Use the second trimester (which will probably be your most comfortable—and the easiest for you to do some serious chowing down in) as your chance to load up on the nutrition your babies need to grow. If you didn't gain any weight during the first trimester (or if you lost weight due to severe nausea and vomiting), your practitioner may want you to gain an average of 1½ to 2 pounds per week starting now. If you've been gaining steadily through the first trimester, you can aim a little lower. Either way, that may seem like a lot of weight in a short time, and you're right—it is. But it's weight that's important to gain. Supercharge your eating plan with extra servings of protein, calcium, and whole grains. Heartburn and indigestion starting to cramp your eating style? Spread your nutrients out over those 6 (or more) mini-meals.

As you head into the home stretch (the third trimester), you'll still need to continue your steady rate of gain. By 32 weeks, your babies may be 4 pounds each, which won't leave much room in your crowded-out tummy for food. Still, even though you'll be feeling plenty bulky already, your babies will have to bulk up quite a bit more—and they'll appreciate the nutrition a healthy diet provides. So focus on quality over quantity, and expect to taper down to a pound a week or less in the 8th month and just a pound or so total during the 9th. (This makes more sense when you remember that most multiple pregnancies don't make it to 40 weeks.)

Multiple Timeline

Already counting down your 40 weeks? You might not have to count that many after all. A twin pregnancy is considered full term a full 2 weeks earlier, at 38 weeks—certainly reason to celebrate (2 weeks less of puffiness, heartburn . . . and waiting!). But just as most singletons fail to arrive on their due date, multiples keep their moms and dads (and practitioners) guessing, too. They might just stay put until 38 weeks (or longer)—or they might make their appearance before they've clocked in even a full 37 weeks. In fact, most do.

If your babies do end up overstaying their 38-week term, your practitioner will likely elect to induce, taking into account how they're doing and how you're doing. ACOG's recommendation that low-risk twin pregnancies be delivered by the end of the 38th week may also be factored in (and that's one significant reason why few twin pregnancies are allowed to go longer than a full 38 weeks). Be sure to have an endgame discussion with your practitioner long before the end is near, because many differ on how they typically handle the late stages of a multiple pregnancy.

Exercise

"I'm a runner, but now that I'm pregnant with twins, is it safe to keep up my workouts?"

Exercise can benefit most pregnancies, but when you're staying fit for three, you'll have to exercise care, too. First, check in with your practitioner. Even if exercise is green-lighted during the first and second trimesters, your practitioner will likely steer you toward more gentle options and away from any workout that puts downward pressure on your cervix (like running) or that raises your body temperature significantly (running can do that, too). Most

Extra, Extra!

Not surprisingly, extra babies come with extra precautions—and that's a good thing. With extra precautions come extra-excellent chances that your multiple babies will thrive and arrive safe, sound, and healthy.

Here are some of the extras you can expect when you're expecting twins or more:

- Extra practitioner visits. Good prenatal care is the ticket to a healthy pregnancy and a healthy baby—at least doubly so when you're expecting multiples. So expect more frequent prenatal checkups—you'll likely be seen every 2 to 3 weeks (rather than every 4) up until your 7th month and even more often after that. And those visits may get more in-depth as your pregnancy progresses. You'll get all the tests singleton moms get, but you may also get transvaginal ultrasounds to keep an eye on cervical length (to check for signs of preterm labor) as well as more nonstress tests and biophysical profiles in your third trimester (see page 380). You'll also likely be screened for gestational diabetes earlier and more often than a singleton mom would be.
- Extra pictures. Of your babies, that is. You'll get extra ultrasounds to monitor your babies and make sure their development and growth is on track. Which means extra reassurance, plus extra peeks at that precious pair (or trio)—and extra pictures for your baby book (or books!).
- Extra close attention. Your practitioner will keep an extra close eye on your health to reduce your risk of certain pregnancy complications more common in multiple pregnancies (see page 451). With all that extra attention, any problem that develops will likely be caught and treated quickly.

experts recommend that moms-to-be of multiples stay away from high-impact aerobic exercise (again, like running) after 20 weeks if any cervical shortening has been detected on ultrasound (because it increases the risk of preterm labor for them), and to stop running by 28 weeks even if there is no cervical shortening. Unfortunately, these guidelines hold true for experienced runners like you, as well.

Looking for a more appropriate fitness routine for the three of you? Good choices include swimming or pregnancy water aerobics, stretching, prenatal yoga, light weight training, and riding a stationary bicycle, all exercises that don't require you to be on your feet while you do them (though do ask your practitioner if walking is safe in your case—it is most of the time). And don't forget your Kegels (page 229), the anywhere-anytime exercises designed to strengthen your pelvic floor (which needs extra reinforcement when there are extra babies inside).

No matter what you're doing during your workout, if the exertion is causing Braxton-Hicks contractions or raising any other red flags listed on page 140, stop immediately, rest, drink some water, and call your practitioner if they don't subside within 20 minutes or so.

Mixed Feelings

"Everybody thinks it's so exciting that we're going to have twins, except us. We're scared and even disappointed. What's wrong with us?"

Multiple Connections

As a multiples mother-to-be, you're about to join a special club already filled with thousands of women just like you—women who are also expecting double the delight and, chances are, double the self doubt. Never been a joiner? Membership in this particular club does come with plenty of rewards. By talking to other moms-to-be of multiples, you'll be able to share your joy, your fears, your symptoms, your funny stories (the ones nobody else would get) with those who know just how you're feeling. You'll also be able to score reassuring advice from other expectant moms who have multiples on the way (as well as from those who've already had their multistork delivery). Join a discussion group online (check out WhatToExpect.com for a multiples message board) or ask your practitioner to hook you up with other pregnant-with-multiples moms in his or her practice and start your own group. There are also national organizations that can provide you with contact information for local clubs, including the National Organization of Mothers of Twins Clubs, nomotc.org, or you can use an online search engine to find a local multiples chapter. You can also check out online sites that cater specifically to parents of multiples, including mothersof multiples.com and twinstuff.com.

Absolutely nothing. Prenatal daydreams don't usually include two babies. You prepare yourself psychologically, as well as physically and financially, for the arrival of one baby—and when you suddenly discover you're having two instead, feelings of disappointment aren't unusual. Neither is trepidation. The impending responsibilities of caring for a single infant are plenty daunting without having them doubled.

Some expectant parents are happy to hear they're expecting multiples right from the start, but many others take some time getting used to the news. It's just as common to feel initial shock as initial joy—to feel you're being deprived of experiencing the cozy bond you'd always imagined with a single baby, but can't immediately see yourselves having with a pair. Guilt about questioning your double blessing (especially if becoming pregnant was a struggle to begin with) can compound your conflicted feelings. All of these feelings (and the others you might be experiencing) are a completely normal reaction to the news that your pregnancy and your lives are taking an unexpected turn.

So accept the fact that you're ambivalent about the dual arrivals, and don't saddle yourselves with guilt (since your feelings are normal and understandable, there's absolutely nothing to feel guilty about). Instead, use the months before delivery to get used to the idea that you'll be having twins (you will!). Talk openly and honestly to each other (the more you let your feelings out, the faster you'll work through them). Talk to anyone you know who has twins, and if you don't know any moms and dads of multiples, look to message boards. Sharing your feelings with others who've felt them, and recognizing that you're not the first expectant parents to experience them, will help you accept and, in time, become excited about this pregnancy and the two beautiful babies you'll be holding one day soon. Twins, you'll find, may

be double the effort at first, but they're also double the fun down the road.

Insensitive Comments

"When I told my friend that we're having twins, she said to me, 'Better you than me.' Why would she make such a nasty comment?"

That might be the first insensitive comment you've been ambushed by during your multiples pregnancy, but it probably won't be the last. From coworkers to family members to friends to those perfect (make that not-so-perfect) strangers in the supermarket, you'll be amazed at the remarkably rude things people feel completely comfortable saying to an expectant mom of multiples.

What's up with the lack of tact? The truth is, many people don't know how to react to the news that you're carrying multiples. Sure, a simple "Congratulations!" might be in order, but most people assume that twins are special (they are) and therefore need to be recognized with a "special" comment. Curious about what it must be like to be pregnant with twins, in awe of what you'll be going through once they're born, they're clueless about the right response—so they dish out the wrong one. Their intentions are good, but their follow-through stinks.

