Signs of Preterm Labor

It's a good idea for every expectant mom to be familiar with the signs of premature labor, since early detection can have a tremendous impact on outcome. Think of the following as information you'll probably never use but should know, just to be on the safe side. Read this list over, and if you experience any of these symptoms before 37 weeks (or think you might be experiencing them but aren't sure), call your practitioner immediately:

- Persistent cramps that are menstrual-like, with or without diarrhea, nausea, or indigestion
- Regular painful contractions coming every 10 minutes (or sooner) that do not subside when you change positions or drink water (not to be confused with the Braxton Hicks contractions you might be already feeling, which don't indicate early labor; see page 340)
- Constant lower back pain or pressure or a change in the nature of lower backache
- A change in your vaginal discharge, particularly if it is watery or tinged or streaked pinkish or brownish with blood
- An achiness or feeling of pressure in the pelvic floor, the thighs, or the groin
- Leaking from your vagina (a steady trickle or a gush)

Keep in mind that you can have some or all of these symptoms and not be in labor (most pregnant women experience pelvic pressure or lower back pain at some point). In fact, the majority of women who have symptoms of preterm labor do not deliver early. But only your practitioner can tell for sure, so pick up the phone and call. After all, it's always best to play it safe.

For information on preterm labor risk factors and prevention, see page 31. For information on the management of preterm labor, see page 559.

labor and delivery to play out if all goes according to "plan." Besides listing those preferences, the typical birth plan factors in what's practical, what's feasible, and what the practitioner and hospital or birthing center will accommodate (not everything on a birth plan may fly with them) or have available. It isn't a contract but a written understanding between a patient and her practitioner and/or hospital or birthing center. Not only can a good birth plan deliver a better birth experience, but it can also head off unrealistic expectations, minimize disappointment, and eliminate major conflict and miscommunication between a birthing mom and her birth attendants. Some practitioners routinely ask an expectant couple to fill out a birth plan, while others are happy to oblige if one is requested. A birth plan is also a springboard for dialog between patient and practitioner. Not sure how your practitioner feels about some of your birth preferences? Now, well before labor starts, is the time to find out.

Some birth plans cover just the basics, while others are extremely detailed (down to the birthing room music, lighting, and guest list). And because every expectant woman is different—not only in what she'd like out

of the birth experience but what she can likely expect given her particular pregnancy profile and history—a birth plan should be individualized (so don't fill yours out based on one you saw on another mom's blog). Some of the issues you may want to tackle in your birth plan, should you decide to fill one out, are listed below. You can use it as a general guideline, then flesh it out as needed. For a sample birth plan, see the *What to Expect Pregnancy Journal and Organizer*.

- How far into labor you'd prefer to remain at home
- Eating and/or drinking during active labor (page 406)
- Being out of bed (walking around or sitting up) during labor
- Being in a tub for labor and/or birth (page 326)
- Personalizing the atmosphere with music, lighting, items from home
- Who you'd like to have with you (besides your partner) during labor and/or at delivery—including a doula (page 328), your other children, friends, family
- Taking pictures and videos
- The use of a mirror so you can see the birth
- The use of an IV (intravenous fluid; page 407)
- The use of a catheter
- The use of pain medication and the type you'd prefer (page 331)—or wishes about alternatives to pain meds (page 334)
- Artificial rupture of the membranes (page 409) and/or leaving membranes intact
- External fetal monitoring (continuous or intermittent) or internal fetal monitoring (page 407)
- The use of oxytocin to induce or augment contractions (page 424)
- Delivery positions (page 412), use of a birthing bar (page 414), and so on
- Use of warm compresses and perineal massage (pages 432 and 384)
- Episiotomy (page 408)
- The option of "laboring down" (page 429)
- Vacuum extraction or forceps use (page 410)
- Cesarean delivery, including option of "gentle cesarean" (page 438)
- Special requests around suctioning baby, such as suctioning by the father
- Holding the baby immediately after birth, allowing baby time to creep from belly to breast (page 434)
- Plans for breastfeeding right away, having a lactation consultant there to help
- Delayed cord clamping (page 416)
- Dad catching the baby and/or cutting the cord (page 434)

Don't Hold It In

Do you often hold in your pee to avoid making yet another run for the bathroom? Not going when you've got the urge can inflame your bladder, which can irritate your uterus and cause contractions. It can also lead to a urinary tract infection, another cause of preterm contractions. So don't hold it in. When you gotta go, go . . . promptly.

Water Birth

Your baby spends 9 blissful months doing water ballet in a warm pool of amniotic fluid, and then makes a sudden, harsh entrance into a cold, dry world. Advocates of water birth say that allowing a baby to arrive in conditions that mimic those of the womb—warm and wet—can ease the transition and make that entry more peaceful, reducing a newborn's stress.

If you choose to have a water birth, you'll not only spend your labor in a warm tub or pool, but you'll also deliver your newborn while you're still in the water (your baby will be pulled gently into the soothing water and then slowly lifted into your arms). Your partner can be in the water with you during labor to support you and he can play catch (literally) with the baby during delivery. During labor, cold cloths, spray bottles, and plenty of water will keep you refreshed (as much as possible—you're having a baby, after all) while the midwife or other medical personnel monitors your baby's condition with an underwater Doppler device.

Water births are really an option only for low-risk pregnancies, but they're available in more and more settings. Most birthing centers and some hospitals offer the option of water births and most birthing centers have large tubs or Jacuzzis in the birthing rooms (or portable birthing tubs on wheels that can be rolled into your room) that can also be used for soothing soaks or hydrotherapy, even if you ultimately decide against actually giving birth in water (or if it turns out not to be possible in your case). It's less likely that a hospital will have a tub large enough to accommodate a water birth, so if you prefer a water birth but are delivering in a hospital that doesn't offer the option or doesn't have tubs, ask whether it might be possible to bring your own birthing tub that you've rented or purchased (see below).

You can also choose to have a water birth at home—as long as you have your midwife's approval and the right equipment on hand. Most home water birth tubs look like deep kiddie pools—they're inflatable, large enough to allow you to move around freely, deep enough so your pregnant belly can stay fully submerged, and have soft sides, allowing

- Cord blood banking (page 295)
- Postponing weighing the baby and/or administering eye drops until after you and your baby greet each other
- Special requests around the placenta (seeing it, preserving it; see page 362)

You may also want to include some postpartum items on your birth plan, such as:

- Your presence (and/or dad's) at baby's weigh-in, the pediatric exam, and baby's first bath
- Baby feeding in the hospital (see page 478)
- Circumcision (see *What to Expect the First Year*)
- Rooming-in (usually required by hospital when mom and baby are both doing well; see page 474)
- Other children visiting with you and/or with the new baby
- Postpartum medication or treatments for you or your baby

you to lean against (or over) the edges comfortably. You can purchase or rent a birthing tub online or from your midwife (some midwives loan out tubs at no cost—or you might also be able to borrow one from a friend who's been there, done that). If you're purchasing, expect to shell out a few hundred dollars for the tub and all the equipment that goes along with it, including liners, heater, filter, and tarp. On a tighter budget? You can also use your home's bathtub (assuming it's deep enough for your big belly and with enough room around the tub for your midwife to reach you during delivery or if an emergency arises). Of course, you'll have to make sure it's cleaned and sterilized (with a water-bleach mixture) before the big day arrives. You'll also have to make sure you have a floating thermometer to monitor the water temperature and keep it stable at approximate body temperature (95°F to about 100°F, but no more than 101°F, because your body temperature could rise, causing the baby's heart rate to increase). Birthing tubs come with heaters, so that's one less thing to worry about if you do end up using one.

Since a baby's breathing will not start until he or she comes out of the water and into the air (babies don't breathe in utero), drowning is not considered a risk of water births. For several reasons, however, a baby's underwater entry should be limited to no more than a few moments (10 seconds is the norm in the U.S.). First, because the umbilical cord can tear, cutting off the baby's oxygen lifeline unexpectedly. Second, because once the placenta separates from the uterus—which can happen at any time after delivery—it can no longer provide the baby with sufficient oxygen. And finally, because the fluid your baby will be born into isn't sterile. Remember, birth is a messy business. Most women will poop when pushing (the midwife will scoop the feces out of the tub), and there will also be blood and urine in the water you're sitting in. If the baby aspirates (inhales) the fluid—unlikely except in the case of fetal stress during labor—he or she could be at risk of a serious infection.

Thinking you'd like your baby to make an underwater appearance into the world? Though it's a personal decision to make (like so many other birth decisions), it's one best made in consultation with your practitioner, so you can be sure it's a safe option for you and your baby. For more information on water births, go to waterbirth.org.

- Arrangements for newborn screening (page 360)
- The length of the hospital stay, barring complications (page 468)

Of course, the most important feature of a good birth plan is flexibility. Since childbirth—like most forces of nature—is unpredictable, the best-laid plans don't always go, well, according to plan. Though chances are very good that your plan can be carried out just the way you drew it up, there's always the chance that it won't. There is no way to predict precisely how labor and delivery will progress (or not progress) until it gets underway—or how you'll really feel about those contractions once they get started. A birth plan you design ahead of time may not end up being medically advisable—or what works for you in the moment—and may have to be adjusted at the last minute for your baby's wellbeing and yours. A change of mind (yours) can also prompt a change of plan (you were dead set against having an epidural, but somewhere around 5 cm, you become dead set on having one).

Doulas: Best Medicine for Labor?

Think three's a crowd? For many couples, not when it comes to labor and delivery. More and more are opting to share their birth experience with a doula, a woman trained as a labor companion. And for good reason. Some studies have shown that women supported by doulas are less likely to require cesarean deliveries, induction, and pain relief. Births attended by doulas may also be shorter, with a lower rate of complications.

The term "doula" comes from ancient Greece, where it was used to describe the most important female servant in the household, the one who probably helped mom out the most during childbirth. What exactly can a doula do for you and your birth experience? That depends on the doula you choose, at what point in your pregnancy you hire her, and what your preferences are. Some doulas become involved well before that first contraction strikes, helping with the design of a birth plan and easing prelabor jitters. Many will come to the house to help a couple through early labor. Once at the hospital or birthing center, the doula takes on a variety of responsibilities, again depending on your needs and wishes. Typically, her primary role is as a continuous source of comfort, encouragement, and support (both emotional and physical) during labor. She'll serve as a soothing voice of experience (especially valuable if you're first-timers), help with relaxation techniques and breathing exercises, offer advice on labor positions, and do her share of massage, hand holding, pillow plumping, and bed adjusting. A doula can also act as a mediator and an advocate, ready to speak for you as needed, translate medical terms and explain procedures, and generally run interference with hospital personnel. She won't take the place of your coach (and a good doula won't make him feel like she's taking his place, either) or the nurse on duty—instead, she will augment their support and services (especially important if the nurse assigned to you has several other patients in labor at the same time or if labor is long and nurses come and go as shifts change). She will also likely be the only person (besides your coach) who will stay by your side throughout labor and delivery—a friendly and familiar face from start to finish. And many doulas don't stop there. They can also offer support and advice postpartum

Bottom line: Birth plans, though by no means necessary (you can definitely decide to go with the childbirth flow), are a great option, one that more and more expectant parents are taking advantage of. To figure out whether a birth plan is right for you and what should be in it, talk it over with your practitioner at your next visit.

