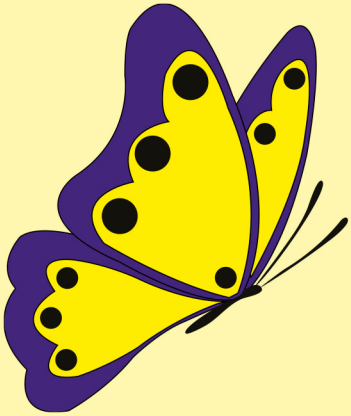
Pregnancy and Fibromyalgia

FIBROMYALGIA ACTION UK

Registered Charity No. 1042582



This guide is only available online

www.fmauk.org/fibropregnancy

The Fibromyalgic Pregnancy and Beyond

Category: Information Booklets

Published on Saturday, 27 August 2011 14:52

From preconceptual care to postnatal success
by Denyse King RM

Editors Note: This booklet is not available in a published printed form yet. As soon as funds are available, we will have these printed and available from the office. Until then it will be available online in this form with a published booklet being made available in the future.

Important info before reading this guide.

1. This booklet is intended for use as a guide only. It is not to be used in place of a consultation with your usual maternity healthcare professional.
2. Services, policies and techniques used will vary between hospitals depending on what is thought to offer the best healthcare for the residents of their local population.
3. If you have any preconception, pregnancy, childbirth or postnatal questions that this booklet doesn't answer then please email me using this form.

Contents

The 12 Month Pregnancy

So you've decided you want to have a baby? Congratulations, you have taken the first step towards becoming a parent. Your body is going to be your baby's home for the duration of your pregnancy and you have recognised the need to make it the best you can offer to your unborn child. As a midwife I am aware that many people put more effort into planning a holiday than they do into organising one of the most important events of their lives. Although everyone should view pregnancy as lasting at least 12 months; preconception care is especially important if you have medical problems. The better prepared you are, the better you will cope with this major life change.

The countdown begins here:

At least 12 months before you begin trying to conceive a baby, stop smoking and drink in moderation only. Make an appointment to see your GP, so that you can tell him/her that you are planning to become pregnant. Make a list of things to discuss with your GP which should include:

1. Any prescribed medications you currently take and if they are suitable for pregnancy and breast feeding, (inform your GP if you are taking any recreational drugs as these will have an effect on your baby and the pregnancy).
2. Discuss when to stop taking the oral contraceptive and which other contraception method you should use.
3. When you should have your next cervical smear test.
4. Are all your immunisations up to date?
5. Do you need any Genetic screening such as Cystic Fibrosis, Sickle cell and Thalassaemia?
6. Do you need any other screening for infectious diseases, or for illnesses such as diabetes?
7. Is your weight within a healthy range to encourage conception and sustain a pregnancy?

Adopt a healthier lifestyle

Try to have a parenting partnership and encourage each other to adopt similarly healthy lifestyles at least 12 months before you begin trying to conceive your baby.

Exercise - Start or continue to exercise daily for as long as you can manage comfortably. I strongly recommend gentle exercise, such as walking or swimming in a warm pool as a minimum; if you can manage more than this then do so. Exercise helps your body do everything more efficiently. When you exercise, your body processes medications more effectively (which can mean you may find that you need to take less!), digests food better (helping you on your way to maintaining a more healthy weight), your sleep patterns are more restorative (significantly lacking in FM sufferers), and your mood is elevated in comparison to when your body receives no exercise.

Folic acid- When you stop taking your oral contraceptive you should begin taking 400micrograms of folic acid (0.4mg) each day, even though you won't be trying to conceive straight away. It won't do you any

harm and it will give you time to make it into a habit. Folic acid helps prevent some structural defects in babies, particularly ones of the brain and spinal cord; this is also known as neural tube defects.

You should also eat foods which are rich in folic acid such as green leafy vegetables, nuts (avoid peanuts during this period, pregnancy and until you have stopped breastfeeding), cooked dried beans, citrus fruits, avocado, raspberries, raw mushrooms and vegemite. It is also important to take a vitamin supplement which is suitable for pregnancy as certain vitamins are not. If you drink herbal teas check they are safe during pregnancy and the same goes for any essential perfume oils you may use, such as rose and clary sage.

Essential fatty acids- Increase your intake of these to help maximise fertility. They are also good for the development of your baby's nervous system and brain. They can be found in foods which contain the oils Omega 3, 6 & 9. These are in numerous products today even certain brands of eggs and milk.

Protein-protein rich food is an essential part of our diet and can be found in foods such as eggs, meat, pulses, and grains such as quinoa. Eat no more than a palm sized amount of protein with each meal for a balanced diet.

Calcium- Helps strengthen bones and helps your body absorb vitamin D. Calcium is found in foods such as cheese, yogurt, milk, ice cream, kale, collard greens, turnip greens, broccoli, tofu and tinned salmon or sardines.

Try to eat foods in a variety of colours with each meal to ensure that your diet is balanced. For example, if you had free range meat, red, green and yellow roasted peppers (try coating them in pesto sauce before popping them under the grill), carrots and broccoli and some potatoes or rice, your meal will contain many vitamins and minerals which are vital for health.

For men- Maximise sperm count and motility by eating regular portions of fish, eggs, mushrooms, oysters, pumpkin seeds and other zinc rich food. Smoking and alcohol have been found to reduce sperm counts and to increase the production of damaged sperm.

Odds and ends

Visit your dentist early on in your 12 month pregnancy to complete any dental work you may require and to gain advice about what changes pregnancy may cause to your teeth and gums. If you haven't managed to quit smoking yet, you and your partner should do so at least 4 months before you begin trying to get pregnant as well as avoiding alcohol and any unnecessary drugs. Finally and perhaps most important of all, enjoy and cherish the company of your partner during this exciting time in your lives.

Conception and moving forward into the next stage of your new life

Conception

This is by far one of the most intricate and complex functions your body will ever perform and you are likely to be blissfully unaware that it has done so flawlessly. The very first step in this amazing process is when an egg cell from the woman is fertilized by a sperm cell from a man. Sounds simple, but it is far from it. In order for conception to occur, the egg and sperm cells must first be in the same place at the same time.

There are several ways this can happen: in a heterosexual relationship make love a few times a week, but don't make it a mechanical procedure you repeat with military precision! (Sperm will usually live for 3-5 days inside a woman's body so don't worry if you wish to make love less often.)

Make Lovemaking Enjoyable

Many people with fibromyalgia (FM) find certain aspects of making love uncomfortable so it is important that you both work on finding out what is most comfortable and enjoyable for you. It is advisable to overheat the room you plan to use for lovemaking so that you can enjoy yourself without the discomfort experienced when exposed to a cooler environment. You may find that having a warm bath will relax you enough to want to spend some time enjoying your partner sexually although you may feel drowsy to start with. Take as much time as you want to pamper and prepare yourself.

Some medications for FM can decrease your libido, as do constant pain and years of non-restorative sleep! Therefore you may find that one of the many lubricants on the market designed to enhance female enjoyment will be of benefit to you. These lubricants warm whichever part of the body you choose to put them on, so try other areas such as your nipples as well as the more obvious one. You can buy them from most pharmacies and some supermarkets, on the shelf in the female products section.

Choose a position that is the most comfortable for you. By being comfortable, you are more likely to find lovemaking an enjoyable (if somewhat strenuous) experience. If you find penetration especially uncomfortable there are a few positions which reduce the depth of penetration, for example: if the woman lies on her back or side, with the neck supported comfortably and the man slowly enters her with the woman closing her legs once she beings to feel uncomfortable. Some lubricant on your legs and his penis will help make this position very comfortable.

If you are feeling energetic or experimental then standing is another position that reduces the depth of penetration. If you can, try to orgasm as this makes your cervix dip into the pool of sperm and there is some thought that this creates a bit of a vacuum to help move the sperm in the right direction. You may find orgasm will cause some discomfort afterward, how little or much depends on your body. There are no hard and fast rules except this one: 'if you don't enjoy it, don't do it!' You may also find that you benefit from the endorphin release after orgasm.

Make sure you have enough time after lovemaking to recuperate and that you take some painkillers beforehand if you know that you are usually uncomfortable during or afterwards (as long as you do not go over the maximum recommended daily dose). Ask your partner to gently stroke or smooth you (instead of trying to massage you which may be too uncomfortable) with warmed massage or baby oil as this may help to prevent any cramping in your limbs. A hot water bottle, lavender bag or warm bath or shower may help ease any discomfort. Contrary to popular belief a bath or shower will not wash the sperm away, enough will stay inside to give conception a good chance, it only takes one to get to the egg to do the job, all the rest of the sperm are superfluous (and responsible for non-identical twins).

Can FM Cause Fertility Problems?

It is perfectly normal to take up to a year to get pregnant so just try to relax and enjoy this time stage of your lives. One useful tip is for men to avoid tight underwear during this time to allow the testicles to stay away from the body providing a beneficial cooler environment for the sperm; some women find men in boxers extremely sexy! FM is not known to cause infertility problems or increase the risk of miscarriage.

However other conditions, such as endometriosis, can reduce fertility in moderate to severe cases. Mild endometriosis is not thought to be associated with reduced fertility. If you have endometriosis you can discuss what options are available to you with your GP or specialist when planning your pregnancy. Once pregnant, the discomfort and pain caused by endometriosis can lessen and for some disappears for the duration of the pregnancy.

Every pregnancy carries a risk of infection from sexually transmitted disease, both for you and your unborn child, so please make sure that you are certain that both you and your partner (and any third party involved) are free of infectious diseases. Your GP or local sexual health clinic will be able to advise you further on this.

Conception Completed

Okay, so you've managed to conceive, now what happens? Well, you will likely carry on unaware this miracle has occurred, but as this is a planned pregnancy you will be no doubt wondering if you've managed to accomplish it. The soonest you will know for certain will be around the time of your next expected menstrual period.

Odds and ends

- Now that you have begun trying to conceive and are aware that you will not know you are pregnant for up to 5 weeks there are some precautions you need to take:

- Try to reduce any possible exposure to hazardous fumes if you work in an environment where you may be exposed.
- Reduce your risk of eating foods containing the bacteria, listeria, by avoiding un-pasteurised foods such as soft cheeses, green top milk, soft ice creams, pate, raw meat, raw vegetables, smoked mussels and others. I would advise you to always read the food packaging to help avoid un-pasteurised foods. Listeria can grow at very low temperatures, which is why cooking foods at a high temperature is important during pregnancy.
- Fish is an excellent source of nourishment at this time but certain fish (Orange roughy, sea perch, catfish, shark, bluefin tuna, marlin and ling) are thought to be high in mercury levels and should be avoided.
- Avoid contact with pet litter or wear gloves if you cannot avoid this in order to reduce the chance of you coming into contact with toxoplasmosis which can be found in animal faeces.

