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

reason why some doctors won't perform a VBAC on a mom who's more than a week past her due date (older babies may be larger babies). Second and subsequent babies are, on average, larger than first babies—still, having a too-large-to-fit baby before doesn't mean you'll definitely have one this time.

VBAC can be an excellent choice if you've had a vaginal birth before. Research suggests that if you've already delivered a baby vaginally before having one or more by c-section, your likelihood of having a safe and successful VBAC is greater than 90 percent.

If, despite best efforts, you end up having a repeat c-section instead of a VBAC, try not to be disappointed. Remember that even a mom who has never had a cesarean delivery before has a nearly 1 in 3 chance of having one. No regrets, either, if you decide ahead of delivery (in consultation with your practitioner) that you'd rather schedule an elective repeat c-section than attempt VBAC. Again, what's best for your baby—and best for you—is what matters.

"My ob is encouraging me to try for a VBAC, but I'm not sure why I should bother going through labor when I might end up needing a c-section anyway."

Your feelings definitely factor in to the decision of whether or not to give VBAC a chance. Still, your ob has a point. The risks of VBAC are very low, while a c-section, after all, is still major surgery. A vaginal birth means a shorter hospital stay, a lower risk of infection, and a faster recovery—all good reasons to consider VBAC. What's more, if you were hoping to get an epidural during labor, you still can—even if a VBAC is in the works. There are even perks for baby if you give labor a try (see box, this page).

Elective Cesareans

Considering a scheduled cesarean that's not medically necessary (or opting out of a trial of labor)? Here's something to consider first: The best time for your baby to arrive is when he or she is ready. When an elective delivery is planned, there's the possibility that baby will inadvertently be born too soon (particularly if the dates are off to begin with). Another potential perk for your baby if you elect to let labor take its course (or try VBAC instead of scheduling a repeat cesarean delivery): There's evidence to suggest that babies who have gone through at least some labor have fewer health problems than those who never did—even if mom ultimately ends up with a medically necessary c-section.

The best strategy: Weigh the pros and cons of VBAC, factor in your feelings, and then make the decision that feels right for you—whether it's to give labor a try or head straight for the OR—without regret.

Group B Strep

"My doctor is going to test me for group B strep infection. What does this mean?"

It means that your doctor's playing it safe, and when it comes to group B strep, safe is a very good way to play it.

Group B strep (GBS) is a strain of bacteria that lives quietly in the vaginas of between 10 and 35 percent of healthy women—which makes them "carriers" of GBS (or GBS-positive). That's no problem for them, since being GBS-positive doesn't cause symptoms of any kind (and it isn't related to group A

Lifesaving Screenings for Newborns

Most babies are born healthy and stay that way. But a very small percentage of infants are born apparently healthy and then suddenly sicken due to a metabolic disorder. Though most of these conditions are very rare, they can be life-threatening if they go undetected and untreated. Testing for these and other metabolic disorders is inexpensive, and in the very unlikely event that your baby tests positive for any of them, the pediatrician can verify the results and begin treatment immediately—which can make a tremendous difference in the prognosis.

Luckily, there are ways to screen for such metabolic disorders. Drops of blood, taken routinely from an infant's heel after birth, are used to test for 21 (or more) serious genetic, metabolic, hormonal, and functional disorders, including PKU, hypothyroidism, congenital adrenal hyperplasia, biotinidase deficiency, maple syrup urine disease, galactosemia, homocystinuria, medium-chain acyl-CoA dehydrogenase deficiency, and sickle cell anemia.

All 50 states and the District of Columbia require newborn screening for at least 21 disorders, and more than half of all states screen newborns for all 29 disorders for which the American College of Medical Genetics (ACMG) recommends testing. Check with your practitioner or your local board of health to find out what tests are done in your state. You can also look up your state's requirements at the National Newborn Screening & Genetics Resource Center's (NNSGRC) website: genes-r-us.uthscsa.edu. If your hospital doesn't automatically provide all 29 tests, you can arrange to have them done. For more information about newborn screening, check with the March of Dimes: marchofdimes.com.

The CDC also recommends, and some states require, screening tests soon after birth for congenital heart disease (CHD). This condition, which affects 1 in 100 babies, can lead to disability or death if not caught and treated early. Happily, when a baby gets a diagnosis early and is treated early, those risks are reduced significantly—and in most cases, completely. Screening for CHD is simple and painless: A sensor is placed on your baby's skin to measure your little one's pulse and the amount of oxygen in his or her blood. If the results of the screening test seem questionable, the doctor will be able to do further testing (echocardiogram—an ultrasound of the heart, for instance) to determine if anything is wrong. If your state doesn't require the test, ask the pediatrician if it could be given to your baby anyway.

strep, the kind that causes throat infections), but it can be a problem for their babies. That's because a baby who picks up GBS when exiting a mom's vagina is at risk of developing a serious infection—about 1 in every 200 babies born to GBS-positive mothers will.

And that's why expectant moms are routinely tested for GBS—usually between 35 and 37 weeks (testing before 35 weeks isn't accurate in predicting who will be carrying GBS at the time of delivery). Some hospitals and birthing centers offer a rapid GBS test that can screen women during labor and provide results within the hour, taking the place of the screen routinely done between weeks 35 and 37. Ask your practitioner if that's an option at the facility where you'll be delivering.

How's the test done? It's performed using vaginal and rectal swabs. If you test positive (meaning you're a carrier), you'll be given IV antibiotics during labor—and this treatment virtually eliminates any risk to your baby. (GBS can also show up in a urine culture obtained at a prenatal checkup. If it does, it'll be treated right away with oral antibiotics and again in labor with IV antibiotics.)

If your practitioner doesn't offer the GBS test during late pregnancy, you should request it. Even if you weren't tested but end up in labor with certain risk factors that point to GBS (like preterm labor, a fever during labor, or water breaking more than 18 hours before delivery), your practitioner will just treat you with IV antibiotics to be sure you don't pass any infection you might have on to your baby. If you've previously delivered a baby with GBS, your practitioner may also skip the test and proceed straight to treatment during labor.

Playing it safe through testing—and, if necessary, treatment—means that your baby will be protected from a GBS infection. And that's a very good thing.

Taking Baths Now

"Is it okay for me to take a bath this late in pregnancy?"

Run that tub—and carefully hop (or hoist yourself) in. A warm bath is not only safe in late pregnancy, but can be just the ticket for soaking away those aches and pains and stresses after a long day (and what day isn't long when you're 8 months pregnant?).

If you're worried about bathwater entering your vagina (you may have heard that one through the pregnancy grapevine), don't be. Unless it's forced—as with douching, something you shouldn't be doing anyway—water can't get where it shouldn't go. And even if a little water does make its way up, the cervical mucous plug that seals the entrance to the uterus effectively protects its precious contents from an invasion of infectious organisms, should there be any floating around in your tub.

Even once you're in labor and the mucous plug is dislodged, you can still spend time in the bath. In fact, hydrotherapy during labor can provide welcome pain relief. You can even opt to give birth in a tub (see page 326).

One caveat when you're tubbing for two, especially this late in the pregnancy game: Make sure the tub has a nonslip surface or mat on the bottom so you don't take a tumble—and easy does it getting in and out. And as always, avoid irritating bubble baths.

