NEW Mother's Handbook

Care for You and Your Baby

WESTERN MARYLAND
HEALTH SYSTEM
Caring for What Matters Most

Visit us at www.wmhs.com

Western Maryland Health System

TABLE OF CONTENTS

Introduction

The nursing staff from the Perinatal Unit at the Western Maryland Regional Medical Center created this book especially for you. Whether you are expecting your first child or you are already an experienced mom, this book will provide helpful information and answers for the many questions you may have in the coming months.

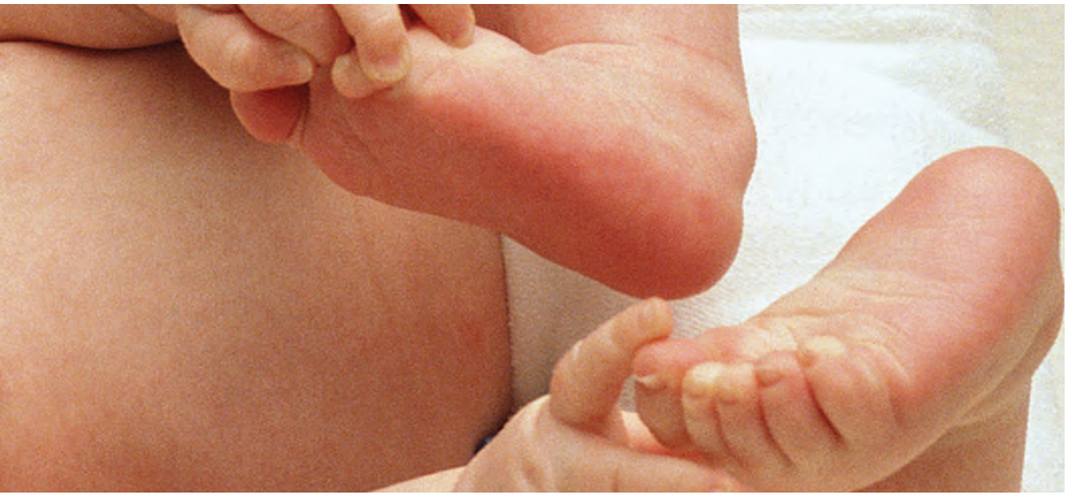
The first section is devoted to your pregnancy. Regular visits to your obstetrician are essential throughout your pregnancy. This book was designed to provide you with additional information about your pregnancy and should not be used as a substitute for care by your obstetrician. Please be sure to discuss specific questions or concerns you may have with your provider.

The second section of the book provides lots of information about the birth of your child. The third section has helpful, practical information on infant care. In addition, there is a glossary of terms that should be useful. Our nurses also offer a number of free educational programs on these topics so please ask for a schedule of upcoming programs or visit our website at www.wmhs.com.

The birth of a child is one of the most joyous occasions a family can experience and we look forward to helping you welcome your child into the world.

Special Thanks!

Special thanks to the following staff for developing this book:
Debbie Fornwalt, Chris Gilmore, Shari McFarland, and Pam Mulligan.



Childbirth Classes

Childbirth classes are offered to expectant parents and their families. They are held in the auditorium of the Western Maryland Regional Medical Center.

You can register for the classes by calling the Postpartum Unit on 6 South at **240-964-6400**.

THE CHILDBIRTH CLASSES INCLUDE:

Preparation for Childbirth: Two 3-hour classes

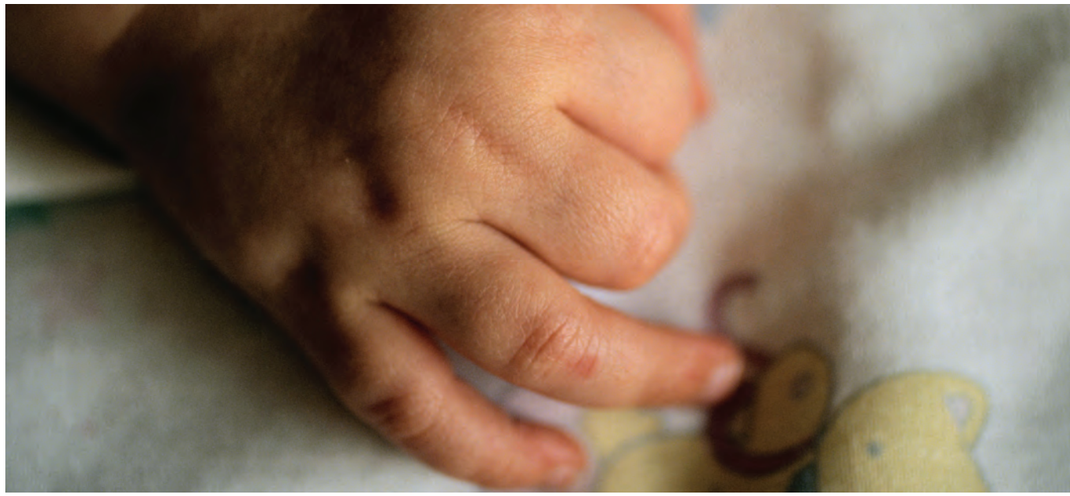
Basic childbirth class participants are encouraged to attend a special speaker class during their last trimester of pregnancy.

OTHER CLASSES OFFERED:

Breastfeeding: Why To? How To? Can Do! (One 3-hour class)

The Newborn: What to Expect (One 3-hour class)

Sibling Class: For the Big Brother or Sister to Be (One 2-hour class)



SECTION I: YOUR PREGNANCY

YOU AND YOUR BABY

(Trimester by Trimester)

As your pregnancy progresses, you will begin to notice several changes in your body. Some, like an increase in your weight, are very obvious; but others can occur without you even knowing that they are happening. To explain these changes, it is easier to divide your pregnancy into three parts or trimesters. Each trimester lasts three months.

FIRST TRIMESTER

MOM: This trimester, for the first three months, lasts from week 1 to week 12 of your pregnancy. During this time, your baby is growing rapidly, and at the beginning of this time, you are not even aware that you are pregnant.

Several changes happen to you and your body. Most women notice a missed period as the first sign of their pregnancy. The other sign most frequently noticed is morning sickness or bouts of nausea or vomiting. Although it is commonly called morning sickness, it can occur at any time of the day. You may also have to urinate more frequently. This will continue until the end of your pregnancy. You will feel fullness in your breasts and the brown area around your nipples will become darker. You may begin to feel tired more often. This can be caused by hormonal changes or lack of iron, which is also known as anemia.

Again, during these first three months, you may not even be aware that you are pregnant, but everything you do during this time is very important to your baby's health. You need to make arrangements to see your doctor as soon as you think that you may be pregnant or you miss a period. You need to rest more frequently and you need to eat the right kinds of food so your baby grows and develops properly. It is important to remember that you may not experience all of the symptoms explained in this book.

BABY:

First Month
- Head and body are forming
- Arms and legs start to form
- Heart beats at day 25

Second Month
- Internal organs are formed
- Spine and major joints now move
- Baby is one inch long

Third Month
- Eyes, nose, mouth, and ears can be seen
- Sex organs develop
- Fingers and toes have soft nails
- Baby is four inches long and weighs about one ounce

SECOND TRIMESTER

MOM:

The second trimester, or second three months, lasts from week 13 to week 24. During this time, you will begin to feel like you are really pregnant. You start to notice a weight gain. This weight gain is important to you and your baby so it is not the time to diet.

Nausea or morning sickness should be going away and you will start to feel less tired and have more energy. You won't have to go to the bathroom as much because the baby is moving away from the pelvic cavity, where it places pressure on your bladder, to the abdominal cavity. You may start to experience some back pain at this time. A dark line down the center of your abdomen may appear. This is normal and is due to a change in your hormones. Your breasts are becoming larger and softer. You may notice yellowish liquid, called colostrum, coming out of your nipples. This is formed before the real breast milk.

Pregnancy is a time of great change - not only to your body, but also to your emotions. There may be times when you feel excited, times when you feel tearful, and times when you feel scared. All of these feelings are normal and can occur at anytime during your pregnancy. The most exciting thing that happens during this time is that you will feel your baby move for the first time. This movement, called quickening, is usually felt around the end of the fourth month or the start of the fifth month.

BABY:

Fourth Month
- Heartbeat is strong
- Body parts are fully formed
- Baby kicks, moves, sleeps, and swallows
- Baby is 6 to 7 inches long and weighs about 5 ounces

Fifth Month
- Growth is very rapid
- Baby is active; mothers can feel strong movements
- Baby is 8 to 12 inches long and weighs one-half to 1 pound

Sixth Month
- Skin appears clear and wrinkled
- Soft fine hair covers the baby's body
- Baby is 11 to 14 inches long and weighs about 1 to 1 1/2 pounds

THIRD TRIMESTER

MOM:

The third trimester, or the last three months, lasts from week 24 to week 40. During this time, you may begin to feel anxious and have mixed feelings about the birth of your baby because you are gaining weight faster and the baby is growing bigger. Your uterus is becoming very large. Your abdomen is firm when you touch it. All of these things together make it difficult to sleep. It is uncomfortable for you to lie on your stomach or back. Many women have trouble sleeping and become more tired during this part of their pregnancy. Your hands, legs, and feet may swell. You may also experience some shortness of breath as the baby grows.

Now, you can actually see your baby move from the outside, as well as feel it moving inside. You may begin to feel painless cramping, or what are called Braxton-Hicks contractions. These are practice contractions that help get the uterus ready for labor. Call your provider if you experience any regular cramping or contractions that last for longer than an hour as this may indicate real or true labor.

BABY

Seventh Month

Baby can suck its thumb, cough, and hiccup
Baby kicks and stretches
Baby can open and close eyes
Baby is 15 inches long and weighs about 3 pounds

Eighth Month

Baby has periods of sleeping and waking
Brain is growing rapidly
Baby is 18 inches long and weighs about 5 pounds

Ninth Month

Lungs are completely developed
Baby may settle in head down position
Baby will be full term and weigh 6 to 9 pounds at 40 weeks

PRENATAL CARE - DO I NEED IT?

Prenatal care is very important for you and your baby's health during pregnancy. This may be your first baby, but even if it isn't, you still need prenatal care. As soon as you think you are pregnant, you should make an appointment with an obstetrician or a midwife. You should always keep your appointments - even if you are feeling well. Your provider will tell you how often you will need to see him or her.

THE USUAL SCHEDULE FOR CARE FOR A HEALTHY PREGNANCY IS

- Once a month through your 6th month of pregnancy, up to 28 weeks
- Every two weeks during your 7th and 8th months (28 to 36 weeks)
- Once a week from your 9th month on (after 36 weeks to when you deliver)

WHAT SHOULD YOU EXPECT AT YOUR DOCTOR'S VISIT?

First Appointment

History (Medical and Family) and Physical. Please be honest. It is very important that you give complete information to ensure that you and your baby will get the care you need.

Pelvic Exam. The purpose of this exam is to check for sexually transmitted diseases and other infections that may affect your baby and you. During this exam, your doctor will take a PAP smear, which is a scraping from the surface of your cervix. This will not hurt. It will let your doctor know if your cervix cells are normal.

Blood Tests. Your doctor will probably have you to go to the hospital to have blood drawn from your arm. The tests that will be done are ones to determine Hepatitis, Complete Blood Count (CBC), Rapid Plasma Reagin (RPR), blood type, Rh type, and whether you are protected from German measles. These tests are explained in the next section of this book.

Urine Test. A urine specimen will be checked for protein and sugar. Positive results may indicate that you have diabetes, kidney disease, or other conditions.

Following Appointments

At your following appointments, the doctor and his or her staff will

- Ask how you have been feeling
- Take your blood pressure and weight
- Check your urine specimen for protein and sugar

- Monitor your baby's heart rate and activity level
- Measure your uterus
- Answer any questions you may have. (It's a good idea to write them down at home as you think of them.)
- Discuss any concerns you may have

TESTS DURING PREGNANCY

Complete Blood Count. This is a test that checks your blood for anemia or low iron. It will help determine the kind of pre-natal vitamins that will be best for you and how many iron tablets you will need to take.

Rapid Plasma Reagin (RPR). This is a test that determines if you have syphilis.

Hepatitis B Virus (HBV) Screening Test. This blood test will show whether you have been exposed to HBV. Your baby can be at risk of being infected from you if you are positive for HBV. Hepatitis B is a disease that can cause chronic inflammation of the liver and can be transmitted to your baby at birth.

Blood Type and Rh Factor. This is a blood test to determine your blood type. The four major blood types are A, B, AB, and O. Each type has an Rh factor. This is shown as a + or - sign after the blood type. When your Rh factor is negative and your baby is born with a positive Rh factor, the baby has a slight chance of getting Rh disease. To prevent this disease, you will be given a medication called Rhogam.

Rubella Antibody Test. This is a blood test that will determine if you have immunities to Rubella, which is what causes German measles. An infection of Rubella in the first trimester of pregnancy can cause congenital abnormalities, miscarriage, or stillbirth in infected women.

Toxoplasmosis. This is a blood test to detect toxoplasmosis, which is an infection caused by a parasite. It is most often contracted by handling cat feces or by eating undercooked meat that contains the parasite.

Group B Streptococcus. Group B Strep is a common bacteria that is relatively harmless in adults and children. However, it can be dangerous for a newborn. In rare cases, a woman with Group B Strep can infect her baby during delivery. If you carry these bacteria, your doctor will treat you with intravenous antibiotics during labor to prevent infection in your baby. If you are only treated one time before you deliver, your baby will have some blood tests right after birth.

This test is performed at the 35th to 37th week of gestation. A cotton swab is used to obtain a sample from your vaginal and anus areas. Results are available in 48 hours. This is not a sexually transmitted disease. Approximately 50 percent of all women harbor Group B Strep in their vaginal canal. It is not the same organism that causes strep throat. Adults do not usually exhibit symptoms or have illnesses from these bacteria.

AIDS or HIV. This is a blood test that will determine if you have the virus that causes AIDS, Acquired Immune Deficiency Syndrome, which is a fatal disease. HIV stands for Human Immunodeficiency Virus, which is the virus that causes AIDS. If you have HIV, you can pass it to your baby. If your partner has had other sexual partners or has used IV drugs, make sure he uses condoms during sex. You can call the AIDS Hotline at 1-800-333-AIDS for more information on HIV and AIDS.

AFP Test. AFP stands for Alpha-fetoprotein and a high level of this protein could mean your baby has a neural tube defect, such as spina bifida, anencephaly, or certain types of abdominal wall defects. A low level could mean a chromosomal abnormality, such as a Downs Syndrome. The AFP test is a blood test to measure this protein level and is usually done in the 16th week of pregnancy. This is a screening test and does not mean that your baby definitely has a problem. Further testing will be needed, depending on the results.

Sonogram. This test uses sound waves to make a picture of your baby in the uterus. This test will help determine

- When your baby is due
- Amount of amniotic fluid
- Location and position of your baby and placenta
- Number of babies in your uterus
- Suspected problems
- The sex of your baby. (This is not 100 percent accurate, so don't buy all pink or blue!)

Amniocentesis. This procedure takes a small sample of amniotic fluid from your uterus. Cells from this fluid are examined to determine the presence of genetic abnormalities or other problems and fetal lung maturity. If you are being tested for genetic or other problems, it is usually done around the 15th week of gestation. Testing for fetal lung maturity is done closer to your due date.

Why Would You Need Amniocentesis?

- If you are 35 years of age or older
- If you have had previous children with a birth defect, chromosomal abnormality, or neural tube defect
- If you have a family history of genetic disorders
- If you have abnormal AFP test
- If you are in early labor and your doctor feels it is best to deliver the baby and wants to check the maturity of your baby's lungs

This test is done with the use of an ultrasound machine so that the physician can safely see where the baby and placenta are. Your abdomen is cleansed and sometimes a local anesthetic is used. A thin needle is inserted through the abdomen into the uterus, where a few teaspoons of amniotic fluid are drawn. This is usually not painful but you may feel some cramping or a pressure sensation where the needle enters the uterus. This test is safe, except for a very small risk of miscarriage, early delivery, or infection. Your doctor will discuss these risks with you before the procedure.

Chorionic Villa Sampling. This is a test done for genetic studies between 9 and 12 weeks of pregnancy. The study is done vaginally or through the abdomen using ultrasound. A sterile small tube (called a catheter) is inserted near the placenta. A tiny portion of the placenta, called chorionic villa, are removed and studied. This study can be performed earlier than amniocentesis so you can know much earlier if your baby has a problem. If a problem is identified, you can prepare for a special needs child or you may choose to terminate the pregnancy. The preliminary results will be available in 2 to 3 days and the final results take about 2 to 3 weeks.

Non-Stress Test (NST). This test is done to determine how well your baby is doing in the womb. It is painless. An NST is one way of determining how well the placenta is functioning. The placenta provides oxygen and nourishment to your baby. When the baby moves, the heart rate increases in much the same way your heart rate increases when you exercise. This suggests that the baby is healthy and doing well. A fetal monitor will be put on you using two belts around your waist to keep the equipment in place. The monitor will show the baby's heartbeat and any contractions you may be having. Every time the baby moves, you will push a button that will make a mark on the graph paper in the monitor. The test takes 20 to 40 minutes, depending on how active your baby is. If the baby is asleep, it will take longer.

