Birth Control Options

"I'm definitely not ready to have another baby yet. What are my options for birth control?"

Okay, maybe sex isn't the first thing on your minds these days—and these sleep-deprived nights. Maybe it's the last thing on your mind most of the time. Yet there will come a night (or a Sunday afternoon when baby's napping) when you'll get the urge to sweep the pacifiers and burping cloths off the bed and sweep each other off your feet—when lust will return to your life, and passion will pick up where it left off (approximately) pre-baby.

So be prepared. If you'd like to avoid back-to-back pregnancies, you'll need to use some form of birth control as soon as you begin having sex again. And because you never know when the urge might strike, it's good to have that birth control in hand (or by your bed) well in advance.

Unless you're a gambling twosome, counting on breastfeeding to provide birth control is dicey (see previous question). In other words, you'll want to consider a more reliable form of birth control—and there are plenty to choose from, even if you're a breastfeeding mom. There might even be some new options on the market since the last time you picked a birth control method (or ones that better fit your needs now).

Before you decide on which form of contraception is best for you, read up on all the following methods, and discuss them with your partner and your practitioner. Each of the methods has its benefits and drawbacks, depending on your medical and gynecological history, your lifestyle, whether you want to become pregnant again in the future (and how certain you want to be about avoiding pregnancy in the meantime), your practitioner's recommendation, and your feelings and your partner's. All of these methods are effective when used correctly and consistently, though some offer more reliable results than others:

Oral contraception. Available in most states by prescription only (a few states allow over-the-counter sales), oral contraception (OC or "the Pill") is among the most effective nonpermanent methods of birth control, with a success rate of about 99.5 percent (most failures are due to a user's missing a day or taking pills in the wrong order). Another plus: It allows for spontaneity in sex.

There are two basic types of oral contraception: combination pills (which contain both estrogen and progestin) and progestin-only pills (mini-pills). Both work by preventing ovulation and by thickening cervical mucus to keep sperm from reaching an egg, should one be released. They also prevent a fertilized egg from implanting in the uterus. The combination pills are slightly more effective in preventing pregnancy than the minis. For maximum effectiveness, the mini-pills must be taken at the same time every day (combination pills have a slightly longer window).

Some women experience side effects from OC (which vary, depending on the pill), most commonly: fluid retention, weight changes, nausea, breast tenderness, an increase or decrease in sex drive, hair loss, and menstrual irregularities. After the first few cycles of pill use, side effects often diminish or disappear completely. In general, today's oral contraceptives trigger fewer side effects than OC did years ago.

Some versions of the Pill (Yasmin, Cyclessa) deliver constant levels of estrogen and a new type of progestin (these are called monophasic pills) or

use three different levels of estrogen and progestin (called triphasic) to reduce bloating and PMS. Another option that may be especially appealing to women who aren't fond of their monthly flow is Seasonale. It comes in a package with 84 hormone pills and 7 inactive pills; women take the hormones for 12 weeks straight before taking a break for their period (which then comes only 4 times a year). Some women, however, experience more breakthrough bleeding with Seasonale than with monthly pills. Most doctors agree that it's safe to take any monophasic pill continually—by skipping the inactive pills—to avoid having a monthly period altogether.

Women who are over age 35 and heavy smokers may be at increased risk of serious side effects (such as blood clots, heart attack, or stroke) from OC. The Pill may also be unsuitable for women with certain medical conditions, including a history of blood clots, diabetes, hypertension, and certain types of cancer. And OC sometimes is less effective in overweight or obese women.

On the plus side, OC appears to protect against a whole host of conditions, including ovarian and uterine cancer. Other benefits experienced by some women who take OC are diminished PMS, very regular periods, and (with certain varieties) clearer skin. There is some controversy about whether OC affects your breast cancer risk, so talk to your doctor about any concerns you may have, especially if there's a family history of premenopausal breast cancer.

If you're planning to have another baby, fertility may take longer to return if you're using OC than if you're using a barrier contraceptive. Ideally, you should switch to a barrier method (see page 515) about 3 months before the time you plan to start TTC (trying to conceive). About 80 percent of women ovulate within the first 3 months after stopping the Pill, 95 percent within a year.

If you decide to try OC (or go back to it), your doctor will help you determine which type and which dose is best for you, based on whether you're breastfeeding (oral contraception containing estrogen is not recommended during breastfeeding, so nursing moms are limited to a progestin-only pill, aka the mini-pill), as well as on your menstrual cycle, weight, age, and medical history. Making sure the Pill works the way it's supposed to is up to you—so take it as prescribed. If you miss even one pill, or if you have diarrhea or vomiting (which can interfere with absorption of OC by your body), use backup protection (such as a condom) until your next period. See your doctor every 6 months to 1 year for monitoring of your health, report any problems or signs of complications that show up between visits, and be sure to inform anyone prescribing medication of any kind that you are on oral contraception (some herbs and medications, such as antibiotics, interact adversely with OC, making it less effective).

The Pill doesn't protect against STDs, so use a condom, too, if there's a chance of contracting an STD from your partner. OC increases the need for B_6, B_{12}, C, riboflavin, zinc, and folic acid (it reduces the need for other nutrients), so continue taking your prenatal (or a breastfeeding supplement) while on the Pill.

Injection. Hormonal injection, such as Depo-Provera, is a highly effective method of birth control (with a success rate of 99.7 percent) that stops ovulation and thickens cervical mucus to keep sperm and egg from meeting. The shot, given in the arm or buttock, is effective for 3 months. Depo-Provera is a progestin-only injection, so it is safe for breastfeeding mothers.