Driving Now

"I can barely fit behind the wheel. Should I still be driving?"

You can stay in the driver's seat as long as you fit there—and if it's become a tight squeeze, moving the seat back and tilting the wheel up should help. Assuming you've got the room—and you're feeling up to it (and aren't too distracted)—driving short distances is fine up until delivery day.

Car trips lasting more than an hour, however, might be hard to sit through late in pregnancy—and can restrict circulation—no matter who's driving. If you must drive a longer distance, be sure to shift around in your seat frequently and stop every hour to get up and walk around. Doing some neck and back stretches may also keep you more comfortable.

Don't, however, try to drive yourself to the hospital while in labor (a

Popping Placenta

Animals do it. Tribal women do it. Chinese medicine has advocated for it for hundreds of years. And now it seems half of Hollywood is doing it—along with plenty of other American moms. Eating your placenta after giving birth (called placentophagy) may not sound particularly appetizing, but it's an option more moms are putting in their birth plans. And maybe you're wondering whether you should order it up, too.

The placenta, the incredible organ that nourished and nurtured your baby during his or her 9-month stay in your uterine home, is usually just discarded after delivery. But proponents of placentophagy say that tossing your placenta is a waste—that consuming it instead can raise your energy levels, ward off anemia, give your milk supply a boost, balance hormones, and lower your chances of postpartum depression.

Not game to gobble up your placenta, say, in a smoothie? Not to worry—few new moms do. The most common way to eat your placenta—and undoubtedly the easiest to swallow—is in pill form. In a process called placenta encapsulation, your placenta is dried, powdered, and sealed into vitamin-size capsules (there are companies who will do it for you), but it comes at a price. Some moms opt to do it themselves at home, for free (DIY kits—or instructions—are available online). The placenta can also be distilled into an alcohol-based solution for you to take in drop form in your smoothies or other drinks.

There are no clinical trials or scientific research to back the effectiveness of these placenta preparations, and most medical experts are skeptical about the perks of eating the afterbirth. They point out that the touted benefits may be the result of a placebo effect (if you expect to feel good after eating your placenta, you'll probably feel that way)—and also point to women who end up sick after they've popped placenta pills or snacked on placenta. Another major potential downside to downing placenta, according to experts: There's the very real possibility of spreading infection when you're handling a raw, blood-filled organ, easily contaminated by bacteria.

If you're considering using your placenta after delivery, be sure to find out if the hospital or birthing center you're delivering in will allow you to pack it up and take it home (or send it off for processing). Not all will. Of course, you won't have to contend with hospital protocols if you're delivering at home.

really strong contraction might prove dangerous on the road). And don't forget the most important road rule on any car trip, whether you are driver or passenger (and even if you're a passenger being driven to the hospital or birthing center in labor): Buckle up. See how to buckle your pregnant self up safely—as well as what to do about those air bags—on page 267.

Traveling Now

"I may have to make an important business trip this month. Is it safe for me to travel this late in pregnancy, or should I cancel?"

Before you schedule your trip, schedule a call or visit to your practitioner. Different practitioners have differing points of view on last trimester travel. Whether yours will encourage

you or discourage you from hitting the road—or the rails or the skies—at this point in your pregnancy will probably depend on that point of view, as well as on several other factors. Most important is the kind of pregnancy you've been having: You're more likely to get the green light if yours has been uncomplicated. How far along you are (most practitioners advise against flying after the 36th week) and whether you are at any increased risk at all for premature labor will weigh into the recommendation, too. Also very important is how you've been feeling. Pregnancy symptoms that multiply as the months pass also tend to multiply as the miles pass, and traveling can lead to increased backache, aggravate varicose veins and hemorrhoids (if you'll be sitting in a cramped airplane seat), and restrict circulation, increasing the risk of a blood clot. Other considerations include how far and for how long you will be traveling (and how long you will actually be in transit), how physically demanding the trip will be, and how necessary the trip is (optional trips or trips that can be easily postponed may not be worth making now). If you're traveling by air, you'll also need to factor in any restrictions of the airline you choose. Some will not let you travel in the last month or two without a letter from your practitioner stating that you're not going into labor imminently (as in, during the flight). Others offer more wiggle room (if not seat or leg room). And some may practice an unofficial don't-ask-don't-tell policy (after all, it's hard to judge how pregnant a woman is just from a glance at the check-in desk).

If your practitioner gives you the go-ahead, there are still plenty of other arrangements you'll need to make besides the travel ones. See page 268 for tips to ensure happy (and safer and more comfortable) travels for the pregnant you. Getting plenty of rest and staying well hydrated will be especially key. But most important on your to-do list will be making sure you have the name, phone number, and address of a recommended practitioner (and the hospital or birthing center where he or she delivers) at your destination—one, of course, whose services will be covered by your insurance plan should you end up requiring them. If you're traveling a long distance, you may also want to consider the possibility of bringing along your partner on the remote chance that if you do end up going into labor at your destination, at least you won't have to deliver without him. And you might want to look into travel insurance, just in case an unexpected complication forces you to cancel your trip.

Sex Now

"I hear a lot of conflicting opinions on whether sex in the last weeks of pregnancy is safe—and whether it triggers labor."

Still have the get-up-and-go you need to get it on? Then get up and go for it. The research that's been done (both by scientists and by those playing doctor at home) indicates that sex (and orgasm, for one or both partners) doesn't trigger labor unless conditions for labor are ripe—that is, the cervix is ready for action. Then, it's theorized, the prostaglandins in semen (like the prostaglandins sometimes used to help induce labor), and perhaps the oxytocin released with orgasm, might be able to help get the labor party started. But even then, under the right and ripest circumstances, you can't bank on sex taking you to the birthing room—as many overdue do-it-yourselfers have discovered. In fact, one study found that low-risk women who had sex in the

Preparing for the Unexpected

Birth plan? Done! Childbirth education classes? Doing! Disaster readiness? Ummm . . . say what? In all your pre-baby prep you probably haven't given much thought to disaster preparedness, but experts say every expectant mom should. Disasters, whether natural or human-made, are fortunately uncommon—but they almost always strike unexpectedly. With a little bit of advance planning, you and your baby-to-be can weather the storm (perhaps literally) of any disaster. Some things to think about:

- Have a communication plan. Landlines can go out and wireless networks can become overloaded during a disaster, making it impossible to reach your partner and other family by phone. Plan ahead to text and use social networks and messaging apps you share with family to get in touch during and after a disaster.
- Have a plan for medical emergencies and emergency delivery (see page 400 for a how-to). Talk to your practitioner now about emergency options in case you go into labor or are having bleeding or other symptoms of a complication when phone lines are down, the practitioner's office isn't open, or you can't get to the hospital. And be sure you have a copy of your electronic health record handy in case you find yourself with an unfamiliar care provider in an emergency.
- Prepare an emergency kit and bag. Experts recommend having an emergency kit with at least 3 days' worth of non-perishable food on hand (think nuts, freeze-dried fruit, whole grain crackers, peanut butter, granola bars, and canned goods with pull tabs, water (at least 1 gallon per person or pet for 3 days), prenatal vitamins, prescription medication, external cell phone batteries, a battery operated radio, a blanket, a first aid kit, flashlight, extra batteries, hand sanitizer, and other things you may need). Have an emergency kit in your car, too. Visit ready.gov for more tips.

