Chapter 1

Seeing Double Lines: I Think I'm Pregnant!

In This Chapter

- Knowing what symptoms to look for
- Getting the answer to that all-important question: Are you pregnant?
- Finding a healthcare practitioner to meet your needs
- Figuring out your due date
- Considering medications you may be taking

So you think you may be pregnant! Or maybe you're hoping to become pregnant soon. Either way, you want to know what to look for in the early weeks of pregnancy so that you can know for sure as soon as possible. In this chapter, we take a look at some of the most common signals that your body sends you in the first weeks of pregnancy, and offer advice for confirming your pregnancy and getting it off to a great start.

Recognizing the Signs of Pregnancy

So assume it has happened: A budding embryo has nestled itself into your womb's soft lining. How and when do you find out that you're pregnant? Quite often, the first sign is a missed period. But your body sends many other signals — sometimes even sooner than that first missed period — that typically become more noticeable with each passing week.

- **Honey, I'm late!** You may suspect that you're pregnant if your period hasn't arrived as expected. By the time you notice you're late, a pregnancy test will probably yield a positive result (see the next section, "Determining Whether You're Pregnant," for more on pregnancy tests). Sometimes, though, you may experience one or two days of light bleeding, which is known as *implantation bleeding,* because the embryo is attaching itself to your uterus's lining.
- **You notice new food cravings and aversions.** What you've heard about a pregnant woman's appetite is true. You may become ravenous for pickles, pasta, and other particular foods, yet turn up your nose at foods you normally love to eat. No one knows for sure why these changes in appetite occur, but experts suspect that these changes are, at least partly, nature's way of ensuring that you get the proper nutrients. You may find that you crave bread, potatoes, and other starchy foods, and perhaps eating those foods in the early days is actually helping you store energy for later in pregnancy, when the baby does most of its growing. As with any other time in life, though, be careful not to overeat. You may also be very thirsty early in pregnancy, and the extra water you drink is useful for increasing your body's supply of blood and other fluids.
- **Your breasts become tender and bigger.** Don't be surprised by how large your breasts grow early in pregnancy. In fact, large and tender breasts are often the first symptom of pregnancy that you feel because very early in pregnancy, levels of estrogen and progesterone rise, causing immediate changes in your breasts.

Joanne's story

One day a couple of years after my first daughter was born, I found myself heading to the grocery store to buy pickles and ketchup, intent on mixing them together to make a lovely, tasty, green-and-red meal. I was craving it so much that it didn't even occur to me what an odd dish it is. In fact, it wasn't until I had cleaned up the dishes that I realized that pickles and ketchup had been my only craving during the early months of my first pregnancy. I had no other reason to think I was pregnant again; I hadn't even missed a period. But the next morning I tested myself, and sure enough, it was time for round two.

Determining Whether You're Pregnant

Well, are you or aren't you? These days, you don't need to wait to get to your practitioner's office to find out whether you're pregnant. You can opt instead for self-testing. Home tests are urine tests that give simply a positive (often two lines — hence the title of this chapter) or negative result (only one line). (By the way, these tests are very accurate for most people.) Your practitioner, on the other hand, may perform either a urine test similar to the one you took at home or a blood test to find out whether you're pregnant.

Getting an answer at home

Suppose you notice some bloating or food cravings, or you miss your period by a day or two. You want to know whether you're pregnant, but you aren't ready to go to a doctor yet. The easiest, fastest way to find out is to go to the drugstore and pick up a home pregnancy test. These tests are basically simplified chemistry sets, designed to check for the presence of *human chorionic gonadotropin* (hCG, the hormone produced by the developing placenta) in your urine. Although these kits aren't as precise as laboratory tests that look for hCG in blood, in many cases they can provide positive results very quickly — by the day you miss your period, or about two weeks after conception.

The results of home pregnancy tests aren't a sure thing. If your test comes out negative but you still think you're pregnant, retest in another week or make an appointment with your doctor. A urine test is positive at a level of about 20-50 IU/L while a blood test is positive at a level of 5-10 IU/L, depending on the test. So a blood test will be positive a little earlier than a urine test. An ultrasensitive blood test can even detect an hCG level of about 1-2 IU/L. hCG is found in the maternal blood at 6-12 days after ovulation (20-26 days from last menstrual period of ovulation occurs on day 14).

Going to your practitioner for answers

Even if you had a positive home pregnancy test, most practitioners want to confirm this test in their office before beginning your prenatal care. Your practitioner may decide to simply repeat a urine pregnancy test or to use a blood pregnancy test instead.

