Emotionally, you may feel vulnerable and overwhelmed, as though you're reaching the end of your rope. In addition to frustration over not being able to push yet, you may feel discouraged, irritable, disoriented, and restless, and may have difficulty concentrating and relaxing (it might seem impossible to do either). You may also find excitement reaching a fever pitch in the midst of all the stress. Your baby's almost here!

What you can do. Hang in there. By the end of this phase, which is not far off, your cervix will be fully dilated, and it'll be time to begin pushing your baby out.

- Continue to use breathing techniques if they help. If you feel the urge to push, resist. Pant or blow instead, unless you've been instructed otherwise. Pushing against a cervix that isn't completely dilated can cause it to swell, which can delay delivery.

FOR FATHERS

What You Can Do During Transitional Labor

The going's getting tough—but here's how to help your partner-in-labor keep going.

- If your laboring spouse has an epidural or other kind of pain relief, ask her if she needs another dose. Transition can be quite painful, and if her epidural is wearing off, she won't be a happy camper. If it is, let the nurses or the practitioner know. If mom's continuing unmedicated, she'll need you more now than ever (read on).
- Be there, but give her space if she seems to want it. Often, women in transition don't like being touched—but, as always, take your cues from her. Allow her to lean on you if she wants. Abdominal massage may be especially offensive now, though counterpressure applied to the small of her back may continue to provide some relief for back pain. Be prepared to back off—even from her back—as directed.
- Don't waste words. Now's not the time for small talk, and probably not for jokes, either. Offer quiet comfort, and guide her with words that are brief and direct.
- Offer lots of encouragement, unless she prefers you to keep quiet. At this moment, eye contact or touch may communicate more expressively than words.
- Breathe with her through every contraction if it seems to help her through them.
- Help her rest and relax between contractions, touching her abdomen lightly to show her when a contraction is over. Remind her to use slow, rhythmic breathing in between contractions, if she can.
- If her contractions seem to be getting closer and/or she feels the urge to push—and she hasn't been examined recently—let the nurse or practitioner know. She may be fully dilated.
- Offer her ice chips or a sip of water frequently, and mop her brow with a cool damp cloth often. If she's chilly, offer her a blanket or a pair of socks.
- Stay focused on the payoff you're both about to get. It won't be long before the pushing begins—and that anticipated bundle arrives in your arms.

Baby's Movements During Labor

You've been counting (and enjoying) baby's kicks for the last few months, attuned to your wee one's every wiggle. But what about during labor? Is your baby still kicking up those cute little feet—and will you be able to feel those movements? The answer is yes . . . and maybe. Your baby will still move around during labor—and in fact may do some impressive spins to help ease out of the birth canal—but you may not feel much of that movement at all. First, your focus (understandably) is likely to be on those contractions, making movements easy to miss. Second, if you've had an epidural, you'll be numb—which means you might not feel a thing (including those movements). But that's where fetal monitors or Dopplers come in—to track baby's heartbeat, assuring all is well. One less thing for you to have to worry about during labor!

- If you didn't have an epidural before but would like one now, ask for it.
- If you don't want anybody to touch you unnecessarily, if your coach's once comforting hands now irritate you, don't hesitate to let him know.
- Try to relax between contractions (as much as is possible) with slow, deep, rhythmic breathing.
- Keep your eye on the prize: That bundle of joy will soon be arriving in your arms.

Laboring Down

Woo-hoo—you've reached that magic 10 cm mark! You're fully dilated and it's finally time to start pushing out baby, right? Not so fast—or at least that's what your doctor or midwife will tell you if he or she practices the art of "laboring down." Laboring down allows your uterus to do most of the work of bringing baby farther down the birth canal, and it means you won't need to start pushing in earnest until baby's head is at +2 station or nearly crowning (or until you feel that tremendous urge to push)—even if you're already fully dilated. This process of waiting for baby to come down the birth canal on his or her own can take a few minutes or an hour or two, during which you'll follow only natural, gentle urges to push (or not push at all). In fact, contractions often slow down or stop during this time, giving you a break from the hard labor you've been experiencing. The benefit to laboring down? You'll get to conserve energy until it's really needed, and take a rest while your uterus does the heavy lifting. Plus, studies show that laboring down significantly decreases pushing time. Have an epidural? You can still labor down.

Stage Two: Pushing and Delivery

Up until this point, your active participation in the birth of your baby has been negligible. Though you've definitely taken most of the abuse, your cervix and uterus (and baby) have done most of the work. But that's about to change. Now that dilation is complete, it's your turn to push your baby the rest of the way through the birth canal—and out (unless you'll be laboring down, in which case you can catch a break before you begin pushing; see box, page 429). Pushing and delivery generally take between 30 minutes and an hour, but can sometimes be accomplished in 10 (or even fewer) short minutes or in 2, 3, or even more very long hours.

The contractions of the second stage are usually more regular than the contractions of transition. They are still about 60 to 90 seconds in duration but sometimes further apart (usually about 2 to 5 minutes) and possibly less painful, though sometimes they are more intense. There now should be a well-defined rest period between them, though you may still have trouble recognizing the onset of each contraction.

