Chapter 1

From Here to Maternity

In This Chapter

- Checking out your health and family history
- Preparing your body for pregnancy
- Understanding the effects of medications and vaccines
- Making it happen: Conception made easy

Congratulations! If you're already pregnant, you're about to embark upon one of the most exciting adventures of your life. If you're thinking about getting pregnant, you're probably excited at the prospect and also a little nervous at the same time.

In this chapter, we go over what you need to know before you conceive. (We also provide some information on medications and vaccines that those who are already pregnant may be interested in, too.) The first step is to visit your practitioner and go over your family and personal health history. That way, you can discover whether you're in optimal shape to get pregnant, or whether you need to take some time to gain or lose weight, improve your diet, quit smoking, or discontinue medications that could be harmful to your pregnancy. We also give you some basic advice about the easiest way to conceive, and we touch on the topic of infertility.

Getting Ready to Get Pregnant: The Preconceptional Visit

By the time you miss your period and discover you're pregnant, the embryo, now two weeks old or more, is already undergoing dramatic changes. Believe it or not, when the embryo is only two to three weeks old, it has already developed the beginnings of its heart and brain. Because your general health and nutrition can influence the growth of those organs, having your body ready for pregnancy before you conceive really pays off. Schedule what's called a *preconceptional visit* with your practitioner to be sure your body is tuned up and ready to go.

Sometimes you can schedule this visit during a routine gynecological appointment: When you go in for your annual PAP test, mention that you're thinking about having a baby, and your practitioner will take you through the preliminaries. If you aren't due for your annual exam for several more months and you're ready to begin trying to get pregnant now, go ahead and schedule a preconceptional visit with your practitioner, and bring along the father-to-be, if at all possible, so both of you can provide health histories — and know what to expect from this adventure.

If you're already pregnant and didn't have a preconceptional visit, don't worry. Your practitioner will go over these topics at your first prenatal visit, which we discuss in Chapter 5.

Taking a look at your history

The preconceptional visit is a chance for your practitioner to identify areas of concern so she can keep you and your baby healthy — even before you get pregnant. A multitude of factors come into play, and the practitioner is likely to ask you about the following:

- **Previous pregnancies and gynecologic history:** Information about previous pregnancies can help your practitioner decide how best to manage your future pregnancies. You'll be asked to describe any prior pregnancies, any miscarriages or premature births, any multiple births — in short, any situations that can happen again. Knowing whether you had problems in the past, like preterm labor or high blood pressure, is helpful for the practitioner. Your gynecologic history is equally important because information like prior surgery on your uterus or cervix or a history of irregular periods also may influence your pregnancy.
- **Your family history:** Reviewing your family's medical history alerts your practitioner to conditions that may complicate your pregnancy or be passed on to the developing baby. You want to discuss your family history because you can take steps before you conceive to decrease the chance that certain disorders, such as having a family history of neural tube defects (spina bifida, for example), will affect *your* pregnancy (see the sidebar "Why the sudden hype on folic acid?" later in this chapter). In Chapter 8, we discuss in more detail different genetic conditions and ways of testing for them.

  For those of you considering the use of donor eggs or sperm, keep in mind that the donor's genetic history is just as important as any other biological parent's. Find out as much as you can.

- **Looking at your ethnic roots:** Your preconceptional visit involves questions about your parents' and grandparents' ancestry — not because your practitioner is nosy, but because some inheritable problems are concentrated in certain populations. Again, the advantage of finding out about these problems before you get pregnant is that if you and your partner are at risk for one of these problems, you have more time to become informed and to check out all your options (see Chapter 5).

Evaluating your current health

Most women contemplating pregnancy are perfectly healthy and don't have problems that can have an impact on pregnancy. Still, a preconceptional visit is very useful because it allows you to make a game plan and find out more about how to optimize your chances of having a healthy and uncomplicated pregnancy. You can discover how to reach your ideal body weight and how to start on a good exercise program, and you can begin to take prenatal vitamins with folic acid.