As with oral contraception, side effects of hormonal injections can include irregular periods, weight gain, and bloating. For some women, periods become fewer and lighter, and many women will have no periods while using Depo-Provera. Other women might experience longer and heavier periods. And, like OC, the shot is not for every woman, depending on her specific health and medical condition, and it doesn't protect against STDs.

The greatest advantage to the shot is that it prevents pregnancy for 12 weeks, and this can be compelling for someone who doesn't like to have to think about birth control or who often forgets to take a pill or insert a diaphragm. It also protects against endometrial and ovarian cancers. But there are disadvantages, too: having to return to your practitioner every 12 weeks for another shot, the fact that the effects of the shot can't be immediately reversed (if you suddenly want to TTC), and that it may take up to a year for fertility to return after you stop Depo-Provera.

Patch. The Ortho Evra patch, a matchbox-size adhesive patch, delivers the same hormones as the combination pill but in patch form. Unlike OC, the patch maintains a steady state of hormonal levels because it continuously delivers hormones through the skin. The patch is worn for 1 week at a time and is replaced on the same day of the week for 3 consecutive weeks (you can use an app or an alarm on your phone as a reminder). The 4th week is "patch free," during which you'll get your period. The patch can be changed any time of the day. If you forget to change the patch and leave it on beyond the 7 days, the hormones are still effective for an additional 2 days.

Most women choose to wear the patch on the abdomen or bottom. It can also be worn on the upper torso (excluding the breasts), the back, or the upper outer arm. Since the patch isn't affected by moisture, humidity, temperature, or activity, it can be worn in any weather, when showering or working out, even in a sauna or hot tub.

Like other hormonal contraceptives, the patch is highly effective (about 99.5 percent). It may be less effective in overweight or obese women. Side effects are similar to those of OC, but there may be a greater risk of blood clots with the patch. It does not protect against STDs.

Ring. The NuvaRing is a small (about the size of a silver dollar), transparent, flexible plastic ring that can flatten like a rubber band, be inserted into the vagina, and left in place for 21 days. Once inserted, the ring releases a steady flow of low doses of estrogen and progestin. The exact positioning of the ring inside the vagina isn't a key to effectiveness because it's not a barrier method of birth control. You can easily insert the ring yourself once a month (you won't feel it once it's inserted, and neither will your partner during sex). Once you remove it (again, easily), you'll get your period. Then 1 week after the last one was removed, you'll insert a new ring, even if your period hasn't stopped yet. If you're likely to have trouble remembering the monthly insertion, a calendar reminder or app can keep you on track. Studies show that the level of cycle control with the NuvaRing is better than that with OC, which means there's little breakthrough bleeding. Because the hormones are the same as those used in the combination pills, side effects are generally the same, and those women who are advised not to use OC are also advised not to use contraceptive rings. The ring is also not for breastfeeding mothers. It has a success rate of about

99 percent, and is a good choice for obese women. The NuvaRing does not protect against STDs.

Implant. The under-the-skin progestin implant has been shown to be a safe and effective method of birth control (with a success rate of about 99.9 percent), though the method may be less effective in obese women. Nexplanon is a single flexible plastic rod about the size of a matchstick that is implanted under the skin of the upper arm. It releases a low, steady dose of progestin to thicken cervical mucus and thin the lining of the uterus, as well as stop ovulation. The implant is safe during breastfeeding, and it can prevent pregnancy for up to 3 years. The most common side effect is irregular bleeding—especially in the first 6 to 12 months of use. Most women find their periods become fewer and lighter (though some have longer, heavier periods), and some women stop having periods completely. Serious problems with Nexplanon are rare. It does not protect against STDs.

IUD (Intrauterine device). The IUD is the most widely used reversible birth control method for women in the world, but not so in the U.S., where only 11 percent of women using contraception opt for it. Which is surprising, since today's IUDs are considered among the safest methods of birth control—and are as effective as sterilization (over 99 percent). They're also the most convenient, and, for most women, trouble free—definitely worth considering.

An IUD is a small plastic device that is inserted into a woman's uterus by her gyn provider, and can be left in place (effectively preventing pregnancy) for a number of years, depending on the type of IUD. There are two types of IUDs. The ParaGard copper IUD releases copper in the uterus to immobilize sperm, and also prevents implantation. This long-lasting IUD can be left in for 10 years (talk about set it and forget it!). The Mirena IUD releases progestin into the uterine walls, thickening cervical mucus and blocking sperm, while also preventing implantation. It lasts for 5 years—still a pretty good chunk of protected time.

The major advantage of an IUD is that it offers the ultimate in convenience. Once it is inserted (which, by the way, can happen any time you'd like, including right after your vaginal or cesarean delivery, or at your 6-week postpartum checkup), it needs absolutely no maintenance, except to check regularly (monthly is a good idea) for the string attached to it. This allows for a completely spontaneous sex life—with no pausing to find and insert a diaphragm or put on a condom, or remembering to take a daily pill. Another plus: The IUD does not interfere with breastfeeding, and the hormones in the Mirena are safe for a breastfeeding baby.

You can increase the already excellent protection from pregnancy provided by the IUD if you use condoms and/or spermicides for the first 2 or 3 months after insertion (when most failures, which are rare to begin with, occur).