What you may be feeling. Common in the second stage (though you'll definitely feel the following a lot less—and you may not feel anything at all—if you've had an epidural):

- Pain with the contractions, though possibly not as much
- An overwhelming urge to push (though not every mom feels this, especially with an epidural)
- Tremendous rectal pressure (ditto)
- A burst of renewed energy (a second wind) or fatigue
- Very visible contractions, with your uterus rising noticeably with each
- An increase in bloody show
- A tingling, stretching, burning, or stinging sensation at the vaginal opening as your baby's head crowns (it's called the "ring of fire" for good reason)
- A slippery wet feeling as your baby emerges

Emotionally, you may feel relieved, exhilarated, and excited that you can now start pushing—or, if the pushing stretches on for much more than an hour, frustrated or overwhelmed. In a prolonged second stage, you may find your preoccupation is less with seeing the baby than with getting the ordeal over with (and that's perfectly understandable). Some moms can also feel inhibited or unsure when they begin pushing, especially if they don't quite get the hang of it at first. After all, birthing a baby is a natural process—but it doesn't always come naturally.

What you can do. It's time to get this baby out. So get into a pushing position (which one will depend on the bed, chair, or tub you're in, what's most comfortable and effective for you, and your practitioner's preferences). A semi-sitting or semi-squatting position is often the best because it enlists the aid of gravity in the birthing process and may offer you more pushing power. Tucking your chin to your chest when you're in this position will help you focus your pushes where they need to be. Sometimes, if the pushing isn't moving your baby down the birth canal, it may be helpful to change positions. If

FOR FATHERS

What You Can Do During Pushing and Delivery

It's push time, and here's how you can help:

- Continue giving comfort and support (a whispered "I love you" can be more valuable to her during the pushing stage than anything else), but don't feel hurt if the object of your efforts doesn't seem to notice you're there. Her energies are necessarily focused elsewhere.
- Help her relax between the contractions—with soothing words, a cool cloth applied to forehead, neck, and shoulders, and, if feasible, back massage or counterpressure to help ease backache. If she's laboring down (see box, page 429), encourage her to rest up.
- Continue to supply ice chips or sips of ice water to moisten her mouth as needed—she'll be parched from pushing.
- Support her back while she's pushing, if necessary. Hold her hand, wipe her brow—or do whatever else seems to help her. If she slips out of position, gently help her back into it.
- Periodically point out her progress. As the baby begins to crown, remind her to keep an eye on the mirror so she can have visual confirmation of what she is accomplishing. When she's not looking, or if there's no mirror, give her inch-by-inch descriptions. Take her hand and touch baby's head together for renewed inspiration.
- If you're offered the opportunity to catch your baby as he or she emerges or, later, to cut the cord, don't be afraid. Both are relatively easy jobs, and you'll get step-by-step directions and backup from the attendants. You should know, however, that the cord can't be snipped like a piece of string. It's tougher than you may think.

you've been semi-sitting, for example, you might want to get up on all-fours.

Once you're ready to begin pushing, give it all you've got. The more efficiently you push and the more energy you pack into the effort, the more quickly your baby will make the trip through the birth canal. Frantic, disorganized pushing wastes energy and accomplishes little—plus it can take its toll on you. Keep these pushing pointers in mind:

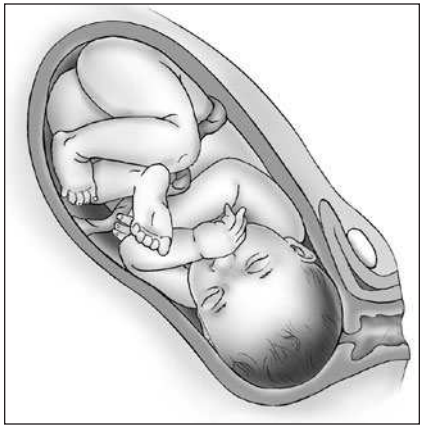
- Relax your upper body and your thighs and then push as if you're having a bowel movement (the biggest one of your life). Focus your energy on your vagina and rectum, not your chest (which could result in chest pain after delivery) and not your face (straining with your face could cause bruises on your cheeks and bloodshot eyes, not to mention do nothing to help get your baby out). It may help to look down, past your bump, as you push.
- Speaking of bowel movements, since you're bearing down on the whole perineal area, anything that's in your rectum may be pushed out, too—trying to avoid this while you're pushing can slow your progress. Don't let inhibition or embarrassment break the pushing rhythm. Involuntary pooping

(or peeing) is experienced by nearly everyone during delivery. No one else in the room will think twice about it, and neither should you (you probably won't even notice it). Pads will immediately whisk away anything that comes out.