Why Would You Need This Test?

- If you have gestational diabetes, high blood pressure or any other problem with the pregnancy, the doctor may order this test 2 or 3 times a week starting between 32 and 36 weeks gestation.
- If you are due or past due, this test is ordered routinely and is usually done once a week until you deliver.

AN ACTIVE BABY IS A HEALTHY BABY

Biophysical Profile. This test determines your baby's well being using a combination of an NST and a sonogram.

Breast Stimulation Test (BST). This test is done to determine the well being of your baby. You will be placed in a room on a bed and hooked to a monitor. At the beginning of the test, the monitor will record any contractions that you may have within 30 minutes. If no contractions are detected, you will be asked to stimulate your nipples until you have a contraction that can be recorded on the monitor. Your doctor will read the test.

One-Hour Glucose Tolerance Test. Most expectant mothers are given a glucose-screening test between the 24th and 28th weeks of pregnancy to check for a condition called gestational diabetes, a high blood sugar condition that some women get during pregnancy. Unlike other types of diabetes, it usually goes away once the baby is born. Diet and exercise usually succeed in controlling it, but in some cases a medication called insulin is necessary.

You will be asked to drink a special sugar solution, which tastes like flat soda pop. An hour later, your blood will be drawn to check your blood sugar level. If your reading is abnormal, you will be given a similar but lengthier exam called a glucose tolerance test at a later date to verify the results.

Who is Most at Risk?

- Women who have diabetes
- Women who have had gestational diabetes during an earlier pregnancy
- Women who have previously had one or more large babies
- Women who are obese
- Women who have had pregnancy-related problems, such as miscarriage or pre-eclampsia.
- Women who are older
- Women with hypertension
- Women who were large babies themselves (more than 9 pounds)
- Women with a parent or sibling who is an insulin-dependent diabetic

Most women who develop gestational diabetes have normal, healthy babies. Fifty percent of all women who have gestational diabetes will develop full-fledged diabetes within the next 20 years. If you are diagnosed with gestational diabetes, your baby will need to have blood sugar testing for 24 hours after birth. Only 2 to 5 percent of expectant mothers develop gestational diabetes.

Glucose Tolerance Test. On the night before the test, you will be asked not to eat or drink anything except water after your evening meal. Do not smoke during this time or until the test is complete. (Of course, you should not smoke at all during your pregnancy.) The morning of the test, a blood sample will be drawn to determine your fasting blood sugar. You will then drink a glucose solution and blood samples will be drawn at one, two, and three hours after you drink the solution. If there are two or more abnormal readings from the four samples taken then you will be diagnosed with gestational diabetes.

If you choose not to follow the treatment plan for gestational diabetes, your baby could develop any or all of these:

Macrosomia: Your baby will be large, which can result in a difficult delivery or a Cesarean delivery.

Hypoglycemia: If your blood sugar is high during labor, your baby's body will produce too much insulin to control it, resulting in the baby having unstable blood sugar.

Respiratory Distress Syndrome: Your baby may have more difficulty breathing than a baby of the same age because of the diabetes.

RISKS AND WARNING SIGNS DURING PREGNANCY

SIGNS OF POSSIBLE PROBLEMS

1. Menstrual-like cramps or belly pain that does not go away.
2. Vaginal bleeding, itching, or burning.
3. Unusual vaginal discharge (a small amount of clear or white mucous is normal).
4. Urinary difficulties, such as pain, burning, bleeding, or an urge to urinate frequently or a decrease in urine.
5. Rapid weight gain, sudden swelling of the hands, feet, or face.
6. Severe headache, dizziness, blurred vision, or spots before your eyes.
7. Fever and/or chills. Temperature of 100.4 or above.
8. Repeated vomiting.
9. Baby's movement slows down or stops.
10. Gush or trickle of water from your vagina.
11. Severe pain under your ribs over your stomach.

If you notice any of these warning signs:
TAKE IMMEDIATE ACTION

1. Call your obstetrician.
2. Call Labor and Delivery
3. Go the Emergency Department at the Western Maryland Regional Medical Center.

OBSTETRICIAN'S PHONE NUMBER_____

LABOR AND DELIVERY UNIT: 240-964-6300

BETTER SAFE THAN SORRY!

COMMON DISCOMFORTS OF PREGNANCY AND WAYS TO RELIEVE THEM

Backache: This can occur any time during your pregnancy and is usually caused by fatigue, stretching muscles, posture change, or the weight of the baby and your uterus. If it does not go away after one hour, rest on your left side and call your provider or the Labor and Delivery Unit.

Try some of these remedies to help alleviate or take away some of the discomfort.

- Always use good posture
- Ask your doctor about some exercises that may help
- When sitting, rest with your legs propped up.
- Sleep on a firm mattress or put a board under your mattress
- Wear low-heeled shoes or flats
- Do not lift more than 15-20 pounds
- Avoid sitting or standing for long periods of time

Bladder Pressure: This occurs early in your pregnancy and is caused by increased blood supply to the area. It usually disappears during the second trimester, only to reappear in the latter part of your pregnancy due to the weight of the baby and the uterus on the bladder.

Some ways of dealing with this problem are

- Avoid drinks with caffeine, such as coffee, tea, or soda. Drink water instead.
- Do Kegal exercises. These exercises strengthen the muscles around the vagina and rectum.
  - Kegal Exercise: This exercise should be done everyday for the rest of your life. First you must locate the pelvic floor muscles. While going to the bathroom, concentrate on the muscles responsible for starting and stopping the flow of urine, but don't bear down on them. Lift the muscles in and up. Once you have learned how to do Kegal exercises, you will be able to practice it anytime while sitting, standing, or lying down. Start by doing two or three at a time and gradually work up to 100 times a day.
- Go to the bathroom to urinate frequently. Don't try to "hold it." Having pain or passing blood when you urinate is not normal. If this happens, call your doctor.

Constipation: This is caused by a variety of factors, including:

- The uterus pressing on the intestines
- Not drinking enough water
- Not eating enough fruits and vegetables
- Prenatal vitamins and iron supplements

Some ways to improve this are:

- Eat a diet high in fiber (fruits and raw vegetables).
- Drink at least eight to ten classes of water, juice, or milk daily.
- Exercise every day.
- Do not use laxatives or give yourself an enema without first talking to your doctor.

Dizziness: This is common anytime during your pregnancy. It occurs if you move too quickly.

Ways to decrease this are:

- Go from one position to another slowly.
- Eat several small meals.

Heartburn and Indigestion: These conditions usually start in the second half of your pregnancy. The burning sensation often extends from the lower throat to the bottom of your breastbone. It will come and go until after the baby is born.

What You Can Do About It

- Avoid rich or spicy foods, as well as chocolate, citrus, coffee, and alcohol.
- Eat small, frequent meals and chew your food slowly and thoroughly. Give yourself two to three hours to digest your meal before going to bed.
- Sleep with 2 or 3 extra pillows to keep your head about six inches up from the mattress.
- Wear clothing that is loose around your abdomen and waist.

If the problem persists, talk to your doctor about an over-the-counter antacid that is safe during pregnancy.

Nausea: This can occur anytime during pregnancy. It usually occurs during the first 12 weeks and again before delivery.

Ways to help alleviate it, include:

- Eat some dry toast, crackers, or cereal before getting out of bed.
- Avoid sudden movements.
- Drink liquids between meals instead of with them.
- Eat 5 or 6 small meals a day instead of 3 large ones.
- Avoid greasy, fried, and spicy foods.

Hemorrhoids: These can occur at anytime during your pregnancy. They can also occur when you are pushing during labor. They are due to pressure on the rectum, constipation, and poor circulation to the rectum.

Things to Do

- Avoid constipation.
- Don't strain when having a bowel movement.
- Take a warm bath to help soothe the area.
- Avoid sitting for long periods of time.

Edema (Swelling): This can occur anytime during pregnancy, although it usually occurs during the last trimester. Swelling in your feet and hands gets worse when you stand for long periods of time and when the weather is warm.

Ways to help include

- Don't cross your legs.
- Sit with your legs raised whenever possible.
- Wear support stocking or socks, especially if you have varicose veins or have to be on your feet a lot.
- Try to limit very salty foods, such as chips, hot dogs, sausages, and lunchmeats.
- Drink a lot of water, at least 8 to 10 glasses a day.

If your swelling should increase or if you start to notice swelling in your face, call your doctor.

Colostrum: Colostrum is a watery, yellow liquid that is produced in your breasts starting about 16 weeks into your pregnancy. Later in your pregnancy, this colostrum can leak from your breasts and dry and crack on your breasts. To avoid this, wash your nipples with warm water only. Soap can cause more drying and cracking.

Leg Cramps: These can occur anytime during pregnancy.

Things that may help include:

- Point your toes toward your nose.
- Increase your calcium intake with products like milk, cheese, and yogurt.
- Don't wear high heels.
- Do not rub the area that is cramping.

Vaginal Discharge: You may notice an increase during pregnancy.

Be sure to:

- Use only soap and water when washing your vaginal area.
- Always wipe from front to back.
- Do not douche or use any vaginal creams or suppositories unless your doctor has ordered them.

Shortness of Breath: This can occur throughout your pregnancy. This is due to the uterus pushing organs in the abdomen against your diaphragm, which makes it difficult to take a deep breath.

Things To Do:

- Rest when you need to.
- DO NOT SMOKE

Fatigue: This can occur early, late, or all through your pregnancy. Growing a healthy baby takes a lot of energy! This can also be a sign that you have anemia.

Things to Do:

- Rest when you feel tired.
- Avoid long hours of work.
- Lie down at least once a day on your left side for one hour.
- Eat foods that are high in iron, such as eggs, prunes, and meats.
- Take the vitamins that your doctor has prescribed.

Braxton-Hicks Contractions: These will occur late in your pregnancy. These are "practice" contractions that get your uterus in shape for labor and delivery. It feels like a tightening or balling up in your uterus. If you should get these during pregnancy, don't panic.

Things To Do:

- Drink two to three glasses of water.
- Lie down on your left side for one hour.

If after doing the first two steps the contractions start to get more intense and closer together, call the Labor and Delivery Unit or just go to the hospital.

HOW TO GET A GOOD NIGHT'S SLEEP

Pregnancy sometimes causes sleep disturbances. These can include nausea, heartburn, restless leg syndrome, and snoring. Sometimes you may already have some bad sleep habits before you became pregnancy.

Follow these steps for a better night's sleep

- Do not smoke or drink.
- Nicotine and alcohol can harm your baby and make it difficult for you to sleep.
- Cut down on caffeine. Caffeine is found in substances such as tea, coffee, soda, and chocolate. Avoid these entirely or especially in the afternoon and evening.
- Make your bedroom a sleep sanctuary.
- You may feel warmer when you are pregnant. Keep your bedroom at a comfortable temperature.

NUTRITION AND YOUR PREGNANCY

EATING WISELY FOR YOU AND YOUR BABY

Your baby depends on you to eat properly before and during your pregnancy. Eating right can mean fewer complications during your pregnancy and delivery, less chance of birth defects, less chance of a premature baby, a stronger, healthier baby at birth, and a stronger, healthier you.

From the moment of conception, your baby depends on the food you eat to supply energy, protein, vitamins, calcium, iron, and other materials. Your body has increased needs for many nutrients during this period, too. If you follow a good, healthy diet, you and your baby will be healthier.

Good nutrition is important even before you know you are pregnant. In the first month after conception, the baby has already begun to form all his or her organs and body parts. In the early months, the baby is growing longer and heavier. So, from the moment of conception through the time that you are breastfeeding, nutrition is important.

Your health also depends on your diet. While you are supplying nutrients for your baby, your own body continues to need all these nutrients as well. In fact, during pregnancy you need more of many nutrients just for yourself. Your body will be storing protein and calories that will be needed if you choose to breastfeed.

WHAT SHOULD YOU EAT?

Nutrition experts suggest that meals and snacks be planned to include a variety of food from these general food groups:

- Bread, cereal, rice, and pasta
- Vegetables
- Fruits
- Milk, yogurt, and cheese
- Meat, poultry, fish, dried beans, eggs, and nuts

Another category often mentioned is fats, oils, and sweets. These foods provide mostly calories, with very few nutrients and should be eaten only in limited amounts. The nutrients you eat each day are broken down, absorbed into your bloodstream, and delivered to your baby by the way of the placenta.

HOW MUCH WEIGHT SHOULD YOU GAIN?

Healthy weight gain can range from 15 to 40 pounds, depending on your pre-pregnancy weight. Underweight women should gain more weight than women who are within their ideal weight. Overweight women should gain less weight. Gaining weight is an essential part of pregnancy.

Many women find it hard to avoid gaining too much weight. This can really be a problem if you decrease your physical activity. You need to be careful with your food choices to get the protein, vitamins, and minerals you and your baby need without getting the extra pounds. Avoid foods that are low in nutrients but high in calories, such as cookies, doughnuts, chips, soft drinks, cakes, and pies. Instead, choose fresh fruits, vegetables, and skim milk.

Some women do not gain enough weight. Studies have shown that a mother's weight gain during pregnancy is important to the birth weight of the infant. Babies born to mothers who lose weight or gain less than 10 pounds are frequently very small and have smaller than normal body organs. Pregnancy is not the time to lose weight or severely restrict food intake.

WHAT SHOULD YOU AVOID?

There are some things you should avoid during your pregnancy, such as:

- Pre-packaged salads since they are possible sources of parasites and bacteria
- Smoking
- Alcohol
- Drugs

Women who smoke frequently have babies with low birth weight and length. A mother's use of alcohol during pregnancy increases the risk of severe birth defects, including growth retardation, abnormal facial characteristics, and mental retardation. A study in the American Journal of Psychiatry has linked fetal exposure to alcohol with mental illness later in life.

Many drugs have been shown to cause severe birth defects. Marijuana and cocaine impair fetal growth and development. Babies of mothers who use drugs are also born addicted to drugs.

All medicines, even aspirin, should be used only with permission from your physician.

CAN CAFFEINE AND ASPARTAME AFFECT YOUR BABY?

Consuming large amounts of caffeine (the equivalent of 7 cups of coffee a day) means higher risks of miscarriage, stillbirth, and pre-mature births. Controversial evidence suggests that excessive use of aspartame (more commonly known as NutraSweet) may be bad for your baby. However, there is no evidence that moderate use of either caffeine or aspartame is harmful. The most cautious recommendation for pregnant and nursing mothers is to avoid caffeine and aspartame or use them sparingly.

CAN YOU REALLY EAT TWICE AS MUCH WHEN YOU ARE PREGNANT?

NO - this is an old wives' tale. Your body becomes more efficient during pregnancy and is able to absorb more of the nutrients you eat. Consuming twice as much is likely to mean excessive weight gain for you. You need only 300 extra calories a day when you are pregnant, and even fewer are needed during your first trimester.

WHAT IF YOU ARE A VEGETARIAN?

With careful planning, a vegetarian diet during pregnancy can provide all the necessary vitamins, minerals, protein, and other nutrients you need. Your body requires about 15 percent more protein during pregnancy than normal. You should aim to eat approximately 60 grams of protein each day.

If you regularly eat dairy and egg products, you will have not problem getting adequate protein. Protein is responsible for building and repairing the body's cells and tissues. If you do not eat dairy and egg products, you will need to make sure you are getting enough protein from non-animal sources, such as dried beans, peas, lentils, and tofu at each meal.

WHY DO PREGNANT WOMEN NEED WATER?

Water plays many vital roles in a healthy pregnancy.

- Water is your body's transportation system and carries nutrients through your blood to your baby.
- Water also helps to prevent bladder infections, which are common during pregnancy. If you drink enough water, your urine will stay diluted, reducing your risk of infection.
- Water can also stop constipation and help prevent hemorrhoids.
- The more water you drink during pregnancy, the less water your body will retain.
- Water prevents dehydration. This is especially important in the third trimester when dehydration can actually cause contractions that trigger pre-term labor.

HOW MUCH WATER IS ENOUGH?

Eight 8-ounce glasses a day (that's 48 to 64 ounces), plus one 8-ounce cup for each hour of light activity. Juices can contribute to your fluid intake, but keep in mind that they can also provide a lot of extra calories. Caffeinated beverages, such as coffee, tea, sodas, etc. do not count as part of your fluid intake because they are diuretics, meaning that they cause you to urinate more so you actually lose water.

If you don't like the taste of water, try adding a wedge of lemon or lime or a little juice for additional flavor.

If you have trouble keeping track of how much water you drink each day, fill a 64-ounce pitcher and try to finish it by the end of the day.

While nutrition does not guarantee freedom from problems, it is definitely a positive factor - and one that you can have control over.

SEX DURING PREGNANCY

CAN I HAVE SEX WHILE I AM PREGNANT?

Yes. With a normal pregnancy, you can keep having sex until your water breaks. However, you should check with your doctor first if you are having problems with your pregnancy, such as placenta previa or bleeding or if you have a history of miscarriages.

WILL SEX HARM MY BABY?

