeing of two people, one very small and vulnerable, to consider every time you take a drug. Weighing the potential risks of taking a medication against the potential benefits it will provide is always wise—but it's smarter still when you're pregnant. Likewise, involving your practitioner in the decision of whether or not to take a drug is a good idea in general, but when you're pregnant, it's essential.

So, just like the labels say: Always ask first. Before you take any medication while you're expecting—even if you've popped it routinely in the past-without thinking twice—check with your practitioner about whether it's safe now.

Keeping Current

The many lists of safe, possibly safe, possibly unsafe, and definitely unsafe drugs and medication during pregnancy change all the time, especially as new medications are introduced, others change from being prescription-only to over-the-counter, and still others are being studied to determine their safety during pregnancy. To stay current on what is or isn't safe, always ask your practitioner first. You can also turn to the U.S. Food and Drug Administration (fda.gov), the March of Dimes Resource Center at (888) MODIMES (663-4637) or marchofdimes.org, or safefetus.com to check on the safety of a certain medication during pregnancy.

Common Medications

Here's the lowdown on some of the more common medications you might consider taking during pregnancy. Even if a medication on this list is believed to be safe, be sure to ask your practitioner before taking it for the first time during pregnancy.

Tylenol. Acetaminophen is usually given the green light for short-term use during pregnancy, but be sure to ask your practitioner for the proper dosage.

Aspirin. Aspirin is generally not recommended—especially during the third trimester, since it increases the risk for complications before and during delivery, such as excessive bleeding, as well as problems in the newborn. Some studies suggest that very low dosages of aspirin may help to prevent preeclampsia in certain circumstances, but only

your practitioner will be able to tell you whether it should be prescribed in your case. Other studies suggest that low-dose aspirin, in combination with the blood-thinning medication heparin, may reduce the incidence of recurrent miscarriage in some women with a condition known as antiphospholipid antibody syndrome. Again, only your practitioner can tell you whether it would be advisable in your case.

Advil or Motrin. Ibuprofen generally shouldn't be used in pregnancy, especially during the first and third trimesters, when it can have the same blood-thinning effects as aspirin. Use it only if it's specifically recommended by a physician who knows you are pregnant.

Aleve. Naproxen, a nonsteroidal anti-inflammatory drug (NSAID), is not recommended for use in pregnancy at all.

Nasal sprays. For relief from a stuffy nose, most steroid-containing nasal sprays are fine to use. Check with your practitioner for a preferred brand and dosing. Saline sprays are always safe to use, as are nasal strips. When it comes to nonsteroidal nasal decongestant sprays containing ozymetazoline (like Afrin), steer clear unless you have a clear okay from your prenatal practitioner. Many practitioners will not give the green light to these sprays at all, and others will advise only limited use (1 or 2 days at a time) after the first trimester.

Antacids. Heartburn that won't quit (you'll have plenty of that) often responds to Tums or Rolaids—plus you'll get a dose of calcium to boot. Maalox and Mylanta are also usually given the green light. For all these choices, be sure to check with your practitioner for the right dosage.

Gas aids. Many practitioners will okay gas aids, such as Gas-X or Mylicon, for the occasional relief of pregnancy bloat, but check first.

Antihistamines. Not all antihistamines are safe during pregnancy, but several will probably get the green light from your practitioner. Benadryl (generic name: diphenhydramine) is the antihistamine most commonly recommended

Get Smart About Antibiotics

Antibiotics can be a lifesaver, literally, when used against potentially dangerous bacterial infections—but they can also be overused or used the wrong way, leading to antibiotic-resistant infections. Here are some smart facts about antibiotics:

- Antibiotics are prescribed for bacterial infections. They don't work (and shouldn't be used) on viral infections, like colds or the flu.
- There are many antibiotics that are safe for pregnancy use, so don't hesitate to take them if your practitioner prescribes them for a bacterial infection (like a UTI).
- Take your antibiotics exactly as your practitioner tells you. Don't skip doses, and always finish the entire course of antibiotics unless instructed not to do so.
- Discard any leftover medications, and never save antibiotics for the next time you become sick.
- Only take antibiotics prescribed for you, by a doctor who knows you're pregnant.
- When taking antibiotics, consider taking a probiotic supplement to replenish beneficial bacteria. Try to space out the doses—probiotics shouldn't be taken within a couple of hours of antibiotics.

Medication and Lactation

Wondering whether you can open the medicine cabinet more often (and with less worry) when you're breastfeeding than when you were expecting? The good news is that most medications—both over-the-counter and prescription—are compatible with breastfeeding and safe for baby. Even when a certain drug must be shelved during lactation, there's often a safe substitute—which means you probably won't have to give up breastfeeding if you must take a medication. Also remember: While it's true that what goes into your body usually does make its way into your milk supply, the amount that ultimately ends up in your baby's meals is a tiny fraction of what ends up in you.

Most drugs, in typical doses, appear to have no effect on a nursing baby at all. These include common medications such as:

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin)
- Antacids (Maalox, Mylanta, Tums)
- Laxatives (Metamucil, Colace)
- Antihistamines (such as Claritin; Benadryl is also safe but may cause drowsiness in a baby)
- Decongestants (Afrin, Allegra, and so on)
- Bronchodilators (Albuterol)
- Most antibiotics
- Most anti-yeast/fungal medications (Lotrimin, Mycelex, Diflucan, Monistat)
- Corticosteroids (Prednisone)
- Thyroid drugs (Synthroid)
- Most antidepressants

during pregnancy. Claritin (loratadine) is also considered safe by most experts, but check with your practitioner, because not all will give it the okay, particularly in the first trimester. Some practitioners allow the use of chlorpheniramine (Chlor-Trimeton) and triprolidine on a limited basis, but most advise choosing a better alternative, so be sure to ask before reaching for those.

Decongestants. Most practitioners say to stay clear of decongestants containing phenylephrine and pseudoephedrine (such as Sudafed, Claritin-D, and DayQuil). Some will okay very limited use after the first trimester (for example, once or twice daily for no more than a day or so), since more frequent use can reduce blood flow to the placenta. Don't take decongestants without asking your practitioner first, but don't worry if you've already taken them—just let your practitioner know. Vicks VapoRub is safe to use as directed.

Antibiotics. If your doctor has prescribed antibiotics for you during pregnancy, it's because the risk posed by the infection you're fighting is greater than any risk of taking the medication (and many are considered completely safe). You'll likely be put on antibiotics that fall into the penicillin or erythromycin families. Certain antibiotics are not recommended (such as tetracyclines, often used to treat acne), so be sure that any doctor prescribing antibiotics knows that you're pregnant.

Cough medicines. Expectorants such as Mucinex, and cough suppressants such as Robitussin or Vicks 44, as well as most cough drops, are considered safe

- Most sedatives
- Most medications for chronic conditions (such as for asthma, heart conditions, high blood pressure, diabetes, and so on)

A few classes of medications can be significantly harmful for the breastfeeding mom's milk supply and her baby. Drugs like some beta-blockers, epilepsy and seizure drugs, cancer drugs, lithium, ergots (used to treat migraines), and lipid-lowering drugs should be shelved when you're breastfeeding.

The research jury is still out on other medications (certain classes of antihistamines, for instance, or certain types of antidepressants). And other medications are safe, but only if they are used sparingly and temporarily (such as narcotics for pain after a cesarean delivery). Be sure to check with your practitioner or your baby's pediatrician for the most up-to-date info on what's safe and what isn't. You can also check out the National Library of Medicine's Drug and Lactation database (LactMed) at toxnet.nlm.nih.gov (click on LactMed), the Infant Risk Center at infantrisk.com, or MotherRisk at motherrisk.org for more information on which medications are safe and which aren't when you're breastfeeding.

In some cases, a less-safe medication can safely be discontinued while a mom is breastfeeding, and in others, it's possible to find a safer substitute. When medication that isn't compatible with breastfeeding is needed short-term, nursing can be stopped temporarily, with breasts pumped to keep up supply but milk tossed (pump and dump). Or dosing can be timed for just after nursing or before baby's longest sleep.

The bottom line on medication and lactation: Make sure you get the green light from your practitioner or baby's pediatrician on any medication you take or are thinking about taking while you're breastfeeding, as well as any herbal remedy or supplement.

during pregnancy, but ask your practitioner about dosing.

Sleep aids. Unisom, Tylenol PM, Sominex, Nytol, Ambien, and Lunesta are generally considered safe during pregnancy, and they are okayed by many practitioners for occasional use. Always check with your practitioner before taking these or any sleep aids.

Antidiarrheals. Most antidiarrheals aren't recommended for use during pregnancy (both Kaopectate and Pepto-Bismol contain salicylates—an active ingredient that is considered off-limits when you're expecting), though Imodium usually gets the green light after the first trimester.

Anti-nausea. Unisom Sleep Tabs (which contain the antihistamine doxylamine), taken in combination with vitamin B_6, decrease the symptoms of morning sickness but get dosing instructions from your practitioner. The downside of taking this remedy during the day: sleepiness. Diclegis, a time-released formula that combines those same ingredients and is available by prescription, may cause less drowsiness and is considered completely safe.