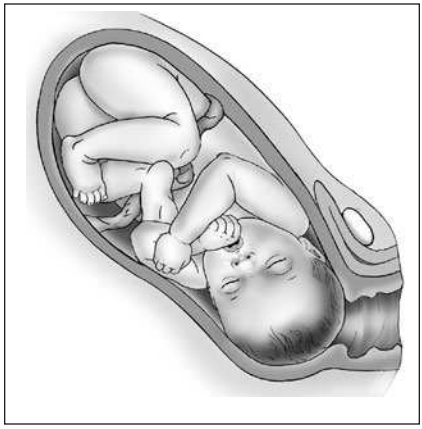
- Take a few deep breaths while the contraction is building so you can gear up for pushing. As the contraction peaks, take a deep breath and then push with all your might—holding your breath if you want or exhaling as you push, whatever feels right to you. If you'd like the nurses or your coach to guide you by counting to 10 while you push, that's fine. But if you find it breaks your rhythm or isn't helpful, ask them not to. There is no magic formula when it comes to how long each push should last or how many times you should push with each contraction—the most important thing is to do what comes naturally. You may feel as many as 5 urges to bear down, with each push lasting just seconds—or you may feel the urge to bear down just twice, but with each push lasting longer. Follow those urges, and you'll deliver your baby. Actually, you'll deliver your baby even if you don't follow your urges or if you find you don't have any urges at all. Pushing doesn't come naturally for every woman, and if it doesn't for you, your practitioner, nurse, or doula can help direct your efforts, and redirect them if you lose your concentration.
- Don't become frustrated if you see the baby's head crown and then disappear again. Birthing is a 2-steps-forward, 1-step-backward proposition. Just remember, baby's moving in the right direction.
- Rest between contractions. If you're really exhausted, especially when the pushing stage drags on, your practitioner may suggest that you not push for several contractions so you can rebuild your strength.
- Stop pushing when you're instructed to (as you may be, to keep the baby's head from being born too rapidly). If you're feeling the urge to push when you are asked not to push, pant or blow instead.
- Remember to keep an eye on the mirror (if one is available) once there's something to look at. Seeing your baby's head crown (and reaching down and touching it) may give you the inspiration to push when the pushing gets tough. Besides, unless your coach or someone else is taking a video, there won't be any replays to watch.

What your practitioner and nurse will be doing. While you're pushing, the nurses and/or your practitioner will give you support and direction (and if necessary, will use their hands to apply some gentle pressure on your abdomen to help coax baby down), continue to monitor your baby's heartbeat with either a Doppler or fetal monitor, and prepare for delivery by spreading sterile drapes and arranging instruments, donning surgical garments and gloves, and sponging your perineal area with antiseptic (though midwives generally just don gloves and don't do any draping). Most practitioners will use their fingers to gently stretch the perineum (much like perennial massage described on page 384) before your baby's head emerges. Some will use lubricants or oils (like olive or mineral oil) to make your perineum slippery, enabling baby's head to glide out more easily (and avoid tears). If necessary (it's unlikely), an episiotomy will be performed, or possibly vacuum extraction, or even less likely, forceps will be used.

A Baby Is Born

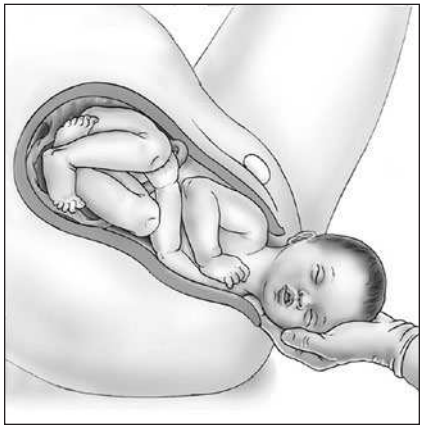


1. The cervix has thinned (effaced) somewhat but has not begun to dilate much.



2. The cervix has fully dilated and the baby's head has begun to press into the birth canal (vagina).

3. To allow the narrowest diameter of the baby's head to fit through the mother's pelvis, the baby usually turns sometime during labor. Here, the slightly molded head has crowned.



4. The head, the baby's broadest part, is out. The rest of the delivery should proceed quickly and smoothly.

Once your baby's head emerges, your practitioner will suction your baby's nose and mouth to remove excess mucus, then help ease the shoulders and torso out. You probably will have to give only one more small push to help with that—the head was the hard part, and the rest slides out pretty easily.

A First Look at Baby

After 40 or so weeks of waiting (and too many hours of laboring and delivering), there's no doubt that your just-born baby will be a sight for your sore eyes: perfectly beautiful to you in every way.

That said, 9 months of soaking in an amniotic bath, followed by compression in a contracting uterus and cramped birth canal can take a temporary toll on a newborn's appearance. Babies who were neatly plucked from their uterine homes (especially if they arrived via scheduled c-section, before labor started) will have an initial edge in the looks department—they'll be rounder and smoother. What can you expect your newborn baby to look like at first sight, besides picture perfect? Here's a realistic heads-up on some typical newborn characteristics, head to toe:

Oddly shaped head. At birth, an infant's head is, proportionately, the largest part of the body, with a circumference as large as his or her chest. As your baby grows, the rest of the body will catch up. Often, the head has molded to fit through mom's pelvis, giving it an odd, possibly pointed "cone" shape. If baby has pressed hard against your cervix before it was fully dilated, there may be a lump on that sweet noggin, too. The lump will disappear in a day or two, the molding within 2 weeks, at which point your baby's head will begin to take on that cherubic roundness.

Newborn hair. Some newborns are virtually bald or sport just a light coating of peach fuzz, some have a thick mane. But hair today will be gone, eventually. All babies lose their newborn hair (though this may happen so gradually that you don't notice), and it will be replaced by new growth, possibly of a different color and texture.

Vernix coating. Remember that cheesy coating that was keeping baby's skin protected in that amniotic bath? Premature babies have quite a lot of this coating at birth, on-time babies have just a little, and overdue babies may have none at all—except possibly in skin folds and under fingernails.