A blood pregnancy test checks for hCG in your blood. This test can be either qualitative (a simple positive or negative result) or quantitative (an actual measurement of the amount of hCG in your blood). The test your practitioner chooses depends on your history and your current symptoms and on her own individual preference. Blood tests can be positive even when urine tests are negative.

Calculating your due date

Only 1 in 20 women actually delivers on her due date — most women deliver anywhere from three weeks early to two weeks late. Nonetheless, it's important to pinpoint the due date as precisely as possible to ensure that the tests you need along the way are performed at the right time. Knowing how far along you are also makes it easier for your doctor to see that the baby is growing properly.

The average pregnancy lasts 280 days — 40 weeks — counting from the first day of the last menstrual period. Your due date — what doctors once referred to as the EDC, for estimated date of confinement (in the old days, women were actually "confined" to the hospital around the time of their delivery) — is calculated from the date on which your last menstrual period (LMP) started.

If your cycles are 28 days long, you can use a shortcut to determine your due date. Simply subtract three months from your LMP and add seven days. If your last period started on June 3, for example, your due date would be March (subtract three months) 10 (add seven days). If your periods don't follow 28-day cycles, don't worry. You can establish your due date in other ways. If you've been tracking ovulation and can pinpoint the date of conception, add 266 days to that date (the average time between the first day of your LMP and ovulation is about 14 days, or 2 weeks).

If you're unsure of the date of conception or the date your last period started, an ultrasound exam during the first three months can give you a good idea of your due date. A first-trimester ultrasound predicts your due date more accurately than a second- or third-trimester one.

You can also use a pregnancy wheel to calculate how far along you are. To use this handy tool, line up the arrow with the date of your last menstrual period and then look for today's date. Just below the date you see the number of weeks and days that have gone by. (If you know the date of conception, rather than your last period, there is a line on the wheel corresponding to this, too.) There are now online wheels (`http://www.premierus.com/wheel/`) as well as apps that you can download to calculate your due date.

Selecting the Right Practitioner for You

Finding the right practitioner to care for you (and your baby) is a decision you shouldn't take lightly. Your healthcare is always important, but your new and sometimes overwhelming condition means you want a practitioner who's in sync with your approach to pregnancy. This person should be someone you trust and feel safe with. You may already have a practitioner if you've had a previous child. If not, there's no need to feel overwhelmed. This section helps you make that important decision.

Considering your options

Many kinds of professionals can help you through pregnancy and delivery. Be sure to choose a practitioner with whom you feel comfortable. Review this list of the basic five:

- **Obstetrician/gynecologist:** After completing medical school, this physician receives another four years of special training in pregnancy, delivery, and women's health. She should be *board certified* (or be in the process of becoming board certified) by the American Board of Obstetrics and Gynecology (or an equivalent program if you're from a country other than the United States).
- **Maternal-fetal medicine specialist:** Also known as a *perinatologist* or *high-risk obstetrician,* this type of doctor has

completed a two- to three-year fellowship in the care of high-risk pregnancies, in addition to the standard obstetrics residency, to become board certified in maternal-fetal medicine. Some maternal-fetal medicine specialists act only as consultants, and some also deliver babies. You might seek the care or even a consultation with a high-risk specialist if you have had a history of problem pregnancies (prior preterm delivery, history of preeclampsia, or multiple miscarriages), if you have underlying medical problems (like diabetes or chronic hypertension), or if your fetus has been diagnosed with a disorder.

- **Family practice physician:** This doctor provides general medical care for families — men, women, and children. She is board certified in family practice medicine. This kind of doctor is likely to refer you to an obstetrician or maternal-fetal medicine specialist if complications arise during your pregnancy.
- **Nurse-midwife:** A nurse-midwife is a registered nurse who has completed additional training to obtain a master's degree in nursing and is also licensed to perform deliveries. A certified nurse-midwife typically practices in a setting where there is a physician available and refers patients when complications occur.
- **Nurse practitioner:** A nurse practitioner is a registered nurse who has completed additional training to obtain a master's degree in nursing and is trained to provide routine prenatal care, but typically does not perform deliveries. She usually practices in conjunction with a physician; whether you see the nurse practitioner or the physician for your prenatal visits depends on the individual practice and where you are in your pregnancy.

