Special Deliveries

Your baby's birth day is bound to go more smoothly if you have a birth plan in hand. Just remember, though—even the best-laid plans don't always turn out as expected.

By Diana Tonnessen

Every woman is different and each birth is a special delivery. Each of us must make her own way through the transition to motherhood . There's no right or wrong way to birth a baby; it's simply done in whatever way you can manage. To be sure, it's easier when you have some idea of what to expect, a well-conceived birth plan and plenty of supportive players— even if things don't go quite as you had expected.

In the end all that really matters is the safe delivery of that very special package you've been awaiting all these months—your baby.

Questions For You and Your Partner

You'll want to make these important decisions before the baby's born:

- Circumcision: If you have a boy, should he be circumcised (surgical removal of the foreskin covering the penis)? It's usually a matter of personal, cultural or religious preference. The decision should be made in the interest of the newborn. If circumcision is performed, make sure to discuss appropriate analgesia techniques with your doctor.

- Breast or bottle: Hungry already? If all goes well during labor and delivery, your baby will be ready for that first feeding just moments after birth. So the time to decide whether you'll breast- or bottle-feed your baby is before the birth. (For help making that decision, see "Breast or Bottle," page 158.)

- Cord blood banking: The umbilical cord contains stem cells that some researchers say may be used to treat certain diseases of the blood and immune system. If your child or another member of your family should ever need a stem cell transplant, also known as a bone marrow transplant, these cells might be able to be used. Problem is, simply saving cord blood doesn't guarantee it's usable either for your child or another family member should they become ill or even that it will offer a cure. The odds of using cord blood for a self-transplant may be as low as one in 200,000 by age 18, and the chance that anyone in your family will need these cells is quite unlikely. While a sibling has the best chance of matching, there is only a 25% chance or less that these cells could even be used. In most cases an unrelated donor can be found.

  Research into cord blood is ongoing and many questions remain including uncertainties about the success rates of the proceedure and viability of cells in long-term storage. Also, by the time, if at all, an individual were to ever need his or her own cord blood for transplantation, there may be other medical approaches in the future to manage various diseases.

  If you don't store your child's cord blood, that doesn't mean that treatment won't be available if ever the need arose. There may also be a cord blood match in a public cord blood bank, from which most cord blood transplants are currently being done. Public or free cord blood banks are already available as part of the National Marrow Donor Program.

  Still, some parents may feel strongly enough about storing cord blood exclusively for use within their own family and opt to pay for private storage. Banking your baby's cord blood can be expensive, and the quality of private banks may vary. Though cord blood banks must register with the Food and Drug Administration, the federal government does not regulate collection and storage procedures.

  Contact the American Association of Blood Banks or visit the following Web sites to help you decide: *www.parentsguidecordblood.com* (a parent-operated site) or *www.marrow.org* (the National Marrow Donor Program, which contains a nationwide listing of programs that accept donations).

Questions For Your Doctor

Where will you deliver the baby? If you haven't already decided on a birthplace for your baby, now's the time to do so. Of course, your choices depend on what's available in your area, where your obstetrician handles deliveries and what your insurance will cover. Ask at which hospitals your doctor has privileges, then set up a tour.

What is your obstetrician's policy about fetal monitoring? Fetal monitoring of the baby's heart rate is used to see how the baby's doing during labor. The normal fetal heart beats between 120 to 160 times per minute. A higher, lower or irregular heart rate may signal a problem. Monitoring may be done via:

- Auscultation. This method, in which the doctor uses a fetoscope, or hand-held ultrasound wand, to check the baby's heart rate is the least invasive.

- External electronic monitor. Two belts containing sensors are strapped around the mother's belly. The sensors are attached to a machine, which records the fetal heart rate and the length and intensity of contractions. External monitoring usually is done

continually, restricting the mother to bed.

- Internal electronic monitor. An electrode inserted through the vagina is attached to the baby's scalp to record the fetal heart rate. A catheter inserted into the uterus monitors contractions. This method can be used only after the amniotic sac has ruptured.

When and how is labor induced? If your water has broken, you're more than two weeks overdue or you have high blood pressure or other health problems that threaten the health of either you or the baby, your obstetrician may feel that nature needs a little nudge. Here's what may help:

- Stripping the membranes: Your doctor inserts a gloved finger through the cervix and sweeps over the membranes connecting the amniotic sac to the uterine wall, causing the release of prostaglandins that ripen the cervix and trigger contractions.