Tdap Vaccine

"My practitioner told me I need to get the Tdap vaccine this month. But I thought I already had that shot as a child."

Time to roll up that sleeve again, mama. The CDC recommends that every pregnant woman get the Tdap vaccine (which prevents diphtheria, tetanus, and pertussis) between 27 and 36 weeks of each pregnancy, regardless of when she was last vaccinated with

on everything from breastfeeding to baby care.

Though an expectant father may worry that hiring a doula will relegate him to third-wheel status, that isn't the case. A good doula is also there to help your coach relax so he can help you relax. She'll be there to answer questions he might not feel comfortable broaching with a doctor or nurse. She'll be there to provide an extra set of hands when you need your legs and back massaged at the same time, or when you need both a refill on ice chips and help breathing through a contraction. She'll be an obliging and cooperative member of your labor team—ready to pitch in, but not to push dad (or the medical team) aside and take over. And if dad's not in the picture, a doula can be an especially helpful helping hand by your side throughout the entire labor, delivery, and even postpartum period.

How do you locate a doula? Doulas don't need to be certified, but many birthing centers and hospitals keep lists of doulas, and so do some practitioners. Ask friends who've recently used a doula for recommendations, or check online for local doulas. Once you've tracked down a candidate, arrange a consultation before you hire her. Ask her about her experience, her training, what she will do and what she won't do, what her philosophies are about childbirth (if you're planning on asking for an epidural, for instance, you won't want to hire a doula who discourages the use of pain relief), and whether she will be on call at all times and who covers for her if she isn't. Ask whether she provides pregnancy and/or postpartum services, and what her fees are—a consideration for many couples, since doulas aren't covered by insurance. Some doulas offer discounts or even donate their services to those who can't afford their services or to military families (especially when the partner is deployed and won't be at the birth). For more information or to locate a doula in your area, contact Doulas of North America at dona.org.

An alternative to a doula is a female friend or relative who has gone through pregnancy and delivery herself and who you feel totally comfortable with. The plus: Her services will definitely be free. The drawback: She probably won't be quite as knowledgeable. One way to remedy that is having a "lay doula," a female friend who goes through 4 hours of training in doula techniques (ask if your hospital has such a training course). Researchers have found that a lay doula can provide many of the same benefits as a professional one.

the Tdap or Td vaccine. That's because immunity from pertussis (and tetanus and diphtheria) wanes after several years. If you've never been vaccinated against tetanus (either with the DTaP series as a child or with Td or Tdap as an adult), you'll need to receive 2 doses of Td early in pregnancy in addition to the regularly scheduled Tdap in the third trimester.

Why the recommendation? It's to protect your baby when he or she is born. Very young babies are vulnerable to pertussis (also called whooping cough), a contagious respiratory illness that can lead to pneumonia and even death. Until your baby is vaccinated against the disease with the full series of the DTaP vaccine (the childhood version of the Tdap, given beginning at 2 months), the antibodies that your body makes after receiving your Tdap shot will be passed along to your little one, effectively protecting him or her from

FOR FATHERS

Take One for the Team

Are your immunizations up to date? Get your Tdap booster shot if you haven't already (and other booster shots you may need) as well as a seasonal flu vaccine to protect the precious baby who's joining the family. Seventy percent of babies who get whooping cough are infected by immediate family members—and that includes dads. Good news for the needle-phobic: unlike moms, dads don't need a Tdap booster during each pregnancy—one time only.

the disease. And the studies back this up. Research has found that when moms receive the recommended Tdap booster during pregnancy, their babies are 50 percent less likely to catch pertussis than babies whose moms aren't vaccinated. And it's not just you who needs the vaccine. It's important that anyone else who will be in close contact with your newborn—baby's dad, baby's grandparents, the babysitter—get a booster, too. That way they won't contract the disease and spread it to baby, and your little one will be "cocooned" against pertussis.

And here's some great news for busy moms-to-be: If the beginning of your third trimester (when you're scheduled for your Tdap vaccine) coincides with flu season (when you'll need a flu shot) you won't have to schedule two appointments. Research shows that it's completely safe to be vaccinated with both at the same time—making getting the vaccines you need to protect yourself and your baby-to-be a whole lot easier.

Speaking of vaccines, now's the perfect time to begin learning about all the vaccines your little one will be on the receiving end of during his or her first few years of life. There's no better or safer way to protect your precious bundle from preventable, sometimes life-threatening childhood diseases than by making sure he or she is vaccinated completely and on time, according to the recommended schedule. See *What to Expect the First Year* for more information about vaccines, their benefits, and their safety.

ALL ABOUT:

Easing Labor Pain

Let's face it. Those 15 or so hours it takes to birth a baby aren't called labor because they're a walk in the park. Labor (and delivery) is hard work—hard work that can hurt, big time. And if you actually consider what's going on down there, it's really no wonder that labor's a pain. During childbirth, your uterus contracts over and over again to squeeze a relatively big baby through one relatively tight space (your cervix) and out through an even tighter one (your vagina, the same opening you probably once thought was too small for a tampon). Like they say, it's pain with a purpose—a really cute and cuddly purpose—but it's still pain.

But while there may be no getting around the pain of labor altogether (unless you're scheduled for a cesarean

delivery, in which case you'll be skipping labor and labor pain), there are plenty of ways to get through it. As a laboring mom, you can select from a wide menu of pain management and relief options, both medicated and nonmedicated (and you can even opt for a combo from both columns). You can choose to go unmedicated throughout your entire labor or just through part of labor (like those relatively easy first centimeters). You can use the breathing and relaxation techniques you learned in childbirth education classes (Lamaze, for instance, or Bradley), or you can turn to alternative approaches (like acupuncture, hypnosis, or hydrotherapy). Or you can birth your baby with a little help—or a lot of help—from medicated pain relief, such as the very popular epidural (which leaves you with little or no pain during labor but allows you to remain awake during the entire process).

Which option is for you? To figure that out, look into them all. Read up on childbirth pain management (this section covers the gamut). Talk to your practitioner. Get insights from friends who have recently labored. Chat about it online. And then do some thinking. Remember that the right option for you might not be one option but a combination of several (reflexology with an epidural chaser, or a variety of relaxation techniques topped off with a round of acupuncture). Remember, too, the value of staying flexible—and not just so you can stretch yourself into some of those pretzel-like pushing positions you learned in childbirth class. After all, the option or options you settle on now may not sit well later, and may need to be adjusted mid-labor (you were planning on an epidural but found you could handle the pain—or vice versa). Most of all, remember that (assuming no medical circumstances end up getting in the way), it's your choice to make—your birth, your way. So read on before you belly up to the birthing bar.

Managing Your Pain With Medications

Here are the most commonly used labor and delivery pain medications:

Epidural. A full two-thirds of women delivering at hospitals choose to relieve their labor pain with an epidural. Why do so many laboring moms request the epidural by name? For one, it's an extremely safe way to net good pain relief—only a small amount of medication is needed to achieve the desired effect, and the drug barely reaches the bloodstream (unlike general anesthesia or tranquilizers), meaning your baby isn't affected. For another, it's relatively easy to administer (it's injected directly into the epidural space, which is between the ligament that sheathes the vertebrae and the membrane that covers the spinal cord) and it's very patient friendly (you'll likely get that sweet relief within 10 to 15 minutes). The pain relief is local, focused on the lower part of the body (where the pain is the greatest), allowing you to be an active participant during childbirth and completely alert when it's time to greet your baby bundle. What's more, an epidural can be given to you as soon as you ask for one (and an anesthesiologist is available to administer it)—no need to wait until you're dilated a certain amount. Happily, studies show that an early epidural doesn't increase the chances of a c-section.

Here's what you can expect if you're having an epidural:

- First, an IV of fluids is started to prevent a drop in blood pressure.
- In some hospitals (policies vary), a catheter (tube) is inserted into the bladder just before or just after the epidural is administered and stays in place to drain urine while the epidural is in effect (since you may not feel the urge

Pushing Without the Pain

Does pushing have to be a pain? Not always. In fact, many women find they can push very effectively with an epidural, relying on their coach or a nurse to tell them when a contraction is coming on so they can get busy pushing. But if pain-free pushing isn't getting you (or your baby) anywhere—with the lack of sensation hampering your efforts—the epidural can be stopped so you can feel the contractions. The medication can then be easily restarted after delivery to numb the repair of a tear, if necessary.

to pee). In other hospitals, the bladder is drained with a catheter as needed.

- Your lower and midback are wiped with an antiseptic solution, and a small area of the back is numbed with a local anesthetic. A needle is placed through the numbed area into the epidural space of the spine, usually while you're lying on your side or sitting up and leaning over a table or being supported by your coach or nurse. You may feel a little pressure as the needle is inserted or a little tingling or a momentary shooting pain. If you're lucky (and many women are), you might not feel a thing. Besides, compared to the pain of contractions, any discomfort from a needle poke is likely to be pretty minimal.
- The needle is removed, leaving a fine, flexible catheter tube in place. The tube is taped to your back so you can move from side to side. Three to 5 minutes after the initial dose, the nerves of the uterus begin to numb. Usually after 10 minutes, you'll begin to feel the full effect. The medication numbs the nerves in the entire lower part of the body, making it hard to feel any contractions at all (and that's the point).
- Your blood pressure will be checked frequently to make sure it's not dropping too low. IV fluids and lying on your side will help counteract a drop.
- Because an epidural is sometimes associated with the slowing of a baby's heartbeat, continuous fetal monitoring is usually required. Though such monitoring limits your movements somewhat, it allows your practitioner to monitor the baby's heartbeat and allows you to "see" the frequency and intensity of your contractions (because, ideally, you won't be feeling them).

There are few side effects with an epidural, though some women might experience numbness on one side of the body only (as opposed to complete pain relief). Epidurals also might not offer complete pain control if you're experiencing back labor (when the fetus is in a posterior position, with its head pressing against your back). And keep in mind that you won't be able to labor (or deliver) in water if you have an epidural.