The IUD should not be used by a woman who has untreated gonorrhea or chlamydia. It should also not be used by a woman with active pelvic inflammatory disease (PID), known or suspected uterine or cervical malignancy or premalignancy, or abnormalities of the uterus or an unusually small uterus. Ask your doctor about the safety of an IUD if you (or your partner) have an STD. An allergy or suspected allergy to copper rules out the use of a copper IUD.

Possible complications include cramping (which can be mild to moderate) during insertion (and, rarely, for a

few hours or even days following), uterine perforation (extremely rare), accidental expulsion (it might go unnoticed and leave you unprotected), and tubal or pelvic infections (also rare). Having an IUD in place does not increase the risk of an ectopic pregnancy. Some women may experience spotting between periods during the first few months after insertion. The first few periods may also last longer and be heavier. It's also not unusual for a woman to continue having heavier and longer periods while using an IUD, though the progestin-releasing Mirena may lessen the amount of bleeding (most women find their periods get lighter or disappear completely with the Mirena). Keep in mind that IUDs don't protect against STDs.

Diaphragm. The diaphragm is a barrier method of birth control—a dome-shaped rubber cap that's placed over the cervix before sex to block the entry of sperm. It's 94 percent effective when used properly (meaning, it's the right size, it's inserted properly, and it doesn't slip) along with a spermicidal gel, meant to inactivate any sperm that might slip past the barrier. Aside from possible increases in urinary tract infections and an occasional allergic reaction triggered by either the spermicide or the rubber, the diaphragm is safe. In fact, used with a spermicide, it appears to reduce the risk of pelvic infections that can lead to infertility (though it doesn't protect against STDs). It in no way affects breastfeeding.

With the diaphragm, size absolutely matters. It must be prescribed and fitted by a medical professional—and refitted after every delivery, since pregnancy and childbirth change the size and the shape of the cervix. As for the spontaneity factor, the diaphragm doesn't exactly get high marks—you have to stop to insert it (or insert it before things get started), then check to make sure it's properly inserted before each sex session (unless you'll be having an encore sexual performance within a few hours, in which case you just need to add more spermicide). The diaphragm then has to be left in place for at least 6 to 8 hours after sex (but no longer than 24 hours in a row). Some experts suggest it's probably prudent to remove it within 12 to 18 hours, and some recommend women insert their diaphragms as part of their bedtime routines so they don't forget or neglect to use it in a moment of passion (though again, it can't be kept in place for more than 24 hours at a time). Either way, there's a lot of keeping track and clock-watching. And there's maintenance involved, too—cleaning the diaphragm after use, storing it properly in its case (not loose in the bottom of your purse or in your jeans pocket), and checking it regularly for holes by holding it up to a light.

Cervical cap. The cervical cap is similar to the diaphragm in many ways. It must be fitted by a medical professional, must be used with a spermicide, and does its job by acting as a barrier to sperm. Its success at preventing pregnancy is lower than the diaphragm's (approximately 60 to 75 percent), but it does offer a couple of advantages. Shaped like a large thimble, the pliable rubber cap has a firm rim that fits snugly around the cervix, making it only about half the size of the diaphragm. A convenience plus: Instead of the 24-hour outside limit recommended for the diaphragm, the cap can be left in place for 48 hours (though an unpleasant odor can develop when it's left in that long).

The FemCap, another type of cervical cap (with a success rate of 85 percent), is a silicone dome shaped like a sailor's hat. It comes in three sizes and fits over the cervix with a brim that

seals against the vaginal walls and has a groove that stores the spermicide and traps the sperm. It also has a removal strap.

Vaginal sponge. The Today sponge, which covers the cervix and blocks sperm from entering the uterus while also continuously releasing a spermicide that keeps sperm from moving, is made of plastic foam. It is soft, round, and about 2 inches in diameter with a nylon loop attached to the bottom for removal. The upsides to the sponge: It doesn't require a visit to the doctor or a prescription, is relatively easy to use, provides continuous protection for a full 24 hours after insertion, and has no effect on breastfeeding. On the downside, it's somewhat less effective than the diaphragm (about 80 percent), can increase the risk of yeast infections, and can be uncomfortable to insert. It should not be left in longer than recommended, and you'll need to check carefully to make sure the whole sponge is removed intact (a piece left behind could cause odor and infection). The sponge also can't be reused, so you'll have to stay stocked up.

Condom. Also called a rubber, a condom (as you probably know) is essentially a penis cover designed to trap sperm when they're ejaculated so they can't gain access into the vagina. It's made of latex or natural skin (from the intestines of a sheep)—and if used consistently and correctly, it's a pretty effective birth control method (with a success rate of 98 percent). The condom is totally harmless—that is, unless one or both partners has an allergic reaction to the latex material or the spermicide (if latex is an issue, opt for the natural skin). It has the advantage of being easily available and portable (for on-the-fly activities), and of reducing the risk of transmitting STDs, such as gonorrhea, chlamydia, and HIV (the latex variety is better at preventing transmission of HIV), as well as the Zika virus. Because it in no way interferes with breastfeeding and because it clearly doesn't require postpartum refitting (as does the diaphragm), it is an ideal "transitional" method. Some couples find that condoms get in the way of spontaneous fun—especially because you have to wait until erection to put it on—and some find it decreases sensitivity and/or causes vaginal irritation (with more potential for irritation postpartum). Other couples don't mind condoms a bit, and may even find a way to make putting it on part of foreplay.