You won't hurt your baby by having sex, even in a position with your partner on top. The thick mucus plug that seals the cervix helps guard against infection. The amniotic sac and the strong muscles of the uterus protect your baby. Though your fetus may thrash around a bit after orgasm, it is because of your pounding heart and not because he or she knows what is happening or feels pain. However, there may some important circumstances in which you might be advised by your doctor not to have intercourse.

WILL IT FEEL AS GOOD?

It will feel even better for some women and not as good for others. Increased blood flow to the pelvic area can cause engorgement of the genitals and heighten the sensation. But the same engorgement gives other women an uncomfortable feeling of fullness after intercourse ends. Also, some women feel abdominal cramps during or after intercourse.

IS IT NORMAL NOT TO BE IN THE MOOD WHILE I AM PREGNANT?

Yes. The big changes in your body are bound to change your sex life. Some women, temporarily free from worries about conception and contraception, feel sexier than ever. But others are just too tired or nauseated to have sex, especially in the first trimester. The second trimester is often marked by a resurging libido. Your desire may wane again in the third trimester as birth and labor are closer and your belly is quite large.

WILL MY PARTNER'S SEX DRIVE CHANGE?

Most men find their pregnant partner truly attractive. But a partner's desire may be dampened by concerns for the health of the mother and baby, apprehension about the burdens of parenthood, and fear that sex can hurt the baby.

ADDITIONAL INFORMATION

You should not have sex if you have bleeding or water leaking from your vagina.
If intercourse is painful, change position or don't do it!

Communication with your partner is very important at this time. Only your partner will know if he has had other sexual partners or has a history of IV drug use. If there is any doubt, insist that he wear a condom for the welfare of you and your baby. This way you avoid the chance of being exposed to the AIDS virus, Hepatitis B, or any other sexually transmitted disease.

Don't be shy about discussing your concerns with your doctor!

THE BENEFITS OF STAYING ACTIVE DURING PREGNANCY

Why exercise? It's hard enough just to get dressed every day when you feel bloated and sick to your stomach. But believe it or not, a little effort can leave you feel peppy and perhaps a bit like your pre-pregnancy self. Because exercise promotes muscle tone, strength, and endurance, it can help you carry the weight you gain during pregnancy, prepare you for the physical stress of labor, and make getting back into shape after the baby is born much easier.

KNOW YOUR LIMITS: TIPS FOR A SAFE WORKOUT

Medical experts cannot say enough good things about exercising during pregnancy, as long as it is moderate and does not put you at risk for slips and falls. Such activities as swimming, walking, and low-impact aerobics are good choices.

Even if you are normally quite graceful, relaxin, a hormone that relaxes the pelvic joints in preparation for childbirth, also loosens all ligaments and joints, making you more susceptible to sprains and other injuries. That is why it is doubly important to pick the right activity.

If you are committed to keeping fit, do so on a regular basis. According to the American College of Obstetrics and Gynecology, it is best to exercise at least three times a week. Working out sporadically can put you at risk for injury; plus, you don't benefit from exercise by working out only once in a while.

- Check with your doctor before starting an exercise program.
- Wear loose-fitting, breathable clothing and supportive shoes.
- Warm up before exercising.
- Keep moving. Switch positions or walk in place instead of standing in one position for a prolonged period of time.
- After the first trimester, avoid doing exercises where you are flat on your back.
- Don't do deep knee bends, lunges, or full sit-ups.
- Avoid overdoing it.
- If you feel uncomfortable or are in pain, stop immediately.
- Drink lots of water before, during, and after exercising.
- Get up from the floor slowly and carefully.
- Skip outdoor activities when it is hot and humid.
- Steer clear of dangerous sports such as horseback riding, downhill skiing, mountain climbing, and most contact sports. Racket sports, such as tennis and squash, are not recommended, especially during your last two trimesters because the side-to-side movements can be hard on the knees and the ball could hit your tummy.
- Cool down; walk in place for a few minutes or stretch.

PREGNANCY COMPLICATIONS

PLACENTA PREVIA

What is it?

Placenta previa is a condition in which the placenta implants either partially or totally over the opening of the cervix.

Why is this a problem?

As the pregnancy progresses or as dilation begins, the stretching of the muscle fibers of the uterus causes the placenta to separate from the area around the cervix causing painless, bright red bleeding. As the separation enlarges, the bleeding increases and the ability of the placenta to support the baby decreases sharply.

How will I know if I have this problem?

It is usually detected when you have your first sonogram. Often, the placenta will migrate up the uterine wall away from the opening as the pregnancy progresses, and it may not be a problem by the time you are due to deliver.

What happens if the placenta remains over my cervix?

You may be placed on bed rest at about 12 weeks' gestation and remain so until you reach 32-37 weeks. During this time, the baby will be delivered by C-section. If you have bleeding before this, you will be placed on bed rest. If you do start to bleed, you must go to Labor and Delivery immediately.

Will I always have to have a C-section?

No. "Once a C-section, always a C-section" is no longer true. You may have a vaginal delivery with your next pregnancy.

GESTATIONAL DIABETES

What is gestational diabetes?

Gestational diabetes is a high-blood sugar condition that some women develop during pregnancy. Usually, it goes away after the baby is born, unlike other types of diabetes.

Diabetes develops when the body can't efficiently produce or process insulin, a hormone the pancreas makes that allows cells to turn glucose (raw sugar) into usable fuel.

Your body has to produce extra insulin because increasing levels of pregnancy hormones interfere with insulin function and make your body a little more resistant to it. If your body cannot process that additional insulin sufficiently, you will most likely develop gestational diabetes.

Your doctor will give you a blood test called a glucose-screening test. You'll most likely have this test done as a routine part of your prenatal care. (See the section on Tests During Pregnancy for additional information.)

How will having diabetes affect my pregnancy?

It really depends on how well you take care of yourself. If your diabetes goes untreated, there are consequences for your pregnancy. If your diabetes is well controlled throughout your pregnancy, there is much less reason to worry.

The main risk in having extra glucose in your blood is that it crosses over to the baby, which means your baby can become abnormally large. A big baby obviously makes labor and delivery more difficult. It increases the risk of a delivery by a Cesarean section and the possibility that your baby could end up with jaundice or breathing problems.

Some researchers believe large babies are more prone to obesity later in life. As adults, they are also more apt to develop Type 2 diabetes, also known as non-insulin dependent diabetes or adult onset diabetes.

Babies born to women with pre-pregnancy diabetes, especially women with poor control over the condition, also face greater risk of having a child with birth defects.

How common is gestational diabetes?

It is quite common, considering it is a rather serious medical condition. Two to five percent of all pregnant women in the United States have diabetes. Of course, some women had it before they became pregnant. But others with no history of the condition can develop gestational diabetes.

What are the risk factors?

The most at risk are women who have had diabetes, or gestational diabetes, or previously had one or more large babies. Obese women are at risk, as are those who have had pregnancy-related problems, such as a miscarriage or pre-eclampsia.

Others who are at risk include

- Older mothers
- Women who were large babies themselves
- Women with high blood pressure
- Women with a parent or sibling who is an insulin-dependent diabetic

How do I know if I have it?

Usually women have no warning, which is why all pregnant women are routinely tested. Some women may experience symptoms, such as extreme thirst or fatigue.

Since some women who get gestational diabetes have no risk factors, doctors routinely give women a glucose screening test between their 24th and 28th weeks of pregnancy. About an hour after you drink a "syrupy" soft drink, a blood sample is drawn and then analyzed. If the test is positive, you will undergo an even more detailed screening.

How is it treated?

The first step is to control your glucose levels by adhering to a special diet. Most doctors recommend you follow the nutrition guidelines set by the American Diabetes Association, which encourages you to eat healthy foods in the right amounts and limit fats and sugars. Although a lot of women struggle with their diet during pregnancy, eating a balanced diet and controlling weight gain are critically important for women with diabetes.

If a nutritional approach does not work, which is the case for about one in ten women with gestational diabetes, your doctor may prescribe insulin shots for you to give to yourself. Whether or not you take insulin, you will need to monitor your glucose levels if you have gestational diabetes. You will learn how to do this using a home glucose meter or strips.

If you have diabetes and are planning to become pregnant, try to get your diabetes under control in the months before you conceive. High blood glucose levels in the first trimester increase the chance of birth defects. Your pregnancy will probably be considered high risk, but that does not mean you will encounter problems during your pregnancy, particularly if your blood glucose levels are normalized.

Will I continue to have diabetes after my baby is born?

You will be checked postpartum for diabetes, and the good news is that diabetes disappears after delivery in most women. Nonetheless, if you had gestational diabetes, you increase your risk of developing diabetes later in life. Women who were obese before and during pregnancy are much more likely to remain diabetic after pregnancy.

Tips to help control your blood sugar levels

Eat a variety of foods, distributing calories and carbohydrates evenly throughout the day. Make sure both your meals and snacks are balanced.

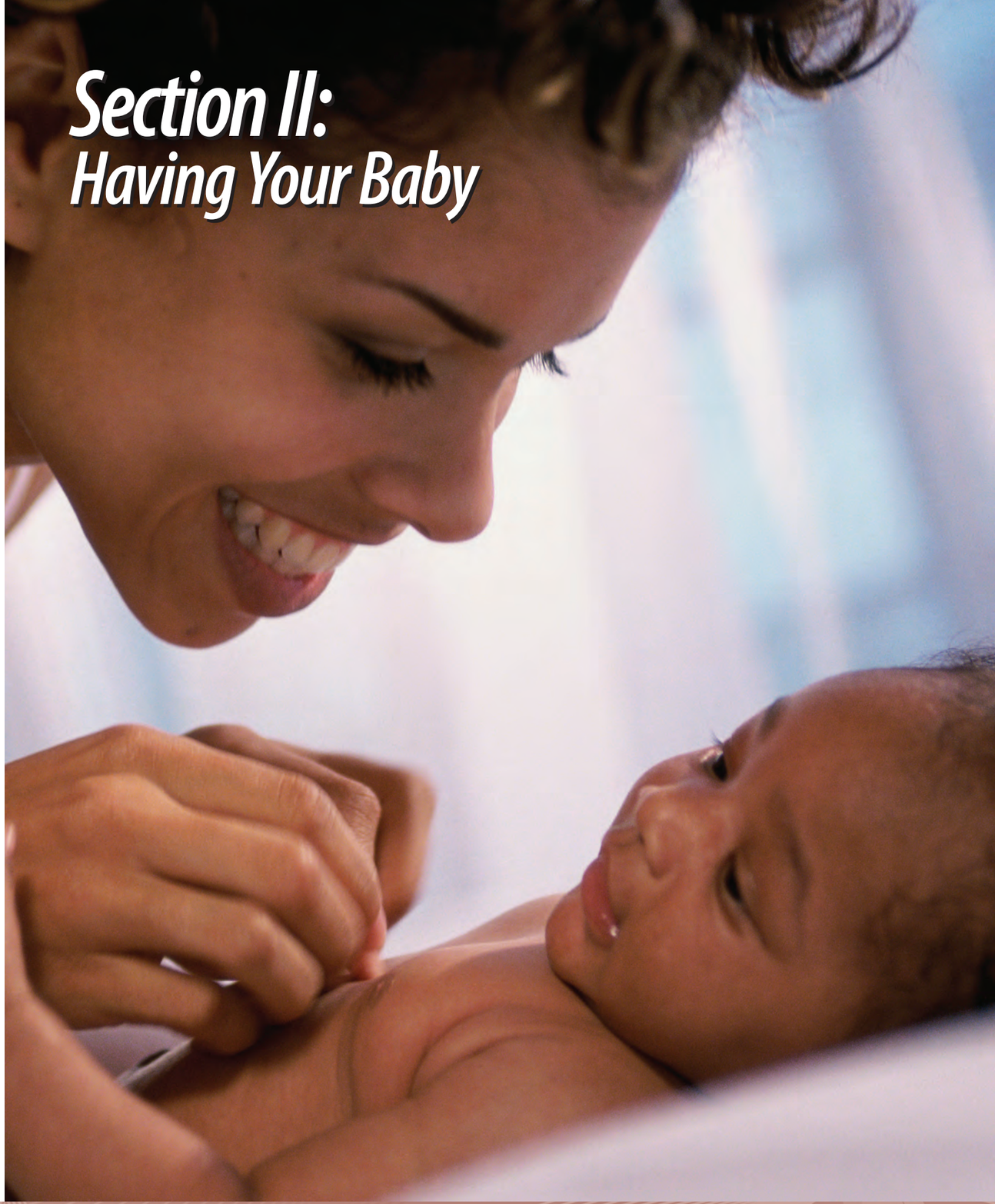
Don't skip meals. Be consistent in the amount of food you eat at each meal and when you eat. Your blood sugar will remain more stable if your food is distributed evenly throughout the day and consistently from day to day.

Include high-fiber foods. Foods high in fiber include fresh fruits and vegetables, whole grain breads and cereals, dried peas, beans, and legumes. These foods are broken down and absorbed more slowly than carbohydrates, which helps to keep blood sugar levels from going too high after meals.

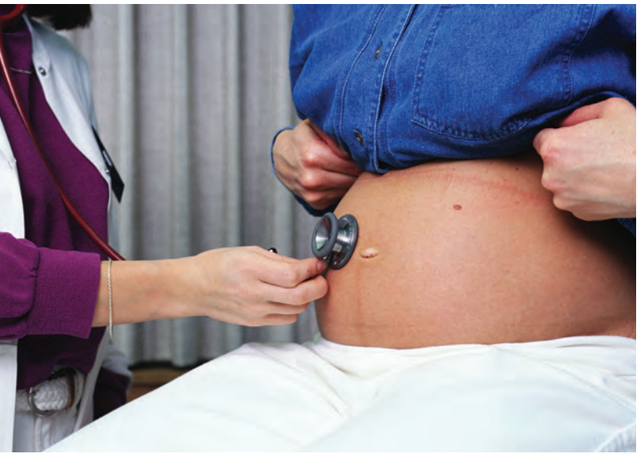
Eat a good breakfast. Blood glucose levels during pregnancy are most likely to be out of whack in the morning. To keep your level below 120, you may need to modify your morning menu. You may have to limit carbohydrates (breads, cereal, fruit, and milk) boost protein, and possibly avoid fruit altogether.

Overall, a diet for gestational diabetes is a balanced and healthy one.

Section II: Having Your Baby



SECTION II: HAVING YOUR BABY



PLANNING FOR THE BIG EVENT

Having a baby involves much planning and preparation. There are many decisions that have to be made, some sooner than others. Rather than getting overwhelmed and feeling anxious, make your decisions one at a time, and try to ask questions to become more informed. Your plan (or "birth plan", as some people call it) needs to address several important issues. Some of these include:

WHICH DOCTOR WILL YOU CHOOSE?

If you do not have a doctor, or if you would like more information about prenatal care, call your local clinic, health department or health insurance plan. Remember, it is important to start seeing a doctor as early in your pregnancy as possible.

WILL YOU BREAST OR BOTTLE FEED?

This is a very important decision for you to make. If possible, breastfeeding is best for babies. Breast milk provides all the nutrients a baby needs in the first months of life. It can also help to protect against certain illnesses during the first few months. But, whether to breast or bottle feed is a personal decision, and you need to make the choice that you are the most comfortable with.

WHAT TYPE, IF ANY, OF PAIN CONTROL DO YOU WANT?

There are several different methods of pain control available and you should talk to your doctor about the risks and benefits of each one before making your decision. There is a section in this book about the different methods of pain control.

WHICH DOCTOR WILL YOU CHOOSE FOR YOUR BABY?

A pediatrician is a doctor that specializes in infant and child care. He or she may want to meet with you before your baby is born, especially if this is your first child. If you do not have a pediatrician, ask your doctor to give you several names of some so that you can decide.

HOW WILL YOU GET TO THE HOSPITAL?

You should plan in advance for this. Travel the route to the hospital and find out how long it will take you to get there. Also, you need to plan for child care if you have other children.

WHO WILL BE WITH YOU WHILE YOU ARE IN LABOR?

Whether it is the father of the baby or another family member, it is important to decide who will be with you when the time arrives. This should be decided ahead of time, so your coach can help you to get ready for labor.

IF YOU HAVE A BOY, WILL YOU HAVE HIM CIRCUMCISED?

Circumcision is a procedure that involves removing the foreskin from the penis. It is optional, and is a decision made by the parent. If you are unsure about whether to have your child circumcised, talk to your doctor or your baby's doctor about the risks and the benefits involved. There is a section in this book with more information and the pros and cons.

WHAT KIND OF CHILD CARE WILL YOU CHOOSE IF YOU HAVE TO GO BACK TO WORK?

It can save you time to decide on this before the baby is born. If you plan to use a child-care facility, you should visit several and watch how the children are being taken care of before you make a choice.

WHAT TYPE OF BIRTH CONTROL ARE YOU GOING TO USE AFTER THE BABY IS BORN?

There are a variety of birth control methods available. No one way is right for every person. You should talk to your provider about the methods that will work for you, and you should decide on this before the baby is born.

BREAST FEEDING VS. FORMULA FEEDING

BREAST IS BEST

Babies are designed to breastfeed and breast milk is the only food specially customized to their delicate gastrointestinal systems.

Research on human milk has exploded in the last decade, and breastfeeding tends to outweigh formula when it comes to advantages for the baby and mother.