Combined spinal epidural (aka "walking epidural"). The combined spinal epidural delivers the same level of pain relief as a traditional epidural, but uses a smaller amount of medication to reach that goal. Not all anesthesiologists or hospitals offer this type of epidural (ask your practitioner if it'll be available to you). The anesthesiologist will start you off with a shot of analgesic directly into the spinal fluid to help relieve some pain, but because the medication is delivered only in the spinal fluid, you'll still feel and be able to use the muscles in your legs, at least somewhat. When you feel you need more pain relief, more medication is placed into the epidural space (through a catheter inserted at

the same time the spinal medication was administered).

Keep in mind that the nickname walking epidural is misleading. Though you'll be able to move your legs, they'll probably feel weak, so it'll be unlikely you'll actually want to walk around.

Spinal block. Similar to the epidural, the spinal block is usually given just before delivery. It's faster acting and stronger than an epidural, but also lasts for a shorter time. Though it is primarily reserved for cesarean deliveries (if an epidural hasn't already been started and there's less time to spare) it can also be used in a vaginal birth if mom is in the market for speedy pain relief as she closes in on delivery. Like the epidural, this regional block is administered by an anesthesiologist while you're sitting or lying on your side, but unlike the epidural, no catheter is left in place—it's given as a 1-dose injection directly into the fluid surrounding the spinal cord.

Pudendal block. A pudendal block is usually reserved for the vaginal delivery itself. Administered through a needle inserted into the vaginal area, the medication reduces pain in the region but not uterine discomfort. It's useful when forceps or vacuum extraction is used, and its effect can last through the repair of a tear or an episiotomy (if needed).

General anesthesia. General anesthesia is used rarely, only in specific cases for emergency surgical births. An anesthesiologist injects drugs that put you to sleep into an IV.

The major downside to general anesthesia (besides the fact that mom has to miss the birth) is that it sedates the baby along with the mother. The medical team will minimize those sedative effects by administering the anesthesia as close to the actual birth as possible. That way the baby can be delivered before the anesthetic has reached him or her in amounts large enough to have an effect. When you come to, you may be groggy, disoriented, and restless. You may also have a cough and sore throat (due to the tube that's routinely inserted through the mouth into the throat) and experience nausea and vomiting (though it's less likely if you were given anti-nausea medications in your IV).

Demerol. This IV-administered drug, which dulls pain and induces a relaxed state, isn't often used anymore, but can be useful in certain circumstances—as when a laboring mom needs short-term help coping with contractions. Demerol can be repeated every 2 to 4 hours, as needed. Keep in mind, though, that if you want to be "present" during labor, this probably isn't the pain relief for you. Many women don't like that drugged, drowsy feeling, and some find they are actually less able to cope with labor pain while under the effects of Demerol. There may also be some side effects, including nausea, vomiting, and a drop in blood pressure. And if Demerol is given to a mom too close to delivery, her baby may be sleepy and unable to suck at birth. Less frequently, baby's breathing may be depressed and supplemental oxygen may be required. Any effects on the newborn are generally short term and can be treated.

Nitrous oxide. This dentist office staple, more commonly known as laughing gas, doesn't eliminate pain (and it definitely won't make you break out in giggles), but it does take the edge off contractions and could be a good alternative for women who choose not to go for an epidural. You're able to self-administer the laughing gas during labor—taking a few puffs when you feel you need a little relief and setting it aside when you don't. Not all doctors and hospitals offer laughing gas, so ask ahead if you're considering it.

Moms in Recovery

If you're in recovery, you'll want to discuss the best pain-relief strategy during labor, delivery, and postpartum, and to make sure hospital staff is aware that medications should be administered judiciously.

Tranquilizers. These drugs (such as Phenergan and Vistaril) are used to calm and relax an extremely anxious mom-to-be so that she can actively participate in the process of labor instead of fighting it. Like analgesics, tranquilizers are usually administered once labor is well established, and well before delivery. But they are occasionally used in early labor if a mother's anxiety is slowing down the progress of her labor. Some women welcome the gentle drowsiness, while others find it keeps them from feeling in control, and also dims the memory of this memorable experience. Dosage definitely makes a difference. A small dose may relieve anxiety without impairing alertness. A larger dose may cause slurring of speech and dozing between contraction peaks, making it difficult to use breathing and relaxation techniques learned in childbirth class. Though the risks to a fetus or newborn from them are minimal, most practitioners prefer to stay away from tranquilizers unless they're really necessary. If you think you might be extremely anxious during labor, you may want to try learning some nondrug relaxation techniques now, so you won't end up needing this kind of medication.

Managing Your Pain with CAM

Not every mom-to-be wants traditional pain medication, but most still want their labor to be as comfortable as possible. And that's where natural childbirth techniques (see page 304) or complementary and alternative medicine (CAM) therapies (or both!) can come in—either as alternatives to pain medication or as relaxing supplements to it. Even if you're sure there's an epidural with your name on it waiting at the hospital, you may want to explore the world of CAM, too. (And to explore it well before your due date, since many of the techniques take practice—or even classes—to perfect.) But remember to seek out CAM practitioners who are licensed, certified, and have plenty of labor and delivery experience.

Acupuncture and acupressure. These techniques can be effective forms of pain relief. Researchers have found that acupuncture, through the use of needles inserted in specific locations, triggers the release of several brain chemicals, including endorphins, which block pain signals, relieving labor pain—and maybe even helping boost labor progress. Acupressure works on the same principle as acupuncture, except that instead of poking you with needles, your practitioner will use finger pressure to stimulate the points. Acupressure on the center of the ball of the foot is said to help back labor. If you're planning to use either during labor, let your prenatal practitioner know that your CAM practitioner will be attending, too (these techniques are not DIY).

Reflexology. Reflexologists believe that the internal organs can be accessed through points on the feet. By massaging the feet during childbirth, a reflexologist can relax the uterus and stimulate the pituitary gland, apparently reducing the pain of childbirth and even shortening labor. Some of the pressure points are so powerful that you should

avoid stimulating them unless you are in labor (or are overdue). Again, if you're using reflexology you'll need to let your prenatal practitioner know that your reflexology practitioner will be joining you in labor.

Physical therapy. From massage and hot compresses to ice packs and intense counterpressure on your sore spots, physical therapy during labor can ease a lot of the pain you're feeling. Massage at the hands of a caring coach or doula or a skilled health professional can bring relaxing relief and help diminish pain.

Hydrotherapy. This one's easy: Just settle into a jetted tub (or a soaking tub) for a session of hydrotherapy during your labor to reduce pain and relax. Many hospitals and birthing centers provide tubs to labor—or even deliver—in. No tub available? You can try a warm shower for some relief. For more on water births, see page 326.

Hypnobirthing. Though hypnosis won't mask your pain, it can get you so deeply relaxed that you are totally unaware of any discomfort. Hypnosis doesn't work for everyone—for the fullest effect, you have to be highly suggestible. Some clues that your mind will be open to hypnosis: You have a long attention span and a rich imagination, you're able to tune out activity and noise around you, and you enjoy alone time. More and more expectant moms are signing up for hypnobirthing classes so they can learn the techniques necessary to self-hypnotize themselves through labor and delivery, though you can also hire a medically trained hypnotherapist to be by your side through childbirth. Just keep in mind that hypnobirthing isn't something you can opt into when that first contraction hits. You'll have to practice plenty during pregnancy to be able to achieve total relaxation, even with a therapist guiding you. One big benefit of hypnobirthing: While you're completely relaxed, you're also completely aware of every moment of your baby's birth. For more information, go to hypnobirthing.com.

Distraction. If you took a childbirth education class such as Lamaze, you may have learned about directing your attention to a focal point to manage your pain. The idea is to concentrate on something other than the contractions, so that you're not focused on the pain. Distraction works the same way. Anything that takes your mind off the pain—watching TV, playing games on your phone, listening to music, meditating—can decrease your perception of it. So can focusing on an object (an ultrasound picture of your baby, a soothing landscape, a photo of a favorite place). Visualization exercises can help, too (for instance, picturing your baby being pushed gently by contractions, moving peacefully through your birth canal).

Transcutaneous electrical nerve stimulation (TENS). This technique uses electrodes that deliver low-voltage pulses to stimulate nerve pathways to the uterus and cervix, in theory blocking pain. Studies aren't clear on whether TENS is really effective at reducing labor pain, but if you're interested, ask your practitioner if it's an option for you.

Just Breathe

Hoping to skip the meds but can't—or don't want to—go the CAM route? Lamaze (or other kinds of natural childbirth techniques) can be very effective in managing the pain of contractions. See page 304 for more.

Labor Disputes

Maybe you're not technically a mommy yet—or a daddy—but that probably doesn't mean you don't already have some pretty definite ideas about how you'd like to parent when the time comes (soon!): Breast or bottle? Stay-at-home or back-to-work? Baby-wearing or strollers? Separate sleep or co-sleep? And you've probably also noticed that these and other hot button topics capture a lot of social media attention, the good, the bad, and especially, the judgey. But you may also find that these so-called mommy wars extend to labor choices, too, pitting home-birth moms against hospital-birth moms, unmedicated-birth moms against moms who opt for an epidural, VBAC moms against moms who sign up for a second c-section. Guilt? There's plenty of that to go around ("You didn't even *try* to labor first?"), plus a fair amount of shaming and finger wagging ("What? You let your doctor induce you?").

But the truth is—and it's a truth that really deserves to go viral—there's room for every safe childbirth choice in the birthing room, but there should be no room for judging. Every mom and dad, every labor, every situation is different—and what works for one doesn't necessarily fly with the next. The bottom line that matters, as always, is a healthy mom-and-baby bottom line—and any choice or circumstance that delivers a safe delivery is a good one. And there's no disputing that.

Making the Decision

You now have the lowdown on pain management and pain relief options for labor and delivery—the information you'll need to make an informed decision. But before you decide what's best for you and your baby, you should:

- Discuss pain management and relief options with your practitioner well before that first contraction kicks in. Ask about the options you're considering, what side effects may be experienced when using medication options, under what circumstances medication may be absolutely necessary, and when the choice is all yours.
- Consider keeping an open mind. Though it's smart to think ahead about what might be best for you under certain circumstances, it's impossible to predict what kind of labor and delivery you'll have, and whether or not you'll want or need medication—or even if you'll have access to the type of pain relief you're hoping for. Even if you're absolutely convinced that you'll want an epidural, you may not want to close the door on some CAM approaches. After all, your labor may turn out to be more manageable (or a lot shorter) than you'd thought. And even if you're sold on a med-free delivery, you may want to think about leaving the medication window open—even just a crack—in case your labor turns out to be tougher than you'd bargained for.