Swelling of breasts and genitals. Boy and girl parts can appear swollen at birth. Breasts of both male and female newborns can also be swollen (and sometimes even engorged, secreting a white or pink substance nicknamed "witch's milk"), thanks not to their own

Your baby will be handed to you or placed on your belly, the umbilical cord will be clamped (see page 416) and cut—either by the practitioner or by your coach—and the midwife or nurse will give baby a rub to help get his or her breathing and crying going. (If you've arranged for cord blood collection, it will be done now.) This is a great time for some caressing and skin-to-skin contact, so lift up your gown and bring baby close. In case you need a reason to do that, studies show that infants who have skin-to-skin contact with their mothers just after delivery sleep longer and are calmer hours later. Breastfeeding could be initiated now or, if need be, after the initial evaluation (see below). Here's a fun fact: If you keep your newborn skin-to-skin on your belly after birth, he or she will instinctively creep (over a period of 20 minutes to an hour or longer) toward your breast, find your nipple (bobbing

hormones, but mom's. Those same hormones may also stimulate a white, sometimes blood-tinged vaginal discharge in baby girls. These effects are normal and will disappear in a week to 10 days.

Puffy eyes. Swelling around the eyes, normal for someone who's been soaking in amniotic fluid for 9 months and then squeezed through a narrow birth canal, may be exacerbated by the ointment used to protect baby's eyes from infection. Most of the puffiness will—poof!—disappear within a few days.

Eye color, TBD. Brown? Green? Blue? For most babies, it's way too early to call. Caucasian baby eyes are usually (but not always) slate blue, no matter what color they will turn later on. In babies of color, eyes are usually brown at birth, but the shade of brown may ultimately do some changing.

Skin surprises. Your baby's skin will appear pink, white, or even grayish at birth (even if it will eventually turn brown or black). That's because pigmentation doesn't show up until a few hours after birth. A variety of rashes, tiny "pimples," and whiteheads may also mar your baby's skin thanks to maternal hormones, but all are temporary. You may also notice skin dryness and cracking, caused by such a long soak in an amniotic bath and first-time exposure to air—these, too, will pass without any treatment.

Lanugo. Fine downy hair, called lanugo, may cover the shoulders, back, forehead, and temples of full-term babies. This will usually be shed by the end of the first week. Such hair can be more abundant, and will last longer, in a premature baby and may already be gone in an overdue one.

Birthmarks. A reddish blotch at the base of the skull, on the eyelid, or on the forehead, called a salmon patch, is very common, especially in Caucasian newborns. Mongolian spots—bluish-gray pigmentation of the deep skin layer that can appear on the back, buttocks, and sometimes the arms and thighs—are more common in Asians, southern Europeans, and African Americans. These markings eventually disappear, usually by age 4. Hemangiomas, elevated strawberry-colored birthmarks, vary from tiny to about quarter size or even larger. They eventually fade to a mottled pearly gray, then often disappear entirely. Coffee-with-cream colored (café-au-lait) spots can appear anywhere on the body—they're usually inconspicuous and don't fade.

For much more on your baby, head to toe, see *What to Expect the First Year*.

that cute little head while searching for it), and then latch on.

What's next for your baby? The nurses and/or a pediatrician will evaluate baby's condition, and rate it on the Apgar scale at 1 minute and 5 minutes after birth (see *What to Expect the First Year* for more), give a brisk, stimulating, and drying rubdown, possibly take baby's footprints for a keepsake, attach an identifying band to your wrist (and to baby's dad's wrist) and to your baby's ankle, administer nonirritating eye ointment to prevent infection (you can ask that the ointment be administered after you've had time to cuddle with your newborn), weigh baby, and then wrap him or her to prevent heat loss. (In some hospitals and most birthing centers, some of these procedures may be omitted—in others, many will be attended to later, so you can have more time to bond with your newborn.)

Then you'll get your baby back (assuming all is well) and you may begin breastfeeding if you haven't already and you'd like to (see Beginning Breastfeeding, page 478). Sometime after that, baby will get a more complete pediatric exam and some routine protective procedures (including a heel stick, vitamin K shot, and hepatitis B vaccine), either in your room or in the hospital nursery (dad can go along or stay with you). Once your baby's temperature is stable, he or she will get a first bath, which you (and/or dad) may be able to help give.

Stage Three: Delivery of the Placenta

The worst is over, and the best has already come. All that remains is tying up the loose ends, so to speak. During this final stage of childbirth (which generally lasts anywhere from 5 to 30 minutes or more), the placenta, which has been your baby's life support inside the womb, will be delivered. You will continue to have mild contractions approximately a minute in duration, though you may not feel them (after all, you're preoccupied with your newborn!). The squeezing of the uterus separates the placenta from the uterine wall and moves it down into the lower segment of the uterus or into the vagina so it can be expelled.

Your practitioner will help deliver the placenta by either pulling the cord gently with one hand while pressing and kneading your uterus with the other or exerting downward pressure on the top of the uterus, asking you to push at the appropriate time. You might get some Pitocin (oxytocin) via injection or in your IV to encourage uterine contractions, which will speed delivery of the placenta, help shrink the uterus back to size, and minimize bleeding. Once the placenta is out, your practitioner will examine it to make sure it's intact. If it isn't, he or she will inspect your uterus manually for placental fragments and remove any that remain. (If you'd like to keep the placenta, be sure your practitioner knows about this plan, and that both he or she and the hospital have agreed to it ahead of time. See page 362 for more.)