ADVANTAGES FOR BABY

Breastfeeding reduces the risk of allergies, asthma, ulcerative colitis, Crohn's disease, necrotizing entercolitis, juvenile diabetes, diarrhea, ear infections, childhood lymphomas, salmonella, bronchitis, pneumonia, and a host of other illnesses. Breastfed babies tend to have improved eyesight and score seven to eight points higher on IQ tests than formula-fed infants.

Breastfeeding may also protect against SIDS.

ADVANTAGES FOR MOMS

There are a number of advantages breastfeeding provides mothers. Breastfeeding helps protect women from postpartum hemorrhage, ovarian cancer, osteoporosis, and breast cancer.

Breastfeeding at least one of your children will reduce your risk of breast cancer by 20 percent in women ages 20 to 49 and by 30 percent in women ages 50 to 74.

Breastfeeding stimulates the production of prolactin and oxytocin in both mother and baby. These hormones promote feelings of warmth, love, cuddliness, and well-being. This can help reduce mom's stress level when the baby is fussy.

Breastfeeding less expensive than purchasing formula. The cost of the least expensive formula is more than $1,000 for a one-year supply.

FORMULA IS FINE

Women should not feel pressured into breastfeeding. While formula is not an exact replica of breast milk, most babies thrive on it. Please talk to the nurses and lactation consultants about any concerns you have about feeding your baby. We are here to support every mother.

PREPARING TO BREASTFEED

Your pregnant body is preparing itself for breastfeeding. The milk ducts and milk producing cells are developing in your breasts and more blood goes to your breast than before. Breast size has nothing to do with the ability to nurse successfully.

The hormonal changes of pregnancy are usually sufficient to prepare most women's nipples for breastfeeding. Avoid using soap directly on your nipples. This may remove the natural emollients that are secreted by the Montgomery glands. If you have inverted nipples, you may want to speak with your doctor and/or a lactation consultant. Inverted nipples will not prevent you from being able to breastfeed, but you may need additional assistance at the beginning.

Even before your baby is born, learn as much as you can about breastfeeding. Talk to other moms who have breastfed, read books, call your local LaLeche League International Chapter, and take a breastfeeding class. WMHS offers a breastfeeding class and our lactation consultants are available to speak with you by appointment. Visit www.wmhs.com for more information. The more you know about the mechanics and the benefits of breastfeeding, the more likely you are to succeed.

CIRCUMCISION ADVANTAGES AND DISADVANTAGES

WHAT IS CIRCUMCISION?

It is the surgical removal of the extra skin from the end of the penis. Today in the United States, over 70 percent of boys are circumcised. It is the most common operation performed on males in the U.S. Only about 48 percent of the boys in Canada and 24 percent in the United Kingdom are circumcised. Circumcision is quite uncommon in the rest of Europe, in Asia, and in Central and South Americas.

In the United States, circumcision (like formula feeding and tonsillectomy) reached its peak in the 1950s and 1960s, when about 90 percent of the boys were circumcised. During the 1970s, though, circumcision came into question.

Circumcision does hurt. Anesthetics can reduce the pain. A dorsal penis block provides pain control for up to 6 hours, but involves an injection prior to the procedure.

ADVANTAGES

Circumcised males have ten-fold fewer urinary tract infections.

A lower rate of syphilis, genital herpes, genital warts, and AIDS in circumcised men has been reported in a number of studies.

Males circumcised in the newborn period almost never develop cancer of the penis.

Cancer of the cervix has been reported to be less common in the partners of circumcised men.

Circumcision usually prevents phimosis (the inability to retract the foreskin) by the appropriate age.

When the foreskin of an uncircumcised penis is first successfully retracted, it sometimes gets stuck. The head of the penis begins to swell, which often requires an urgent circumcision. Newborn circumcision prevents this uncomfortable emergency, called paraphimosis.

Circumcision reduces the incidence of balanoposthitis, an infection or inflammation of the skin of the penis due to trauma or poor hygiene.

Effective personal hygiene is easier with a circumcised penis.

Many boys who are not circumcised at birth will require the procedure later, resulting in greater cost and greater risk.

NATURAL FORESKIN

The human male body comes with an intact foreskin.

Proper penile hygiene and safe sexual practices will prevent phimosis, balanoposthitis, penile cancer, cervical cancer, AIDS, and other sexually transmitted diseases.

Men with an intact foreskin, on average, have a longer period between erection and ejaculation than their circumcised counterparts.

Circumcision is painful.

Circumcision is costly, with more than $140 million spent on the procedure in the U.S. alone.

There can be complications with circumcision. The true incidence of complications is unknown, but recent large studies have estimated the risk of complications to be between 0.2 percent and 0.6 percent, with most of the complications minor and short term-although amputation does occur rarely.

Bleeding is the most common complication, and newborn circumcision should not be performed if there is a family history of bleeding problems. It should also be delayed in any child who is sick, premature, or who has an abnormality of the penis.

The risks and benefits of circumcision are fairly well balanced. Don't be misled by anyone who tells you that one option is clearly better than the other. It is a matter of personal preference. Sometimes it is a question of culture or faith. Sometimes it is a question of fitting in with peers during the growing-up years.

As parents, you need to follow your hearts!

LABOR AND DELIVERY

WHAT SHOULD I TAKE TO THE HOSPITAL?

For You

- This book
- Bra (a nursing bra if you are planning to breastfeed) and underwear
- Toiletries
- Cell phone charger
- Robe and slippers
- Small amount of money for newspaper, etc.
- Lip balm
- Important telephone numbers
- Camera
- Clothes to wear home (should be loose fitting)

For Baby

Clothes for baby's photo and trip home

Baby book

Infant car seat

Pair of socks or booties

Blanket for the trip home

Newborns will not be discharged to go home without a properly installed car seat

CERVICAL RIPENING

WHAT IS IT?

The cervix is the opening to the uterus. Normally, the cervix softens and thins out (called ripening) as you get ready to go in to labor. This process is started by a hormone produced in the body called prostaglandin. Sometimes the cervix does not soften on its own. Cervical ripening agents, such as Prepidil and Cervidil, are made of prostaglandin and are used to aid this process and help labor to start.

HOW IS IT DONE?

1. You may have a light liquid breakfast
2. Report to Labor and Delivery on the 6th floor of Western Maryland Regional Medical Center.
3. You will be given a patient gown and be placed on a fetal monitor.
4. An IV will be started to give you fluids.
5. Cervidil is a time-release prostaglandin tablet with a string attached. The doctor will do a vaginal exam and place the tablet next to your cervix.
6. Cytotec is a tablet that may be taken by mouth or placed intravaginally by your doctor.
7. You are kept on a fetal monitor for two hours. After that time, you can walk around on the Perinatal Unit.

WILL I GO INTO LABOR?

Possibly. The primary purpose for ripening is to prepare the cervix for labor. In some cases, it may only start the process and you will be sent home. If you do go into active labor, you will remain in Labor and Delivery until your baby is born.

SHOULD I BRING MY COACH OR FAMILY?

That is your choice. However, if your coach is working in the area, he or she does not need to be here. You can call him or her if you go into labor. The same holds true for family and friends. Please ask friends and relatives not to call Labor and Delivery; tell them you will call them with an update.

WILL I BE UNCOMFORTABLE?

Cervical ripening often causes menstrual-like cramps. This will be all you experience unless you go into active labor.

I'M BORED! NOW WHAT?

Bring something to keep you occupied, such as books, magazines, games, knitting, etc. It is also a good time to watch some of the infant care videos that are available.

THREE POSSIBLE ENDINGS

Cervical ripening begins. You stay 8 to 12 hours for observation and then go home.

Cervical ripening stimulates spontaneous labor and you have your baby.

Cervical ripening occurs but contractions do not begin and your doctor decides to induce labor.

INDUCTION

WHY DO I NEED AN INDUCTION?

Induction of labor may occur anytime after the 39th week of your pregnancy with good dates or if your pregnancy has gone past your due date or you are experiencing medical problems, your doctor may decide to induce labor.

WHAT ARE SOME MEDICAL REASONS FOR INDUCTION?

- High blood pressure
- Diabetes
- Rh disease
- Post-dated pregnancy
- Small for gestational age pregnancy
- Ruptured membranes without contractions

CAN I HAVE AN ELECTIVE INDUCTION?

Inductions for your or your doctor's convenience are not done. There are strict criteria that must be met in order to have an elective induction scheduled.

HOW IS INDUCTION DONE?

Your doctor may ripen your cervix first with Cervidil or Cytotec, and then do one of the following:

- Rupture the membrane (bag of water) to start labor
- Stimulate existing contractions or induce contractions using a hormone called oxytocin (Pitocin) through an IV. This hormone is normally produced by the body.

HOW DO I PREPARE FOR INDUCTION?

- Take nothing by mouth after midnight. (If you are coming in for cervical ripening, you may have clear liquids.)
- Take a shower before coming to the hospital
- Come to Labor and Delivery on the 6th floor of Western Maryland Regional Medical Center.

LABOR

HOW WILL I KNOW WHEN I AM REALLY IN LABOR?

As your delivery date gets closer, you may begin to wonder, "How will I know I'm in labor?" Real labor is not exactly like you see in the media. Often it takes several hours to decide if you are actually in labor.

You may notice a periodic tightening or balling up of your uterus (contractions) that gradually become longer, stronger, and closer together. Contractions may also be felt in your back.

Come to the hospital when your contractions become uncomfortable and are a 5 to 7 minute intervals for at least an hour.

As your cervix begins to open up, you may notice a slimy, pink mucous-like discharge. This is your mucous plug. You may, however, lose your mucous plug and not actually be in labor. If this is your only symptom, you are not in labor. You may actually lose your mucous plug several weeks prior to going into labor.

Your water could break first, even without having any contractions. If at anytime during your pregnancy you notice a watery discharge, come to the hospital immediately. The only absolute way to know you are in labor is to come to the hospital and have someone check you to determine if your water has broken or if your cervix is beginning to open.

If you are in doubt about what to do, call the Labor and Delivery Unit at **240-964-6300**.

PAIN MANAGEMENT FOR LABOR AND DELIVERY

We encourage our patients to be well informed about their pain management options. Please, if at all possible, attend the childbirth classes offered by the Western Maryland Health System. You can attend as early as your first trimester. Your instructor will teach you breathing and relaxation skills, which will be of vital importance when you are in real labor. Being educated about your body, the labor and delivery process, and the proper breathing and relaxation techniques will help to reduce your anxiety, which will also reduce your discomfort.

While some women choose birth without medication, many women wonder and worry about the pain and discomfort they might experience during childbirth. Please talk with your doctor about the options that may be right for you.

Narcotics: There are several narcotics that may be used to reduce pain and anxiety during labor. Demerol, Stadol, or Nubain, for example, can be given right into your IV. These drugs can cross the placental barrier to the baby and may depress breathing after for a short time. You and your baby will be carefully watched during labor to decrease the chance of this happening.

Epidural: With epidural anesthesia, you can be alert and relatively pain-free to enjoy the birth of your baby. You lie curled on your side or sit on the edge of the bed for the injection. The anesthesiologist passes a catheter (a very thin, flexible hollow tube) through the needle, then withdraws the needle and tapes the catheter in place so medication can be added as needed. The catheter is placed into a space just outside the spinal canal. Medication is injected through the catheter, which remains in place until after you deliver your baby.

This will cause numbness from the waist down and your contractions will be less painful. You may not feel them at all. If you need to have a C-section delivery, your epidural can usually be used for anesthesia. Sometimes an epidural can impair your sensation so much that pushing is difficult. In that case, you may need forceps or a vacuum delivery to help you. Your epidural may also be turned off to enable you to push better.

Local: A local or numbing medicine may be used right before your baby is born if an episiotomy is needed. The medicine is injected directly into the area where the episiotomy is to be performed and lasts until the area is repaired.

Pudendal Block: A pudendal block is a type of pain relief that is sometimes used for a forceps for vacuum delivery. A numbing medication is injected through the vaginal walls and numbs a larger area than the local.

Spinal Anesthesia: A spinal is very similar to an epidural, but it is in a slightly different spot in your back and the catheter is not left in place. It lasts for a limited amount of time and is often used for a C-section delivery.

General Anesthesia: In some cases, such as an emergency C-section, you may be put to sleep. General anesthesia can be done much quicker than a spinal or epidural.

THE THREE STAGES OF LABOR

STAGE I

Your body prepares to give birth. Contractions gradually get longer, stronger and closer together. The cervix (mouth of the uterus) gradually dilates (opens) until it is open wide enough for the baby to pass through. Your cervix dilates from 1-10 centimeters. This is the longest stage of labor. It could take 12-18 hours or more.

Helpful Hints:

1. Relax - Get into a comfortable position using lots of pillows for support. You may even want to bring your favorite pillow from home. Keep all muscles, from head to toe, as loose and relaxed as possible.
2. Breathe - Concentrate on breathing in through your nose and exhaling out through your mouth. Breathe at a slow, steady pace. Childbirth classes will teach you much more detailed breathing techniques.
3. Activity - If you are not able to sleep, then walk, sit up and change positions often. Many women find it relaxing to sit in the shower or use the Jacuzzi. The Jacuzzi can only be used if your membranes (water) are not broken.
4. Other Tips - Eat ice chips to relieve dry mouth. Use a warm or cold washcloth on your back to relieve back pain.

Have someone rub your back.

Listen to your favorite music.

STAGE II

Finally! This is what you have been waiting for. Your cervix has opened completely and you may now begin to push your baby out. This stage may last two hours or more and ends when your baby is born.

It is possible to shorten the length of time that you will push by using a technique called "laboring down." This is most effective if you have an epidural since the urge to push may be very strong. Laboring down means to delay the start of the pushing, once you are fully dilated, until the baby is very low in the birth canal. When you delay pushing, you may reduce swelling to the perineum and may reduce your chances of tearing during the birth.

Another way to reduce your chances of tearing would be to avoid an "assisted delivery." This would be when your doctor uses either a vacuum or forceps to deliver the baby, which sometimes must be done. By laboring down and allowing the baby's head to stretch the vagina and perineum, you decrease your chances of a fast, explosive delivery that may result in tears. However, despite all measures, tears and episiotomies sometimes still occur.

STAGE III

After the baby is born, you will deliver the placenta (afterbirth). This usually takes 15-20 minutes.

During this time, your doctor will repair (suture) any lacerations that have occurred during the birth process or may repair an episiotomy if one was done. Lacerations are small tears that sometimes occur in the vagina or skin and muscle around the vagina opening. Lacerations/tears commonly occur in the perineal area—the area between the anus and vaginal opening. An episiotomy is an incision made in the perineum to widen the vaginal opening.

CESAREAN BIRTH (C-SECTION)

WHAT IS IT?

A Cesarean section is a method of delivering a baby through a surgical incision in the mother's abdomen.

WHY WOULD I NEED TO HAVE A C-SECTION?

Factors that may require a C-section include:

- Very premature infant
- Maternal heart condition
- Infant too large to pass through the pelvis
- Pregnancy Induced Hypertension (Toxemia) if induction is unsuccessful
- Active case of genital Herpes
- Placenta previa (placenta covers the cervical opening)
- Labor does not cause the cervix to dilate
- Obstetrical emergency such as prolapsed cord, abruptio placenta (placenta separates from the uterine wall before the baby is born), or fetal distress

WHAT WILL HAPPEN IF MY DOCTOR DECIDES TO DO A C-SECTION?

- Intravenous (IV) fluids will be started
- A Foley catheter will be inserted to keep the bladder empty during the surgery and it will be left in until the morning after the procedure
- The area around the incision site will be shaved
- Heart and blood pressure monitors are applied to the mother
- An antacid is often given through your IV to neutralize stomach acids to help prevent you from getting sick
- Epidural or spinal anesthesia is given if it is not an obstetrical emergency
- General anesthesia is given for obstetrical emergencies
- The area around the incision site will be cleansed
- Your coach may be with you for the birth if a spinal or epidural is used

HOW LONG WILL I BE IN SURGERY?

The actual delivery of the baby takes from 2-10 minutes depending on the urgency of the situation. Delivery of the placenta and closing of all the layers of abdominal tissue takes approximately 45-60 minutes. The skin may be sutured or closed with surgical staples.

WHAT CAN I EXPECT FROM MY HOSPITAL STAY?

You will be taken to a recovery room where a nurse will watch you very closely for 1 to 2 hours. The monitors placed before surgery will remain on during this time. You will be encouraged to move your legs, turn whenever possible, and take deep breathes. After this, you will be moved to a room on the Postpartum Unit (6 South) where you will remain for the next 2-4 days.

HOW LONG DOES RECOVERY FROM A C-SECTION TAKE?

A C-section is major surgery. The recovery period is usually 4-6 weeks. It is not unusual to feel some disappointment at being unable to have a vaginal birth. Do not lose sight of the fact that you have a beautiful son or daughter. You are not a failure.

It is necessary for you to get up and move around quickly after the surgery. The sooner you do this, the better you will feel, and the faster you will recover. More uncomfortable than the incision itself are the gas pains that may develop post-op. Moving around and using a rocking chair will help get things moving. Avoid carbonated beverages, straws, and gas producing foods.