Early Pregnancy - physical and emotional challenges

You are pregnant!

Well done, may I be the first, well okay maybe second or third person to congratulate you on your success. I hope you had some fun getting to this stage. By this stage of about 5 weeks I expect you will have already done a pregnancy test if you were planning on becoming pregnant. The tests are so sensitive now that as early as the first day of your missed period, the test can detect your pregnancy although the indicator may only show up as very faint, but faint or not if it is there so is your baby! From now until the end of week 10 your baby will make it's presence know in a variety of ways by changing the way things taste and smell, rewiring your emotions enough to make you want to weep at adverts for toilet roll and for some, making even waking up a more tiring experience than usual. Sorry to have to be the one to break this to you but you have just jumped onto the pregnancy rollercoaster.

Does pregnancy make FM worse or vice versa?

There is not a lot of research based and documented evidence about how fibromyalgia is affected by early pregnancy and vice versa. The studies that have been done only had a very small number of participants in them and the results were contradictory with some saying FM symptoms became much worse during the pregnancy and others saying that FM sufferers declared that after the initial few months they felt better than they did before they were pregnant (this could be due to a hormone called relaxin and we will discuss this as your pregnancy progresses). It would be advisable for you to keep pregnancy related symptoms and FM symptoms separate in your mind as we have a tendency to blame or relate everything to FM and it isn't always the case.

What you can do to make pregnancy symptoms easier to cope with:

Stress Keep your stress levels as low as possible. Have warms baths and try listening to relaxation tapes (you know the ones with dolphins squeaking, raindrops falling, ocean waves etc.), you won't mind being teased about listening to "hippie music", when you are drifting off in your own world with a smile on your face! Guided mental imagery and progressive muscle relaxation really do work and give you an excuse for lounging in the bath.

Exercise By about week 6 your body will have increased your blood volume by about 50% and it is more important than ever that you keep as mobile as possible in order to help your body smoothly circulate this increased blood flow and to prevent blood clots. At risk of contradicting myself, I am also advising that you rest when you need to; your body is working extremely hard and you need to try and sleep often.

Fatigue This is a symptom that has no cure except to sleep. Naps work well especially for people with FM who are lacking in restorative sleep to start with. Little and often is better than none and please remember your increased exhaustion is more likely to be due to your pregnancy not a flare up of your FM. If you need to go to bed at 4 pm to feel rested, then do so, you wont be any good to anyone if you wear yourself out completely. Avoid caffeine and other stimulants as they won't make you feel more awake, are unsafe for your pregnancy in moderate to large doses and have been linked as a FM flare trigger. A little bit of caffeine in chocolate, for example, is an acceptable amount a few times a week and dark chocolate is loaded with iron.

Nausea Try to eat several small meals a day to ease the strain on your nauseous tummy. Crushed fruit frozen in ice cube trays is kind to sick tummies and still nourishing for your body. Motion sickness bands work wonderfully to ease the nausea and you can buy them without prescription at any major chemists. Ginger also eases nausea and can be found in gingersnaps, ginger soda and tea or in capsule form. If you feel so ill that you can't bear the thought of swallowing anything try sprinkling a few drops of ginger essential oil on a warm flannel and inhaling the vapour. Drink plenty of fluids as dehydration will make your nausea worse and also exacerbate any FM symptoms.

Cravings These can start at any time during the pregnancy or not at all, simply eat what you crave within moderation. Craving non nutritional substances (coal, match heads, paper, ice, to name but a few) is known as pica rather than cravings and if you experience this urge please discuss it with your midwife or doctor as some non-nutritional substances are harmful to your baby as well as yourself.

Mood swings (also known as the pregnancy rollercoaster). Mostly to blame for this somewhat bewildering sensation is the fact that your endocrine glands have floored the accelerator (hormone production wise) and are now in overdrive without having given you time to even put on your seatbelt and your placenta is about to do exactly the same. So yes you do have an excuse for weeping copiously when your favourite house plant dies. FM can often cause low moods, only to be expected when coping with pain, weakness and fatigue on a daily basis but it is worth keeping in mind that if you suffered from low

moods and depressions before pregnancy then you are more at risk of depression during and after pregnancy. If you or your partner are at all concerned then talk to your doctor about what help is available and do it sooner rather than later.

Libido Early pregnancy with its constant tiredness, nausea and mood swings can make your sexuality the furthest thing from your mind. However for some, the increased blood flow to your breast and genitals can cause an increased sexual arousal and desire for sex. There is no right or wrong way to feel and whichever way you do; it is likely to change as your pregnancy continues. Just to reassure you, if you feel so inclined, penetrative sex is not linked with an increase in risk of miscarriage.

A means to an end I hope this hasn't seemed all doom and gloom. Although early pregnancy is sometime a struggle, it is a struggle with a purpose. You are going through this while doing the most important job of your life, growing your baby. The symptoms won't last forever, in fact by week 11 -12 you will begin feeling more like your old self as your body begins to adjust to these changes.

Tips to help you navigate the screening and diagnostic odyssey

Is my baby (foetus) okay?

This question is likely to cross every expectant parent's mind at least once during the pregnancy. For those with pre–existing medical conditions this worry can be magnified out of all proportion. There are many reassurances that pregnancy screening and diagnostic testing can provide. However there occasionally are also some questions that can never be completely answered until after your baby is born. These tests described should be offered to you and your partner as an option, for it is your choice whether you have them.

Screening options

These will give you a risk result reflecting the likelihood of your baby having certain disorders. They are usually in the form of a scan or blood test and do not directly carry a risk to your baby's health.

Ultrasound screening

An ultrasound in early pregnancy can verify your due date and determine whether or not you are carrying multiple babies. Unlike x-rays, ultrasound uses sound waves to produce a video "picture" of the foetus moving inside your uterus. This picture is generated from an instrument, called a probe that is placed either on your abdomen or in your vagina. Some people with FM complain that they find the ultrasound waves from the probes irritating as they pass through the skin, describing the sensation as a painless but irritating electric current.

The good news is that you can watch your baby on the screen while the scan is being done and this should be a pleasant distraction. Some women with FM may find the full bladder required for a good scan at this stage of pregnancy almost excruciatingly painful. Make sure the person doing your scan is aware you suffer from FM and if necessary explain the problems a prolonged period of time with a full bladder may cause. When you empty your bladder after the scan, the sudden release of fluid from your tense muscles may cause you to feel quite faint so it would be sensible to ask your partner to come in the toilet with you. This is not unique to FM sufferers but seems to be much more common in people with FM and connective tissue disorders. The hospital should have a toilet cubicle able to accommodate you both.

Ultrasound can be used to detect a problem or monitor a condition in the foetus during pregnancy. From week 11 to week 13 and 6 days, a nuchal translucency scan can be done to check for risk of chromosomal abnormalities such as Down's, Edwards and Patau's syndromes and is often combined with blood tests taken just before the scan; your overall risk will be calculated from the results of both the scan and the blood tests (see *first trimester combined screening* below). This is not a diagnostic test giving a yes or no answer; this is a form of screening which gives you a risk factor for these disorders. If you are considered to be at increased risk then an appointment will be made for you to discuss what options are available to you, including diagnostic testing.

If you are six or more months pregnant and the baby is positioned correctly, a scan should be able to determine foetal gender, although some hospitals have a policy of not reporting on this, so you may need to pay privately to find out your baby's sex. Later in pregnancy, a scan can track the baby's growth, locate the placenta, determine the volume of amniotic fluid and detect some types of birth defects such as ones involving the heart valves or kidneys. A full bladder is not required for scan at this stage so you may find these scans quite enjoyable except for the electric "zapping".

First trimester combined screening

Three or four hormone levels (the number varies between hospitals) are measured in your blood and the results are combined with information on your age, weight and stage of pregnancy. A computer programme then works out the risk of your baby having Down's syndrome, Patau's syndrome, Edward's syndrome or Spina bifida. The results are obtained from a blood sample from the mother normally around 16 weeks pregnant but can be done anytime during 15 weeks to 20 weeks and 5 days. It is offered to all pregnant women who have not had a nuchal scan.

It is not uncommon for people with FM to find their arm aches at the site where the needle was inserted for 24 hours or so after the blood test so it may be wise to ask if you can have all your routine pregnancy bloods done at the same time. The majority of neural tube defects and a high proportion of babies with Down's Syndrome can be detected with this test. Further testing such as ultrasound and/or amniocentesis

may be required with an abnormal test. The Spina bifida part of this test (AFP) can still be done even if you have had a nuchal scan (or if you do not wish to know your risk of having a baby with Down's syndrome), but you will not be offered the Down's syndrome screening part of this test if you had a nuchal scan, as you will have been given a risk result for Down's syndrome when you had the nuchal.

Alpha-Fetoprotein Test (AFP)

This blood test is still offered in some maternity hospitals though many now offer 18 -20 week detailed scanning instead. The AFP test is performed between the 15th and 20th weeks of pregnancy and is used to help detect neural tube defects. Neural tube defects are abnormalities in the brain and spinal cord of the foetus. Defects in the central nervous system occur when the neural tube (the brain and spinal cord tissues) fail to close as the foetus develops. When the brain and spinal cord are exposed directly to the amniotic fluid which surrounds the baby, it is called an "open defect." Sometimes, the poorly developed neural tube is covered by skin or bone, referred to as a "closed defect."

The two common neural tube defects are anencephaly and Spina bifida. Babies with anencephaly are born with deformities of the head and brain and die soon after birth. Those born with spina bifida can live a long time, but may suffer paralysis in the lower body and legs. Often, there is also a lack of bladder and/or bowel control which may be treated with surgery. The chance of producing a child with a neural tube defect is one to two for every thousand live births. Babies born to mothers who have had a previous child with the same problem are at greatest risk, as are those with parents or grandparents who have neural tube defects.