Most important, remember, as you sort through all your options, to keep your eye on the bottom line—a bottom line that has a really cute bottom. After all, no matter how you end up managing the pain of childbirth—and even if you don't end up managing it the way you'd planned to or the way you'd really hoped to—you'll still manage to give birth to your baby. And what could be a better bottom line than that?

CHAPTER 12

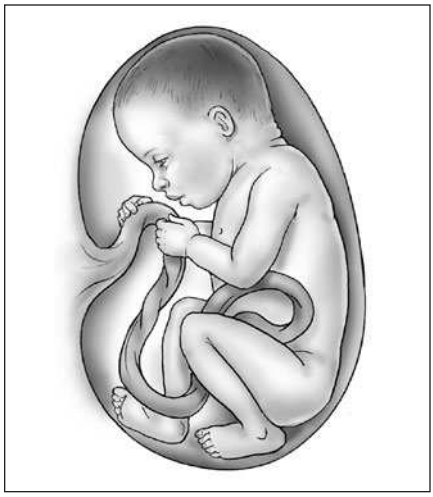
The Eighth Month

Approximately 32 to 35 Weeks

In this next-to-last month, you may still be loving every expectant moment, or you may be growing weary of, well, growing. Either way, you're sure to be preoccupied with—and super excited about—the much-anticipated arrival of your baby. Of course, along with that heaping serving of excitement, you and your partner may also be experiencing a side of trepidation—especially if this is your first foray into parenthood. Talking those very normal feelings through—and tapping into the insights of friends and family members who've preceded you into parenthood—will help you realize that everyone feels that way, particularly the first time around.

Your Baby This Month

Week 32 This week your baby is tipping the scales at almost 3½ to 4 pounds (about a half gallon of milk) and topping out anywhere from 15 to 17 inches. And growing isn't the only thing on your little one's agenda these days. While you're busy getting everything ready for baby's arrival, baby's busy prepping for that big debut, too. In these last few weeks, it's all about practice, practice, practice, as baby hones the skills needed to survive outside the womb, from swallowing and breathing to kicking and sucking. And speaking of sucking, your little one has been able to suck on a sweet little thumb for a while now. Another change this week: Your baby's skin is



Your Baby, Month 8

no longer transparent. As more and more fat accumulates under the skin, it's finally opaque.

Week 33 Baby's gaining weight almost as fast as you are these days (averaging out to about half a pound a week), which puts the grand total so far at more than 4¼ pounds. Still, your baby has plenty of growing to do. He or she may grow a full inch this week alone and may come close to doubling in weight by birth day. And with that much baby inside your uterus now, your amniotic fluid level has maxed out (there's no room for more fluid). Which explains why those pokes and kicks are sometimes extremely uncomfortable: There's less fluid to cushion the pushing. Antibodies are also being passed from you to baby as your little one continues to develop an immune system of his or her very own. These antibodies will definitely come in handy on the outside and will protect your baby-to-be from a world of germs.

Week 34 Your baby could be as tall as 17 to 18 inches right now and weigh nearly 5 pounds—as much as a bag of sugar, only much sweeter. Got male (a male baby, that is)? If you do, then this is the week that his testicles are making their way down from his abdomen to their final destination: his scrotum. (About 3 to 4 percent of boys are born with undescended testicles, which is nothing to worry about—they usually make the trip down south before the first birthday.) And in other baby-related news, those tiny fingernails have probably reached the tip of those little fingers by this week, so make sure you have baby nail clippers on your shopping list!

Week 35 Your baby stands tall this week—if he or she could stand, that is—at about 18 inches, and continues to follow the half-pound-a-week plan, weighing in at about 5¼ big ones. While growth will gradually taper off when it comes to height (the average full-termer is born at about 20 inches), your baby will continue to pack on the pounds until delivery day. Something else he or she will be packing on in the few weeks that remain are brain cells. Brain development continues at a mind-boggling pace, making baby a little on the top-heavy side. And speaking of tops, it's likely your baby's bottom is. Most babies have settled into a head-down, bottoms-up position in mom's pelvis by now, or will soon. That's a good thing, since it's easier on you if baby's head (the biggest part of his or her body) exits first during delivery. Here's another plus: Baby's head may be big, but it's still soft (at least, the skull is), allowing that tight squeeze through the birth canal to be a little less tight.

Your Body This Month

Here are some symptoms you may experience this month (or may not experience, since every pregnancy is different). Some of these symptoms may be continuing from last month, while others may be new to the list. Chances are as your baby load grows and grows, so will your symptom load (or overload)—with the discomforts of late pregnancy multiplying.

Physically

- Strong, regular fetal activity
- Increasing vaginal discharge
- Constipation
- Heartburn, indigestion, flatulence, bloating
- Occasional headaches
- Occasional lightheadedness or dizziness, especially when getting up quickly or when your blood sugar dips
- Nasal congestion and occasional nosebleeds; ear stuffiness
- Sensitive gums that may bleed when you brush
- Leg cramps
- Backache
- Achiness in the lower abdomen or along both or either sides
- Occasional, sudden sharp or shock-like sensations in the pelvic area (aka "lightning crotch")
- Mild swelling of ankles and feet, and occasionally of hands and face
- Varicose veins in legs and/or vulva
- Hemorrhoids
- Itchy belly
- Protruding navel (a popped-out belly button)
- Stretch marks
- Increasing shortness of breath as the uterus crowds the lungs

Your Body This Month

An interesting bit of pregnancy trivia: Measurement in centimeters from the top of your pubic bone to the top of your uterus roughly correlates with the number of weeks you're up to—so, at 34 weeks, your uterus measures close to 34 cm from the pubic bone.

- Difficulty sleeping
- Increasing Braxton Hicks contractions (see question, below)
- Clumsiness
- Enlarged breasts
- Colostrum, leaking from nipples (though this premilk may not appear until after delivery)

Emotionally

- Increasing eagerness for the pregnancy to be over
- Apprehension about labor and delivery
- Increasing absentmindedness
- Jitters about becoming a parent
- Excitement—at the realization that it won't be long now

What You Can Expect at This Month's Checkup

After the 32nd week, your practitioner may ask you to come in every 2 weeks so your progress and your baby's can be more closely watched. You can probably expect the following:

- Weight and blood pressure
- Urine, for protein
- Fetal heartbeat
- Height of fundus (top of uterus)
- Size (you may get a rough weight estimate) and position of the fetus, by palpation (feeling from the outside)
- Feet and hands for swelling, and legs for varicose veins
- Group B strep culture at 35 to 37 weeks (see page 359)
- Symptoms you have been experiencing, especially unusual ones
- Questions and problems you want to discuss—have a list ready

What You May Be Wondering About

Braxton Hicks Contractions

"Every once in a while my uterus seems to bunch up and harden. What's going on?"

It's practicing. With delivery right around the corner, your body is warming up for the big day by flexing its muscles—literally. Those uterine calisthenics you're feeling are called Braxton Hicks contractions—practice-for-labor contractions that usually begin sometime after the 20th week (though they're more noticeable in the last few months of pregnancy). They play a part in pumping up blood flow to the placenta (get ready), toning the muscles of the uterus (get set),

and softening the cervix (go . . . soon). These rehearsal contractions (typically experienced earlier and with more intensity in second and subsequent pregnancies) feel like a tightening sensation that begins at the top of your uterus and then spreads downward, lasting from 15 to 30 seconds, though they can sometimes last as long as 2 minutes or more. If you check out your bump while you're having a Braxton Hicks, you might even be able to see what you're feeling: Your usually round belly might appear pointy or strangely bunched up. Weird to watch, but normal.

Though Braxton Hicks contractions are not true labor, they may be difficult to distinguish from real labor—especially as they become more intense, which they often do as pregnancy edges to a close. You may notice them more often when you've got a full bladder, if you're dehydrated, after sex, when you or baby are very active, or even when someone touches your belly. And though they're not efficient enough to deliver your baby (even when they get really uncomfortable), they may give you a leg up on labor by getting effacement and early dilation of the cervix started when the time is right.

To relieve any discomfort you may feel when you're getting a Braxton Hicks, try changing your position—lying down and relaxing if you've been on your feet, or getting up and walking around if you've been sitting. A warm bath may also help relieve discomfort. A drink of water may help, too. You can also use this labor rehearsal to practice your breathing exercises and the various other childbirth techniques you've learned, which can make the real contractions easier to deal with when they do arrive.

If the contractions don't subside with a change in activity, and if they become progressively stronger and more regular (especially if you feel pressure in your lower back), you may be in real labor, so be sure to put in a call to your practitioner. A good rule of thumb: If you have more than 4 Braxton Hicks in an hour, call your practitioner and let him or her know. If you're having a hard time distinguishing Braxton Hicks contractions from the real thing—especially if this is your first pregnancy and you've never experienced the real thing—give your practitioner a call, being sure to describe exactly what you're feeling.

Aching Ribs

"I keep feeling a dull achy pain on my side, near my rib cage—almost like my ribs are bruised. Is that because the baby is kicking me?"

It may be yet another in the long list of pregnancy pains that have been kicking you in the butt these days—but you can't blame baby's kicking for this pain in your ribs. No, those achy-breaky ribs are courtesy of pregnancy hormones, which have been loosening the joints in the area. In some moms-to-be this loosening causes the ribs to bow out (called subluxated ribs), to make room for expanded lungs (which need extra oxygen) and an ever-expanding uterus. You may also be feeling the ache because of inflammation of the cartilage attached to the ribs as they loosen and expand (and possibly because of the pressure placed on the ribs by your uterus or larger-than-usual breasts), or rarely, because of a dislocated rib (again, because of rib expansion to accommodate your pregnancy).

There is some relief in sight: Your ribs may feel less stretched—and less achy—during the last few weeks of pregnancy, when your baby moves down into position for birth—and of course once you deliver. Until then, keep the clothes you're wearing loose so you're

not putting more pressure on those aching ribs, especially when you're sleeping (or trying to sleep). A pregnancy belly-support band can help to evenly distribute the weight of your growing belly, removing the strain off the muscles of the abdomen, which pull on the ribs and cause rib pain. Shifting positions may also lessen your discomfort, as may a warm bath or a heating pad placed over your clothes. Nothing working? Acetaminophen (Tylenol) can help ease the ache. And be sure to avoid heavy lifting, which can make it worse (and which you shouldn't be doing now anyway).

"Sometimes I get the feeling like my baby has jammed his feet up into my rib cage, and it hurts."