Coughing and deep breathing are very important, especially in the early post-op period. Place a pillow over your incision and apply pressure by placing your arms across your abdomen, then cough or clear your throat several times. This helps prevent lung complications such as pneumonia.

Vaginal discharge is normal after a C-section just as after a vaginal delivery. It will be red for the first few days, progress to brown, then to pale yellow.

VAGINAL BIRTH AFTER C-SECTION (VBAC)

CAN I HAVE A VAGINAL BIRTH AFTER A C-SECTION?

Yes, you can! The American College of Obstetrics and Gynecology highly recommend having a vaginal birth after a C-section whenever possible. In some cases this is not possible and your physician will help you make a decision.

WHY SHOULD I TRY TO HAVE A VAGINAL BIRTH?

- You will have a shorter and easier recovery
- You are not subjected to the risks of anesthesia and major surgery
- It is better for your body to go through labor to trigger the release of important hormones
- The birth process also helps to squeeze excess fluid out of the baby's lungs
- It is less costly

WHAT RISKS ARE INVOLVED?

There is a very slight risk that your uterus could come apart where the old internal incision is, but this is rare. If this complication (called a uterine rupture) occurs, you will have an emergency C-section.

HOW DO I ARRANGE FOR A VBAC?

To determine if this is an option for you, your doctor will need to review your surgical records. He or she can then advise you and make the arrangements.

SKIN TO SKIN TIME AND THE GOLDEN HOUR

We want to provide the BEST welcome to every baby. The first hour following delivery is an important part of newborn care. This is called "The Golden Hour".

The nursing staff will be placing your new baby "skin to skin" on mom's chest for the first hour. This may occur in the labor/delivery room or the C-section room. This position helps the baby adapt to his or her new world by helping stabilize his or her temperature and blood sugar. It also promotes breastfeeding for those mothers who choose to breastfeed. Mothers who choose to formula feed will also have their baby placed skin to skin. Dads are also encouraged to participate in skin to skin with their baby. A blanket will be used to cover mom (or dad) and baby during this time.

We know that visitors and family members and anxious to hold your new baby, but we ask that during this all important first hour your baby be held by ONLY mom or dad. Visitors and family members will be able to hold the baby once the new family is transferred to the postpartum unit.

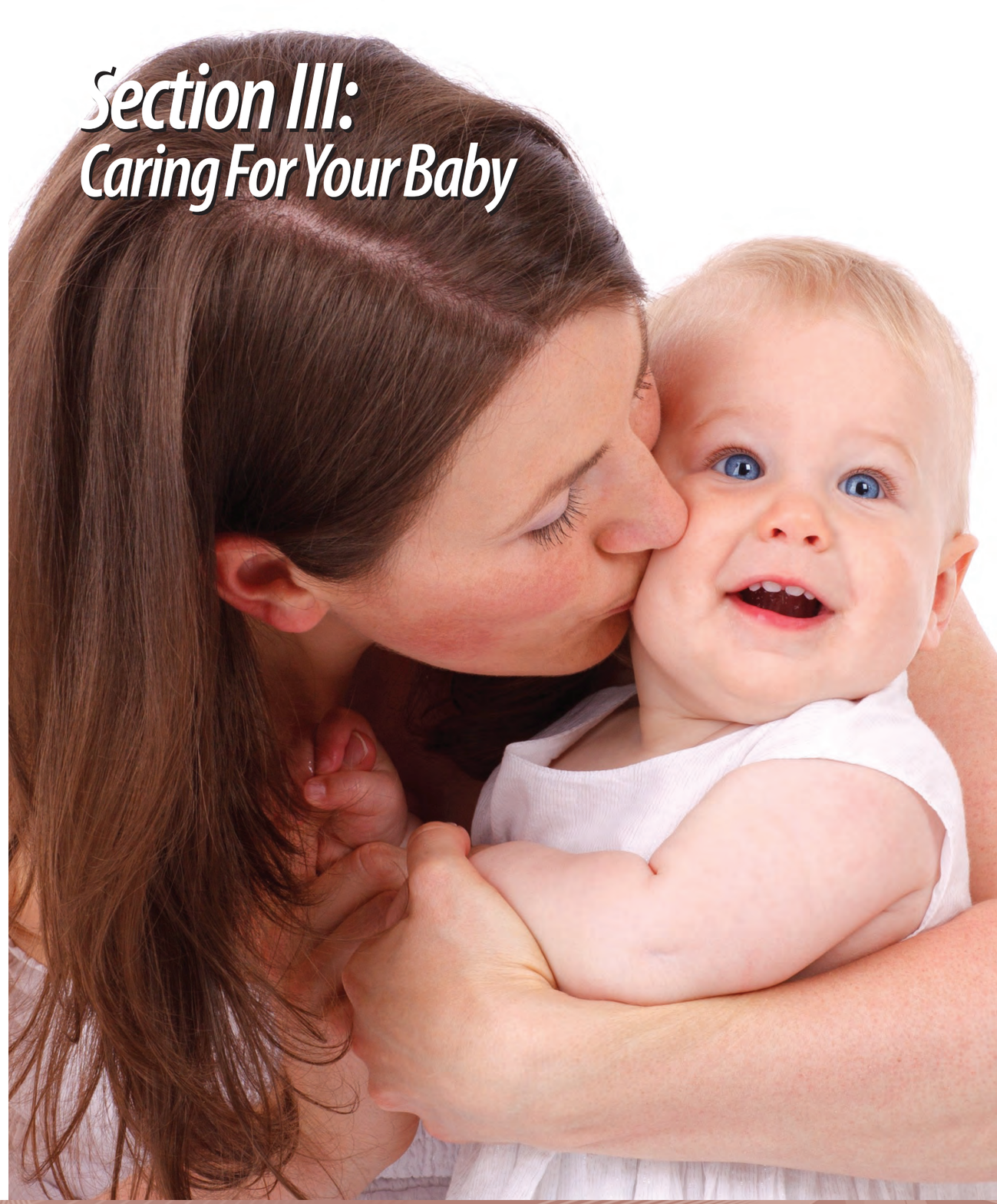
NEWBORN SCREENING TESTS

Newborn babies can be tested for some conditions that cause mental retardation or other health problems. Testing all babies is important because babies with these conditions usually look normal. The Maryland Department of Health and Mental Hygiene offers newborn screening as a service to families with new babies. This testing is done to help assure that your baby will be as healthy as possible.

By using a simple blood test, we are able to test for six conditions that can cause mental retardation or other disorders. Treatment, if started early, can sometimes prevent mental retardation. You need to remember, however, that these six conditions are not the only causes of mental retardation. In addition to these six tests, your baby can also be tested for sickle cell disease. Babies with this disease need special health care.

In order for your baby to have this very important test, you must first give your permission. You will be asked to sign a consent form in labor and delivery before your baby is born. Once you have done that, a small amount of blood is taken from your baby's heel. This test is done on all babies, and complications such as infection of the heel are very rare. This test is done before your baby leaves the hospital and again in the doctor's office at two weeks of age.

Section III: Caring For Your Baby



SECTION III: CARING FOR YOUR BABY

WHEN TO CALL THE DOCTOR

IS MY BABY SICK?

Bringing home a new baby is a time of excitement, joy, pride, anticipation and worry. Will you know what your baby needs? Is he/she healthy? You don't want to be overprotective but you don't want to be too casual either. As you get to know your baby's routine, you become able to judge his/her state of health. Don't worry, you will know when something is really wrong with your baby.

SOME THINGS TO WATCH FOR:

Temperament: If your baby is pleasant, happy and feeding well, he/she is probably not sick. If your baby has a runny nose and a big smile, he/she is probably all right. If he/she has a runny nose and is irritable or sleeping more than usual, you may have a problem.

Unusual crying: If your baby suddenly starts to cry more than usual and can't be comforted, he/she may be sick. Note any change in the character of your baby's cry. If it is coarse, weak, or unusually high pitched, he may be seriously ill. Babies may also become listless when ill. If he/she seems unhappy, doesn't cry, and is inactive or difficult to awaken, you may have a problem. Pay attention to your baby's signals and notify your pediatrician if you sense that something is wrong.

Appetite: Your baby's appetite varies day by day. A hungry baby should feed vigorously. A baby who tires easily from sucking or loses interest in feeding is probably sick. Also, if you notice your baby spitting up more than usual, with more effort, or if the spit-up is greenish in color, he/she may be sick. On the other hand, your baby may seem more hungry than usual - that is usually a growth spurt. Increased appetite, especially in breastfed babies usually occurs around 10 days, 2-3 months, and 5-6 months. Just nurse more frequently on demand to increase your milk supply to meet the baby's needs.

Abnormal bowel movements: Young babies, especially breastfed babies, often have very soft or liquid bowel movements. However, if your infant's stools become very watery he/she may have diarrhea. Monitor your baby's bowel movements and see whether the diarrhea continues. If it does continue, be sure your baby takes enough fluids or breastfeeds at least as often as usual so he/she doesn't get dehydrated. Your baby should wet a minimum of 6 diapers a day. If he/she seems listless and the diarrhea persists, call your pediatrician. Also if your baby begins to have small, hard, dry bowel movements or her/his stool is streaked with blood or mucous or has the consistency of jelly, call your pediatrician.

Difficulty Breathing: If your baby's breathing is labored or if he/she is having any kind of trouble breathing, get help immediately. If he/she seems to be having severe difficulty or you notice a blue color to his/her lips or skin, call 911. Otherwise, call your pediatrician or go to the Emergency Department at the hospital.

Fever: Fever alone is not a reason to worry. A baby can have a low grade fever and be seriously ill or have a high fever and be only mildly ill. However, if your baby is less than 3 months old and has a fever of 101 or more, call your pediatrician. A fever combined with other symptoms, such as vomiting or diarrhea can be cause for concern.

SEVEN REASONS BABIES CRY AND HOW TO SOOTHE THEM

Babies cry. This is how babies communicate. Babies can't talk, so they must cry to let us know that something is wrong. A large part of parenting is trial and error, and you'll learn quickly how to anticipate your baby's needs. These are the most common reasons babies cry.

I'm hungry

The baby will usually start by rooting, sucking on his fist or thumb and then start to cry if you don't recognize those signs. When your baby is crying, check first to see if your baby is hungry. Offer a bottle or the breast, depending on what feeding option you have chosen.

Change my diaper

Some babies will let you know right away when they need to be changed. This one is easy to check and simple to remedy.

I'm too cold or hot

Newborns like to be bundled up and kept warm. (As a rule, they need to be wearing one more layer than you need to be comfortable). So when your baby feels cold, like when your baby is naked during a diaper change or for a bath, he/she will let you know that he/she is not happy by crying. Be careful not to overdress your baby; babies are less likely to complain about being too warm than too cold and won't cry about it as vigorously.

I want to be held

While newborns seem to thrive on a lot of attention, they can easily become over stimulated. You may find that your baby cries longer than usual after spending a holiday with many adoring family members or has periods at the end of each day when he seems to cry for no reason. Newborns have difficulty filtering out all the stimulation they receive; the lights, the noise, or being passed from person to person can be over whelming. Crying is their way of saying "I've had enough." When this does happen, take him somewhere calm and quiet and let him vent for a while.

I don't feel good

If you've just fed your baby and checked her diaper and she is not too cold or hot, but she's still crying consider checking her temperature to make sure she isn't sick. The cry of a sick baby tends to be distinct from the hunger or frustration cry, and you'll soon learn when your baby just doesn't sound right and needs to be taken to the doctor.

None of the above

Sometimes you might not be able to figure out what's wrong. Many newborns develop periods of fussiness when they're not easily soothed. These periods of fussiness can range from a few minutes of hard-to-console crying to full-blown colic. Colic (see separate section on colic) is defined as inconsolable crying for at least three hours per day, at least three days per week. Even if your baby is not crying for three hours, these episodes may be difficult for you. When all else fails, try the tips below.

NOTHING'S WRONG - WHAT SHOULD I DO?

Wrap him up and hold him close

Newborns like to feel as warm and secure as they did in the womb, so try swaddling (see separate section on swaddling) your baby in a blanket or holding him up against your shoulder. Some babies find swaddling too constrictive and will respond better to other forms of comfort such as sucking a pacifier or rhythmic movement.

Let her hear a rhythm

Babies are used to the sound of your heartbeat; that's another reason they love to be held close. You can also try playing soft music, singing a lullaby, or even just putting him/her close to the steady rhythm of an electric fan or the white noise of a vacuum cleaner.

Put your baby in motion

Sometimes just the motion of carrying your baby around will be enough to calm him/her. It may also help to rock him/her gently in a rocking chair or swing at the same rate as your heart (around 60-100 beats per minute), put him/her in him/her car seat or carrier and sit it on a running dryer (do not leave your baby unattended), or take him/her for a ride in the car.

Rub your baby's tummy

Rubbing your baby's back or belly is one of the most soothing things you can do for him/her, especially if he/she is having gas pains, which is often the problem with colicky babies.

Let your baby suck on something

Even when he/she is not hungry, sucking on something can steady an infant's heart rate, relax him/her stomach, and calm him/her flailing limbs. Give him/her a pacifier or a finger to clamp onto and suck.

TAKE CARE OF YOURSELF

No baby has ever cried to death, but a crying baby can be very stressful for new parents. You're already sleep deprived and may already be unsure about how to care for this baby. Mom's emotions are all over the place due to the hormonal changes she's going through. Dad may not be sure what role he should play in caring for the newborn or whether he'll ever get Mom's attention again. Add a crying baby to this and many parents can become overwhelmed with feelings of incompetence. If you know your baby's needs have been met and you've tried to calm him but he is still crying, it's time to take care of yourself so you don't get too frustrated.

- Put your baby down and let him/her cry for a while.
- Call a friend or relative and ask for advice.
- Give yourself a break and let someone else take over.
- Put on some quiet music to distract yourself.
- Take deep breaths.
- Remind yourself that nothing is wrong with your baby and crying won't hurt him/her. He/she may just be having a good cry about something and can't tell you what it is.
- Repeat to yourself, "He/she will out grow this phase."
- Babies and their parents are pretty tough and somehow manage to get through even the most difficult crying episodes. Take heart that by the time your baby is 6 to 8 weeks old, he/she will be able to sooth him/herself and much of the crying will stop.

BREASTFEEDING THE FIRST 6 WEEKS

We have several IBCLCs (lactation consultants) who are available to assist breastfeeding mothers as needed. Any member of the nursing staff is also available to help as well.

The more relaxed you are, the easier a feeding will be. Atmosphere is very important, especially in the early days of breastfeeding when you are still trying to get the hang of it.

SIMPLE STEPS TO SUCCESSFUL BREASTFEEDING

1. Start breastfeeding as soon after birth as possible. Immediately after delivery, during the "Golden Hour", is ideal. Your baby will be wide awake during this time.
2. Hold your baby close with his/her mouth at your nipple and his/her belly to your belly.
   a. Football hold - baby lying at your side with you sitting up and his head in your hand.
   b Cradle hold - you are sitting up and the baby's head is held in the crook of your arm.
   c. Side lying - you and your baby lying down facing each other.
3. Offer the breast to your baby. Hold your breast in the "C" hold - with your fingers below supporting your breast and your thumb above. Be sure to keep your fingers back - not too close to your nipple - so your baby can latch on properly. Tickle your baby's lips with your nipple. This should start his/her rooting reflex. When he/she opens his/her mouth wide, pull him/her in close onto the breast.
4. When the baby latches on, he/she should have a "mouthful" - not just the tip of the nipple. The baby's lips should be curled out, cheeks should stay rounded (no dimpling), and tongue should not click while nursing. His/her whole jaw should be moving all the way up to his/her ears.
5. Allow the baby to nurse as long as he/she wants. It is not necessary to remove him/her from one breast to place on the other. Keep your baby on as long as he/she is actively nursing. When he/she comes off, burp him/her. If your baby has nursed on the first side at least 10 minutes, then you can offer the other breast. Otherwise continue to nurse on the first breast.
6. Be patient. Babies go through a sleepy period after birth and may not nurse well right away. Don't be afraid to ask for help! All the nurses are trained to help you get off to a good start with your breastfeeding experience.
7. Relax and enjoy your baby. Enjoy the closeness that breastfeeding allows.

In the first six weeks, as your milk supply adjusts and your baby learns how to nurse, you may notice:

Engorgement - an Overfull Breast

Sometime during the first week after you give birth, you may find that your breasts feel very swollen, tender, throbbing, lumpy, and uncomfortably full. Sometimes the swelling extends all the way to the armpit. You may also run a fever. Some swelling is normal but engorgement is not.

What Causes Engorgement?

Between two and six days after you give birth, an abundance of breast milk comes in or becomes available to your baby. As that happens, more blood flows to your breasts, and some of the surrounding tissue swells. The result is full breasts. Not every mom experiences true breast engorgement. Breast engorgement is not normal and is due to not nursing frequently enough or long enough to properly empty the breast.

How can I treat it?

You can help ease engorgement by:

1. Wearing a supportive nursing bra. Be sure it is not too tight.
2. Breastfeeding frequently, every 2-3 hours, even if it means waking your baby. Have the baby nurse on both breasts at each feeding during this time to relieve the pressure.