Some women, however, do have medical disorders that can affect the pregnancy. Expect your practitioner to ask whether you have any one of a list of conditions. For example, if you have diabetes, optimizing your blood sugar levels before you get pregnant and watching those levels during your pregnancy are important. If you're prone to high blood pressure *(hypertension),* your doctor will want to control it before you get pregnant, because controlling hypertension can be time-consuming and can involve changing medications more than once. If you have other problems — epilepsy, for example — checking your medications and controlling your condition are important. For a condition like *systemic lupus erythematosus* (SLE), your practitioner may encourage you to try to become pregnant at a time when you're having very few symptoms.

You can expect questions about whether you smoke, indulge in more than a drink or two a day, or use any recreational/illicit drugs. Your practitioner isn't interrogating you and is unlikely to chastise you, so you can feel comfortable answering honestly. These habits can be harmful to a pregnancy, and dropping them before you get pregnant is best. Your practitioner can advise you on ways to do so or refer you to help or support groups.

You also need to discuss any prescription or over-the-counter drugs you take regularly and your diet and exercise routines. Do you take vitamins? Do you diet frequently? Are you a vegetarian? Do you work out regularly? Discuss all these issues with your practitioner.

Why the sudden hype on folic acid?

Folic acid was something your mother never thought about when she was expecting you. But within the past decade, folic acid has become a nutritional requirement for all pregnant women. The change came in 1991, when a British medical study demonstrated that folic acid (also known as *folate,* a nutrient in the B vitamin family) reduced the recurrence of birth defects of the brain and spinal cord (also called *neural tube defects*). This reduction — by as much as 80 percent — occurred in cases where a mother's previous child was affected. Subsequent studies have shown that even among women who have never had children with brain or spinal cord defects, those who consume enough folic acid can lower their baby's risk of *spina bifida* (a spinal defect) and *anencephaly* (a brain and skull defect) by 50 to 70 percent.

Today, all women who are considering pregnancy are advised to consume 0.4 milligrams of folate every day, starting at least 30 days before conception. You start early so that plenty of the nutrient is in your system at the time the neural tube is forming. If spina bifida, anencephaly, or similar conditions run in your family — especially if you've ever carried a child with these problems — you should get ten times the usual amount (4 whole milligrams) every day.

Since 1996, the U.S. Food and Drug Administration has required that all enriched grains — flour, cornmeal, pasta, and rice — be fortified with folic acid. Other good sources include green leafy vegetables, beans, and liver. But to make sure you get the full measure, take a supplement. Any good prenatal vitamin gives you at least 0.4 milligrams.

If you haven't had a recent physical exam or PAP smear, your practitioner will probably recommend that you have it done during this preconceptional visit.

Answering Commonly Asked Questions

Your preconceptional visit is a time for you to ask your practitioner questions. In this section, we answer the most common questions — about body weight, medications, vaccinations, and quitting birth control.

Getting to your ideal body weight

The last thing most women need is another reason to be concerned about weight control. But this point is important: Pregnancy goes most smoothly for women who aren't too heavy or too thin. Overweight women stand a higher-than-normal risk of developing diabetes or high blood pressure during pregnancy, and they're more likely to end up delivering their babies via cesarean section. Underweight women risk having too-small (low birthweight) babies.

Try to reach a healthy, normal weight *before* you get pregnant. Trying to lose weight after you conceive isn't advisable, even if you're overweight. And if you're underweight to begin with, catching up on pounds when the baby is growing may be difficult. (Read more about your ideal weight and weight gain in Chapter 4.)

Reviewing your medications

Many medicines — both over-the-counter and prescription — are safe to take during pregnancy. If you're taking medications essential for your health, discuss them with your physician prior to stopping them or changing your dose or regimen. But a few medications can cause problems for the baby's development. So let your doctor know about *all* the medications you take. If one of them is problematic, you can probably switch to something safer. Keep in mind that adjusting dosages and checking for side effects may take time.