The best way to react? Don't take it personally, and don't take it too seriously. Realize that even as your friend opened her mouth and inserted her foot, she was almost certainly trying to wish you well (and she probably has no idea that she offended you, so try not to take offense). Remember, too, that you can be the best spokeswoman for moms of twins everywhere—and you'll have lots of chances to spread the wonderful word on multiples.

"People keep asking me if twins run in my family or if I had fertility treatments. I'm not ashamed that I had IVF, but it's also not something I want to share with everyone."

A pregnant woman brings out the nosy like no one else, but a woman expecting multiples becomes everybody's business. Suddenly, your pregnancy goes public—with people you hardly know (or don't know at all) prying into your personal life (and bedroom habits) and prodding you for personal information without thinking twice. But that's just the point: These people aren't really thinking twice—or even once. They're not asking to be intrusive, they're just curious (multiples are fascinating stuff, after all), and they haven't been educated in twin etiquette. If you're open to sharing the details, then by all means, go for it ("Well, first we tried Clomid, and when that didn't work, we tried IVF, which means that my husband and I went to a fertility clinic . . ."). By the time you're halfway done with your story, the questioner will probably be bored to tears and looking for the nearest exit. Or, you can try one of these responses the next time someone asks about the conception of your twins:

- "They were a big surprise." This can be true whether you've conceived with or without fertility help.
- "Twins run in the family—now." This will shut them up while keeping them guessing.
- "We had sex twice in one night." Who hasn't at some point? Even if the last time was on your honeymoon, it's not a lie—and it'll be the end of the line for their line of questioning.
- "They were conceived with love." Well, that's a given, no matter what—and where do they go from there?

- "Why do you ask?" If they're TTC (trying to conceive) themselves, then maybe it'll open up a conversation that could help them (infertility can be a lonely road, as you probably know). If not, it could stop them in their nosy tracks.

Not in the mood for a witty retort—or to even respond at all (especially after you've been asked the same question 5 times in a single day)? There's nothing wrong with letting the questioner know that the answer is none of her business, which it isn't. "That's a personal matter" says it all.

Safety in Numbers

"We'd barely adjusted to the fact that I was pregnant when we found out I'm carrying twins. Are there any extra risks for them, or for me?"

Extra babies do come with some extra risks, but not as many as you'd think. In fact, not all twin pregnancies are classified as "high risk" (though higher-order multiples definitely fall into that category), and most expectant mothers of multiples can expect to have relatively uneventful pregnancies, at least in terms of complications. Plus, entering your twin pregnancy armed with a little knowledge about the potential risks and complications can help you avoid many, and will prepare you should you encounter any. So relax (twin pregnancies are really safe), but read up.

For the babies, the potential risks include:

Early delivery. Multiples tend to arrive earlier than singletons. More than half of twins, the majority of triplets, and practically all quadruplets are born premature. While women pregnant with a single baby deliver, on average, at 39 weeks, twin delivery, on average, occurs at 35 to 36 weeks. Triplets usually come (again, on average) at 32 weeks, and quadruplets at 30 weeks. (Keep in mind that term for twins is considered 38 weeks, not 40.) After all, as cozy as it can be for your little ones in the uterus, it can also get pretty crowded as they grow. Be sure you know the signs of preterm labor, and don't hesitate to call your practitioner right away if you're experiencing any of them (see page 559).

Low birthweight. Since many multiple pregnancies end early, the average (repeat: average) baby born of a multiple pregnancy arrives weighing 5½ pounds, which is considered low birthweight. Most 5-pounders end up doing just fine health-wise, thanks to advances in caring for these small newborns, but babies born weighing less than 3 pounds are at increased risk for health complications as newborns, as well as for long-term disabilities. Making sure your prenatal health is in top-notch condition and your diet contains plenty of nutrients (including the right amount of calories) can help get your babies to a bigger bottom line. See *What to Expect the First Year* for more on low-birthweight babies.

Twin-to-Twin Transfusion Syndrome (TTTS). This in-utero condition, which happens in about 9 to 15 percent of identical twin pregnancies in which the placenta is shared, arises when one or more placental arteries from one twin deposits blood in the placenta that returns to the other twin through a placental vein. If there aren't other common vessels present to equalize the delivery of blood to both fetuses, the result can be one baby getting too much blood and the other too little. (Fraternal twins are almost never

Pregnancy Reduction

Sometimes an ultrasound reveals that one (or more) of the fetuses in a multiple pregnancy can't survive or is so severely malformed that the chances of survival outside the womb are minimal—and worse yet, that the unhealthy fetus may be endangering your other healthy one(s). Or there are so many fetuses that there is a significant risk to the mother and all her babies. In such cases, your practitioner may recommend a pregnancy reduction. Contemplating this procedure can be agonizing—it may seem like sacrificing one baby to protect another—and may leave you plagued with guilt, confusion, and conflicted feelings. You may come to your decision of whether to proceed (or not proceed) easily, or it may be an excruciating decision-making process.

There may be no easy answers, and there are definitely no perfect options, but you'll want to do whatever you can to make peace with the decision you end up making. Review the situation with your practitioner, and seek a second opinion, or third, or fourth, until you're as confident as you can be about your choice. You can also ask your practitioner to put you in touch with someone from the bioethics staff of the hospital (if that's available). You may want to share your feelings with close friends, or you may want to keep this personal decision private. If religion plays an important role in your life, you'll probably want to look to spiritual guidance. Once you make your decision, try not to second-guess: Accept that it's the best decision you can make under the difficult circumstances. Also try not to burden yourself with guilt, no matter what you choose. Because none of this is your fault, there's no reason to feel guilty about it.

If you end up undergoing pregnancy reduction, you may expect to experience the same grief as any parent who has lost one or more babies. See page 596 for help coping.

affected because they never share a placenta.) This condition is dangerous for the babies, though not to the mom. If it's detected in your pregnancy, your practitioner will likely refer you to a perinatologist who may suggest laser therapy of the placenta (using a special device placed in the uterus) to stop the transfusion. Alternatively, although less effective, the physician may opt to use amniocentesis to drain off excess amniotic fluid every week or two, which improves blood flow in the placenta and reduces the risk of preterm labor. If you're dealing with TTTS, check out fetalhope.org for more information and resources.

Other complications. There are other fetal complications that are more likely to occur in a multiple pregnancy, but that are still uncommon. Ask your practitioner about other additional risks for your babies and how you can best modify them.

A multiple pregnancy can also impact the health of the mother-to-be:

Preeclampsia. The more babies you're carrying, the more placenta you've got on board. This added placenta (along with the added hormones that come with two babies) can lead to high blood pressure, and sometimes to preeclampsia. Preeclampsia affects 1 in 4 mothers of twins and usually is caught early,

thanks to careful monitoring. For more on the condition and treatment options, see page 550.

Gestational diabetes. Expectant multiples moms are slightly more likely to have GD than singleton moms. That's probably because higher hormone levels can interfere with a mom's ability to process insulin. Diet can usually control (or even prevent) GD, but sometimes extra insulin is needed (see page 548).

Placental problems. Women pregnant with multiples are at a somewhat higher risk for complications such as placenta previa (low-lying placenta, page 554) or placental abruption (premature separation of the placenta, page 556). Fortunately, careful monitoring (which you'll be getting) can detect placenta previa long before it poses any significant risk. Placental abruption can't be detected before it happens, but because your pregnancy is being carefully watched, steps can be taken to avoid further complications if an abruption occurs.

Bed Rest

"Will I have to be on bed rest just because I'm carrying twins?"

To bed rest or not to bed rest? That is the question many moms-to-be of multiples ask, and practitioners don't always have an easy answer. That's because there really isn't an easy answer. The obstetrical jury is still out on whether bed rest helps prevent the kinds of complications sometimes associated with a multiple pregnancy (such as preterm labor and preeclampsia). And even though most research shows there's no benefit, many practitioners continue to prescribe some version of bed rest, especially under certain circumstances (for instance, if mom's cervix has shortened or she has high blood pressure, or if one or both of the babies isn't growing well). Since the risk of complications increases with each additional baby, bed rest is even more likely to be prescribed in higher-order multiple pregnancies.