Occasionally, a baby will manage to wedge a foot into his mama's ribs—and that's one kind of rib tickling that doesn't tickle. You may be able to change baby's position by changing yours, or by bouncing on a birthing ball. Or, you can also try a gentle nudge or a few pelvic tilts to dislodge that little foot. Or try this mama move: Sit up straight and take a deep breath while you raise one arm over your head, then exhale while you drop your arm and repeat with the other arm. Baby's not budging, at least not for long? Sometimes the rib jamming becomes chronic, lasting until your little pain-in-the-ribs engages, or drops into your pelvis, which usually happens 2 or 3 weeks before delivery in first pregnancies (though often not until labor begins in subsequent ones).

Shortness of Breath

"Sometimes I have trouble breathing, even when I'm just sitting doing nothing. Does that mean my baby isn't getting enough oxygen?"

It's not surprising you're feeling a little spare on air these days. Your ever-expanding uterus is now crowding out all your other internal organs in an effort to provide spacious-enough accommodations for your ever-growing baby. Among those organs feeling the crunch are your lungs, which your uterus has compressed, limiting their ability to expand fully when you take a breath. This, teamed with the extra progesterone that has already been leaving you breathless for months, explains why a trip upstairs these days can make you feel as if you've just run a marathon (winded, big time). Fortunately, while this shortness of breath may feel uncomfortable to you, it doesn't bother your baby in the least. Your little one is kept well stocked with all the oxygen he or she needs through the placenta—no breathing, deep or otherwise, needed.

Some relief from that winded feeling usually arrives toward the end of pregnancy, when your baby drops into your pelvis in preparation for birth (in first pregnancies this generally occurs 2 to 3 weeks before delivery, in subsequent deliveries often not until labor begins). Until then, be sure to take it easy and slow down, decreasing the amount of work your lungs have to do. You may find it easier to breathe if you sit straight up instead of slumped over and sleep in a semi-propped position, bolstered by 2 or 3 pillows. When you're feeling especially breathless, lift your arms over your head to take pressure off your rib cage so you can breathe in more air. Try some breathing exercises as well: Breathe in slowly and deeply, making sure your rib cage—not your abdomen—is expanding (put your hands on the sides of your rib cage and make sure the ribs push out against your hands as you inhale deeply). Breathe out slowly and deeply, feeling the contraction of your rib cage. Return to this type

Choosing a Pediatrician

Choosing a pediatrician (or a family practitioner) is one of the most important decisions you'll make as a parent—and actually, one you shouldn't wait until you become a parent to make. Sifting through your choices and making your selection now, before your baby starts crying inexplicably at 3 a.m., will ensure that your transition to parenthood is that much easier. It will also allow for an informed—not rushed—decision.

If you're not sure where to begin your search, ask your practitioner for a referral (if you've been generally happy with the care you've been getting during pregnancy) or poll friends, neighbors, or coworkers who have young children for their favorite pediatricians. You can also look online for local pediatrician groups (though online listings of physicians are not always accurate) or local parent groups to ask for their recommendations. Or contact the hospital or birthing center where you'll be delivering (you can call the labor and delivery floor or pediatrics, and ask a nurse on duty for some suggestions—no one gets a better look at doctors than nurses do). Of course, if you're on a health insurance plan that limits your choices, you'll have to pick from that list.

Once you've narrowed your options to 2 or 3, call for consultations—most pediatricians or family practitioners will oblige. Bring a list of questions about issues that are important to you, such as office protocol (for instance, whether there are call-in hours for parents or when you can expect calls to be returned), breastfeeding support, circumcision, the use of antibiotics, whether the doctor handles all well-baby visits or if they're typically handled by nurse-practitioners in the practice. Also important to know: Is the doctor board certified? Which hospital is the doctor affiliated with, and will he or she be able to care for the newborn in the hospital? For more questions to ask and issues to consider, check out *What to Expect the First Year*.

of deep breathing whenever you feel a little breathless.

Sometimes breathlessness can be a sign that iron stores are low, so check in with your practitioner about it. Call 911 or head to the ER if shortness of breath is severe and accompanied by rapid breathing, blueness of the lips and fingertips, sweating, chest pain, and/or rapid pulse.

Morning Sickness, Again

"I've been feeling nauseous again recently, but I thought that was only a first trimester pregnancy symptom."

Feel like you've seen this movie before—and aren't happy to see a sequel? While first trimester morning sickness definitely gets more attention (and more expectant sufferers), for some mamas-to-be, the third trimester variety can cause just as much misery, sometimes even more. Especially discouraging if you thought you'd seen the last of that nausea and vomiting, at least in this pregnancy.

Remember those pregnancy hormones you blamed for your first trimester morning sickness? You can blame them again—along with your ever-growing uterus, which has been crowding out your digestive tract, causing stomach acids to bubble back up the esophagus,

leading to reflux and a return of nausea. With less space to hold your meals and no easy way to digest them, extra food often has nowhere to go, other than up and out (another case for grazing on mini-meals). Braxton Hicks contractions can also unsettle your stomach, sometimes causing stomach cramps and even vomiting.

Try combating this pregnancy queasiness with the tips for early pregnancy morning sickness (see page 132) and heartburn (page 159). And be sure to stay hydrated—especially if you've been vomiting. Dehydration is never safe when you're expecting, but it's especially unsafe in late pregnancy, since dehydration can lead to preterm contractions.

Mention your queasiness to your practitioner, too. He or she might suggest antacids or anti-nausea meds if it's really bad. Your practitioner should also be able to rule out other, less likely reasons for this late-onset nausea and vomiting, including preeclampsia and preterm labor.

Lack of Bladder Control

"I watched a funny movie last night and noticed I was peeing myself a little every time I laughed. What is that about?"

It's called stress incontinence—appropriately, since it can really stress a mama out. This sudden, often inconvenient, and embarrassing loss of bladder control—which can cause you to spring a small leak when you cough, sneeze, lift something heavy, or even laugh (though there's nothing funny about that)—is the result of the mounting pressure of your growing uterus on your bladder. Some expectant moms also experience urge incontinence, the overwhelming, seemingly out-of-nowhere need to pee (gotta go *now*!) during late pregnancy. Try these tips to help prevent or control stress or urge incontinence:

- Empty your bladder as completely as possible by leaning forward each time you pee.
- Practice your Kegels. Being faithful to your Kegels will help prevent or correct most cases of pregnancy-induced incontinence—plus, looking ahead, they'll also help prevent postpartum incontinence of both the urinary and fecal variety. For a Kegel how-to, see page 229.
- Do Kegels or cross your legs when you feel a cough, sneeze, or laugh coming on, or the urge to pee coming on.
- Wear a panty liner if you need one or you're afraid you'll need one. Graduate to a maxipad (or bladder control pad) when leaks might be especially inconvenient.
- Stay as regular as you can, because impacted stool can put pressure on the bladder. Also, straining hard when you're pooping can weaken pelvic floor muscles. For tips on fighting constipation, see page 185.
- If it's the urge that's driving you crazy (and always sending you to the bathroom in a hurry), try training your bladder. Urinate more frequently—about every 30 minutes to an hour—so that you go before you feel that uncontrollable need. After a week, try to gradually stretch the time between bathroom visits, adding 15 minutes more at a time.
- Continue drinking enough fluids, even if you experience stress incontinence or frequent urges. Limiting your fluid intake will not limit leaks, and it may lead to a UTI and/or dehydration. Not only can both of these lead to a lot of other problems

(including preterm contractions), but UTIs can make stress and urge incontinence worse. See page 528 for tips on keeping your urinary tract healthy.

To be sure that the leak you've sprung is urine (which it almost certainly is) and not amniotic fluid, it's smart to give it the sniff test. If the liquid that has leaked doesn't smell like urine (urine smells ammonia-like, while amniotic fluid has a sweet smell), let your practitioner know as soon as possible.

How You're Carrying

"Everyone says I seem to be carrying small for the 8th month. My midwife says everything's fine, but is it possible my baby's not growing as fast as she should?"

The truth is, you can't tell a baby by her mom's belly. How you're carrying has much less to do with the size of your baby and much more to do with these factors:

- Your own size, shape, and bone structure. Bumps come in all sizes, just like expectant moms do. A petite mom may carry more compactly (small, low, and out in front) than a larger mom—or she may seem to be carrying "larger" in comparison to her slighter scale. A bigger-boned mom may have less to show bump-wise, simply because there's more area for her uterus and her baby to spread out in. Same for some very obese women—with so much room in an already ample abdomen, these moms-to-be may never seem to "pop" at all.
- Your muscle tone. A mom-to-be with very tight muscles may not show as soon or as much as one whose muscles are slacker. For that reason, and because each baby tends to end up a little larger than the last, second- and more-time moms tend to end up a bit larger, too.
- Your baby's position. How your fetus is positioned on the inside may also affect how big or small you look on the outside.
- Your weight gain. A bigger weight gain doesn't necessarily predict a bigger baby, just a bigger mom. If you've kept your weight gain within recommended guidelines, you may appear smaller because you're sporting less fat, not because you're carrying less baby.

The only assessments of a baby's size that are worth paying attention to are the ones you get from your practitioner—not the ones you get from your sister-in-law, your coworkers, social media buddies commenting on your bump selfies, or know-it-all nosey-bodies in the supermarket checkout line.

Oh, My Aching Pelvic Bones

Does your pelvis sometimes feel as if it's coming apart at the seams— with wrenching pain in the pubic area (or in the perineum or upper thighs) that makes walking agonizing and climbing stairs or getting in and out of the car excruciating? You may have what's called pelvic girdle pain or symphysis pubis dysfunction—a surprisingly common and unexpectedly painful condition that affects up to 25 percent of moms-to-be, usually late in the last trimester, as ligaments that normally keep the pelvic bone aligned become over-relaxed and stretchy in preparation for labor. To find out how to deal with this often debilitating pain, see page 561.

The Gender Guessing Game

All belly and glowing skin? You're having a boy. Spreading hips, nose, and zits? It's a baby girl on board. If you've opted out of the gender reveal, you've probably generated plenty of predictions on your baby's sex based entirely on how you're carrying, how you're feeling, and how you're looking. Just remember that those predictions—by old wives or others—have about a 50 percent chance of coming true. (Actually, a little better than that if a boy is predicted, since 105 boys are born for every 100 girls.)

In other words, keep them guessing.

In other words, it's what's inside that counts—and apparently, what's inside your little bump is a baby who's plenty big enough.

Your Size and Your Delivery

"I'm tiny, just 5 feet tall—and I'm wondering whether that'll make it harder for me to deliver vaginally."

Size matters when it comes to birthing your baby—but inside size, not outside size. It's the internal numbers—the size and shape of your pelvis in relation to the size of your baby's head—that determine how difficult (or easy) your labor will be, not your height or your build. A petite mom can have a roomier (or more accommodatingly configured) pelvis than a plus-size mom—or she can have a baby with an easier-to-fit head.