As with all antenatal screening tests, a low risk test result does not guarantee a normal baby at birth. About 20 percent of the infants born with neural tube defects have normal alpha-fetoprotein (AFP) levels. Most of these are closed defects which are typically less severe. Conversely, an initial abnormal test reading does not mean the foetus has a neural tube defect. Abnormal levels of AFP are frequent - occurring in about 50 of every 1,000 women tested. Only one or two of those 50 actually have a neural tube problem. A high AFP may be due to a miscalculation of the baby's age, or if you are pregnant with twins!

Risk Results and What Happens Next

If you are identified as being at increased risk of carrying a baby with whichever of these syndromes is named next to the risk result then you will be offered an appointment to discuss your options; one of which will be an amniocentesis. An increased risk result does not mean that your baby definitely has this syndrome but it tells us that further testing should be offered to help us provide you with more detailed information. You will be given an appointment to discuss this test before it happens and further information

to read. Only a small number of women who are in the higher risk group will be pregnant with a baby who has Down's, Edward's or Patau's syndrome.

With an increased risk for AFP result, an ultrasound is usually done to determine your baby's age, look for more than one baby or scan for neural tube defects and other abnormal conditions, which may also be responsible for the elevated test. If the ultrasound shows a single baby at the approximate age determined by the initial due date with no abnormalities, an amniocentesis will be offered. An abnormally high level of AFP in the amniotic fluid indicates a 90 percent chance that a serious problem is present. An abnormally low AFP reading may indicate that there is a chromosomal problem. If you are identified as being in the lower risk group for Spina bifida, Down's, Edward's or Patau's syndrome it does not guarantee that your baby will not have these syndromes, it just means you have lower risk of this.

The lower the number, the higher the risk

So, for example, 1 in 180 is a higher chance than 1 in 400 of your baby having an abnormality. Please try to keep in mind that even with a 1:4 chance (25%) chance of an affected baby; you still have a higher chance of a healthy baby than one who has the condition you have been screened for.

Diagnostic Testing (Yes or No answers)

Screening options, as described above, give healthcare practitioners a baseline to judge if it is appropriate to offer you a diagnostic test with its associated risk of miscarriage. A diagnostic test can give you a yes or no answer in relation to whether your baby has a chromosomal abnormality. It can not promise that your baby is perfect as it can't detect structural defects, though detailed scans can pick up many major structural defects.

Before you decide to have any diagnostic test you must make a decision about how you will feel if you are told your baby has an abnormality and what steps you may wish to take, as a termination of your pregnancy will be offered even though many chromosomal abnormalities are compatible with life. You will need to consider how you would care for and cope with, a disabled baby, child and eventual adult if you chose this option instead of termination.

Amniocentesis

An amniocentesis involves withdrawing and testing a small amount of the amniotic fluid surrounding your baby (foetus). It provides very reliable information about:

- Rhesus disease or other blood incompatibilities between mother and baby
- chromosomal abnormalities
- certain defects related to abnormal brain and spinal cord

- the sex of your baby (if you do not wish to know please tell your midwife or doctor).

Amniocentesis is generally performed in conjunction with ultrasound to prevent injury to the baby, the cord and placenta. You shouldn't be concerned about the loss of amniotic fluid as only a small amount is withdrawn and your body rapidly replaces it with no harm to the baby. This fluid contains cells that can be grown in a laboratory where they can be examined and tested. The timing of this procedure will vary depending upon the initial reason for evaluation. For example, to look for chromosomal abnormalities an amniocentesis is done at about 16 weeks of pregnancy. It checks the number of chromosomes (which carry the genetic code) to see if the number and pattern is normal.

Amniocentesis is considered 99.5% safe but does carry an associated risk of miscarriage. The national rate for associated miscarriage averages around 1:100, and therefore it is not offered as a routine test. It is performed only to detect a highly probable medical problem; for example from an increased risk factor calculated during the first trimester combined screening.

The actual procedure requires you to have a moderately full bladder (yikes) and to lie still for at least 20 minutes. For many people with FM this means cramps at worst, twitching muscles and stiffness at best. However, you must try to endure the discomfort of maintaining one position as the test requires quite precise positioning of the needle. The needle itself is only in place for a few seconds before it is withdrawn, leaving behind a thin plastic tube through which the fluid is drawn up. If you have negotiated an agreement with your doctor that you can move at some point during the amniocentesis, then this will be the time when he is most likely to encourage you to shift slightly to ease those muscles. If your partner has FM then try not to squeeze too hard when offered a comforting hand to hold or you may do some damage to the fingers clutched in yours!

Chorionic Villus Sampling (CVS)

CVS involves obtaining a sample from your placenta for chromosome or DNA analysis. Chorionic villus refers to the part of the placenta that attaches it to the lining of the uterus or womb and it is from this area that placental tissue is removed to perform the chromosome test.

CVS is usually offered to women who already know they are at risk of having a baby with a genetic disorder. A genetic disorder is an inherited condition that is carried in the family, such as muscular dystrophy or cystic fibrosis. CVS may also be useful for women who have had a baby with a chromosomal disorder such as Down's syndrome or are at increased risk because of their age, although most women have amniocentesis to test for these disorders. The only advantage of CVS over amniocentesis for chromosomal disorders is that the results are available earlier in the pregnancy. CVS is usually done between 10.5 and 13 weeks of pregnancy although there are situations where it is performed later.

About 1 in 50 women who have the test will have a miscarriage. About half of these are due to the test itself and the other half would have happened anyway, but it is often impossible to be sure of the cause. There have been a small number of reports in medical journals that CVS may be linked to the risk of limb abnormalities and that this may be more of a risk if the CVS is done before 9 weeks of pregnancy. However all CVS tests are followed up by a full detailed anatomy scan at 20 weeks to check your baby.

During The Trans Abdominal CVS (through your tummy)

If the doctor chooses to use the trans abdominal approach, your abdomen will be cleaned with antiseptic and a local anaesthetic may be injected into the area where the sampling needle is to go. The sampling needle is then put in and guided into the placenta. This part of the test usually lasts less than a minute but will undoubtedly feel much longer to the person who is having it done to them. This method may be most suitable for women with FM who suffered heavy periods and cramping before pregnancy or those who have a tendency to suffer from cervical spasm.

During The Trans Cervical CVS (through the neck of your womb)

If the doctor chooses to use this method because of the position of your placenta, a speculum will be inserted into the vagina to help the doctor to see your cervix. This is the same instrument that is used when you have a cervical smear. A very thin instrument (forceps) is passed along the cervical canal into the placenta to take a sample. In both cases the test is done with the help of an ultrasound machine so that the needle or forceps can be correctly positioned at all times.

Test results

The test results can take anywhere from 3 to 14 days to come back depending upon which technique is being used. The stress of this wait is unavoidable and the result cannot be rushed although some hospitals will allow you to send a sample away privately for rapid (3 day) testing. However this result only reports on Down’s, Edward’s and Patau’s syndromes, you will still need to wait the full 14 days for the complete chromosomal report. This may put you, your partner and your relationship under considerable strain, so beware those of you who have stress triggered flare ups and try to put into place whichever relaxation techniques work best for you.

If you have heavy bleeding and/or severe cramping pains (or any pain that you wouldn’t normally associate with a FM flare up) you should contact your maternity hospital immediately.

Common Changes During Pregnancy

Pregnancy is a miraculous time of constant change for you and your baby. During the second and third trimester of your pregnancy you will continue to experience physical and emotional changes. Some symptoms are natural while others may be warning signs of complications.

Breasts

Right from the beginning, your breasts may be larger, firmer and more tender than usual. The areola, the dark area around the nipples, may get larger and grow darker in colour. Halfway through your pregnancy, your breasts may start to secrete fluid (colostrum) in small amounts. Toward the end of your pregnancy, you may want to put gauze pads inside your bra to protect your clothes. The veins right under your skin may become more noticeable, too. This is caused by an increased blood supply preparing your breasts for milk production. For most women, if you are planning to breastfeed your infant, no special nipple preparation is required. It is recommended that you keep your nipples dry and wash with warm water - no soap.

Urination

When your uterus expands, it puts pressure on your bladder. The need to urinate is common in the first stages of pregnancy, and in the last weeks. Don't try to control this by drinking less fluid. Your baby needs you to drink at least one and half litres of liquids a day. You may find it more comfortable to have a readily accessible restroom during the first three months of your pregnancy and when you are nearing birth, when the baby suddenly pressing on your bladder may mean you need a toilet… FAST!

Nausea

Some women suffer with "morning sickness" and some women are never nauseated. "Morning sickness" isn't necessarily confined to the morning hours. For some women it is an all-day problem and for some very unlucky women, it doesn't pass until after their baby is born. Happily, for most women, the nausea has passed by four months of pregnancy. Try eating smaller meals of simple and somewhat bland foods, avoiding spicy and highly acidic foods, and rest in a semi reclined position immediately after eating for just a few minutes.

If your nausea is more severe than this, try eating a dry cracker (rye is very nourishing) just before getting up in the morning. Sometimes a little bland food in the stomach will help you digest a breakfast later. You need to eat well to grow a healthy baby. Medication is usually reserved for those who have significant vomiting or dehydration. Take your antenatal vitamins or iron during the day when nausea is less of a problem and always try to take iron with a piece of fruit or small glass of fruit juice as the vitamin C helps you to absorb the iron more efficiently.

“Morning” sickness survival tips:

- Ginger fizzy (with the fizz stirred out) and crackers are a traditional remedy. Ginger fizzy with a stronger “bite” seems to work better. Drinking lemonade (or smelling a lemon) may help settle your stomach if ginger fizzy does not work. If you are too nauseated to stomach anything then you can sprinkle a few drops of ginger essential oil on a flannel and inhale the vapours until the nausea eases and then try to drink something.
- If crackers do not work or get boring, try potato chips. They are a good source of potassium but be aware of their high salt content.
- Quench your thirst and settle your stomach with anything you are craving. You need the fluids and nutrients.
- Try to drink 10 cups of fluid a day to avoid dehydration. A cup of ice chips or a cup of watermelon cubes counts for about a half cup of fluid.
- Make a running list of odours which trigger nausea and post it on your refrigerator to alert others. You may want to get help with tasks like grocery shopping or changing diapers, if you have young children.
- Summer heat, humidity and stale air seem to aggravate morning sickness. Try to stay in a cool room whenever possible.
- During winter months if you are chilly, put on layers instead of turning up the heat. An overly warm house will make you lose fluids through perspiration.