Topical antibiotics. Small amounts of topical antibiotics when needed for a cut or other injury, such as bacitracin or Neosporin, are safe during pregnancy.

Topical steroids. Small amounts of topical hydrocortisones (such as Cortaid) are safe during pregnancy. Use sparingly on rashes or bug bites when necessary.

Antidepressants. Though the research on the effects of antidepressants on pregnancy and on the fetus is ever-changing,

Making the Most of Your Meds

If you rely on oral medications to control a chronic condition, you may have to do a little adjusting now that you're expecting. For instance, if morning sickness has you down, taking your meds right before going to bed—so that they can build up in your system before the morning upchucking begins—may keep you from losing most of the dose through vomiting. If you must take a medication on an empty stomach (especially first thing in the morning) yet find it impossible to do because of nausea, ask your practitioner about using an anti-nausea medication that comes in suppository form (like Phenergan) before taking your medication.

Something else that you'll have to keep in mind—and that your team of doctors will have to keep an eye on: Some medications are metabolized differently during pregnancy, so the dosage you're used to isn't necessarily the right dosage now that you're expecting. If you're not sure whether your dosing is correct now that you're pregnant or if you think it might need to be adjusted because you have gained a lot of weight—or if you just have a hunch you're getting too much medicine or not enough—check with your doctors.

it does appear that there are several meds that are safe to use, others that should be completely avoided, and still others that can be considered on a case-by-case basis, their use weighed against the risk of untreated (or undertreated) depression. See page 45 for more.

If You Need Medication During Pregnancy

Has your practitioner recommended or prescribed a medication for you? Here are some steps you can take to help ensure that you're medicating safely for two:

- Lower risks and boost benefits. While weighing the risks and benefits of taking a medication with your practitioner, see if you can tip the scales even further in your favor and your baby's by boosting benefits (like taking a cold medication at night, when it will help you sleep) or reduce the risks (perhaps taking the medication for the shortest possible time, at the lowest effective dose).
- Ask and tell. Always clear a medication that's been prescribed by a different health care provider (say, an antibiotic for an ear infection prescribed by the ENT or an antidepressant prescribed by your internist or therapist) with your ob practitioner.
- Watch out for multitasking medications. Many OTC meds combine several active ingredients for multi-symptom relief, and one or more of these may not be pregnancy safe. For instance, an acetaminophen-based pain reliever might be combined with a sleep aid or a decongestant, or in some cases, even a cough suppressant. So check the active ingredients list to make sure the product you're choosing contains only the ingredient (or ingredients) your practitioner has cleared.
- Ask your practitioner ahead of time about side effects to look out for and which you should report, if any.

PART 5

The Complicated Pregnancy

CHAPTER 19

Managing Complications

If you've been diagnosed with a complication or suspect you may be having one, you'll find information about symptoms and treatments in this chapter. If you've had a problem-free pregnancy so far—and there's no reason to believe it will be anything but smooth sailing throughout—this need-to-know chapter is not for you. In fact, you don't need to know any of it. While information is definitely empowering when you need it, reading about all the things that could go wrong when they're not going wrong (and aren't likely to go wrong) is only going to stress you out—and for no good reason. Skip it, and save yourself some unneeded worry.

Pregnancy Complications

The following pregnancy complications, though more common than some, are still unlikely to be experienced by the average mom-to-be. So read this section only if you've been diagnosed with a complication or you're experiencing symptoms that might indicate one. If you are diagnosed with a complication, use the information about the condition in this section as a general overview—so you have an idea of what you're dealing with—but expect to receive more specific (and possibly different) advice from your practitioner. That's, of course, the advice you should follow.

Subchorionic Bleed

What is it? A subchorionic bleed (also called a subchorionic hematoma) is the accumulation of blood between the uterine lining and the chorion (the outer fetal membrane, next to the uterus) or under the placenta itself, often (but not always) causing noticeable spotting or bleeding.

Bleeding During Pregnancy

Thankfully, most bleeding or spotting during pregnancy doesn't mean anything is wrong with your baby or your pregnancy. But sometimes, bleeding indicates something more serious—a problem with the placenta, for instance, a threatened miscarriage, or rarely, an ectopic pregnancy. Which is why you should report any spotting or bleeding you notice to your practitioner.

During the first trimester, call if you notice:

- Light, pink to dark red spotting. It's usually nothing to worry about, but check in anyway. It could be the result of implantation, irritation of the cervix after sex or a pelvic exam, a minor vaginal infection, or something else innocuous (see page 143).
- Light to heavy bright red spotting. Often, this type of spotting doesn't mean something is wrong, but you should definitely check in with your practitioner. Light to heavy red spotting could indicate a subchorionic bleed (facing page) or a threatened miscarriage (page 546).
- Spotting (pink, red, or brown) accompanied by cramping—call right away. Though such symptoms may not mean anything worrisome is happening, it's important to get checked out right away, since such symptoms could sometimes indicate a threatened miscarriage (page 546) or an inevitable miscarriage (page 582). Your practitioner will want to check to see if the cervix is opened or closed, and will likely use ultrasound to check for a fetal heartbeat.
- Heavy bleeding and cramping—call right away. Some women bleed heavily during the first trimester—even accompanied by cramping—and their pregnancies proceed normally. But about half of all women who have bleeding and cramping in the first trimester end up experiencing a miscarriage. For more information on early miscarriage, see page 582.
- Bleeding and very sharp pain in the lower abdomen with tenderness, shoulder pain, and/or rectal pressure—call right away (or dial 911). These symptoms could indicate an ectopic pregnancy (see page 588) that has ruptured or is about to.

In the second trimester, call if you notice:

- Spotting (light bleeding) or heavy bleeding (in the second or third trimester). Call your practitioner right away, since bleeding in the last 2 trimesters could be caused by placenta previa (page 554), placental abruption (page 556), a tear in the uterine lining, or (if it's after week 20) premature labor (page 559)—all of which need to be checked out and treated (if possible) as soon as possible. While spotting or bleeding during the second or third trimesters is not a definitive sign that there is something serious going on, it's a good idea to have it evaluated, just to be on the safe side.
- Heavy bleeding with blood clots, accompanied by cramping. In the second trimester, these symptoms unfortunately usually mean a late miscarriage is inevitable. See page 589 for more on late miscarriage.

The vast majority of women who have a subchorionic bleed go on to have perfectly healthy pregnancies. But because (in rare cases) bleeds or clots that occur under the placenta can cause problems if they get too large, all subchorionic bleeds are monitored.

How common is it? Of those women who experience first-trimester bleeding, 20 percent of them are diagnosed with a subchorionic bleed as the cause.

What are the signs and symptoms? Spotting or bleeding, often beginning in the first trimester, may be a sign. But many subchorionic bleeds are detected during a routine ultrasound, without there being any noticeable signs or symptoms.

What can you and your practitioner do? If you have spotting or bleeding, call your practitioner. An ultrasound may be ordered to see whether there is a subchorionic bleed, how large it is, and where it's located.

Threatened Miscarriage

What is it? A threatened miscarriage is a condition that suggests a miscarriage might take place. There is usually (but not always) some vaginal bleeding, and sometimes abdominal cramps, but the cervix remains closed and the fetal heartbeat can be seen on ultrasound.

You'll Want to Know . . .

Occasional cramping in your lower abdomen early in pregnancy is probably the result of implantation, normally increased blood flow, or ligaments stretching as the uterus grows, not a sign of an ectopic pregnancy. For more on ectopic pregnancy, see page 588.

You'll Want to Know . . .

Roughly half of all expectant women who are diagnosed with a threatened miscarriage go on to have a perfectly healthy pregnancy and baby.

How common is it? About 1 of every 4 pregnant women has some bleeding during the first few months.

What are the signs and symptoms? Symptoms of a threatened miscarriage include:

- Abdominal cramps with or without vaginal bleeding during the first 20 weeks of pregnancy, with a cervix that remains closed
- Vaginal bleeding during the first 20 weeks of pregnancy without cramps, with a cervix that remains closed

What can you and your practitioner do? The first thing your practitioner will do if you have bleeding and/or cramping is a pelvic exam to check whether the cervix is opened or closed, and to gauge the amount of bleeding. You'll also likely get an ultrasound to check for the baby's heartbeat.

Your practitioner may also test your blood hCG level over a period of days to be sure the levels are rising, indicating the pregnancy is continuing. A blood test might also be used to check your progesterone levels.

Depending on the results of these tests, your practitioner may prescribe bed rest (plus pelvic rest, see page 576), and may, depending on your particular

Wait and See

Sometimes it's too early to see a fetal heartbeat or visualize the fetal sac on ultrasound, even in a healthy pregnancy. Dates could be off or the ultrasound equipment not sophisticated enough. If your cervix is still closed, you are spotting only lightly, and the ultrasound isn't definitive, a repeat ultrasound will be performed in a week or so to let you know what's really going on. Your hCG levels will also be followed. It's important to stay realistic but also to stay positive, as well as hold off on any action until the pregnancy has proved to be unviable.

circumstance, recommend you take supplemental progesterone to help sustain the pregnancy.

