Kara K.’s Pregnancy & Parenting Notes  
February 2008

Things to Keep in Mind while Reading This:

• These notes were compiled from reading 10+ books on pregnancy & child rearing, taking Lamaze & lactation classes, hospital tours & doctors’ appointments, expert consultations, thousands of AMOM listserv emails and personal conversations, web surfing, and hundreds of magazines & handouts over a couple years. Many of these sources emphasize single-baby pregnancies. Thus, if an item does not specifically mention that it applies to twin or other multiple pregnancies, it may only apply to singleton pregnancies. This can be a key issue when reading nutrition, exercise, & other recommendations contained herein.

• These notes are most detailed in two key topic areas: (1) nutrition for women carrying multiple babies and (2) breastfeeding and pumping milk. But the majority of topics are compilations of a variety of details from multiple sources; so, based on my own experience, they tend to offer more than any single source can provide.

• These notes almost exclusively emphasize information that was not already known or obvious to me. Thus, in some cases, information found here is hard to find & thus may be easily missed in most parents’ reading of the baby literature. The best single book I have found for pregnancy is the famous *What to Expect When You’re Expecting*, though it’s not the easiest to read (given its density of information & pregnancy-stage-related sequencing of info.). If I were to be pregnant for the first time, I’d turn to that (and to this set of Notes ☺) as my main reading materials. Time is limited, so such focus may be necessary for parents to be! After the baby/babies arrive/s, I would turn to *Baby 411* (by Austin’s own Dr. Ari Brown!); that seems to provide loads of the latest & greatest wisdom – in a very no-nonsense, clear style. To get feedback from a variety of parents on a great range of specific questions, I’d check in at the Berkeley Parents Network home page ([http://parents.berkeley.edu/](http://parents.berkeley.edu/)), where every past topic & accompanying recommendations have been posted.

• Sources of info are referenced at the end of most notes, in parentheses. More info on these sources can be found in the References section at the end of this file.

• Please let me know if you find something valuable to add here! You can add it where you think it applies & use highlighted text or Tools/Track Changes to allow me to find it easily. Or you can send the note to me via email (kkockelm@mail.utexas.edu) & I’ll find a spot to add it. If you can share info re. the source (e.g., a URL or book title & publication year), that’d be great too.

• If anything may be in error, please do let me know! I have read many non-concordant opinions on important issues & am not always clear where the truth lies. There also may be other, less controversial items where I’ve made an error. Thanks for any help you can give!

• Feel free to call with any contributions, questions or concerns you have: 512-471-0210.

*Good luck with your pregnancy & parenting!! It’s the toughest job we’ll ever love.* ☺
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IN GENERAL…

Pregnancy Essentials: Eat right, enjoy moderate exercise (to get blood going to babies & help ease many negative symptoms of pregnancy), avoid toxins, alleviate stress. (PP)

With multiples on board: Get horizontal time each day, esp. after 24 weeks. Don’t be afraid to exercise, but don’t start anything new & try to switch to very low impact exercise, like swimming, treading water, yoga & recumbent biking, esp. after ~24th week. Gain weight EARLY (i.e., 2 lbs/week from ~10th to 24th week), & eat loads of calcium (6 full servings of milk or cheese/day) & protein (125 gm/day!) after 24th week (to keep babies happy inside). Supplement iron (25 mg in prenatal vitamin + another 25 mg, via ferrous sulfate tablets, for example, or 2 servings of MaltoMeal or pre-heated/listeria-killed liverwurst, if you want to get this via food). (KK’s own suggestions ☺) Avoid all long-distance travel after 24th week, & figure out a way to keep your life low-stress from week 20 on. A lot of folks end up with contractions & bed rest after week 20, week 26, week 30. And babies end up being born early, requiring much more time & work on your part (since preemies are much tougher to care for & less likely to take to nursing). Be prepared, so that you can relax, enjoy life, & get those babies to term (37 weeks in the case of twins)! Term is your goal. You & your children will benefit dramatically from achieving this.

A few suggestions!

• Get a waterproof easily-timeable watch (like an Ironman watch), in order to schedule pumping and feeding times (waking yourself up in the middle of the night, to make sure newborns are feeding regularly).

• If you’re planning to hire a nanny (which can help ensure you remain sane, particularly in the case of multiple babies), get this person on board several weeks before the child(ren) is (are) born, so she/he can set up the children’s room for you & buy all the supplies you hadn’t thought of. She/he can run all sorts of errands in the early days, while you’re still in the hospital or at home sleeping with the baby/ies. This is particularly important when carrying multiples, since you need to relax, to keep those babies inside. Note: Having 10+ hours of good help a week after the baby/ies is/are born can mean a world of difference in how you perceive your children and your life. This time should be relished, not suffered through. Do what you can to get sufficient time on your own, so that you can look forward to all the thrills your children bring to your life.

• Diaper Genies are probably best only for poopy diapers. One has to use both hands (to hold the diaper & one to try & to get the odd top open), & then one has to shove the dirty, wet diaper well into the dense bag inside. Who wants to do this? They also fill up very quickly, particularly with twins! Aim to get a foot-pedal-operated can for all other diapers, which you can avoid touching & which will prove much more useful in the longer term (i.e., beyond diapers!).

• For some women, breastfeeding is the most physically painful long-term activity they ever undertake. It can be very stressful on the nipples and breast tissues for many weeks, and even months. With twins, imagine 200 minutes a day of nipple stimulation. Nursing on demand is important, but can mean nursing every 1.5 hours. Preemies have smaller mouths and less energy. For women bearing multiple babies, rent a hospital-grade pump at the start (for the first month at an absolute minimum, while your breasts are being calibrated to produce enough milk) & do not go more than 4 hours without solid stimulation. (Pumping
every 2 hours for a 48-hour period will simulate a baby growth spurt & help get supply up. Double-pumping [e.g., 15 minutes + 15 minutes, with a rest in between] & drugs & herbs can also help supply.) Watch out for cracked nipples, plugged ducts, mastitis, and thrush; knowledge/awareness and prevention are key (e.g., checking for plugs regularly during the first month while lying down). Be sure to stimulate sufficient milk supply by feeding at least every 3 hours during the early weeks; only go longer (e.g., 4 hours once per night) once you are sure your supply will meet your baby’s needs. If milk supply is an issue, be sure to empty those breasts with a pump & with hand compressions. Remember: This may very well be the hardest thing you ever do. Be as mentally ready as you can. Get through the first two months (talk to a top lactation consultant right away if things are not going so well – even over the phone will be very useful), & you’ll be in great shape for long-term nursing. Hang in there!! (Note: A more formal list of key tips for successful nursing & pumping can be found in the Breastfeeding section of this document.)

• Crib “wedges” to keep babies on a slight angle & side-wedges to keep babies from rolling over aid digestion, help avoid spitup (& choking on spitup), & allow you to keep babies on their sides (thus avoiding a flattened head). Use a boppy or bouncy seat to also keep baby up, as he/she is getting milk to go down. Place a blanket under one end of the changing pad. (Again, these are to avoid spitup issues.)
• Make bottles ahead of time & keep in fridge. Keep a small plastic bucket of 2 inches of water by the microwave & heat this up when needing warm up fridge bottles. (The bucket handle allows you to carry warming bottle easily, while holding a baby in other arm.) Keep burp cloths near your bed & other feeding locations.
• Feel free to try & schedule feedings every 3 hours early on if you newborn happens to be good at nursing deeply (or you’re using bottles). Sometimes a snack in between feeds is also needed. You can get a baby on this schedule if he/she’s drinking deeply at those times.
• Dry washed bottles upside down over cookie cooling trays, on top of paper towels. (Or, if you find you fill the dishwasher daily anyhow, wash them & their accoutrements in there.)
• Place Symphony in Motion mobile over crib end & alongside changing table so that it also can be used for babies who are getting changed (which is much more useful than babies who are supposed to be sleeping [and hopefully lying on their sides, so not looking up]).
• Place a pillow under head-end of crib (both ends if sleeping twins feet-to-feet), & a folded blanket under changing table head, to keep spit ups to a minimum & help keep kids more comfortable.
• Buy a pumping bra to free up your hands for breast compressions, emailing, eating, etc.
• If you value your sleep, I recommend you move kids to their own room(s) as soon as you can. Don’t use a monitor there (assuming it’s close enough that you can still hear them if they’re crying hard). Let them learn to sleep on their own. They will get more good sleep out of this arrangement, and so will you. (Note: We kept our fraternal boy/girl twins apart, and our daughter slept in our room for quite a while [while we used her room as an office], since she was not interrupted by us or my pumping in the middle of the night.)
• Pay music, and sing with your kiddos! We had music on for at least 4 hours each day (perhaps two different CDs each day). They will learn to “sing” before they learn to talk. The pattern recognition in these songs is great fun for them, and you. (You might want to try music in another language regularly. That’ll add to the experience!)
• Suggest to friends & relatives that clothing items that are not for infants are greatly appreciated at your shower. (You’ll find children grow out of those little items so quickly
that they are largely untouched. Not having to clothes shop as the kids get 9 & 12 months is a fabulous treat, in my opinion. I would opt for items that are size 9 months & up! [even through age 2 is great!] You’ll get duplicates of many things at your shower, no doubt. And some things won’t quite meet your needs. Don’t be afraid to get a credit at the stores where these items were purchased, and buy the things that you really do need. (We registered for all sorts of things that we bought second-hand eventually, for example. So we were able to buy critical items with the difference. Babies R Us is very good about knowing what they’ve sold, and taking it back, for example.)

**TIMING OF DEVELOPMENT:**
270 days from conception to delivery ~9 months (O&M) = 38.5 weeks (vs. ~40 weeks from last cycle’s first day)

*First Trimester:*
Weeks 5-10= critical for neural development. (i.e., 3 to 8 weeks after conception) (BT)
First 8 weeks are the most critical, b/c most malfunctions occur at this time. (YPA30)
Poppyseed-sized heart starts beating in week 6; can be heard on a stethoscope in week 11.
  Genitals start to form in week 10. Nausea starts to wane in week 12, while uterus moves from pelvic floor to front & center of abdomen. At week 12, fetus is fully forms (from tooth buds to toenails); the most critical development phase is past & chances of healthy delivery are strongly increased. (BT)
Vaginal ultrasound can determine if there is more than 1 sac, often by 5th or 6th week. (KK)

*Second Trimester:*
Gentle prodding in week 13 will cause fetus to squirm. A triple screen blood test (AFP, hCG & estriol) is scheduled between weeks 15 & 20. Ultrasound often done between weeks 15 & 20. Lungs are exhaling amniotic fluid by week 17, circulatory system is operating, & urinary tract is running. Most women feel baby moving between 16 & 20 weeks. Top of uterus reaches belly button by about week 20 & will grow 1 cm/week. Week 21 is about the time to look into birthing classes. Loud sudden noises in week 22 may cause baby to flail limbs. At week 23, baby is proportioned like a newborn. (BT)
The brain develops last, in weeks 20-36. (YPA30)

*Third Trimester:*
Ultrasounds for gender typically best at weeks 24+ (but Silverberg said that around week 18-20, one can usually tell). (GPSP) [KMK’s perinatologist’s sono tech was able to decisively tell at 16 weeks.]
By 21 weeks the digestive system is starting to work & baby can swallow fluid, producing meconium. (YPA30) Brain develops between weeks 20 & 36. ** (YPA30)
Baby may have hiccups, which you will feel as little blips. Very good chance (~85%) of survival if baby prematurely born after week 27. After week 30, 90% of preemies will survive & ~60% of those without long-term health problems or disabilities. ** (BT)
Pre-register at the hospital by ~week 31 & write out a “birth plan”, with your preferences during delivery (e.g., epidural, birthing positions you’d like to try & whether son will be circumcised). (BT)
Pack a labor bag, with lollipops, fruit, talc or cornstarch for massages, CDs & CD player, snacks for spouse, insurance card, robe, big t-shirt, socks, cheap slippers. (YPA30 & ST)
Stress tests of babies at 32 weeks will note if the fetal heartbeat increases with movement (it should; if not, they could be under some distress). (YPA30)
Fat is forming under fetal skin by week 32. Baby is exercising its lungs by week 33, inhaling amniotic fluid. Mother is gaining ~1 lb/week (2 lbs/week for twins, probably!!) & half of that goes to fetus. In fact, baby gains 50% of its birth weight during weeks 33 to 40!!

(BT) Amniotic fluid falls at ~34 weeks with twins (~36 weeks with singleton). (ST)

Week 35+: Obstetrician will/should be checking cervix weekly. 99% of babies born now survive. Your uterus has expanded to 1,000 times original size & reaches up to base of rib cage. The baby may drop, engaging the pelvic bones. Mother’s weight gain peaks at ~37 weeks. Waxy surface of baby’s skin has largely disappeared & is swallowed by fetus, to show up as dark-green, tar-like meconium of first bowel movement. (BT)

Week 39: Average full-term newborn is 20” long & 7.25 lbs. Boys tend to weigh a bit more than girls. If child hasn’t arrived by week 42 (38 with twins0, doctor probably will consider inducing. (BT) Umbilical cord ~24” long, & amniotic sac is carrying baby’s urine. (YPA30)

DRUGS & MEDICINES:

Try to avoid every drug or medicine during first trimester (b/c placenta hasn’t developed yet, to protect child). (Dr. Grogono’s nurse, Karen Armstrong). Tylenol, Surfak (for constipation) & a couple other drugs are okay. But check first.

FINE, esp. during 2nd & 3rd trimesters: Acetaminophen, Cepacol lozenges & Chloraseptic spray & Sucrets (for sore throats), Sudafed & Actifed (for congestion), Robitussin & Benylin (cough – but nothing with [high] alcohol), Maalox & Mylanta & Tums & Rolaid & Pepcid AC (for heartburn & indigestion), Surfak & Colace stool softener & Fibercon & Milk of Magnesia (NO laxatives – according to Kevin Stephens list), Kaopectate & Immodium (for diarrhea), Tums & Calcet & Citracal & other Calcium supplements (for leg cramps – since these are caused by too much phosphorus [from milk products]), Anusol & Preparation H & Tucks (for hemmorhoids), Emetrol (for nausea) (KStephens)

Also: Monistat is OK & many antibiotics, but not tetracycline – taking the lowest doses possible. (O&M) Benadryl (which is anti-itching too!) permitted (but some recent research now suggesting antihistamines can increase the incidence of certain problems for babies). (YPA30) Ob Dr. Grogono’s list also includes Benadryl (see warning above), Actifed, Kaopectate, Mylanta, Maalox, & some other items.

BAD: Aspirin, ibuprofen, Nasal Spray, Laxatives (!! KStephens)

Tylenol/acetophetamines hurt the liver if you overdose, & alcohol increases its breakdown.