Excessive salivation

This condition is caused by excessive secretion of the salivary glands in the mouth and is quite annoying and difficult to treat. It tends to diminish in the latter half of pregnancy. Mints and frequent small meals and dry cracker snacks can be helpful.

Heartburn

Heartburn is another common complaint of pregnant women although it isn’t your heart that is burning, it’s your stomach! This is common indigestion, but it can still be an aggravation. It is alright to use antacid preparations such as Gaviscon but do not use baking soda or sodium bicarbonate preparations for your heartburn. Before you buy an over-the-counter remedy, ask your midwife, GP or pharmacist which product is recommended. In severe cases of heartburn, you might want to elevate the head of your bed to encourage your stomach fluids to stay put! (Ask your partner to add 4" of books or bricks beneath the head posts to elevate the head of the bed). You can reassure your partner that this will not affect their restful sleep, it looks high but it isn’t noticeable once you are lying down.

Constipation

You need to drink lots of fluids while you are pregnant. This is one way to avoid constipation, a common complaint of pregnant women. Exercise every day to help your body process food more efficiently. Try all the natural remedies first including extra water, dried and fresh fruit and lots of vegetables, including the addition of bran and bran products to your diet. If none of these work, ask your GP to prescribe a very mild laxative or stool softener. Don't be shy about discussing this problem it is a by-product of your pregnancy.

Uncomfortable breathing

This may be a problem once the baby is large enough to interfere with your breathing muscles. It can sometimes be caused by things other than your growing baby, such as low iron levels so you may need to ask your midwife to test your blood. First try slowing down your movements and practice deep breaths from the chest. If you still have trouble breathing, or if you have any chest pain, contact your local maternity hospital.

Backache

You may experience backaches due to the added weight gain from your pregnancy, but that isn't the only reason your back may hurt. As your womb grows, your pelvic bone joints relax, which can also cause pain in your lower back. Comfortable shoes may help a little, good posture will help too, but exercise will probably relieve your backache more than anything else. Strong muscles can take more stress before they become strained. Develop a routine of back exercises every day from the beginning of your pregnancy. Your midwife or GP will be happy to advise you.

Sciatica

Toward the end of the pregnancy, some women feel that the baby is pushing on a nerve in their back, which is often called sciatica. This pain can be concentrated in your back or shoot down one or both legs making walking more difficult. To try and relieve this pressure you can get on your hands and knees and let the baby's weight fall toward the floor. You can also try getting on your knees and resting your forearms on the floor or sitting straddled on a chair so your arms rest on the back. Use this position when you are watching telly or reading to encourage your baby into the optimum position for late pregnancy and delivery. This will relieve the pressure on your back as the baby shifts, and may give you a lot of backache relief. A warm bath, hot or cold compresses (hot water bottle, wheat bag or bag of frozen vegetables) sometimes work too.

Insomnia

Early in your pregnancy, you may be very sleepy and feel as if you are sleeping all the time ...then at the end of your pregnancy; you'll wish those days were back again! Most often trouble with sleeping comes

from the difficulty of finding a comfortable sleeping position. For example, if you've always slept on your stomach, you won't be able to do so by the middle of your pregnancy!

However even the simple act of turning over at night, later on in your pregnancy can become a task of monumental proportions as it may take you several separate motions to do what used to be one fluid movement. Most annoying, I agree, but it is all because your hips are loosening up in preparation for allowing your baby to pass through during birth.

Shortness-of-breath or heartburn may aggravate this situation, so prop yourself or your bed head up at night. Also, an active foetus can help keep you awake, and you are much more aware of your baby's movements at night as you have time to concentrate on them. To keep your baby and yourself, as calm as possible at night; don't drink caffeinated beverages in the evening after supper. Try a soothing herbal tea such as camomile and honey after your 3rd month of pregnancy, before this very few herbs are safe so avoid drinking or eating herbs without advice from a qualified practitioner.

Exercising a few hours before you go to bed may help you rest easier...or a warm bath may do the same thing. Unfortunately nothing except giving birth will make turning over in the night easier. It is important not to take alcohol or sleeping pills to try to solve your insomnia...there are safer solutions, just ask your midwife or GP for more advice.

Skin changes

Many women get very upset about changes in the colour of their skin, but these changes are common. Your skin may simply look "flushed," like you are blushing or you may develop brownish markings on your face. Some women get a dark line down the middle of their abdomen, where the skin darkens considerably from the navel to the pubic hair this will fade or disappear entirely after birth. Acne crops up to plague some, or acne may actually be improved during pregnancy in others. Changing hormone levels are responsible for these skin colour changes, but they usually all go away or fade dramatically after your baby is born.

Varicose veins

Varicose veins, "varicosities," are caused when the veins in your legs get weak and enlarge with blood. They have to work harder to carry blood back up your legs to your heart. Sometimes pregnancy can aggravate this problem. The swelling uterus partially cuts off circulation from your legs. Exercise will help, honest, and you have probably noticed that I can't recommend exercise enough!

Try not to stand without moving for long periods of time. When you sit, try to prop your legs up to make return circulation easier and paddle your feet back and forth and swirl them round from time to time. Varicose veins are more of a problem for women having their second or third child. But even if you are

having your first baby, try to do as much as you can to aid instead of hinder the circulation in your legs. Rest periodically with your legs up. Short walks at different times during the day will help move your blood around your body faster.

Support tights help tremendously, but avoid all tight clothing such as knee highs that will only cut off circulation more. The vulval area can also suffer from varicosities during pregnancy. Again, rest periods spread out during your day will help. This time, place a pillow under your buttocks to elevate your hips and aid circulation although I wouldn't advise this at the same time as propping yourself up on pillows, unless you want to know what it feels like to fold yourself in half!

Haemorrhoids

Ever heard the facetious saying "Pregnancy is very glamorous"? Read on to find out more of potential "delights" (albeit usually only temporary), in store for some of you. Many women suffer with haemorrhoids, or get haemorrhoids for the first time while they are pregnant, but this doesn't necessarily have to happen to you.

Haemorrhoids are enlarged veins right at the opening of the rectum. Though they are sometimes due to the blockage of circulation caused by the increased size of the baby you are carrying, they can also be caused by the straining due to constipation. Keep your fluid intake up to help avoid this.

If you do suffer with haemorrhoids, try lying on your side with your hips elevated on a pillow. Soaking in a warm tub can help, too. You can use over-the-counter ointments such as witch hazel moistened wipes. Be sure to ask us if they are safe for your baby. The medication in ointments is frequently absorbed through the skin and may affect your baby. If you suspect your haemorrhoids are bleeding, call your GP or midwife.

Prevention is the word here! Eat correctly and add fruits, raw vegetables, bran products and lots of water to your diet every single day. See the section on diet for more information.

Vaginal discharge

You may notice more vaginal discharge during your pregnancy. This mucus secretion occurs from the cervix in response to the hormones of pregnancy and helps to keep harmful bacteria at safe levels. Mucus secretion is different from leaking of amniotic fluid. All this is quite normal and there really isn't much that can be done to change the situation. Of course, excessive discharges that have a bad odour should be evaluated by your GP.

Many women seem to get yeast or other vaginal infections while they are pregnant that need treatment (have I mentioned how glamorous pregnancy is?) but they are not harmful to the baby. A simple safe treatment for yeast infections during pregnancy is plain active yogurt. Spread it on the itchy area and enjoy the soothing relief. Use this treatment as often as you need, in conjunction with wearing cotton underwear

and loose clothing for at least three days; if you are not completely better then see your GP. If you experience discharge that is watery or comes in gushes, put a sanitary pad on and call your local maternity hospital.

Abdominal pain / round ligament pain

Especially during the latter half of pregnancy, when the uterus and your baby are growing larger, you may experience lower abdominal discomfort. One source is round ligament pain. Round ligaments are cord-like structures that originate beneath the groin region and extend to the top of the uterus on both sides.

Round ligament pain is described as sharp pain in either or both groin regions and is caused by stretching and spasms of the round ligaments. Sudden movements like rolling over in bed or walking may aggravate round ligament pain. Reduced physical activity, application of warm heat or use of a pregnancy support strap may help. Constipation can also cause abdominal pain. If abdominal pain is severe or continues, please call your local maternity hospital. There can be other more serious causes which are discussed in the complication in pregnancy section.

Cravings

It's important to keep eating your balanced diet, no matter what your cravings are. If you feel like eating a pot of spinach at 2 o'clock in the morning, wash it well, and eat it raw or cooked. On the other hand, if you feel like eating hot chilli or a half dozen of your favourite candy bars...that's another issue! A desire to eat strange foods or non-food items might mean a nutritional deficiency that needs correcting.

Pica

This is the medical term for the unusual cravings for non-food items such as clay, ice or laundry detergent that you might have while you are pregnant. No one knows quite why this happens, but some women experience it, and it can be harmful. Please contact your midwife or GP if you experience this.

Dizzy spells

Some pregnant women do faint. This is caused by the circulation changes happening in your body, and usually goes away by the second half of pregnancy. Lying on your back toward the end of pregnancy may also cause dizziness; so, resting and sleeping on your left side is the recommended position. Don't change positions suddenly. When you are lying down, ease yourself up to a standing position in stages. This will give your body time to adjust to the new position.

The reason why you faint is because if your brain suddenly looses a lot of its blood supply; the fastest way it can equalise the blood supply is by throwing you to the floor so your body is horizontal! This means less

effort for your brain to get the blood back up to it. All quite simple and perhaps less scary, when you understand why but still dangerous if you faint and hit your head.

Swelling

Not infrequently, later on in pregnancy, swelling can occur in the joints and cause pain that feels like arthritis. This is especially seen with women who develop leg swelling during the day and notice stiff sore-finger joints the following morning after resting overnight.

A similar situation occurs in Carpal Tunnel Syndrome where a nerve that supplies sensation to the hands becomes entrapped in a tunnel of tissue because of swelling. The involved nerve produces numbness in one or both hands more frequently at night. Both conditions may be improved by salt restriction during pregnancy and the natural fluid loss that occurs after delivery. A hand splint may also be helpful and your GP or physiotherapist will recommend this if needed.

Swelling

Again, pressure from the growing uterus and your changing hormones can cause swelling, especially in your legs and hands. Some of this is blockage of drainage pathways in your upper legs caused by the pressure of the baby and some is caused by water retention. Support tights and resting with your legs elevated should help a little. If your feet, ankles or legs are swollen and not relieved by a night in bed (make sure you ask your midwife to check your blood pressure if the swelling is new or has come on suddenly) then ask your partner to place 2 or 3 bricks or books under each foot post to elevate the foot of the bed. Be sure to avoid excessive salt intake, which will only make you retain more water. Notify your midwife, GP or obstetrician if swelling increases dramatically or occurs in your face or around your eyes as this may be an indication of rising blood pressure.