If an exam shows that your cervix is opened, or if there is no fetal heartbeat on ultrasound, a miscarriage is unfortunately considered inevitable. For more information on miscarriage, see Chapter 20.

Hyperemesis Gravidarum

What is it? Hyperemesis gravidarum (HG) is the medical term for severe pregnancy nausea and vomiting that is continuous and debilitating (not to be confused with typical morning sickness, even a pretty bad case). HG begins early in the first trimester (with a diagnosis usually coming about 9 weeks into pregnancy) and usually starts to lift between weeks 12 and 16. Most cases fully resolve by week 20, but in some women, the condition can continue throughout pregnancy.

Left untreated, HG can lead to weight loss (usually about 10 pounds or 5 percent of prepregnancy body weight), malnutrition, and dehydration. Treatment of severe HG often requires hospitalization—mostly for the administration of IV fluids and antinausea drugs, which can effectively safeguard your wellbeing and your baby's.

How common is it? HG occurs in about 1 to 2 percent of all pregnancies. It is more common in first-time moms, in young moms, in obese moms, and in moms carrying multiples. Extreme emotional stress (not your run-of-the-mill, everyday stress) may also increase your risk, as might endocrine imbalances (high thyroid levels) and vitamin B or other nutrient deficiencies. And if you had HG in a previous pregnancy, you're somewhat more likely to encounter it with subsequent pregnancies.

What are the signs and symptoms? The symptoms of HG include:

- Very frequent and severe nausea and vomiting (in other words, vomiting all day, every day)
- The inability to keep any food or even liquid down
- Signs of dehydration, such as infrequent urination or dark, scant urine
- Weight loss of more than 5 percent
- Blood in the vomit

What can you and your practitioner do? Diclegis (a combination of vitamin B_6 and doxylamine, the antihistamine found in Unisom SleepTabs) is often prescribed for tough morning sickness cases. You can combine the medication with some of the natural remedies used to fight morning sickness, including ginger, acupuncture, and acupressure wristbands (see page 137). Some experts suggest that magnesium

You'll Want to Know . . .

As miserable as hyperemesis gravidarum makes you feel, it's very unlikely to affect your baby. Most studies show no health or developmental differences between infants of moms who experience HG and those who don't.

supplements (oral or spray form) or even Epsom salt baths may help ease symptoms, so ask your practitioner about these options, too. But if you're vomiting continually and/or losing significant amounts of weight, your practitioner will assess your need for bed rest, IV fluids, and/or hospitalization, as well as some sort of antiemetic (antinausea) drug (such as Phenergan, Reglan, or scopolamine), if Diclegis alone hasn't worked. Once you're able to keep food down again, it may help to tweak your diet to eliminate fatty and spicy foods, which are more likely to cause nausea, as well as to avoid any smells or tastes that tend to set you off. In addition, try to graze on many small high-carb and high-protein meals throughout the day, and be sure your fluid intake is adequate. Keeping an eye on your urinary output is the best way to assess whether you're dehydrated—dark, scant urine is a sign you're not getting, or keeping down, enough fluids.

One thing to remember is that you're not alone—even if you think the typical pregnant woman who complains about her morning sickness can't relate. For support from moms who have been there, done that, and gotten through it (and given birth to healthy babies), check out the HER Foundation at helpher.org.

Gestational Diabetes

What is it? Gestational diabetes (GD)—a form of diabetes that appears only during pregnancy—occurs when the body becomes more resistant to insulin (the hormone that lets the body turn blood sugar into energy) and is less able to regulate the increased blood sugar of pregnancy effectively. Since GD usually begins between weeks 24 and 28 of pregnancy, a glucose screening test is routine at around 28 weeks. If you came into pregnancy obese, however, GD may show up earlier (or you may have undiagnosed Type 2 diabetes), which is why your practitioner may recommend screening earlier and more often. GD almost always goes away after delivery, but if you've had it, you'll be checked postpartum to make sure it's gone.

Diabetes, both the kind that begins in pregnancy and the kind that started before conception, is not harmful to either a mom or her baby if it is well controlled. But if excessive sugar is allowed to circulate in a mother's blood and then enter the fetal circulation through the placenta, the potential problems for both mother and baby are serious. Women who have uncontrolled GD are more likely to have a too-large baby, which can complicate delivery. They are also at risk for developing preeclampsia (see page 550) and stillbirth. Uncontrolled diabetes could also lead to potential problems for the baby after birth, such as jaundice, breathing difficulties, and low blood sugar levels. Later in life, he or she may be at an increased risk for obesity and Type 2 diabetes. Research also suggests that early uncontrolled GD (before 26 weeks) in a mom is associated with a greater chance of autism in her child. But it's important

to remember: Those potential negative effects don't apply to moms who get the help they need to keep their blood sugar under control.

How common is it? GD is fairly common, affecting around 7 to 9 percent of expectant moms. Because it's more common among obese women, rates of GD are rising along with rising obesity rates in the U.S. Older moms-to-be are more likely to develop GD, as are women with a family history of diabetes or GD. Native Americans, Hispanic Americans, and African Americans are also at somewhat greater risk for GD.

What are the signs and symptoms? Most women with GD have no symptoms, though a few may experience:

- Unusual thirst
- Frequent urination in large amounts
- Fatigue (which may be difficult to differentiate from pregnancy fatigue)
- Sugar in the urine (detected at a routine practitioner visit)

What can you and your practitioner do? Around your 28th week (earlier if you're overweight or obese or have other risk factors), you'll be given a glucose screening test (see page 294) and, if necessary, a more elaborate 3-hour glucose tolerance test. If these tests show you have GD, your practitioner will likely put you on a special diet (similar to the Pregnancy Diet), suggest you exercise regularly, and recommend you keep your weight gain within recommended limits to keep your GD under control. You may also need to check your blood glucose levels at home. If diet and exercise alone aren't enough to control your blood sugar level (they usually are), you may need supplementary insulin. The insulin can be given in shots, or metformin (or less often, glyburide) might be used as an alternative treatment for GD. Fortunately, virtually all of the potential risks associated with GD can be eliminated through the careful control of blood sugar levels achieved by good self-care and medical care.

Can it be prevented? Many of the same steps that can be taken to control GD can also help prevent it in the first place. Conceiving at an ideal weight lowers risk, as can gaining the right amount of weight during pregnancy. So, too, can good dietary habits (eating plenty of fruits and vegetables, lean protein, beans, and whole grains, limiting sugar, refined grains, and white potatoes, and making sure you're getting enough folic acid) and regular exercise (research shows that obese women who exercise cut their risk of developing GD by half).

Having GD during pregnancy does put you at greater risk of developing Type 2 diabetes after pregnancy. But keeping your diet healthy, staying at or getting to a normal weight, and, even more important, continuing to exercise after baby is born (and beyond) significantly cuts that risk. So does breastfeeding your baby. Experts say that breastfeeding improves glucose metabolism and insulin sensitivity, cutting the risk of developing diabetes down the road by half—and the longer you breastfeed, the lower your risk becomes.

You'll Want to Know . . .

If your GD is well controlled and your pregnancy carefully monitored, it's very likely your pregnancy will progress normally and your baby will be born healthy.

Preeclampsia

What is it? Preeclampsia is a disorder that generally develops late in pregnancy (after week 20) and is characterized by a sudden onset of high blood pressure, often (but not always) protein in the urine, and possibly other signs and symptoms. There may be excessive swelling (especially of the hands and face) with preeclampsia, but a diagnosis of the condition won't be made on the basis of swelling alone (swelling in pregnancy is usually completely normal). Pregnancy-induced hypertension involves only an increase in blood pressure, and is not the same as preeclampsia.

While it's unclear exactly what causes preeclampsia (see box, facing page), experts believe that it occurs when blood vessels in the placenta don't develop properly—they're narrower than normal—limiting the amount of blood that flows through them. These changes in blood flow to the placenta lead to high blood pressure and excessive swelling in the mom. And because the placenta doesn't function properly, it isn't as able to eliminate waste products fast enough, so those waste products build up in the blood, causing certain proteins that should stay in the bloodstream to leak into the urine. All this damage to the walls of these blood vessels can also result in changes in blood clotting, which in turn can lead to a host of other problems.

If preeclampsia goes untreated, it could progress to eclampsia, a much more serious condition involving seizures (see page 563). Unmanaged preeclampsia can also cause a number of other pregnancy complications, such as premature delivery or intrauterine growth restriction.

How common is it? About 8 to 10 percent of pregnant women are diagnosed with preeclampsia, with the risk higher for women carrying multiple fetuses, women over 40, obese women, and women with high blood pressure, diabetes, or gestational diabetes. Preeclampsia is more common in first pregnancies, and if you're diagnosed with preeclampsia in one of your pregnancies, you have a 1 in 3 chance of developing the condition in future pregnancies. That risk is higher if you're diagnosed with preeclampsia in your first pregnancy or if you develop preeclampsia early in any pregnancy.