Now that the work of labor and delivery is done, you may feel overwhelmingly exhausted or, conversely, experience a burst of renewed energy. You are likely to be very thirsty and, especially if labor has been long (and particularly if you weren't allowed to eat), hungry. Some women experience chills in this stage, while all experience a bloody vaginal discharge (called lochia) comparable to a heavy menstrual period.

How will you feel emotionally after you've delivered your baby? Every new mom reacts a little differently, and your reaction is normal for you. Your first emotional response may be joy, but it's just as likely to be a sense of relief. You may be exhilarated and talkative, elated and excited, a little impatient at having to push out the placenta or submit to the repair of a tear or an episiotomy, or so in awe of what you're cuddling in your arms (or so beat, or a little bit of both) that you don't notice. You may feel a closeness to your spouse and an immediate bond with your new baby,

FOR FATHERS

What You Can Do After Delivery

Your baby is here! While you're basking in the moment, you can also:

- Offer some well-earned words of praise to the new mom—and congratulate yourself, too, for a job well done.
- Begin bonding with your little one—with some holding and cuddling, and by doing soft singing or talking. Remember, your baby has heard your voice a lot during his or her stay in the uterus and is familiar with its sound. Hearing it now will bring comfort in this strange new environment.
- Don't forget to do some cuddling and bonding with mom, too.
- Ask for an ice pack to soothe her perineal area, if the nurse doesn't offer one.
- Ask for some juice for mom—she may be very thirsty. After she's been rehydrated, and if both of you are in the mood, break out the bubbly—champagne or sparkling cider if you brought some along.
- Snap baby's first photos or capture your amazing newborn on video.
- You'll also have the opportunity to be with your newborn for the first exam, first bath, and other routine procedures.

or (and this is just as normal) you may feel somewhat detached (who is this stranger sniffing at my breast?). No matter what your response now, you will come to love your baby intensely. These things just sometimes take time. (For more on bonding, see page 471.)

What you can do

- Do some quality snuggling, skin-to-skin. Speak up, too. Since your baby will recognize your voice, cooing, singing, or whispered words will be especially comforting (it's a strange new world, and you'll be able to help baby make some sense out of it). Under some circumstances, your baby may be kept in a heated bassinet for a while or be held by your coach while the placenta is being delivered—but not to worry, there's plenty of time for baby bonding.
- Spend some time bonding with your coach, too—and enjoying your cozy new threesome.
- Help deliver the placenta, if necessary, by pushing when directed. Some moms don't even have to push at all for the placenta to arrive. Your practitioner will let you know what to do, if anything.
- Hang in there during repair of any episiotomy or tears.
- Continue (or start) breastfeeding if baby is still with you.
- Take pride in your accomplishment—you did it, mama!

All that's left to do, then, is for your practitioner to stitch up any tear (if you're not already numbed, you'll get a local anesthetic) and clean you up. You'll likely get an ice pack to put on your perineum to minimize swelling—ask for one if it's not offered. The nurse will also help you put on a maxipad or add some thick pads under your bottom (remember, you'll be bleeding a lot). Once you're feeling up to it, you'll be transferred to a postpartum room.

Cesarean Delivery

You won't be able to participate actively at a cesarean delivery the way you would at a vaginal one, and some would consider that a definite plus. Instead of huffing, puffing, and pushing your baby into the world, you'll get to lie back and let everybody else do all the heavy lifting. In fact, your most important contribution to your baby's cesarean birth will be preparation: The more you know, the more comfortable you'll feel. Which is why it's a good idea to look this section over ahead of time, even if you're not having a planned cesarean delivery.

Thanks to regional anesthesia (like epidurals) and the liberalization of hospital regulations, most moms (and their coaches) are able to be full-on spectators at their cesarean deliveries. Because they aren't preoccupied with pushing or pain, they're often able to relax (at least to some degree) and marvel at the birth. This is what you can expect in a typical cesarean birth:

- An IV infusion will be started (if it isn't already in) to provide speedy access if additional medications or fluids are needed. Most doctors will give you antibiotics through your IV to prevent infection down the road.
- Anesthesia will be administered: either an epidural or a spinal block (both of which numb the lower part of your body but allow you to be fully awake and alert). In rare emergency situations, when a baby must be delivered immediately, a general anesthetic (which puts you to sleep) may be used.
- Your abdomen will be washed down with an antiseptic solution. A catheter (a narrow tube) will be inserted into your bladder to keep it empty and out of the surgeon's way.
- Sterile drapes will be arranged around your exposed abdomen. A screen will be put up at about shoulder level so you won't have to see the incision being made, though some hospitals have clear drapes so you can have a view of baby emerging.
- If your coach is going to attend the delivery (which he probably will be able to), he will be suited up in sterile garb. He will sit near your head so that he can give you emotional support and hold your hand, and he may have the option of viewing the actual surgery. If you've planned to have a doula with you during the delivery, she can be with you during your c-section as well.
- If yours is an emergency cesarean delivery, things may move very quickly. Try to stay calm in the face of all that activity, and don't let it worry you—that's just the way things work in a hospital sometimes.
- Once your doctor is certain that the anesthetic has taken effect, an incision

Cesarean delivery

Tying Your Tubes After Delivery

Thinking about ending your baby-making career after this delivery—and contemplating a permanent solution to birth control? Though it's far easier for dads to take this step (vasectomy, the male version of sterilization, is much less invasive), moms choosing to have their tubes tied can opt to add the procedure to their birth plans. Whether you're delivering vaginally or via c-section, having a tubal ligation right after your baby's birth definitely saves time and money and will certainly make postpartum sex (when you finally get around to it) more convenient. Not sure if you're done, done, done? See more about birth control on page 511.