- Ripening or dilating the cervix: Your doctor may apply topical prostaglandins or use special instruments to soften and dilate the cervix.

- Rupturing the amniotic sac: Your doctor may artificially break your water, which usually jump-starts contractions or makes them stronger. If this doesn't work, your ob-gyn may use another method, as well, since both you and your baby are at increased risk of infection after the sac has been broken.

- Oxytocin: A synthetic form of this hormone, which causes contractions or makes them stronger, may be given intravenously.

What kinds of pain medication are available should you decide you need it? If you've never been through labor, it may be hard to gauge how best to manage the pain until you're in the throes. The best strategy: Take childbirth classes and learn the breathing and relaxation techniques that are the hallmark of natural childbirth. But familiarize yourself with pain relief options (regional analgesia techniques).

- Epidural block: Numbs you from the waist down, blotting out the pain of labor contractions and the stretching of the vagina as the baby is pushed out. Larger doses may also be used to control pain during a cesarean birth, allowing the mother to stay alert and awake during the surgery. It involves inserting a catheter in the epidural space within your spine, which is first numbed by a local anesthetic.

- Pudendal block: Anesthetic is injected through the wall of the vagina to block pain in the pudendal nerve, a nerve which carries sensations from the vagina, the lower rectum, and the perineum. A pudendal block usually is administered shortly before delivery to block pain in the area of the perineum.

- Spinal block: Anesthetic is injected into the lower back, which blocks pain from the waist down. It's given only once during labor—usually right before delivery—and lasts just an hour or two.

- Saddle block: This is the same as a spinal block, but numbs a smaller area—the buttocks, perineum and vagina.

- General anesthesia: This is used only for emergency cesarean birth, cesarean delivery when epidurals are not safe or when the baby must be delivered quickly.

Under what conditions would your obstetrician recommend cesarean delivery? About one in four babies today is born via cesarean—and the odds are higher if you're over 35. Still, cesarean deliveries, which involve lifting the baby through an incision in the mother's abdomen, are meant to protect you and your baby and can be lifesaving. The most common medical reasons for cesarean births are:

- Previous cesarean deliveries. Many women who had a past cesarean birth can try to deliver vaginally (see below). Still, depending on the type of uterine incision you have, or the condition that gave rise to the first cesarean birth, a repeat cesarean may be the only recourse.

- Multiple gestations. If you're having twins and don't develop any complications, you can safely deliver the babies vaginally. However, the risks of vaginal delivery increase for women carrying more than two babies, so cesarean birth may be an option.

- The size or position of the baby. You may need a cesarean if your baby is exceptionally large or your pelvis is small, a condition called cephalopelvic disproportion. Likewise, if the position of the baby during labor is breech (buttocks- or feet-down), a cesarean may be safer; if the baby is transverse (lying sideways in the uterus), a cesarean is a must.

- Problems with the placenta or umbilical cord. A cesarean birth may be required if either the placenta or umbilical cord is blocking the birth canal.

- Other medical conditions in the mother. Examples include an active genital herpes infection or high blood pressure.

- Failure of labor to progress or labor that is too stressful for the baby.

- In a cesarean birth, the mother may receive an epidural block and be awake and alert during the surgery. The father usually can remain with her. General anesthesia is reserved only for emergency cesarean births, when the baby needs to be delivered quickly.

If you've had a cesarean birth in the past, will you be able to deliver vaginally this time? Many women who previously gave birth by cesarean may be able to deliver subsequent babies through the vagina in what's known as a vaginal birth after cesarean (VBAC). The advantages include a shorter hospital stay, lower risk of infection and faster recovery. However, there are some risks with VBACs, and your doctor may decide that another cesarean is necessary.

One factor that will help determine whether or not you are a good candidate for a VBAC is the type of uterine incision you had for the previous cesarean birth. This will be indicated in your medical records—and not necessarily reflected by the scar on your

belly. If you had a transverse uterine incision (horizontal across the lower part of the uterus) or a low vertical incision, VBAC may be an option. A high vertical incision is associated with an increased risk of uterine rupture, which could endanger you and the baby. Other deciding factors are the size and position of the baby, signs that the baby may have problems during labor or a vaginal delivery, placenta problems or medical problems with the mother, such as preeclampsia.