To increase effectiveness, you shouldn't linger long after sex when you're using a condom—the penis should be withdrawn before the erection is totally lost and while the condom is held on, to avoid leakage of semen. The use of a lubricating cream (or a lubricated condom) will help slip the covered penis in more comfortably during those dry postpartum and breastfeeding months. But choose your lube with care: Don't use oil-based lubricants or Vaseline, because they can damage a latex condom (always check the instructions on the package before using an oil-based lubricant).

Thought condoms kept only guys covered? There's one for you, too. The female condom is a thin, lubricated polyurethane pouch that lines the vagina and is held in place by a closed inner ring near the cervix and an outer open ring at the opening of the vagina. A female condom is inserted into the vagina up to 8 hours before intercourse and is removed right after. The downsides to the female condom: It is more expensive than the male condom, may prevent full sensation, and is clearly noticeable once in place. Plus, it's yet another birth control method

that depends on a woman's compliance, unlike the male condom, which at least shares the load. And it's a little less effective than the male condom (about 95 percent). But like the male condom, it prevents STDs.

Spermicide foams, creams, jellies, suppositories, and contraceptive films. Used alone, these antisperm agents are only so-so effective (approximately 72 to 94 percent) at preventing pregnancy. They are available without a prescription, but can be messy and inconvenient. They can be inserted up to 1 hour before intercourse.

Emergency contraception. The emergency contraception pill (ECP) is the only method of birth control that can be used after unprotected sex (or as backup when your contraceptive method has failed, as with a broken condom, slipped diaphragm, or missed pills) but before a pregnancy is established. ECP is sold over-the-counter as Plan B One-Step, Take Action, Next Choice One Dose, and My Way. Ella, another ECP, is available with a prescription. ECPs reduce a woman's risk of pregnancy by 75 percent when taken within 72 hours of unprotected sex. The sooner ECPs are taken after unprotected sex, the more effective they are. (Your doctor might also recommend using ordinary birth control pills as emergency contraception, but check to confirm the dose you should use.) Emergency contraception pills will not work if you're already pregnant. Important distinction: ECP is not a so-called abortion pill, like RU486. ECPs work primarily by temporarily stopping ovulation. ECPs are not recommended for use during the first 6 weeks postpartum because their high estrogen content can increase the risk of blood clots and are not recommended while breastfeeding.

Sterilization. Sterilization is frequently the choice of couples who feel that their families are complete, don't have a problem with closing (and locking) the door to conception, and are eager to dispense with contraception altogether (and who's not eager for that?). It's increasingly safe (with no known long-term health effects) and virtually foolproof. The occasional failure can be attributed to a slip-up in surgery or, in the case of vasectomy, not using alternative birth control until all viable sperm have been ejaculated. Though sterilization is sometimes reversible, it should be considered permanent.

A vasectomy (the tying or cutting of the vasa deferentia, the tubes that transport sperm from testicles to penis) is an easy, in-office procedure done with local anesthesia, and it carries far fewer risks than female sterilization. It doesn't (as some men fear) affect the ability to achieve erection or ejaculate—all that's missing is the sperm (not the semen). Research has also shown that there is no increased risk of prostate cancer for men with vasectomies.

Tubal ligation is a procedure done on women under regional or epidural anesthesia (right after delivery if you want; see page 439) in which a small incision is made in the abdomen (near the belly button or bikini line) and the fallopian tubes are cut, tied, or blocked. It does require some downtime, usually 2 days to a week (sometimes more) of only light activity for most women—which you're going to be adhering to anyway if you just delivered.

Another permanent birth control option for women is called Essure. An alternative to tubal ligation, this type of sterilization doesn't require an abdominal incision (as tubal ligation does). A soft, flexible microinsert is placed into each fallopian tube via a catheter (tube) inserted through the cervix. Over the

course of 3 months, new tissue grows in the fallopian tube (inside the insert), blocking the tubes completely. A backup method of birth control must be used until the doctor can confirm through testing that your tubes are effectively blocked (usually after 3 months). Sounds pretty perfect, but this method isn't without controversy. The FDA is investigating reports that the procedure may cause pain, bloating, and heavy bleeding.

Fertility awareness. Couples who prefer not to use contraception at all can opt for the fertility awareness method (FAM), aka natural family planning. This approach relies on becoming aware of a number of body signs or symptoms to determine the time of ovulation. If done perfectly correctly, the FAM approach can be just as successful at avoiding pregnancy as some other birth control methods (in the 90 percent effectiveness range).

So what makes for perfect practice of fertility awareness? The more factors a couple takes into consideration, the better the success rate—and there's a long list of factors, including cervical mucus changes (the mucus is clear, copious, thin, has an egg-white consistency, and can be pulled into a long string at ovulation), basal body temperature changes (the baseline temperature, measured first thing in the morning, drops slightly just before ovulation, reaches its lowest point at ovulation, and then immediately rises to a high point before returning to the baseline for the rest of the cycle), and cervical changes (the normally firm cervix becomes a little softer, and it's also slightly higher and more open than normal during ovulation). Ovulation predictor kits can also help to pinpoint ovulation (though using them every month to prevent pregnancy can get pretty pricey). Saliva tests for ovulation can also help some women predict when ovulation is about to happen and are more cost effective. Once you're armed with all the ovulation information you need, the key will be avoiding sex from the first sign that you're about to ovulate until 3 days after. Need more ovulation information? See *What To Expect Before You're Expecting.*

ALL ABOUT:

Getting Back into Shape

It's one thing to look 6 months pregnant when, in fact, you are 6 months pregnant . . . and another to look it when you've already delivered. Yet most new moms can expect to leave the birthing room with a little bundle in their arms—and a sizable one still around their middles.