Avoid aspirin, b/c of hemmorages – esp. in the 3rd trimester. (PP)

Avoid fever, esp. in the first trimester when a high body temperature can lead to limb defects.

Take Tylenol, drink plenty of water, & dress appropriately. (YPA30)

Hair highlighting = fine, b/c scalp is protected by foil & then washed (this is esp true after first trimester) (O&M) Highlights (which don’t touch the scalp) are fine at any time during pregnancy. (BT)

EATING RIGHT – FOOD:

Snack every 3 hours to keep blood sugar up. (PP & YPA30)

Most important for avoiding premature delivery of twins = Nutrition + plenty of rest (~2-3 times/day). Exercise & nutrition = most significant factor in preparing your body for the demands of multiples. Rest & relaxation are also important. Be very conscious of stress on your pelvic floor & a feeling of babies falling out. (HT)
Iron, calcium, protein = Very important in 2\textsuperscript{nd} & 3\textsuperscript{rd} trimesters. Unfortunately, can’t get enough for twins (50 mg, 1800 mg, & 125 mg/day) without really focusing on these. Omega 3 fatty acids (1 gm/day, for baby brain development) also require conscious consumption (via flax seed or lots of nuts, since fish oils carry risk of mercury). Egg yolks, peanuts & beef carry choline, which also is an important food focus, for neural development. Zinc is also helpful for brain size.

Rest ~2 hr/day when carrying multiples & consume extra iron. You’ll be especially monitored for pre-eclampsia & will be seen by docs twice as often. Bed rest increases blood flow to babies, to aid their development. Only walk or swim or stationary bike, due to extra stress. Stop work 8+ weeks before due date. Take childbirth classes 3 months ahead. (YPA30)

Pre-pregnancy: 2 months prior to conceive, avoid all raw & undercooked meats (including sushi) & eggs with runny yolks. (O&M) Raw poultry & cracked eggs can harbor salmonella (so avoid egg nog, hollandaise, homemade ice cream, cesar dressings). Cook eggs well & clean all surfaces. (YPA30)

Quantity: Women who eat little &/or “starve” create children used to hardship, who will store food very efficiently & grow fat. If this starvation of the mother is early in the pregnancy, the child will be small all over/symmetrically. If late, the child will have a big head, as the body saves all it can for the brain.

Recommend 6-11 grains, 3-5 veggies, 2-4 fruit, 2-3 milk, 2-3 mean or other protein (PP). For snacks for mothers of multiples, recommend nut butters over bread, rice cakes, fruit & veggies, humus, pita, cottage cheese. (HT)

Wheat germ is best food available, per ounce (& stimulates appetite!), while eggs have best protein. Milk, cottage cheese & yogurt are all also terrific foods to have regularly. (WTE) Wheat germ is the most wholesome food available, ounce per ounce. (WTE) Add to yogurt shakes or over cereal! (KK)

Fruits = good snacks between meals (i.e., without other foods), b/c they cause other foods to ferment (melons especially do this) → painful. (HT)

Prenatal Vitamins: KK used Stuart Natal’s generic version

(\texttt{http://www.stuartnatal.com/stuartnatal\_plus\_3/stuartnatal\_difference.html}) → 27 gm iron & 200 mg calcium, 1 mg folate, & 25 mg zinc, but twin moms supposedly need 50 gm iron/day & 1800 mg calcium = HARD to get!! (+ \textasciitilde 100+ gm protein – fortunately, cottage cheese 1 cup has 28 gm of protein, but virtually no iron).

Don’t consume after the Use By dates. Refrigerate all unused foods right away.

Wash hands & nails for 20 secs, after handling meats. Hot-water wash cutting boards. Microwave sponge. (O&M)

Dr. Luke (who directs U Michigan Multiples Clinic) argues that pattern of weight gain is key, & more important than total weight gain. Women with twins should gain 24 lbs by 24 weeks (40-50 lbs total), vs. triplets 36 by 24 (50-60 total). Weight gain by 20 weeks dramatically affects fetal growth in middle & late periods; gain during 20-28 weeks immediately affects growth; gain after 28 weeks does not affect weight of fetuses as much as earlier gains. Women who start underweight should gain the added weight that would make their start-weight normal. Target birth weight of children is 6 lbs 3 ozs at 36 weeks. (Info at \texttt{www.twinsmagazine.com/articles/fostering.html}) TPG’s Laura Menzies (multiples nurse) recommends only 40 to 50 lb weight gain for twins.
Pregnancy fat deposits in shoulder blades, upper arms & thighs & will be helpful late in pregnancy when a woman can’t eat as much. Will also serve during nursing. (ST)

For twins, Dr. Luke recommends 175 gm protein per day (!), 8 calcium servings (= glass of milk or 1 oz of cheese; 10 such servings when nursing twins!), 2 eggs per day, & emphasizes animal proteins. Also, 3500 lbs/day for twins (vs. 4000 for triplets), over ~7 meals/snacks each day. Plus, drink >96 oz of water each day, since dehydration is often a factor in early labor. (Info at www.twinsmagazine.com/articles/fostering.html)

NAS recommends 24 lbs by 24 weeks, and 1.25 lbs/week after that (for twins).

**Calories:**
+300 cal/day via meats & milk (protein & calcium) during 2nd & 3rd trimesters, to gain an avg of 28 lbs for singleton. (O&M), +500/day (per child) during exclusive breastfeeding (but can cut this a bit to drop weight, ~1 lb weight loss per week is safe) (O&M)

**Fish:**
Avoid raw fish, lox, smoked fish, & shell fish – unless cooked thoroughly, due to Listeria.
Canned fish are fine. (O&M)
Don’t eat smoked fish, due to the sodium nitrate preservatives. (PP)
Avoid high-mercury fish = large fish = shark, swordfish, domestic tuna, king mackerel, tile fish. Less than once per month, one can have pike, pickerel, large bass, orange roughy, oysters from Gulf. Canned tuna = small tuna = fine 2 time/week (just 2-3 oz, not entire can). (O&M) NYT (2003) article using USFDA results of mercury ppm suggest pregnant women not eat tilefish, swordfish, shark, & king mackerel, which have 1.45, 1.00, .96 & .73 ppm on average. Others with the “most mercury”: grouper has .27 to .43, Tuna (fresh or frozen) has .43, Northern lobster has .31, Halibut .23, Pollock .20, Dungeness crab .18, canned tuna .17, & blue crab .17. SF Chronicle article 12/03 states “About 8 percent of U.S. women of childbearing age have enough mercury in their blood to put a fetus at risk.” and that albacore canned tuna is much more problematic than cheaper, light tuna. “Recent FDA testing shows that canned albacore contains almost three times the mercury as canned light tuna -- and critics say that means a single 6-ounce can of albacore a week could put many women, depending on their size, over the safe mercury limit.” Note: Tunas are warm-water fish (vs. salmon = cold-water fish, so lower mercury).

What YOU eat, hear & do is what the baby responds BEST to when born. (PP) Have found that babies whose mothers ate lots of carrots have predilection for carrots when born. It seems healthier diets by pregnant moms lead to babies having healthier food interests. (BT)

Don’t really need to supplement with vitamins if you eat healthy. (PP)
Best sources of Omega 3’s EPA and DHA are high-fat (10-15 per cent) **cold-water fish like salmon, sardines, mackerel, herring, trout** and pilchards. EPA and DHA fatty acids make up 15-30 per cent of the oil content of these fish. Oily fish containing these important EPA and DHA fatty acids should be eaten regularly - preferably with their skins. Fresh wild fish are superior to fish harvested on fish-farms. This is because commercial fish foods contain less vitamin A and C, and less of the omega-3 fatty acids than ocean foods. Fresh fish is also superior in omega-3 fat content to frozen or canned varieties.
Omega 3 reduces hypertension & likelihood of pre-eclampsia. It allows for longer pregnancies and higher birthweights. And some people believe it’s good for fetal brain development. You can take capsules/supplements too, but don’t exceed 2.4 g of omega 3 fatty acids/day. (YPA30) Salmon, herring, mackerel, & tuna are high in Omega 3, but don’t eat uncanned tuna & eat < 12 oz of canned tuna/week. Eat as often as you like bass, salmon, catfish, flounder, sole, Pacific halibut, orange roughy, cooked clams, cooked crab, scallops, shrimp. Avoid lake trout, sushi, ceviche, any raw fish, Hawaii’s, Carribean & Florida’s warm tropical fish [like snapper, mahi mahi, grouper, tuna]. (YPA30) EPA recommends < 8 oz (6 oz once cooked) fish per week for pregnant & nursing women, and 3 oz (2 oz cooked) per week for young children. Important to vary the species of fish. (Whole Foods www.epa.edu/mercury/)

Omega 3 & 6 are the building blocks of the protective brown fat that babies need to survive after born (as they struggle to keep themselves warm for first 2-3 days outside the womb & protect their brains), & to protect adult hearts. (ST) YPA30 writes that one should aim to get no more than 2.4 g of Omega 3/day (~1/3 Tbl of flax seed oil?? & how much ground flax seed??)

Flax seed: Best taken as seed, ground up in grinder as needed (with whole seed stored in fridge). Oil fine too, but no fiber. Capsules okay, but still less good. (10 1000gm capsules = 1 Tbl of oil = 8600 mg of Omega 3 & 2700 mg of Omega 6) “Our bodies function best when our diets contain a well-balanced ratio of these fatty acids, meaning no more than 4 times as much omega-6 as omega-3.” “A deficiency of omega-3’s is linked to various skin disorders, arthritis and joint stiffness, irritable bowel syndrome, premenstrual syndrome, immune dysfunction, and depression.” “flaxseed helps restore balance and lets omega-3’s do what they’re best at—balancing the immune system, decreasing inflammation, and lowering some of the risk factors for heart disease.” “Flaxseed and flaxseed oil reduced the growth of existing tumors, but another component of flaxseed, called lignans, appeared to help prevent the development of new ones.” “Flax seed has at least 75 times more lignan than almost any other plant.” “Lignans are phytoestrogens, meaning that they are similar to but weaker than the estrogen that a woman’s body produces naturally. Therefore, they may also help alleviate menopausal discomforts such as hot flashes and vaginal dryness. They are also antibacterial, antifungal, and antiviral.” (http://www.bodyandfitness.com/Information/Herbal/Research/flax.htm)

“Whole flax seed comes with Nature’s own finest packaging – its natural hard hull keeps it fresh. You can store clean, dry, good quality whole flax seed at room temperature for up to a year. Some people keep a jar of flax seed handy on their kitchen counter. After grinding, you should refrigerate it in an airtight, opaque container. Ground flax seed handled this way will keep for up to 90 days. Ground flax seed provides more nutritional benefits than does whole seed.” (from http://www.flaxcouncil.ca’s FAQs). 1 Tbl = 8 gm = 35 – 50 cals = 41% fat, with Omega 3’s being 57% of that fat, so I estimate that 1 Tbl offers ~1.7 gm of Omega 3. 28% of flax seed weight = fiber. (using data at http://www.flaxcouncil.ca/pdf/smartch.pdf)

TPG’s dietician Kelli Webb wrote that “Dr. Luke’s book Program Your Baby’s Health: The Pregnancy Diet for Your Child's Lifelong Well-being recommends 1000mg Omega-3 fatty acids per day & mentions that tuna has 500mg in a 3-oz serving. Of course, tuna is a higher mercury fish and the current recommendation is less than 12-oz per week of tuna.” (12/03)
TPG Dietician’s Kelli Web also says flax seed better than oil b/c contains great fiber. Do continue Omega 3’s while nursing. However, flax is an anticoagulant, so don’t overdo it if worried at all about blood clotting needs (e.g., placenta previa issues).

**Eggs & Egg Products:**

Eggs offer the best quality protein of any food available. (WTE) Dr. Luke recommends 2/day (& 3500 cal/day, which seems impossible…)

Egg Beaters are simply egg whites with color, so excellent source of protein (but not other vitamins). (ST)

Refrigerate eggs & cook through (no runny yolks!). No raw cookie & other batter, no tiramisu (raw egg), no Caesar salad dressing, no mousses (unless you ask beforehand & are comfortable that no raw eggs were used in the prep). Raw Egg Beaters are fine, however! (O&M) No home-made ice-cream, home-made mayo or eggnow, raw cookie dough, …. (Grogono)

Eggs are best source of choline, which is critical for brain cell membrane. Beef & peanut butter are also great sources of choline. (Lettuce, wheat bread, califlower & tomato also have some.) (TPG Dietician’s handout)

**Vegetables:**

Wash veggies with soap & water, to remove pesticides. Or choose organic produce. (PP & YPA30) Wash hands to remove bacteria & chemicals/pollutants. Fellow who has worked for Whole Foods for years said organic produce hasn’t been proven safer; mainly it’s a more environmentally friendly way to farm (since only organics are used, so the soil’s nutrient content doesn’t fall). Washing is what’s important. But thin/soft-skinned fruits & veggies can be dangerous (e.g., strawberries). Also, BT suggests that, if you’re going to buy organic produce, best to buy those without peels, like strawberries, bell peppers, spinach, celery, apples & green beans. (BT)

Lettuce – Discard outer leaves. (O&M)

Potatoes exposed to the sun turn green to avoid insects & will sicken adults. Don’t eat such things. (PP)

**Cheeses:**

All cheeses to be consumed by a pregnant woman should be pasteurized. Many people still avoid all soft cheeses (e.g., brie, blue, queso fresco), even if they say pasteurized, b/c they still may be more easily contaminated with listeria. (BT) Cottage & cream cheese are fine! (O&M)

Feta Cheese: Many large manufacs of Feta use pasturerized milk & have never had an incident of Listeria. (Note: Listeria shows up 3 weeks after you eat something infected.) (O&M)

Listeria is VERY rare (e.g., < .01% of cheeses). Lynne said everyone gets sick from it, so you will know. (Dr. Grogono’s NP, Lynne) But BT disagrees: While most other healthy adults can carry isteria bacteria without getting sick, pregnant-women may begin to experience flu-like symptoms, muscle aches, fever, diarrhea & upset stomach up to a month after exposure. Tell your doctor asap, since early diagnosis & treatment with antibiotics can overcome this one for your baby. (BT) **
Processed Meats:
Refrigerated processed meats have a small chance of Listeria; this includes smoked fish, hot
dogs, unwashed veggies → OK if HEAT up (& then store cold) before consume (till
steaming, for example). Also, nitrates are used to preserve lunchmeats & hot dogs, where
are not so great. (O&M; BT)
Give up smoked, refrigerated seafood. Canned fish & meats are fine.