What are the signs and symptoms? Symptoms of preeclampsia can include any or all of the following:

- A rise in blood pressure (to 140/90 or more in a woman who has never had high blood pressure before)
- Protein in the urine
- Severe headaches that aren't relieved by acetaminophen (Tylenol)
- Pain in the upper abdomen
- Blurred or double vision
- Rapid heartbeat
- Scant and/or dark urine
- Abnormal kidney function
- Exaggerated reflex reactions
- Severe swelling of hands and face
- Severe swelling of the ankles that doesn't go away
- Sudden excessive weight gain unrelated to eating

What can you and your practitioner do? Regular prenatal care is the best way to catch preeclampsia in its early stages (your practitioner might be tipped off by a rise in your blood pressure, or any of the symptoms listed above). Being alert to any such symptoms (and alerting your practitioner if you notice them)

The Reasons Behind Preeclampsia

No one knows for sure what causes preeclampsia, though there are a number of theories:

- A genetic link. Researchers hypothesize that the genetic makeup of the fetus could be one of the factors that predisposes a pregnancy to preeclampsia. So, if your mother or your partner's mother had preeclampsia during their pregnancies with either of you, you are somewhat more likely to have preeclampsia during your pregnancies. But the baby's genes are not the only ones in play. Something in the mom-to-be's genetic makeup can also predispose her to preeclampsia, say experts.
- A blood vessel defect. It has been suggested that this defect causes the blood vessels in some women to constrict during pregnancy instead of widen (as usually happens). As a result of this vessel defect, researchers theorize, there is a drop in the blood supply to organs like the kidney and liver, leading to preeclampsia. The fact that women who experience preeclampsia during pregnancy are at an increased risk later in life of having some sort of cardiovascular condition also seems to indicate that the condition may be the result of a predisposition to high blood pressure.
- Gum disease. Pregnant women with severe gum disease are more than twice as likely to have preeclampsia than women with healthy gums. Experts theorize that the infection causing the periodontal disease may travel to the placenta or produce chemicals that can cause preeclampsia. Still, it is not known if periodontal disease causes preeclampsia or if it is just associated with it.
- An immune response to a foreign intruder: the baby. This theory suggests that the woman's body becomes "allergic" to the baby and placenta. This "allergy" causes a reaction in the mother's body that can damage her blood and blood vessels. The more similar the father's and mother's genetic markers are to each other, the more likely this immune response will occur.

also helps, particularly if you had a history of hypertension before pregnancy, developed it during this pregnancy, or if you have diabetes or gestational diabetes.

In 75 percent of cases, preeclampsia is mild. However, even a mild case can progress to severe preeclampsia or eclampsia very quickly if it's not diagnosed and treated promptly. In severe preeclampsia, blood pressure is consistently much higher and can lead to organ damage and other more serious complications if not properly managed.

If you have a mild case, your doctor will probably recommend regular blood and urine tests (assessing platelet counts, liver enzymes, kidney function, urinary protein levels) to check if the condition is progressing, a daily kick count in the third trimester (recommended anyway; see page 315), blood pressure monitoring, changes to your diet (including eating more protein, fruits, veggies, low-fat dairy, and healthy fats, and less salt, as well as drinking enough water). Some form of bed rest may also be prescribed, as well as an early delivery (as close to 37 weeks as possible).

You'll Want to Know . . .

Fortunately, in women who are receiving regular medical care, preeclampsia is almost invariably caught early on and managed successfully. With appropriate and prompt medical care, a woman with preeclampsia near term has virtually the same excellent chance of having a positive pregnancy outcome as a woman with normal blood pressure.

In a more severe case, you'll most likely be treated in the hospital with careful fetal monitoring (including nonstress tests and ultrasounds to check for fetal wellbeing and growth), medication to lower your blood pressure, magnesium sulfate (an electrolyte with antiseizure properties that may help prevent progression to eclampsia), and early delivery—often once you've reached 34 weeks of pregnancy if your condition is stable. If it becomes unstable, the doctor may give you corticosteroids to speed your baby's lung maturity and deliver him or her right away, regardless of gestational age.

Keep in mind that while preeclampsia can be kept in check, the only way to absolutely cure the condition is by delivering your baby. The good news is that 97 percent of women with preeclampsia recover completely, with a speedy return to normal blood pressure, after delivery. That said, women with a history of preeclampsia have a higher risk of stroke, blood clots, and heart attack later in life, so be sure you continue to practice healthy habits—eating well, exercising, not smoking, and so on—and get good medical care and follow-up after your baby is born.

Can it be prevented? Research has suggested that for women at risk for preeclampsia, aspirin or other anticlotting drugs during pregnancy may reduce the risk. This has led to the recommendation that women who have a higher risk of preeclampsia, but don't have signs or symptoms, be prescribed a low-dose aspirin daily (81 milligrams per day) after the 12th week of pregnancy.

Coming into pregnancy at a healthy weight may lower the risk of preeclampsia. Some research has also suggested that good nutrition—including adequate intakes of vitamins and minerals (especially magnesium)—may reduce risk, as may regular exercise and proper dental care. One unexpected (and yummy) way to help prevent preeclampsia: regularly eating dark chocolate during the second half of pregnancy.

HELLP Syndrome

What is it? Like preeclampsia, HELLP syndrome is a serious pregnancy complication related to blood pressure. It can occur by itself or in conjunction with preeclampsia, almost always in the last trimester. The acronym stands for H (hemolysis, in which red blood cells are destroyed too soon, causing a low red-cell count), EL (elevated liver enzymes, which indicates that the liver is functioning poorly and is unable to process toxins in the body efficiently), and LP (low platelet count, which makes it difficult for the blood to form clots).

When HELLP develops, it can threaten both a mother's life and that of her baby. Women who don't get the diagnosis and aren't treated quickly run about a 1 in 4 chance of suffering serious complications, primarily in the form of extensive liver damage or stroke.

How common is it? About 50,000 moms-to-be in the U.S. develop HELLP

each year, with the risk higher in women who have preeclampsia or eclampsia (about 10 to 20 percent of these women also develop HELLP) or have had HELLP in a previous pregnancy.

What are the signs and symptoms? The symptoms of HELLP are very vague, consisting of (in the third trimester):

- Nausea
- Vomiting
- Headaches
- General malaise
- Pain and tenderness in the right upper abdomen or chest
- Viral-type illness symptoms

Blood tests reveal a low platelet count, elevated liver enzymes, and hemolysis (the breakdown of red blood cells). Liver function rapidly deteriorates in women with HELLP, so treatment is critical.

What can you and your practitioner do? The only effective treatment for HELLP syndrome is delivery of your baby, so the best thing you can do is be aware of the symptoms of the condition (especially if you already have or are at risk for preeclampsia) and call your practitioner immediately if you develop any. If you have HELLP, you might also be given steroids (to treat the condition and help mature the baby's lungs) and magnesium sulfate (to prevent seizures).

Can it be prevented? Because a woman who has had HELLP in a previous pregnancy is at increased risk of having it again, close monitoring is necessary in any subsequent pregnancy. Taking the same steps to prevent and treat preeclampsia (see facing page) may help prevent a recurrence of HELLP.

Intrauterine Growth Restriction

What is it? Intrauterine growth restriction (IUGR) is a term used when a baby is smaller than normal during pregnancy. A diagnosis of IUGR is given if your baby's weight is below the 10th percentile for gestational age based on ultrasound measurements. IUGR can occur if the health of the placenta or its blood supply is impaired or if the mother's nutrition, health, or lifestyle prevents the healthy growth of her fetus.

Babies who have IUGR often have a low weight at birth—called small for gestational age (or SGA). But not all babies who are SGA had IUGR. Some are healthy babies who are just born smaller than average because they're genetically destined to be.

There are two types of IUGR: symmetrical IUGR, in which all parts of the baby's body are proportionally small, and asymmetrical IUGR, when the baby has a normal size head and brain but the rest of the body is small.

How common is it? IUGR occurs in about 10 percent of all pregnancies. It's more common in first pregnancies, in fifth and subsequent ones, in women who are under age 17 or over age 35, in those who had a previous low-birthweight baby, and in those who have placental problems or uterine

You'll Want to Know . . .

More than 90 percent of babies who are born small for gestational age do fine, catching up with their bigger birth buddies in the first couple of years of life.

You'll Want to Know . . .

A mom who has already had a low-birthweight baby has only a modestly increased risk of having another one—and, to her advantage, statistics show that each subsequent baby is actually likely to be a bit heavier than the preceding one. If you had an IUGR baby the first time around, controlling all the possible contributing factors can reduce the risk this time.

abnormalities. Carrying multiples is also a risk factor, but that's often simply the result of crowded conditions (it's hard to fit more than one 7-pounder in a single womb).

What are the signs and symptoms? Surprisingly, carrying small is not usually a tip-off to IUGR. In fact, there are rarely any obvious outward signs that the baby isn't growing in utero as he or she should be. Instead, IUGR is usually detected during a routine prenatal exam when the practitioner measures the fundal height—the distance from your pubic bone to the top of your uterus—and finds that it's measuring too small for the baby's gestational age, or through an ultrasound, which can detect a baby whose growth is slower than expected for his or her gestational age.