How soon after you become a new mother will you stop looking like a mother-to-be? Genes will play a role in how quickly you'll slip back into your skinny jeans, as will your metabolism, how much weight you gained during pregnancy, and, of course, your postpartum eating habits. But there's no getting around it: Getting back into shape (and out of those baggy sweats) will definitely take getting back into the exercise habit.

"Who needs exercise?" you may wonder. "I haven't stopped moving since I got home from the hospital. Doesn't that count?" Unfortunately,

Workout Rules for the First 6 Weeks

- Wear a supportive bra and comfortable clothing (nothing that rubs on tender spots, traps moisture, or doesn't allow breathing room).
- Try to divide your exercise schedule into 2 or 3 brief sessions rather than doing a single long session a day (this tones muscles better and will be easier on your recovering body—plus you're more likely to be able to fit it in and keep it up).
- Start each session with the exercise you find least strenuous.
- Do exercises slowly, and don't do a rapid series of repetitions. Instead, rest briefly between movements (the muscle buildup occurs then, not while you are in motion).
- Avoid jerky, bouncy, erratic motions during the first 6 weeks postpartum, while your ligaments are still loose. Also avoid knee-to-chest exercises, full sit-ups, and double leg lifts during this period.
- Keep a water bottle next to you during your workouts, and sip often.
- Take it slowly and sensibly. "No pain, no gain" wasn't a motto created with new moms in mind. Don't do more than recommended, even if you feel you can, and stop before you feel tired (that is, more tired than being a new mom has already made you). If you overdo it, you probably won't feel it until the next day, by which time you may be so exhausted and achy that you won't be able to exercise at all. Plus, pushing yourself can actually slow your postpartum recovery.
- Don't let taking care of your baby stop you from taking care of yourself. Your baby will love lying on your chest as you go through your floor routine.

not that much. Exhausting as it is caring for a newborn, that kind of activity won't tighten up the perineal and abdominal muscles that have been stretched and left saggy by pregnancy and childbirth—only a regular workout program will. And the right kind of postpartum exercise will do more than tone you up. It will help keep baby-toting backaches at bay, promote healing and recovery from labor and delivery, help pregnancy-loosened joints tighten up, and improve circulation. Kegel exercises, which target the perineal muscles, will help you avoid stress and urinary incontinence and postpartum sexual problems. Finally, exercise can make you happier. As exercise-released endorphins circulate in your system, boosting your mood and your ability to cope, you'll find yourself much better equipped to handle the stresses of new parenthood, and even beat back baby blues. In fact, research shows that moms who resume exercising within 6 weeks of delivery feel better about themselves—and just plain feel better.

Don't even think about starting off with a bang, however, even if you feel surprisingly well and mega-motivated. Instead, ease your recovering body slowly and steadily back into workout mode with the following basic exercises. Supplement these with an online or DVD postpartum workout, take a class for new moms, or just make daily strolls (or Strollercize) with baby a part of your daily routine.

First Weeks After Delivery

Eager to get that prebaby body back? Then you'll be happy to hear that it's time to step up to the exercise ladder. But before you take that step, make sure the pair of vertical muscles that form your abdominal wall have not separated during pregnancy. If they have, you'll have to close them up before the workouts start heating up (see box, facing page). Once the separation has closed, or if you've never had one, you can work up to the following exercises. At first, do these exercises in bed, then move on to a well-cushioned floor, or an exercise or yoga mat:

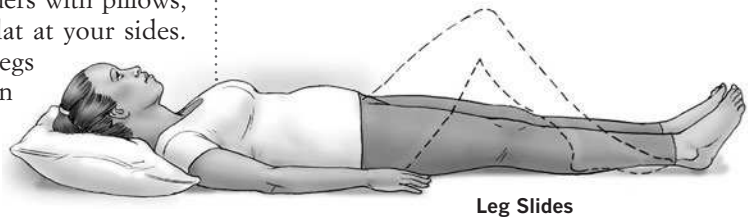
Pelvic Tilt. Lie on your back, knees bent, soles flat on the floor. Support your head and shoulders with pillows, and rest your arms flat at your sides. Take a breath. Then exhale as you press the small of your back against the floor for 10 seconds. Then relax. Repeat 3 or 4 times to start, increasing gradually to 12, and then 24.

Pelvic Tilt

Leg Slides. Lie on your back, knees bent, soles flat on the floor. Support your head and shoulders with pillows, and rest your arms flat at your sides. Slowly extend both legs until they are flat on the floor. Slide your right foot, flat on the floor, back toward your buttocks, inhaling as you go. Keep the small of your back against the floor. Exhale as you slide your leg back down. Repeat with your left foot. Start with 3 or 4 slides per side, and increase gradually until you can do a dozen or more comfortably. After 3 weeks, move to a modified leg lift (lifting one leg at a time slightly off the floor and lowering it again very slowly), if it is comfortable.

Head/Shoulder Lift

Head/Shoulder Lift. Lie on your back, knees bent, soles flat on the floor. Support your head and shoulders with pillows, and rest your arms flat at your sides. Take a deep, relaxing breath, then raise your head very slightly and stretch your arms out, exhaling as you do. Lower your head slowly and inhale. Raise your head a little more each day, gradually working up to lifting your shoulders slightly off the floor. Don't try full sit-ups during the first 6 weeks—and then only if you have always had very good abdominal muscle tone. Check first, too, for an abdominal separation (see box, facing page).