Calories & Weight Gain:
+300 cal/day via meats & milk (protein & calcium) during 2nd & 3rd trimesters, to gain an avg
total of 28 lbs for singleton. (O&M). After birth, +500/day per child for exclusive
breastfeeding (but can cut this a bit to drop weight, ~1 lb/week is safe) (O&M)
If you gain weight too fast while pregnant, you can cut out all but one serving of fat. If
you gain weight too slowly, you can cut back your exercise to ~15 min./day (vs., e.g, 1
hour). (WTE)
25-35 lbs is typical recommended gain for singleton pregnancies; 7-10 lbs of this is in fat
stores, the rest is related to baby (such as amniotic fluid, breast size…). 44 pounds is a
good target weight for twins; eat extra dairy & protein. (YPA30)
Some women gain no weight in their last couple weeks of pregnancy, & weight gain
certainly drops off in the last month of pregnancy. (WTE)
Gas & bloating can diminish appetite, so be sure to eat slowly (so you inhale less air
while eating) & eat more often (but less each time), while sitting down. Constipation will
also reduce room for eating, so watch out for this. (WTE)
Dr. Luke (who directs U Michigan Multiples Clinic) argues that pattern of weight gain is key, &
more important than total weight gain. Women with twins should gain 24 lbs by 24
weeks (40-50 lbs total), vs. triplets 36 by 24 (50-60 total). Weight gain by 20 weeks
dramatically affects fetal growth in middle & late periods; gain during 20-28 weeks
immediately affects growth; gain after 28 weeks does not affect weight of fetuses as
much as earlier gains. Women who start underweight should gain the added weight that
would make their start-weight normal. Target birth weight of children is 6 lbs 3 ozs at 36
weeks. (Info at www.twinsmagazine.com/articles/fostering.html)
NAS also recommends 24 lbs by 24 weeks, and 1.25 lbs/week after that for twin pregnancy.
(LM’s handouts)

Caffeine:
Recommend 100 mg/day or less = 3 teas (6 oz each, brewed 3 min each), 2-3 12 oz softdrinks,
1 cup coffee. (O&M) LM’s dietician recommends max of ~200 mg/day.
12 oz Coke has ~45 mg, 6 oz coffee ~150 (but only ~70 for instant), 40 mg for 5 min brewed
tea, 45 gm for 2 oz sweet chocolate.
Seems to be no added risk of miscarriage if 2 or fewer coffees per day. Do drink lots of water
& mix this with decaffeinated sode. (Note: 1 soda ~ 1/3 caffeine of 1 cup of coffee.) (PP)
Pregnancy leads to an overall “slower feeling”, like having finished a big meal. You’ll want
more caffeine, but, interestingly, only half as much will result in the same effects. So one
can drink less comfortably! (PP) Note: Lots of wrenching activity (physical or mental)
causes the release of adesonine, to brake one’s activity (via sleep). Caffeine removes
these brakes. (PP)
Sweeteners:
Fine, up to 3x per day (e.g., in yogurt, hot cocoa, softdrink), extensively studied with no evidence of impacts. (Note: Sachcharin has been taken off the federal cancerous list recently). (O&M) Most people recommend Splenda, over Nutra Sweet, and Nutra Sweet over saccharin, because saccharin passes through the placenta (& is banned in Canada? [ST]), while Splenda can’t even really get absorbed, since body cannot recognize it (though it’s the most natural of the 3). Nutra Sweet is formed from 2 amino acids. Note: Splenda can cause gas. (ST)
TPG’s dietician Kelli Webb says saccharin crosses the placenta, NutraSweet comes from 2 amino acids combined in unusual way; Splenda doesn’t really get absorbed b/c body doesn’t recognize so considered best.
Sweeteners seem to be fine in small amounts. (PP)

Sugar & Sweets:
Too much blood sugar results in too big babies. High birthweight females often associated with breast cancer too. (PP) Sweets reduce insulin in the body ~1 hour later; the baby feels this, esp. when a mother is on bedrest. Avoid this. (GPSP)

Teas & Herbs:
Excessive tannins bind certain minerals like FE, so one cannot absorb them. (Avoid long steep times, I guess?) Chamomile has a mild effect, so limit to once per day; gingerale drink is fine (b/c it’s artificially flavored, not real ginger). Avoid EVERY other type of herb, e.g., licorice; many are bad news. (O&M)
Avoid herbal teas b/c they may have odd ingredients. Mint, rosehips, orange spice (& chamomile; no???) are fine. (PP)
Make sure your tea is made from boiling water, or has a short steeping time. Don’t consume sun-made tea or often warm restaurant teas, since bad bacteria can grow at warm temperatures & with long steeping times. (YPA30)
Chamomile helps digestion, red raspberry reduces nausea & stabilize hormones, peppermint reduces gas pains & stomach acids. (YPA30)

Water:
8-10 8 oz glasses/day & more if exercising, it's hot, or high altitude. Be sure that the urine remains a light color. It may be darker in the mornings, however. (O&M)
Carbon water filters can reduce chlorine byproducts in water. (O&M) Drink 6-8 glasses of liquids/day, before & after exercise, & don’t allow yourself to get thirsty. (YPA30)
More urine (& 40% more blood, of course?) from both you & your baby means a need for more water, yet you’ll have less space to hold this, so you must drink (& urinate) often – and snack! (PP)
Blood volume with twins increases ~100% (!!! others say 33% & 40% only!), so need fluids (~10+ glasses/day) & salt. (HT)
Soups are also ideal for meeting reduced stomach size & high fluid requirements of pregnancy. (HT)

Sodium:
Keep sodium to < 3000 mg/day to avoid swelling & blood pressure problems. (YPA30)
Protein:

Protein is VERY important, esp. for athletic women! Should get ~60 g/day (~10 eggs or 9 oz of meat), for normal women; 80 g/day for athletic women. But most Americans get what they need. (O&M) ST & others recommend >100 gm/d for twin pregnancies. ST recommends ~110 gm/d minimum, & average ~130 gm/d.

One can put protein power (including silken tofu powder) into shakes. (HT) ST recommended Aria, which is a combo of soy & whey proteins. Egg whites are very high in protein & can be purchased dry; Egg Beaters are simply egg whites with color. (ST) Protein is what builds the baby’s tissues. So it’s critical. (PP)

The respiratory & cardiovascular changes of the first trimester result in much fatigue for the mother. One needs to eat enough fuel so that the body isn’t breaking down proteins for energy. For full-term twins, 100-110 gm/day of protein (& 4,000 cal/day) is recommended. (HT)

One can get ~25 gm of protein from 100 gm (3.5 oz) of chicken, 28 gm per cup of cottage cheese (! wow!), ~10 gm per egg, 11 gm per wheat bagel, 4 gm/2 Tbl wheat germ, 20 per ½ cup of lima & kidney beans, 13 per ½ cup of oats & 7 for brown rice. (HT) HT also says 34 gm per ½ cup of soybeans, but, in reality, on a package of soy beans, it’s 11 gm/½ cup & on lima beans, it’s 6 gm. (Also, ~9% & 8% of USRDA in iron.)

Soak beans & grains overnight to increase their digestability; cumin (!!) also helps digestion. (HT) – And tastes great in KK’s lentils!

Granola made with rolled oats, wheatgerm, seeds, nuts, raisins, yogurt & fruit = Great foods → great breakfast! (HT) Quick oats have lost much of their good material, so really want rolled oats (which can be quickly cooked for ~3 minutes in microwave). (ST) Meat contains ~14 times more pesticides than plant foods, & ~5 times more than dairy products. (HT)

TPG Dietician’s Kelli Webb said powdered egg white great for protein. Yolks (& peanut butter & beef) great for choline (important in neural development). E.g., a woman pregnant with twins and trying to add those 2 lbs/week can add peanut butter to an evening shake.

Oils & Fats:

Balance in Omega fatty acids is important for baby's BRAIN development, eye, & nervous systems. This is true from conception until the baby is 2 years old. Decrease corn & sunflower oils, & INcrease olive, canola, peanut oils, soybeans, salmon, sardines, tuna, .... (O&M)

Oils turn rancid under heat, O2, & light → forming free radicals. Olive oil is does not really have fatty acids, but has polyunsaturated fats, which are good. It does not work well at high heat, however, so canola oil better for a lot of cooking. Use extra virgin, unrefined, cold-pressed olive oils for best results. (HT)

J Williamson uses canola oil for high-temp cooking & olive (which is less stable at high heat) for medium-temp cooking. She says Omega 3 is VERY important in 3rd trimester (for brain development). She recommends adding flax seed oil to smoothies (not cooking with it, since it’s quite unstable) & eating flax-seed crackers, & buying special eggs rich in Omega 3.

Chewing pumpkin seeds, walnuts, soybeans = “easy way” to get essential fatty acids. (HT) Pesto sauce is made from walnuts & pinenuts & thus is a good source. (ST)
Fats are Sat'd or Unsat'd. Saturated fats come from animal foods (meat, cheese, eggs, dairy & palm oil. NOT essential for health. Mono-unsat'd is considered to be one of the healthiest types of general fat. It is found mainly in olive oil, rapeseed oil, canola oil, nuts and seeds. Poly-unsat'd is NOT as good; however, it contains the EFAs (essential fatty acids): Omega 3 & 6.

**EFAs & Omega 3**

http://www.annecollins.com/dietary-fat/omega-3-efa-6-chart.htm -> Omega-3 - Alpha-Linolenic Acid (LNA) - is the essential fatty acid in shortest supply. According to experts, our current consumption of this fatty acid has shrunk to one sixth of 1850 levels. By comparison, our intake of omega 6 fatty acids has doubled since 1940. Excess intake of omega 6 can cause increased water retention, raised blood pressure and raised blood clotting. We should INCREASE our intake of omega-3 fatty acids and REDUCE our intake of omega-6 fatty acids.

Omega-3 fatty acids are necessary for proper baby brain development and are especially crucial during the last trimester, when a lot of brain development occurs. From Kashi Website: Omega-3s are found in both plant and animal foods. Plant sources provide only one type of omega-3, called alpha-linolenic acid, and rich sources include flax oil and seeds, walnuts, canola oil, hemp seeds and oil and soybean oil. Animal sources provide two different types of omega-3s, eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA). The richest sources of EPA and DHA are fish like salmon, lake trout, tuna, herring, mackerel and sardines. Several brands of DHA enriched eggs as well as DHA fortified foods are also now becoming available. Tips For Eating More Omega-3s: Sprinkle ground flax seeds into fruit smoothies, cereal, oatmeal, yogurt, salads, and add them to baking recipes. Combine a little flax oil or canola oil with olive oil when creating homemade salad dressings. Use mayonnaise made with canola oil. Start eating fish a couple times per week. Snack on walnuts. Use canned tuna and salmon for sandwiches and salads. (Joanna eats up to 2 tuna cans per week, to avoid having too much mercury.)

Flax/Linseed OIL (not linseeds) ~58 gm of Omega 3 per 100 gm of oil, vs. 11.5 for walnut & 7 for canola & soybean. Omega 6's = highest (74 g) in safflower oil & grapeseed & sunflower & walnut (68, 63, 58) & soybean, corn & sesame (51, 50, 43). Canola/rapeseed & flax/linseed are just 20 & 15. In NUTS, walnuts are the only ones with Omega 3 (just 5.5 gm/100 gm); walnuts & almonds are highest in Omega 6's (28 & 10 gm/100 gm). In SEEDS, flax/linseed = 15-25 gm/100 gm Omega 3 vs. Sunflower & Sesame & Pine nuts = 30, 25, & 25 Omega 6 gm/100 gm. All fats = 120 cal/Tbl. Hemp oil is the "best balance of omega 6:3". ** Canola (aka rapeseed) oil meets the 1:3 recommended balance between Omega 3’s & 6’s; it’s 7 gm & 20 gm/100 gm. ** (Vs. soy ~7 & 51. Walnuts ~5.5 & 28. What’s hemp?? And what are Omega contents of fish?)

DHA is an Omega 3 fatty acid found in fish & is key to eye function of baby & higher cognitive development of children. Omega 3’s alpha-linolenic acid also can be converted to DHA (from flax seeds, wheat germ, walnuts, canola oil, soybeans), but not quite as well as eating fish oil first. EFAs before conception are also key, & seem to be strong predictors of baby & breastmilk composition. (TPG Dietician’s handout)

**Omega 6 Fatty Acids** (e.g. linoleic acid) Found in unrefined safflower, corn, sesame and sunflower oils vs. **Omega 3 Fatty Acids** (e.g. alpha-linolenic acid) Found in oily fish, linseed or flax oil, hemp oil, soybean oil, pumpkin seeds, walnuts, dark green vegetables (~ want 3:1, vs. presently ~15:1). Light, air and heat destroy Essential Fatty Acids (Omega 6 & 3), so processing
and packaging methods are extremely important. Ideally, when buying oils, choose mechanically processed, organic oils in opaque glass containers. Both these essential fatty acids are vital for good health. They regulate mental health, growth and vitality and are believed to assist the transport and uptake of oxygen throughout the body. EFA deficiency is associated with cardiovascular disease, cancer, diabetes, multiple sclerosis and other degenerative conditions.

**Balance between Omega 6 and Omega 3:** The optimum balance between these two EFAs in our diet is considered to be three omega 6 to one omega 3. This contrasts with the current balance in the average Western diet of 10 or 20-1 in favor of omega 6. *i.e. eat more omega 3.*

http://www.kentucky.com/mld/kentucky/entertainment/dining/6627131.htm: **Limit processed foods.** They are often rich sources of soybean oil and therefore filled with omega-6 fatty acids, which compete against omega-3s for entry into key cells in the heart and brain. By flooding your diet with omega-6's, you make it more difficult for your body and brain to get enough omega-3's, experts say. **Use olive oil.** Although it's not a huge source of omega-3 fatty acids, substituting it for other oils that are loaded with omega-6's -- safflower, soybean, corn -- can help tip the balance back in favor of omega-3's. **Eat varied types of omega-3 foods.** Every food group contains them, though not in such high doses as fish. Among the standouts: wild rice, kidney beans, melon, spinach, cauliflower, broccoli, Boston lettuce, gouda and Parmesan cheese, cherries, grape leaves and mungo beans. Of course, all these foods have just a fraction of the omega-3's found in fish and fish oils. Many contain only short-chain omega-3's, which are inefficiently converted by the body to the long-chain omega-3's found in seafood. Oily fish = Best way, but farm-raised salmon can have appreciably greater amounts of PCBs than wild salmon. (PCBs are a known cancer-causing agent in animals and a suspected one in humans.) And because of concerns about the level of mercury in some species of fish, the Food and Drug Administration advises children, pregnant women and women who might soon become pregnant not to eat any shark, swordfish, king mackerel or tilefish. 2 gm of Omega 3 EFAs per 100 gm of raw salmon. Can buy capsules of fish oil supplements ~500 gm (!!??).