Determining whether you're at high risk

The question of whether you and your pregnancy are at high risk has no black-and-white answer, especially at the beginning. But it helps to be aware of the kinds of situations (which you may either have or develop) that can put a pregnancy at high risk:

- Diabetes
- High blood pressure
- Lupus
- Blood disorders
- Heart, kidney, or liver disorders

- Twins, triplets, or other multiple fetuses
- A premature delivery in a prior pregnancy
- A previous child with birth defects
- A history of miscarriage
- An abnormally shaped uterus
- Epilepsy
- Some infections
- Bleeding
- Advanced maternal age (over age 35)

Remember that midwives and most family practice physicians are not equipped to handle high-risk pregnancies. If you have or develop any of these conditions, consult an obstetrician or a maternal-fetal medicine specialist.

Asking questions before you choose

Before you make a decision, you want to be complete and thorough in your search. Make sure you know what you want out of the experience. When you're deciding on a practitioner, ask yourself the following key questions:

- **Am I comfortable with and do I have confidence in this person?** You should trust and feel at ease not only with your practitioner but also with the whole constellation of people who work in the practice. Would you feel free to ask questions or express your anxieties to them? Another point to keep in mind is how your general personality fits in with the practice's philosophy. For example, some women prefer a low-key, low-tech approach to prenatal care, while others want to have every possible diagnostic test under the sun. Does this practitioner deliver in a setting where you feel most comfortable having your baby? Your past medical and obstetrical history can also influence the approach you take to your pregnancy and the provider you choose.
- **How many practitioners are involved in the practice?** You may end up choosing between a practitioner who works with one or more partners and one who is in solo practice. Many group practices rotate you through appointments with each of the doctors, getting to know them all so that you feel comfortable having any one of them deliver your baby. Some practices utilize nurse

practitioners to help render prenatal care (see previous section). Practically speaking, you're likely to bond more with one or two people in the practice than with others, which is natural, given that most women and most practitioners have many varied personalities. A provider who practices alone should tell you who handles deliveries when she is ill, off duty, or out of town.

Ask your practitioner about her policy for after-hours problems or emergencies — including questions you may need to ask by telephone during evening or weekend hours.

- **Where do I want to deliver?** If your pregnancy is uncomplicated, any good hospital or birthing center will work just fine. Some women may even choose a home birth. If you're at risk for some complications, however, you should consider a hospital delivery and ask whether the hospital you'll be delivering in has a labor and delivery suite and a nursery equipped to handle any problems that may arise if, for example, the baby is born early. You may also want to ask the following questions:
  - Is an anesthesiologist on-site 24 hours a day, or can your doctor call in an anesthesiologist quickly in case of an emergency?
  - Can the hospital provide you with *epidural* anesthesia (a form of pain control during labor)? If epidural anesthesia isn't readily available, or you're not interested in this form of pain relief, find out what other options are available for pain management.
  - Are you allowed to *room in* — that is, keep the baby in your room as much as possible — after delivery? Also, are accommodations available for your partner to stay with you during your postpartum hospitalization?
- **Can this practitioner refer me to a nearby specialist if needed?** Consider whether you may need the services of a maternal-fetal medicine specialist or a *neonatologist,* a physician who specializes in the care of infants who are born early or who have other medical problems. Ideally, your practitioner can refer you to someone quickly if anything comes up.
- **Will my insurance plan cover this practitioner?** Now that managed care has become an important part of the health insurance industry, check to see whether your plan covers your practitioner of choice. Some places allow you to select an "out-of-network" physician if you pay part of the cost yourself.

Weeks versus months

Most of us think of pregnancy as lasting nine months. But face it — 40 weeks is a little longer than nine times four weeks. It's closer to ten lunar months (in Japan, they actually speak of pregnancy as lasting ten months) and a bit longer than nine 30-to-31-day calendar months. That's why your doctor is more likely to talk in terms of weeks.

Because you start counting from the date of your last menstrual period, the count actually begins a couple of weeks before you conceive. So when your doctor says you're 12 weeks pregnant, the fetus is really only 10 weeks old!

Keeping Your Medicines and Vaccinations in Check

After you find out you're pregnant, you may wonder about the risks involved with certain medications and vaccinations. Maintaining good health throughout your pregnancy is a critical step in delivering a healthy baby. Review the following sections to see what risks and benefits are associated with certain medicines and vaccinations.

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:

- Pain medications (for example, acetaminophen)
- Anti-viral medications (for example, acyclovir)

- Antiemetics/anti-nausea medications (for example, phenothiazines, trimethobenzamide, and Diclegis, a combination of doxylamine and vitamin B6, which has recently been approved by the Food and Drug Administration for morning sickness and is in the safest drug classification for pregnancy [category A])
- Antihistamines (for example, doxylamine)
- Low-dose aspirin — often used to decrease risk for preeclampsia in patients at risk
- Minor tranquilizers and some antidepressants (for example, meprobamate, chlordiazepoxide, and fluoxetine)
- Antibiotics (for example, penicillin, cephalexin, trimethoprim-sulfamethoxazole, and erythromycin)
- Anti-viral agent used in patients with HIV: Zidovudine

The following are some of the common medications that women should 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.