Remember, too, how important it will be to take care of your baby and yourself during a disaster—to eat regularly, stay hydrated, and get the rest you need, as hard as those might be to do in such a stressful situation. And speaking of stress, try to make sure it doesn't overwhelm you—especially since extreme stress is sometimes linked to preterm labor. Tap in to the relaxation techniques you're using to stay calm during pregnancy (and if you're not using them already, prepping for just-in-case is another good reason to start). Some numbers to keep handy, if disaster does strike (and outside help is reachable): The National Disaster Distress Helpline, 1-800-985-5990, or text TalkWithUs to 66746. You can also contact your local American Red Cross chapter or public health department for more information and help.

final weeks of pregnancy carried their babies slightly longer than those who skipped sex during that time.

Bottom line on going for your bottom lines: Based on what's known, most obs and midwives allow patients with normal pregnancies to make love right up until delivery day. Check with your practitioner to see what's safe in your situation. If you get a green light (chances are, you will), then by all means hit the sheets—if you have the will and the energy (and the gymnastic skills that might be necessary at this

point). If the light is red in your case (and it probably will be if you are at high risk for premature delivery, have placenta previa, or are experiencing unexplained bleeding)—or if you're just not in the mood for lovemaking—try getting intimate in other ways. While you still have some evenings to yourselves, rendezvous for a romantic candlelit dinner or a moonlit stroll. Cuddle while you watch TV, or soap each other in the shower. Or use massage as the medium. Or do everything but what's on your no-fly list (get a list of restrictions from your practitioner). This may not quite satisfy like the real thing, but try to remember you have a whole lifetime of lovemaking ahead—though the pickings may continue to be slim in that department at least until baby's sleeping through the night.

Your Twosome

"The baby isn't even born yet, and already our relationship has changed. We're both so wrapped up in the birth and the baby, instead of in each other."

Little babies bring big changes when they arrive, and often, even before they arrive. Not surprisingly, your relationship with your partner is one place where you'll notice that change, and it sounds like you've glimpsed it already. And that's actually a really good thing. When baby makes three, your twosome is bound to undergo some shifting of dynamics and reshuffling of priorities. But this predictable upheaval is usually less stressful—and easier to adapt to—when a couple begins the natural and inevitable evolution of their relationship during pregnancy. In other words, the changes to your relationship are more likely to represent a change for the better if they begin before baby's arrival. Couples who don't anticipate at least some disruption of romance-as-usual—who don't realize that wine and roses will often give way to spit-up and strained carrots, that lovemaking marathons will place (well) behind baby-rocking marathons, that a party of three is not always as cozy as a party of two, at least not in the same way—often find the reality of life with a demanding newborn harder to handle.

So think ahead, plan ahead—and be ready for change. But as you get yourselves into nurture mode, don't forget that baby won't be the only one who'll need nurturing. As normal—and healthy—as it is to be wrapped up in your expected extra special delivery, it's also important to reserve some emotional energy for the relationship that created that bundle of joy in the first place. Now is the time to learn to combine the care and feeding of your baby with the care and feeding of your twosome. While you're busily feathering your nest, make the effort to regularly reinforce romance. Hug early and often each day. Hold hands while you're browsing for last-minute baby gear. Grab his butt, or a kiss, or a nuzzle for no reason at all. Cuddle in bed, reminiscing about your first date or dreaming about a second honeymoon (even if it won't be in the cards for many moons). Bring massage oil to bed now and then. Even if you're not in the mood for sex—or it's seeming too much like hard work these days—any kind of touching can keep you close, while reminding you both that there's more to life than Lamaze and layettes.

Keeping this very important thought in mind now will make it easier to keep the love light burning later when you're taking turns walking the floor at 2 a.m. And that love light, after all, is what will make the cozy nest you're busily preparing for your baby a happy and secure one.

ALL ABOUT:

Breastfeeding

If you've given any thought to what's going on behind those giant bra cups you've likely traded up for over the last 8 months or so, chances are, it's pretty clear: Your breasts are already on board with breastfeeding. Whether the rest of you is signed up, too, or whether you're still weighing your baby-feeding options, you'll probably want to learn more about this amazing process, a process that turns breasts (your breasts!) into the perfect purveyors of the world's most perfect infant food. You'll get some valuable highlights and insights here, but for much more on breastfeeding (from the why-to's to the how-to's), see *What to Expect the First Year*. Here are the highlights.

Why Breast Is Best

Just as goat's milk is the ideal food for kids (goat kids, that is), and cow's milk is the best meal for just-born calves, your human breast milk is the perfect meal for your human newborn. Here are the reasons why:

It's custom made. Tailored to meet the nutritional needs of human infants, breast milk contains at least 100 ingredients that aren't found in cow's milk and that can't be precisely replicated in commercial formulas. And unlike formula, the composition of breast milk changes constantly to meet a baby's ever-changing needs: It's different in the morning than it is in the late afternoon, different at the beginning of a feeding than at the end, different the 1st month than the 7th, and different for a preemie than for a full-term newborn. It even tastes different, depending on what you've been snacking on (like your amniotic fluid does when you're pregnant). A one-of-a-kind food for your one-of-a-kind baby.

It's easy to digest. Breast milk is designed for a new baby's brand new digestive system. The protein and fat in breast milk are easier to digest than those in formula, and its important micronutrients are more easily absorbed.

It's a tummy soother. Breastfed babies are almost never constipated, thanks to the easier digestibility of breast milk. They also rarely have diarrhea, since breast milk appears to reduce the risk of digestive upset both by destroying harmful microorganisms and by encouraging the growth of beneficial ones. You know the much-touted pre- and probiotics that are added to some formulas? They're naturally occurring in breast milk.

It doesn't make a stink. On a purely aesthetic note, the poops of a breastfed baby are sweeter smelling (at least until solids are introduced).

It's an infection preventer. With each and every feeding, nursers get a healthy dose of antibodies to boost their immunity to bugs of all varieties (which is why breastfeeding is sometimes referred to as a baby's first immunization). In general, breastfed babies come down with fewer colds, ear infections, lower respiratory tract infections, urinary tract infections, and other illnesses than formula-fed infants, and when they do get sick, they'll usually recover more quickly and with fewer complications. Breastfeeding also improves the

immune response to vaccines for most diseases (such as tetanus, diphtheria, and polio). Plus, it may offer some protection against sudden infant death syndrome (SIDS).

It's a fat flattener. Breastfed infants are less likely to be too chubby. That is, in part, because breastfeeding lets baby's appetite call the shots (and the ounces). A breastfed baby is likely to stop feeding when full, while a bottle-fed infant may be urged to keep feeding until the bottle's emptied. What's more, breast milk is actually ingeniously calorie controlled. The lower calorie foremilk (served up at the start of a feed) is designed as a thirst-quencher. The higher calorie hindmilk (served up at the end of a feed) is a filler-upper, signaling to a nurser that it's quitting time. And research suggests that the fat-defeating benefits of breastfeeding follow a baby out of the nursery—and into high school. Studies show that former breastfeeders are less likely to battle weight as teens—and the longer they were breastfed, the lower their risk of becoming overweight. Another potential long-term health plus for nursers: Breastfeeding is linked to lower cholesterol levels and lower blood pressure later in life.