If you've delivered via cesarean. Since an incision has already been made to get your baby out—and you're already numb from the anesthesia—there's little extra fuss or muss involved. Your doctor will simply clip (or clamp) your fallopian tubes before stitching your incision back up.

If you've delivered vaginally. The doctor will make a small incision under the belly button. The benefit to doing the procedure right after delivery is that your uterus is still large, so there's easy access to your fallopian tubes. Most doctors will perform a tubal ligation right after a vaginal birth only if mom has received an epidural during labor and it's still in place.

You likely won't need any extra recovery time or experience any extra pain from the procedure—beyond what you'd experience anyway after delivery (and if you did, it would be hard to differentiate one pain from the other). You probably also won't need any additional pain medication (again, beyond what you might take for postpartum pain).

(usually a horizontal bikini cut) is made in your lower abdomen, just above the pubic hairline. You may feel a sensation of being "unzipped," but you won't feel any pain.

- A second incision (usually a low-horizontal one) is then made, this time in your uterus. The amniotic sac is opened, and, if it hasn't already ruptured, the fluid is suctioned out—you may hear a sort of gurgling or swooshing sound.
- The baby is then eased out, usually while an assistant presses on the uterus. With an epidural (though not likely with a spinal block), you will probably feel some pulling and tugging sensations, as well as some pressure. If you're eager to see your baby's arrival and drapes are blocking the view, ask the doctor if the screen can be lowered slightly.
- Your baby's nose and mouth are then suctioned—then you'll hear the first cry, the cord will be quickly clamped and cut, and you'll be allowed a quick glimpse of your newborn. In a hospital offering a "gentle c-section," your baby may be placed on your chest and you'll be able to hold (or even breastfeed) your baby right away.
- While the baby is getting the same routine attention that a vaginally delivered infant receives, the doctor will remove the placenta.
- Now the doctor will quickly do a routine check of your reproductive organs and stitch up the incisions that

Don't Forget to Cover Baby

One of the many calls you'll have to make now (or within the next few weeks) is to your health insurance company so your baby can be added to your plan. Not insured or want to change Affordable Care Act plans? Since having a baby qualifies you for a Special Enrollment Period, you can enroll in or change Marketplace coverage now even if it's not Open Enrollment time, for 60 days after the birth of your little one. Go to healthcare.gov for more information.

were made. The uterine incision will be repaired with absorbable stitches, which do not have to be removed. The abdominal incision may be closed with either stitches (which may or may not be absorbable) or surgical staples.

- An injection of oxytocin may be given intramuscularly or into your IV to help contract the uterus and control bleeding.

You may have some cuddling time—and even some skin-to-skin time in the delivery room, but a lot will depend on your condition and the baby's, as well as hospital rules. Many hospitals allow skin-to-skin time after a cesarean delivery as long as your baby is medically stable (just ask the nurses to hand you your baby)—and especially if "gentle cesareans" are offered. If you can't hold your baby, perhaps your spouse can. If your baby has to be whisked away to the NICU (neonatal intensive care unit) or the nursery, don't let it get you down. This is standard in some hospitals after a cesarean delivery and is more likely to indicate a precaution than a problem. And as far as bonding is concerned, later can be just as good as sooner—so not to worry if the snuggles have to wait a little while.

CHAPTER 15

Expecting Multiples

Have two (or more) passengers aboard the mother ship? Then chances are, you have at least double the joy and excitement—and at least double the questions: Will the babies be healthy? Will I be healthy? Am I more likely to have complications? Will I be able to stick with my regular practitioner, or will I have to see a specialist? How much food will I have to eat, and how much weight do I have to gain? Will there be enough room inside of me for two babies? Will I be able to carry them to term? Will I have to go on bed rest? Will giving birth be twice as hard?

Carrying one baby comes with its share of challenges and changes. Carrying more than one—well, you've probably already done the math. But not to worry. You're up for it—or at least you will be once you're armed with the information in this chapter . . . and the support of your partner and your practitioner. So sit back (comfortably, while you still can) and get ready for your amazing multiple pregnancy.

What You May Be Wondering About

Choosing a Practitioner

"We just found out we're having twins. Can I use my regular ob, or do I need to see a specialist?"

Having twins is definitely special—but it doesn't definitely require a specialist's care. Just make sure you really like your regular ob before you commit—since twin pregnancies always come with more office visits, you'll be seeing a lot of each other.