3. If necessary, to help your baby latch on, manually express or pump milk until the areola softens up. It may be easier to manually express milk in the shower; the warm water itself may cause enough leakage to soften the areola.
4. While the baby is nursing, gently massage the breast he/she is on. This encourages milk to flow and will help relieve some of the tightness and discomfort.
5. To soothe the pain and help relieve swelling, apply cold packs to the breast for a short period after nursing. Crushed ice in a plastic bag works well.
6. Applying fresh cabbage leaves to your breasts can help relieve engorgement. Take two large leaves from the head of cabbage and place them over your breasts. Leave them on for 30-45 minutes or until they become transparent. Refrigerate the cabbage leaves prior to use for additional relief.
7. If your pain is severe, take a mild pain reliever as recommended by your provider.

How Long Does Engorgement Last?

Fortunately, engorgement passes pretty quickly. It should diminish within 24-48 hours. You are producing milk to feed your baby. Soon, with your baby's help, you'll produce the right amount of milk.

Mastitis - a Breast Infection

Mastitis can leave you feeling as if you have come down with the flu. It may start with a lump (a plugged duct) then you may notice areas of redness, hardness, soreness, or heat in your breast, and swelling of the affected milk duct. Common and more serious signs of infection include: chills, a fever of 101 or 102 degrees, and fatigue. About one in twenty moms get it in both breasts at the same time.

How Can I Treat Mastitis?

Notify your provider of your symptoms as soon as possible. If the infection is diagnosed early, it is easy and quick to treat, and you won't need to stop nursing from the affected breast. If untreated, mastitis can cause complications. It can lead to breast abscesses, which may require surgery. Rest is important. Keep your baby close and nurse him/her frequently. Emptying the breast is recommended and feeding your baby often is the best way to empty the breast. Drink plenty of fluid to keep yourself hydrated.

Should I Stop Breastfeeding if I Have Mastitis?

No. It's important that you continue breastfeeding through the infection. Now is not the time to wean. Try warm compresses on your breasts for several minutes before each feeding; this should help your "let down reflex" and make nursing more tolerable. If your baby doesn't empty the affected breast during each feeding, finish the job yourself with a breast pump. Apply ice after nursing to reduce inflammation.

Will it affect my baby?

No, your breast tissue is infected, not your milk. It is safe and beneficial to have your baby nurse from the affected breast.

Sore Nipples

Sore nipples are common to new breastfeeding moms. You may feel some tenderness in the beginning of a feeding during the first few days, but severe or prolonged pain associated with nursing is neither necessary nor normal. If the pain is intense or lasts longer than a few days, it is a sign that you may need to make some changes in your positioning or latch on. With proper positioning and good latch on, after the first days you can expect little or no discomfort.

What Causes Sore Nipples?

Usually, sore nipples are caused by a baby who latches on improperly or is positioned wrong at the breast. You should place your breast well into the baby's mouth so his/her lips are curled out. If he/she has to suck or pull your nipple into his mouth it can cause soreness and pain for you. Sometimes a poor latch is caused by early use of artificial nipples (bottles or pacifiers).

An ill-fitting bra can also cause nipple soreness by putting pressure on your nipples. Nursing pads and plastic bra linings may also cause soreness if they don't allow the skin to breathe by aggravating the pain by trapping moisture.

What can I do?

Your baby needs to take a large mouthful of breast, not just the tip of nipple, into his mouth before he/she begins to suck. If the baby is just sucking on the tip of the nipple, it will likely hurt and eventually become sore. Most mothers feel immediate relief when they position the baby properly. Use the "C" hold, fingers underneath and thumb on top, compress the breast when latching on and during the feeding. If your baby latches on without opening his mouth wide enough, break the suction by putting your finger into the corner of his/her mouth, take him from the breast and start again.

Some babies suck in their lower lip along with the nipple and areola and this may cause you pain. If your baby clamps down too soon, use your index finger to press down on his chin to open his/her mouth. Don't ever pull your baby from your breast without first breaking the suction.

Some experts say the best treatment for sore nipples is to express a little colostrum or breast milk and rub it gently on your nipples. The healing properties of mother's milk often takes care of the mild condition.

Lansinoh, a purfied, hypoallergenic lanolin cream formulated especially for sore cracked nipples is avail able at many pharmacies and considered safe for babies.

Stop using artificial nipples, if possible, to help improve your baby's latch.

BOTTLE FEEDING BASICS

HOW OFTEN TO FEED?

You do not need to follow a rigid schedule in the early weeks. You may work out a pattern for feeding within a month or two. Offer the bottle every 2-3 hours at first, or as your baby seems hungry. Until the baby reaches about 10 pounds, he/she will probably take 1-3 ounces every feeding. Don't force more than he/she seems ready to eat.

DO I NEED TO STERILIZE THE BOTTLE?

Before you use new bottles, nipples, and rings, you should sterilize them by submerging them in a pot of boiling water for at least 5 minutes. Allow them to dry on a clean towel. After that, a good cleaning in hot, soapy water or a cycle through the dishwater is sufficient. If you have well water, repeated sterilization may be best.

DO I NEED TO STERILIZE MY DRINKING WATER FOR MAKING FORMULA?

You don't need to unless your pediatrician recommends it due to your local water supply. If you use well water, you will likely be told to sterilize it or use bottled water for mixing formula. If you decide to boil the water, save yourself some time by preparing enough for the whole day.

WHAT IS THE BEST WAY TO WARM A BOTTLE?

Warm a bottle in a pan of hot, not boiling, water or by running it under the tap. You can also buy a bottle warmer designed for this purpose. There is no health reason to feed your baby warmed milk, although your baby may prefer it. If your baby is used to drinking a bottle at room temperature or slightly cold, you save yourself the time and hassle of preheating bottles, especially when he/she is crying to be fed right now.

Never use a microwave oven to heat a bottle. Microwave ovens heat unevenly and it can create hot pockets, leading to burns, as well as cause a breakdown of nutrients in the breastmilk or formula.

HOW CAN I MAKE SURE MY BABY IS DRINKING COMFORTABLY?

Listen and observe. If you hear a lot of noisy sucking sounds while he drinks, he/she may be taking in too much air. To help him/her swallow less air, hold him/her at a 45-degree angle. Also take care to tilt the bottle so the nipple is always filled with formula. Never prop a bottle. The baby may choke. Feeding time is a good time for bonding and snuggling.

WHY DO BABIES SPIT UP?

Babies spit up frequently during their first few months because they swallow air during feedings or because they've eaten too much. They may trickle one or two mouthfuls of milk down their chin or onto your shirt while burping or taking a break from feeding. You can help your baby expel any swallowed air and reduce the amount he/she spits up by burping your baby every 3-5 minutes during feedings. Avoid vigorous play and try to keep your baby upright for about half an hour after he/she is done eating to let the food digest.

If your baby continues spitting up even after you burp, try feeding him/her smaller amounts.

Make each feeding calm, quiet, and leisurely. Avoid interruptions, sudden noises, bright lights, and other distractions.

Try to feed your baby before he/she gets frantically hungry. He/she is less likely to gulp and end up swallowing too much air.

If you use a bottle, make sure the nipple hole is neither too big nor too small. The right sized hole will allow a few drops of formula to come out when the bottle is inverted, and then the flow should stop.

HOW DO I KNOW IF THE BABY IS GETTING ENOUGH TO EAT?

Once the first sleepy day or two have passed, your baby may seem to be hungry all the time. He/she probably is, since breast milk is digested within a couple hours after consumption. Most newborns want to nurse 8 to 15 times a day after the first 3 to 4 days of life. Feed your baby as often as he/she needs it. Schedules have no place in your routine while you are first starting to breast feed.

Weighing the baby will not reassure you because newborns usually lose 5-10 percent of their birth weight and most take 2 weeks to regain it.

THERE ARE SOME SIGNS THAT YOUR BABY IS GETTING ENOUGH TO EAT:

- Your baby eats at least every 2-3 hours, or he/she is nursing at least 8 times in 24 hours for the first 2-3 weeks.
- Your breasts (after your milk comes in) are being emptied and feel softer after nursing.
- Your baby has firm skin that bounces right back if pinched. (If you pinch a small piece of a dehydrated baby's skin, it will stay puckered.)
- The number of wet diapers starts to increase by the 5th day, or there are at least 6-8 wet diapers in a 24-hour period.
- Sometimes it is difficult to tell if a disposable diaper is wet. Remove it from the baby and hold the used one in one hand and a clean one in the other. The wet diaper should feel heavier than the clean one. Also, try putting a small piece of tissue or toilet paper in the diaper each time; you can pull it out and check for moistness.
- You can hear your baby swallowing while nursing.
- Your baby has mustard yellow stools. However, frequent dark stools are normal until the 5th day of life. They should gradually become lighter in color.

THERE ARE SOME SIGNS THAT YOUR BABY MAY NOT BE GETTING ENOUGH TO EAT:

- Your baby feeds less than 10 minutes.
- You rarely hear your baby swallow.
- Your breasts remain firm after nursing.
- Your baby is fussy or sleeping most of the time.

- Your baby has dimples in his cheeks or makes clicking noises while nursing.
- Your baby is wetting fewer than 6 diapers in a 24-hour period 5 days after birth.
- Your baby is not having a bowel movement at least once a day or is having small, dark stools 5 days or more after birth. Older babies may have infrequent bowel movements - even every few days.
- Your baby becomes more yellow, instead of less, after the first week.
- Your baby does not develop a round face by about 3 weeks.
- Your baby's skin remains wrinkled after the first week.

If you are concerned about any of these, call your pediatrician. You may also call the nursery at WMRMC at **240-964-6430**.

BABY CARE

CPR

There is a video on CPR for parents to watch after your baby is born. Ask your nurse to show it to you.

To perform infant CPR according to the American Heart Association guidelines:

a. Determine unresponsiveness
b. Open the airway
c. Check for breathing
d. Give 2 breaths
e. Check for brachial pulse
f. Give 5 compressions to 1 breath x 20
g. Re-check pulse and call for help

CARE OF A CHOKING BABY (CONSCIOUS)

a. Check for cough or cry
b. Give 5 back blows
c. Give 5 chest thrusts
d. Repeat back blows and chest thrusts until successful in relieving choking

CARE OF A CHOKING BABY (UNCONSCIOUS)

a. Shake and shout, and call for help
b. Open airway
c. Check for breathing
d. Give 2 breaths
e. Reposition airway and repeat 2 breaths
f. Give 5 back blows
g. Give 5 chest thrusts
h. Check mouth and repeat breaths, blows the thrusts until successful in relieving obstruction
i. Activate the EMS after first completed cycle

SLEEP POSITION

1. The back is the safest position (helps reduce the risk of SIDS)
2. Use a firm mattress
3. Keep soft, plush or bulky items out of the baby's immediate sleeping environment

For developmental purposes, place the baby on his/her stomach while he/she is awake.

CIRCUMCISION

1. If the infant leaves the hospital with the gauze still on:

   Change the dressing when it is soiled.

   If it sticks, add more Vaseline and gently work off or soak with warm water and work off.

   If bleeding, apply pressure with a clean wash cloth or 4x4 for several minutes. A small amount of bleeding is okay; report anything more to the doctor.

2. Remove the gauze the morning after you go home and leave it off.
3. When the gauze is off, wash with soap, rinse, and pat dry. Apply Vaseline to the head of the penis with each diaper change until healed (approximately 7 days). This prevents sticking to the diaper.
4. On day 3-4 there may be a slight greenish-yellow film on the head of the penis. This is normal. It will heal in about 7 days.
5. If the foreskin retracts over the head of the penis, gently pull it back.

BATH

1. Every other day after discharge.
2. Sponge bath until the cord falls off (2-4 weeks)
3. Avoid chilling the infant.
   a. No drafts.
   b. Wash then dry each body part, keeping the rest covered.
4. Assemble your equipment (do not leave infant on work area to get things)
   a. Warm water
   b. Good working space
   c. Soap (suggest Dial Cream - antibacterial and moisturizing soap)
   d. Wash cloths
   e. Towels
   f. Clean clothes
   g. Diaper
   h. Diaper rash ointment
   i. Vaseline (circumcision care)
   j. Baby lotion (optional)
   k. Hair brush or comb
5. Do not use baby powder!

Eyes:
   a. Clean water
   b. Wash from the inner corner to the outer edge, change position on the cloth and do the other eye.
   c. Signs and symptoms of infection
      1. Redness
      2. Yellow/green drainage
      3. Swelling
      4. Crusting

Face and Neck:
   a. Use soap.
   b. Do not put anything into the nose or ears: use a washcloth and finger.
   c. Make sure you clean in all the creases and behind the ears.

Hair:
   a. Use soap or shampoo.
   b. Use a brush to help prevent cradle cap.
   c. Rinse well.

Arms to Hands:
   a. Wash/rinse/dry.
   b. Inspect fingers for hair strands or string.
   c. Grasp reflex/check for it.

Abdomen/Back:
   a. Wash/rinse/dry.
   b. Try not to get the cord wet.
   c. Breast engorgement may be caused by the mother's hormones.
   d. Use log roll.

Legs to feet:
   a. Wash/rinse/dry.
   b. Inspect toes for string or hair.

Diaper Area:

Female:

Always wash front to back.

Vaginal discharge.

White mucous.

Blood tinged caused by mother's hormones.

Male:

Wash/rinse/dry

Wash under scrotum and penis

Circumcision care:

Gentle washing first several days

Apply large amount of Vaseline to site (prevents sticking to the diaper)

If foreskin retracts over the head of the penis, gently pull it back

Uncircumcised penis - do not retract skin until the doctor tells you to.

DIAPER RASH

Skin protectants

- A&D, Desitin, or ask your doctor. If there is an open area, you may use Vaseline.
- Barrier between stool and skin
- Frequent diaper changes.

If it does not clear up, your baby will need to see the doctor.

CORD CARE

Keep the cord dry. It should fall off in approximately 2-4 weeks.

Signs and symptoms of infection

- Redness around cord
- Foul odor
- Drainage
- Moistness

BULB SYRINGES

Squeeze bulb away from the face of the baby.

Insert tip of the syringe into the end of the nose or cheek and let go.

Remove tip from nose or mouth and squeeze bulb to discard secretions.

Wash bulb in warm, sudsy water and rinse. (Make sure all the water is out of the syringe before you use it again).

FEEDING

Challenge after birth

- Sleepy/not interested
- Need to get baby awake and eating
  Unwrap, rub skin, talk to, change diaper
- Burping

BOTTLE/FORMULA

Feed every 2-4 hours during hospital stay (offer at least 1 ounce)

Every 2-4 hours during the day (unless doctor says otherwise)

Burp frequently (every 1/2 ounce)

Preparation

Wash bottle in hot soapy water/rinse well.

Dilute powder/concentrate with water (boil if using well water).

Make about 1 ounce more than baby usually takes.

Warm bottle to room temperature before feeding (place in hot water; never use the microwave).

Discard unused formula.

JAUNDICE

Jaundice is a common and usually harmless condition in newborn infants. It is the yellowish coloring of the eyes and skin. Approximately 2/3 of all full-term newborns get physiologic or newborn jaundice.

It usually appears on the 2nd or 3rd day of life and often disappears within a week.

Frequent feedings should be encouraged.

After discharge, watch your baby closely. Contact your baby's doctor if:

- The baby becomes more jaundiced
- The baby is eating poorly
- The baby is sluggish and hard to wake

SECURITY/SAFETY

Hospital

Nurses should be wearing identification badges with their pictures on them.

Nurses should be dressed in lavender uniforms. Most common kidnapping situation is someone in a lab coat coming to take the baby for a test.

Safety measure:

Never give your baby to someone you are not comfortable with.

Always put your baby's crib on bedside away from the door.

Do not leave baby unattended in room. (For example, take to bathroom door with you.)

Home

Never leave baby unattended in a car or at home. (Put baby in infant seat in bathroom while you shower.)

Do not advertise that you have a newborn. No signs in the yard.

Never leave baby unattended with pets.

Lock your doors when home alone.

ELIMINATIONS

Urinations

6-8 wet diapers/day
Light yellow in appearance

Bowel Movements

Meconium to green to soft yellow seedy.
Number varies (more frequent if breast feeding).
Breast-fed babies stools are more liquidly. Normal.

Signs of Constipation

Hard
Not frequent

Signs of Diarrhea

A noticeable or sudden increase in the number of stools.

A change in their consistency with an increase in fluid content.

A tendency for the stools to be greenish in color and contain mucous or blood.

Consult your pediatrician when your infant has diarrhea.

RECTAL TEMPERATURES

Your baby's doctor recommends that your baby's temperature be taken rectally. It is easy to do, just follow these instructions.

1. You will be given an electronic rectal thermometer to take home with you. Take it out of its clear plastic case.
2. Lubricate the end with petroleum jelly.
3. Place the baby on his stomach and spread the buttock so the anus (lower end of the digestive tract) is easily seen.
4. Push the button on the front of the thermometer until it beeps. Gently insert the thermometer 2 centimeters (slightly less than an inch) into the anus.
5. Hold the thermometer in place until it beeps, then read the temperature on the screen.
6. Wipe the thermometer off with alcohol after each use.

The normal temperature will range from 97F to 100F.