Exposure to the following drugs and chemicals is considered to be safe during pregnancy:

- Acetaminophen
- Acyclovir
- Antiemetics (for example, phenothiazines and trimethobenzamide)
- Antihistamines (for example, doxylamine)
- Low-dose aspirin
- Minor tranquilizers and some antidepressants (for example, meprobamate, chlordiazepoxide, and fluoxetine)
- Penicillin, cephalexin, trimethoprim-sulfamethoxazole, erythromycin, and several other antibiotics
- Zidovudine

The following are some of the common medications that women ask about before they get pregnant:

- **Birth control pills:** Women sometimes get pregnant while they're on the Pill (because they missed or were late taking a couple of pills during the month) and then worry that their babies will have birth defects. But oral contraceptives haven't been shown to have any ill effects on a baby. Two to three percent of *all* babies are born with birth defects, and babies born to women on oral contraceptives are at no higher risk.

- **Ibuprofen (Motrin, Advil):** Occasional use of these and other *nonsteroidal anti-inflammatory agents* during pregnancy (for pain or inflammation) is okay and hasn't been associated with problems in infants. However, avoid chronic or persistent use of these medications during pregnancy (especially during the last trimester) because they have the potential to affect platelet function and blood vessels in the baby's circulatory system, and because your baby's kidneys process them just like your own kidneys do.
- **Vitamin A:** This vitamin and some of its derivatives can cause miscarriage or serious birth defects if too much is present in your bloodstream when you get pregnant. The situation is complicated by the fact that vitamin A can remain in your body for several months after you consume it. Discontinuing any drugs that contain vitamin A derivatives — the most common is the anti-acne drug Accutane — at least one month before trying to conceive is important. Scientists don't know whether topical creams containing vitamin A derivatives — anti-aging creams like Retin A and Renova, for example — are as problematic as drugs that you swallow, so consult your physician about them.

  Some women take supplements of vitamin A because they're vegetarians and don't get enough from their diet, or because they suffer from vitamin A deficiency. The maximum safe dose during pregnancy is 5,000 international units (IU) daily. (You need to take twice that amount to reach the danger zone.) Multiple vitamins, including prenatal vitamins, typically contain 5,000 IU of vitamin A or less. Check the label on your vitamin bottle to be sure.

  If you're worried that your prenatal vitamin plus your diet will put you into that "danger zone" of 10,000 IU per day, rest assured that it would be extremely difficult to get that much vitamin A in your diet.
- **Blood thinners:** Women who are prone to developing blood clots or who have artificial heart valves need to take blood-thinning agents every day. One type of blood thinner, *coumadin,* or its derivatives can trigger miscarriage, impair the baby's growth, or cause the baby to develop bleeding problems or structural abnormalities if taken during pregnancy. Women who take this medicine and are thinking of getting pregnant should switch to a different blood thinner. Ask your practitioner for more information.
- **Drugs for high blood pressure:** Many of these medications are considered safe to take during pregnancy. However, because a few can be problematic, you should discuss any medications to treat high blood pressure with your doctor (see Chapter 17).
- **Antiseizure drugs:** Some of the medicines used to prevent epileptic seizures are safer than others for use during pregnancy. If you're taking any of these drugs, discuss them with your doctor. Don't simply stop taking any antiseizure medicine, because seizures may be worse for you — and the baby — than the medications themselves (see Chapter 17).

- **Tetracycline:** If you take this antibiotic during the last several months of pregnancy, it may, much later on, cause your baby's teeth to be yellow.
- **Antidepressants:** Many antidepressants (like Prozac) have been studied extensively and are considered safe during pregnancy. Recent studies on selective serotonin uptake inhibitors (SSRIs) showed a small increase in certain birth defects, particularly with paroxetine, while other studies showed no increased risk. Most doctors believe that the absolute risk is very small. Although most data doesn't show an increase in prematurity or low birth weight, some data suggests a possible small increased chance of miscarriage in the first trimester. Some reports also show a very small risk (0.6 to 1.2 percent) of a newborn condition called persistent pulmonary hypertension with exposure in the latter half of pregnancy. If you're taking an antidepressant and planning to conceive, ask your doctor whether you'll be able to keep taking the medication while you're pregnant.
- **Bupropion:** Bupropion is an antidepressant, but also a medicine used for smoking cessation (for example, Wellbutrin or Zyban). Very little info exists on use during pregnancy, but the available data doesn't suggest any significant problems with fetal development. Although you shouldn't use it as a first line for depression, its use for smoking cessation may be beneficial.