Omega 3 eggs have about 7-10 times more omega-3 fatty acids than a regular large egg. Alpha-linolenic acid (ALA) is the parent compound of the omega-3 fatty acid family. It is required in the diet because humans cannot manufacture it. The other essential fatty acid for humans is linoleic acid, the parent compound of the omega-6 family. **(http://www.ameriflax.com/default.cfm?page=Eggs)** KK has also seen on the web & in stores ~100 mg – 350 mg/egg of Omega 3, vs. ~33 mg in regular egg. Also reduced Omega 6's in some eggs, resulting in overall better balance.

Limit fish to no more than 12 oz/week (& canned tuna to 6 oz per week). (BT)

Add some flaxseed. And some canola oil, too. Both are good plant sources of omega-3 fatty acids. A tablespoon of flaxseed has four times more omega-3's than omega-6 fatty acids. Canola oil has twice the amount of omega-6's as omega-3's: That's a far better ratio than corn, safflower and even olive oil. (Avocados and nuts are also often touted as good sources of omega-3's, but avocados have about 16 times as many omega-6's as omega-3's. Nuts provide omega-3 fatty acids, but also a lot of omega-6's.)

Check the oil in canned goods. Many types of tuna and other canned fish come packed in soybean oil, which swamps the omega-3's. Experts say better choices are fish packed in olive or canola oil or in water. Consider fish oil supplements. If you're not going to follow the American Heart Association's recommendation of two servings of fish a week, dietary supplements are another option.
**Vitamins:**

For single babies, O&M feel only folate is important to supplement. Prenatal vitamins are expensive, so you can switch to a regular multivitamin 3 dy/week after conception, & you really don’t need this if you’re eating well. (O&M)

KK taking generic “equivalent” of StuartNatal vitamins. All contain 1 mg of folic acid, 25 mg iron, & may differ on presence of other vitamins.

Vitamin bars: Joanna Williamson suggests that Kashi bars don't have all the supplemented nutrients in them, like Luna bars, which makes them a good little snack during pregnancy (it's not wise to mega-dose on vitamins, so she won't take prenatal if she eats a Luna bar that day).

Folate/Folic Acid: Needed for neural development; the 1st 28 days (& even before conception) = Critical. Before-conception folate may also reduce chances of Down's syndrome b/c the egg intended for release undergoes some chromosomal prep right before ovulation. Rice, tortillas, avacados, asparagus, beans, spinach, oranges... all contain this B vitamin. (O&M)

Avacados contain more folate per oz than any other fruit (45 microgms/half cup). Advised to take 400 microgm/day if pregnant or trying to get pregnant. Avacados also have more energy-boosting phosphorous than bananas! (BT)

For DNA & neural dvlpmt. First 28 d of pregnancy. Take >1 month before & 1+ month of pregnancy. U.S. requires flour be enriched with this vitamin. (PP)

Folic acid is very important for cell division, so one needs 3 to 4 times the normal levels. (GPSP) Twins may need more folate than is provided in your prenatal vitamin. Vitamin B9 is folic acid, & it’s needed just the first trimester (& before conception); can get this in bananas, green beans, citrus fruits, spinach, egg yolks, peas, & yogurt. (YPA30)

Vit C is very important, A is important too (but can be overdone, b/c it's not soluble; it comes from milk & chicken & liver -- but don't eat too much, e.g., only 1 slice of liverwurst per week) (O&M)

Vit D comes from sun exposure & is a hormone. (Norwegians have lower preg rates b/c of lower sun exposure.) (O&M) ST believes only ~30 min of sun exposure/day is needed (vs. vitamins & Vit D enriched milk), but young kids shouldn’t get much sun exposure. Too much Vit D &/or Calcium → Kidney stones. (PP)

Iron: 27 mg/day for 1 baby (= 8 oz of liverwurst [should heat beforehand, due to listeria], 25 oz of ground beef, 4 cups chicken, 8 cups spinach, 27 eggs, 10 wheat bagels) vs. USRDA = 18; take with Vit C (or OJ) to help absorption (but not Calcium); clams (& tofu) are very high in this! (O&M)

For twins, should get 50 mg/d (vs. USRDA ~15-20). Excessive iron → black stool. Avg Chinese get ~2 times amount of iron from veggies as Americans. Soybeans have ~8.4 mg/½ cup (?? KK saw just 9% of USRDA in ½ cup of soybeans, on bag…). Kale supposedly has 4 gm/cup, chicken only has ~3 gm/6 oz serving, & there is no iron in milk. (HT) Will need extra iron if carrying multiples. (YPA30) Prenatal Vitamins: http://www.stuartnatal.com/stuartnatal_plus_3/stuartnatal_difference.html → 27 gm iron, but twin moms supposedly need 50 gm iron/day = HARD to get!! (+ ~100+ gm protein – fortunately, cottage cheese 1 cup has 28 gm of protein, but virtually no iron). Note: Best to get iron from food, vs. elemental iron in some supplements is the least absorbable kind. (ST)

Important for O2 transfer to baby. (Iron pill best absorbed on empty stomach.) (PP)
Very important first trimester. (PP) Blood volume increases by 33%, so one needs more iron for O2 transport. (GPSP)

http://www.ajcn.org/cgi/content/full/71/5/1147#F1 -> iron absorption with milk/cheese/yogurt falls from ~100% to 40% as calcium goes from ~35 mg to 350+ gm (sigmoidal curve). Iron absorption also falls significantly (~40%) with tea & coffee.

Note: Base level of iron absorption ~15% assumed, so a fall of 60% (from 100 to 40%) is probably from 15% absorbed, to 6% absorbed, from what I can tell...

http://health.allrefer.com/alternative-medicine/iron-3.html suggests heme iron is very well absorbed, regardless of diet, while nonheme iron is what's affected. Healthy adult absorbs ~15% of iron, & this will fall as adult has too much iron in his/her system.

(where does one get heme vs. non-heme iron??)

**Zinc:**

Very imp for growing cells, & women often miss this requirement! O&M says singletons need 12 mg/d (vs. 8 regularly), but NAS recommends 15 & 30 mg/day for women carrying twins. (KK’s prenatal vitamin has 25 mg.) All meats are ~2-4 mg/3 oz serving & milk is just 1 gm. Zinc lozenges are NOT a good idea, b/c they are too high & may cause nausea. Avoid these before & during pregnancy; they can be somewhat toxic.

(KK’s zinc lozenges offer just 100% of USRDA, so how can that be too high? However, she did vomit after consuming one before breakfast in week 28 of pregnancy [which is extremely unusual for her].) Legumes & grains are good sources of Zinc. (O&M) Zinc is for genes & brain development. Get from whole grains, nuts, & meat. (PP) Zinc can increase baby size, esp. in thin women. It’s in meat, seafood, & milk. (YPA30) LM doesn’t have her mothers supplement, but 100% USRDA lozenges probably fine (though finally made KK ill in 28th week, on empty morning stomach).

**Calcium:**

For TWINS = 1800 mg/day = 6 (!) milk servings per day (LM’s dietician). (vs. O&M says singleton moms need just 3 yogurts/day, or 3 milks, 8 oz sardines, or 8 cups spinach, which doesn’t sound right. LM’s dietician says really should be 1200 mg, or 4 milks/day for singletons)

Cottage cheese has lots of protein, but not so much calcium! Fortunately, regular cheese is a good source of calcium (200 mg per 1 oz cheese). Ice cream has 200 mg per 1 cup. Sardines have ~400 per 3 oz & salmon has ~170 per 3 oz serving.

Calcium is very important 2nd trimester. (PP) (vs. HT suggests last 2 months are most imp.)

Most abundant mineral in body. When one is inactive, body will deplete the bones for calcium, so bed rest should not be overdone. Calcium must be adequate – esp. during the last 2 months of pregnancy when >50% of fetal bones are built. Need ~1200 mg/d, & there are 220 g/cup of milk – 400 g/cup of kale & soybeans! 500 g/7 oz salmon. (HT) Cows milk products are not part of the diet elsewhere & may “clog up” the body (via mucus & acne). Mothers avoiding cows milk may clear up ear infections & other issues for their children. (HT)

Need 1200 g/day of calcium >> prenatal vitamin. (YPA30)

The phosphorous in milk actually reduces the uptake of calcium, & the milk’s protein leaches calcium from one’s bones! It’s a paradox. (HT) Goat’s milk (incl. feta cheese) & soy milk may be more digestible. Sea veggies contain the highest amounts of calcium per gram of anything. One should soak these to rehydrate them (& to reduce their salt) & then can cook with other veggies. They are high in iodine, so no need for iodonized salt with these. (E.g., can use sea salt.) (HT)
**Alcohol & other Toxins:**

Pre-pregnancy: Alcohol reduces chances of conceiving, so avoid this about 2 weeks to 2 months prior to trying. (Heavy drinking [e.g., 5+ drinks/week reduces sex hormones for ovulation.] (O&M)

Cooking with Alcohol: One must simmer for ~30 minutes to get the alcohol content down by just 65%! & 1 hour to get it down 75%!, but this should be fine. (O&M)

Enjoy alcohol-free wines & beers!

Alcohol cuts blood supply to the fetal brain & impacts nerve cell transmissions. Moderate to large amounts lead to retardation. We don’t know about low amounts (e.g., < 2 drinks/week). Our ignorance suggests abstinence. (PP)

*Smoking:* The nicotine of smoking & smoke mimic important neurotransmitters creating problems for the child’s mental & overall development (& predisposing the child to becoming a smoker). It also reduces blood flow & the CO attaches to the hemoglobin, so less O₂ makes it to the child. Smoking is worse than starving. (!) (PP)

**Other Toxins:** Embryos have 1 cell through which they create 1,000s (via division). Adults don’t have any cellular division. Any toxin is far worse for a developing child than an adult. Do not pump your own gas. Do not use solvents, nail polish, oil-based paints, bleach or ammonia. (PP) No studies have yet linked household solvents to birth defects, but, if you wish to be cautious, have someone else pump gas & pick up drycleaning (& let drycleaned clothes air outside before bringing in). (BT)

**TRAVEL:**

Take LOTS of fluids when flying. (O&M)

No travel after 28 weeks, typically, with twins. No travel recommended earlier either (e.g., beyond 26 weeks) if esp. high-risk (e.g., placenta previa).

Move legs about to avoid blood pooling (which can cause nausea & other problems).

**BIRTH DEFECTS:**

35 is a special age simply b/c it’s the last year before a woman’s risk of chromosomal abnormalities exceeds risk of having a child born with Down’s syndrome. Both risks increase with age, because older eggs are more fragile & more likely to suffer “breaks” in their chromosomal content. The risks rise from 1/1000 & 1/400 at age 30, to 1/300 & 1/200 at age 35, to 1/100 & 1/65 (!!) at age 40. (O&M or PP?)

With twins, recommend amniocentesis after age 32, because two kids have twice the risk, so that counteracts risk of amnio to them even earlier.

Doctor should do Rh factor, Hep B & expanded AFP (for Downs Syndrome) tests. Have I had these? (Note: Debra Monks said AFP tests are no so accurate for twins, having lots of false positives.)

CVS (chorionic villus sampling) can be performed from 10-12 weeks with tiny piece of placental tissue, vs. Amniocentesis: at 15-20 weeks with 1 oz sample of (each) amniotic sac’s fluid.

Amnios are done for higher risk groups at about 16 weeks. (YPA30)
BODY CHANGES DURING PREGNANCY:

Nausea:
Nausea in the morning is often due to low blood sugar. (HT)
Nausea may be due to higher levels of progesterone & hCG, which slow the digestive tract & do other things. (SGR read this on-line somewhere…)
Often want to avoid garlic & cigarette odors; often like citrus & lemon odor. Having many mini-meals reduces stomach acids & thus nauseau. (Even beyond 1st trimester, smaller stomach size requires mini-meals to avoid indigestion.) (PP)
Can keep bread or crackers near bed to each in morning. Keep saltines nearby at all times. (PP)
Exercise helps body adapt & can ease nauseau. (PP)
Emetrol = over the counter fructose syrup (tastes like Kaopectate though!) to coat stomach & quell stomach. (Grogono’s nurses)
Ginger, grated into tea or candied or in gingerale, is helpful. There also are lollipops sold for nausea. (Special Additions has these. (BT)
Some people recommend only liquids in between meals, to help control nausea. (GPSP)
Toast/crackers before get out of bed, take small snacks all day long, avoid fatty foods, suck on lemons, alternate wet & dry foods, apply pressure on inside wrist for 1 minute three times. (YPA30)

Weight Gain:
28 lbs is average (7 lb = fat, 7 = baby, 2 = uterus, 1 = breasts, 3 = blood, 3 = water, 3 = placenta + fluid). (Note: Muscle is 20% denser than fat.) (O&M) If the mother is thin to begin with, she might gain ~28-36 lbs; if heavy or fat, 16-24 lbs. (GPSP)
Body will fight to hang onto fats, so you could gain even if eating less. Body may get nauseated to avoid foods higher in toxins & as a result of metabolic changes, as the body fights to start building fat & hang onto all calories. (PP)
Diabetes = problem to watch, as it transfers to your child. Eat complex carbs (~6-11 carb servings/day) & mini-meals to fill in your “glucose valleys”, so insulin doesn’t build up & become less effective in the blood. Keep fats low, since they inhibit insulin. Eating carbs (esp. whole grains & fibers) will help with constipation, which is common. (PP)
3-5% of pregnancies develop gestational diabetes → requires many mini-meals/day (e.g., 3 regular & 3 snacks).