Stretch marks

Stretch marks show up usually on breasts, the buttocks and lower abdomen, but they might also occur in other places. Moisturizing creams probably won’t do much to help because stretch marks are caused by the breakdown of elastic tissue right below the skin’s surface. Excessive and rapid weight gain will make matters worse, so keeping your weight gain under control will do more to avoid stretch marks than any single thing you can do. The good news is that stretch marks usually change to a pale white within a year or two after pregnancy, and so become less noticeable.

Nose bleeds

Some women have frequent nose bleeds during pregnancy caused by extra blood supply in the nasal lining. Just treat with finger pressure on the side of the nose which is bleeding. Call if the bleeding is heavy

and you are unable to stop with nasal pressure. Nasal congestion is also a common complaint. Avoid nose drops unless prescribed by your GP or obstetrician.

Headaches

Headaches are one of the most common complaints along with nausea in the first few months of pregnancy. Most headache remedies are not helpful although you can use peppermint oil sticks on your forehead or area when the pain is most concentrated although take care to avoid your eyes. These headaches are caused by blood circulation changes and will usually stop after the first half of your pregnancy. If you notice the headaches are associated with sensitivity to light, excessive nausea or vomiting, fever, or blurred or sparkling vision, call your local maternity hospital.

Braxton-Hicks contractions

The uterine muscle contracts spontaneously from early pregnancy until the onset of real labour. Usually the contractions are irregular and painless (Braxton-Hicks contractions) and may produce “false” labour if they become painful. If they progressively become closer together, last longer and become more painful, notify your midwife or local maternity hospital so they can make certain you are not in premature or early labour.

Emotional changes

Many pregnant women may feel downright joyous one minute then break into tears the next. These up and down mood swings are part of the hormonal changes going on in your body. The impending changes in your life can be quite overwhelming. When any woman gets pregnant, she worries about the health of the baby, the pain of labour, about the future and how she will adjust to being a mother, about a hundred different issues, all surrounded by the addition of a baby into her life. Please talk to your midwife or GP if you find yourself becoming increasingly anxious or distressed as there is help that can be offered.

What to do about mood swings

Most of these anxieties can be eliminated by asking questions or just talking about your worries. Expect these mood shifts, and don’t think something is drastically wrong when they occur. No matter how much a woman wants a baby, she still may feel inadequate once she becomes pregnant. The key to working through depression and anxiety is to talk about your feelings. You should communicate your feelings, even if you think they are too embarrassing.

Try not to worry and concentrate on living your life one day at a time. When you feel anxious, pamper yourself with a warm, relaxing bath or whatever else you like to do that relaxes you. Make a point of getting out of the house every day, even if only for a short walk. Reach out to others when you need a comforting word. You will be surprised how many people will tell you they have felt the same at some point in their

lives, anxiety and depression is not uncommon. If you still feel depressed, be sure to talk it over with your midwife or GP before it has a chance to affect your overall health.

Sexual changes

With your mood shifts come other emotional changes, too, including your feelings about sex. Desire for sex may rise or fall significantly during pregnancy. If you lose interest in sex, don't worry. It happens to a lot of women and doesn't usually last long. You may find that your partner's sex drive falls dramatically due to his concerns over possibly hurting the baby or being too intimately close to the baby. Reassure him that normal sexual intercourse during a healthy pregnancy will cause no harm to the baby. Be sure to discuss your feelings and have your partner read this booklet. Remember, pregnancy is a natural process and a woman's body is designed to cope with it and still function as normal in the majority of cases.

Less common changes and complications during pregnancy

Pregnancy is a normal state for women, but sometimes complications arise that require immediate attention. Almost all complications give some kind of warning sign, and you or your partner are likely to be the first to notice a symptom that needs attention. Your blood pressure, urine, weight, position of your baby and baby's heartbeat are checked at each appointment because changes in these vital signs could signal a problem. Problems that are caught early have the best chance of being treated and eliminated or controlled.

Call your maternity hospital immediately if you experience any of these symptoms:

- Bleeding from breast nipples, rectum, bladder or coughing up of blood
- Vaginal bleeding, no matter how slight (unless slight spotting after an internal exam)
- Swelling of hands or face
- Dimness or blurring of vision
- Severe or continuous headaches
- Abdominal pains that don't go away with heat and rest or a bowel movement
- Chills or fever over 40 degrees
- Persistent vomiting
- Painful or burning urination
- Decreased foetal movement
- Sudden or slow escape of fluid from the vagina

Early pregnancy bleeding

There are many causes of bleeding during pregnancy and these vary depending upon when the bleeding occurs. If you experience bleeding early in your pregnancy, you will be sent for a scan to determine the cause. Two serious causes of early pregnancy bleeding are miscarriage and ectopic pregnancy. Two minor causes of early pregnancy bleeding are post coital (after love making) and cervical erosion (relatively painless but sounds horrid), which many women with FM have probably experienced. My gynaecologist says that us women with FM are 'bleeders', if there is a problem that means we will bleed, for example between period spotting, cervical erosion, endometriosis and so on, we are more likely to get it! I certainly agree with him purely from a personal perspective though I don't know if there is any research being done into this to see if it is factual.

Miscarriage is the most common serious cause of early bleeding and occurs in 15-20 percent of all pregnancies, usually within the first three months. Most miscarriages cannot be prevented. They are nature's way of dealing with pregnancies that are not developing properly. It is characterized by bleeding more than you would during a heavy period and is usually associated with cramping. An ectopic pregnancy, or the implantation of a fertilized egg outside the womb (usually in a fallopian tube), is another serious cause of early bleeding.

Ectopic pregnancies occur in less than one percent of all pregnancies and are almost always associated with severe pain in one side of your upper groin area. Most of the bleeding is internal, which can be life-threatening because of its hidden nature. Call your local maternity hospital immediately if you experience severe abdominal pain early in your pregnancy, or abdominal pain combined with pain in your shoulder tips. If you have FM associated discomfort that you have when not pregnant, you need not worry unless it became more painful than usual for you, comes and goes in 'waves' or is associated with bleeding.

Late pregnancy bleeding

Bleeding late in pregnancy can be serious, but the most common cause is "bloody show," one of the first signs of labour. This is caused by the thinning of the cervix and is usually associated with thick mucus. Cervical irritation and pelvic exams can also cause bleeding.

The most serious late pregnancy bleeding is caused by either placenta praevia or placental abruption. When these conditions occur, they are most often in the final three months of the pregnancy. Placenta praevia results when the placenta partially or completely covers the cervix. As your cervix thins in preparation for labour, it will stretch any placental tissue attached to it and bleeding will occur. The other serious cause of late bleeding; placenta abruption, occurs when the placenta prematurely detaches from the inner lining of the womb. This is usually accompanied by sudden severe abdominal pain. Either condition can lead to the death of your unborn baby. Do not ignore any pain that is unusual for you, sudden

and/or severe in onset. Women with FM are able to cope with large amounts of pain but you must be sensible and avoid the urge to try to be stoic if experiencing pain during pregnancy. Let the professionals decide for you if you are not sure. That is what we are paid for!

If you experience significant bleeding in your pregnancy, you may be hospitalized for observation and evaluation. If the bleeding is serious or if the fetal monitor shows a persistent, non-reassuring fetal heart rate pattern, a caesarean birth may be required. Please be reassured by the fact that most bleeding is the result of minor causes that require no treatment. It is important however, for you to know that bleeding can indicate serious problems. You should report all bleeding to your local maternity hospital or GP immediately so that the severity of this blood loss and the wellbeing of both you and your baby can be assessed.

High blood pressure in pregnancy

Fewer than 10 percent of pregnant women develop a syndrome associated with high blood pressure, also known as Pregnancy Induced Hypertension (PIH) or pre-eclampsia. The exact cause of this potentially serious condition is unknown.

When changes of blood pressure are detected early, you and your baby can avoid serious problems. However, with PIH you will often feel quite well except for possible headaches in the beginning. As a sufferer of FM, you will have built up a tolerance to feeling unwell on a more or less, regular basis and this condition is sometimes ignored by women without pre-existing medical conditions until greatly advanced. This is one of the reasons why attending regular scheduled antenatal appointments is so important. Pre-eclampsia can cause damage to multiple organs in your body if undetected. Your baby can suffer from a lack of oxygen and nutrients which can lead to growth problems, on-going health problems throughout life or even death.

Women who are overweight, diabetic or older than 40 years are considered to be at an increased risk of developing this complication of pregnancy. Mothers with kidney disease, twins or a history of high blood pressure are also considered as likely candidates. There is no known link to FM pre-disposing you to an increased risk of PIH or pre-eclampsia.

High blood pressure is caused when the blood vessels in the body contract, increasing the pressure and lessening the amount of blood flowing to the uterus, placenta and to your baby. Mild changes in blood pressure for a brief period are unlikely to cause problems. However, prolonged and severe spasm of the vessels can be potentially harmful and need closer monitoring, including drug treatment for some women in order to lower the blood pressure.

A sudden weight gain or noticeable swelling of the face and hands can indirectly signal high blood pressure. Some women with FM may suffer with swollen hands, ankles and feet anyway. If this is the case with you then mention it to your midwife or obstetrician so they are aware of this fact. What you are looking

for is swelling that is not normal for you and please note that you should never have noticeable, sudden swelling in your face.

Some women experience no distinct symptoms at all. Headaches, visual disturbances, or pain in the upper abdomen may indicate a more serious problem and you should call your local maternity unit if any other occur. By monitoring your blood pressure, weight and urine at each antenatal visit, your midwife, GP or obstetrician should be able, in most cases, to make an early diagnosis of the problem and take steps to help you avoid serious complications.

Each case of pre-eclampsia is treated differently depending upon a variety of factors usually determined through more specialised investigations and how close you are to your due date. Reduced activity as an outpatient or hospitalisation until stabilised on medication to lower your blood pressure may become necessary, but the eventual birth of your baby will expedite your recovery from this disorder. If you have needed medicating during your pregnancy to help stabilise your blood pressure, then you may need to continue taking these tablets for an indeterminate time during your postnatal period. Your GP will closely monitor you if this is the case.