SWADDLING

Swaddling is the art of snugly wrapping your baby in a blanket of warmth and security. It can also keep him/her from being disturbed by his/her own startle reflex, and it may even help him/her stay warm and toasty for the first few days of life until his/her internal thermostat kicks in. Most importantly, it is a method that can help a baby calm down.

You probably won't leave the hospital without a lesson in this technique. Ask one of the staff to show you and then try it yourself. It will get easier the more you do it. It can be used to help settle your baby down when he/she over stimulated or when he just needs to feel something close to the tightness and security of the womb. You should stop doing this once your baby is about a month old because it can interfere with mobility and development in older babies. When your baby begins to kick off the covers, it's a sign he/she no longer appreciates being bundled snugly.

COLIC (0-12 months)

Some babies seem like they cry all the time - this may be colic. Colic isn't an actual disease, just a term used to describe uncontrollable crying in an otherwise healthy baby. If your baby is under 5 months old and cries for more than three hours a day on more than three days a week for at least three weeks and there's no medical explanation for this distress, chances are he/she is colicky. A colicky baby may also act truly uncomfortable. He/she may alternately extend or pull up his legs and pass gas. The crying and discomfort can afflict your baby at any time of day, but it's usually most intense between 6 p.m. and midnight.

About 20 percent of babies become colicky, usually starting between 2 and 4 weeks of age. The condition is equally common among first-born and later-born, boys and girls, breast and formula fed babies. Sixty percent of babies will be through the worst of it by 3 months, and 90 percent are better by 4 months of age.

Colic is one of the great mysteries of baby life. No one knows why some babies are more prone to it than others. It may be that some babies have more immature or sensitive digestive systems than others. A newborn's digestive tract contains very few of the enzymes or digestive juices needed to break down food, so processing the proteins in breast milk or formula can lead to painful gas. The act of screaming itself can cause your baby to swallow a lot of air that, too, leads to gassiness.

Occasionally breastfed babies become colicky because of something in the mother's diet. Dairy products are one of the main culprits. It you are breastfeeding, try cutting back on milk, cheese, and yogurt for a week to see if that makes a difference. If your baby's colic improves, keep these foods to a minimum. Some breastfed babies seem to be bothered if mom eats a lot of spicy food, wheat products, nuts, strawberries, some vegetables (such as cabbage, broccoli, and cauliflower), garlic, caffeine, and alcohol.

To see if one of these foods is making your baby uncomfortable, avoid them all for a few days. If your baby seems better, reintroduce one food at a time, allowing a few days between re-introductions. If he/she starts fussing again after you start eating a certain food, you've discovered the offending substance. You may have to abstain from it until your baby outgrows his/her sensitivity, which will probably be at around 3 months, but kicking coffee or any other food for a few months is a small price to pay for happy child.

WHY DO NEWBORNS LOOK SO FUNNY?

Few newborns would win a beauty contest just after birth, but you have to consider what they have been through. It is normal for their heads to be pointy and their genitals to be swollen.

Physical Characteristics

Newborns have big heads, short necks, short legs, and distended torsos. They sometimes look a lot like E.T. The average newborn has spent about 12 hours squeezing through the birth canal, so his/her head may be mishapen or kind of pointy.

Don't become overly concerned about the fontanels or soft spots. These are the openings in your baby's skull that allow the bones to compress enough to fit through the birth canal during labor. The rear fontanel takes about four months to close, while the front one takes between nine and eighteen months. Expect your baby's genitals and possibly his face and eyes to be somewhat swollen from the extra dose of female hormones he got from mom just before birth. These extra hormones cause these changes in girl babies too.

Your baby's arms and legs may look oddly short - this is normal. He/she has spent a lot of time being curled up in the uterus. His arms and legs will uncurl over the next couple of weeks. He/she may like to be swaddled (being wrapped up tight in a blanket). This is comforting to a newborn.

Skin

Newborn skin varies in appearance according to gestational age (how far into your pregnancy when your baby was born). Premature babies have thin, transparent-looking skin that may be covered with lanugo (a fine downy hair). Babies born prematurely will also be covered with vernix (a cheesy white substance that protects your baby's delicate skin while he's in the amniotic fluid.) Babies that are born after their due date will have a slightly wrinkly appearance and very little, if any, lanugo. Full-term and post-term babies will have only a few traces of vernix in the folds of their skin.

Babies of all races and ethnicities are born with fairly light, often pinkish skin. The pink tint comes from the red blood vessels, which show through your baby's still-thin skin. Your baby's true skin color will develop gradually over the course of his first year.

Birthmarks

Birthmarks come in a wide range of shapes, sizes, and colors and can show up anywhere on a child's body.

The most common varieties are:

- Café au lait spots, permanent tan or light brown flat patches that sometimes appear in multiples. About 20 percent of all newborns have these discolorations. They usually get smaller as a child grows.
- Moles, which vary in size and may be raised or flat, smooth or hairy, black or brown. Large ones are known as nevi.
- Mongolian spots are bluish or greenish spots on the back or buttocks, which usually fade by school age, although they may never disappear altogether. They are most common in babies with dark skin.

- Dark berry-colored port-wine stains. Light ones may fade, but most endure and enlarge as the child grows.
- Raised crimson marks known as strawberry hemangiomas (because they look and feel like a strawberry) that appear on about 10 percent of babies. They tend to grow for several years and then usually disappear by age 10.
- Cavernous hemangioma, a lumpy bluish or bluish-red mass that grows quickly in the child's first six months, then slows and starts shrinking by about 18 months, and is usually gone by the time a child reaches the teen years.
- Your baby may have small pus-filled bumps that leave dark brown marks when they burst. It's probably pustulr melanosis, a newborn rash more common in African-American babies. There's no need to treat it; it will usually disappear by the time your baby is three or four months old. About half of babies are born with milia, which are white dots on their faces that look like tiny pimples. These also disappear without any special treatment. Don't squeeze them.

Hair

Newborn hair doesn't actually have much bearing on what your child's hair will eventually be. Babies born with carrot tops can turn out to be blondes and sometimes blondes turn out to be brunettes. For babies of color, the big issue tends to be texture. The texture of the hair will get a bit coarser over the first six months.

Eyes

Caucasian babies, not all of them, are born with dark blue eyes that can take weeks or months to reveal their true color. As with the hair color and texture, the eye color you see at six months is what you get.

Changes to expect during the next six weeks

By the time your baby is 6 weeks old, most of your baby's newborn skin conditions will probably have cleared up; if not, they will soon. His/her umbilical cord will have fallen off, leaving him/her with a belly button. After the first few days of life, your baby will start gaining weight rapidly (an average of about 1 1/2 to 2 pounds per week), which means he/she will get plumper, his/her skin will fill out and yor baby will start to look like a "real" baby. His/her eyes and hair will also be making their way toward their final color and texture destinations. Even if your baby is born with a full head of hair, he/she may lose some or all of it. Don't worry if this happens because all of your baby's hair moves from the "growing" to the "resting" phase at the same time (unlike yours, in which different areas in different phases at any one time), and that is perfectly normal.

SIDS - SUDDEN INFANT DEATH SYNDROME REDUCING THE RISK

WHAT IS SIDS?

SIDS is an abbreviation for Sudden Infant Death Syndrome, also known as crib death. SIDS isn't any one illness or disease. It is a diagnosis given when an apparently healthy baby under the age of one dies without warning, and doctors and investigators can't pinpoint a cause after performing a full investigation including an autopsy, review of family and medical history, and examination of the death scene.

Each year in the United States, SIDS claims the life of approximately 4,500 infants, 90% of whom are six months and under. SIDS death rates have declined more than 42% since 1992, but SIDS remains the leading cause of death in the U.S. for persons under one year of age.

WHAT CAUSES SIDS?

No one knows for sure what causes SIDS, but researchers around the world are working feverishly to figure it out. They are getting closer every day. A leading candidate is an anatomical defect, most likely in the brain. That defect may lead to a failure in the way the baby breathes or controls blood flow to the body. Another possibility is that a developmental delay exists and proper breathing or blood flow control takes longer to appear in affected infants than in normal infants. When babies with any of these problems are confronted with a challenge, such as sleeping on their stomach and rebreathing CO2, overheating, breathing cigarette smoke, or momentary loss of blood pressure during sleep, they may be too vulnerable to survive.

WHICH BABIES ARE MOST AT RISK?

All babies under the age of one are at risk for SIDS. Some children have a higher risk of SIDS than the general population does. Noted SIDS expert and pediatrician William Sears has identified these characteristics:

Any baby who:

- Was born prematurely
- Has a mother who smoked or abused drugs during pregnancy or was under the age of 20 at the time of her first pregnancy
- Is around a smoking parent or caregiver
- Was born to a mother who had poor or nonexistent prenatal care
- Is being bottle fed (Some evidence suggests that breastfeeding may reduce the risk of SIDS)
- Is a sibling of a previous SIDS baby
- Is placed in the crib on his/her stomach

SIDS is most common between 1 and at 3 months of age, with 90% of cases in infants under 6 months, although babies are still considered at risk for SIDS up to the age of one year. SIDS strikes most often during sleep (but not always), usually between the hours of 10 p.m. and 10 a.m. - the usual hours of extended sleep. Also, SIDS is more common during cold weather months.

Research also shows that African-American infants are 2 1/2 times more likely to die of SIDS than white infants, and Native American babies are 3 times the risk. Boys of all ethnicities are at slightly higher risk than girls by a ratio of 1.5 to 1, according to Sears. Low birth weight infants, twins, and other multiples are also at a higher risk. Asians in North America are at a lower than average risk.

HOW CAN I REDUCE MY BABY'S RISK OF SIDS?

Put your baby to sleep on his/her back.

This is the single most important thing you can do to help protect your baby. Research shows that stomach sleeping doubles your baby's risk of SIDS.

Use firm, flat bedding and keep toys out of the crib.

Several studies have linked soft bedding to an increased risk of SIDS. Always put your baby to sleep on a firm, flat mattress with no pillow, fluffy blanket, sheepskin, or comforter under him. Any blankets and bumpers should be thin, flat, and fastened securely to minimize the risk of covering the baby's head or face. Don't put stuffed toys or other soft materials in your baby's crib. Waterbeds, beanbags, and other soft surfaces are all unsafe for an infant to sleep on.

Do not use a Boppy-style pillow for sleep.

Avoid overheating.

A room that is too warm and too much bedding are associated with an increased risk of SIDS. Keep the room that your baby sleeps in at a comfortable temperature (around 60-70 degrees). Signs that your baby may be overheated include sweating, damp hair, heat rash, rapid breathing, restlessness, and fever.

Breastfeed your baby if you can.

Research shows that breastfed babies are at a lower risk for SIDS.

Take your baby for regular checkups.

Babies who are up to date on their immunizations are less at risk for SIDS.

Don't smoke during pregnancy and don't allow smoking around your baby.

Women who smoke cigarettes during or after pregnancy put their baby at increased risk for SIDS. Recent studies have found that the risk of SIDS rises with each additional smoker in the household, with the numbers of cigarettes smoked a day, and the length of the infant's exposure to cigarette smoke. Keep the air around your baby smoke free!

GLOSSARY

Afterbirth - a common term for the placenta after it has been delivered.

Alpha-fetaprotein - protein produced by the fetus's liver that can be detected between the 16th and 18th weeks of pregnancy. High levels may be associated with a neural tube defect called spina bifida; low levels may be associated with Down Syndrome.

Amniotic fluid - clear fluid in the amniotic sac in which the fetus grows. It cushions the fetus, allows for fetal movement, helps the lungs develop, stabilizes the baby's temperature, and provides a barrier against infection.

Anencephaly - a rare birth defect resulting in little or no brain and a malformed skull.

Apgar score - the first test most babies are given at one and five minutes after birth. Assesses five basic indicators of health: respiration, pulse, activity level, response to stimulation, and appearance.

Areola - the dark area on the breast surrounding the nipple. This may spread or darken further during pregnancy.

Bag of waters - sac filled with amniotic fluid in which the fetus grows; it may rupture naturally as labor begins or may be "ruptured" by your physician to speed up labor.

Bilirubin - bilirubin is a by-product of the normal breakdown of old red blood cells. It causes a harmless type of jaundice in about 50 percent of newborns because their young livers cannot metabolize it quickly enough.

Birth canal - the passageway (made up of the cervix, vagina and vulva) that the baby travels through during birth.

Bloody show - the discharge (often mucous tinged with blood) that appears as labor approaches. Sometimes refers to light bleeding; other times is used to mean the mucous plug that dislodges when the cervix begins to efface and/or dilate.

Braxton-Hicks contractions - irregular or "practice" contractions starting around the 8th month that prepare the uterus for labor. May be painless and intense.

Breech position - when the baby's bottom or feet, rather than the head, face the mother's cervix as labor nears. Three to four percent of full-term babies are positioned this way.

Cephalopelvic disproportion - when a baby's head is too large to pass through the mother's pelvis. This condition accounts for 5 percent of the C-section deliveries.

Cerclage -placing a suture around a weak cervix (called incompetent cervix) to support a pregnancy to term. Most successful in preventing miscarriage and pre-term labor when performed early in pregnancy at about 18-20 weeks.

Cervix - the narrow, lower end of the uterus.

Cesarean section - a surgical procedure in which a baby is delivered through an incision in the abdomen and uterus. Used when a woman cannot give birth vaginally or if the baby is in distress.

Chlamydia - a common sexually transmitted disease, often with no visible symptoms, treatable with antibiotics. If untreated, chlamydia can make a woman infertile or be passed on to an infant during childbirth, causing pneumonia, eye infections, and in severe cases, blindness.

Chronic - ongoing or recurring. Chronic medical conditions include diabetes, epilepsy, and chronic fatigue syndrome.

Circumcision -the surgical removal of the sheath of skin (called a foreskin) that covers the head of the penis.

Colostrum - a precursor to breast milk that is rich in fats, protein, and antibodies; colostrum is sometimes called "early milk." Most women produce it a few days before and after childbirth; some women produce small amounts of it from the 5th and 6th month of pregnancy.

Conception - when a sperm and egg join to form a single cell, usually in the Fallopian tubes. After joining, the fertilized egg travels into the uterus, where it implants in the lining on its way to growing into an embryo and then a fetus.

Congenital - existing at or from birth, or acquired during development in the uterus and not through heredity.

Contraction - during labor, the strong, rhythmic tightening of the uterus. Pre-labor contractions are usually irregular and do not increase in intensity or duration.

Crowning - the appearance of the baby's head at the vaginal opening during labor.

Cyanosis - a bluish coloration of the skin caused by a lack of oxygen in the blood.

Dehydration - too little water in the body's tissues. Infants can become dehydrated quickly from vomiting and diarrhea.

Diarrhea - loose, watery, and frequent bowel movements - often associated with a virus or a bacterial infection. In infants, diarrhea can quickly cause dehydration.

Dilatation - the opening of the cervix during labor.

Down's Syndrome - the most common chromosomal abnormality. Down's syndrome causes a mild to severe mental retardation, as well as other physical problems such as heart defects.

Due date - the date, set by a doctor and based on the 1st day of a woman's last menstruation, when a baby's birth is expected. Because the date setting is not an exact science, the medical term for due date is EDD, or Expected Due Date.

Eclampsia - seizure occurring in pregnant women, caused by pre-eclampsia, a serious condition (characterized by high blood pressure and protein in the urine) that can develop late in pregnancy, during labor, or in the early postpartum period. Eclampsia is the second leading cause of maternal death in the U.S.

Ectopic pregnancy - when a fertilized egg does not enter the uterus, but instead implants elsewhere, usually in the Fallopian tube. Must be surgically removed to prevent rupture and damage.

Edema - the accumulation of fluid in the body's tissues, which causes swelling, often of the hands and feet. Common during pregnancy due to extra blood production and pressure of the vena cava from the growing uterus, which slows circulation.

Effacement - the thinning (sometimes called ripening) of the cervix in preparation for delivery. During effacement, the cervix goes from more than an inch to paper thin.

Egg - a reproductive cell produced by the ovary; also called an ovum.

Electronic fetal monitor - a device that monitors a fetus's progress and vital signs when a woman is in labor. Records the fetal heartbeat and the mother's contractions.

Embryo - term used to describe a developing baby until 8 weeks it is called a fetus.

Engagement - engagement, also called lightening or dropping, is when the fetus descends into the pelvic cavity. In first-time mothers, this usually happens 2-4 weeks before delivery; babies of women who have already had children usually don't engage until labor begins.

Episiotomy - an incision in the perineum (the area between the vagina and the anus) to enlarge the vaginal opening and prevent tearing during delivery.

Estrogen - a hormone produced in the ovaries that works with progesterone to, among other things, regulate the reproductive cycle.

Fallopian tubes - the pair of narrow ducts in a woman's abdomen that transports eggs from the ovaries to the uterus. When an ovary releases a mature egg, the nearest Fallopian tube opens and draws it in.

Fertilization - when an egg is penetrated by a sperm - usually in one of the Fallopian tubes.

Fetal presentation - the position of the baby, such as feet down (breech) or head down (vertex), inside a woman's uterus. About 96 percent of babies present in the vertex position; some who present in breech position can be turned by a doctor before delivery begins.