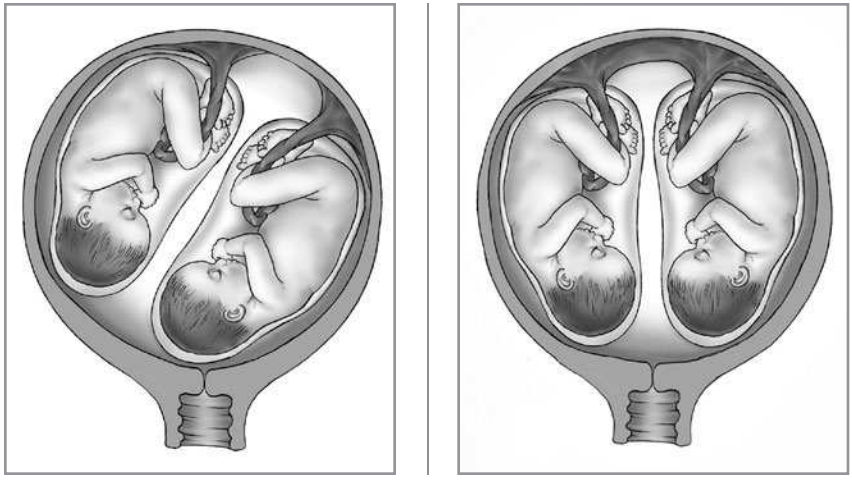
Do you like your ob but also like the idea of extra-careful care? Many

general ob practices send patients who are pregnant with multiples to a specialist for periodic consultations, or refer them to a specialist later in pregnancy (or at any point if things take a turn for the complicated)—a good compromise if you'd like to combine the familiar comfort of your ob's care with the expertise of a specialist's. Moms-to-be of multiples who have any other risk factors (they're older, have a history of miscarriage, or have a chronic health condition) may want to start off with or consider switching over full-time to a maternal-fetal medicine specialist (also known as a perinatologist). Talk that possibility over with your ob if your pregnancy falls into a higher risk category. If you're carrying triplets or more, your best bet is to get your prenatal care from a perinatologist right from the beginning.

When choosing a practitioner for your multiple pregnancy (likely a physician, since most midwives don't offer care for multiple pregnancies; see box, facing page), you'll also want to factor in hospital affiliation. Ideally, you'll want to deliver at a facility with the ability to care for premature babies (one with a NICU) in case your bundles arrive early, as multiples often do.

Also ask about the doctor's policy on topics specifically related to multiple births: Will you be induced at 37 or 38 weeks as a matter of course, or will you have the option of carrying beyond that time frame if all is going well? Will a vaginal birth be possible under certain circumstances (or at least a trial of labor), or does this doctor routinely schedule moms of twins for cesarean delivery? Will you be able to deliver vaginally in a birthing room or

Fraternal or Identical?



Fraternal twins (left), which result from 2 eggs being fertilized at the same time, each have their own placenta. Identical twins (right), which come from 1 fertilized egg that splits and then develops into 2 separate embryos, may share a placenta and amniotic sac or—depending on when the egg splits—may each have their own.

Midwife Care for Multiples?

Even if your regular practitioner is a midwife, it's possible that you'll be able to stick with her, at least for part of your pregnancy, as long as it stays low risk—and assuming her credentials, license, and experience allow her to care for and deliver twin pregnancies.

Unfortunately, many midwives don't meet that set of criteria, which means that while it's possible you'll find one who can care for and deliver twin pregnancies, it's more likely that you won't. While some midwives will provide prenatal care for low-risk twin pregnancies, others will care for a mom of twins only up to a certain gestational age, and others won't take a twin pregnancy on at all, due to the potential of it turning high risk. What's more, some states don't allow midwives to care for or deliver multiples—and many birthing centers won't allow twin deliveries, either.

But that doesn't mean you have to write off midwife care entirely. Midwives who have collaborative agreements with obs who can act as backups in case of complications are more likely to agree to signing up a mom of twins. And even if your care does need to be transferred to an ob or perinatologist at some point, your midwife may be able to stay involved in your pregnancy and even attend your birth.

Have your heart set on a home birth? You may have a hard time finding a midwife who will deliver twins at home, especially if you live in a rural area where an ob (and hospital) backup may be too far away.

If you do decide to use a midwife for your prenatal care, at least initially—and especially if you choose to have her (or him) deliver your babies—be sure to choose someone who has plenty of experience managing twin pregnancies.

is it routine to deliver multiples in an operating room?

For more general information about choosing a practitioner, see page 10.

Pregnancy Symptoms

"I've heard that pregnancy symptoms are way worse when when you're having multiples. Is that true?"

Twice the babies sometimes spell twice (or more) the pregnancy discomforts, but not always. Every multiple pregnancy, like every singleton pregnancy, is different. An expectant mom of one may suffer enough morning sickness for two, while a mom-to-be of multiples might sail through her pregnancy without a single queasy day. The same with other symptoms, too.

But though you shouldn't expect a double dose of morning sickness (or heartburn, or leg cramps, or varicose veins), you can't count it out. The miseries do, on average, multiply in a multiple pregnancy, and that's not surprising, given the extra weight you'll be carrying around and the extra hormones you're already generating. Among the symptoms that might be—but won't necessarily be—exponentially exacerbated when you're expecting twins or more:

- Morning sickness. Nausea and vomiting can be worse in a multiple pregnancy, thanks to—among other things—the higher levels of hormones circulating in a mom's system. Morning sickness can also start earlier and last longer. And severe nausea and vomiting (hyperemesis gravidarum,

Seeing Double—Everywhere?