It keeps allergies on hold. Babies are almost never truly allergic to breast milk (though occasionally an infant may be sensitive to something mom has eaten). The formula flip side? More than 10 percent of babies turn out to be allergic to cow's milk formula (a switch to a soy or hydrolysate formula usually solves the problem but isn't ideal, since those stray even further in composition from the gold standard formula: breast milk). And there's more good news on the allergy front—evidence that breastfed babies may be less likely to develop asthma and eczema.

Prepping for Breastfeeding

Luckily, nature has worked out all the mechanics, so there's not much you'll need to do to get your breasts ready to feed your baby. Some lactation experts recommend that during the last months of pregnancy you skip the soap on your nipples and areolas—just rinse with water, instead. Soap can dry the nipples, which may lead to cracking and soreness early in breastfeeding. If your nipples are dry, you can apply a lanolin-based cream such as Lansinoh—otherwise, it's not necessary.

The no-prep rule applies even to women with small or flat nipples. Flat nipples don't need to be prepped for nursing with breast shells, hand manipulation, or a manual breast pump during pregnancy. Not only are these prepping techniques often less effective than no treatment, but they can do more harm than good. The shells, besides being uncomfortably bulky, can cause sweating and rashes. Hand manipulation and ahead-of-time pumping can stimulate contractions and, occasionally, even trigger breast infection.

It's a brain booster. Breastfeeding, according to some evidence, appears to slightly increase a child's IQ, at least through age 15, and possibly beyond. This may be related not only to the brain-building fatty acids (DHA) in breast milk, but also to the closeness and mother-baby interaction that is built into breastfeeding, which is believed to nurture a newborn's intellectual development.

Got Pierced?

You're all set to nurse your baby-to-be, but you're afraid there's a little something in the way: a nipple piercing. No worries. There's no evidence that nipple piercing has any effect on a mom's ability to breastfeed. Still, be sure to remove any nipple jewelry before baby opens up wide and you insert your breast. This is not only due to the potential for infection for you, but because the jewelry could pose a choking hazard for your baby or injure his or her tender gums, tongue, or palate during feedings.

It's safe. You can be sure that the milk served up from your breasts is always prepared perfectly—and never spoiled, contaminated, expired, or recalled.

It's made for suckers. It takes longer to drain a breast than a bottle, giving newborns more of the comforting sucking satisfaction they crave. Plus, a breastfed baby can continue to comfort-suck on a nearly empty breast—something an empty bottle doesn't allow.

It builds stronger mouths. Mama's nipples and baby's mouth are made for each other—a naturally perfect match. Even the most scientifically designed bottle nipple can't match up to a breast nipple, which gives a baby's jaws, gums, teeth, and palate the ultimate workout—a workout that ensures optimum oral development and some perks for baby's future teeth (like better alignment). Another mouth perk to breastfeeding: Babies who are breastfed are less likely to get cavities later on.

It expands the taste buds early on. Want to raise an adventurous eater? Start at the breast. Developing those little taste buds on breast milk, which takes on the flavor of whatever you've been eating, may acclimate a baby early on to a world of flavors. Researchers have found that nursed babies are less likely to be timid in their tastes than their formula-fed peers once they graduate to the high chair—which means they may be more likely to open wide to that spoonful of yams (or that forkful of curried chicken) later on.

Breastfeeding offers a pile of perks for mom (and dad), too:

Convenience. Breast milk is the ultimate convenience food—always in stock, ready to serve, and consistently dispensed at the perfect temperature. It's fast food, too: no formula to run out of, shop for, or lug around, no bottles to clean or refill, no powders to mix, no meals to warm (say, when you're on a conference call and baby's wailing in the background). Wherever you are—in bed, on the road, at the mall, on the beach—all the nourishment your baby needs is always on tap, no muss (or mess), no fuss. And if you and your baby aren't in the same place at the same time—you're at work, in school, at dinner, or even away for the weekend—a stash of expressed breast milk can be served up in bottles.

Money in the bank. The best things in life are free, and that includes breast milk and breast milk delivery (open baby's mouth, insert mommy's breast). On the other hand, bottle-feeding (once you factor in formula, bottles, nipples, cleaning supplies) can be a pretty pricey proposition. There's no waste with breastfeeding, either—what baby doesn't end up drinking at one feed will stay fresh for the next. And because breastfed babies are generally healthier babies—you're likely to save money on

FOR FATHERS

When Father Knows Breast

Up until now, you've thought of your spouse's breasts sexually. And that's natural. But here's something that's also natural—and something you're probably well aware of already. Breasts are built the way they are for another good reason and to serve another really important purpose: baby feeding. There is no more perfect food for an infant than breast milk, and no more perfect food delivery system than a breast (make that 2 breasts). Breastfeeding offers an overwhelming number of health benefits for both babies (from preventing allergies, obesity, and illness to promoting brain development) and their moms (nursing is linked to a speedier recovery postpartum and a reduced risk of diabetes and of breast, ovarian, and uterine cancer later in life).

Without a doubt, the decision to choose breast over bottle can make a dramatic difference in your baby's life—and in your partner's. And perhaps surprisingly, your support in that decision can make a dramatic difference in breastfeeding success. So if you haven't already, give her your vote of breastfeeding confidence, which counts for a lot more than you'd think. Even though you may not know letdown from latch-on yet, knowing that you're behind her every step of the way (especially when the going gets tough, which it often does at first) will have an enormous influence on whether mom sticks with breastfeeding (and the longer she sticks with it, the more health benefits for both her and baby). In fact, researchers have found that when dads are supportive of breastfeeding, moms are likely to give it a try 96 percent of the time. When dads are ambivalent, only about 26 percent give it a try. So take your influence seriously. Read up on breastfeeding, take a class together, talk to other dads whose partners have breastfed, and ask whether a lactation consultant (basically, a nursing coach) will be available at the hospital or birthing center when baby's ready to chow down for the first time. (Lesson one: It's a natural process, but it doesn't always come naturally.) If your partner is hesitant to ask for help—or she's just too tired after delivery—be her breastfeeding advocate and make sure she gets it.

Help get your spouse started, cheer her on, and then sit back and watch in wonder as those amazing breasts of hers take on one of life's most important (and incredibly special) jobs: baby feeding. Sure, it takes only two to breastfeed, but it often takes three to make it happen.

health care costs (and lost wages, too, since you'll be less likely to miss work because of a sick baby).

Speedier postpartum recovery. It's only natural that breastfeeding is best for newly delivered moms, too—after all, it's the natural conclusion to the pregnancy-childbirth cycle. It'll help your uterus shrink back to prepregnancy size more quickly, which in turn will reduce your flow of lochia (the postpartum bloody discharge), decreasing blood loss. And by burning upward of 500 extra calories a day, breastfeeding can help you shed leftover pregnancy pounds faster. Some of those pounds were laid down as fat reserves earmarked specifically for milk production—now's your chance to use them.

Some protection against pregnancy. It's far from a sure bet, but breastfeeding

Breastfeeding After Breast Surgery

How does past breast surgery affect your breastfeeding future? That depends on what kind of surgery you had and how it was performed. Here's an overview:

If you've had a breast reduction or lumpectomy, you'll probably still be able to breastfeed, but you may not produce enough milk to nurse exclusively. Check with your surgeon to see if care was taken to preserve milk ducts and nerve pathways during the procedure—if so, chances are good that you'll be able to produce at least some milk.