How will you know what size your pelvis is (after all, it doesn't come labeled)? Your practitioner can make an educated guess about its size, usually using rough measurements taken at your first prenatal exam. Your baby's size will be approximated, too, as your due date approaches. If there's some concern that your baby's head is too large to fit through your pelvis, ultrasound may be used to get a better view (and measurement).

Of course, in general, the overall size of the pelvis, as of all bony structures, is smaller in people of smaller stature. But that's the genius of genetics: Nature doesn't typically present a tiny mom with giant offspring. Instead, babies are usually pretty well matched to mom's size and the size of her pelvis—even if they are destined for bigger things later on. And chances are, your baby will be just the right size for you.

Your Weight Gain and the Baby's Size

"I've gained so much weight that I'm afraid my baby will be huge and hard to deliver."

Just because you've gained a lot of weight doesn't necessarily mean your baby has. Your baby's weight is determined by a number of variables: genetics, your own birthweight (if you were born large, your baby is more likely to be, too), your prepregnancy weight (heavier women tend to have heavier babies), and the quality of your pregnancy diet. Depending on those variables, a 35- to 40-pound weight gain can yield a 6- or 7-pound baby and a 25-pound weight gain can net an 8-pounder. On average, however, the more substantial the weight gain, the bigger the baby. Moms who have GD that isn't well controlled may also be more likely to have a very large baby.

By palpating your abdomen and measuring the height of your fundus (the top of the uterus), your practitioner will be able to give you some idea of your baby's size, though such guesstimates can be off by a pound or more. An ultrasound can gauge size more accurately, but it may be off the mark, too.

Even if your baby does turn out to be on the big side, that doesn't automatically predict a difficult delivery. Though a 7-pound baby often makes its way out faster than a 10-pounder, most women are able to deliver a large baby (or even an extra-large baby) vaginally and without complications. The determining factor, as in any delivery, is whether your baby's head (the largest part) can fit through your pelvis.

Baby's Position

"How can I tell which way my baby is facing? I want to make sure he's the right way for delivery."

Playing "name that bump" (trying to figure out which are shoulders, elbows, bottom) may be endlessly entertaining, but it's not the most accurate way of figuring out your baby's position. Your practitioner will be able to give you a better idea by palpating your abdomen for recognizable baby parts. The location of the baby's heartbeat is another clue to its position: If the baby's presentation is head first, the heartbeat will usually be heard in the lower half of your abdomen—and it will be loudest if the baby's back is toward your front. If there's still some doubt, an ultrasound offers the most reliable view of your baby's position.

Still can't resist a round of your favorite evening pastime (or resist patting those round little parts)? Play away—and to make the game more interesting (and to help clue you in), try looking for these markers next time:

- Baby's back is usually a smooth, convex contour opposite a bunch of little irregularities, which are the "small parts"—hands, feet, elbows.
- Sometime around the 8th month, baby's head usually settles near mom's pelvis—it is round, firm, and when pushed down bounces back without the rest of the body moving.
- Baby's bottom is a less regular shape, and softer, than the head.

Bottoms up—hopefully!

Breech Baby

"At my last prenatal visit, my doctor said he felt my baby's head up near my ribs. Does that mean she's breech?"

Even as her accommodations become ever more cramped, your baby will still manage to perform some pretty remarkable gymnastics during the last weeks of her stay. In fact, although most fetuses settle into a head-down position between weeks 32 and 38 (breech presentations occur in fewer than 5 percent of full term pregnancies), some don't let on which end will ultimately be up until a few days before birth. Which means that just because your baby is bottoms down now doesn't mean she will be breech when it comes time for delivery.

What if your baby does stubbornly remain breech as delivery approaches? Keep reading to find out.

"If my baby is breech, can anything be done to turn him?"

There are several ways to try to coax a bottoms-down baby bottoms up. On the low-tech side, your practitioner may recommend simple exercises (like

Face Forward

It's not just up or down that's important when it comes to your baby's position—it's also front or back. If baby's facing your back, chin tucked onto chest (as most babies end up), you're in luck. This so-called occiput anterior position is ideal for birth, because your baby's head is lined up to fit through your pelvis as easily and comfortably as possible, smallest head part first. If baby's facing your tummy (called occiput posterior, but also known by the much cuter term "sunny-side up"), it's a setup for back labor (see page 401), because his or her skull will be pressing on your spine. It also means your baby's exit might take a little longer.

As delivery day approaches, your practitioner will try to determine which way (front or back) your baby's head is facing—but if you're in a hurry to find out, you can look for these clues: When your baby is occiput anterior (face toward your back), your belly will feel hard and smooth (that's your baby's back). If your little one is posterior, your tummy may look flatter and softer because your baby's arms and legs are facing forward, so there's no hard, smooth back to feel.

Do you think—or have you been told—that your baby is posterior? Don't worry about back labor yet. Most babies turn accommodatingly to the anterior position during labor. Some midwives recommend giving baby a nudge before labor begins by getting on all fours and doing pelvic rocks. Others suggest placing warm towels on mom's back and cold ones on her tummy because babies naturally turn away from cold. These tactics can also be tried during labor. Whether they can successfully flip a baby is unclear, but they can't hurt. And who knows—they could help relieve any back pain you have now.

the ones described in the box on page 350). Two other options come from the CAM camp. One is moxibustion (see page 79), which uses a form of acupuncture and burning herbs to help turn a fetus (although, studies show, with a low success rate). The other is the Webster technique (as well as other chiropractic maneuvers; see page 79). Clearly, it's important to use a CAM practitioner who is experienced and has had plenty of success using these therapies to turn breech babies, and to make sure your practitioner is on board with the therapy you're considering.

If your baby seems determined not to budge, your practitioner may suggest a somewhat higher-tech yet hands-on approach to manipulating your baby into the coveted heads-down position: external cephalic version (ECV). ECV is usually performed around weeks 36 to 38 or very early in labor when the uterus is still relatively relaxed and before mom's membranes have ruptured. It's always done in a hospital, in case an emergency c-section is needed (which happens rarely). Since an ample amount of amniotic fluid is necessary to help facilitate a safe ECV, levels are checked first via ultrasound. Ultrasound may also be used to guide the doctor during ECV, and baby's heart rate will be watched with an electronic fetal monitor to make sure he's doing well before and after the procedure. Medication may be given to prevent contractions, so the uterus

stays relaxed, and you may also get an epidural (which not only prevents any pain but also keeps the uterus relaxed, apparently boosting the odds of ECV success). Your practitioner will apply his or her hands to your abdomen, one near baby's head, one near baby's bottom (you'll feel some pressure, and possibly some discomfort, though not if you've had an epidural) and try to gently turn your little one around.

ECV is successful in nearly two-thirds of attempts. The success rate is even higher for those who have an epidural as well as those who have delivered before (thanks to those more lax uterine and abdominal muscles), but it's slightly lower for obese women, since abdominal padding can make maneuvering baby more challenging. The more experience a doctor has in turning babies, the better the success rate generally is (some doctors have a rate as high as 90 percent). And happily the complications rate is low across the board (less than 1 percent for serious complications that might lead to an emergency c-section). Some babies refuse to turn at all (though often a doctor will suggest multiple attempts), and a small number of contrary fetuses turn and then flip back into a breech position (in which case, your doctor might also suggest trying again).

Having multiples? You're most likely not a candidate for ECV. Ditto if you had a prior c-section.

"If my baby stays in a breech position, will I still be able to try for a vaginal birth?"

Whether you'll be able to give vaginal birth a chance will depend on a variety of factors, including your practitioner's policy and your situation. Most obs routinely perform a c-section when a baby refuses to budge out of a breech position, because many studies have suggested it's a safer way to go. There are some doctors and midwives, however, who feel it's reasonable to attempt a vaginal delivery in certain circumstances, especially if they're experienced delivering breech babies vaginally. The best-case circumstance: when a baby is in a frank breech position (buttocks first, with legs straight up and flat against his or her face) and it's clear that mom's pelvis is roomy enough to accommodate a vaginal delivery.

The bottom line if your baby remains bottom down: You'll need to be flexible in your childbirth plans. Even if your practitioner green-lights a trial of labor, it's just that—a trial. If your breech baby doesn't move down the birth canal, or if other problems come up, you'll likely wind up having a c-section. Talk the options over with your practitioner now so you'll be prepared for any possibility come delivery day.

Other Unusual Presentations

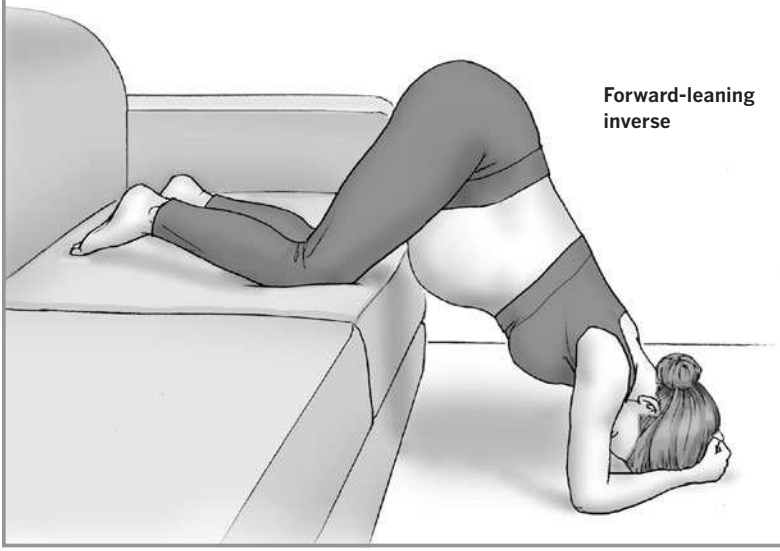
"My doctor said that my baby's in an oblique position. What's that, and what does it mean for delivery?"

Babies can squirm their way into all kinds of unusual positions, and oblique is one of them. What this means is that your baby's head (though down) is pointed toward one of your hips, rather than squarely on your cervix. An oblique position makes a vaginal exit difficult, so your practitioner might do ECV (see facing page) or suggest other techniques to try to coax your baby's head straight down. If none of those work (even after multiple attempts), he or she will probably opt for a c-section.