Fluid retention

A low-sodium diet is not generally necessary, but certain foods and liquids do contain an excessive amount of salt that promote increased fluid retention in some women. You may want to consider cutting out of your regular diet:

- Bacon, sausage, ham, pork and luncheon meats
- Canned soups, canned vegetables, canned meats and fishes
- Salted popcorn, pretzels, potato crisps, nachos, salted nuts, etc.
- Tomato juice, bouillon cubes, adding salt to meals

Premature labour

Labour usually occurs sometime after the 37th week of pregnancy, (37 - 42 weeks is considered full term.) A baby born before 37 weeks is considered premature. These infants may require special care in breathing and maintaining their body temperatures or they may be perfectly healthy. Although premature birth does represent the greatest risk overall to your newborn baby, each baby will be assessed as an individual at birth.

Warning signs of premature labour

Premature labour is labour that starts before 37 weeks of pregnancy, or more than three weeks before your due date. Signs and symptoms include:

1. Uterine contractions — more than four in one hour.
2. Menstrual period type cramps — may come and go or be constant.

3. Abdominal cramps — with or without diarrhoea.
4. Low backache — comes and goes or remains constant.
5. Pelvic pressure — feels like your baby is pushing down.
6. Change in vaginal discharge — a sudden increase in amount or if it becomes more mucous-like, watery, slightly bloody, neon yellow or green tinged.

If you have one or more of these symptoms, you might be in premature labour. You should call your local maternity hospital immediately for advice. They will likely invite you in to check you and your baby over and observe you for a while before making a decision about what care to offer you.

Atypical antibodies and prevention of haemolytic disease in the newborn

Are you sitting comfortably dear reader? There is no way to make this topic interesting so you may as well settle yourself down somewhere with lots of cushions, just in case you fall asleep while reading about this boring but vitally important information. You will be offered a series of routine blood tests at one of your first antenatal visits. One of these will be to determine your blood type and Rh factor. The most common blood type is Type O; the most common Rh factor is positive. People with Type O, B, A, or AB positive blood have a positive Rh factor. Those with Type O, B, A, or AB negative blood have a negative Rh factor. Still awake? Okay then read on…

When your blood type is Rh negative, and your baby's father's is Rh positive, your baby could inherit the father's positive blood type, which could cause a problem during pregnancy. If your blood type is Rh negative, your body's immune system can recognize the baby's Rh positive blood cells that escape into your circulation. As you now know, these cells are different from yours. Because they are different from yours, your body will produce antibodies to destroy your baby's red blood cells. These antibodies not only attack your baby's blood cells that are in your circulation, but cross the placenta in an attempt to destroy your baby's blood cells in his or her circulation.

These newly formed antibodies may not be a problem during your first pregnancy; however they can lead to a serious disease in any subsequent pregnancies. This is known as haemolytic disease of the newborn (HDN). If your body produces a high level of antibodies, more of your baby's blood cells will be destroyed. Eventually, this produces anaemia in your baby. This can cause the death of your baby before birth. Live births can be complicated by severe jaundice, mental retardation, hearing loss or cerebral palsy. Scared now? Try not to be, the blood test I mentioned at the beginning of this section check for antibodies and if any are found, they are monitored closely throughout your pregnancy.

The good news is that haemolytic disease of the newborn can be prevented in most cases by giving you an injection of Anti D which prevents your immune system from reacting to your baby's red blood cells. The

Anti D finds your baby's red cells in your circulation and throws a chemical cloak over them, neutralising them so you don't produce antibodies against your baby's red blood cells.

Once your blood type is determined to be Rh negative, the option of anti D should be discussed with you. Your consent is needed to give you this injection and you need to be aware that it is a blood product, albeit a very small amount of technically 'safe' blood. However, some religious beliefs discourage the administration of blood products no matter how small. This injection is routinely offered to women with Rh negative blood during pregnancy and within 72 hours following birth. If your Rh factor matches the baby's father or you are Rh positive, you have nothing to worry about because Rh disease cannot affect you or your baby under these circumstances.

Group B Streptococcus (GBS)

Group B Strep is a common bacteria that can be found in many women, most commonly in the vagina or rectum. It is not routinely screened for during pregnancy but can sometimes cause serious medical problems for your baby. Most babies who acquire this infection from their mothers do not have any problems. Only 1-2 percent of all babies who are exposed to GBS during pregnancy become infected, however it is the most common cause of bacterial infection in newborn babies.

Affected babies can develop early infections during the 24 – 48 hours of life and sometimes after this period. As with any newborn you should monitor them for signs of being unwell, raised temperature, extreme drowsiness, lack of appetite and the like. If you have any concerns report them to your midwife or GP immediately. The early infections can be quite severe and may affect your baby's lungs, blood, spinal cord or brain which can lead to death in a small percentage of babies. Later infections can also be severe and usually manifest themselves as meningitis which can have long-term effects.

If GBS is detected during pregnancy, usually when a swab is taken if you've 'broken' your waters, then treatment can be offered. This treatment of pregnant women with GBS can't always prevent infection in the baby. A pregnant woman can become positive again for GBS after treatment and before the baby is born. The best way to prevent GBS infection is the use of intravenous antibiotics during labour. Certain risk factors increase the chance that a baby of a mother with GBS will become infected. These women may benefit from treatment with antibiotics during labour and delivery.

Mothers at increased risk for GBS are those with:

- Fever during labour
- Previous child with GBS infection
- Prolonged ruptured membranes ('broken waters'). The definition of prolonged varies between hospitals so enquire as to what your hospital's policy is if it became necessary to do so.

- Premature rupture of membranes (before reaching 37 weeks of pregnancy)
- Premature labour (less than 37 weeks of pregnancy)

Changes in the Last Few Weeks

You can expect more changes in the last weeks of your pregnancy. You will probably feel tired beyond your usual FM type of tired and as if you have been pregnant forever! This is all part of getting ready and being willing to go through the labour and birth process.

Engagement

You may notice that your bump is lower than usual. This is when the baby “drops” or engages down into the bony part of your pelvis. When this happens, you might be able to breathe easier as the pressure on your diaphragm will lessen. However the waddling gait you may already have developed will now become more pronounced as you instinctively try to widen your hips to make room for your baby’s head. You may hear your hips ‘creak’ as you lie awake in the night. It is not unusual to have you sleep patterns further disturbed by the movements of your baby at this stage and the fact that it now may take you about 6 separate and distinct movements to turn over in bed! Your midwife will be checking to see if your baby’s head had engaged in your pelvis. This is one way to tell if you will have a chance of being able to give birth vaginally.

You may find this part of the examination particularly uncomfortable, especially if the midwife uses something called a ‘Pawlick’ grip where she places a finger and thumb on alternate sides of the lowest part of your baby. Many midwives now use a two handed form of this check which you may find more comfortable. She will be doing this to confirm what part of the baby she thinks is lowermost in your womb. As all people with FM know, it is a very individualised condition and it is likely that your midwife’s knowledge of FM is going to be limited to begin with, so if you feel this or any part of the examination is too uncomfortable please tell your midwife. By keeping her informed of what you can and cannot cope with in relation to your FM you will be helping your midwife to give you the best possible care.

Engorgement

Your breasts enlarge even more near the end of the pregnancy, and milk may start to seep from them. You can make use of breast pads if you wish and make sure your bra is comfortable and fits well. You will need to be measured again for your feeding bras. If they do not fit properly then you will spend more time than you need to pushing yourself back into the cups after you turn over at night! A good fitting and supportive bra is essential to help prevent discomfort in your upper back as your shoulders get accustomed to this additional weight. If you are finding your breasts are uncomfortable at this stage then you can use room

temperature cabbage leaves. Separate the leaves from the stem and place under your bra cup against the skin of your breast, use enough leaves to cover the whole breast. It is best to use room temperature leaves as women with FM may find that chilled leaves cause the vessels in your breasts to go into spasm.

"Red hot pokers"

Now I know that it would be an understatement to say that pain is not an uncommon sensation to FM suffers however you may experience new types of sensations during the latter stages of pregnancy which are completely normal. Pressure is sometimes reported in the vaginal area, anytime from 32 weeks pregnant through till delivery. You may also experience shooting pains or a "red hot poker" sensation in this area.

Additional delights of the latter stages of pregnancy

To make things worse, you may feel the need to urinate frequently and will begin to feel as if you have mapped out your local shopping precinct by toilets locations. You are likely to feel heavy, clumsy and out of patience with pregnancy. Will it make you feel better if I tell you that even women without FM feel the same at this stage? Probably not but this is for a good cause, really it is. The more fed up you get, the more you will convince yourself that you are willing to go through **anything** (!) to get this baby out of you and into the real world. That is your first real step towards preparing yourself for labour and birth.

Is This Really Labour?

Plan to monitor your early labour contractions in the comfort of your own home. You are likely to cope with your contractions better in the comfort of your own home. You should prepare to call your midwife for advice when your membranes rupture or when your contractions are from five to seven minutes apart. It is advisable to call earlier if are quite a distance from where you intend to give birth.

Very early labour is sometimes called false labour as it can take a few days to become established into regular contractions. It is important to know the difference between established and very early labour. Very early labour involves cramps or contractions of the lower abdomen, similar to established labour, but there is a vital difference. Very early labour does not cause a change in the cervix, it doesn't come in regular intervals, and it may disappear altogether if you change positions or walk around.

Some labour contractions cause back pain and some cause lower abdominal pain, or both. Expect to cope quite well with these early contractions as you are used to coping with some amount of pain as part of your day to day living with FM. In fact you may not recognise labour pains for what they are to begin with, especially if you feel them in your back but are used to FM associated back pain. Try to move around, have a warm bath, gentle massage may be a comfort to some women as well as placing a full, covered hot

water bottle against the spot where the contractions hurt the worst. When you think you are in labour, sit down and time your contractions from the start of one contraction to another for several contractions. If you find they are evenly spaced, and are coming closer and closer together, and do **not** go away if you change position or walk around, then you are probably going into established (real) labour.

Very Early Labour (sometimes called 'false' labour)

- No "bloody show."
- Contractions irregular and not progressively closer together.
- Walking, changing activity or positions may relieve or stop the contractions.
- No change in cervix.
- No dilation

Established ('real') Labour

- A "bloody show" may be the first sign. It is usually associated with cramp-like pains.
- Contractions get stronger, occur more frequently and last longer.
- Walking, changing activity or position doesn't affect intensity or frequency of contractions.
- Cervix dilates.
- Frequency - Time from the start of one contraction to the beginning of another.
- Duration - Time from the start of one contraction to the end of the same contraction.