If you've had breast augmentation, your chances of being able to breastfeed successfully are good, since augmentation is less likely to interfere with breastfeeding than a breast reduction. Still, it will depend on the technique, the incision, and the reason why it was done. While many women with implants are able to nurse exclusively, a significant minority may not produce enough milk.

No matter what kind of breast surgery you had, you can improve your chances of breastfeeding success by reading up, taking a class, and working with a lactation consultant right from the start. For much more, see *What to Expect the First Year.*

your baby may suppress ovulation (and your period) for several months. Is this a birth control bet you should take, without a backup? Probably not, unless back-to-back pregnancies are your objective (see page 27 for more).

Health benefits for mom. Plenty of perks here: Women who breastfeed have a slightly lower risk of developing uterine cancer, ovarian cancer, and premenopausal breast cancer. They're also less likely to develop Type 2 diabetes, rheumatoid arthritis, and osteoporosis than women who don't breastfeed. Another benefit for breastfeeding moms: Research suggests that women who breastfeed are somewhat less likely to suffer from postpartum depression (though PPD can strike a breastfeeding mom and can also strike a mom after she weans, as hormones fluctuate once again).

Nighttime feeds that are a (relative) breeze. Have a hungry baby at 2 a.m.? You will. And when you do, you'll appreciate how fast you'll be able to feed that baby if you're breastfeeding. No stumbling to the kitchen to prepare a bottle in the dark. Just pop a warm breast into that warm little mouth.

Eventually, easy multitasking. Sure, nursing your newborn will take both arms and a lot of focus at first. But once you and baby become nursing pros, you'll be able to do just about anything else at the same time—from eating dinner to playing with your toddler.

Built-in bonding. The benefit of breastfeeding you're likely to appreciate most is the bond it nurtures between you and your little one. There's skin-to-skin and eye-to-eye contact, and the opportunity to cuddle and coo built right into every feed. True, bottle-feeding mamas (and daddies) can get just as close to their babies—but it takes a more conscious effort (there's always the understandable temptation to prop a bottle when you're busy or hand off feedings when you're tired).

Making the Choice to Breastfeed

For more and more soon-to-be moms, the choice is clear. Some know they'll opt for breast over bottle long before they even decide to become pregnant. Others choose breastfeeding once they've read up on its many benefits. Some teeter on the brink right through pregnancy and even delivery. And even those who are pretty convinced that nursing isn't for them still can't shake the nagging feeling that they should do it anyway.

Undecided? Here's a suggestion: Try it—you may like it. You can always quit if you don't, but at least you will have cleared up those nagging doubts. Best of all, you and your baby will have reaped some of the most important benefits of breastfeeding, if only briefly.

Just be sure to give breastfeeding a fair trial. The first few weeks can be challenging, even for the most enthusiastic breastfeeders, and are always a learning process (though getting lactation support can make things much easier if you're having a hard time). A full 4 to 6 weeks of nursing is generally needed to establish a successful feeding relationship and give a mom the chance to figure out whether breast is best after all.

Also keep in mind that breastfeeding isn't an all-or-nothing deal. For some moms, combining both breast and bottle is the best formula. For more on combining breast and bottle, see *What to Expect the First Year*.

When You Can't (or Choose Not to) Breastfeed

Maybe you've decided that breastfeeding definitely isn't for you. Or there's a reason why you won't be able to (or end up not being able to) breastfeed, either at all or exclusively. Either way, remember that you can offer your baby as much love and nurturing when you bottle-feed as you can with breastfeeding. So reach for the formula without guilt or regret. To learn more about bottle-feeding with love, see *What to Expect the First Year.*

CHAPTER 13

The Ninth Month

Approximately 36 to 40 Weeks

Finally. The month you've been waiting for, working toward, and stressing about just a little bit is here at long last. Chances are you're at once very ready (to hold that baby . . . to see your toes again . . . to sleep on your stomach!) and not ready at all. Still, despite the inevitable flurry of activity (more practitioner appointments, last-minute layette and gear items to shop for, projects to finish at work, paint colors to pick for baby's room), you may find that the 9th month seems like the longest month of all. Except, of course, if you don't deliver by your due date. In that case, it's the 10th month that's the longest.

Your Baby This Month

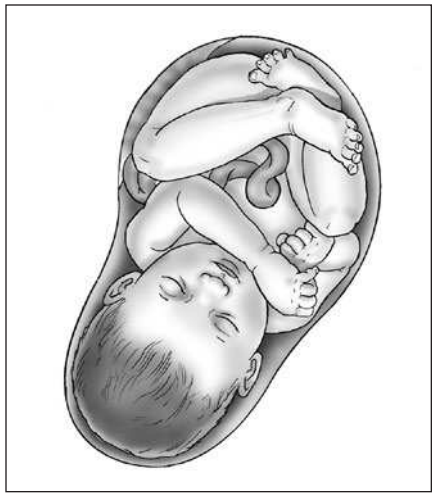
Week 36 Weighing somewhere around 6 pounds and measuring anywhere from 18 to 19 inches tall, your baby is almost ready to be served up into your arms. Right now, most of baby's systems (from circulatory to musculoskeletal) are just about equipped for life on the outside. Though the digestive system is ready to roll, too, it hasn't really gotten a workout yet. Remember, up until this point, your baby's nutrition has been arriving via the umbilical cord—no digestion necessary. But that's soon to change. As soon as baby takes his or her first suckle at your breast (or suck from the bottle), that digestive system will be jump-started—and those diapers will start filling.

Week 37 Here's some exciting news: If your baby were born this week, he or she would be considered full term. Mind you, that doesn't mean baby is finished growing—or getting ready for life on the outside. Still gaining weight at about half a pound a week, the average fetus this age weighs about 6½ pounds (though size varies quite a bit from fetus

to fetus, as it does from newborn to newborn). Fat continues to accumulate on your baby, forming kissable dimples in those cute elbows, knees, and shoulders, and adorable creases and folds in the neck and wrists. To keep busy until the big debut, your baby is practicing to make perfect: inhaling and exhaling amniotic fluid (to get the lungs ready for that first breath), sucking on his or her thumb (to prepare for that first suckle), blinking, and pivoting from side to side (which explains why yesterday you felt that sweet little butt on the left side and today it's taken a turn to the right).

Week 38 Hitting the growth charts at about 7 pounds and the 20-inch mark (give or take an inch or two), your little one isn't so little anymore. In fact, baby's big enough for the big time—and the big day. With only 2 (or 4, max) weeks left in utero, all systems are almost go. To finish getting ready for his or her close-up (and all those photo ops), baby has a few last-minute details to take care of, like shedding the vernix (the greasy white substance protecting that tender new skin) and lanugo (the fine downy hair that covered your cutie's body for warmth). Baby's also producing more surfactant, which will prevent the air sacs in the lungs from sticking to each other when breathing begins. Your little one will be here before you know it!