Be sure to have a discussion with your practitioner early in your pregnancy about his or her philosophy on bed rest. Some practitioners prescribe it routinely for all expectant moms of multiples (often beginning between 24 and 28 weeks), while most do it on a case-by-case basis, taking a wait-and-see approach.

If you are put on bed rest, see page 573 for tips on coping with it. And keep in mind that even if you aren't sent to bed, your practitioner will probably still advise you to take it easy, cut back on (or stop) work, and stay off your feet as much as possible during the latter half of your pregnancy—so get ready to rest up anyway.

Vanishing Twin Syndrome

"I've heard of vanishing twin syndrome. What is it?"

Detecting multiple pregnancies early using ultrasound technology has many benefits, because the sooner you and your practitioner discover you've got two (or more) babies to care for, the better care you'll be able to get. But there's sometimes a downside to knowing so soon. Identifying twin pregnancies earlier than ever also reveals losses that went undetected before the days of early ultrasound.

The loss of a twin during pregnancy can occur in the first trimester (often before a mom even knows she's carrying twins) or, less commonly, later in the

pregnancy. During a first-trimester loss, the tissue of the miscarried twin is usually reabsorbed by the mother's body. This phenomenon, called vanishing twin syndrome, occurs in about 20 to 30 percent of multiple pregnancies. Documentation of vanishing twin syndrome has grown significantly over the past few decades, as early ultrasounds—the only way to be sure early in pregnancy that you're carrying twins—have become routine (and are used even earlier and more often in an IVF pregnancy). Researchers report more cases of vanishing twin syndrome in women older than 30, though that may be because older mothers in general have higher rates of multiple pregnancies, especially with the use of fertility treatments.

There are rarely any symptoms when the early loss of a twin occurs, though some women experience mild cramping, bleeding, or pelvic pain, similar to a miscarriage (though none of those symptoms is a sure sign of such a loss). Decreasing—not disappearing—hormone levels (as detected by blood tests) may also indicate that one fetus has been lost.

The good news is that when vanishing twin syndrome occurs in the first trimester, a mom usually goes on to experience a normal pregnancy and delivers the single healthy baby without complication or intervention. In the much less likely case that a twin dies in the second or third trimester, the remaining baby may be at an increased risk of intrauterine growth restriction, and the mother may be at risk of preterm labor, infection, or bleeding. The remaining baby would then be watched carefully and the rest of the pregnancy monitored for complications.

For help coping with the loss of a twin in utero, see page 599.

ALL ABOUT:

Multiple Childbirth

Every delivery day is an unforgettable one, but if you're carrying twins (or more), yours probably won't be the typical birth story you've heard from moms who've delivered just one. Not surprisingly, things can get a little more complicated when you've got two babies or more heading for the exit—and a lot more interesting.

Will your labor and delivery be twice the effort? What will be the ideal way to deliver your multiple newborns into your arms? The answers can depend on a lot of factors, such as fetal position, your health, the safety of the babies, and so on. Multiple births have more variables—and more surprises—than single births. But since you'll be getting two (or more) for the price of one labor, your multiple childbirth will be a pretty good deal no matter how it ends up playing out. And remember that whatever route your babies take from your snug womb to your even snugger embrace, the best way is the one that is the healthiest and safest for them—and for you.

Laboring With Twins or More

How will your labor differ from the labor of a mother of one? Here are a few ways:

- It could be shorter. Will you have to endure double the pain to end up cuddling double the pleasure? Nope. In fact, when it comes to labor, you're likely to catch a really nice break. The labor is often shorter with multiples—which means that if you'll be delivering vaginally, it may take less time to get to the point where you can start pushing. The catch? You'll be hitting the harder part of labor sooner.
- Or it could be longer. Because a multiples mom's uterus is overstretched, contractions are sometimes weaker. And weaker contractions could mean that it might take longer to become fully dilated.
- It'll be watched more closely. Because your medical team will have to be twice as careful during your multiple delivery, you'll be monitored more during labor than most moms of singletons. Throughout labor (if you're delivering in a hospital—the most common scenario), you'll likely be attached to two (or more) fetal monitors so your practitioner can see how each baby is responding to your contractions. Early on, the babies' heartbeats may be monitored with external belt monitors—this could allow you to go off the monitors periodically so you can walk around or hit the whirlpool tub (if you're so inclined). In the latter stages of labor, Baby A (the one closest to the exit) may be monitored internally with a scalp electrode while Baby B is still monitored externally. This will put an end to your mobility, because you'll be tethered to a machine. If you're delivering at home with a midwife, your babies will be monitored with a Doppler more frequently.
- You'll probably have an epidural (again, assuming you're delivering in a hospital). If you've had your heart set on one anyway, you'll be happy to hear that epidurals are strongly encouraged—or even required—with multiple deliveries, in case an emergency c-section becomes necessary to deliver one or all of your babies. If you'd like to avoid an epidural, talk to your practitioner ahead of time.
- You'll probably deliver in an operating room. Chances are, you'll be able to labor in a comfy birthing room, but when it's time to push, you'll be wheeled into the OR. Most hospitals require this, just to be on the safe side (and in case an emergency c-section becomes necessary), so ask ahead.

Delivering Twins

Here's what you can expect when delivering your twins:

Vaginal delivery. About half of all twins born these days come into the world vaginally, but that doesn't mean the birthing experience is the same as it is for singleton moms. Once you're fully dilated, delivery of Baby A may be a cinch (3 pushes) or a protracted ordeal (3 hours). Though that latter scenario is far from a given, some research has shown that the duration of pushing is usually longer in a twin delivery than in a singleton delivery. The second twin in a vaginal delivery usually comes within 10 to 30 minutes of the first, and most multiples moms report that delivering Baby B is a snap compared with Baby A. Depending on the position of Baby B, he or she may need some help from the practitioner, who can try external or internal version (see box, page 456) to move baby into the birth canal or use vacuum extraction to speed the delivery.

Mixed delivery. In rare (very rare) cases, Baby B must be delivered by c-section after Baby A has been delivered vaginally.

Position, Position, Position

Quick . . . flip a coin. Heads (up) or tails (down)? Or maybe one (or more) of each? How multiples will end up at delivery time (and how you'll end up delivering) is anybody's guess. Here's a look at the possible ways your twins may be presenting and the likely delivery scenarios for each situation.

Vertex/vertex. This is the most cooperative position that twins can wind up in on delivery day, and they wind up in it about 40 percent of the time. If both your babies are vertex (heads down), you'll likely be able to go into labor naturally and attempt a vaginal birth. Keep in mind, however, that even perfectly positioned singletons sometimes need to be delivered by c-section. This goes double for twins. If you're hoping to have a midwife attend your delivery (or even if you'd like to deliver at home), the vertex/vertex position is the best-case scenario.

Vertex/breech. The second-best-case scenario if you're hoping for a vaginal birth for your twins is the vertex/breech setup. This means that if Baby A is head-down and well positioned for delivery, it may be possible for your practitioner to manipulate Baby B from the breech position to vertex after Baby A is born. This can be done either by applying manual pressure to your abdomen (external version) or literally reaching inside your uterus to turn Baby B (internal version). The internal version sounds much more complicated than it is—because Baby A has essentially warmed up and stretched out the birth canal already, the procedure is over with pretty quickly. (Still, an arm reaching into your uterus to pull out a baby isn't pretty without pain meds—another reason why many doctors strongly recommend epidurals for multiples moms.) If Baby B remains stubbornly breech, your practitioner may do a breech extraction, in which your baby is pulled feet first right out the exit.

Breech/vertex or breech/breech. If Baby A is breech or if both your babies are bottoms-down, your practitioner will almost certainly recommend a c-section. Though external version is commonplace for breech singletons (and can work in the above mentioned vertex/breech multiple pregnancy), it's considered too risky in this scenario.

Baby A oblique. Who knew there were so many positions for babies to lie in? When Baby A is oblique, it means his or her head is pointed down, but toward either of your hips rather than squarely at your cervix. In a singleton pregnancy with oblique presentation, a practitioner would probably try external version to bring the baby's head where it needs to be (facing the exit), but that's risky with twins. In this case, two things can happen: An oblique presentation can correct itself as contractions progress, resulting in a vaginal birth, or more likely, your practitioner will recommend a c-section to avoid a long, drawn-out labor that may or may not lead to a vaginal birth.