Pain Relief

Okay now this is a tricky section to write. The thing is, we are all so different and therefore so are our reactions to the pain of labour and how we perceive and cope with it. Some need minimal or no pain relief at all and some want everything going. Both options are absolutely fine, midwives will be guided by your needs and tell you what all your options are at the time as these will vary according to what stage of labour you are in and what medications you are currently using. In my experience, women with FM seem to tolerate pain for longer than women without FM. This is probably due to having built up a certain amount of tolerance to pain through living with FM.

Breathing

Okay, okay, I know we all have to breathe! I am talking about structured, controlled breathing in this instance. Let me explain… As your contraction begins to build you can: Inhale slowly and deeply through your nose. Concentrate on how your breath feels as it passes over your throat area. Then gently plug your ears with the respective index fingers and close your eyes. Exhale slowly producing a long and continuous humming sound, repeat as often as required. This serves to distract you from the pain but also has the added benefit of getting a good flow of oxygen to your hard working muscles. Also I have seen women try

the following various techniques: Visualisation (you are ambling along a sandy beach, in a meadow etc.), affirmation (your body is strong, is working well for you, knows what it is doing etc.), conscious relaxation of tense muscles, non-focussed awareness (notice what you see, hear, feel, smell and then forget about it, move onto the next sensation), vocalising (moaning, making single sounds like ‘oh, oh’, groaning), singing or prayer.

Mobility

Moving around during labour is often a great help to women. For those of us with FM, changing position and the ability to wander around to some extent during labour is almost vital if you want to avoid the pain associated with stiff muscles from staying in one position too long. Moving around; even if only to change your position from sitting, to standing to kneeling on all fours, can help to ease your baby deeper into your pelvic outlet, the start of your birth canal. Walking up and down stairs or stepping on and off a step in a sideways movement is thought to also help shift your baby deeper into your pelvic outlet. Some women find that kneeling on all fours or sitting on a birthing stool can help them push more effectively. A bean bag or large ball such as one used for abdominal exercising can be very comfortable to sit on while in labour and will encourage you to sit in a good position too.

TENS

This is a hand held, battery powered device that sends electrical impulses through your lower back through 4 electrodes. You control the intensity of the stimulus and are able to boost it during a contraction. The theory behind this is that it blocks some of the pain signals from passing through the ‘pain gate’ thus restricting the amount of pain your brain has to process. In my opinion you will either love or hate this method, if it works for you it will work well and vice versa. The majority of women I cared for with FM found this very helpful in helping them to feel in control of their labour pain. Unlike most of the other pain relief methods, this cannot be used in conjunction with hydrotherapy and you will need to rent one before going into labour as most hospital do not have a large enough supply.

Hydrotherapy

Anyone with FM will have been advised to try warm/hot water for pain relief, so you will have the distinct advantage of knowing whether this works for you already. The labour/birthing pools used in maternity care are much deeper than a normal household bath, about the depth of a Jacuzzi tub. I would advise women with FM to consider this as one of their methods of pain relief. It is completely reversible, if you do not like it you can get out and try something else, you can use alternative pain relief methods in conjunction with this such as gas and air, breathing and massage. The added buoyancy of the water makes it much easier for you to change positions as well.

Hypnosis

Hypnosis is just a fancy term for being really relaxed, and for really focussing in on just one thing, while everything else fades into the background. Hypnosis for birth is proving increasingly popular, and research shows that it really makes a difference to birth outcome and maternal satisfaction. Hypnosis is all about the mind's ability to affect the body's reactions and self-hypnosis is a state of deep relaxation, where the mum remains fully alert and fully in control throughout. To find out more about HypnoBirthing classes near you, go to www.hypnobirthing.co.uk. For more information and birth stories, go to the US website at www.hypnobirthing.com.

Massage

Massage is a good technique to use during labour. It can be especially beneficial for women with FM who are unable to change positions easily, say for example if they have opted to have an epidural. In these cases massage may help prevent muscles stiffening up and the discomfort associated with this. It is advisable for you and your partner to experiment with massage during your pregnancy to find what pressure you can tolerate and which parts of your body you prefer to have massaged. Some women with FM find even gentle massage too uncomfortable and labour is not the right time to discover this. If like me, you are one of those people who find massage too uncomfortable, don't despair.

Here are some similar techniques which may work in much the same way as massage for you: Hot compresses such as a flannel or hot water bottle placed on your back or wherever else you hurt or ice packs used in the same way, a warm blanket over your entire body or a lengthy warm shower, take the shower head off the wall and direct the spray to precisely the area you need it most. One other technique you may wish to consider is acupressure however I am not able to advise you on this and suggest that you seek out the advice of a qualified practitioner during your pregnancy www.gotosee.co.uk/therapies/Acupressure.htm for list of practitioners under timings/costs/sessions.

As I mentioned above, the amount of pain people can tolerate varies widely. In my experience, women with FM seem to tolerate pain for longer than women without FM. This is probably due to having built up a certain amount of tolerance to pain through living with FM. Next I am going to discuss the methods of pain relief that use drugs to help with the pain of labour and birth.

Entonox (Gas and Air)

This used to be known as 'laughing gas'. It is a combination of oxygen and nitrous oxide and you inhale it through a mouth piece or face mask. It doesn't really relieve the pain you feel but it does change how you perceive the pain. It also gives you something to focus on as you need to breathe it in a certain way and begin to use it at a certain point during your contraction. Your midwife will show you how to use it if you

chose to use this method. It can make you feel quite giddy (and a few women feel queasy) but the effects wear off quickly when you stop inhaling it. It is completely reversible and you can use it in conjunction with hydrotherapy, TENS or Pethidine and in several different positions. It does not seem to affect women with FM any differently than others.

Pethidine

This drug has similar properties as morphine but is safer to use during labour. It is given by injection in your thigh or bottom. It often affects the vomit centres in your brain and so is usually given with an anti-sickness drug. It should take effect within about 20 minutes after being injected and while it won't take your pain away, it does help you feel differently about it and the effects will last a couple of hours. On the minus side, it is not available for home births and it does not work for everyone.

Some women really do not like the effects or say it feels like it put the pain 'on top of them' but once it is in your body it cannot be taken out again so it is best to ask for a smaller dose when trying it for the first time. It can affect your baby if given too close to the time of birth, making your baby slow to take its first breaths so your midwife will want to perform an internal examination to see how dilated you are before administering the pethidine to you. Be reassured that this can be reversed in your baby by giving it an injection after birth if necessary.

Epidural

This is an injection of local anaesthetic into your lower back. It is the only thing that can 'take away' your pain in labour. All the other types discussed are pain 'relievers'. The anaesthetist punctures a hole in your back with a needle, threads a thin plastic tube in and the needle is removed leaving a long plastic tube in for the duration of your labour. This is taped securely to your back. It will take about 10-20 minutes to work after administered. This can only be done by a qualified anaesthetist and so this is not available at home births. Epidurals can have some side effects immediately or soon after starting such as low blood pressure, nausea, dizziness or itching skin.

An epidural will make you feel very numb in your legs and you will not be able to be as mobile as you may wish. It is important to ask for help to regularly change position in order to prevent you stiffening up otherwise you may be almost immobile the next day from a FM reaction to lying in one position too long. A few hospitals offer mobile epidurals where you are able to move around with greater ease and in some cases even walk around. You may find it difficult to pass urine, if this is the case then a midwife can insert a catheter to release the urine from your bladder. Very occasionally epidurals will have windows where the pain still breaks through so that you will feel a contraction in a small area. Epidurals can increase your

chances of needing assistance to birth your baby, usually in the form of a ventouse or forceps delivery as you are not able to push as effectively.

Epidurals can very occasionally cause bad or severe headaches the following 24-48 hours after birth which may be an important deciding factor for those of you who suffer with FM related headaches. Some people complain of back pain for varying lengths of time after having had an epidural.

Different ways you may give birth

Every birth is unique! There are a multitude of factors that may influence each form of delivery. Vaginal birth is the most common and so will be the topic for this month. To begin with here is a reminder of the differences between early labour (little or no dilating of the cervix occurs during this phase) and established labour (the time when you should come into hospital if all else is well with you and the pregnancy).

Early Labour

- No “bloody show.”
- Contractions irregular and not progressively closer together.
- Walking, changing activity or positions may relieve or stop the contractions.
- No change in cervix.
- No dilation

Established Labour

- A “bloody show” may be the first sign. It is usually associated with cramp-like pains.
- Contractions get stronger, occur more frequently and last longer.
- Walking, changing activity or position doesn’t affect intensity or frequency of contractions.
- Cervix dilates.
- Contractions should be regular and happen at least every ten minutes or more
- Duration of contractions is 30 seconds or more

Induction of labour

Commonly, induction of labour may be recommended if you go more than 10 - 12 days overdue. The best way for you to be induced is to have your waters broken followed by an oxytocin drip (drug to stimulate contractions) if required. Women with FM may find that the rapid onset of labour is painful as natural labours usually begin more slowly allowing you to build your endorphin levels. Ways you can lessen your pain is by walking around the labour room and /or changing your position frequently. Your partner can help by following you with your drip stand. If you go overdue you will also be offered a membrane sweep a week or so before your induction to try and get you to go into labour naturally.

This involves having an internal examination, with one finger being used to sweep the membranes around the neck of your womb (cervix). Although this only takes a few minutes to do, it feels like a cervical smear

but with more pressure and women with FM may find this very uncomfortable. You may need to take additional pain relief before your appointment and use a hot water after to ease any cramps you may have. Additionally, even though it will likely be the last thing on your mind, you should try the natural induction method at home before any of these procedures. This involves sexual intercourse in either the spoon or kneeling position and works quite well.

Monitoring in labour

If your labour has been induced by medical methods it will be suggested that your baby be monitored continuously as changes in the heart rate pattern may be the first sign of a problem. The belt that holds the monitor against your belly can be extremely uncomfortable for women with FM and you may need to ask the midwife for 20 minute breaks from the monitor. If your baby is coping well, the midwife can listen in with a hand held monitor. If you are induced or need oxytocin during your labour the midwife will want to perform vaginal examinations every 2 hours to make sure the induction or acceleration of the labour is working.