Week 39 Not much to report this week, at least in the height and weight department. Fortunately for you and your overstretched skin (and aching back), baby's growth has slowed down—or even taken a hiatus until after delivery. On average, a baby this week still weighs in at between 7 and 8 pounds (the size of . . . a baby!) and measures 19 to 21 inches (though yours may be a little bigger or smaller). Still, progress is being made in some other areas, especially baby's brain, which is growing and developing up a storm (at a rapid pace that will continue during the first 3 years of life). What's more, your baby's pink skin has turned whitish or whitish-grayish (no matter what skin your baby will ultimately be in, since pigmentation doesn't occur until soon after birth). A development that you may have noticed by now if this is your first pregnancy: Baby's head might have dropped into your pelvis. This change of baby's locale might make for easier breathing (and less heartburn), but could also make it harder for you to walk (make that, waddle).



Your Baby, Month 9

Week 40 Congratulations! You've reached the official end of your pregnancy (and maybe the end of your rope). For the record, your baby is fully full term and could weigh in anywhere between the 6- and 9-pound mark and measure anywhere from 19 to 22 inches, though some perfectly healthy babies check in slightly smaller or bigger than that. You may notice when your baby emerges that he or she (and you'll know for sure which at that momentous moment) is still curled into the fetal position, even though the fetal days are over. That's just sheer force of

habit (after spending 9 months in the cramped confines of your uterus, your baby doesn't yet realize there's room to spread out now) and comfort (that snug-as-a-bug position feels good). When you do meet your new arrival, be sure to say hello—and more. Though it's your first face-to-face, your baby will recognize the sound of your voice—and that of dad's. And if baby doesn't arrive on time (choosing to ignore the due date on your app), you're in good—if impatient—company. About 30 percent of all pregnancies proceed past the 40-week mark, though (thankfully) your practitioner will probably not let yours continue beyond 42 weeks.

Weeks 41–42 So, looks like baby has opted for a late checkout. Fewer than 5 percent of babies are born on their actual due date—and around 10 percent decide to overstay their welcome in Hotel Uterus beyond week 41, thriving well into the 10th month (though you may have lost that "thriving" feeling long ago). Remember, too, that most of the time an overdue baby isn't overdue at all—it's just that the due date was off. Less often, a baby may be truly postmature. When a postmature baby does make a debut, it's often with dry, cracked, peeling, loose, and wrinkled skin (all completely temporary—soft new baby skin is soon to follow). That's because the protective vernix was shed weeks before, in anticipation of a delivery date that's since come and gone. An "older" fetus will also have longer nails, possibly longer hair, and definitely little or none of that baby fuzz (lanugo) at all. In general, postmature newborns tend to be more alert and open-eyed (after all, they're older and wiser). Just to be sure all is well, your practitioner will likely monitor your overdue baby closely through nonstress tests and checks of the amniotic fluid or biophysical profiles.

Your Body This Month

In your last month of pregnancy symptoms, some may be lingering from last month, while others may be brand new. Still others may hardly be noticeable because you're so used to them or because they are eclipsed by new and more exciting signs indicating that labor may not be far off:

Physically

- Changes in fetal activity (more squirming and less kicking, as your baby has progressively less room to move around)
- Vaginal discharge becomes heavier and contains more mucus, which may be streaked red with blood or tinged brown or pink after sex or a pelvic exam or as your cervix begins to dilate
- Constipation or looser stools as labor nears
- 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
- Leg cramps at night
- Increased backache and heaviness
- Buttock and pelvic discomfort and achiness
- Increased swelling of ankles and feet, and occasionally of hands and face
- Itchy belly
- Protruding navel (a popped-out belly button)
- Stretch marks
- Varicose veins in the legs and/or vulva
- Hemorrhoids
- Easier breathing after baby drops
- More frequent urination after baby drops, since there's pressure on the bladder once again
- Increased difficulty sleeping
- More frequent and more intense Braxton Hicks contractions (some may be painful)
- Increasing clumsiness and difficulty getting around
- Colostrum leaking from your nipples (though this premilk substance may not appear until after delivery)
- Extra fatigue or extra energy (nesting syndrome), or alternating periods of each
- Increase in appetite or loss of appetite

Emotionally

- More excitement, more anxiety, more apprehension, more absentmindedness
- Relief that you're almost there

Your Body This Month

Your uterus is right under your ribs now, and your measurements aren't really changing that much from week to week anymore. The top of your uterus is around 38 to 40 cm from the top of your pubic bone. Your weight gain slows down or even stops as D-day approaches. Your abdominal skin is stretched as far as you think it can go, and you're probably waddling more now than ever, possibly because the baby has dropped in anticipation of impending labor.

- Irritability and oversensitivity (especially with people who keep saying, "No baby yet?")
- Impatience and restlessness
- Dreaming and fantasizing about the baby

What You Can Expect at This Month's Checkup

With appointments scheduled weekly this month, you'll be spending more time than ever at your practitioner's office. These visits will be more interesting—the practitioner will estimate baby's size and may even venture a prediction about how close you are to delivery—with the excitement growing as you approach the big day. In general, you can expect your practitioner to check the following:

- Your weight (gain generally slows down or stops)
- Your blood pressure (it may be slightly higher than it was at midpregnancy)
- Your urine, for protein
- Your feet and hands for swelling, and legs for varicose veins
- Your cervix (the neck of your uterus), by internal examination, to see if effacement (thinning) and dilation (opening) have begun
- The height of the fundus
- The fetal heartbeat
- Fetal size (you may get a rough weight estimate), presentation (head or buttocks first), position (front or rear facing), and descent (is the presenting part engaged in the pelvis yet?) by palpation (feeling with the hands)
- Questions and concerns you want to discuss, particularly those related to labor and delivery—have a list ready.

You can also expect to receive a labor and delivery protocol from your practitioner (when to call if you think you are in labor, when to plan on heading to the hospital or birthing center). If you don't, be sure to ask for these instructions—you'll need them!

What You May Be Wondering About

Urinary Frequency—Again

"During the last few days, it seems like I'm in the bathroom constantly. Is it normal to be peeing this often now?"

Having a first trimester flashback? That's because your uterus is right back where it started: down low in your pelvis, pressing squarely on your bladder. And this time, the weight of your uterus is significantly greater, which means the pressure on your bladder is greater, too—as is that need to pee. So you go, girl—again, and again, and again. As long as frequency isn't accompanied by signs of infection (see page 528), it's completely normal. Don't be tempted to cut back on fluids in an attempt to cut back on your trips to the bathroom—your body needs those fluids more than ever. And as always, go as soon as you feel the urge (and can find a bathroom).

Lactating Blood

You may have expected to leak a little colostrum from your nipples later in pregnancy, but blood? Yet a bloody nipple discharge (you might notice it as spotting on the inside of your bra or red-tinged fluid when you squeeze your nipples) is not uncommon during pregnancy (usually late in pregnancy and more commonly in first-timers), and it's usually nothing to be concerned about. Why does it happen? Your breasts have been going through a lot in the last almost 9 months as they prepare for the all-important job of feeding your baby—including a lot of expansion and a lot of increased blood flow. Maybe the blood is just the very normal response to the increasing blood supply in your breasts—or it's coming from a capillary that burst as your breasts inflated their way through the cup alphabet. Or it could be a milk duct that's swollen thanks to pregnancy hormones. Or maybe it's a papilloma (a small benign lump) in a milk duct that's been irritated. Or your nipples could just be really raw (especially if you've been tweaking them a lot to see if colostrum appears, or in an effort to get labor started).