Leg Slides

Close the Gap

Don't look now, but there might be a hole in the middle of your belly (and it's not your navel). A very common pregnancy condition known in obstetrical circles as diastasis (up to half of moms experience it), it's a gap in your abdominal muscles that can develop as the abdomen expands. It can take a month or two after delivery for this gap to close, and you'll have to wait until it does before you start those crunches and other abdominal exercises, or you'll risk an injury. To determine if you have a separation, examine yourself this way: Lie on your back, knees bent, soles flat on the floor. Support your head and shoulders with pillows, and rest your arms flat at your sides. Raise your head slightly with your arms extended forward, then feel for a soft lump above your navel. Such a lump indicates a separation.

If you do have a separation, you may be able to help correct it more quickly with this exercise: Lie on your back, knees bent, soles flat on the floor. Support your head and shoulders with pillows, rest your arms flat at your sides, and inhale. Cross your hands over your abdomen, using your fingers to draw the sides of your abdominal muscles together as you breathe out, pulling your belly button inward toward the spine while raising your head slowly. Exhale as you lower your head slowly. Repeat 3 or 4 times, twice a day.

After Your Postpartum Checkup

Now, with your practitioner's go-ahead, you can gradually graduate to a more active workout program that includes power walking, running, biking, swimming, water workouts, aerobics, yoga, Pilates, weight training, or similar routines. Or sign up for a postpartum exercise class. But don't try to do too much too soon. As always, let your body be your guide.

PART 4

Staying Healthy When You're Expecting

CHAPTER 18

If You Get Sick

So you were probably expecting to experience at least a few of the less pleasant pregnancy symptoms during your 9 months of expecting (a little morning sickness, a few leg cramps, some heartburn and fatigue), but maybe you weren't expecting to come down with a nasty cold or an ugly (and itchy) infection. The truth is, pregnant women can get sick with the best of them—actually, even better than the best of them, since the normal suppression of the immune system (so mom's body doesn't reject her baby as "foreign") makes expectant moms easier targets for germs of every variety. What's more, being sick for two can make you at least twice as uncomfortable—especially since so many of the remedies you're used to reaching for may need to stay behind medicine cabinet doors for now.

Prevention is, of course, the best way to avoid getting sick in the first place and to keep that healthy glow of pregnancy going strong. But when it fails (as when a coworker brings a stomach bug to the office, your nephew's wet kisses are sweet but saturated with cold germs, or you pick up some bacteria with those fresh-picked blueberries), quick treatment, in most cases under the supervision of your practitioner, can help you feel better fast.

What You May Be Wondering About

The Common Cold

"I'm sneezing and coughing, and my head is killing me. What can I take that won't affect my baby?"

Common colds are even more common when you're pregnant, because your normal immune system is suppressed. The good news is that you're the only one those nasty bugs will be bugging. Your baby can't catch your cold or be affected by it in any way. The not-so-good news: The medications and supplements that you might

be used to reaching for to find relief (or to prevent a cold), including ibuprofen, extra doses of vitamin C and zinc, and herbals (like echinacea), are usually off limits when you're expecting (see page 538 for information on taking medications during pregnancy). So before you pick the shelves of your local drugstore clean, pick up the phone and call your practitioner to find out which over-the-counter remedies are considered safe in pregnancy, as well as which will work best in your case. (If you've already taken a few doses of a medication that isn't recommended for pregnancy use, don't worry. But do check with your practitioner for extra reassurance.)

Even if your standard cold remedy is shelved for now, you don't have to suffer with a runny nose and hacking cough. Some of the most effective cold remedies don't come in a bottle and are also the safest for both you and your baby. These tips can help nip a cold in the bud, before it blossoms into a nasty case of sinusitis or another secondary infection, while helping you feel better faster. At the very first sneeze or tickle in the throat:

- Rest, if you need it. Taking a cold to bed doesn't necessarily shorten its duration, but if your body is begging for rest, be sure to listen—especially now that it's begging for two. On the other hand, if you feel up to it (and you're not running a fever or coughing), light to moderate exercise can actually help you feel better faster.
- Feed your cold, and your baby. Eat as well as you can, given how crummy you feel and how little appetite you probably have. Especially seek vitamin-C-rich foods, like citrus and melon.
- Flood your cold with fluids. A runny nose can cost your body fluids you and your baby need. Warm fluids (like ginger tea or chicken broth) will be particularly soothing for your scratchy throat.
- Stay up even when you're lying down. Elevating your head with a couple of pillows will make it easier for you to breathe through a stuffy nose. Nasal strips (which gently pull your nasal passages open, making breathing easier) may help, too. Or try decongesting with a vapor rub, like Vicks.
- Stay moist. Keeping your nasal passages moist will ease congestion, so run a humidifier, especially at night, and use saline nasal spray (it's drug free, so you can use it as often as needed) or saline rinses (but steer clear of neti pots, since they're more apt to spread germs).
- Soothe with salt water. Gargling with warm salt water (¼ teaspoon of salt to 8 ounces of warm water) can ease a sore or scratchy throat, wash away postnasal drip, and help control a cough.
- Calm a dry cough the sweet way. A couple of teaspoons of honey can actually suppress the kind of dry cough that often comes with and after a cold as effectively as an OTC cough syrup. Honey's too sweet straight up? Mix it with hot water and lemon.