Considering nutritional supplements

Many women choose to treat common ailments with over-the-counter plant extracts or other natural medications. Some are considered completely safe during pregnancy, but keep in mind that, because they are considered nutritional supplements, these agents are not regulated by the FDA. Despite the fact that many pregnant women use these supplements, very few studies have evaluated their safety or shown that they actually give a benefit during pregnancy. Many of these pills are also unregulated for dose, so one pill may contain twice as much as the next. Some of these supplements are combinations of different herbs or extracts and the interactions are unknown and unstudied. St John's wort, for instance, is an herb commonly used to treat depression, sleep disorders, and viral infections. Not only can this herb interact with other medications, but also, its safety/benefit during pregnancy has not been studied, so use it with caution.

Some herbal medications should not be used during pregnancy because they can cause uterine contractions or even miscarriage. A short list of agents that are not recommended during pregnancy includes mugwort, blue cohosh, tansy, black cohosh, Scotch broom, goldenseal, juniper berry, pennyroyal oil, rue, mistletoe, and chaste berry.

Recognizing the importance of vaccinations and immunity

People are immune to all kinds of infections, for one of two reasons:

- **They've suffered through the disease.** Most people are immune to chickenpox, for example, because they had it when they were kids, causing their immune systems to make antibodies to the chickenpox virus.
- **They've been vaccinated.** That is, they've been given a shot of something that causes the body to develop antibodies.

Rubella is a common example. Your practitioner checks to see whether you're immune to *rubella* (also known as *German measles*) by drawing a sample of blood and checking to see whether it contains antibodies to the rubella virus. (*Antibodies* are immune system agents that protect you against infections.) If you are not immune to rubella, your practitioner is likely to recommend that you be vaccinated against rubella at least three months *before* becoming pregnant. Getting pregnant before the three months are over is highly unlikely to be a problem. No cases have been reported of babies born with problems due to the mother having received the rubella vaccine in early pregnancy. Many vaccines, including the flu vaccine, are safe, and in fact recommended, while you're pregnant. See Table 1-1 for information on several vaccines.

Most people are immune to measles, mumps, poliomyelitis, and diphtheria, and your practitioner is unlikely to check your immunity to all these illnesses. Besides, these illnesses aren't usually associated with significant adverse effects for the baby. Chickenpox, on the other hand, does carry a small risk that the baby can contract the infection from her mother. If you've never had chickenpox, tell your practitioner, so you can discuss possible vaccination before you get pregnant.

Finally, if you're at risk of HIV infection, get tested before contemplating pregnancy. Some states now require that doctors discuss and offer HIV testing to *all* pregnant women. If you have contracted HIV, taking certain medications throughout pregnancy will decrease the chances that your baby also will contract HIV.

A vaccine has recently been made available for the human papilloma virus (HPV), the virus associated with some kinds of abnormal pap smears, genital warts, and cervical cancer. Studies suggest that it's similar to other vaccinations that are safe in pregnancy; just to be extra careful, wait at least 30 days after the shot before attempting pregnancy.

Table 1-1 Safe and Unsafe Vaccines before or during Pregnancy

Disease	*Risk of Vaccine to Baby during Pregnancy?*	*Immunization Recommendations*	*Comments*
Cholera	None confirmed	Same as in non-pregnant women	
Hepatitis A (inactivated)	None confirmed	Okay if high risk for infection or for prevention due to recent exposure	
Hepatitis B	None confirmed	Okay if high risk for infection	Used with immunoglobulins for acute exposure; newborns need vaccine
Human Papilloma Virus	None confirmed, but little data	If found to be pregnant after initiating series, give remainder postpartum	
Influenza (inactivated)	None confirmed	Recommended	
Measles	None confirmed	No	Vaccinate postpartum
Mumps	None confirmed	No	Vaccinate postpartum
Plague	None confirmed	Selected vaccination if exposed	
Pneumococcus	None confirmed	Okay, if high risk	
Poliomyelitis	None confirmed	Only if exposed	Get if traveling to endemic area
Rubella	None confirmed	No	Vaccinate postpartum
Rabies	Unknown	Indication same as for nonpregnant woman	Consider each case separately
Smallpox	Possible miscarriage	No, unless emergency situation arises or fetal infection	