Mention the bleeding to your practitioner. To be on the safe side (always the best side to be on), as well as to put your mind at ease, he or she may suggest that you have a breast ultrasound and exam done now and a mammogram done after delivery—especially if the bleeding lasts longer than a week and/or if you've noticed a lump along with the bleeding. If everything checks out, as it almost certainly will, just avoid squeezing your nipples so you don't increase the irritation that's probably led to the bloody discharge in the first place (your nipples will get squeezed plenty when baby arrives).

Most of the time, such so-called lactating blood goes away after delivery. If it doesn't, still no worries—you can breastfeed even if you're lactating blood. The small amount of blood your baby will ingest along with the breast milk won't be harmful.

Leaky (or Not Leaky) Breasts

"A friend of mine says she had milk leaking in the 9th month. I don't. Does this mean I won't have any milk?"

Milk isn't made until baby's ready to drink it—and that's not until 3 to 4 days after delivery. What your friend was leaking was colostrum, a thin, yellowish fluid that is the precursor to breast milk. Colostrum is chockfull of antibodies to protect a newborn baby and has more protein and less fat and milk sugar (the better to digest it) than the breast milk that arrives later.

Some, but far from all, moms-to-be leak this phenomenal fluid toward the end of their pregnancies, sometimes during sex, sometimes spontaneously. But even those who aren't leaking colostrum are still producing it. Not leaking, but still curious? Squeezing your areola may allow you to express a few drops (but don't squeeze with a vengeance—that'll only result in sore nipples). Still can't get any? Don't worry. Your baby will be able to net what he or she needs when the time comes to get busy at your breast. Not leaking definitely isn't a sign that your supply won't keep up with demand.

Going Down?

You may be in for a surprise—and a treat—at this month's weigh-in. Most expectant moms who reach the end of pregnancy also reach the end of pregnancy weight gain. Instead of watching the numbers on the scale go up (and up), you may start seeing those numbers go nowhere—or even go down—over the last few weeks. What's up (or rather, down) with that? After all, your baby isn't losing weight—and your ankles are still plenty puffy, thank you very much. What's happening, actually, is perfectly normal. In fact, this weight gain standstill (or downward trend) is one way that your body gets ready for labor. Amniotic fluid starts to decrease (less water equals less weight), and loose bowels (common as labor approaches) can also send the numbers down, as can all that sweating you're doing. And if you think this weight loss is exciting, wait until delivery day. That's when you'll experience your biggest 1-day weight-loss total ever!

If you are leaking colostrum, it's probably just a few drops. But if you're leaking more than that, you may want to consider wearing nursing pads in your bra to protect your clothes (and to prevent potentially embarrassing moments). And you might as well get used to the wet t-shirt look, since this is just a glimpse of leaky breasts—and wet bras, pajamas, and blouses—to come.

Incidentally, don't worry about "wasting" colostrum if you're leaking it—you'll continue to produce it until it's time for your real milk to come in.

Spotting Now

"Right after my husband and I had sex this morning, I began to spot a little. Does this mean labor is beginning?"

Don't place the birth announcement order just yet. Pinkish-stained or red-streaked mucus appearing soon after sex or a vaginal exam, or brownish-tinged mucus or brownish spotting appearing within 48 hours after the same, is usually just a normal result of the sensitive cervix being bruised or manipulated, not a sign that labor's about to start up. But pinkish- or brownish-tinged or bloody mucus accompanied by contractions or other signs of oncoming labor, whether it follows sex or not, could be signaling the start of labor (see page 395).

If you notice bright red bleeding or persistent red spotting at any time, call your practitioner.

Prelabor Water Breaking

"How likely is it that my water's going to break before I go into labor?"

Many moms-to-be stress about springing an amniotic leak late in pregnancy, but few ever do. Contrary to popular pregnancy belief, your "water" (more accurately, your membranes) isn't likely to "break" (more accurately, rupture) before labor begins. In fact, more than 85 percent of women enter the birthing room with their membranes fully intact. In other words, it's probable that the forecast for the rest of your pregnant future will remain "mainly dry."

If you do end up being among the 15 percent who spring a prelabor leak, you'll probably notice the tell-tale gush or trickle more if you're lying down than if you're standing up. That's because when you're upright (standing, walking, even sitting), your baby's head acts like a cork in a bottle, blocking the opening of the uterus and keeping most of the amniotic fluid in.

The bright side of a prelabor water break is that it's usually followed by labor, typically within 24 hours. If labor doesn't start spontaneously within that time, your practitioner will probably start it for you. Which means your baby's arrival will be just a day away, either way.

Though it really isn't necessary, wearing a panty liner or maxipad (or if you're really stressing, a bladder control pad) in the last weeks may give you a sense of security, as well as keep you fresh as your vaginal discharge increases. You also might want to place heavy towels, a plastic sheet, or hospital bed pads under your sheets in the last few weeks, just in case your water breaks in the middle of the night.

Baby Dropping

"If I'm past my 38th week and haven't dropped, does it mean I'm going to be late?"

Just because your baby doesn't seem to be moving toward the exit doesn't mean his or her arrival will be late. Dropping, also called lightening, is what happens when a baby descends into mom's pelvic cavity, a sign that the presenting part (first part out, usually the head) is engaged in the upper portion of the bony pelvis. In first pregnancies, dropping generally takes place 2 to 4 weeks before delivery. In expectant moms who have had children previously, it usually doesn't happen until labor begins. But as with almost every aspect of pregnancy, exceptions to the rule are the rule. You can drop 4 weeks before your due date and deliver 2 weeks late, or you can go into labor without having dropped at all. You can even seemingly drop and then undrop: Your baby's head can appear to settle in and then float up again (meaning it's not really fixed in place yet).

Often, dropping is obvious. You might not only see the difference (your belly seems lower—perhaps a lot lower—and tilted farther forward), but feel the difference, too. As the upward pressure of the uterus on your diaphragm is relieved, you can breathe more easily, literally. With your stomach less crowded, you can eat more easily, too—and finish up your meals without a side of heartburn and indigestion. Of course, these welcome changes are

Baby's Crying Already?

The most joyous sound a new parent hears is that first cry the baby makes after he or she is born. But would you believe that your little one is already crying inside you, if silently? It's true, according to researchers, who found that third-trimester fetuses show crying behaviors—quivering chin, open mouth, deep inhalations and exhalations—and startle responses when a loud noise and vibration were sounded near the mom's belly. It's known that the crying reflex is well developed even in premature infants, so it's not surprising that babies are perfecting this skill long before they're ready to emerge (and it explains why they're so good at crying once they come out!).

How Is Baby Doing?

As your pregnancy nears its end (yes, it will end), your practitioner will be keeping a closer eye on your health and your baby's—especially once you pass the 40-week mark. That's because 40 weeks is the optimum uterine stay for babies. Those who stick around much longer can face potential challenges (becoming too big to arrive vaginally, experiencing a decline in their placenta's function, or a dip in amniotic fluid levels). Luckily, your practitioner can tap into plenty of tests and assessments of fetal wellbeing to make sure all's well and will end well . . . eventually:

Kick counts. Your record of fetal movements (see page 315) can provide some indication of how your baby is doing. Ten movements in an hour or 2 is usually reassuring. If you don't notice enough activity, other tests are then performed.