Under what conditions would your obstetrician use forceps or vacuum extraction? Instruments typically are used to assist in roughly one out of 10 deliveries, for one of the following reasons: if labor goes smoothly, but pushing the baby out becomes problematic (you become too tired or you bear down for hours without much progress); if the baby's heartbeat becomes slow or erratic; or if the baby's position in the uterus makes delivery difficult. The doctor will either use forceps, a device resembling two large spoons that is placed around the baby's cheeks and jaw (which have plenty of fat padding) to guide the baby's head out of the birth canal, or vacuum extraction, in which a plastic suction cup is inserted into the vagina and applied to the baby's head.

Questions For The Hospital Staff

Does the hospital have birthing rooms? If so, how many? Many hospitals have birthing rooms (also known as LDRs—labor/delivery/recovery, or LDRPs—labor/delivery/recovery/postpartum), in which you labor, deliver the baby and recover without having to be shuffled from the labor room to a separate delivery room and back. Most birthing rooms have the look and feel of a bedroom instead of a hospital room, which can be more relaxing and lead to an easier delivery.

Can the father and other support people stay with you in the delivery room? It's a fact: having the constant support of a spouse, partner, relative or friend can help your labor and delivery go more smoothly. Your support person can help you practice breathing or relaxation exercises before the big day. Then, during labor and delivery, he or she can hold your hand, help you focus, provide physical support when you're up and about, time and talk you through contractions and shower you with encouragement.

Most moms are happy to have a spouse, friend or relative as their support staff. But professional labor assistants, known as doulas, also may be hired to provide comfort and support. (To find a doula in your area, ask your doctor or contact Doulas of North America at (888) 788-DONA; *www.DONA.org*.)

Most hospitals allow your spouse and support people to stay with you throughout labor and delivery. Ask about the hospital's policy in advance so there'll be no surprises later on.

Is the hospital equipped to handle high-risk pregnancies? Does it have a neonatal intensive care unit? If not, how would an emergency be handled?

If complications arise during the birth, hospitals that have neonatal intensive care units on hand are lifesaving. If your hospital doesn't have one, ask how the staff would handle an emergency. Most make arrangements for the transfer of mother and baby to the nearest hospital with a neonatal intensive care unit.

Are private rooms available? Before requesting a private room, check with the hospital and your insurance provider about the extra cost.

What kind of care will the baby receive right after it's born? If the baby is healthy, you may be able to hold and breastfeed him or her immediately after birth.

What kinds of newborn tests will your baby receive? Most states require certain newborn tests for metabolic diseases such as phenylketonuria (PKU) and hypothyroidism, both of which can cause mental retardation if untreated. The number of conditions tested for vary greatly by state. Talk to your pediatrician or ob-gyn about what tests are routinely done at your hospital and about any need for further testing through a private lab. For example, there are more than 40 rare diseases that can be tested for using an advanced technique called tandem mass spectrometry.

Will the baby be permitted to stay in the room with you (if you so desire) or will it be kept in the nursery? Many hospitals now offer rooming-in (helpful for breastfeeding) in which the baby stays with you rather than in the nursery. When you need rest, the baby can then spend some time in the nursery.

Is there a lactation consultant on staff? A lactation consultant, trained to help breastfeeding mothers and their babies with what are often the very awkward beginning stages of nursing, can make all the difference between first-feeding success and the frustration that could lead to failure. **p**

When will you know when it's time?

The classic signs that labor is imminent are:

- Show: The mucus plug that seals off the cervix during pregnancy is dislodged and pushed into the vagina as the cervix begins to open. Look for clear, pink or slightly bloody vaginal discharge anywhere from a few days before labor begins to the actual onset of labor.
- Rupture of membranes: A gush or trickle of fluid from your vagina may be a sign that the fluid-filled amniotic sac has broken. Usually happens at the start of labor or sometime during labor
- Contractions: Strong, rhythmic cramps that feel like a backache or menstrual cramps usually signify the onset of labor. (Braxton-Hicks contractions, painless contractions that feel like a tightening of the uterus, may occur for weeks or even months before labor begins.)