Transverse/transverse. In this setup, both babies are lying horizontally across your uterus. A double transverse almost always results in a c-section.

Got triplets (or more) in there? Your babies can assume any number of these positions (and maybe even keep you guessing until right up to delivery).

See facing page for more on triplet delivery.

This is usually done only when an emergency situation has come up that puts Baby B at risk, such as placental abruption or cord prolapse. (Those all-important fetal monitors tell your doctor just how well Baby B is doing after Baby A's arrival.) A mixed delivery is definitely not fun for mom. In the moment, of course, it can be very scary, and after the babies are born, it means recovery from both a vaginal birth and a surgical one—a big double ouch. But when it's necessary, it can be a baby-saving procedure, well worth the added recovery time.

Planned cesarean delivery. Possible reasons for this plan include a previous c-section (a VBAC, or vaginal birth after cesarean, is not common practice for multiples), placenta previa or other complications, or fetal positions that make vaginal delivery unsafe. With most planned c-sections, your spouse, partner, or coach can accompany you into the OR, where you will probably be given an epidural or a spinal block. You may be surprised by how fast it all goes after you're numb: Baby A's and Baby B's birth times will be separated by anywhere from seconds to just a minute or two. Hoping to hold and breastfeed your babies as soon as possible after delivery? So-called gentle cesarean deliveries are also an option for twins, assuming all is going well. See page 438 for more.

Unplanned cesarean delivery. An unplanned c-section is the other possible way your babies might enter the world. In this case, you may walk into your usual weekly prenatal appointment and find out that you're going to meet your babies the same day. Best to be prepared, so in those later weeks of pregnancy, be sure to get your bag packed and ready to go. Reasons for a surprise cesarean delivery include conditions such as intrauterine growth restriction (where the babies run out of room to grow) or a sharp rise in your blood pressure (preeclampsia). An unplanned c-section scenario may also arise during labor if there are any signs of distress in the babies or if you labor for a very long time and don't progress at all. A uterus holding 10 or more pounds of babies may be too stretched to contract effectively, so a cesarean delivery might be the only way out.

Delivering Triplets (or More)

Wondering if your higher-order multiples are destined to take the abdominal route out? A cesarean delivery is most often scheduled for triplets and quads—not only because it's usually safest, but because c-sections are more common in high-risk deliveries (a category higher-order multiples always fall into) and because they're more common among older moms (who give birth to the majority of triplets or quads). But some doctors say that vaginal delivery can be an option if Baby A (the one nearest the "exit") is in a head-down presentation and there are no other complicating factors (such as preeclampsia in the mom or fetal distress in one or more of the babies). In some rare cases, the first baby or the first and second may be delivered vaginally, and the final baby (or babies) may require a cesarean delivery. Of course, more important than having all of your babies exit vaginally is having all of you leaving the delivery room in good condition—and any route to that outcome will be a successful one.

Multiple Recovery

Besides having your hands (and if you're nursing, your breasts) twice as busy, your recovery from a multiple delivery will be very similar to that of a singleton delivery (you can read all about it in Chapters 16 and 17). You can also expect these postpartum differences:

- You'll be going with more flow. Your lochia (after-delivery bleeding) may be heavier and last longer. That's because more blood was stored up in your uterus during your pregnancy and it all has to go now. See page 461 for more.
- Afterpains may be more of a pain. Your uterus was extra-stretched by your multiple load, so it'll take more contracting to get it back to size—and those contractions may be extra painful. See page 462 for more.
- Your back won't catch a break. All the extra weight you carried around weakened your abs, which means they won't be as supportive of your poor, aching back, at least not until they tighten back up. Extra-loosened ligaments pose the same painful problem. In the meantime a belly band can pick up some of the slack. See page 494 for more.
- Your tummy will take extra time. A belly that took one (actually, two or more) for the team—generously providing room and board for multiple babies—will take longer to return to its normal size, and that's to be expected. In its way: your still extra-enlarged uterus, the extra fluids that will need to be flushed out, the extra fat reserves your body produced for your babies, and the extra-loose skin you're in. Give it (and yourself) time. See page 504 for more.
- Your recovery will be slower. In general, having just run a double (or triple) baby marathon will leave you lagging for longer. Especially if you were on bed rest or otherwise restricted in activity, you'll need to slowly build up your strength and stamina.

PART 3

After the Baby Is Born

CHAPTER 16

Postpartum: The First Week

Congratulations! The moment you've been awaiting for 40 (or so) weeks has finally arrived. You've put long months of pregnancy and long hours of childbirth behind you, and you're officially a mother, with a new bundle of joy in your arms instead of in your belly. But the transition from pregnancy to postpartum comes with more than just a baby—none of it is nearly as cute. It also comes with a variety of new symptoms (goodbye pregnancy aches and pains, hello postpartum ones) and a variety of new questions: Why am I sweating so much? Why am I having contractions if I've already delivered? Will I ever be able to sit again? Why do I still look 6 months pregnant? Whose breasts are these anyway? Hopefully, you'll have a chance to read up on these and many more pertinent postpartum topics in advance. Once you're on full-time mom duty, finding the time to read anything (never mind finding the time to use the toilet or take a shower) won't be easy.

What You May Be Feeling

During the first week postpartum, depending on the type of delivery you had (easy or difficult, vaginal or cesarean) you may experience all, or only some, of the following:

Physically

- Vaginal bleeding (lochia) similar to but possibly heavier than your period
- Abdominal cramps (afterpains) as your uterus contracts, especially when nursing

- Exhaustion
- Perineal discomfort, pain, numbness, if you had a vaginal delivery (especially if you had stitches)
- Some perineal discomfort if you had a c-section (especially if you labored first)
- Pain around the incision and, later, numbness in the area, if you had a c-section (especially a first one)
- Discomfort sitting and walking if you had a repair of a tear, an episiotomy, or a cesarean delivery
- Difficulty urinating for a day or two
- Constipation, and a lot of discomfort with bowel movements
- Hemorrhoids, continued from pregnancy and/or new from pushing
- All-over achiness, especially if you did a lot of pushing
- Bloodshot eyes, and/or black-and-blue marks around eyes, on cheeks, elsewhere, from pushing
- Sweating, particularly at night
- Hot flashes
- Swelling in your feet, ankles, legs, and hands, continued from pregnancy, plus possibly extra from any IV fluids
- Breast discomfort and engorgement beginning around the 3rd or 4th day postpartum
- Sore or cracked nipples, if you're breastfeeding
- Stretch marks (possibly including ones you never noticed before)

Emotionally

- Elation, blues, or swings between the two
- New mom jitters—trepidation about caring for your new baby, especially if you're a first-timer
- Excitement about starting your new life with your new baby
- A feeling of being overwhelmed by the challenges now and ahead
- Frustration, if you're having a hard time getting started breastfeeding

What You May Be Wondering About

Bleeding

"I expected some bleeding after delivery, but when I got out of bed for the first time and saw the blood running down my legs, I was a little freaked out."

Grab a pile of pads, and relax. This discharge of leftover blood, mucus, and tissue from your uterus, known as lochia, is normally as heavy as (and often heavier than) a menstrual period for the first 3 to 10 postpartum days. It may total up to 2 cups before it begins to taper off (not that you'll be measuring it), and at times it may seem pretty profuse. A sudden gush when you stand up in the first few days is normal—it's just the flow that accumulates when you've been lying down or sitting. Because blood and an occasional blood clot are the predominant ingredients of lochia during the immediate postpartum

Puff Mama, Part 2

No longer pregnant, but still plenty puffy (or maybe even more puffy)? Extra fluids accumulate during pregnancy, of course, but IV fluids during labor and delivery pump in even more. So if you had an IV, you can expect to experience additional swelling in your legs and ankles (and maybe your hands and face, too) afterward. It will take time to drain those accumulated fluids, but you can help speed up the process by circling your ankles (make 10 circles clockwise, then 10 counterclockwise), getting up and moving around as soon as you're able, and drinking lots of water to flush your system.

period, your discharge can be quite red for anywhere from 5 days to 3 weeks, gradually turning to a watery pink, then to brown, and finally to a yellowish white. Maxipads, not tampons, should be used to absorb the flow, which may continue on and off for just a couple of weeks or for as long as 6 weeks. In some moms, light bleeding continues for as long as 3 months. The flow is different for everyone.