The nonstress test (NST). You'll be hooked up to a fetal monitor (the same kind that's used during labor) in your practitioner's office to measure the baby's heart rate and response to movement. You will be holding a clicker (like a buzzer on *Jeopardy!*), and each time you feel the baby move, you'll click. The monitoring goes on for 20 to 40 minutes and is able to detect if the fetus is under any stress.

Fetal acoustic stimulation (FAS) or vibroacoustic stimulation (VAS). Does your baby need a little pick-me-up? If your little one isn't as active during a nonstress test as doctors would like, a sound-and-vibration-producing instrument will be placed on your tummy to give baby a little stimulus so your practitioner can more accurately measure that little heartbeat and those movements.

The contraction stress test (CST) or oxytocin challenge test (OCT). If the results of a nonstress test are unclear, your practitioner may order a stress test. This test, done at a hospital, tests how the baby responds to the "stress" of uterine contractions to get some idea of how he or she will handle full-blown labor. In this somewhat more complex and time-consuming test (it may take a number of hours), you're hooked up to a fetal monitor. If contractions are not happening on their own, you'll be given a low-dose IV of oxytocin (or you'll be asked to stimulate your nipples) to jump-start the contractions. How your baby responds to contractions indicates

often offset by a new set of discomforts, including pressure on the bladder (which will send you to the bathroom more frequently, again), pressure on the pelvic joints (which will make it harder to walk . . . or waddle), and pressure in the perineal area (sometimes causing pain). You might also experience sharp little shocks or twinges on the pelvic floor (similar to lightning crotch sensations you may have experienced earlier on in pregnancy, but this time, thanks to baby's head pressing hard on it) and a sense of being off balance (because your center of gravity has shifted once more).

It is possible, however, for baby to drop unnoticed. For instance, if you were carrying low to begin with, your pregnant profile might not change noticeably after dropping. Or if you never experienced difficulty breathing or getting a full meal down, or if you always urinate frequently, you might not detect any obvious difference.

Your practitioner will rely on two more indicators to figure out whether or

his or her condition and that of the placenta. This rough simulation of the conditions of labor can allow your practitioner to make a prediction about whether or not your baby can safely remain cocooned in your uterus and whether he or she can meet the strenuous demands of true labor.

A biophysical profile (BPP). It's picture time, baby. Using an ultrasound and fetal heart rate monitor, a BPP will look at five aspects of life in the uterus: findings from a NST, fetal breathing, fetal movement, fetal tone (the ability of your baby to flex and extend an arm or leg), and amniotic fluid volume. When all these are normal, your baby is probably doing fine. If any of these are unclear, further testing (such as a CST or a VAS) will be given to provide a more accurate picture of your baby's condition.

The modified biophysical profile. The "modified" biophysical profile combines the NST with an evaluation of the quantity of amniotic fluid. A low level of amniotic fluid may indicate that a baby is not producing enough urine and the placenta may not be functioning up to par. If your baby reacts appropriately to the nonstress test and levels of amniotic fluid are adequate, it's likely that all is well.

Umbilical artery Doppler velocimetry. This test is performed when there is evidence of fetal growth lag and uses a special ultrasound to measure the flow of blood through the umbilical artery. A weak, absent, or reverse flow during the second half of the fetal cardiac cycle (when the heart is filling with blood rather than pumping it out) indicates the baby is not getting adequate nourishment and probably not growing well.

Other tests of fetal wellbeing. These include regular ultrasound exams to document fetal growth and fetal scalp stimulation (which tests how a fetus reacts to pressure on, or pinching of, the scalp) during an NST.

Most of the time, babies pass these tests with flying colors, which means they can continue to stay put until they're good and ready to make their debuts. Rarely, the NST results can be labeled "nonreactive." Because these tests yield plenty of false positives, a nonreactive result doesn't definitely diagnose distress, but it will mean that your practitioner will continue to test your baby and, if it turns out there's any indication of fetal distress, will either induce your labor (see page 567) or perform a cesarean delivery.

not your baby's head is engaged: First, he or she will do an internal exam to see whether the presenting part—ideally the head—is in the pelvis. Second, he or she will feel that part externally (by pressing on your belly) to determine whether it is fixed in position or still "floating" free.

How far the presenting part has progressed through the pelvis is measured in "stations," each a centimeter long. A fully engaged baby is said to be at "zero station"—that is, the fetal head has descended to the level of the prominent bony landmarks on either side of the midpelvis. A baby who has just begun to descend may be at –4 or –5 station. Once delivery begins, the head continues on through the pelvis past 0 to +1, +2, and so on, until it begins to "crown" at the external vaginal opening at +5.

Though an engaged head strongly suggests that the baby can get through the pelvis without difficulty, it's no guarantee. Conversely, a fetus that is still free

What's Considered Term?

Confused about when your baby is officially considered term? Post-term? Well, ACOG comes to the rescue with his handy glossary of "term" terminology:

- Preterm. A baby born between 20 weeks and 37 weeks is considered preterm.
- Early Term. If your baby is born between 37 weeks 0 days and 38 weeks 6 days, that's considered early term.
- Full Term. Babies born between 39 weeks 0 days and 40 weeks 6 days are considered full term. (Full term in twin pregnancies is 38 weeks.)
- Late Term. Got a late termer? That means arrival at between 41 weeks 0 days and 41 weeks 6 days.
- Post-term. Who's overstayed their welcome? Babies born after 42 weeks 0 days are considered post-term.

floating going into labor isn't necessarily going to have trouble negotiating the exit. And in fact, the majority of babies who haven't yet engaged when labor begins come through the pelvis smoothly. This is particularly true in moms who have already delivered 1 or more babies.

Changes in Baby's Movements

"My baby used to kick so hard. I can still feel him moving, but he seems less active now."

When you first heard from your baby, way back in the 5th month or so, there was ample room in the uterus for acrobatics, kickboxing, and punching. Now that conditions are getting a little cramped, his gymnastics are curtailed. In this snug uterine straitjacket, there is little room for anything more than turning, twisting, and wiggling—which is probably what you've been feeling. And once your baby's head is firmly engaged in your pelvis, he will be even more restricted in his movements. But this late in the game, it's not important what kind of fetal movement you feel (or even if it's only on one side), as long as you feel it. If, however, you feel no activity (see next question) or significantly diminished activity, check with your practitioner.

"I've hardly felt the baby kick at all this afternoon. What does that mean?"

Chances are your baby has settled down for a nap (older fetuses, like newborns, have periodic interludes of deep sleep) or that you've been too busy or too active to notice any movements. For reassurance, check for activity using the test described on page 315. It's a good idea to repeat this test routinely twice a day throughout the last trimester. Ten or more movements during each 1 to 2 hour test period (squirms and wriggles count, but not hiccups) mean that your baby's activity level is normal. Fewer movements suggest that medical evaluation might be necessary to determine the cause of the inactivity, so put in a call to your practitioner if that's the case. Though a baby who is relatively inactive in the womb can be perfectly healthy, inactivity at this point sometimes indicates fetal distress. Picking up this distress early and taking steps to intervene can often prevent serious consequences.