First Trimester: This has the most interesting changes, as the placenta anchors itself, one’s blood supply needs increase (to eventually ~40% more than before), baby organs are all established. (PP) Weight gain is ~2-3 lbs during this trimester. (GPSP) Earliest signs of pregnancy are often breast size increases, darkened areolas, increases in vaginal secretions & in urination, & fatigue. (GPSP) The respiratory & cardiovascular changes of the first trimester result in much fatigue for the mother. One needs to eat enough fuel so that the body isn’t breaking down proteins for energy. (HT) Weight gain is < 5 lbs & uterus is ~3” below belly. Baby is about 4” long & weighs < 1 oz. (YPA30)

Second Trimester: Brain development of fetus occurs. There is rapid growth of the fetus, because all organs are in place. (PP) Mother with single baby should be gaining ~1 lb/week after the 4th month. (GPSP) Women gain 17-24 lbs, & the uterus is now 3” above the belly. Baby weights 2 lbs & is 16” long. (YPA30)
Third Trimester: Organs mature, baby fat is added, there’s no real growth!! (PP) At delivery time, the uterus is ~6” above the belly. And mom has gained 25+ lbs. Baby weighs an avg of 7.25 lbs & is 21” long at birth. Umbilical cord is ~24” (!) long, with 2 arteries & 1 vein to the placenta. (YPA30)

Miscellaneous Changes:
HAIR: More hair follicles are growing & resting, vs. falling out, resulting in luxurious or heavy hair for most women. A few months after birth, falling-out phase will come back & you’ll lose ~500 (vs. typical 100) per day. Don’t panic! (BT)
BRAIN & MEMORY: Mother’s brain actually shrinks in 3rd trimester but comes back a few months after birth. Concentration, short-term memory, & learning ability are significantly IMPAIRED in late pregnancy!! Lack of sleep may contribute to this. Try to leave yourself reminders in hard-to-overlook spots. (BT)
EYESIGHT: Corneas of eyes swell, along with the rest of the body, so eyesight will diminish & glasses won’t work. Sight should return to normal within 3 months of delivery. Fluctuating hormones will dry the corneas & cut tear production → need lubricating eye drops! (Note: more curved corneas means tortuous contact lens wearing for some.) (BT)
BLOOD volumes may increase up to 50%, to support circulation of the fetus, due to raised estrogen. This causes women to “glow” & their oil glands to rev up, triggering acne flares. (BT) More blood means more work for the heart, and thus exercise is harder. Just make sure you can carry on a conversation while exercising, in order to not overdo it. (Grogono’s NP Lynne) There are lots of vessels in the placenta that need to be filled. Dilated vessels mean slightly lowered blood pressure in pregnant women, explaining the dizziness when standing up too fast. (However, vessels tighten in ~7% of pregnancies, resulting in a dangerous hypertension.) (BT)
Blood volume increases by 33%, so one needs more iron for O2 transport. (GPSP)
Iron supplements (in prenatal vitamins) & regular exercise (with plenty of water) are helpful in combating these blood flow changes. Note: Warning signs of preeclampsia are constant & severe headaches, swelling of hands &/or feet, abdominal pain, visual disturbances & weight gain of >1 lb/day. (BT) Preeclampsia is a problem in ~1/3 of multiple-baby pregnancies (!). It requires bedrest.
Breathe deeply, to counteract diaphragm’s being squeezed by the uterus, which also slows the blood return from the legs – esp. with multiples/twins. Exercise is also key to a healthy pregnancy, by facilitating circulation & respiration. (HT)
Pregnant women often suffer from a low blood pressure, which means they need to rise slowly, to avoid dizziness. (YPA30)
SKIN: Other skin changes: Melasma (blotchy pigmentation, brought on by increased melanin prodxn), spider veins (as blood vessels grow & dilate, making preexisting capillaries visible), skin tags (tiny, leathery flaps that crop up in high-friction areas, like the neck & underarms & may just fall off eventually, or can be trimmed off), more moles & current moles darken; dry, itchy skin (from stretching & hormone-induced skin dehydration); a linea negra (down center of belly, due to melanin); & stretch marks (from hormones & pressure, causing skin to tear, leaving red striations that eventually fade to a silvery white). (BT) Stretch marks are hereditary + due to how much you grow. They will
probably go away in a couple years, & exercise may help. You also can get plastic surgery. (JOT) The linea negra almost always disappears. The vascular blood “spiders” will fade a great deal later. (YPA30)

- To keep skin supple, DRINK WATER, take warm (not hot) showers & use a moisturizing soap & cleaner. After pregnancy & after breast-feeding, Retin A or alpha-hydroxy acis may help fade stretch marks. (BT) A humidifier will help keep skin more supple. (WTE)
- For intense itching, have husband massage (including the vaginal area) with coconut or other natural oils. (HT)
- Pregnant women often feel warmer. ST says mom’s temperature goes up to better “grow” the babies. It’s not that they’re giving off heat. (ST)
- Many anti-acne creams contain benzoyl peroxide, salicylic acid or retinols, which could harm baby. Instead, use a very mild cleanser like Cetaphil to wash face twice a day. (BT)

NOSE: Your nose will perceive odors differently, esp. during queasy early months (to help you stay away from foods with bacteria & natural toxins). Later in pregnancy, your sense of smell worsens, as your head feels like you have a cold! You may have frequent nosebleeds or a chronic case of postnasal drip, thanks to hormones enlarging nasal passages. 😋 Thus, use a saline nasal spray, drink fluids & run a humidifier at night. (BT) You may complain of congestion → drink water, use humidifier + nasal jelly. (YPA30)

GUMS: Dilated blood vessels leave gums swollen & tender, & more exposed to infection. Cavities are 10 times more likely! Brush teeth & tongue after meals & flow and swish with anti-bacterial mouthwash once a day too. Add some professional cleanings. (BT)

IMMUNE SYSTEM: Placenta sends out an enzyme to stop natural killer cells in blood, but still mothers are more resistant to viruses during pregnancy. You can still get sick. If you’re in 2nd or 3rd trimester during flu season, consider getting a flu shot. **(BT) Bouncing on an exercise ball for a few minutes (& any kind of aerobic activity?) revs & drains the lymphatic system (& resulting in smelly urine next day, if your body really needs a cleaning). (ST)

BREASTS: Nipples become sensitive, erect, areolas expand & darken, glands alongside become more prominent. Weight increases by 2 lbs each & a cup size or more. Will be tender & sore. Buy a good bra. (BT, YPA30) Colustrum arrives in 2nd trimester; leave it alone (don’t try to express it). (YPA30)

DIGESTIVE TRACT: Heartburn, gas, indigestion & constipation are common side effects of a digestive slowdown, due to progesterone slowing stomach activities, so that nutrients are better absorbed for baby. One can avoid fatty, acidic & spicy foods & avoid lying down right after meals (or at least propping self up in bed). If you feel a burn, have a bit of yogurt, chew some gum, or drink an OTC liquid antacid like Maalox or Mylanta to neutralize stomach acid & wash it back where it belongs. For indigestion, more & smaller meals are a good idea (e.g., 6 rather than 3). For constipation, bulk up on fiber, drink plenty of water & get regular exercise. (BT)

Eating slower, reducing fats, & reducing stress can reduce heartburn. (WTE) Heartburn is esp. a problem in 3rd trimester. Avoid carbonated beverages, take smaller meals & avoid eating while flying flat or in bed. (YPA30)

HANDS: More at risk for carpal tunnel syndrome (up to 45% of pregnant women develop it!), since wrist tendons swell & put pressure on nerve. One can change positions & take regular breaks & try to keep arms & wrists straight when typing. (How??) (BT)
GENITALS: Levels of estrogen, progesterone, & androgens (male hormones produced by fetuses) may enhance libido & more blood is flowing through erogenous zones. Vaginal secretions are higher, & all this results in some good 2nd-trimester sex. Careful though, the blood flow & secretions create a breeding ground for yeast, & hemorrhoids & vulvar varicosities can be painful. Eat live-culture yogurts, & use ice packs & witch hazel compresses for pain. (BT)

Orgasm can lead to labor if the baby is at term, so traditional doctors recommend no sex 6 weeks before the due date. (HT)

Humans are the only species that has sex while pregnant! If it’s a high-risk pregnancy, one probably should avoid masturbation, since that can result in intense orgasms. Pregnant women will often feel some brief cramping after sex (!); if this endures for > 1 hour, call the doctor. (HT)

LEGS: Varicose veins bulge & ankles balloon, & extra pounds can put pressure on nerves, bringing on nocturnal leg cramps. One can wear maternity support hose, chug fluids, avoid prolonged standing or sitting, put feet up at least waist high a few times a day, try gentle calf stretches before bed, & be sure to get plenty of calcium (for leg cramping). (BT)

Leg cramps typically occur at night & due to low calcium (but high phosphorus). Take a calcium supplement that does not have phosphorus (vs. drinking milk or eating meat, which have lots of phosphorus). Stretch, use maternity hose, take warm baths, massage your legs, take Tylenol & rest on left side. (YPA30)

For varicose veins, exercise, walk, elevate hips & legs, put on hose [rolling these on] before getting out of bed, lie on left side, don’t cross legs, & don’t stand for long periods. (YPA30) Bouncing on an exercise ball for a few minutes (& any kind of aerobic activity?) helps avoid varicosities (while revving the lymphatic system). (ST)

FEET: Swelling feet (in the afternoon) mean a need for extra large shoes, such as flat slip-ons. There’s an old saying about growing a shoe size with every pregnancy. The hormone relaxin loosens the ligaments, & the foot spreads. One can do cool footbaths & prop feet up often, while carrying a few pairs of shoes a size or half-size larger. (BT) Do ankle circles & walk, to alleviate swelling. (YPA30)

BACK: May become quite sore. Treat this with rest, heat, & Tylenol. (YPA30)

Hemorrhoids: Put feet up 1 hr/day; drink lots of fluid & eat lots of fiber. (YPA30)

HORMONES:

Ovulation: Ovaries respond to 2 signals, FSH (which gets the eggs ready, by triggering prodxn of estrogen) & LH (which releases the chosen egg). Several eggs try to mature into follicles, but only one is chosen typically. Body temp rises with LH surge. Once the chosen eggs are released, the remaining follicle produces progesterone. And mucus forms, typically making it easier for sperm to travel through the cervix. This mucus is sticky, clear, & relatively thin (much like uncooked egg whites!). And it’s a great indicator of ovulation. (O&M)

Placenta essentially governs the woman’s body with hormonal info. (& serves as a shield between my bloodstream & the babies, so blood doesn’t go directly).

Progesterone keeps baby in the womb, while estrogen breaks membranes & dilates/relaxes the cervix, getting the baby ready to depart.
Twins → doubled hormones → earlier & wider dilation, + more Braxton-Hicks contractions. Doctors should not be surprised about this. (HT)

EXERCISE:
Exercise = great for pregnancy. (O&M) Good to have some weight bearing exercise + stretching. (PP)
Exercise helps combat pregnancy constipation, due to digestive slowdown (along with fluids & fiber). (BT)
Breathe deeply, to counteract diaphragm’s being squeezed by the uterus, which also slows the blood return from the legs – esp. with multiples/twins. Exercise is also key to a healthy pregnancy, by facilitating circulation & respiration. (HT)
Joanna Williamson says exercise can shunt too much blood away from core & out to muscles being used (esp. leg muscles, which are big users of oxygen). However, by keeping your heart rate moderate & not overdoing it, she feels one should be fine. In some contrast, YPA30 writes that very little blood is shunted to muscles & away from baby (but still suggests that exercise is not recommended for those carrying multiples). And that exercise helps reduce swelling by pumping water into blood & then on its way to the heart. Exercise relieves backaches, varicose veins, constipation, & eases labor & recovery. (YPA30)
Warm-up & down for 5 min. (O&M)
DRINK FLUIDS to help you stay cool & avoid cramps → 2 cups ~1 hr before & 8 oz every 20-30 min including during swimming, + 2 cups afterward. (O&M) Stay hydrated, with salts & sugar. Snack every ~3 hours (fruit or complex carb right after exercise, but not before). (PP) Salt is fine for pregnant women, because it increases water retention, keeping an electrolyte balance. (GPSP)
Avoid exercise at 8,000+ feet esp. in first few days & esp. heavy exercise. (O&M)
Allow sweat to stay on arms & body to vaporize – rather than wiping it off, in order to help you cool most naturally. (O&M)
Avoid hot, humid conditions & hot tubs (because they heat you up), & very dry conditions (b/c they dehydrate you – watch the color of your urine). (O&M) Don’t exercise if you feel uncomfortably hot, which is esp. likely on hot humid days. It’ll be harder to lose heat by sweating on those days. You need good circulation, & you want the vaginal temperature to be < 100.4°F. (PP) Don’t ever allow your body temp to exceed 100.4°F. (YPA30)
Esp. be careful during first trimester, & while trying to conceive!! (O&M)
More blood means more work for the heart, means that exercise is harder. Just make sure you can carry on a conversation while exercising, in order to not overdo it. (Grogono’s NP Lynne)
Loose ligaments & modified center of gravity late in pregnancy mean one needs to be careful with sports like tennis & aerobics. Body produces relaxin hormone during pregnancy, to relax pelvic joint, but also relaxing other joins & ligaments. So be especially careful: looser joints + extra weight make you more prone to accident & injury. (MO’S) If you do fall down hard & baby stops moving, go get a non-stress test for baby at hospital or perinatologist’s. (YPA30)
Joints may move during pregnancy → all you need is 1 session with a good physical therapist. (HT)
** Exercise in the first trimesters is tough in some ways, because you are increasing your blood flow & requirements, so you are more likely to feel nauseated, hot &/or cold. It’s harder to exercise, but very important to help accelerate these changes. (PP)

Careful lying on back 2nd & 3rd trimester (it may reduce blood flow, which you hopefully will notice by getting dizzy &/or nauseated). (O&M) You should raise one hip & lie to the side at least a bit. Also, move slowly when getting up from a sitting or laying position, so head doesn’t lose blood flow too fast. (Grogono) Weight-bearing exercise good in first trimester, but Stairmaster, swimming & other low impact exercise = important/helpful in 3rd trimester. Swimming reduces swelling & stresses on one’s back & makes it easier for the heart to pump. (YPA30) Swimming helps baby position self better & grow. (ST)

Exercise physiologists note that water immersion, such as during swimming, puts pressure on extremities, causing blood to concentrate in core, near babies & heart. This is good, but does mean a higher stroke volume per beat & a slower heart beat. (Note: Athletes tend to have higher heart rates in their preferred/best sport, so this may counteract any reductions here for some good swimmers.) KK noticed a big problem kicking her legs & staying energized in weeks 23 & 24 when trying to shift to kicking after 30 minutes (60 lengths) of crawl stroke. Was this due to too low a heart rate? In the past, her heart rate has been elevated when swimming (e.g., 135 bpm, vs. 120 on the recumbent bike). So it seems odd. But it felt a lot like vagal stimuli response (i.e., loss in blood flow).

Late in 3rd trimester, an abdominal belt (over hips & under gut) may be helpful for exercise. (PP)

Pregnant women have much higher heart rates during exercise (up to ~30 bpm higher). (PP & YPA30) But their internal temperatures are lower (!!) at rest & during exercise. And their blood sugar falls during exercise (which is the opposite of what happens to non-pregnant women). All 3 of these responses are designed to protect the fetus. (PP)

Exercise helps prepare a body for pregnancy, for shorter & more comfortable labor. Athletes typically experience higher performance levels after a pregnancy, thanks to the pregnancy. Also, babies of such moms are often better prepared & healthier, but a tax slimmer. They also tend to be more relaxed & aware of their environment. (PP)

Baby heart rate is higher. 180 bpm should be the highest a baby’s goes, for safe exercise.