(continued)

Table 1-1 ***(continued)***

Disease	*Risk of Vaccine to Baby during Pregnancy?*	*Immunization Recommendations*	*Comments*
Tetanus and diptheria	None confirmed	Recommended if no primary tetanus/diphtheria series given or no booster in past 10 years, or if high-risk exposure like a cut from a sharp non-sterile object	
Typhoid	None confirmed	Only for close, continued exposure or travel to endemic area	
Varicella (chickenpox)	None confirmed	Immunoglobulins recommended in exposed nonimmune women; should be given to newborn if around time of delivery	Vaccine recently available but little information concerning pregnancy; vaccinate postpartum (second dose 4 to 8 weeks later)
Yellow fever	Unknown	No, unless exposure is unavoidable	

Quitting birth control

How soon can you get pregnant after you stop using birth control? It depends on what kind of birth control you use. The barrier methods — such as condoms, diaphragms, and spermicides — work only as long as you use them; as soon as you stop, you're fertile. Hormone-based medicines — including the Pill, Depo-Provera, NuvaRing, and the birth control patch (for example, Ortho-Evra) — take longer to get out of your system. You may ovulate very shortly after stopping the Pill (weeks or days, even). Usually, hormones from pills aren't detectable several days after the last active Pill or the last patch. On the other hand, it can take three months to one year to resume regular ovulatory cycles after stopping Depo-Provera.

We know of no hard-and-fast rules about how long you should wait after stopping birth control before you start trying to conceive. In fact, you can start to try to conceive right away. If you're Fertile Myrtle, you may get pregnant on the first try. But keep in mind that if you haven't resumed regular cycles, you may not be ovulating each month, and it may be more difficult to time your intercourse to achieve conception. (At least you can have a good time trying!) If you get pregnant while your cycles are irregular, it also may be harder to tell exactly what day you conceived and, therefore, to know your due date.

If you use a non-hormone intrauterine device (IUD), you can get pregnant as soon as you have it removed. With hormone containing intrauterine devices or with sub-dermal implantable devices, fertility may take 3 to 12 months to resume after removal. Rarely, a woman conceives with her IUD in place. If this happens to you, your practitioner may choose to remove the device, if possible, because getting pregnant with your IUD in place puts you at risk of miscarriage, *ectopic pregnancy* (a pregnancy that gets stuck in the fallopian tube), or early delivery. Getting pregnant with an IUD in place more than likely doesn't put the baby at increased risk of birth defects.

Knowing when to see a doctor about infertility

Infertility, or sub-fertility, is a problem that is affecting more couples than ever before, as people wait longer and longer to have children. One in ten couples older than 30 has trouble conceiving. After age 35, the ratio is one in five. Of course, age isn't a problem for everyone. Some women reportedly get pregnant even in their 50s. (According to Guinness World Records, the world's oldest spontaneously pregnant mother was 57½ when she conceived.) But face it: Spontaneous pregnancy in a woman's late 40s and 50s is rare.

When should you seek a doctor's help? Generally, after you've been trying unsuccessfully to get pregnant for six months to a year. But if you have a history of miscarriages or difficulty conceiving, if you're older than 35, or if you already know that your partner has a low sperm count, you may want to get help before six months are up. No matter what your situation, don't despair. Reproductive technologies become more sophisticated — and more successful — with each passing year. At this point, couples can try various techniques with complicated-sounding names — ovarian stimulation with fertility medications, intrauterine insemination (with or without sperm washing), intracytoplasmic sperm injection, use of donor sperm or donor eggs, and in vitro fertilization (and its many variations) — depending on their particular cause of infertility. For a couple that has trouble conceiving right away, chances are better than ever that they will eventually become pregnant. Check out *Infertility For Dummies* by Jackie Meyers-Thompson and Sharon Perkins (Wiley) for more information. If you're having trouble getting pregnant and you're not sure whether it's time to see an infertility specialist, discuss it with your practitioner.

Introducing Sperm to Egg: Timing Is Everything

This book's title notwithstanding, we're going to assume that you know the basics of how to get pregnant. What many people don't know, though, is how to make the process most efficient, so that you give yourself the best chance of getting pregnant as soon as you want to. To do that, you need to think a little about *ovulation* — the releasing of an egg from your ovary — which happens once each cycle (usually once per month).