Some women take vitamin A supplements 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 15).
- **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 15).
- **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 and Zoloft) have been studied extensively and are considered safe during pregnancy. Recent studies on selective

serotonin reuptake 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. Some of the newer antidepressants like Cymbalta, Celexa, Lexapro, and Effexor appear to be safe in pregnancy, but because they are new, data is limited. If you need to start an antidepressant during pregnancy, many doctors feel that sertraline (Zoloft) is the best first-line drug. But if you're already taking an antidepressant, ask your doctor whether you'll be able to keep taking the medication while you're pregnant or need to switch to something safer.

Aside from birth defects, there's also been concern that SSRIs were associated with an increased risk for autism. More recent studies, however, did not find a significant increase in the risk of this disorder in women taking SSRIs during pregnancy.

- **Bupropion:** Bupropion is an antidepressant, but it's also prescribed to help people stop smoking (for example, Wellbutrin or Zyban). Very little info exists on its 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.
- **Fluconazole:** Fluconazole is an oral medication used to treat yeast or other fungal infections. A recent study showed that oral fluconazole used during the first trimester was not associated with an increased risk of birth defects overall, but that it may be associated with an increased risk of a specific heart defect known as Tetralogy of Fallot.
- **Decongestants:** A mounting body of recent evidence suggests that decongestants like phenylephrine and phenylpropanolamine, when used during the first trimester, may be associated with an increased risk of birth defects. If possible, you should avoid taking these medications until you have completed your first trimester, but if you

inadvertently took some before you found out that you were pregnant, the likelihood of a birth defect resulting from it is still very low.

- **Lithium:** Lithium is a medication that is used occasionally to treat bipolar disorder. It is thought that this medication places women who take it during pregnancy at an increased risk for having a child with a specific cardiac abnormality known as Ebstein's anomaly. If possible, an alternative medication should be chosen for the first trimester, but if lithium is inadvertently taken during the first trimester, the risk is still quite low. Women taking lithium during early pregnancy should have a fetal echocardiogram around 20 weeks. This is a special type of ultrasound done to diagnose cardiac abnormalities, including Ebstein's anomaly.

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

Many vaccines are safe, and in fact recommended, while you're pregnant. (See Table 1-1 for information on several vaccines.) Here is some further information on some common vaccinations:

- **Rubella:** Your practitioner tests 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. If you are already pregnant when you learn that you are not immune to rubella, your practitioner will recommend that you get the vaccine after you deliver your baby, just before you go home from the hospital.

- **Flu:** The influenza vaccine is safe and recommended during pregnancy. Pregnant women who get the flu are at increased risk of complications as a result of it. The vaccine poses no harm to your developing baby.
- **Tetanus, diphtheria, and pertussis:** It is recommended that women get an adult tetanus, diphtheria, and pertussis (Tdap) vaccine during each pregnancy, ideally between weeks 27 and 36 of pregnancy.
- **Measles, mumps, and poliomyelitis:** Most people are immune to measles, mumps, and poliomyelitis, 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.
- **Chicken pox:** Chicken pox carries a small risk that the baby can contract the infection from her mother. If you've never had chicken pox, tell your practitioner so you can discuss possible vaccination before you get pregnant, or if you are already pregnant, after delivery before you go home.
- **Human papilloma virus:** Vaccines are available for the human papilloma virus (HPV), which is associated with some kinds of abnormal pap smears, genital warts, and cervical cancer. Studies suggest it's similar to other vaccinations that are safe in pregnancy; however, it is still recommended that you not receive this vaccination during pregnancy. If you inadvertently got vaccinated before realizing that you were pregnant, the risk to your developing baby is very low, but you should not get subsequent doses until after delivery.

Testing for HIV

If you're at risk for 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 will also contract HIV.