Vaginal birth

The first stage of labour starts with the beginning of your regular contractions and is completed when your cervix reaches 10 centimetres dilatation. The first stage of labour can take quite a long time, especially with a first baby. It isn't at all uncommon for the first stage of labour to last 12 or more hours. Your contractions will begin gradually and build up to up 4 every 10 minutes towards the end of the first stage of labour. Fighting against the contractions can lead to additional strain for muscles already compromised by FM. If your labour has begun naturally, without medical induction then a birthing pool may be ideal for help in relaxing into your contractions.

It takes active concentration to relax muscles but you may already have experience of doing this when suffering a flare up, in which case you are miles ahead of women in labour who do not have FM. I have found that women with FM, on the whole, have much higher pain thresholds than women without and cope much better with labour, needing much less pain relief than they expected.

The second stage of labour starts when your cervix is fully dilated and is completed with the birth of your baby. The second stage of labour is much shorter than the first stage, usually between 1 -3 hours. By now your cervix has dilated enough for your baby's head to pass through and when the head has moved low enough you will begin feeling urges to push. This stage may make you feel quite shaky as your muscles will be tired from the first stage but you will be surprised at the surge of energy you get with these contractions. You are much stronger than you realise. It may feel like your bowels are moving, but don't worry about this... it is just the pressure of the baby's head on your back passage.

Each time you have a contraction, the baby moves farther and farther down.. As you bear down, or push, your baby's head begins to appear. Between contractions it will recede a little but will move further down

with each push and finally, your baby is born! You will be encouraged to gather up your baby into your arms and if you do not feel able to do this, the midwife or your partner will pass you your child. A new LIFE! A new person in the world! Congratulations, it was probably scary, it probably hurt a lot at some points but the reward in your arms was worth every second. You'll feel exhausted and excited; all your great expectations are here, finally. Congratulations to you both, you have already done a most important parenting task, you are already fantastic parents and the most special people in the universe to your child…keep up the good work.

The third stage of labour begins after the birth of your baby and is completed with the delivery of the placenta. The third stage of labour is the passing of the afterbirth, or placenta. If all went well with your delivery and your blood loss is within normal limits, you can ask your midwife for a natural 3rd stage. Another option is to have an injection to make your womb clamp down and this shears your placenta off so that your midwife can gently pull it out. Then it's time for a warm bath, food, and bonding with your new baby. Some hospitals will allow you to pay for a private room so that your partner can stay with you both. If this is not an option for you, make sure you explain what help you will need and ask for it when you need it! The staff may not have a thorough understanding of the help you require because of FM and will treat you like the other women on the ward unless you ask for assistance.

Assisted deliveries

There are two types of instrumentally assisted vaginal birth techniques; the vacuum extraction method and the use of forceps. These are usually performed by obstetricians although in a few hospitals in England there are some midwives who have been trained to perform these procedures.

Vacuum extraction is used to assist the birthing of your baby by applying suction to your baby's head. This technique may be suggested if you have done most of the work of birthing your baby on your own but have run out of energy just before the end. The vacuum cup will be applied to your baby's head, the suction started and as you push the doctor will gently angle and pull on your baby's head at the same time. It should not cause any trauma to you as the cup and hose are soft but your baby's head may have a blister for several days after wards.

The paediatrician can prescribe some painkillers for your baby if necessary. If you need help birthing your baby vaginally, have done most of the work yourself and your baby is not distressed, then this is the best method for women with FM. It should cause no extra physical trauma to you and will speed the end of a long labour that has exhausted you. Then you can regain your strength as you gaze adoringly at your baby, or while you sleep while your birth partner spends some time gazing adoringly at your baby.

Forceps are used if the baby or yourself are physically distressed or threatened by your labour continuing and if the baby is at an appropriate depth in your birth canal for this method to be effective. For this procedure you will need an episiotomy (a cut to your labia) to widen the working area where the doctor will need to insert the forceps and clamp them around either side of your baby's head. There may be some damage to your vagina or rectum and you will need stitches to help close the area where you were cut. The operating theatre team will be on standby before the doctor begins a forceps delivery in case the baby's head does not come down and deliver. If this is the case then you will need a caesarean section.

Caesarean section is the third type of assisted birth and involves delivery of your baby through a cut in your abdomen. It is used when a vaginal delivery is not possible or there is an urgent danger to you or your baby during labour. Some women mistakenly believe that this is the most sensible way to birth a baby is by pre planned caesarean section as no labour will be involved. This is not correct as labour is a natural state for a woman's body to be in at the end of pregnancy and you will heal much faster from a natural birth than from a surgical birth.

If a caesarean is required then you will need to have an epidural inserted or, for emergency procedures, you will need a general anaesthetic. Caesareans are somewhat more risky because they involve major surgery and some type of anaesthesia and infections, bleeding and wound complications occur more frequently with caesarean births. However, if you have had a caesarean because you or your baby's health was at risk then the value of this operation far outweighs the risks.

Vaginal Birth after Caesarean (VBAC). Until very recently, most thought that once a woman had a caesarean birth, any future babies should be delivered by a repeat caesarean. Today, an effort is being made to allow certain women to deliver vaginally after a previous caesarean birth. This option is not appropriate for everyone, but you can and should consider discussing this with your obstetrician. When compared to another caesarean birth, VBAC is associated with a shorter hospital stay, easier and faster recovery and an earlier resumption of your normal state of health.

When do I need to choose?

It is sensible to have an idea of what you want to do early in the pregnancy and I would recommend that you discuss your options with the consultant and midwife at your 20 week visit. A number of things can happen during your pregnancy that may alter your final plans so I suggest that you finalise your delivery choice at about 36 weeks.

Please remember that natural vaginal births are the normal way to have your children and the least physically stressful even with FM.

The Postnatal Map

Welcome to the final chapter in this booklet: the must have map to guide you through the postnatal period with your sense of humour intact!

Whether this is your first baby or your sixth, the thrill of seeing your own infant for the first time is still there - tiny feet, tiny hands, a wonderful fresh chance to bring about positive change in this world. All those months of expectation have come to life in one tiny child, your own miracle.

Plan ahead

Most people with FM are skilled in the art of planning and this skill will come in handy when you have a new baby, especially during the first two or three months after you bring your baby home. You know that you're going to be tired, so if possible, plan to have some help during those first two months. But remember to make one point clear before friends or relatives arrive: **you are taking care of the baby; they are taking care of the other essential chores that need doing - not the other way around!** If no one is close by to help, ask your midwife about home visiting programs and local postnatal support agencies, such as doulas and maternity nurses. If they can't help then email me and I will try to get the number of the agency that offers a service in your area.

Plan to have your baby's clothes, nappies and bedding ready. Think of friends who have had babies in the last five years. Chances are they still have plenty of wearable and useable items that their children have outgrown. Babies have no concept of 'fashion trends' so why waste money on new clothes for them when there are plenty of good quality second hand items available? Use the money you save to buy yourself some home help instead!

Getting to know your baby

During your pregnancy you may have formed expectations about the sex and appearance of your baby. It may be difficult to adjust these expectations with reality. It may take a while for you and your family to get to know your new baby. Every baby is unique and every parent's relationship with their baby is also unique. The first few days and weeks of your baby's life can be a marvellous adventure as your baby grows. However, when you are in pain and already sleep deprived, it can be a struggle to form an immediate deep bond with a demanding infant when you are also trying to cope with the demands of living with FM. I know of people (mothers and fathers) who took up to two years to feel that they had 'bonded' with their child. If you are having difficulty developing a loving relationship with your baby, let your midwife, GP or health visitor know as they can offer support in these situations.

Your own changes don't stop with the birth

Now that your months of great expectations have taken the form of a baby, you can expect more physical and mental changes in yourself during the weeks following the birth. You'll be sore from the delivery,

probably weak from over exertion of your muscles and quite tired. Don't let these feelings frighten you, they are not a FM flare up and will resolve over the next few weeks.

Exercise and combating exhaustion

As discussed above, take all help that is offered. Your most important job is to care for your baby and yourself. The vacuum cleaner won't mind if someone else uses it! Try to avoid overexerting yourself in the first few weeks. If necessary temporarily move as much as possible onto the ground floor of your house so that everything you need for your baby is close to hand and let someone else get the shopping and do other chores for you. Eventually you will feel your strength returning, especially if you challenge yourself to do a bit more each day to build your strength. Muscles that do not get used do become weaker but do allow yourself a few weeks to take it easy first. I think it is important to warn you that your stomach isn't instantly going to be flat. Don't expect to leave the hospital and be back to your pre-pregnant size. It took nine months to get to that size so allow it the same amount of time to return to normal but remember that normal will be slightly different than pre-pregnancy!

Pain relief and medications

Make sure your GP reviews your pain medication so that you are taking the best one for this period of your life. Don't forget the healing power of gentle massage and the soothing properties of warm water. Take your baby into the bath with you, there is nothing stopping you from combining your baby's mealtime with a chance for you to have a lovely long soak in warm (not hot) water. Make sure there is someone else there to make sure you don't fall asleep and to take the baby from you when you are ready to get out.

Breastfeeding

This may seem like hard work at first but give it a couple of weeks and you will begin to realize the advantages of this method. When you are breastfeeding you can do nothing but rest yourself. There is no messing about with preparing feeds in bottles, saving you time and effort, and with the release of breast milk comes some 'feel good' hormones to sooth your nerves which have been jangled by your baby's cries. To help you all bond as a family, try feeding your baby in bed, cradled between the two of you. Your partner can watch to make sure you don't fall asleep and help you by putting the baby in the cradle after you have finished feeding and by doing the nappy change if necessary. Contrary to popular rumour, partners do like to help with the new baby!

Your hormone levels

These will begin to return to normal and, in the process, your moods may swing much the same as in the beginning of pregnancy. You may experience some mild depression commonly referred to as 'baby blues'.

These feelings shouldn't last very long. Postpartum depression is a serious condition that is different from 'baby blues'. If you are currently on anti-depressants as part of your FM therapy, they may not be the right ones for you to take at this time. Speak to your GP if you begin to feel 'flat', as it may be that a simple readjustment of your medication will resolve this for you.

Resuming lovemaking

Your normal periods may not start again for several months if you are breastfeeding, but you can get pregnant again as early as 21 days after birth so make sure you use contraception. I know you are thinking that there is no way you could possibly want to make love so soon after giving birth, and with a demanding baby to care for, but hormones are funny things.