After leaving the ovary, the egg spends a couple of days gliding down the fallopian tube, until it reaches the uterus (also known as the *womb*). Most often, pregnancy occurs when the egg is fertilized within 24 hours from its release from the ovary, during its passage through the tube, and the budding embryo then implants in the uterus's lining. (See Figure 1-1 for a quick look at the anatomical aspects.) In order to get pregnant, your job (and the father-to-be's) is to get the sperm to meet up with the egg as soon as possible (ideally, within 12 to 24 hours) after ovulation.

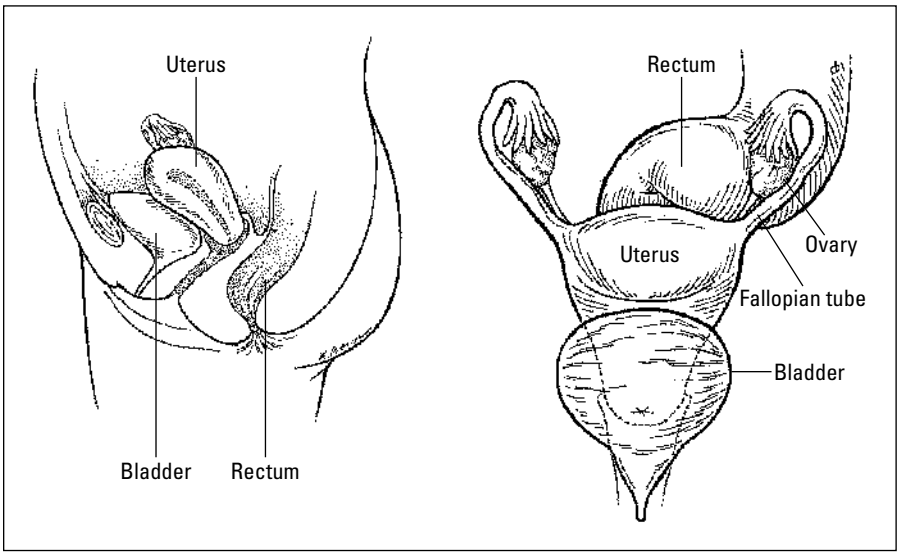

Figure 1-1: An overview of the female reproductive system.

The absolute prime time to have sex is 12 hours prior to ovulation. Then the sperm are in place as soon as the egg comes out. Sperm are thought to live inside a woman's body for 24 to 48 hours, although some have been known to fertilize eggs when they are as much as seven days old. No couple should count on getting pregnant on the first try. On average, you have a 15 to 25 percent chance each month. Roughly half of all couples trying to get pregnant

conceive within four months. By six months, three-fourths of them make it; by a year, 85 percent do; and by two years, the success rate is up to 93 percent. If you've been trying unsuccessfully to conceive for a year or more, a fertility evaluation is warranted.

Pinpointing ovulation

So when does ovulation happen? Typically, about 14 days before you get your period. If your menstrual cycles are 28 days long, that's 14 days after the first day of your previous period. If you have a 32-day cycle, you probably ovulate on about the 18th day of your cycle. (Each cycle begins on the first day of a period.) To make sure that you get the sperm in the right place at the right time, have sex several times around the time of ovulation, starting five days before you expect to ovulate and continuing for two to three days afterward. How often? Once every two days is probably adequate. Having sex daily or more often can cause the sperm count to drop a little in some men.

Doctors once thought that having sex daily would result in a lower sperm count and reduce fertility. However, later medical studies found that this idea is true only in men who have a lower-than-normal sperm count to start with.

Monitoring your basal body temperature

Some women find that they can pinpoint their time of ovulation more easily if they keep track of their temperature, which rises close to the time of ovulation. To do this, you take your temperature (orally) each morning before you get out of bed and before having anything to eat or drink. It typically reaches its lowest point right before your pituitary gland releases *luteinizing hormone* (LH), which triggers ovulation. Two days after the so-called *LH surge,* your temperature rises significantly — about a half to one degree above baseline — and stays elevated until you get your period. (If you get pregnant, it remains high.) You may want to invest in a special basal body temperature thermometer (sold in most drugstores) because it has larger gradations and is easier to read.