Breastfeeding—and/or Pitocin, which is routinely ordered by some practitioners (either via IV or a shot) after delivery—may reduce the flow of lochia by encouraging uterine contractions. These postdelivery contractions (aka afterpains, see next question for more) help shrink the uterus back to its normal size more quickly while pinching off exposed blood vessels at the site where the placenta separated from the uterus.

If you're in the hospital or birthing center and you think your bleeding may be excessive, let a nurse know. Once you're home, if you experience what seems to be abnormally heavy bleeding (see page 571), call your practitioner without delay. If you can't reach him or her, go to the ER (in the hospital where you delivered, if possible). Call your practitioner, too, if you notice no bleeding at all once you get home.

Afterpains

"I've been having crampy pains in my abdomen, especially when I'm nursing. What's that about?"

Thought you'd felt the last of those contractions? Unfortunately, they don't end immediately with delivery—and neither does the discomfort (okay, pain) they can cause. Those so-called afterpains are triggered by the contractions of the uterus as it shrinks (from about 2⅓ pounds to just a couple of ounces) and makes its normal descent back into the pelvis following delivery. You can keep track of the shrinking size of your uterus by pressing lightly below your navel. By the end of 6 weeks, you probably won't feel it at all.

Afterpains can definitely be a pain, but they do important work. Besides helping the uterus find its way back to its usual size and location, those contractions help slow normal postpartum bleeding. They're likely to be more of a pain in women whose uterine muscles are lacking in tone because of previous births or excessive stretching (as with a multiple pregnancy). Afterpains can be much more intense during nursing, when contraction-stimulating oxytocin is released (a good thing, actually, since it means your uterus is shrinking faster) and/or if you had Pitocin following delivery.

The pains should subside naturally within 4 to 7 days. In the meantime, the

good news is now that you've delivered, you can turn once again to ibuprofen (Advil or Motrin) for its more potent pain relief, though acetaminophen (Tylenol) should do the trick, too. If pain relievers don't work, or if the pains persist for more than a week, see your practitioner to rule out other postpartum problems, including infection.

Perineal Pain

"I didn't have an episiotomy, and I didn't tear. Why am I so sore down there?"

You can't expect 7 or 8 pounds of baby to pass unnoticed. Even if your perineum was left neatly intact during delivery, that area has still been stretched, bruised, and generally traumatized, and discomfort, ranging from mild to not so mild, is the very normal result. The pain may be worse when you cough or sneeze, and you may even find that it hurts to sit down. You can try the same tips given in the next answer for post-tear pain.

It's also possible that in pushing your baby out, you developed hemorrhoids and, possibly, anal fissures, which can range from uncomfortable to extremely painful (see page 293). Or perhaps a vulvar or vaginal varicose vein that cropped up during pregnancy was further irritated during pushing and delivery, causing even more pain now. Fortunately, these types of varicose veins usually disappear a few weeks after delivery (and in the unlikely event that they don't disappear after a few months, your doctor can easily treat and remove them).

"I tore, and now I'm incredibly sore. Could my stitches be infected?"

Everyone who delivers vaginally (and sometimes those who have a lengthy labor before delivering via cesarean) can expect some perineal pain. But, not surprisingly, that pain's likely to be compounded if the perineum was torn or surgically cut (aka an episiotomy). Like any freshly repaired wound, the site of a tear or episiotomy will take time to heal, usually 7 to 10 days. Pain alone during this time, unless it is very severe, is not a sign that you've developed an infection.

What's more, infection (though possible) is really very unlikely if you've been taking good care of the area. While you're in the hospital or birthing center, a nurse will check your perineum at least once daily for any signs of infection, like inflammation. The nurse will also instruct you in postpartum perineal hygiene, which is important in preventing infection not only of the repair site but of the genital tract as well (germs can get around). For this reason, the same precautions apply for moms who delivered completely intact. Here's the self-care plan for a healthy postpartum perineum:

- Use a fresh maxipad as needed, but at least every 4 to 6 hours.
- Pour or squirt warm water (or an antiseptic solution, if one was recommended by your practitioner or nurse) over your perineum while you pee to

Welcome Back, Ibuprofen

Have you been missing your old buddy, ibuprofen (Advil, Motrin) during pregnancy? Once you've delivered (and unless your practitioner has advised otherwise), it's safe to pull ibuprofen out of the medicine cabinet again and enjoy its more potent pain relief for all your postpartum discomforts. It's also breastfeeding friendly.

ease burning, and after you're finished peeing to keep the area clean. Pat dry (make sure your hands are clean) with gauze pads or with the paper wipes that come with some hospital-provided pads, always from front to back. Gently does it—no rubbing.

- Keep your hands off the area until healing is complete.

Though discomfort is likely to be greater if you've had a repair (with itchiness around the stitches possibly accompanying soreness), the tips below will be soothing no matter how you delivered. To relieve perineal pain:

Ice it. To reduce swelling and bring soothing relief, use chilled witch hazel pads, an ice pack or disposable glove filled with crushed ice, or a maxipad with a built-in cold pack, applied to the site every couple of hours during the first 24 hours following delivery.

Heat it. Warm compresses or warm sitz baths (a bath in which only your hips and bottom are submerged) for 20 minutes a few times a day will ease discomfort. Ask your practitioner what you can add to the water for extra relief, such as Epsom salts, witch hazel, lavender oil, or chamomile oil.

Numb it. Use local anesthetics in the form of sprays, creams, ointments, or pads recommended by your practitioner. Taking ibuprofen (Advil, Motrin) or acetaminophen (Tylenol) may also help.

Keep off it. To keep the pressure off your sore perineum, lie on your side when possible, and avoid long periods of standing or sitting. Sitting on a pillow (especially one with an opening in the center, like a Boppy) or an inflated or memory foam donut cushion can help. You can also try tightening your buttocks before sitting down.

Keep it loose. Tight clothing can rub and irritate the area, plus slow the healing. Let your perineum breathe as much as possible (for now, favor baggy sweats over spandex leggings).

Exercise it. Kegel exercises, done as frequently as possible after delivery and right through the postpartum period, will stimulate circulation to the area, promoting healing and improving muscle tone. Don't worry if you can't feel yourself doing the Kegels, since the area initially will be numb. Feeling will return to the perineum gradually over the next few weeks—and in the meantime, the work's being done even if you can't feel it.

If your perineum becomes very red, very painful, and swollen, or if you detect an unpleasant odor, you may have developed an infection. Call your practitioner.

Delivery Bruises

"I look more like I've been in a boxing ring than in a birthing room. How come?"

Look and feel like you've taken a beating? That's normal postpartum. After all, you probably worked harder birthing your child than most boxers work in the ring, even though you were facing only a 7- or 8-pounder. Thanks to powerful contractions and strenuous pushing (especially if you were pushing with your face and chest instead of your lower body), you might be sporting a variety of unwelcome delivery souvenirs. These may include black or bloodshot eyes (cold compresses for 10 minutes several times a day may help speed healing) and bruises, ranging from tiny dots on the cheeks to larger black-and-blue marks on the face or upper chest area. You may also be bringing home soreness in your chest

When to Call Your Practitioner

Few moms feel their physical (or emotional) best after delivering a baby—that's just par for postpartum. Especially in the first 6 weeks after delivery, experiencing a variety of aches, pains, and other uncomfortable (or unpleasant) symptoms is common. Fortunately, what isn't common is having a serious complication. Still, it's smart to be in the know. That's why all brand new moms should be aware of symptoms that might point to a postpartum problem, just in case. Call your practitioner without delay if you experience any of the following:

- Bleeding that saturates more than 1 pad an hour for more than a few hours. If you can't reach your practitioner immediately, call the ER or the labor and delivery unit at the hospital you delivered at. Have the triage nurse assess you over the phone and advise you on whether or not you should come into the ER.
- Large amounts of bright red bleeding that occur 1 to 2 weeks after delivery (called delayed or secondary postpartum hemorrhage). But don't worry about light menstrual-like bleeding for up to 6 weeks (in some women as long as 3 months) or a flow that increases when you're active or during breastfeeding.
- Bleeding that has a foul odor. It should smell like your period.
- Numerous or large (lemon-size or larger) clots in the vaginal bleeding. Occasional small clots in the first few days, however, are normal.
- A complete absence of bleeding during the first few postpartum days
- Pain or discomfort, with or without swelling, in the lower abdominal area beyond the first few days after delivery
- Persistent pain in the perineal area beyond the first few days, especially if it doesn't respond to pain relievers
- After the first 24 hours, a temperature of over 100°F for more than a day
- Severe dizziness or significant lightheadedness when standing up
- Nausea and vomiting
- Severe headaches that persist for more than a few minutes
- Localized pain, swelling, redness, heat, and tenderness in a breast once engorgement has subsided, which could be signs of mastitis or breast infection
- Localized swelling and/or redness, heat, and oozing at the site of a c-section incision
- After the first 24 hours, difficulty urinating, excessive pain or burning when urinating, and/or a frequent urge to urinate that yields scanty and/or dark urine. Drink plenty of water while trying to reach your practitioner.
- Sharp chest pain (not chest achiness, which is usually the result of strenuous pushing); rapid breath or heartbeat; blueness of fingertips or lips
- Localized pain, tenderness, and warmth in your calf or thigh, with or without redness, swelling, and pain when you flex your foot. Rest with your leg elevated while you try to reach your practitioner. Don't massage the leg or the tender area.
- Depression or anxiety that affects your ability to cope; feelings of anger toward your baby, particularly if those feelings are accompanied by violent urges. See page 498 for more on postpartum depression.

and/or difficulty taking a deep breath, because of strained chest muscles (hot baths, showers, or a heating pad may ease it), pain and tenderness in the area of your tailbone (heat and massage may help), and/or general all-over achiness (again, heat where it hurts may help).

Difficulty Urinating

"It's been a few hours since I gave birth, and I haven't been able to pee."

Peeing doesn't come easily for most brand new moms during the first 24 postpartum hours. Some feel no urge at all, and others feel the urge but are unable to satisfy it. Still others manage to pee, but with pain and burning. There are a host of reasons why basic bladder function often becomes too much like hard work after delivery:

- The holding capacity of the bladder increases because it suddenly has more room to expand—so your need to pee may be less frequent than it was during pregnancy.
- The bladder may have been traumatized or bruised during delivery. Temporarily paralyzed, it may not send the necessary signals of urgency even when it's full.
- Having had an epidural and/or a catheter may decrease the sensitivity of the bladder or your alertness to its signals.
- Perineal pain may cause reflex spasms in the urethra, making urination difficult. Swelling of the perineum may also stand between you and an easy pee.
- The sensitivity of the site of a tear or episiotomy repair can cause burning and/or pain with urination. Burning may be eased somewhat by standing astride the toilet while peeing so the flow comes straight down, without touching sore spots. Squirting warm water on the area while you pee can also decrease discomfort (use the squirt bottle you were probably given and shown how to use).
- You may be dehydrated, especially if you didn't do any drinking during labor, and didn't receive IV fluids.
- Any number of psychological factors may keep you from going with the flow: fear of pain, lack of privacy, embarrassment over using a bedpan or needing help at the toilet.

As difficult as peeing may be, it's essential that you empty your bladder within 6 to 8 hours after delivery (or after the removal of any catheter) to avoid a UTI, loss of muscle tone in the bladder from over-distension, and excessive bleeding (because an overfull bladder can get in the way of your uterus as it attempts the normal postpartum contractions that stanch bleeding). With those marching orders in mind, the nurse will ask you frequently after delivery if you've accomplished this important goal. You might even be asked to deposit that first postpartum pee into a container or bedpan, so your output can be measured. The nurse may palpate your bladder to make sure it's not distended. To help get things flowing:

- Be sure you're drinking plenty of fluids: What goes in is more likely to go out.
- Take a walk. Getting out of bed and going for a slow stroll as soon after delivery as you're able will help get your bladder (and bowels) moving.
- If you're uncomfortable with an audience (and who isn't?), have the nurse wait outside while you pee.
- If you have to use a bedpan, try to sit on it instead of lying on it.

- Squirt warm water over your perineal area to induce urgency. You can also try warming your perineum in a sitz bath or chilling it with an ice pack
- Turn the water on while you try. Running water in the sink really does encourage your own faucet to flow.

If all efforts fail and you haven't peed within 8 hours after delivery, your practitioner may order a catheter to empty your bladder—another good incentive to try the methods above.

After 24 hours, the problem of too little generally becomes one of too much. Most new moms usually begin urinating frequently and plentifully as the excess fluids of pregnancy are excreted. If you're still having trouble peeing, or if output is scant during the next few days, it's possible you have a UTI (see page 528).

"I can't seem to control my urine. It just leaks out."

The physical stress of childbirth can put a lot of things temporarily out of commission, including the bladder. Either it can't let go of the urine—or it lets go of it too easily, as in your drippy case. Such leakage (called urinary incontinence) occurs because of loss of muscle tone in the perineal area. Kegel exercises can help restore the tone and help you regain control over the flow of urine. See page 492 for more.

That First Bowel Movement

"I delivered 2 days ago and I haven't had a bowel movement. I've felt the urge, but I've been too afraid of opening my stitches to try."

The passing of the first postpartum bowel movement is a milestone every newly delivered mom is eager to put behind her (so to speak). And the longer it takes you to get past that milestone, the more anxious—and the more uncomfortable—you're likely to become.

Several physical factors may interfere with the return of bowel-business-as-usual after delivery. For one thing, the abdominal muscles that assist in elimination have been stretched during childbirth, making them flaccid and sometimes temporarily unable to help out. For another, the bowel itself may have taken a beating during delivery, leaving it sluggish. And of course, it may have been emptied before or during delivery (remember that prelabor diarrhea? The poop that you squeezed out during pushing?), and stayed pretty empty because you didn't eat much solid food during labor.

But it's the psychological factors that most inhibit postpartum pooping: the fear that it will hurt, split open any stitches, or make your hemorrhoids worse; the natural embarrassment over lack of privacy in the hospital or birthing center; and that pressure to "perform." In other words, it's mind over fecal matter.

Here are some steps you can take to get things moving again:

Don't worry. Nothing will keep you from moving your bowels more than worrying about moving your bowels. Don't stress about opening the stitches—you won't. Finally, don't worry if it takes a few days to get things moving—that's okay, too.

Request roughage. If you're still in the hospital or birthing center, select as many whole grains (bran cereal or muffins), beans, and fresh fruits (but not bananas) and salads from the menu as you can. If you're home, make sure you're eating regularly and well—and

Should I Stay or Should I Go?

Wondering when you'll be able to bring baby home? How long you and your baby stay in the hospital will depend on the kind of delivery you had, your condition, and your baby's condition. By federal law, you have the right to expect your insurer to pay for a 48-hour stay following a normal vaginal delivery and 96 hours following a cesarean delivery. If both you and your baby are in fine shape and you're eager to get home, you'll likely be able to go home 24 hours after your vaginal delivery and 2 to 3 days after your cesarean delivery (or earlier if your practitioner gives the early green light).

If you do opt for an early checkout, keep in mind that your baby will need an early checkup, too, just to make sure no problems crop up after discharge. The most convenient option is a home nurse visit (since you won't have to venture out to get your baby checked out). Your insurance plan may pay for a home nurse visit, and all first-time low-income moms are eligible for one through the Affordable Care Act's Maternal, Infant, and Early Childhood Home Visiting program. If a checkup at home isn't an option, make sure you take your newborn for an office visit to the pediatrician within a few days. The nurse or doctor will assess baby's weight and general condition (including a check for jaundice), as well as evaluate how feeding is going. Keeping and bringing along a feeding diary (and a wet and dirty diaper count) will help.

If you do stay the full 48 or 96 hours, take advantage of the opportunity to rest as much as possible. You'll need that energy stash for when you get home.

that you're getting your fill of fiber. As much as you can, stay away from bowel-clogging foods like white bread and rice.