Colds don't typically come with a fever, but if your temperature rises to over 100°F, bring it down promptly with acetaminophen (Tylenol) and call your practitioner (see page 527 for more on fever). Also call if your cold is severe enough to interfere with eating or sleeping, if you're coughing up greenish or yellowish mucus, if you have a cough with chest pain or wheezing, if your sinuses are throbbing (see the next question), or if symptoms last more than 10 to 14 days. It's possible that your cold has progressed to a secondary infection and that prescribed medication may be needed.

Sinusitis

"I've had a bad cold for more than 10 days. Now my forehead and cheeks are starting to really hurt. What should I do?"

Sounds as if your nasty cold may have evolved into an even nastier case of sinusitis—an inflammation of the tissues lining your sinuses. In addition to a lingering or worsening stuffy nose, signs of sinusitis often include pain and tenderness in the forehead and/or one or both cheeks (beneath the eye), achiness around the teeth, and possibly a temporary loss of the sense of smell. The pain of sinusitis usually worsens when you bend over or shake your head. Fever sometimes accompanies these symptoms, but not always.

Sinusitis following a cold is fairly common, but it is far more common among pregnant women. That's because pregnancy hormones tend to swell mucous membranes (including those in and leading to the sinuses), trapping air and mucus behind the narrowed sinus openings, and causing blockages that allow germs to build up and multiply in the sinuses. These germs tend to linger longer there, because immune cells, which destroy invading germs, have difficulty reaching the sinuses' deep recesses. As a result, the symptoms can persist for weeks (or longer, becoming chronic).

Most sinus infections are caused by viruses (sometimes they're caused by allergies), but about 10 percent of the time bacteria get the blame. If your sinus infection is caused by bacteria (often the case when your sinus symptoms are lingering for longer than 10 days or if they're severe and accompanied by fever), your practitioner will prescribe a pregnancy-safe antibiotic to clear it up. If your sinusitis is caused by a virus, antibiotics won't be helpful, so treatment will focus on easing symptoms with pain relievers, nasal steroids, and nasal rinses (some practitioners will okay limited use of certain decongestants after the first trimester; see page 540).

Flu Season

"I usually get a flu shot in the fall, but now I'm wondering if I should skip it this year. Is it safe during pregnancy?"

A flu shot is definitely your best line of defense during flu season. Not only is it safe to receive while you're pregnant, it's considered a very smart move. In fact, the CDC recommends that all moms-to-be get the flu shot. That's because the flu can be much more severe when you're expecting, and is more likely to lead to serious complications requiring hospitalization. And since the CDC puts pregnant women at the top of the priority list (along with the elderly and children between the ages of 6 months and 5 years), moms-to-be can waddle to the front of the flu-shot line, even if the vaccine is in short supply. Talk to your practitioner about getting a flu shot—many ob practices offer it to pregnant patients. You can also stop by a flu shot clinic at your local pharmacy or supermarket.

The flu vaccine offers the most protection if it's given before or early in each flu season (preferably by October). It's never 100 percent effective, because it protects only against the flu viruses that are expected to cause the most problems in a particular year. Still, it greatly increases the chance that you will escape the season flu-free (and H1N1-free, too). And even when it doesn't prevent the flu, the vaccine usually reduces the severity of symptoms—which is extra important when you're expecting, since flu can hit pregnant women especially hard. Side effects occur infrequently and are generally mild.

Flu Shot for Two

Getting a flu shot protects you when you're expecting, but did you know that its benefits carry over to your soon-to-be newborn as well? Researchers have found that babies born to moms who were given the flu shot during the last trimester of pregnancy appear to be protected against the virus until they're old enough to get their own shot, at 6 months. Of course, if you're in the first or second trimester when flu season begins, don't wait to get your shot—you'll need to be protected throughout flu season.

In case you were wondering, you'll have to stick with the needle when it comes to your seasonal flu vaccine, since the nasal spray vaccine (FluMist, which is made from live flu virus), is not approved for or given to pregnant women.

If you suspect you might have the flu (symptoms include fever, achiness, headache, sore throat, and cough), call your doctor right away so that you can be treated (and so that the flu doesn't progress to pneumonia). Treatment may include an antiviral medication (like Tamiflu) along with steps aimed at reducing fever (see next question) and other symptoms.

Fever

"I'm running a little fever. What should I do?"

While a low-grade fever (one that's under 100°F) usually isn't something to worry about when you're expecting, it's also something you shouldn't ignore. So take steps to bring it down promptly, but also keep an eye on the thermometer to make sure the numbers don't start rising.

If your fever reaches 100°F call your practitioner the same day or the next morning if it's the middle of the night. If it climbs to 101°F call right away, even if it's the middle of the night. That's because not only could a fever that goes higher than that be harmful to your developing baby, but the cause of the fever (for instance, an infection that requires treatment) might be harmful even if the fever isn't. While you're waiting to speak to your practitioner, take acetaminophen (Tylenol) to start reducing the fever. Taking a tepid bath or shower, drinking cool beverages, and keeping clothing and covers light will also help bring your temperature down. Aspirin or ibuprofen (Advil or Motrin) should not be taken at any time during pregnancy unless they've been specifically recommended by your practitioner.

Strep Throat

"My preschooler came down with strep throat. If I catch it, is there a risk to the baby?"

If there's one thing kids are good at sharing, it's their germs. And the more kids you have at home (particularly of the daycare-attending or school-going variety), the greater your chances of coming down with colds and other infections while you're expecting.