What can you and your practitioner do? One of the best predictors of a baby's good health is birthweight, so having IUGR can lead to some health problems in a newborn, including having difficulty maintaining a normal body temperature or fighting infection. That's why it's so important to diagnose and begin treating the problem as early as possible during pregnancy to boost baby's chances of a healthy bottom line at birth. A variety of approaches may be tried, depending on the suspected cause, including bed rest, IV feedings if necessary, and medications to improve placental blood flow or to correct a diagnosed problem that may be contributing to the IUGR. If the uterine environment is poor and can't be improved, and the fetal lungs are mature, prompt delivery—which allows baby to start living under healthier conditions—is usually the best way to go.

Can it be prevented? Optimum nutrition, good prenatal care, and the right weight gain for mom can all greatly improve the chances that a baby will grow, develop, and thrive as he or she should—as can eliminating lifestyle factors that can contribute to IUGR (such as mom's smoking, drinking, or using recreational drugs), treating an eating disorder, minimizing physical and excessive psychological stress (such as from depression), and controlling chronic hypertension. Happily, even when prevention and treatment are unsuccessful (or impossible) and a baby is born smaller than normal, the chances that he or she will do well are increasingly good, thanks to the many advances in neonatal (newborn) care.

Placenta Previa

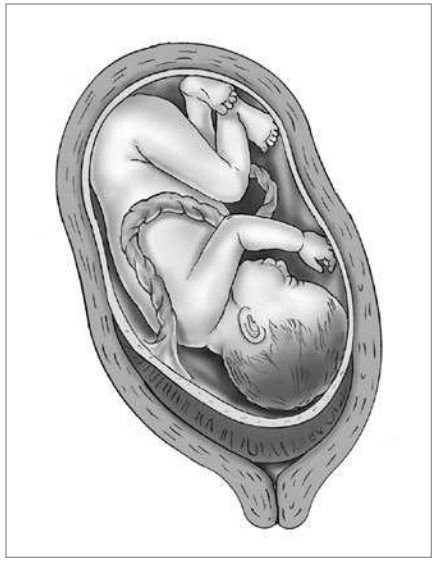
What is it? The definition of placenta previa is a placenta that partially or completely covers the opening of the cervix. In early pregnancy, a low-lying placenta is common, but as pregnancy progresses and the uterus grows, the placenta usually moves upward and away from the cervix. If it doesn't move up and partially covers or touches the cervix, it's called partial previa. If it completely covers the cervix, it's called

total or complete previa. Either can physically block your baby's passage into the birth canal, making a vaginal delivery impossible. It can also trigger bleeding late in pregnancy and at delivery. The closer to the cervix the placenta is located, the greater the possibility of bleeding.

How common is it? Placenta previa occurs in 1 out of every 200 deliveries. It is more likely to occur in women over the age of 30 than in women under the age of 20, and it is also more common in women who have had at least one other pregnancy or any kind of uterine surgery (such as a previous c-section or a D&C that's performed after a miscarriage). Carrying multiple fetuses also increases the risks, as does smoking during pregnancy.

What are the signs and symptoms? Placenta previa is most often discovered not on the basis of symptoms but during a routine second-trimester ultrasound. Sometimes the condition announces itself in the third trimester (occasionally earlier) with bright red bleeding. Typically, bleeding is the only symptom. There's usually no pain involved.

What can you and your practitioner do? If you have no bleeding, and no signs of the more complicated placental condition placenta accreta (see page 565), nothing needs to be done until the third trimester, by which point most early cases of placenta previa have corrected themselves. Even later on, there is no treatment necessary if you've been diagnosed with previa but aren't experiencing any bleeding (you'll just need to be alert to any bleeding or to signs of premature labor, which is more common with placenta previa). If you're experiencing bleeding related to a diagnosed previa, your practitioner will likely put you on pelvic rest (no sex), advise you to take it easy and avoid strenuous activities or exercise, and monitor you closely. If preterm labor seems imminent, you may receive steroid shots to mature your baby's lungs more rapidly. Even if the condition hasn't presented your pregnancy with any problems at all (you haven't had any bleeding and you've carried to term), your baby will still be delivered via c-section.



Placenta previa

You'll Want to Know . . .

Placenta previa is considered to be the most common cause of bleeding in the latter part of pregnancy. Most previas are found early and managed well, with the baby delivered successfully by c-section. About 75 percent of cases are delivered by scheduled c-section before labor starts.

Placental Abruption

What is it? Placental abruption is the early separation of the placenta from the uterine wall during pregnancy, rather than after delivery. If the separation is slight, there is usually little danger to the mother or baby as long as treatment is prompt and proper precautions are taken. If the abruption is more severe, however, the risk to the baby is considerably higher. That's because a placenta's complete detachment from the uterine wall means the baby is no longer getting oxygen or nourishment.

How common is it? It occurs in less than 1 percent of pregnancies, almost always in the second half of the pregnancy and most often in the third trimester. Placental abruption can happen to anyone, but it occurs more commonly in women who have had a previous abruption or have a predisposition to clotting, as well as in those who are carrying multiples, have GD, or have preeclampsia or other high blood pressure conditions of pregnancy. It's also more common in women who smoke or use cocaine. A short umbilical cord or trauma caused by an accident is occasionally the cause of an abruption.

What are the signs and symptoms? The symptoms of placental abruption depend on the severity of the detachment, but will usually include:

- Bleeding (light to heavy, with or without clots)
- Abdominal cramping or achiness
- Uterine tenderness
- Pain in the back or abdomen

What can you and your practitioner do? Let your practitioner know immediately if you have abdominal pain accompanied by bleeding in the second half of your pregnancy. Along with those symptoms, testing for fetal distress (nonstress and stress tests; see page 380) may be helpful in making the diagnosis and deciding on the management strategy, as can ultrasound (though only about 25 percent of abruptions can actually be seen on ultrasound).

If it's been determined that your placenta has separated slightly from the uterine wall but has not completely detached, and if your baby's vital signs stay regular, you'll probably be monitored closely and told to take it easy. If the bleeding continues, you may need to be hospitalized for continuous monitoring and IV fluids. Your practitioner may also administer steroids to speed up your baby's lung maturation in case you need to deliver early. If the bleeding remains manageable and the baby doesn't show any signs of distress, a vaginal delivery may be possible. But if the abruption is significant or if it continues to progress, the only way to treat it is to deliver the baby, usually by c-section.

Chorioamnionitis

What is it? Chorioamnionitis is a bacterial infection of the amniotic membranes and fluid that surround and protect your baby. It's caused by common bacteria such as E. coli or by group B strep (routinely tested for at about week 36). Infection is believed to be a major cause of preterm premature rupture of the membranes (PPROM) as well as of premature delivery.

How common is it? Chorioamnionitis occurs in 1 to 2 percent of pregnancies. Women who experience PPROM are at increased risk for chorioamnionitis because bacteria from the vagina can seep into the amniotic sac after it has ruptured. Women who've had the

infection during their first pregnancy are more likely to have it again in a subsequent pregnancy.

What are the signs and symptoms? Diagnosis of chorioamnionitis is complicated by the fact that no simple test can confirm the presence of infection. The symptoms of chorioamnionitis can include:

- Fever
- Tender, painful uterus
- Increased heart rate in both you and your baby
- Leaking, foul-smelling amniotic fluid (if membranes have already ruptured)
- Unpleasant-smelling vaginal discharge (if membranes are intact)
- Increased white blood cell count (a sign the body is fighting an infection)

What can you and your practitioner do? Be sure to call your practitioner if you notice any leaking of amniotic fluid, no matter how small, or if you notice a foul-smelling discharge or any other of the symptoms listed above. If you are diagnosed with chorioamnionitis, you will likely be prescribed antibiotics and delivered immediately. You and your baby will also be given antibiotics after delivery to make sure no further infections develop.

Oligohydramnios

What is it? Oligohydramnios is a condition in which there is not enough amniotic fluid surrounding and cushioning the baby. It usually develops in the latter part of the third trimester, though it could show up earlier in pregnancy. Though the majority of women diagnosed with oligohydramnios will have a completely normal pregnancy, there is a slight risk of umbilical cord constriction if there's too little fluid for your baby to float around in. The condition may result from a puncture in the amniotic sac after amniocentesis or a spontaneous fluid leak at any time during pregnancy (one so small, you wouldn't necessarily notice it). A low level of amniotic fluid can also suggest a problem in the baby, such as poor fetal growth or a kidney or urinary tract condition (the baby normally excretes urine into the surrounding amniotic fluid, so when that process isn't working as it should, a first indicator is low amniotic fluid).

How common is it? Four percent of pregnant women are diagnosed with oligohydramnios, but the rate rises to 12 percent in pregnancies that are post-term (those that have reached 42 weeks).

What are the signs and symptoms? There are no symptoms, but signs that would point to the condition are a uterus that measures smaller than it should and a decreased amount of amniotic fluid, detected via ultrasound. There might also be a noticeable decrease of fetal activity and sudden drops in the fetal heart rate in some cases.