Professional athletes should a fetal monitor while training to check from time to time. (PP)

Baby should keep moving, hopefully once every 5-10 minutes. (In the 2nd+ trimester you can feel this [but what about with twins?] if the baby’s not moving, he she may be in some shock. Be sure to rest after exercising (~20+ min of rest) & pay attention to your baby’s movements. (PP) Baby movement can be felt by ~20 weeks. To avoid this at night, you can take Tylenol, have a warm bath, & avoid late-day exercise. (YPA30)

Fetal Kick Counts: 10 kicks every 2 hours from 28+ (or 30+) weeks for twins = Good sign in the “hour” after eating. (GPSP & ST) Also, babies tend to be more active at night. (!) (GPSP) But Laura Menzies doesn’t think some kids react to food or exercise, so one cannot really tell. She advises to just get to know your kid(s) & be aware of changes in behavior (e.g., thrashing suggests extreme distress of baby & probably loss of oxygen to baby). Cold liquids & a cold bowl on your abdomen will also typically rouse a fetus. (ST) Laughter, coughing, changing position, eating, & sudden noises also can trigger fetal movements. (Grogono’s literature)
Braxton-Hicks tummy-hug contractions can also be higher after exercising! Of course, this is not a sign of premature labor. (PP) They tend to occur in abdomen, rather than both abdomen & back (like real contractions). They also tend to be irregular & go away with pain medication.

Braxton-Hicks contractions feel like cramps, gas, pain in lower back. (HT) B-H are a different form of real contraction; their rhythm sets them apart. Tylenol PMs can knock out nighttime contractions. Also, drink water, empty bladder & lie on left side to try to stop contractions. (Debra Monks) Braxton Hicks tend to be focused uterine contractions, as the uterus prepares for real, full-uterus contraction. (ST)

Do not exercise if you have a history of miscarriages, if your cervix dilates early in the pregnancy, and/or if there is pelvic pain & any acute illness, like the flu. (PP)**

Should probably not exercise if you have multiple babies. (!) (PP & YPA30)

Probably better to not exercise if you have a baby in breech position after 28 weeks or you have more blood than spotting. (PP)

Crunches & sit-ups: After 16 weeks, one physically cannot do crunches because of the cantelope-sized uterus being in the way, rendering the crunch rather useless. (You’ll find that those muscles are not being worked.) (Grogono’s NP Lynne)

A muscle gap often forms vertically around the navel. One should not/cannot do crunches if this >3 fingers wide. But one can still do chin-to-chest raises. This gap will close with crunches done after pregnancy. (HT)

Always have knees bent up, to keep lower back on floor when doing crunches. This correct posture is key to avoiding back pain. Pelvic tilting on back or on all 4’s is also good for abdominal muscles. (HT) Can relieve back stress by lean forward from hips (with knees bent slightly) & holding that position. (YPA30)

Be sure to relax 20 min two times/day. (HT)

YOGA: For relaxation & realignment of spine & hips. (1) Do a downward dog, holding onto the seat of a chair (stabilized against a wall), rather than palms on the floor – & don’t put head below heart in 3rd trimester. Hold pose 6-8 sec, inhale, raise head, & step forward. (2) Squat behind chair (stabilized by the way again, on the other side), holding onto its back. Relax groin & pelvic muscles. Ease self onto floor to come out of this pose. (3) Sit with just one hamstring across chair seat (e.g., left buttock on right side of chair seat) & stretch other leg & hip straight out to other side. Face to bent-leg side. Hold & breathe. (4) With hand on back of chair, grab one foot or ankle. (Helps w/balance as COG changes.)

Kegels: Important for vaginal/pelvic floor tone. Hold for 5-10 secs. (O&M)

Esp. important after pregnancy, b/c they’ll be very stretched; kegels at this time will protect you from incontinence when you’re 50+ years of age. (Grogono’s NP, Lynne)

An inability to void one’s bladder completely suggests pelvic floor dysfunction – watch for this. Coughs, sneezes & laughing may lead to urine leakage → Do kegels. (HT)

Kegels are long, upward lifting contractions; do ~50 times/day (!). (HT) Hold for a count of 10, and practice 2-3 times a day. If you can stop urinating mid-stream, you’re successful. (YPA30)

10 kegels 3 times a day can speed recovery & reduce risk of incontinence. (BT)
STRESS:
Stretch throughout the day to relieve tension. (HT)
One faculty member, to alleviate stress, would imagine her baby as 14 years old & doing something, each day. (PP)
High maternal stress means the child is more likely to overreact to stress in future (meaning anger & frustration) & will be more susceptible to depression. (PP)
If you feel good about your level of stress, & you’re thriving (in work, for example), that’s good! Avoid anxiety, esp. in 2nd & 3rd trimesters. (!) An afternoon siesta every day is a great way to manage stress. Plus, get others to help out. (PP)
Every day, take at least a few minutes for exercise, a good cry, & progressive relaxation of all muscle groups (while lying down or sitting with your head supported, so that you can totally relax, & by first clenching fists for ~15 secs, then arms, then head & chest & shoulders, legs…). (PP)
Yoga &/or meditation are largely mental & require focusing on one simple thing (e.g., a baby name, baby image, counting breaths, a single sound/mantra … while all other thoughts go), with your back straight for easy breathing. (PP)

** Stress is a common cause of premature delivery. Also, vaginal infections (which can be easily detected via litmus/pH tests) & inadequate snacking & water. ** Stay hydrated & healthy so your baby wants to stay inside! (PP)

Pregnancy Risks:
Placenta previa means a placenta is near (marginal previa) or covering (complete previa) the os (opening from uterus to cervix), so any dilation or jolts can tear placenta & cause hemorrhaging in uterus. Most bleeds begin with a small herald bleed, & a mother may be hospitalized at that point. Women with placenta previa are usually asked to avoid all impact sports, even something like walking later in the pregnancy. A major hemorrhage means bright red blood running down one’s legs & the babies will have to be taken out, without benefit of lung-development steroids, etc. So do be sure to avoid this!

TPG’s LM says: Because of previa, one will probably need to stop exercise after 28 weeks, since one’s uterus is likely to be irritable by that time. Yoga is all right, without pulling the uterus. One can use therapy bands for resistance.
Cannot do vaginal delivery if placenta is within 2 cm of os (opening of cervix into uterus). (ST)

LABOR & DELIVERY:
Cesarean Sections:
22% of U.S. births are Cesarean on first birth. (This is lower for later births, even though women who had to do a Cesarean the first time often are slated for one the second time.) (O&M)
C-section moms are now supposed to stay at hospital ~3-4 days, on insurance (vs. 48 hrs for vaginal births). (GPSP) 25% of US pregnancies are C-sections; 30% if woman in her 40’s & higher % if delivering multiples. (YPA30) C-sections require cut through 5 layers & 6-8 weeks of recovery time. Stapling is fine, vs. sewing cut together. The gut is opened to the air, so the intestine stops/sleeps. Yet the bacteria in there are alive & well & producing gas. You’re allowed clear liquids at first; one you pass some gas, you’re allowed to have solid foods (up to ~48 hours later). Hot water bottles in pillow cases or
microwave-warmed “bed buddy” filled with buckwheat or rice on incision area stimulate the bowels. The hospitals’ “K pads” aren’t warm enough for this. (ST)

Can’t eat if going to have a c-section (just ~popsicles & juice), vs. should be able to eat what you want with vaginal delivery. (Won’t want to eat too much since you may vomit what you don’t need.) (ST)

C-section babies don’t get lungs’ amniotic fluid expelled due to pushing through vaginal canal, so often will need to spit this up somehow, following delivery. (ST)

C-sections result in Gas Pains, esp. on the third day when the bowel begins functioning. To relieve this slightly, one should lie on the left side & bring knees up, try breathing with the abdomen, walk around, & massage abdomen from left to right, avoid straws & fruit juice. (GPSP)

C-section Recovery: An AMOM’er writes: “I've had 2 c-sections. It's been almost 10 years since my first one and I had a lot of pain for 3 months and some pain until 6 months post partum with my singleton. It has now been 5 yrs since my twins were born c-section and I recovered amazingly fast the second time. I think part of that is because I knew what to expect the 2nd time around. I had pain for only a couple of months and was good to go after that! I still have quite a bit of numbness on my lower abdominal area, from the scar line about half way to my belly button! I think this may be because I had 2 c-sections and I have also had a laproscopic hysterectomy. I don't expect to ever regain all the feeling on my stomach, but that doesn't bother me.” Julie B wrote “I had numbness for almost a year, but ridge was gone and I was back into my pre-preg clothes. The ridge took a while, but was back in pre-preg clothes within a few months.”

Postpartum depression = 5 times more likely in mothers of twins!! C-sections → long recovery → depression more common. (HT)

If you start to hemmoraghage at home after a c-sxn, lie down, nurse babies, & do a fundal massage. (ST)

**Signs of Labor:**

Real vs. False Labor: Real labor has regular (vs. irregular) contractions, of increasing (vs. stable) intensity & involves the entire abdomen or back (rather than just various specific locations). Tylenol will not help with the pain of real labor (unlike false labor) & the cervix will dilate with real (but not false) labor. (YPA30)

Signs of Labor: ~4 weeks before: More Braxton Hicks contractions, baby drops into vaginal canal resulting in dull & continuous lower back pain. ~2 weeks before: Mom loses 1-2 lbs of water weight, loses mucus plug from cervical dilation, increase in vaginal fluid once plug has gone. ~1-2 days before: flu-like symptoms (queasiness & disinterest in eating, loose stools), nesting instinct really kicks in (as you seriously tackle work around the home).

TPG’s LM says: In 3rd trimester, most women wear panty liners to stay dry. Typically, twins slowly open the cervix, & the mucus plug will break up & re-form, if slow enough.

Breaking of amniotic sacs may result in a trickle, from just outer bag breaking & head plugging the break; but, if the break is low, one can lose the entire sac’s contents (~4 cups) of water all at once! It should be a clear fluid, maybe with some vernix floating in it. It should smell sweet & salty, like cucumber. It it’s light pink, dilation is happening; if it’s green, that’s a sign of meconium, which is problematic. (ST)
Premature birth: Baby arrives 3+ weeks early; this is about 10% (11% in GPSP) of all births. It results in unprepared babies, with lots of long-run health effects/handicaps. (PP)
Preemies are wrinkled, thin, cold/turn blue quickly, & slowed. They still need to be loved & held though! They will have irregular breathing, because their lungs are still maturing. (GPSP)
Preemies will cry more as they age, vs. term babies. And they’ll fuss more before their developmental breakthroughs (e.g., before crawling). (JOT)
Asthma & ear infections are the most common long-run issues for twins born prematurely at ~32 weeks. (ST)
3.5 lbs or more allows for a good chance of survival. (GPSP) But KK has heard nothing but positive stories for babies born even earlier & smaller. A good NICU seems to do a lot.
To feed a premature child, one must keep her awake (since she’s weak & will try to doze off); one can do this by unwrapping her clothes, rubbing the soles of her feet, stroking the throat under the child. Express some milk first, to allow the child to smell it, & apply warm breast compresses to increase the flow. Lie down with the baby to feed, before the child becomes too hungry & starts to fuss. You also can put a cut-tip plastic nipple over your own nipple, if a baby is getting too used to bottles. (GPSP)
** Stress is a common cause of premature delivery. Also, vaginal infections (which can be easily detected via litmus/pH tests) & inadequate snacking & water. ** Stay hydrated & healthy so your baby wants to stay inside! Sleep & stay clean (including your teeth). (PP)
The baby decides when to depart, a day or two in advance. The mother then determines the time of day, which is usually the evening. Once true labor begins, it cannot be stopped. However, you may have some strong contractions for a couple evenings; these are helping to synch the baby with a 24 hour day & nighttime resting. (PP)
Late Deliveries: Induced labor cases have increased, to 20% of births in US (!), with many/most simply for convenience of the mother & doctor. This is a concern. Spontaneous delivery is always preferable. Induction greatly increases costs & health risk of childbirth, b/c labor is longer & need for C-sections is higher. Doctors say that waiting too long after due date for a baby to come naturally also increases C section odds, b/c baby is bigger. My mom feels this is nonsense. Get a 2nd opinion & be patient for your baby’s arrival. (NYT Article, Jan 14, 2003)
BT magazine reader poll said 54% of first-time moms had their labors induced. 20% elected this because they wanted more control over their delivery. But, in reality, it can mean less control, because the contractions can be more painful, and labors are often longer, leading to further medical interventions (including c-sections). (BT)
Epidurals: This takes 5-30 min to activate & lasts ONLY 45-60 minutes, so will keep doping. (GPSP) Epidurals reduce blood pressure, but the doctors will fluid load women to keep blood volume & pressure up. Epidurals are well done if mom can feel the pressure of contractions, but not the pain. Should be able to walk 2 hours after epidural is ended, which is done when last baby arrives. Often place epidural at ~4 cm dilation, but typically wait to dose it when reach 5-6 cm. (ST) A walking epidural is a fallacy; it’s narcotics only & no numbing medicine; doesn’t work so great & hospitals don’t really want you walking around anyhow. (ST) Epidurals lower your blood pressure & slow down labor, abolishing the natural bear-down reflex (!!!); they will delay the 2nd child’s delivery, so that he/she is more exposed to the anesthesia. ☺️ (HT) Epidurals may leave
you with a hot spot (~5% of cases), b/c a nerve has been hit by the side of the catheter; they can usually shift the catheter slightly to avoid this, or replace it. (ST)

BT magazine reader poll reports that 78% of those receiving epidural found it very helpful, & 4% not at all helpful.