If it looks like multiples are multiplying these days, it's because they are. In fact, nearly 4 percent of babies in the United States are now born in sets of 2, 3, or more, with the majority (about 95 percent) of these multiple births composed of twins. At least twice as amazing, the number of twin births has jumped more than 50 percent in recent years, and higher-order multiple births (triplets and more) have risen an astonishing 400 percent.

So what's up with this multiple-baby boom? While identical twins usually happen by chance, your chance of having fraternal twins (the more common type of twin) increases based on the following factors (some of which can also influence the odds of having higher-order fraternal multiples, too):

Age. The older you are, the higher your odds of having fraternal twins. Moms over the age of 35 are naturally more likely to drop more than 1 egg at ovulation (thanks to often higher levels of FSH, or follicle-stimulating hormone), upping the odds of having twins.

Fertility treatments. As techniques in assisted fertility become more sophisticated, they're less likely to produce multiples, especially higher-order multiples. Still, having any kind of fertility treatments (particularly the kind that stimulates ovulation or implants more than 1 embryo) multiplies the chances of a multiple pregnancy.

Obesity. Women who are obese when they conceive (with a BMI higher than 30) are significantly more likely to have fraternal twins than women with lower BMIs.

Size. There is some evidence that larger, taller women may be slightly more likely to conceive twins than smaller women—but the connection appears weak (meaning size doesn't matter much).

Race. Twins are slightly more common among African Americans and somewhat less common among Hispanics and Asians.

Family history. Do fraternal twins run in your family? Or are you a fraternal twin yourself? Your chances of having multiples are greater than average. And if you've already had a set of fraternal twins, you're twice as likely to have another set in a future pregnancy. Now, that's a win-win-win-win.

see page 547) is more common among moms-to-be of multiples.

- Other tummy troubles. More gastric crowding (and more gastric overloading, since moms of multiples are eating for three or more) can lead to an increase in the kinds of digestive discomforts pregnancy's known for, like heartburn, indigestion, and constipation.
- Fatigue. This is a no-brainer: The more weight you're dragging around, the more you're likely to drag. Fatigue can also increase with the extra energy an expectant mom of multiples expends (your body has to work twice as hard to grow two babies). Sleep deprivation can also wear you out (it's difficult enough to settle down with a watermelon-size belly, let alone one that's the size of two watermelons). And speaking of no-brainers, expecting twins can thicken the normal brain fog of pregnancy.
- All those other physical discomforts. Every pregnancy comes with its share

of aches and pains—your twin pregnancy might just come with a little more than its share. Toting that extra baby can translate to extra backache, hip pain, pelvic twinges, pelvic (and round ligament) pain, crampiness, swollen ankles, varicose veins, you name it. Breathing for a crowd can also seem to be an extra effort, especially as your uterus full of babies gets big enough to crowd out your lungs.

- Fetal movement. Though every pregnant woman might feel at some point that she's expecting an octopus, the 8 limbs you'll be carrying will really pack a punch. Make that many punches, and kicks.

Whether your multiple pregnancy ends up doubling up on discomforts or not, one thing's for sure—it'll also gift you with twice the rewards. Not bad, for 9 months' work.

Eating Well with Multiples

"I'm committed to eating well now that I'm pregnant with triplets, but I'm not sure what that means—eating 3 times as much?"

Belly up to the buffet table, mom—feeding 4 means it's always time to chow down. While you won't literally have to quadruple your daily intake (any more than a woman expecting a single baby has to double it), you will need to do some serious eating in the months to come. Moms-to-be of multiples should cash in on an extra 150 to 300 calories a day per fetus, doctor's orders (good news if you're looking for a license to eat, not so good news if queasiness or tummy crowding has your appetite cramped). Which translates to an extra 300 to 600 calories if you're carrying twins, an extra 450 to 900 calories for triplets (if you've started out with an average prepregnancy weight). But before you take that extra allotment as a free pass to Burritoville (extra guacamole for Baby A, extra sour cream for Baby B, extra refried beans for Baby C), consider this: The quality of what you eat will be just as important as the quantity. In fact, good nutrition during a multiple pregnancy has an even greater impact on baby birthweight than it does during a singleton pregnancy.

So just how do you eat well when you're expecting more than one? Check out the Pregnancy Diet (see Chapter 4) and:

Keep it small. The bigger your belly gets, the smaller you'll want your meals to stay. Not only will grazing on 5 or 6 healthy mini meals and snacks ease your digestive overload, but it'll keep your energy up—while delivering the same nutritional bottom line as 3 squares. As space gets ever tighter, you may even want to eat even less even more often — and you'll probably want to keep some nibbles bedside in case you get hungry during the night.

Make your calories count. Pick foods that pack plenty of nutrients into small servings. Studies show that a higher-calorie diet that's also high in nutrients significantly improves your chances of having healthy full-term babies. Wasting too much of that premium space on junk food means you'll have less room for the nutritious food your crew of cuties needs.

Go for extra nutrients. Not surprisingly, your need for nutrients multiplies with each baby—which means you'll have to tack on some extra servings to your Daily Dozen (see page 90). It's usually recommended that moms of multiples get 1 extra serving of protein, 1 extra serving of calcium, and 1 extra serving