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 immuno-globulins for acute exposure; newborns need vaccine
Human papil-loma virus	None con-firmed, but little data	If found to be pregnant after ini-tiating series, give remaining doses postpartum	
Influenza (inactivated)	None confirmed	Recommended	
Measles	None confirmed	No	Vaccinate postpartum
Mumps	None confirmed	No	Vaccinate postpartum

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

Disease	*Risk of Vaccine to Baby during Pregnancy*	*Immunization Recommendations*	*Comments*
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 women	Consider each case separately
Smallpox	Possible miscarriage	No, unless emergency situation arises or fetal infection	
Tetanus, diphtheria, and pertussus (Tdap)	None confirmed	Recommended for each pregnancy between 27 and 36 weeks	
Typhoid	None confirmed	Only for close, continued exposure or travel to endemic area	
Varicella (chicken pox)	None confirmed	Immunoglobulins recommended in exposed nonimmune women; should be given to newborn if around time of delivery	If nonimmune, vaccinate postpartum (second dose four to eight weeks later)
Yellow fever	Unknown	No, unless exposure is unavoidable	

Debunking old wives' tales

Pregnancy has a certain mystique. Millions of women have been through it, yet predicting in detail what any one woman's experience will be like is difficult. Perhaps that's why so many myths have formed (and survived) over the centuries, most of which are designed to foresee the unknowable future. Here are 12 tales that, alas, are really nothing but nonsense:

- **Old Heartburn Myth: If a pregnant woman frequently experiences heartburn, her baby will have a full head of hair.** Simply not true. Some babies have hair; some don't. Most lose it all within a few weeks, anyway.
- **Mysterious Umbilical Cord Movement Myth: If a pregnant woman lifts her hands above her head, she will choke the baby.** Give us a break. People used to think (and, alas, some still believe) that the mother's movement could cause the baby to become tangled in the umbilical cord, but that's just not true.
- **Curse Myth: Anyone who denies a pregnant woman the food that she craves will get a sty in his eye.** Nope. This myth doesn't mean that someone who stands between a pregnant woman and her craving is in the clear, though: He will most certainly be subjected to threats, name-calling, or icy glares, but no sties.
- **Heart Rate Myth: If the fetal heart rate is fast, the baby is a girl, and if the heart rate is slow, the baby is a boy.** Medical researchers actually looked into this myth. They did find a very slight difference between the average heart rate of boys and that of girls, but it wasn't significant enough to make heart rate an accurate predictor of sex.
- **Ugly Stick Myth: If a pregnant woman sees something ugly or horrible, she will have an ugly baby.** How could this possibly be true? There's no such thing as an ugly baby!
- **Java Myth: If a baby is born with café au lait spots (light-brown birthmarks), the mother drank too much coffee or had unfulfilled cravings during her pregnancy.** Nope. Drinking 150-200 mg caffeinated beverages/day is considered safe (about 1 ½ cups coffee/day – but we are not talking about Starbucks Trenta though). Higher consumption of caffeine has been linked to miscarriage and low-birth weight.
- **Myth of International Cuisine: Eating spicy food brings on labor.** It doesn't, but it may be an effective marketing tool: We know of an Italian restaurant that advertises its Chicken Fra Diavolo as a surefire labor-inducer. The dish may be delicious, but it simply

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can't bring on labor. Nope. Niet. Nunca. Nein. Non.

- **Great Sex Myth: Having passionate sex brings on labor.** What got you into this mess will also get you out? That's just wishful thinking, but go ahead and try it (if you feel like it when you're nine months pregnant). It's likely to be worth the effort.
- **Round Face Myth: If a pregnant woman gains weight in her face, the baby is a girl, and if a woman gains weight in her butt, the baby is a boy.** Neither statement is true, obviously. The baby's sex has no influence whatsoever on the way the mother stores fat.

  Another related myth is that if the mother's nose begins to grow and widen, the baby is a girl. The so-called reasoning here is that a daughter always steals her mother's beauty. Strange concept — and quite untrue.
- **Moon Maid Myth: More women go into labor during a full moon.** Although many labor and delivery personnel insist that the labor floor is busier during a full moon (police say their precinct houses are livelier then, too), the scientific data just doesn't support the idea.
- **Belly Shape Myth: If a pregnant woman's belly is round, the baby is a girl, and if the woman's belly is more bulletlike, it's a boy.** Forget about it. Belly shape differs from woman to woman, but the child's sex has nothing to do with it.
- **Ultrasound Tells All Myth: Ultrasound can always tell the baby's sex.** Nope, not always. Often, by about 18 to 20 weeks' gestation, seeing a fetus's genitalia on ultrasound is possible. But being able to determine the baby's sex depends on whether the baby is in position to give you a good view. Sometimes the sonographer can't see between the uncooperative baby's legs and therefore can't determine the sex. Sometimes, too, the sonographer may be wrong, especially if the ultrasound is done very early in the pregnancy. So even though you can find out the baby's sex through ultrasound in most cases, it's not 100 percent guaranteed.