Keep the liquids coming. Not only do you need to compensate for fluids you lost during labor and delivery, but you need to take in additional liquids to help soften stool if you're clogged up. Water's always a winner, but you may also find apple or prune juice especially effective. Hot water with lemon can also do the trick.

Get off your bottom. An inactive body encourages inactive bowels. You won't be running laps the day after delivery, but you will be able to take short strolls up and down the halls. Kegel exercises, which can be practiced in bed almost immediately after delivery, will help tone up not only the perineum but also the rectum. At home, take walks with baby.

Don't strain. Straining won't break open any stitches you have, but it can lead to or aggravate hemorrhoids. If you already have hemorrhoids, you may find relief with sitz baths, topical anesthetics, witch hazel pads, suppositories, or hot or cold compresses.

Use stool softeners. Many hospitals send new moms home with both a stool softener and a laxative, for a reason: Both can help get you going.

The first few bowel movements may be a pain to pass. But fear not. As stools soften and you become more regular, discomfort will ease and eventually end—and moving your bowels will become second nature once again.

Excessive Sweating and Hot Flashes

"I've been waking up at night soaked with sweat. Is this normal?"

It's messy, but it's normal. New moms are sweaty moms (and sometimes, moms with hot flashes), and for a couple of good reasons. For one thing, your hormone levels are dropping—reflecting the fact that you're no longer pregnant. For another, perspiration (like frequent urination) is your body's way of ridding itself of pregnancy-accumulated fluids (as well as any IV-accumulated fluids) after delivery—something you're bound to be happy about. Something you might not be happy with is how uncomfortable that perspiration might make you, and how long it might continue. Some women keep sweating up a storm for several weeks or more. If you do most of your perspiring at night, as most new moms do, covering your pillow with an absorbent towel may help you sleep better (it'll also help protect your pillow).

Don't sweat the sweat. Do make sure, though, that you're drinking enough fluids to compensate for the ones you're losing, especially if you're breastfeeding but even if you're not.

Hot flashes are common postpartum, too, also because of those hormonal changes. These is-it-hot-in-here-or-is-it-me moments may be more pronounced if you're breastfeeding and may last a few weeks or more—but while they may be a preview of menopause, they're not a sign of it.

Fever

"I've just come home from the hospital, and I'm running a fever of about 101°F. Should I call my doctor?"

Just as it was during your 9 months of pregnancy, it's always a good idea to play it safe during the first week or so after delivery—and that means keeping your practitioner in the loop when you're not feeling well. Although it's always possible that the fever you're running isn't postpartum-related, your practitioner will want to rule out a postpartum infection and treat any infection that's getting you down. While a fever can also occasionally be caused by the combination of excitement and exhaustion that's common in the early postpartum period, it typically wouldn't run as high as 101°F. A brief low-grade fever (less than 100°F) occasionally accompanies engorgement when your milk first comes in, and it's nothing to worry about.

So keep playing it safe postpartum. Report to your practitioner any fever over 100°F that lasts more than a day during the first 3 postpartum weeks or that lasts more than a few hours if it's a higher fever.

Engorged Breasts

"My milk just came in, and now my breasts are gigantic, rock hard, and so painful I can't put on a bra."

Just when you thought your breasts couldn't get any bigger, they do. That first milk delivery arrives, leaving your breasts swollen, painfully tender, throbbing, granite hard—and sometimes seriously, frighteningly gigantic. To make matters more uncomfortable and inconvenient, this engorgement (which can extend all the way to the armpits) can make nursing painful for you and, if your nipples are flattened by the swelling, frustrating for baby. The longer it takes for you and baby to hook up for your first nursing sessions, the worse the engorgement is likely to be.

Happily, though, it won't last long. Engorgement, and all its miserable effects, gradually eases once a well-coordinated milk supply-and-demand system is established, typically within days. Nipple soreness, too—which usually peaks at about the 20th feeding, if you're keeping count—generally diminishes rapidly as the nipples toughen up. And with proper care, so does the nipple cracking and bleeding some women also experience (see *What to Expect the First Year* for more).

Until nursing becomes second nature for your breasts—and completely painless for you—there are some steps you can take to relieve the discomfort and get a good milk supply going (read all about it starting on page 478).

Women who have an easy time getting started with breastfeeding (especially second-timers) may not experience very much engorgement at all. As long as baby's getting those milk deliveries, that's normal, too.

Engorgement If You're not Breastfeeding

"I'm not nursing. I've heard that drying up the milk can be painful."

Your breasts are programmed to fill with milk around the 3rd or 4th postpartum day, whether you plan to use that milk to feed your baby or not. This engorgement can be uncomfortable, even painful—but it's only temporary.

Milk is produced by your breasts only as needed. If the milk isn't used, production stops. Though sporadic leaking may continue for several days, or even weeks, severe engorgement shouldn't last more than 12 to 24 hours. During this time, ice packs, mild pain relievers, and a supportive bra may help. Avoid nipple stimulation, expressing milk, or hot showers, all of which stimulate milk production and keep that painful cycle going longer.

Where's the Breast Milk?

"It's been hours since I delivered, and nothing comes out of my breasts when I squeeze them. Is my baby boy starving?"

Not only is your baby not starving, he isn't even hungry yet. Babies aren't born with a big appetite or with immediate nutritional needs. And by the time your baby begins to hunger for a breast-full of milk (on the 3rd or 4th day postpartum), you'll undoubtedly be able to serve it up.

Which isn't to say that your breasts are currently empty. Colostrum, which provides your baby with enough nourishment for now and with important antibodies his own body can't yet produce (and also helps empty baby's digestive system of excess mucus and bowels of meconium), is definitely present in the tiny amounts necessary. A teaspoon or so per feeding is all your bundle of joy needs at this point. But until the 3rd or 4th postpartum day, when your breasts begin to swell and feel full (indicating the milk has come in), it's not that easy to express by hand. A day-old baby, eager to suckle, is better equipped to extract this premilk than you are.

If your milk doesn't come in at all by the time you've hit day 4, call your practitioner.

Bonding

"I expected to bond with my baby as soon as she was born, but I'm not feeling anything at all. Is something wrong with me?"

Moments after delivery, you're handed your long-anticipated bundle of joy, and she's more beautiful

Breast Milk Timeline

Suckling on colostrum for the first few days not only gets your newborn off to the healthiest start in life, but also gets the breastfeeding party started, stimulating production of the next stage of breast milk. Here's what'll be on tap for your baby in the coming weeks:

Colostrum. You already have this thick clearish-yellow premilk at the ready as soon as baby is born—providing your cuddly cutie with crucial antibodies and just the right kind of nourishment for the first few days of life.

Transitional milk. Next up on the breast milk menu: transitional milk, which is what's filling your breasts (and baby's tiny tummy) during engorgement. It has a whitish-orange color and contains more lactose, fat, and calories than colostrum while still providing a fair amount of those all-important immunoglobulins and proteins.

Mature milk. Mature milk—which looks like watery skim milk slightly tinged light blue—takes over from transitional milk around day 10 to 14 postpartum. Mature milk has two components to it: foremilk and hindmilk. When your little one starts to suckle, the foremilk quenches baby's thirst, but not his or her appetite. As the nursing session progresses, your breast dispenses the hindmilk, which is power-packed with the filling stuff: protein, fat, nutrients, and calories—everything your growing baby needs.

and more perfect than you ever dared to imagine. She looks up at you, and your eyes lock in a heady gaze, forging an instant bond. As you cradle her tiny form, breathe in her sweetness, and cover her soft face with kisses, you feel emotions you never knew you had, and they overwhelm you with their intensity. You're a mom in love.

And maybe you were dreaming—or, at least, pregnant daydreaming. Birthing-room scenes like this one are the stuff dreams—and commercials—are made of, but they don't always play out. Another possible scenario: After a long, hard labor that's left you physically and emotionally drained, a wrinkled, puffy, red-faced stranger is placed in your awkward arms, and the first thing you notice is that she doesn't quite resemble the chubby-cheeked cherub you'd been expecting. The second thing you notice is that she doesn't stop crying. The third, that you have no idea how to make her stop crying. You try to feed her, but she won't latch on. You try to socialize with her, but she's more interested in sleeping—and frankly, at this point, so are you. And you can't help wondering: Have I missed my opportunity to bond with my baby?