What can you and your practitioner do? If you're diagnosed with oligohydramnios, you'll need to get a lot of rest and drink plenty of water. The amount of amniotic fluid will be closely monitored. If at any point oligohydramnios endangers the wellbeing of your baby, your practitioner may opt for a prompt delivery. If the low level of fluid is the result of a problem with the baby's urinary tract, fetal surgery to correct it may be an option.

Hydramnios

What is it? Too much amniotic fluid surrounding the fetus causes the condition known as hydramnios (also called polyhydramnios). Most cases of hydramnios are mild and transient, simply the result of a temporary change in the normal balance of the amniotic fluid production, with any extra fluid likely to be reabsorbed without any treatment.

But when fluid accumulation is severe (which is rare), it may signal a problem with the baby, such as a central nervous system or gastrointestinal (or other congenital) defect, or an inability to swallow (normally, babies swallow amniotic fluid). Consistently high levels of amniotic fluid somewhat increase the risk for preterm premature rupture of the membranes, preterm labor, placental abruption, breech presentation, or umbilical cord prolapse.

How common is it? Hydramnios occurs in about 1 percent of all pregnancies. It is more likely to occur when there are multiple fetuses or when there are fetal abnormalities, and can be related to poorly controlled diabetes or gestational diabetes in the mother.

What are the signs and symptoms? More often than not, there are no symptoms at all with hydramnios, though some women may notice:

- Difficulty feeling fetal movements (because there's too much of a cushion from the extra fluid)
- Discomfort in the abdomen or chest (because the larger-than-normal uterus presses on the abdominal organs and chest wall)

Hydramnios is usually detected during an ultrasound that measures amniotic fluid or at a prenatal exam, when your fundal height—the distance from your pubic bone to the top of your uterus—measures larger than normal (though this finding on a physical exam will be followed up with an ultrasound for confirmation).

What can you and your practitioner do? Unless the fluid accumulation is fairly severe, there's absolutely nothing you need to do except to keep your appointments with your practitioner, who will continue to monitor your condition with ultrasounds (perhaps even weekly). If the accumulation is more severe, your practitioner may suggest you undergo a procedure called therapeutic amniocentesis, during which fluid is withdrawn from the amniotic sac to reduce the level.

Preterm Premature Rupture of the Membranes (PPROM)

What is it? PPROM refers to the rupture of the membranes (or "bag of waters") that cradle the fetus in the uterus, before 37 weeks (in other words, before term). The major risk of PPROM is a premature birth. Other risks include infection of the amniotic fluid and prolapse or compression of the umbilical cord. Rupture of the membranes that

You'll Want to Know . . .

With prompt and appropriate diagnosis and management of PPROM, both mom and baby should be fine, though if the birth is premature, there may be a long stay in the NICU for baby.

takes place before labor starts but after 37 weeks, is covered on page 378.

How common is it? Preterm premature rupture of membranes occurs in 3 percent of pregnancies. Women most at risk are those who smoke during pregnancy, have certain STDs, have chronic vaginal bleeding or placental abruption, have had PPROM previously, have bacterial vaginosis (BV), or are carrying multiples.

What are the signs and symptoms? The symptoms are leaking or gushing of fluid from the vagina. The way to tell whether you're leaking amniotic fluid and not urine is by taking the sniff test: If it smells like ammonia, it's probably urine. If it has a somewhat sweet smell, it's probably amniotic fluid (unless it's infected, in which case the fluid will be foul smelling). If you have any doubts about what you're leaking, call your practitioner to be on the safe side.

What can you and your practitioner do? If your membranes have ruptured after 34 weeks, you'll likely be induced and your baby delivered. If it's too soon for your baby to be delivered safely, you'll probably be put on in-hospital bed rest and given antibiotics to ward off infection, as well as steroids to mature your baby's lungs as quickly as possible for a safer early delivery.

Rarely, the break in the membranes heals and the leakage of amniotic fluid stops on its own. If that happens, you'll be allowed to go home and resume your normal routine while remaining alert to signs of further leakage.

Preterm Labor/Delivery

What is it? Labor that begins after week 20 but before the end of week 37 of pregnancy is considered to be preterm labor.

You'll Want to Know . . .

A baby born prematurely will likely need to spend time in a NICU (neonatal intensive care unit) for the first few days or weeks (or, in some cases, months) of life. Though prematurity has been linked to slow growth and developmental delays, most babies who arrive early and at a healthy (for a preemie) birthweight catch up and have no lasting problems at all. Thanks to advances in medical care, your chances of bringing home a normal, healthy infant after a premature birth are very good.

How common is it? Preterm labor and preterm birth are fairly common. About 12 percent of babies are born preterm in the U.S.

While no one knows for sure what causes premature labor, experts point to a number of factors that increase risk (see page 32 for a list of risk factors). Keep in mind that having one or more of these risk factors doesn't mean you'll necessarily go into preterm labor—and having no risk factors doesn't mean that you won't. In fact, at least half of the women who go into preterm labor have no known risk factor.

What are the signs and symptoms? Signs of premature labor can include all or some of the following:

- Menstrual-like cramps
- Regular contractions that intensify and become more frequent even if you change positions
- Back pressure
- Unusual pressure in your pelvis

Predicting Preterm Labor

Even among women who are at high risk for preterm labor, most will carry to term. One way to predict preterm labor is to examine cervical or vaginal secretions for a substance known as fetal fibronectin (fFN). Studies show that some women who test positive for fFN stand a good chance of going into preterm labor within 1 to 2 weeks after the test. The test, however, is better at predicting which women are not at risk for going into preterm labor (by detecting no fFN) than predicting which women are at risk. When fFN is detected, steps should be taken to reduce the chances of preterm labor. The test is now widely available, but is usually reserved for high-risk women only. If you aren't considered high risk for preterm birth, you don't need to be tested.

Another screening test is one for cervical length. Via ultrasound before 30 weeks, the length of your cervix is measured to see if there are any signs that the cervix is shortening or opening. A short cervix puts you at an increased risk of preterm labor, especially if it began shortening early in pregnancy.

Though still considered experimental, there is a blood test that may be able to help predict preterm labor.

- Bloody vaginal discharge
- Rupture of membranes
- Changes in the cervix (thinning, opening, or shortening) as measured by ultrasound

What can you and your practitioner do? Because each day a baby remains in the womb improves the chances of both survival and good health, holding off delivery as long as possible will be the primary goal. Unfortunately, however, there often isn't much that can be done to stop early labor. The measures that were once routinely recommended (bed rest, hydration, monitoring for uterine activity) don't seem to work to stop or prevent contractions, though many doctors still prescribe them. Progesterone supplementation should be used in women with a prior spontaneous preterm delivery or those who have a short cervix and are not carrying multiples. Antibiotics (if a GBS culture is positive; see page 359) or tocolytics (that can temporarily halt contractions and give your practitioner time to administer steroids to help your baby's lungs mature more quickly, should a preterm birth become inevitable or necessary) may also be given. If at any point your practitioner determines that the risk to you or your baby from continuing the pregnancy outweighs the risk of preterm birth, no attempt will be made to postpone delivery.

Can it be prevented? Not all preterm births can be avoided, since not all are caused by preventable risk factors. However, all the following measures may reduce the risk of preterm delivery (while boosting your chances of having the healthiest pregnancy possible):

- Taking folic acid or a prenatal supplement for a year before pregnancy
- Spacing pregnancies at least 18 months apart, if possible
- Reaching an ideal weight before conception
- Getting good dental care before pregnancy

- Getting early prenatal care
- Eating well
- Receiving the hormone progesterone as weekly shots starting at 16 weeks of pregnancy and continuing through week 36 if you've delivered early before (but not if you're carrying multiples)
- Getting tested for and, if necessary, treated for any infections such as BV and UTIs during pregnancy
- Sticking to any limitations on activity (on the job, for instance, or, if needed, bed rest) prescribed by your practitioner
- Avoiding smoking, drinking, cocaine, and other drugs not prescribed by your doctor

The good news is that 80 percent of women who go into preterm labor will deliver at (or safely close to) term.

Pelvic Girdle Pain (PGP) or Symphysis Pubis Dysfunction (SPD)

What is it? Pelvic Girdle Pain, or PGP (also sometimes called symphysis pubis dysfunction, or SPD) is pain in the pelvic area and joints of the pelvis. It often happens because the ligaments that normally keep your pelvic bone aligned become overrelaxed and stretchy sooner than they should (as delivery nears, things are supposed to start loosening up significantly). This, in turn, can make the pelvic joints unstable, causing mild to severe pain. The pain may also result when a pelvic joint becomes stiff and stops moving normally, causing irritation in the other joints.

How common is it? The incidence of diagnosed PGP is about 1 in 300 pregnancies. However, some experts believe that up to 25 percent of all pregnant women experience PGP—but most of those cases aren't diagnosed.

What are the signs and symptoms? The most common symptom is a wrenching pain (as though your pelvis is coming apart) and difficulty walking. Typically, the pain is focused on the pubic area, but in some women it radiates to the upper thighs and perineum. The pain can worsen when you're walking and doing any weight-bearing activity, particularly one that involves lifting one leg, such as when you're climbing up stairs, getting dressed, getting in and out of a car, even turning over in bed. In very rare cases, the joint may gape apart, which can cause more serious pain in your pelvis, groin, hips, and buttocks.