Remember that a rise in your basal body temperature indicates that ovulation has already occurred. It doesn't predict when you will ovulate, but it does confirm that you're ovulating and gives you a rough idea of when ovulation occurs in your cycle. Doing so can help you time intercourse for your next cycle, which should be approximately the day before you think you ovulate. Reading the signals can be hard because not all women follow the same pattern. Some never see a distinct drop in temperature, and some never see a clear rise.

Using an ovulation predictor kit

Another way to monitor the LH surge is to use a home ovulation predictor kit, which tests the amount of LH in urine. As opposed to basal body temperature (see the preceding section), the LH surge is useful in predicting when ovulation will occur during any given cycle. A positive test for any cycle tells

you that you're ovulating and when. In general, these kits are very accurate and effective. The main drawback is the expense. At $15 to $30 per kit, they're more expensive than taking your temperature, especially if you have to check several cycles to find out when you're ovulating.

Another way of checking for ovulation is available, which involves testing saliva instead of urine. The increased estrogen levels that occur around the time of ovulation cause the saliva to form a crystallized pattern upon drying, which can be seen with a special microscope. Both the urine tests and saliva tests are equally accurate (up to 98 percent) at predicting ovulation. The saliva kit costs about $35 and is reusable.

You can also check when ovulation is occurring by evaluating your own cervical mucus. Just prior to ovulation, it changes to a wet or egg-white consistency. The benefit to checking ovulation this way is that it doesn't cost you any money!

Taking an effective (and fun) approach

In most cases, parents-to-be are well advised to just relax and enjoy the process of trying to conceive. Don't get too anxious if it doesn't happen right off the bat. We often tell our patients: Think about stopping birth control a few months before you actually plan on getting pregnant. This way, you have some carefree months of enjoying great sex without worrying each month about whether you're pregnant. And if you do conceive ahead of schedule, enjoy the nice surprise!

You can take a few steps to improve your chances of conceiving:

- If you smoke cigarettes or marijuana or are on any illegal substance, quit.
- Avoid using K-Y Jelly or other commercial lubricants during sex, because they may contain spermicide. (Try olive oil or vegetable oil instead.)
- Limit your caffeine intake. Drinking more than three cups of coffee per day may decrease your chances of conceiving.
- If you're overweight, get on a smart carb, low-fat diet, exercise regularly, and work on a weight-loss plan. If you're unsure as to how much you'll need to exercise to lose weight on your diet, a physician, dietician, and/or personal trainer can be helpful.

Everything every dad wants to know about sex

One of the most common questions that dads ask is about sex during pregnancy. Your desire for sex — like that of your partner — may increase or decrease. Many men worry that inserting the penis into the vagina, next to the cervix, may injure the baby or lead to preterm delivery. In an uncomplicated pregnancy, you have nothing to worry about at all in this regard. Another common worry is that you may crush the baby by lying on top of your partner. Again, if the pregnancy is normal, being on top isn't a problem (especially during the first months). A cushion of amniotic fluid surrounds the baby. Later on in pregnancy, the size of the mother's abdomen may make the missionary position awkward, or your partner may find it uncomfortable. If she is willing, take the time to find alternative positions that are comfortable for her. Also, remember that libido can wax and wane during pregnancy, or it may wane only (see Chapter 3). For some women, pregnancy is just a sexual turnoff. So try to be understanding if your partner isn't interested in sex.

In some cases, intercourse during pregnancy may not be a good idea. If the mother goes into preterm labor, for example, and her cervix is open significantly, refraining may be wise. In the case of placenta previa with bleeding (see Chapter 16) and in some cases of incompetent cervix (see Chapter 6), foregoing intercourse also makes sense. If your partner has one of these problems or if you're unsure about your partner's situation, talk to her practitioner. And keep in mind that intercourse isn't the only way that you and your partner can express your sexual feelings for each other. Often, embracing, cuddling, or fondling can be satisfying alternatives. Remember, pregnancy (and the possible interruption in your sex life) won't last forever, even though you may sometimes feel like it will.