Absolutely, positively not. The process of bonding is different for every parent and every baby, and it doesn't come with a use-by date. Sure, some moms bond quickly with their newborns—maybe because they've had experience with infants before, their expectations are more realistic, their labors were easier, or their babies are more responsive. But other moms (plenty of them!) find that the attachment doesn't cement with superglue speed. In fact, the bonds that last a lifetime generally form gradually, over time—and you and your baby have lots of that ahead of you.

FOR FATHERS

Bonding with Baby

Bonding begins with that first cuddle, but it's just the very start of your relationship with your baby. That brand new connection between you will deepen and strengthen, not just over the next weeks, but over the many years you'll be sharing as father and child.

In other words, don't expect instant results. You may get them, but no worries if you don't. Look at every moment with your newborn as a new opportunity to strengthen the bond you've been building. Every cuddle, every kiss, every bath, every gaze into those beautiful eyes, every word you speak or song you sing (remember your voice linked you together even before baby was born)—you'll be bonding. Making eye-to-eye contact and skin-to-skin contact (opening your shirt and snuggling baby against your bare chest) every chance you get will tighten the bond—while according to research, helping speed your newborn's brain development. In fact, every opportunity you take to be close to your baby increases your levels of the nurturing hormone, oxytocin, which in turn increases those feelings of closeness. Yes, the relationship may seem a little one-sided at first (until your newborn is alert enough to be responsive, you'll be doing all the smiling and cooing), but every moment of your attention is contributing to your baby's fledgling sense of wellbeing, letting your baby know he or she's secure, cared for, and loved unconditionally. The feedback you'll get once the smiles start coming will confirm that the connection with your baby was there all along.

Has your spouse been mom-monopolizing the baby and the baby care? Let her know that you'd like in. If she tends to baby hog when you're both at home (moms often do this without even realizing it), send her out—or at least, out of the room. That way, she can get some alone time—and you can get the alone-with-baby time that will quickly bring you even closer.

So give yourself that time—time to get used to being a mother (it's a major adjustment, after all) and time to get to know your newborn, who, let's face it, is also a newcomer in your life. Meet your baby's basic needs (and your own), and you'll find that love connection forming—a day (and a cuddle) at a time. And speaking of cuddles, bring them on. The more nurturing you do (especially skin-to-skin, since such snuggles release more of that nurturing hormone, oxytocin), the more like a nurturer you'll feel. Though it may not seem like it's coming naturally at first, the more time you spend cuddling, feeding, massaging, singing to, cooing to, and talking to your baby—the more time you spend skin-to-skin and face-to-face—the more natural it will start feeling, and the closer you'll become. Before you know it, you'll feel like the mom you are (really!), bound forever to your baby by the kind of love you've dreamed of.

"My baby was premature and was rushed to the NICU. The doctors say he'll be there for at least 2 weeks. Will it be too late for good bonding when he gets out?"

Not at all. Sure, having a chance to bond right after birth—to make contact, skin-to-skin, eye-to-eye—is wonderful. It's a first step in the development of a lasting parent-child

connection. But it's only the first step. And this step doesn't have to take place at delivery. It can take place hours or days later in a hospital bed, or through the portholes of an isolette, or even weeks later at home.

And luckily, you'll be able to touch, talk to, and probably hold your baby even while he's in the NICU. Most hospitals not only allow parent-infant contact in the NICU, but encourage it—especially kangaroo care (holding baby skin-to-skin against your chest). Talk to the NICU staff and see how you can get close to your newborn. For more on the care of premature babies, see *What to Expect the First Year.*

Keep in mind, too, that even moms and dads who have a chance to bond in the birthing room don't necessarily feel that instant attachment (see the previous question). Love that lasts a lifetime takes time to develop—time that you and your baby will start having together soon.

Recovery from a Cesarean Delivery

"What will the recovery from my c-section delivery be like?"

Recovery from a c-section is similar to recovery from any abdominal surgery, with a delightful difference: Instead of losing a gallbladder or appendix, you gain a brand new baby.

Of course, there's another less delightful difference. In addition to recovering from surgery, you'll also be recovering from childbirth. Except for a neatly intact perineum, you'll experience all the same postpartum discomforts over the next weeks (lucky you!) that you would have had if you'd delivered vaginally: afterpains, lochia, perineal discomfort (if you went through labor before the surgery), breast engorgement, fatigue, hormonal changes, and excessive perspiration, to name a few.

Here's what you can expect in the recovery room:

Pain around your incision. Once the anesthesia wears off, your incision wound, like any wound, is going to hurt—though just how much depends on many factors, including your personal

Give It Time

So you've been a mom for a week (with the stretch marks, postpartum pains, and bags under your eyes to prove it), and by now you may be wondering: When am I going to feel like one? When will I be able to accomplish latch-on without 20 minutes of fumbling? Or finally get the hang of burping? Or stop worrying about breaking the baby every time I pick her up? When will I be able to coo without feeling awkward? When will I figure out which cries mean what—and how to respond to any of them? How do I put on a diaper so it doesn't leak? Get the onesie over baby's head without a struggle? Shampoo that little patch of hair without dripping soap into those tender eyes? When will the job that nature just signed me up for start coming naturally?

The truth is, giving birth makes you a mother, but it doesn't necessarily make you feel like one. Only time spent on this sometimes bewildering, sometimes overwhelming, always amazing job will do that. The day-to-day (and night-to-night) of parenting is never easy, but it absolutely, positively gets easier.

So cut yourself some slack, pat yourself on the back, and give yourself time, mom. Which, by the way, you are.

Rooming-in Rules

Wondering where all the babies at your local hospital went (you know, the neatly wrapped bundles that used to be on display in the nursery, in row after row of bassinets)? They're rooming-in with their moms, most likely. Full-time rooming-in has become the standard in family-centered maternity care, and for a lot of very sound reasons. It gives new parents (often both parents, since dads are typically welcome to room-in, too) the chance to start getting to know their new arrival right from the start—to spend time snuggling skin-to-skin, to become familiar with baby's hunger cues, to start practicing those soothing techniques they'll definitely need once they arrive home. It also makes it possible for new moms to breastfeed on demand, which boosts the odds of ultimate breastfeeding success. It even reduces the amount of crying and increases the amount of sleeping newborns do (and their moms, believe it or not). Rooming-in is considered so beneficial, in fact, that even NICU families are encouraged to bunk with their babies in a hospital room for a night or two (albeit with a nurse just a call button away) before heading home.

For all those reasons and more, hospital nurseries often don't have many (if any) baby boarders at any given time these days, typically taking in only newborns in need of some extra care. Some hospitals have even shut down their nurseries entirely, sending babies needing medical attention to the NICU instead.

So do new moms have a choice when it comes to rooming-in? At many hospitals, they don't—rooming-in has become a requirement (and when it's not mandatory, it's highly suggested). And that's just fine with most moms and dads—who are often just as happy not to let their brand new little ones out of their sight. But sometimes, rooming-in moms need a break, an hour or two of uninterrupted sleep, or just a chance to rest up from childbirth and get ready for childrearing. If that sounds like you—push that button now and ask for a break. You've earned it, you deserve it, and—hopefully—you'll get it. Just make sure that if you're breastfeeding, your baby isn't given any supplementary bottles while you rest.

pain threshold and how many cesarean deliveries you've had (the first is usually the most uncomfortable). You will probably be given pain relief medication as needed, which may make you feel woozy or drugged. It will also allow you to get some needed sleep. No stress if you're nursing—the medication won't pass into your colostrum, and by the time your milk comes in, you probably won't need any heavy painkillers (though if you do, the small amount of medication that gets into your milk won't be unsafe for baby). If the pain continues for weeks, as it sometimes does, you can also safely rely on over-the-counter pain relief like ibuprofen (Advil or Motrin)—just ask your practitioner about dosing. (If you'd like to avoid narcotic meds from the start, discuss pain relief options with your practitioner ahead of time, and make sure that anyone administering medications is aware of your preference.)

Possible nausea, with or without vomiting. This isn't always an aftereffect of the surgery, but if it is, ask about getting an antinausea medication.