What can you and your practitioner do? Avoid aggravating the condition by limiting weight-bearing positions and minimizing as best you can any activity that involves lifting or separating your legs—even walking, if it's very uncomfortable (some practitioners will even recommend modified bed rest so the pain doesn't worsen). Try stabilizing those floppy ligaments by wearing a pelvic support belt or band that corsets the bones back into place. Kegels and pelvic tilts can help to strengthen the muscles of the pelvis. Physical therapy may be especially helpful, so ask your practitioner for a referral. You can also ask about acupuncture and chiropractic therapies, as well as safe pain relievers.

Very rarely, PGP can make a vaginal delivery impossible and your practitioner may opt for a c-section instead. Even more rarely, PGP can worsen after delivery, requiring surgery. But for most moms, once baby is born and production of ligament-relaxing hormones stop, ligaments return to normal.

Cord Knots and Tangles

What is it? Once in a while, the umbilical cord becomes knotted, tangled, or wrapped around a fetus, often at the neck (when it is known as a nuchal cord). Some knots form during delivery, while others form during pregnancy when the baby moves around. As long as the knot remains loose, it's not likely to cause any problems at all. But if the knot becomes tight, it could interfere with the circulation of blood from the placenta to the baby and cause oxygen deprivation. Such an event happens only rarely, but when it does, it is most likely to occur during baby's descent through the birth canal.

How common is it? True umbilical cord knots occur in about 1 in every 100 pregnancies, but only in 1 in 2,000 deliveries will a knot be tight enough to present problems for the baby. The more common nuchal cords occur in as many as a quarter of all pregnancies but are usually harmless, very rarely posing any risk to the baby. Babies with long cords and those who are large-for-gestational age are at greater risk for developing true knots.

Researchers speculate that nutritional deficiencies that affect the structure and protective barrier of the cord, or other risk factors, such as carrying multiples, having hydramnios, or smoking or drug use may make a woman more prone to having a pregnancy with a serious cord knot.

What are the signs and symptoms? The most common sign of a cord knot is decreased fetal activity after week 37. If the knot occurs during labor (which is when knots are most often detected), a fetal monitor will detect an abnormal heart rate.

What can you and your practitioner do? You can keep a general eye on how your baby is doing, especially later in pregnancy, by doing regular kick counts and calling your practitioner if you notice any pronounced decrease in fetal activity. If a loose knot tightens during delivery, your practitioner will be able to detect the drop in your baby's heart rate, and will make the appropriate decisions to ensure your baby's safe entry into the world. Immediate delivery, usually via c-section, is often the best approach.

Two-Vessel Cord

What is it? In a normal umbilical cord, there are 3 blood vessels—1 vein (which brings nutrients and oxygen to the baby) and 2 arteries (which transport waste from the baby back to the placenta and the mother's blood). But in some cases, the umbilical cord contains only 2 blood vessels—1 vein and 1 artery.

How common is it? About 1 percent of singleton and 5 percent of multiple pregnancies will have a 2-vessel cord. The condition is more common among Caucasians, moms over age 40, and moms with diabetes. It's also more common in multiple pregnancies. Female fetuses are more often affected than males.

What are the signs and symptoms? There are no signs or symptoms with this condition—it's typically detected during a routine anatomy scan ultrasound.

What can you and your practitioner do? If you've been found to have a 2-vessel cord, your pregnancy will be monitored more closely, since the condition comes with a small increased risk of poor fetal growth and occasionally is linked to a malformation. In the absence of any other abnormalities, however, a 2-vessel cord doesn't impact the pregnancy. The baby is most likely to be born completely healthy.

Uncommon Pregnancy Complications

The following complications of pregnancy are, for the most part, rare. The average pregnant woman is extremely unlikely to encounter any of them. So, again (and this deserves repeating), read this section only if you need to—and even then, read just what applies to you. If any of these complications are diagnosed during your pregnancy, use the information here to learn about the condition and its typical treatment (as well as how to prevent it in future pregnancies), but realize that your practitioner's protocol for treating you may be different.

Eclampsia

What is it? Eclampsia is the result of uncontrolled or unresolved preeclampsia (see page 550). Depending on when in pregnancy a woman becomes eclamptic, her baby may be at risk of being born prematurely since immediate delivery is often the only treatment. Although eclampsia is life-threatening for the mother, maternal deaths from it are quite rare in the U.S. With optimum treatment and careful follow-up, the majority of women with eclampsia return to normal health after delivery.

How common is it? Eclampsia is much less common than preeclampsia and occurs in only 1 out of every 2,000 to 3,000 pregnancies, typically among women who have not been receiving regular prenatal care.

You'll Want to Know . . .

Very few women receiving regular prenatal care ever progress from the manageable preeclampsia to the more serious eclampsia.

What are the signs and symptoms? Eclampsia is always preceded by preeclampsia. Seizures—usually close to or during delivery—are the most characteristic symptom of eclampsia. Seizures can also occur postpartum, usually within the first 48 hours.

What can you and your practitioner do? If you start to seize, you'll be given oxygen and drugs to stop the seizures and your labor will be induced or a c-section performed when you're stable. The majority of moms with eclampsia rapidly return to normal after delivery, though careful followup is necessary to be certain blood pressure doesn't stay up and seizures don't continue.

Can it be prevented? Regular prenatal care will help ensure that symptoms of preeclampsia will be picked up early. If you are diagnosed with preeclampsia, your practitioner will keep a close eye on you (and your blood pressure) to make sure your condition doesn't progress to eclampsia. Taking steps to try to prevent preeclampsia can also help avoid eclampsia.

Cholestasis

What is it? Cholestasis of pregnancy is a condition in which the normal flow of bile in the gallbladder is slowed (as a result of pregnancy hormones), causing the buildup of bile acids in the liver, which in turn can spill into the bloodstream. Cholestasis is most likely to occur in the last trimester, when hormones are at their peak. Happily,

cholestasis usually goes away after delivery.

Cholestasis may increase the risks for fetal distress, preterm birth, or stillbirth, which is why early diagnosis and treatment are crucial.

How common is it? Cholestasis affects 1 to 2 pregnancies in 1,000. It's more common in moms carrying multiples, those who have previous liver damage, and those whose mother or sister had cholestasis.

What are the signs and symptoms? Most often, the only symptom noticed is severe itching, particularly on the hands and feet, usually late in pregnancy. This itching shouldn't be confused with itching from dry, stretching skin (which is very common and completely normal during pregnancy).

What can you and your practitioner do? The goals of treating cholestasis of pregnancy are to relieve the itching and prevent pregnancy complications. Itching can be treated with topical anti-itch medications, lotions, or corticosteroids. Medication is sometimes used to help decrease the concentration of bile acids. If cholestasis is endangering the wellbeing of the mother or fetus, an early delivery may be necessary.

Deep Venous Thrombosis

What is it? Deep venous thrombosis, or DVT, is the development of a blood clot in a deep vein. These clots show up most commonly in the lower extremities, particularly the thigh. Women are more susceptible to clots during pregnancy and delivery, and particularly in the postpartum period. This happens because nature, wisely worried about too much bleeding at childbirth, tends to increase the blood's clotting ability—occasionally too much. Another factor that can contribute is the enlarged uterus, which makes it difficult for blood in the lower body to return to the heart. If untreated, a DVT can result in the clot moving to the lungs and becoming life threatening.

How common is it? DVT occurs in 1 in every 500 to 2,000 pregnancies, including the postpartum period. DVT is more common if you are older, overweight, sedentary, a smoker, have a family or personal history of clots, or have hypertension, diabetes, or a variety of other conditions, including vascular diseases. Prolonged bed rest with little activity can also put you at higher risk of DVT, as can long plane rides.

What are the signs and symptoms? The most common symptoms of a deep vein thrombosis include:

- A heavy or painful feeling in the leg
- Tenderness in the calf or thigh
- Slight to severe swelling
- Distension of the superficial veins
- Calf pain on flexing the foot (turning the toes up toward the chin)

If the blood clot has moved to the lungs (a pulmonary embolus), there may be:

- Chest pain
- Shortness of breath
- Coughing with frothy, bloodstained sputum
- Rapid heartbeat and breathing rate
- Blueness of lips and fingertips
- Fever

What can you and your practitioner do? If you've been diagnosed with DVT or any kind of blood clot in previous

Cancer in Pregnancy

Sometimes, life can take a joyful turn and a challenging one, all at once—as when pregnancy and cancer happen at the same time. Whether you were already dealing with cancer when you found you were pregnant, or received a cancer diagnosis after discovering you were pregnant, there will be plenty of information to gather and choices to make in conjunction with both your prenatal team and your oncology team.

Treatment for cancer during pregnancy is a delicate balancing act between providing the best care for mom and limiting possible risk to her baby. The type of treatment you'll get will depend on many factors: how far along in pregnancy you are, the type of cancer, the stage of the cancer, and, of course, your wishes. The decisions you may face weighing your own wellbeing against your baby's may be emotionally wrenching, and you'll need plenty of support in making them.