Avoid medications during labor, since the babies will be strongly affected, since they are so small. (HT)

~70% of twins’ moms are able to leave hospital “right away” (? 3rd or 4th day?? doesn’t sound like right away… 😐). (HT)

13% of twin moms deliver late, > 40 weeks. To speed labor, one can stimulate nipples, orgasm, or apply castor oil (esp. since chemically induced labor takes longer & is tougher on mom). If contractions don’t arrive within ~12 hours of breaking of waters/amniotic sac(s), may need stimulation to speed delivery, to keep vaginal bacterial count down. (HT)

Not necessary to break amniotic sac before labor. The sac protects baby’s head during initial stages of delivery. (Bradley)

Jaundiced babies are yellow, because their livers are not removing dead red blood cells right away. They can be treated somewhat with exposure to light. (GPSP)

Jaundice is very common, as the liver catches up with breakdown of bile. Can often occur a few days after the birth for ~1 week & will then go away. Exposure to sun helps. (JOT)

Babies may appear mottled & bruised from delivery, which fades in a few days. Jaundice results from buildup of bilirubin, a blood byproduct that accumulates when liver can not metabolize all of it. (BT)

An episiotomy is not a great idea; natural tears often heal faster. (HT) Episiotomies can be the most painful part of birth recovery. (YPA30) Only 27% of those responding to BT magazine reader poll said they had had episiotomies. (BT)

Forceps speed delivery but require an episiotomy. (Bradley)

It’s very important to have an electric (position-changeable?) delivery bed in the hospital. Use deep breathing & huffing (not coughing). Ab contractions are important to prevent gas formation. (This increases with inadequate intestinal movement, meaning a very painful recovery – particularly on the 3rd day after delivery, when food is reaching it again.) (HT)

Demand a physical therapist in the hospital. (HT)

Baby’s heart rate can drop during any part of labor, typically b/c cord gets compressed by contraction pulling arm in or chin down over cord. Very normal. (ST)

Mom needs to stay calm during delivery so she & baby have lots of oxygen & energy. Bring music player to hospital & play something soothing. E.g., the CD brand “Sense of Serenity” by diskmktginc. (ST)

**Stages of Delivery:**

Labor transitions from

1. Early Labor (lasting ~8 hours, with a contraction every ~8 minutes for ~30 seconds, & cervix dilating to 3 cm)
2. Active (lasting ~4 hours, with a contraction every 2 min for 60 secs, & cervix dilating to 7 cm)
3. Transition (for ~1 hour, every 1 minutes, 70-90 secs each, & cervix dilating to 10 cm) – this is the most disorienting & intense period of labor, with contractions exhibiting
double-peaking & moms often getting the shakes (a warm blanket will help at this time). Partners are really need here, to help guide & focus the mom’s breathing; coaching & support are key; keep eye contact to distract her. 3 hees to 1 hoo (1 sec each vs. 2 secs) = faster breathing rhythm. Also can mix these up ~3:1 & 2:1 & 4:1 & 1:1 to keep mom focused on breathing, & distracted from pain. (4) Pushing (~0.5 to 2 hours, every 3 min contraction of 60 secs).

In early labor, contractions are ~1 every 30 min or more. One can stay upright & mobile. Load up on carbohydrates ** during this time, like marathoner! You will need all the energy you can get! (You won’t feel like eating during active labor, & hospital probably won’t let you have food & drink since they’re afraid they may have to use general anesthesia – which is extremely rare, however.) (HT) First stage of labor takes one up to ~2 cm of dilation, during a period of 1-10 hours. There are mild contractions, for ~15-20 minutes, of 1-minute duration each. (YPA30)

Once you can no longer talk through a contraction, it’s time to go to the hospital! You should be free to walk around, get on all fours, squat. Gravity helps contractions. But you will have an IV & 2 baby heart monitors, making it a bit tough to walk around. Try getting a “herapin lock” on your back (= small IV?, with no mobility limitations). (HT)

Squatting increases size of pelvic outlet by 1-2 cm over the supine position! It also increase contraction strength, while reducing back pain, birth canal length, duration of 2nd stage of labor, & need for episiotomy. (ST) Child’s head circumference ~20-35 cm. (ST)

The second part of the first stage of labor will take you to 10 cm of dilation & will take ~20 min to 2 hours [vs. 1-10 hrs to get to 2 cm]; contractions will be every 3 minutes & last ~45 secs to 1 minutes. An epidural will be administered. Don’t push unless you are completely dilated. Practice relaxed breathing. (YPA30)

If one of the babies is facing upward, there will be a lot of back pain during the pushing. Changing positions can provide some relief to labor in general, such as walking around & standing. Kneeling on hands & knees, lying on side. Squatting will speed the livery & the strength of the contractions. Lying on your back can make the whole process quite slow & REDUCE the Heart Rates of the babies (really???) ! If you are on your back, definitely keep your head & one hip on a pillow. (YPA30)

You usually can’t eat or drink during labor, b/c nausea & vomiting will result. But you can suck ice. (YPA30)

Save your energy & push towards the end of your labor, when the reflex/urge is irresistible. Do not strain & hold your breath at the same time, as some labor courses suggest. You want low pressure while straining – much like in lifting weights safely. Listen to your body’s natural impulses; moaning & groaning are acceptable! It’s very natural & rather like sex (!), so you want to let yourself go, vs. controlling it. (HT)

Often push for < 5 secs & several times per contraction.

During delivery/pushing stage, hot packs on the perineum relax the muscle & reduce the likelihood of tearing. All Seton nurses do an oil massage of this muscle. One should just pant at this stage, focusing on outbreaths, so you don’t push the baby out too fast & tear tissues. Focus on little pushes. As soon as they see the first baby’s head, they will send a twins mom into the surgical delivery room. (ST) Pre-delivery perineum massage (using almond oil, KY jelly, or cocoa butter) may get perineum ready as well; place thumbs about 1-1.5” inside, press downward & gently stretch till feel slight burning or tingling.
Hold pressure for ~2 minutes until tissues begins to feel numb. Repeat on both sides of the vagina. (BT)

Sometime during pushing & delivery of the child, the docs will suction the nose & mouth, & clamp the cord. Contractions may come every 2-5 minutes, for 60-90 secs. (YPA30)

Baby on left half of uterus is typically lower & delivers first. 50% of twins are headfirst, & 25% are breech – but poor positioning can be changed, sometimes, via babies themselves or special massage techniques by professionals. Squatting helps a breech delivery, particularly if the mother is alone. (HT)

Try to stimulate the delivery of the 2nd child naturally (e.g., sucking of first? nipple stimulation, walking around?); if cannot, doctor typically breaks the second sac (to speed delivery & avoid infection). (HT)

**After Delivery:**

Newborns will often look a bit blue, with creamy white vernix coating in some places. And forceps will leave temporary marks on them. (HT)

Placenta will be delivered in the third stage of labor, & any episiotomy or tearing will be repaired. The uterus will continue to contract for a couple days (!). It is important that bleeding be controlled during this time. (YPA30)

Will need to wear heavy pads for ~4 days after delivery. It’s usually red & heavy flow the first 1-3 days, & then dark brown & thick for 4-10 days. By day 10, you should be on a minipad, as flow eventually turns pinkish brown & then off-white. If you see bright red again, you need to take it easy! And nurse those babies. (ST)

Babies can only see ~8-12” away when born, but very sensitive to light, loud/unmuffled noises, & rubbing (which helps start their breathing). (ST)

Newborn suckling helps avoid painful breast engorgement. Most hospitals will take newborns away, until they get their temperatures up. But immediate bonding is very important! So you should have at least 20 minutes of this. (HT)

Start nursing within a few hours of birth to get the colostrums. Permanent breast milk comes in within ~12 hours. (YPA30)

Colustrum = very important = great for these babies, helps close & line their intestines. “First milk” comes just after colustrum = also special. (JOT) Colustrum is not high in calories, so babies are burning their own fat & losing ~15% of body weight in the first week. Colustrum changes from a clear orangy substance to breast milk after ~5 days. (ST)

Let the babies nurse when they want, & get a lactation consultant in the hospital. (JOT) Note: Austin’s Special Editions (a clothing store) has people to help clients with this too.

Kangaroo with babies early too, skin to skin, to help colonize their guts with good bacteria, to aid their digestion & avoid colic. (ST) Skin to skin activity also boosts mom’s milk production, and babies’ own levels of oxytocin (which relaxes babies, and releases milk from mom). (CH) Best to colonize with mom’s antibodies, b/c child’s system already used to mom’s. Colustrum also helps establish the ideal gut flora. (ST’s handouts) Avoid antibacterial soaps; use mild soaps. Castille soap, glycerin, and tea tree oil soaps are mildest. Dove & Ivory are pretty mild too. (ST) Kangarooing also helps milk supply, while calming baby & helping get her temperature right. (CH)
Cervix dilates in a circle (rather than in a long oval, as one might expect. Shaving the pubic hair & getting an enema are not a bad idea. (YPA30)

After delivery, will spray yourself with warm water bottle before wiping (after using bathroom), to prevent infection. (ST)

Circumcision will take place only after baby boy pees, so they usually wait a day or more. (ST) Circumcision can cause a boy to sort of shut down for ~12+ hours, so it’ll be tougher to nurse him during that time. (CH)

Circumcision is not necessary or even helpful; the foreskin actually protects a boy from various infections (especially while he’s in diapers) & senses pleasure more than the glans underneath. If an infection occurs under the foreskin, simply antibiotic cream can be used. One should not retract the foreskin & try to clean underneath the foreskin, though this used to be the advice docs gave. There are connections between the foreskin & glans that will tear. When boys reach puberty, it will be easier to retract the foreskin & they can clean under there themselves, while in the shower, if they wish. Premature retraction rips the foreskin, typically causing pain. Foreskins can become chapped & resist retraction (exposure of glans) due to chlorinated pools, soapy water, high-sugar diets; if they weren’t in place, the glans would become chapped instead. No need for surgery; the foreskin is attaching more tightly in order to protect better during this period. The foreskin is sensitive & does give pleasure when touched, so little boys will continue to touch themselves. Circumcision earlier in life is probably more painful than later in life. If at a certain point urine sprays when peeing, simply have boy retract his foreskin for that period when peeing. (www.nocirc.org article: Protect Your Uncircumcised Son, by Paul M. Fleiss, MD, MPH, FAAP. Mothering Magazine, November/December 2000.)

Emergency Delivery: Don’t push (unless baby’s head is already starting to come out). No need to cut umbilical cord, & don’t pull out the placenta. If placenta does deliver, save it & keep it above baby’s level, not below. (YPA30)

Lamaze Breathing & Activity during Labor & Delivery:
ST recommends 2 main types of breathing, preferably with a partner: (1) Deep/long breaths during contractions you cannot talk through. For count of 4 in through nose & count of 4 out through mouth. Get it deep, like you’re filling a bowl with liquid. Start off with a deep cleansing breath with the start of a contraction (to alert your partner that a contraction has begun), & find a focal point (stone, or picture, or stuffed animal…). ~8 secs total; (2) Hee-hee light breathing: Upper chest breaths, short in & noisy outward breath ~4 secs total. These are for when you can no longer do deep breathing (b/c doesn’t feel good to get air down to lower abdominal area) & want naturally to switch to this kind of breathing. It can help relieve nausea. Still start with a deep breath – and finish with a deep breath, at end of contraction. (ST)

Breath out in small outbreaths (panting) when head is crowning, so don’t push too hard. (ST)

Moving around the hospital labor room, trying out different positions, facilitates babies going into the best positions. Gravity is helpful, so stay upright as much as possible (e.g., squatting, bending over at hips [with head at hip level]). (ST)

Labor partner should see Stages of Labor info above, esp for Transition stage of labor. Traditional Lamaze method has 3 stages of breathing, which can be quite unnatural & result in hyperventilation, & possibly apnea for child for several days. But it is simpler for obstetricians than the Bradley Way. (Bradley)
Pre-term Labor & Prematurity:
Excessive uterine activity or dilation increases the odds of pre-term labor. One’s vaginal area should be examined regularly. Infections also increase one’s risk of pre-term delivery, as does trauma, tiring travel, & stress. (HT)
Nutrition, exercise, & peace of mind are KEY to avoiding pre-term delivery. (HT)
Studies have found that bed rest does NOT delay labor time, but it does increase birthweight – b/c all the calories go to the babies. The author believes that boosting nutrition is the most important way to avoid prematurity – plus plenty of rest (semi recumbent, or on side ~2 to 3 times/day). Long periods of inactivity create problems, due to swelling, back pain, mental issues& weakness. If one must do bed rest, then do exercises too! E.g., pelvic tiling, weight lifting with arms & legs, kegels, stretching, & exhaling with each movement (to reduce pressure on body – without this, one can do more harm than good when exercising). Also, sing daily & go out to a nice dinner regularly! Pack warm castor oil packs/compresses on your abdomen & vagina, to help bleeding, sore throats & injuries. (HT)
Contractions feel hard, so abdomen feels as hard as your forehead (according to ST & LM, but not according to Joanna Williamson who says it feels much more like a muscle being tensed & not as hard as bone). They come with a wavelike backache (& aren’t continuous), serious menstrual-like cramping (Joanna agrees with that). One may also have bleeding or spotting, abdominal pain & change to heavier vaginal discharge. (ST)
With twins, it’s much tougher to distinguish pre-term labor contractions from Braxton-Hicks contractions, b/c there’s less womb space to feel these. Watch out if the contractions are over >2 hours (with 4 or more per hour). Watch for rhythmic cramping in the lower abdomen, gas pains, diarrhea, GI discomfort, vaginal discharge, or lower backache. (HT)
One can more easily detect contractions by lying down with hands on a monitor (which one can buy or rent). Note the time, frequency & duration of contractions. If > 4 per hour → Call doctor. (HT) By monitoring contractions, one increases her awareness & can balance her day better, to avoid overdoing it. (HT)
Fetal movement differs from contractions, & there may be ~500 movements/day! (But the # will fall to ~200/day by the time of labor.) (HT) Tougher to discern contractions from baby movement when multiple babies are present.
If you detect pre-term labor early, you can end it by resting & taking fluids, just like athletes who require hydration. (HT)
Relaxation & hypnosis also can reduce premature contractions. (HT)
Be very conscious of stress on your pelvic floor & a feeling of babies falling out. (HT)
Signs of premature labor: Menstrual-like cramps, contractions & tightening of abdomen, wavelike backache (lower-back usually), stomach cramps (w/ or w/o diarrhea), change in vaginal discharge, pressure in pelvic area, back or thighs, a feel that something isn’t right → Monitor for 1 hour to see if >5/hour (by lying on side & feeling for abdominal tightening), writing down exact times & durations & noting what you were doing beforehand that may have precipitated the contractions. Drink 2 large glasses of water, empty your bladder, lie on side & call doctor. (AMOM Newsletter)
Preemies often stay in the hospital until they get close to their delivery date. They have a 90% chance of survival if weight > 2.5 lbs. Preemies have low body fat & permeable skin, so
it’s tougher for them to regulate their own temps. They need warm & humid environments. Be sure to talk to & hold your preemies often. (HT)

Older Moms: 2nd labor will take ~1/2 as long as first pregnancy’s labor, but you may show sooner (b/c your skin is already stretched), & you’ll probably carry the baby lower (resulting in more back pain). (YPA30)

Find time to lie down at work, bend with knees, don’t carry >20 lbs if abdomen is large, walk around for leg circulation, watch balance/center of gravity in 3rd trimester. (YPA30)

Support hose &/or girdles can help with swelling & circulation; take deep breaths & do leg & ankle stretches regularly. Sleep on side with top leg bent, on top of a pillow. Avoid travel in the last month of pregnancy. (YPA30)

12 weeks of unpaid leave = guaranteed by federal law (FMLA).