Turn, Baby, Turn

Some practitioners recommend simple exercises to help turn a breech baby into a delivery-friendly, heads-down position. Though there isn't much medical evidence to prove they work, they're probably worth a shot. Ask your practitioner if you should be trying any of these baby-moving moves at home:

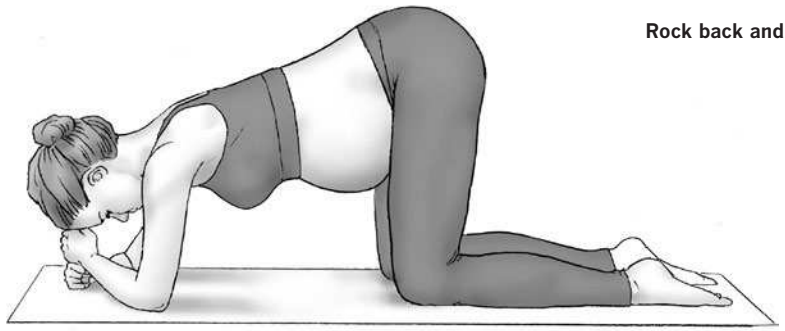
- Rock back and forth a few times on your hands and knees several times a day, with your buttocks higher than your head (see illustration, top right).
- Forward-leaning inverse. Have someone help you with this position: Kneel on the edge of a couch and carefully lower yourself to your hands on the floor and then lower yourself to your forearms, head propped on your arms or hanging freely (see illustration, below). Take 3 breaths, then return to a kneeling position. (Do this 3 or 4 times a day.)
- Knee-to-chest position. If you're alone (with no one around to spot you for safety's sake), you can do a modified version of the forward-leaning inverse: Get on your knees (keep them slightly apart), and then bend over so your butt's up and your belly's almost touching the floor (stay in that position for 20 minutes 3 times a day if you can, for best results); see illustration, middle right.
- Breech pelvic tilts. Lie on your back on a mat or carpeted surface, then lift your hips off the floor (use your heels to push your lower body up), keeping your hands, arms, and shoulders flat on the floor. The idea is to get your hips above your head (see illustration, bottom right). Not feeling the



Forward-leaning inverse

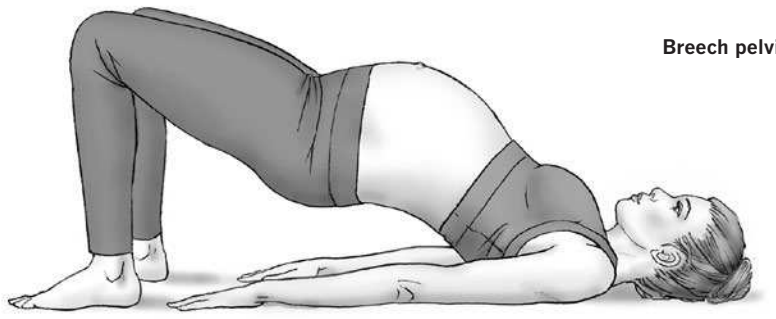
pelvic tilt? For a simpler version, lie on your back and prop up your hips with pillows.

- Hot and cold. Put a cold pack (or a bag of frozen vegetables) on the top of your belly where your baby's head is and place a warm compress on your lower belly (or submerge your lower half in a warm tub). Some say this will encourage baby to seek the warmth and move his or her head away from the cold sensation.
- Music to baby's ears. Playing soothing music or singing near mom's pelvis may coax a baby to flip for a better listen. Again, no proof it works, but certainly no harm trying.



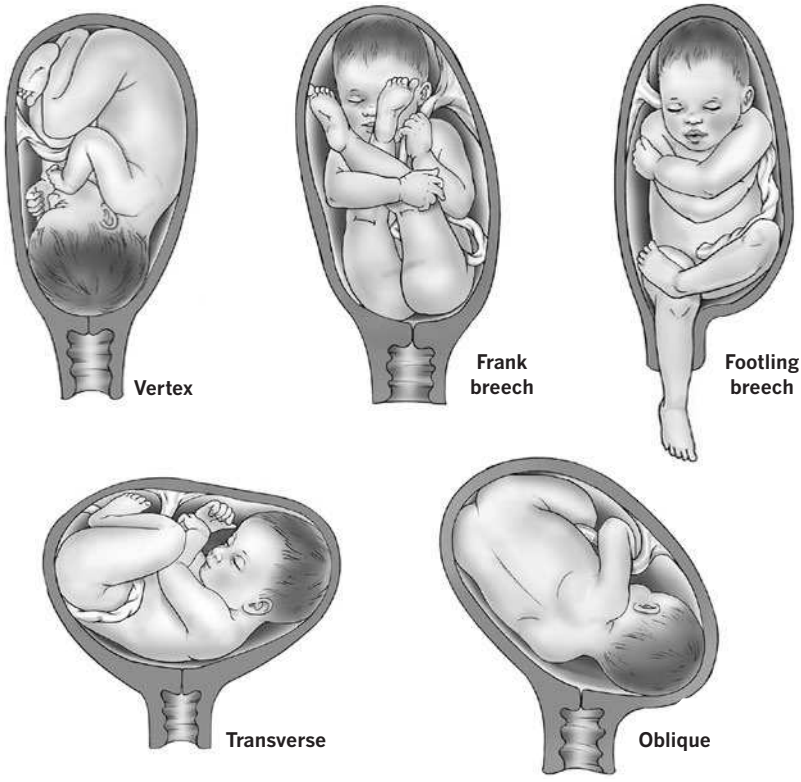
Rock back and forth

Knee-to-chest position



Breech pelvic tilts

How Does Your Baby Lie?



Location, location, location—when it comes to delivery, a baby's location matters a lot. Most babies present head first, or in a vertex position. Breech presentations can come in many forms: A frank breech is when the baby is buttocks first, with his or her legs facing straight up and flat against the face. A footling breech is when one or both of the legs are pointing down. During labor, the first presenting part is baby's foot and leg. A transverse lie is when the baby is lying sideways in the uterus. An oblique lie is when the baby's head is pointing toward mom's hip instead of toward the cervix.

Yet another tight spot a baby can get into is a transverse position. This is when your baby's lying sideways, across your uterus, instead of vertically. Again, an ECV or other techniques will be done to try to turn baby up and down. If that doesn't work, your baby will be delivered via cesarean.

Cesarean Delivery

"I was hoping for a vaginal birth, but my doctor just told me I'll probably have to have a c-section. I'm really disappointed."

Even though it's still considered major surgery (and by far the happiest kind you can have), a cesarean is a very safe way to deliver, and in some

cases, the safest way. It's also a pretty common way—and in the view of many experts, too common. About 32 percent of women are having c-sections these days, which means the chances that your baby will end up arriving via the surgical route are just under 1 in 3, even if you don't have any predisposing factors.

That said, if you had your heart set on a vaginal delivery, the news that your baby may need to arrive surgically instead can be understandably disappointing. Visions of pushing your baby out the way nature intended—and perhaps the way you'd always pictured—can be displaced by concerns about the surgery, about being stuck in the hospital longer, about the tougher recovery, and about the scar that comes standard issue.

First, make sure you've had a discussion with your practitioner about why a cesarean delivery might be necessary in your case (see box, page 354, for reasons why it might be). Ask if there are potential options that can be tried, like attempting to turn your breech baby or doing a trial of labor to see how things progress. If ultimately your practitioner determines that your baby's safest exit strategy is through your abdomen, then consider the following: Most hospitals now strive to make a cesarean delivery as family friendly as possible, with mom awake (but appropriately numb), dad by her side, and a chance to meet, greet, cuddle, and possibly breastfeed baby right after delivery if there's no medical reason why not. In fact, a growing number of hospitals now offer (or may be open to facilitating) a "gentle cesarean." In a gentle cesarean, noise is kept to a minimum and clear drapes are set up so mom can watch as her baby emerges (some drapes have a built-in portal so baby can be handed directly to mom without compromising the sterile surgical environment). EKG electrodes are placed toward mom's back so there's room for baby to snuggle on her chest, and one arm is left free of cuffs, monitors, and IVs so she can hold her freshly delivered baby and even breastfeed. Cord clamping is delayed, as it ideally is in a vaginal birth (see page 416). Have a doula (or a midwife who has cared for you during your pregnancy)? You may be able to invite her into the OR, too.

In other words, a surgical birth experience may be more satisfying (and less disappointing) than you're imagining. And while the recovery will be longer (in hospital and out) and the scar unavoidable (though usually placed unobtrusively), you'll also be delivering with your perineum intact and your vaginal muscles unstretched. One more piece of good news: Studies show that having a c-section doesn't negatively impact your future fertility or how many babies you can have (see page 357). And there's an upside for baby that's purely cosmetic—and temporary. Because there's no tight squeeze through the birth canal, he or she will have an initial edge in appearance over vaginally delivered babies (think round head, not pointy).

But by far the most important thing to keep in mind as your baby's arrival approaches: The best birth is the one that's safest—and when it's definitely medically necessary, a cesarean birth is definitely safest. And after all, any delivery that brings a healthy baby into the world and into your arms is a perfect delivery.

"Why does it seem everyone is having c-sections these days?"

There has actually been quite a push to lower the rate of cesarean delivery in the U.S. Experts are encouraging more trials of labor to promote

Reasons for a Scheduled C

While some women won't find out whether they're having a c-section until they're well into labor, others will get the heads-up ahead of time—joining the ranks of moms-to-be who are scheduled for a cesarean delivery. Though the following don't automatically mean you'll need a c-section, these are the most common reasons why one might be scheduled in advance:

- A previous c-section, when VBAC is not an option (see page 357).
- When a fetus's head is estimated to be too large to fit through mom's pelvis (cephalopelvic disproportion). But since a baby's size can be overestimated, attempting a trial of labor may be possible first (baby may fit more easily than believed).
- Higher-order multiples. Almost all triplets, quads, and more (and many twins) are delivered by c-section.
- Breech or other unusual presentation. Studies show that a cesarean delivery is usually safest when efforts to turn a breech baby haven't succeeded. Many midwives and some doctors may attempt a vaginal breech birth in some circumstances (see page 348).
- A condition in mom or baby that may make labor and vaginal delivery risky.
- Obesity in mom. Obesity increases the odds of a c-section for several reasons. For one, obese moms tend to have ineffective contractions in early labor, which means they don't make progress as quickly. For another, extra abdominal padding makes it harder to monitor a baby during a vaginal delivery. Another factor: Both ECV (to turn a breech baby to a vaginal delivery-friendly position) and VBAC are less successful in obese moms than in average-weight moms. And finally, obese moms often have larger-than-average babies, making cesarean deliveries a safer bet in many (but not all) cases.
- An active herpes infection, especially a primary one, or poorly controlled HIV infection that can be transmitted to the baby during a vaginal delivery.
- Placenta previa (when the placenta partially or completely blocks the cervical opening) or placental abruption (when the placenta separates from the uterine wall too soon).