While surgery may be performed if it's needed, doctors usually delay any other treatment (such as chemotherapy) until the second or third trimesters, when it's safer. Any treatment that might be harmful to the baby (for instance, radiation) will probably be postponed until after delivery. When cancer is diagnosed later in pregnancy, doctors may wait until after the baby is born to begin treatment, or they may consider inducing labor early. The reassuring news is that women diagnosed during pregnancy respond just as well to cancer treatment as women who are not pregnant, all other factors being equal.

For more help, contact the National Cancer Institute at cancer.gov, as well as hopefortwo.org, a support network for expectant moms with cancer.

pregnancies, let your practitioner know. In addition, if you notice swelling and pain in just one leg at any time during your pregnancy, call your practitioner right away. Don't massage the swelling.

Ultrasound may be used to diagnose a blood clot in the leg, and either a special scan (ventilation-perfusion) or CT study can diagnosis a clot in the lung. If it turns out that you do have a clot, you might be treated with heparin to thin your blood and prevent further clotting (though the heparin may need to be discontinued as you near term, to prevent you from bleeding excessively during delivery). Your clotting ability will be monitored along the way.

Can it be prevented? You can prevent clots by keeping your blood flowing—getting enough exercise and avoiding long periods of sitting will help you do this. If you have to fly, get up and move around every hour or two and do ankle roll exercises while you sit. Take stretching breaks frequently during long car rides, too. Staying well hydrated can also help prevent a blood clot. If you're at high risk, you can also wear support hose to prevent clots from developing in your legs. If you've been put on bed rest, take steps to reduce your risk (see page 577 for suggestions).

Placenta Accreta

What is it? Placenta accreta is an abnormally firm attachment of the placenta to the uterine wall. Depending on how deeply the placental cells invade, the condition may be called placenta

When Home Birth Isn't Best

You might have started your pregnancy low risk and had your heart set on a home birth, but when certain complications arise, it's wise to rethink your plans and opt for a hospital birth (or one at a birthing center attached to a hospital). Here are some circumstances when plans for a home birth might need to be changed:

- If you develop any of the pregnancy complications listed in this chapter (other than hyperemesis gravidarum or subchorionic bleed, if those have resolved)
- If you're pregnant with multiples
- If your baby is breech
- If you go into preterm labor
- If your baby has fetal distress

It's also not considered safe to plan for a home birth if you've had a prior cesarean delivery. Though some midwives will attend home VBACs (vaginal births after cesarean), experts agree that the risks far outweigh the benefits.

percreta or placenta increta. Placenta accreta increases the risk of heavy bleeding or hemorrhaging during delivery of the placenta.

How common is it? Only 1 out of 2,500 pregnancies will have an attachment abnormality. Placenta accreta is by far the most common of these, accounting for 75 percent of cases. In placenta accreta, the placenta digs deeply into the uterine wall, but does not pierce the uterine muscles. Your risk of placenta accreta increases if you have placenta previa and have had one or more cesarean deliveries in the past. In placenta increta, which accounts for 15 percent of cases, the placenta pierces the uterine muscles. In placenta percreta, which accounts for the final 10 percent, the placenta not only burrows into the uterine wall and its muscles, but also pierces the outer part of the wall and may even attach itself to other nearby organs.

What are the signs and symptoms? There are usually no symptoms. The condition is usually diagnosed via color Doppler ultrasound or may be noticed only during delivery when the placenta doesn't detach (as it normally would) from the uterine wall after the baby is born.

What can you and your practitioner do? Unfortunately, there is little you can do. In most cases, the placenta must be removed surgically after delivery to stop the bleeding. When the bleeding cannot be controlled by tying off the exposed blood vessels, removal of the entire uterus may be necessary.

Vasa Previa

What is it? Vasa previa is a condition in which some of the fetal blood vessels that connect the baby to the mother run outside the umbilical cord and along the membrane over the cervix. When labor begins, the contractions and opening of the cervix can cause the vessels to rupture, possibly causing harm to the baby. If the condition is diagnosed before labor, a c-section will be scheduled and the baby will be born healthy nearly 100 percent of the time.

How common is it? Vasa previa is rare, affecting 1 in 5,200 pregnancies. Women who also have placenta previa, a history of uterine surgery (including

c-section) or D&C, or a multiple pregnancy are at greater risk. Women who became pregnant through IVF are also at slightly higher risk.

What are the signs and symptoms? There are usually no signs of this condition.

What can you and your practitioner do? Diagnostic testing, such as with ultrasound or, better yet, a color Doppler ultrasound during the second trimester, can detect vasa previa. Women who are diagnosed with the condition will deliver their babies via c-section, usually before 37 weeks, to make sure labor doesn't begin on its own. Researchers are studying whether vasa previa can be treated using laser therapy to seal off the abnormally positioned vessels. You can read more about vasa previa at vasaprevia.com.

Childbirth and Postpartum Complications

Many of the following conditions can't be anticipated before labor and delivery—and there's no need to read up on them (and start worrying) ahead of time, since they're very unlikely to occur during or after your childbirth. They are included here so that in the unlikely event you experience one, you can learn about it after the fact, or in some cases, learn how you can prevent it from happening in your next labor and delivery.

Fetal Distress

What is it? Fetal distress is a term used to describe what occurs when a baby's oxygen supply is compromised in the uterus, either before or during labor. The distress may be caused by a number of factors, such as preeclampsia, uncontrolled diabetes, placental abruption, too little or too much amniotic fluid, umbilical cord compression, prolapse, or entanglement, or intrauterine growth restriction. It can also occur when the mother has been in a position for an extended period of time (such as flat on her back) that puts pressure on major blood vessels, depriving the baby of oxygen. Sustained oxygen deprivation and/or decreased heart rate can be serious for the baby and must be corrected as quickly as possible—usually with immediate delivery (most often by c-section, unless a vaginal birth is imminent).

How common is it? The exact incidence of fetal distress is uncertain (especially because some cases are only temporary), but estimates range from 1 in every 25 births to 1 in every 100 births.

What are the signs and symptoms? Babies who are doing well in utero have strong, stable heartbeats and respond to stimuli with appropriate movements. Babies in distress experience a decrease in heart rate, a change in their pattern of movement (or even no movement at all), and/or pass their first stool, called meconium, while still in the uterus. The only way you might suspect your baby is in distress is because of a noticeable slowdown of movement (after 28 weeks) or if your water broke and it was stained with meconium. The only way to know for sure is with a fetal monitor, nonstress test, or a biophysical profile ultrasound.

What can you and your practitioner do? If you think your baby might be in distress because you've noticed a change in fetal activity (it seems to have slowed down significantly, stopped, or otherwise has you concerned), call your practitioner immediately. Call your practitioner, too, if your water breaks and you notice it's meconium stained (see page 398). Once you are in your practitioner's office or in the hospital (or in labor), you'll be put on a fetal monitor to see whether your baby is indeed showing signs of distress. You may be given oxygen and IV fluids to help better oxygenate your blood and return your baby's heart rate to normal. If the reason your baby's in distress is that you've been on your back for a prolonged period of time, turning onto your left side to take pressure off your major blood vessels may also do the trick. If these techniques don't work, the best treatment is a quick delivery. The same steps will be taken if you didn't notice any symptoms but your baby was seen to be in distress during a routine checkup or nonstress test.

Cord Prolapse

What is it? A cord prolapse occurs during labor when the umbilical cord slips through the cervix and into the birth canal before the baby does. If the cord becomes compressed during delivery (as when your baby's head is pushing against a prolapsed cord), the baby's oxygen supply is compromised.

How common is it? Fortunately, cord prolapse is not common, occurring in 1 out of every 300 births. Certain pregnancy complications increase the risk of prolapse. These include hydramnios, breech delivery or any position in which the baby's head does not cover the cervix, a baby who's small for gestational age, and premature delivery. It can also occur during delivery of a second twin. Prolapse is a potential risk with PPROM or even near term if your water breaks before your baby's head has begun to "engage," or settle into the birth canal.

What are the signs and symptoms? If the cord slips down into the vagina, you may actually be able to feel it or even see it. If the cord is compressed by the baby's head, the baby will show signs of fetal distress.

What can you and your practitioner do? There's really no way to know in advance if your baby's cord is going to prolapse. If you suspect that your baby's umbilical cord has prolapsed and you are not in the hospital yet, get on your hands and knees with your head down and pelvis up to take pressure off the cord. Call 911 or have someone rush you to the hospital (on the way to the hospital, lie down on the backseat, with your bottom elevated). If you are already in the hospital when the cord prolapses, your practitioner may ask you to move quickly into a different position, one in which it will be easier to disengage the baby's head and take pressure off the umbilical cord. Delivery of your baby will need to be very quick, most likely by c-section. Quick delivery will usually prevent any of the problems (such as lack of oxygen) that may occur with a prolapsed cord that becomes compressed.

Shoulder Dystocia

What is it? Shoulder dystocia is a complication of labor and delivery in which one or both of the baby's shoulders become stuck behind the mother's pelvic bone as the baby descends into the birth canal.