Fetus - the name given to a growing baby after 8 weeks of development; before 8 weeks, the developing baby is called an embryo.

Fibroids - uterine fibroids are tumors that grow from cells forming the muscle of the uterus; they can project from the wall of the uterus into the uterine cavity. Fibroids can be as small as a pea or as large as a basketball and are almost always benign.

Fontanel - the soft spots on a baby's head that, during birth, enables the soft bony plates of the skull to flex, allowing the head to pass through the birth canal. Fontanels are completely hardened by a child's 2nd birthday.

Fundal height - the distance between the top of a pregnant woman's uterus (called the fundus) to her pubic bone. Measured to determine fetal age.

Fundus - the upper, rounded portion of the uterus.

Genetic disorder - a disease or condition caused by an abnormality in a person's genetic blueprint. Such conditions include chromosomal disorders involving too much or too little chromosomal material, mutations of genes on the chromosomes and mutations in conjunction with environmental factors such as exposure to drugs or radiation.

Genitals - external sex organs; the penis and testicles in a male and the labia in a female.

Gestation - the period of time a baby is carried in the uterus; full-term gestation is between 38-42 weeks (counted from the 1st day of the last menstrual period).

Gonorrhea - a sexually transmitted disease, usually asymptomatic in females, that can cause sterility if not treated, and can also be passed from mother to baby during delivery.

Gynecologist - a physician who specializes in women's reproductive health.

Hemoglobin - a type of protein in red blood cells that plays a crucial role in transporting oxygen to body tissues.

Hemophilia - a genetic blood disorder, almost always in males, in which blood does not clot properly as a result of an enzyme deficiency.

Hemorrhoid - caused by increased blood volume and pressure from the uterus on the veins in the legs and pelvis, these swollen blood vessels in the anus are common during pregnancy. Constipation can also cause (or compound) the problem.

Hepatitis B - a blood-borne virus (for which there is a vaccine) that affects primarily the liver and, like HIV, has few or no symptoms immediately after infection. It can be passed from mother to child during pregnancy, and can cause cirrhosis, chronic active hepatitis, and liver cancer.

Hepatitis B vaccine - the vaccine against hepatitis B, a virus that affects primarily the liver. This series of 3 shots, given between birth and 2 weeks and at 2 and 6 months, may cause fussiness, low-grade fever, headache, and soreness at the injection site.

Hernia - most common in the abdominal wall, a hernia is a bulge of tissue caused by a weak area or tear in the muscle through which tissue protrudes. In babies, hernias are most common in boys or premature infants and are treated with surgery.

High-risk pregnancy - a pregnancy with a higher than normal risk of developing complications. Such pregnancies include those with multiple fetuses or Rh incompatibility, and when the mother has had problems with miscarriage, pre-term labor or placenta previa in earlier pregnancies.

Hindmilk - breast milk, rich in fat, produced towards the end of a feeding. A baby must nurse for a while (there is no set time - it varies with the individual) to get the hindmilk.

Hormone - a chemical secretion, such as estrogen or progesterone, that the body produces to stimulate or slow down various body functions. The levels of some hormones increase ten-fold during pregnancy.

Hypoglycemia - abnormally low blood sugar levels, symptoms in adults (which may indicate diabetes) include jitteriness, rapid breathing, and lethargy. In newborns, hypoglycemia can be caused by prematurity or being small for gestational age; it can also indicate infection, asphyxia, or congenital heart disease.

Hypospadias - a birth defect in which a boy's urethra, through which urine and semen pass, opens on the underside of the penis rather than on the end.

Hysterectomy - the surgical removal of the uterus.

Implantation - when a fertilized egg attaches itself to the lining of the uterus.

In utero surgery - surgery done in the uterus to correct an abnormality in a fetus.

Incompetent cervix - when the muscles of the cervix are too weak to hold a baby through a pregnancy. A stitch may be placed at the opening of the cervix to hold it together. This is called a cerclage.

Incontinence - inability to control one's bladder or bowels. A common, temporary postpartum symptom that may be helped by Kegal exercises.

Infant - a child under a year of age.

Intrauterine growth retardation - slow growth of a fetus in the womb possibly resulting in a low birth weight baby.

Intraventricular hemorrhage - bleeding into the ventricles of the brain, common in premature infants.

Kegals - these exercises, involving the tightening and relaxing of the muscles of the vagina and perineum (the area between the vagina and the anus), can help prepare for delivery and will also speed postpartum recovery.

Labor - the process of childbirth, in which the rhythmic contractions of the uterine muscles open the cervix and allow a baby to be born.

Laceration - tears in the vagina or skin and muscle around the vaginal opening. First and second degree lacerations are minor and may require a few sutures. Third and fourth degree lacerations involve tearing through the muscle of the anus and into the muscles and tissue of the rectum and require much more repair.

Lactation - the production of milk that usually begins between 2 and 7 days after a woman gives birth.

Lactose intolerance - a disorder of the digestive system in which the body has difficulty digesting dairy products, including cow's milk, butter and ice cream.

Lanugo - the fine hair that covers a fetus from about 26 weeks and is sometimes still present at birth. A baby born at term will usually shed the hair by the end of the first week after birth.

Linea nigra - the darkening of the linea alba, the hard to see white line that runs down the center of the abdomen to the top of the pubic bone during pregnancy. Pigmentation changes usually fade after delivery.

Lochia - vaginal discharge made up of mucous, blood and tissue that continues after delivery for up to six weeks. Usually bright red and as heavy or heavier than a period in the first few days after birth, then gradually tapers off.

Low birth weight - when a full-term infant weighs less than 5.5 pounds at birth. Nearly 7 of every 100 newborns are low birth weight babies, most of these cases are linked to cigarette, alcohol, or drug use during pregnancy and can be prevented.

Lumbar puncture - a procedure in which spinal fluid is drawn from the spinal column to check for diseases, including meningitis.

Magnesium sulfate - one of a group of drugs used to stop pre-term labor.

Meconium - a newborn's first bowel movements which are dark, sticky, and usually greenish-black, and last for the first few days of the infant's life. If meconium is visible in the amniotic fluid prior to delivery, it can be a sign that the fetus is in distress.

Membranes - also known as the bag of waters, this thin sac contains the amniotic fluid and the fetus. The membranes will either rupture spontaneously during labor or be ruptured to speed up labor.

Milia - tiny pimples on a newborn's face, usually around the nose and chin and also sometimes on a baby's torso, arms, and legs caused by clogged pores. Milia will disappear on their own, usually within a few weeks.

Miscarriage - the involuntary loss of a pregnancy before 20 weeks, estimated to end 15-20 percent of all pregnancies. More than 80 percent of miscarriages occur in the first 12 weeks of pregnancy, many before a woman even knows she is pregnant.

Mongolian spot - large bluish birthmark, usually on the lower back or buttocks, more common in darker skinned babies. Usually fades or disappears as a baby grows.

Morning sickness - a set of pregnancy-related symptoms, including nausea, vomiting, and food and smell aversions, that affect many women only in the morning; for many others, the discomfort lasts all day. About 70 percent of pregnant women suffer from morning sickness, which usually begins at 4-8 weeks gestation and subsides by the 14th - 16th week.

Moro reflex - the automatic response to loud noises or sudden movements in which a newborn will extend his arms and legs, arch his back, and sometimes cry out. Newborns can have this reaction even during sleep, but lose it after a few months.

Mucus plug - a collection of mucus, often tinged with blood, that blocks the cervix during pregnancy, known as "bloody show" when discharged prior to labor. The texture and amount of mucus discharged varies from woman to woman.

Multiple birth - more than one baby delivered.

Multiple gestation - the term used to describe more than one fetus in the womb, as in the case of twins, triplets, or other higher order multiples. With the use of fertility drugs, multiples have become more common.

Natural childbirth - general term for Labor and Delivery free of medical intervention.

Neonatal - the period of time from birth to 4 weeks of age.

Nevus - general term for birthmarks.

Newborn jaundice - the yellowing of newborn's skin, usually beginning on the 2nd or 3rd day after birth and lasting a week to ten days, caused by immaturity of the newborn's systems. Jaundice is common, with more than half of all newborns having the disorder.

Non-stress test - a test for abnormalities of the fetal heartbeat in which a monitor is used to listen to the fetus's heart while the mother is at rest. (In a stress test, the fetal heartbeat is monitored in response to uterine contractions).

Ovaries - the female reproductive organs that release eggs into the fallopian tubes, where, if sperm is present, they may be fertilized.

Ovulation - the monthly release of a mature egg from an ovary into one of the Fallopian tubes. A woman is most fertile in the days just before and on the day of ovulation.

Perinatal - the period of time before, during and immediately after birth.

Perineum - the area between the vagina and anus where an episiotomy is performed during childbirth.

Persistent fetal circulation - a condition in which a newborn has difficulty making the transition from living in the womb to the outside world. May produce respiratory problems.

Phenylketonuria - all babies born in the U.S. are tested for PKU at birth, a genetic disorder of a liver enzyme that disrupts normal body functions. If not carefully regulated by diet in infancy, PKU can cause mental retardation.

Phototherapy - the use of ultraviolet light to treat newborns with jaundice.

Pitocin - the brand name of the synthetic form of the hormone oxytocin. The drug used to induce labor.

Placenta - a pancake shaped organ that develops in the uterus just 12 days after conception, providing nutrients for the fetus and eliminating its waste products commonly referred to as the afterbirth because it is delivered after the baby.

Postmature - an infant born at 42 weeks or more. As with prematurity, being postmature can lead to complications; the baby may also be larger and less able to pass through the birth canal or the placenta may no longer be able to provide adequate oxygen or nutrition.

Postnatal care - medical care for both newborn and mother during the first 6 weeks after birth.

Postpartum depression - more severe than the more common and milder "baby blues," postpartum depression is characterized by sadness, impatience, restlessness and inability to care for baby.

Preclampsia - formerly known as toxemia, preclampsia is a condition characterized by high blood pressure and protein in the urine after the 20th week of pregnancy. A serious condition if left untreated; preclampsia can lead to complications or death in the mother or baby.

Pregnancy-induced hypertension (PIH) - elevation of a pregnant woman's blood pressure, usually in the last trimester. Less severe than preclampsia, but can lead to serious complications and should be carefully monitored by a physician.

Premature - the term used to describe babies born at 37 weeks of gestation. Fewer than 10 percent of babies arrive this early.

Premature rupture of membranes (PROM) - rupture of the amniotic sac before labor begins as early as several months before the baby is due. If PROM occurs at 37 weeks or later, most physicians will induce labor; if it occurs before, a woman may be put on bedrest and carefully monitored.

Prenatal care - medical care for a pregnant woman and her fetus throughout her pregnancy. Proper prenatal care is essential to catch any potential problems early on so they can be monitored and treated.

Pre-term labor - labor that begins after 20 weeks, when the fetus is considered viable and before the 37th week, when the baby is considered full term. Prompt medical treatment can occasionally halt or postpone early labor, improving the baby's chances for survival.

Primigravida - term for a woman pregnant for the first time. (Latin)

Progesterone - a hormone produced by the ovaries that helps to regulate a woman's reproductive cycle.

Prolactin - the hormone that activates a mother's milk producing glands. Delivery of the placenta signals a woman's body to begin producing prolactin.

Prolapsed cord - in one of every three hundred or so births, the umbilical cord slips out through the cervix ahead of the baby, which is dangerous because uterine contractions can block blood flow to the baby. Unless the cervix is already dilated and birth is eminent, C-section delivery is the usual solution.

Prolonged labor - when labor does not progress to a vaginal delivery after 18 hours.

Puerperium - the period from the 3rd stage of labor through the uterus's recovery after childbirth.

Quickening - the first fetal movements felt by a pregnant woman, usually between the 18th and 22nd weeks. They can be felt as early as the 14th week and sometimes not until the 26th.

Reflex - an automatic, involuntary movement.

Respiratory distress syndrome (RDS) - common in premature infants, RDS means a baby cannot take in enough oxygen because his lungs aren't fully developed. With proper treatment, about 80 percent of babies fully recover.

Rooting reflex - one of the reflexes present at birth; infants will automatically turn their heads and start sucking when their cheeks are stroked.

Rubella - a mild, highly contagious viral disease that can cause serious birth defects if a pregnant woman is affected. Women who have not had it should make sure they're immunized at conception.

Sciatica - a common pregnancy related condition, caused by pressure on the sciatic nerve, which passes through the pelvis. Symptoms include pain, tingling or numbness in the lower back and down the legs, often first only a few hours, but can in severe cases, linger throughout pregnancy.

Seizure - convulsions caused sometimes by a fever or by another serious condition such as eclampsia or epilepsy.

Sexually transmitted diseases (STD) - diseases spread by sexual relations such as gonorrhea, syphilis, genital warts, chlamydia, trichomoniasis, HIV, Hepatitis B, and human papillamavirus (HPV).

Shaken baby syndrome - the severe injuries that result when a baby (or child) is shaken. Common are swelling of the brain, hemorrhaging, and neck injuries; in extreme cases, shaken baby syndrome can be fatal to the child.

Sickle cell anemia - an inherited chronic anemia caused by abnormally shaped red blood cells and is exclusive to populations of African descent. If carefully monitored, women with sickle cell anemia can give birth to healthy babies.

Sitz bath - a shallow tepid or ice water bath often recommended to soothe the discomfort and pain of conditions such as hemorrhoids or episiotomy stitches.

Sleep apnea - often a complication of prematurity, sleep apnea refers to periods in which a baby stops breathing. Some full-term infants may also have periods of apnea, a factor that has been associated with SIDS. (Adults can also have sleep apnea.)

Small gestational age (SGA) - an infant who is not as big as could be expected given for gestational age is termed "SGA." SGA babies are small because of slow development, not because they have had less time in the womb, like premature babies.

Spina bifida - a birth defect resulting from the incorrect development of the spinal cord that can leave the spinal cord exposed. Spina bifida affects approximately one in every 2,000 babies born in the U.S. Folic acid reduces likelihood of spina bifida, and women are advised to take supplements before and during pregnancy.

Stepping reflex - also called the walking reflex, this is one of the reflexes present at birth. When held over a flat surface, a newborn will move her legs as if she's taking steps.

Stillbirth - the death of a baby after 20 weeks gestation but before birth. Stillbirths are mainly caused by genetic or congenital defects, problems with the umbilical cord or placenta, or a medical condition in the mother.

Stretch marks - about half of all pregnant women will develop these pink or reddish streaks on their breasts, hips, or abdomen sometime during pregnancy as elastic fibers stretch and rupture on their skin. While stretch marks cannot be prevented, they will fade slowly after delivery.

Tachycardia - a rapid heart rate, which can be an indicator of certain congenital heart defects.

Thrombophlebitis - the inflammation of a vein associated with a blood clot.

Thrush - a fungal infection characterized by whitish patches on a baby's tongue or cheeks. Mild cases of thrush resolve without treatment, while more extensive cases require a doctor's care.

Tonic neck reflex - one of the reflexes present at birth, also called the fencing reflex. An infant can crook one arm behind the head while the other is extended away from the body.

Toxoplasmosis - a parasitic infection carried in cat feces and uncooked meat that can cause stillbirth or miscarriage when contacted by a pregnant woman. An estimated 1 in 1,000 women is infected during pregnancy.

Transducer - the device used in ultrasound that omits sound waves and transmits them to a computer, resulting in ultrasound image.

Trimester - a period of three months.

Tubal ligation - a sterilization procedure in which a woman's Fallopian tubes are cut and tied off to prevent pregnancy.

Ultrasound - a procedure that uses sound waves to create a moving image of internal organs and is used to diagnose infertility as well as other problems. During pregnancy, ultrasound is routinely used to monitor the health and development of the fetus.

Umbilical cord - a cord of tissue connecting the fetus to the placenta that carries oxygen and nutrients to the fetus and transports waste products away. At birth, an umbilical cord, which contains two arteries and one large vein, can be as long as several feet.

Undescended testes - when one or both of the testes do not descend into the scrotum. Many times the condition corrects itself; other cases need to be surgically corrected so as not to lead to infertility or testicular cancer.

Uterus - the pear-sloped organ in which a baby grows. During pregnancy, the fist-sized uterus goes from weighing about 2 ounces to weighing 2.5 pounds and able to hold a baby placenta and amniotic fluid.

Vaginal birth - the birth of a baby through the vaginal canal.

Vaginal birth after Cesarean (VBAC) - the vaginal birth of a baby after a woman has already had a child by Cesarean section. While VBACs are increasingly considered a safe option, an estimated 1 percent of women attempting this will have an uterine rupture and require an emergency Cesarean.

Varicose veins - swollen veins, usually in the legs that are a common by-product of pregnancy because of increased blood volume, pregnancy-induced relaxation of the muscle tissue of the veins, and increased pressure on the veins from the growing uterus. Overweight women and smokers are more likely to have them.

Vernix caesosa - this cheesy or waxy substance that coats the fetus in the uterus is believed to protect the skin from exposure to amniotic fluid. Premature babies will be covered with a lot of vernix, while post-term babies will have almost none.

Viable - capable of living outside the womb.

Zygote - the result of a union between egg and a sperm cell: a single fertilized egg before it begins to divide and grow.

IMPORTANT PHONE NUMBERS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____