If your practitioner says you'll need a scheduled c-section, ask for a detailed explanation of the reason (or reasons) why. Ask, too, if any alternatives, such as a trial of labor, are open to you.

vaginal birth after prior cesarean delivery (VBACs; see page 357) and more widespread use of vacuum and forceps delivery to prevent unnecessary surgical deliveries. They're also suggesting that moms be given more time to labor and to push and/or that doctors use Pitocin as needed to nudge nature along (assuming all is going well) before they move on to a c-section. Finally, there's a growing recognition that while c-sections are very safe, they're still major surgery, which comes with greater risk (including that a mom will end up needing a repeat next time). In other words, experts agree: C-sections shouldn't be the delivery of choice, at least when there is a choice.

Still, while rates of c-section have declined about 2 percent over the last few years, and even a little more among low-risk moms, the numbers are still

very high and in the minds of many (including most doctors), too high. Why? There are a number of reasons:

Bigger babies. With more expectant moms exceeding the recommended weight gain of 25 to 35 pounds, and with the rate of GD increasing, more large babies, who may be more difficult to deliver vaginally, are arriving. A wrinkle: Since estimates of a baby's birthweight based on ultrasound measurements can be unreliable (in about 20 percent of cases, estimates are high), a baby who's predicted to be too large to deliver vaginally may end up not so big after all. These over-estimates sometimes result in unnecessary scheduled c-sections.

Bigger moms. The c-section rate has also risen with the obesity rate. Being obese (or gaining too much weight during pregnancy) significantly increases a woman's chance of needing a c-section, partly because of other risk factors that accompany obesity (diabetes, for instance, or hypertension), partly because obese women tend to have longer labors, and longer labors are more likely to end up on the operating table.

Older mothers. More and more women in their late 30s (and well into their 40s) are now able to have successful pregnancies, and though their rates of c-sections have been dropping, older moms are still more likely to require a surgical delivery. The same is true of women with chronic health problems.

Multiples. More and more multiples are being born these days, and there's a higher chance of delivering via cesarean if you're birthing multiple babies (though a vaginal birth with twins is often possible; see page 455).

Repeat c-sections. Though VBAC is still considered a viable option in many cases, and though more and more experts are encouraging VBACs, fewer doctors and hospitals are allowing moms to try one, and more are scheduling surgeries instead of attempting a trial of labor (see page 357 for reasons why).

Fewer instrumental deliveries. Fewer babies are being born with the help of vacuum extraction and even fewer with forceps. That's largely because training in these instrumental deliveries dropped off as c-section rates took off—so many doctors feel more comfortable going straight for the surgical option, when they might have (back in

C-Section Decision During Labor

Often the decision to perform a c-section is made only once labor is well under way—and it's usually to ensure the safety of the mom and her baby. Sometimes it's because labor fails to progress (the cervix isn't dilating, even after attempts have been made to give sluggish contractions a boost with oxytocin, or it's taking too long to push the baby out, and delivery with vacuum extractor or forceps has failed or isn't appropriate). Sometimes it's because there's fetal distress (the baby's heart rate has plummeted to a dangerously low level), or because the uterus has ruptured, or because of a prolapsed umbilical cord (when the cord slips out the birth canal before the baby does, running the risk of being compressed and depriving the baby of oxygen). As always, the safety of both mom and baby will be the prime consideration in whether to turn to a surgical delivery.

FOR FATHERS

Prepping for a C-Section

Wondering if your partner's scheduled c-section means your coaching days are over—even before they've started? No, not at all. While you won't be able to pitch in quite as actively during a surgical delivery as you would during a vaginal birth, your coaching will still be more valuable than you might think. A dad's reaction at a cesarean delivery can actually have an impact on mom's level of anxiety—meaning, a less-stressed father contributes greatly to a less-stressed mother. And there's no better way to reduce your stress than knowing what to expect. So sign up together for a childbirth education class that includes c-sections in the curriculum, read up on surgical deliveries and recoveries (see page 438 and 473), and get as prepped as you can. Be prepared to help her through breathing and relaxing techniques so she stays calm during the c-section, and remember that you'll be by her side to support her as you both welcome your baby into this world.

Any kind of surgery can seem like a scary proposition, but c-sections are extremely safe for both mom and baby. Plus, most hospitals now strive to make them as family friendly as possible, allowing you to watch if you want to (either by lowering the drape or using a clear drape), sit by your spouse's side, hold her hand (which, in most hospitals will not be strapped down), and hold and cuddle the baby right after birth—just like the couples delivering vaginally down the hall. If the hospital where you'll be delivering doesn't officially offer a "gentle cesarean" policy (see page 353), it definitely doesn't hurt to ask the doctor and hospital staff whether some or all of the measures can be applied at your baby's birth.

the day) routinely tried an instrument-assisted birth first. This may change as ob training begins to reflect changing attitudes about these delivery options.

Requests by moms. Since cesarean deliveries are safe and can prevent the pain of labor while keeping the perineum neatly intact, some women (particularly those who've had a c-section before) still prefer them to vaginal deliveries and actually ask ahead for one (see page 359). These numbers are dropping, however, especially as many practitioners have begun discouraging medically unnecessary c-sections. That's because unnecessary c-sections come with unnecessary risks, while vaginal deliveries—when they're possible—are safer, especially for mom.

Time limits in labor. Some doctors put time limits on how long labor should last—how long it "should" take for the cervix to dilate, for instance, or how long a mom "should" push. When artificial time limits are placed on the length of labor, doctors may proceed to a surgical delivery before giving the laboring mom (and her baby) a fair chance to progress. See the box on page 424 for more on these time limits. Happily there are now strong efforts under way to change the recommendations on how long to let a mom labor and push before resorting to a c-section (assuming everything is still proceeding safely)—and that's a "push" that may do a lot to help bring the rate of cesarean deliveries down. Another change that may push c-section rates down:

having moms stays at home a little longer. Moms who show up at the hospital very early in labor may be somewhat more likely to end up having a c-section.

C-section rates are much lower for patients of midwives, not only because midwives attend only low-risk births, but because they tend to let moms take their time with labor and delivery (again, assuming all is well). But even with c-section rates as high as they are these days for doctor-attended births, keep in mind that surgical deliveries still comprise the minority of births. After all, 2 out of 3 women can expect to deliver their babies vaginally.

Repeat Cesareans

"I've had two c-sections and want to go for my third—and maybe my fourth. Is there a limit on how many c-sections you can have?"

Thinking of having lots of babies—but not sure whether you'll be allowed to make multiple trips to the hospital's happiest operating room? Chances are, you'll be able to. There are no arbitrary limits placed on the number of cesarean deliveries a woman can undergo, and having numerous c-sections is generally considered a safe option. Just how safe depends on the type of incision made during the previous surgeries, as well as on the scars that form after the procedures, so discuss the particulars of your case with your ob.

Depending on how many incisions you've had, where you've had them, and how they've healed, multiple c-sections can put you at higher risk for certain complications. These include uterine rupture, placenta previa (a low-lying placenta), and placenta accreta (an abnormally attached placenta). So you'll need to be particularly alert for any bright red bleeding during your pregnancies, as well as the signs of oncoming labor (contractions, bloody show, your water breaking). If any of these occur, notify your practitioner right away.

Scheduled Classes for Scheduled C's

Think a scheduled c-section means you won't have to schedule childbirth classes—or that you should drop out of the ones you signed up for? Not so fast. Childbirth education classes still have plenty to offer you and your partner (including plenty on what to expect with a c-section—and with an epidural). Most classes also offer invaluable advice on taking care of your newborn (which you'll have to master no matter which exit your baby takes), breastfeeding, and possibly getting back into shape postpartum. And don't tune out when the teacher's going over the labor breathing routine with the other couples. You might find those skills come in handy when you're trying to stay relaxed in the OR—or after delivery, when you're confronted with both post-op pain and assorted postpartum aches.

Vaginal Birth After Cesarean (VBAC)

"I had a cesarean delivery with my first baby. Should I try for a vaginal delivery now that I'm expecting baby number 2?"

If you asked the experts, the answer to your question would probably be yes. In fact, ACOG guidelines say that attempting a VBAC (pronounced vee-back) is both a safe and appropriate choice for most women who had a

prior cesarean delivery (or even 2, in some cases). Research shows that the very low risk of uterine rupture (less than 1 percent) is only elevated during VBAC under certain less common circumstances (see below). What's more, VBAC attempts are successful a full two-thirds of the time—meaning that a mom who tries VBAC is just as likely to end up with a vaginal delivery as a mom who never had a c-section.

Yet, with all the mounting evidence—and all the experts—backing up VBAC, many doctors and hospitals won't even consider a vaginal delivery for a mom who has already had a c-section. More than 90 percent of women eligible for trying VBAC end up having a scheduled cesarean delivery instead.

Why are VBAC rates so low? The answer lies more in hospital policies and high malpractice insurance rates than in the safety of VBAC. Some hospitals have stopped offering VBACs because of safety and liability concerns and a shortage of staff and resources to handle emergencies.

That said, there are still plenty of hospitals and doctors, some birthing centers, and many midwives who are open to (and enthusiastically encourage) VBACs. So your first step, if you do decide you'd like to attempt a VBAC, is to find a practitioner who is open to it. And then, taking into account the many factors that are predictive of a successful VBAC, you and your practitioner can decide whether it's the best choice in your case. Here are a few of those factors:

VBAC is recommended only if labor starts spontaneously. If you have to be induced (especially with prostaglandins), VBAC is generally not considered an option. That's because induction (and the stronger contractions it triggers) ups the risk of uterine rupture.

VBAC is recommended only if you have a low-transverse uterine scar. And there's over a 90 percent chance that you do. Vertical uterine incisions (which are more likely to result in a uterine rupture and usually take VBAC off the table) are rarely used.

VBAC is more likely to succeed if the reason for your last c-section no longer exists. For instance, if you had a c-section because of something unique to your previous pregnancy that isn't affecting your current pregnancy—maybe your baby was breech last time but is head-down this time—then a successful VBAC becomes more likely. On the other hand, if you needed a c-section because the size or shape of your pelvis led to an especially slow or stalled labor the first time around, you may encounter the same problem the next time you try to deliver vaginally, making the chances of successful VBAC lower.

VBAC is more likely to succeed if you start out pregnancy at a healthy weight and if you kept your pregnancy weight gain on target. Research shows that VBAC success is 40 percent lower among women who gained more than 40 pounds during pregnancy compared to women who gained less than that. Overweight and obese women who attempt VBACs are also less likely to successfully deliver vaginally in general, even after accounting for baby's larger size (a large baby is more common in overweight women).

VBAC is more likely to succeed if your baby is average size. Research shows that the chance of VBAC failure is 50 percent higher when babies weigh more than 8 pounds 13 ounces at delivery, compared to babies weighing less than 7 pounds 11 ounces. A large baby may also increase the risk of uterine rupture and perineal tears—which is one