So step up preventive measures (see box, page 531). But if you do suspect that you've succumbed to strep, call your practitioner, who will likely run a throat culture. Strep infection won't hurt the baby, as long as it is treated promptly with the right type of antibiotic—one that's effective and pregnancy safe. Don't take medication that was

prescribed for your child or someone else in the family.

Urinary Tract Infection

"I'm afraid I have a urinary tract infection."

Your poor battered bladder, which spends months on end being pummeled by your growing uterus and its adorable occupant, is the perfect breeding ground for less welcome visitors: bacteria. Those little bugs (which usually live quietly in your skin and in your feces) have an easier-than-usual time entering your urinary tract when you're expecting, thanks to the flood of muscle-relaxing hormones. Once there, bacteria make themselves at home and make you miserable—multiplying fast in areas where compression from your expanding uterus (the same compression that has you getting up to pee several times a night) has allowed urine to pool or flow slowly. In fact, urinary tract infections (UTIs) are so common in pregnancy that at least 5 percent of pregnant women can expect to develop at least one, and those who have already had one have a 1 in 3 chance of an encore. In some women, a UTI is "silent" (without symptoms) and diagnosed only after a routine urine culture. In others, symptoms can range from mild to quite uncomfortable (an urge to urinate frequently, pain or a burning sensation when urine—sometimes only a drop or two—is passed, pressure or sharp pain in the lower abdominal area). The urine may also be foul smelling and cloudy.

Diagnosing a UTI is as simple as dipping a stick into a urine sample at your practitioner's office—the stick will react to red or white blood cells in the sample, both of which can indicate an infection. The urine will then be sent off to the lab for further analysis. Treating a UTI is simple, too. Your practitioner will prescribe a course of pregnancy-safe antibiotics specifically targeting the type of bacteria the lab finds in your urine.

Of course, prevention is always the best strategy—but especially when you're expecting. Here are some steps you can take to prevent a UTI—you can also use them, in conjunction with your prescribed treatment, to help speed your recovery from an infection:

- Drink plenty of fluids, especially water, which can help flush out any bacteria. Cranberry juice may also be beneficial, possibly because the tannins it contains keep bacteria from sticking to urinary tract walls. Avoid coffee and tea (even decaffeinated), which may increase irritation.
- Wash your vaginal area well and empty your bladder just before and after sex.
- Every time you urinate, take the time to empty your bladder thoroughly. Leaning forward on the toilet will help accomplish this. It sometimes also helps to "double void": After you pee, wait 5 minutes, then try to pee again. And don't put off the urge when you have it, since regularly holding it in increases susceptibility to infection.
- To give your perineal area breathing room, wear cotton-crotch underwear and panty hose, avoid wearing tight pants or leggings, don't wear panty hose or tights under pants, and sleep without panties or pajama bottoms on if possible (and comfortable).
- Keep your vaginal and perineal areas meticulously clean and irritation-free. Wipe front to back after using the toilet to keep fecal bacteria from entering your vagina or urethra. Wash

daily (showers are better than baths), and avoid bubble bath and perfumed products: powders, shower gels, soaps, sprays, detergents, and toilet paper.

- Ask your practitioner about taking probiotics to help restore the balance of beneficial bacteria.

UTIs in the lower part of the urinary tract are no fun, but a more serious potential risk is that bacteria from an untreated UTI will travel up to your kidneys. Kidney infections that aren't treated can be quite dangerous and may lead to premature labor, low birthweight, and other complications. The symptoms are the same as those of UTIs but are frequently accompanied by fever (often as high as 103°F), chills, blood in the urine, backache (in the midback on one or both sides), nausea, and vomiting. If you experience these symptoms, notify your practitioner immediately so you can be treated promptly.

Yeast Infection

"I think I have a yeast infection. Should I go get some of the cream I usually use, or do I need to see the doctor?"

Pregnancy is never a time for self-diagnosis or treatment—not even when it comes to something as seemingly simple as a yeast infection. Even if you've had yeast infections a hundred times before, even if you know the symptoms backward and forward (a yellowish, greenish, or thick and cheesy discharge that has a foul odor, accompanied by burning, itching, redness, or soreness), even if you've treated yourself successfully with over-the-counter preparations in the past—this time around, call your practitioner.

What kind of treatment you'll get will depend on what kind of infection you have, something only lab tests can determine. If it does turn out to be a yeast infection, which is very common

Bacterial Vaginosis

Bacterial vaginosis (BV) is the most common vaginal condition in women of childbearing age, affecting more than three-quarters of all women and up to 16 percent of pregnant women. BV, which occurs when certain types of bacteria normally found in the vagina begin to multiply in large numbers, is often accompanied by an abnormal gray or white vaginal discharge with a strong fishlike odor, pain, itching, or burning (though some women with BV report no signs or symptoms at all). Experts are not exactly sure what causes the normal balance of bacteria in the vagina to be disrupted, though some risk factors have been identified, including having multiple sex partners, douching, or having an IUD.

Why should you be concerned about something that's so common? It's because during pregnancy, BV is associated with a slight increase in complications—premature rupture of the membranes, for instance, or amniotic fluid infection—which may lead to premature labor. It may also be linked to a slight risk of miscarriage and low birthweight. Though it's unclear whether treating symptomatic BV with antibiotics during pregnancy decreases the risk of complications, most practitioners will treat anyway.

Be sure to mention any symptoms you may have to your practitioner so you can get the right diagnosis . . . and if necessary, the right treatment.