Miscarriages begin with bleeding, & then cramping. (YPA30) But bleeding is relatively common early in pregnancy (~20% of women). It is a sign of a problem when it occurs later in pregnancy. (YPA30)

If go into labor > 4 weeks early, lungs may not be formed & one should typically go on bed rest, get lots of fluids, & take lung-development drugs. (YPA30)

Chores, stairs, serious exercise & lifting can lead to contractions. Need to conserve on energy.

TPG’s LM says: By 26 weeks, most twin moms have had a contraction. Some feel that the babies “ball up” & then there’s a pressure release, with shorter breath. It’s not painful, but it will feel hard (like one’s chin or forehead, rather than nose tip). One should lie down in order to feel the uterus & get a sense of whether contractions are occurring. If I were to have extensive cramping or backaches for 30+ minutes, I should lie down & feel. First-time moms typically efface first & then dilate, while 2nd+-time moms will do both together. (Dr. Grogono seems to think dilation first is not really uncommon, however.) Tight abdominal muscles & first-time pregnancy mean I’ll carry babies up higher, causing more diaphragm pain, but not impeding babies’ growth.

LM says: Signs of pre-term labor are extensive, menstrual-like cramps (not localized, which can be due to baby hitting a nerve); dull, low backaches across entire lower back; feeling like there’s something in the pelvis (e.g., 2-3 tampons); sudden change (in color or texture) of vaginal discharge; contractions every 10-15 minutes apart; achy belly. One should try to relax right away, empty her bladder, drink 2-3 glasses of juice or water, & lie down right away. Call Ob if symptoms get worse during the hour. Avoid the activities you were engaged in beforehand. Heavy housework, heavy lifting, climbing stairs, & active sports can bring on pre-term labor symptoms.

AMOMer Molly K had twins & 27 weeks & was pre-term with her first son as well. She felt like she really need to urinate but had nothing to urinate & this was her sign of pre-term labor, which she wishes she had known. Another woman (who was going to sell me a nursing pillow) lost her twins at 22 weeks; she recommends lots of protein & if working all day, lying down for a couple hours after getting home, & then doing your errands around the house.

Prematurity Issues:

Excellent article: Long-Term Developmental Outcomes of Low Birth Weight Infants at http://www.futureofchildren.org/information2826/information_show.htm?doc_id=79895
Also: ‘Problems at school' for premature babies [http://news.bbc.co.uk/go/\\en/\fr/-/1\hi/health/1399430.stm] “Up to a third of babies born slightly prematurely will go on to have problems at school, a study has suggested.” (Note: Elective vs. non-elective prematurity are very different issues. In general, elective means the children don’t want to leave the womb, so they are in better shape in many ways. [E.g., their mothers haven’t been smoking, drinking, over-doing it.] However, non-elective means the children have tried to mature more [e.g., develop their lungs and eyes earlier] in order to exit the womb early.)

Sleep & Bed rest:
Internet resource for bed rest: www.sidelines.org. Witch hazel helps avoid deep vein thrombosis (blood clots in the legs), which comes from extensive bed rest. Avoid thrombosis (& death!) by stretching legs & pointing toes back to head to see if pain exists before get out of bed, esp. in morning.
Usually by 24th week, best to sleep on left or right sides (left is slightly better, both are fine). Avoid back, of course, because the baby’s weight can put pressure on the vena cava, a major vein, leading to an early recycling of blood, which is bad. (PP) Body shuts down blood to uterus early, while your brain & heart may think you’re getting enough blood, since those are preserved. More fetal kicks may indicate some baby distress when this occurs. (LM) Note: KK didn’t have too much vena cava shutdown unless on a hard surface & flat, or was walking around & lay down quickly, or was bent in an odd position, putting pressure on uterus. When resting or sleeping, heart rate may be slowed enough that blood flow may not be as big of an issue, since nausea was far less likely during that time. (KK)
At 24 weeks, mothers of twins should be lying down 2 hours/day. At 28+ weeks, ~4 hours/day. (LM) (Note: KK started really feeling the need to slow down at these points in time anyhow. So bed rest, to some extent, was desirable.)

NICU Info:
From visit to Seton’s NICU, with developmental nurse Aimee Dirigee [x 17861] (& Sarah Trimmier), we learned that after 30 weeks, the babies are typically able to breathe without steroids & exist without an IV (which is often done via the umbilical cords veins & artery). If born before then, the hospital typically will deliver surfactants (“soap-like bubbles”) to keep alveoli [lung sacs] open. If necessary, they also can deliver steroids to born babies (rather than just to mothers, before birth), but this affects babies more than when it is delivered via moms & thus is not so common. After roughly 32 weeks, the kids can move to gavage feedings of mother’s milk (via very narrow tubes to stomach). After 34 to 36 weeks, they have coordinated suck/breathe abilities & the stamina to bottle feed. Note: Babies lose ~15-20% of their birthweight at first (partly because of loss of fluid in lungs, particularly if didn’t have a large baby go through the birth canal). Also, developmentally, it’s very important to have low-stress environment for premature infants, so that they can calm down & save energy. Thus, it’s important to give them timeouts whenever they show signs of stress (such as lethargy, splayed hands, etc.). The NICU closes 4 times (5 hours total) a day, & for rounds on Tues/Thurs (when teams assess when babies may be released from hospital).
ST says Seton puts babies up in NICU if less than 36 weeks. After a c-section, it’s hard for mom to get up the first day & be with babies. But 2nd day she can do this, typically, in a
wheelchair. It’s possible babies won’t have suck/swallow (& breathe at same time) reflex at 35 weeks, & may not even be able to take a gavage feeding.

If you have babies in the NICU, pump 7-9 times per 24 hrs, with 1-2 of these at night. Hold the baby first, or look & listen to baby while pumping. Apply heat to breast & massage prior to pumping to stimulate let-down. Interrupt pumping to massage again when flow of milk lessens, & then try pumping for a few more minutes. Prior to infant’s discharge, pump 10-12 times per day. (Seton)

For some general NICU info (including terminology), AMOMers turn to:
http://www.pediatrics.wisc.edu/patientcare/sicknewborn/nicu.html

TWINS:

1/80 babies is a twin. (PP) Identical means fertilized egg splits in two. Fraternal means 2 eggs are fertilized. (BT) Fraternal vs. Identical: AMOMer writes “One third of all identicals are di-di (with two placentas and two sacs). We also did the DNA kit from www.affiliatedgenetics.com to confirm my suspicion that they are identical - I was right. The test was just a cheek swab so you don't have to draw blood.”

Fraternal twins also occur more often in very young mothers (under 20) and older mothers (after 35, who are more likely to release multiple eggs). Identical twins can happen to anyone, with any color, at any age. Still no conclusive test as to what causes the egg to split.

Multiple babies means more hormones. (Grogono’s NP, Lynne)

Postpartum depression = 5 times more likely in mothers of twins!! 76% of such moms are constantly exhausted (vs. just 8% of singleton moms). (HT)

Depression ranges from Baby Blues (loss of sleep, feeling overwhelmed) to Depression (avoiding the baby, fears or thoughts of harming baby, weight loss or gain, chest pains) to severe Anxiety (including obsessive thoughts about harming baby, self or others), to Hallucinations. Postpartum Resource Center for Texas: 478-5725 & 1-877-472-1002; national support #s: 800-944-4773 & 805-967-7636.

Exercise & nutrition = most significant factors in preparing your body for the demands of multiples. Rest & relaxation are also important. (HT)

Mothers of multiples need more rest, so they may go on semi-bed rest after the 30th week, where they are semi-recumbent or lying on the left side, 2 to 3 times/days. (GPSP) TPG’s LM asks for 4 hours/day of horizontal time after ~26 weeks (& 2 hr/day before then). This seems to become more & more necessary as the weeks tick away. (KK)

Bed rest for twins is typically a minimum of 1 nap in morning & 1 in evening. Once the fetal lungs are strong enough, there’s usually no more need for bed rest. (GPSP)

Sweets/sugars are tougher on the child (due to insulin reductions following sugar loads) when on bed rest. Avoid this. (GPSP)

It’s a good idea to keep a fetal movement diary for each hour these are detected after 6 months of a high-risk pregnancy. This means timing between 1st & 10th movements, while lying on one’s left side. (GPSP) KK’s girl kicked ~10 times in five minutes & boy kicked ~10 times in 20 minutes during weeks ~27 & on. This is more active than normal, & is correlated with how active they are likely to be when born (according to TPG’s LM).

Consumption of 4,000 cal/day (!!!) & 100+ gm protein/day (!!!) [ST recommends 110 minimum & 130 average gm/d] will result in term twin babies, with weights of 7+ lbs. This is 1,000 cal/day & 40-50 gm/day more than with a singleton. (KK thinks bed rest may be
one way of keeping them fed, by lowering mother’s own caloric requirements.) (HT)
The weight gain should be 50-60 lbs. (!!!) (HT) TPG’s LM suggested gaining 40 to 49 lbs, not 50+; if you can help it. KK gained 42 lbs by 31 weeks & ~28 lbs by week 24 (but force fed self from week 11 to ~week 18, in order to gain the recommended 2 lbs/week).
Divide a food’s RDA by 3; that’s what the mom of twins is getting from her food. (HT)
Chinese get only 7% of their protein from animal sources, vs. 70% in the U.S. They also consume 3 times more fiber. These differences result in higher rates of heart disease, cancer, & diabetes in the U.S. (HT)
Breathe deeply, to counteract diaphragm’s being squeezed by the uterus, which also slows the blood return from the legs – esp. with multiples/twins. Exercise is also key to a healthy pregnancy, by facilitating circulation & respiration. (HT)
Twins → doubled hormones → earlier & wider dilation, + more Braxton-Hicks contractions. Doctors should not be surprised about this. (HT) Older cervixes don’t dilate as much as younger women’s cervixes. (YPA30)
Varicose veins are more likely with twins/multiples, so do regular ankle movements, walk, put legs up, & exercise. Don’t sit with legs crossed. (HT)
Bathe & sleep twins together → saves time & is more natural for them. Bathe them in sink, to avoid back strain. (HT)
Twins play together better, but dizygotic area more competitive. Teachers like to separate twins, to simplify teaching & evaluation, but some twins will develop behavioral problems when they are separated. You & they should choose, not the school. (HT) Note: Several AMOMers write that it was a very good decision to separate their twins. In some cases, one child was able to do many activities better than another. In most cases, the children loved having separate sets of friends.
Twins develop speech slower because they can understand one another → Parents need to be active in coaching their correct pronunciation. (HT)
Twins track singletons in size until ~26 weeks, which is when a single baby’s exponential growth spurt occurs & uterine size constraints are really felt by multiples. (ST)
Twins start smaller but catch up in size & weight by age 2 or 3 (with singletons). (JOT)
Twins tend to have more limited vocabularies at an early age & score ~2-5 pts lower on IQ tests, but probably b/c of verbal/vocal issue. They have this issue due to speaking to one another, depending on just one to make demands/requests of parents, & adults not interacting with them as much individually. Their verbal development is ~6 months behind during ages 3-5. They tend to use fewer words & shorter sentences – perhaps to be heard above the competition. Twins that are the first children in a home are less delayed, since there’s no competition with older siblings. By age 6, vocab differences disappear. (JOT)
Children experiencing developmental delays should be evaluated for Early Childhood Intervention programs (ECI), such as Texas’s: http://www.eci.state.tx.us/ (up to 3 years of age, including speech therapy).
It’s probably helpful to separated twins with other kids for playtimes. And be sure to talk to your babies as individuals & solicit independent responses from each of them. Don’t let one be the spokesbaby. Get a babysitter for 1 & take the other out with you. (JOT)
Bond individually as much as possible with them, by making diaper changes & baths extra special. Carry 1 in sling around the house & outside. (Luke)
Probably best to keep them together in school until the 1st grade. Their bond may be healthy or too dependent → influences your decision to separate or keep together. Don’t let teachers enforce/choose separation. Kids may choose it for you. (JOT)

Studies & experience suggests that “dominance” shifts back & forth between twins. Many people expect a special relationship between twins, but they’re much like siblings, just very close in age! Ignore these stereotypes. However, twins do entertain one another & often end up more confident & more supportive because of their special situation. (JOT)

TPG’s LM says: Women carrying twins can expect to be at home after 32 weeks, in bed & waiting for birth, tired, & not sleeping well. By 26 weeks, most twin moms have had a contraction. Some feel that the babies “ball up” & then there’s a pressure release, with shorter breath. It’s not painful, but it will feel hard (like one’s chin or forehead, rather than nose tip). One should lie down in order to feel the uterus & get a sense of whether contractions are occurring. If I were to have extensive cramping or backaches for 30+ minutes, I should lie down & feel. First-time moms typically efface first & then dilate, while 2nd+time moms will do both together. (Dr. Grogono seems to think dilation first is not really uncommon, however.) Tight abdominal muscles & first-time pregnancy mean I’ll carry babies up higher, causing more diaphragm pain, but not impeding babies’ growth. (LM)

TPG’s LM says: 38 weeks is term for twins. (Isn’t 37 weeks term?) Most twin babies can go home after 36 weeks, however, without restrictions. After 34 weeks, steroids are no longer needed for lung development. Most twin moms are off work by 32 weeks. Cervical changes are common between 28 & 32 weeks. At 28 weeks, one enters the 3rd trimester, & most twin moms are measuring full term & contracting, & working part-time. Babies weigh about 2.5 lbs at this time. (LM)

Twins tend to be more empathetic & start interactive/coordinated play earlier than singletons. But an intellectual gap may exist until they are 6 years old, & a physical gap until age 8. (APT)

Multiples tend to socialize in bigger groups, with both boys & girls, and are less cliquish – and more popular. (APT)

Twins tend to get ~25% less talk time from adults [90 secs per interaction vs. 120 secs]. Most children by the time they are 2 have ~20-100 words in their vocabulary, & up to ~1000 by age 3. (APT)

If one twin tends to dominate continually, do not allow it. Have them tradeoff days for making choices & receiving privileges. Require that each talk to you, rather than one acting as a spokesperson for the other. (APT)

Dizygotic/fraternal twins tend to compete more in play. Identical twins are more cooperative with one another. As they get older, help them to focus on competing for grades with top students, not with each other. In sports, have them focus on competing against the other team, not with each other. (APT)

Be super-fair with them, though that doesn’t mean they always get the same treatment. They are scrutinizing all distinctions, so equality is key. But they are different people & will want different toys, etc. (APT)

Twins tend to be much happier when left together with a stranger, than when being separated with a stranger. (APT)
Let twins have their own toys, once they show that they don’t like sharing. Ownership is very important in establishing their independent identities; otherwise, you may have some serious problems & tension between the two later. (APT)

Twins will tend to triple their weight in the first year, eating a lot.

**BREASTFEEDING:**

Great websites for various breastfeeding details: [http://www.kellymom.com/](http://www.kellymom.com/) & [www.breastfeeding.com](http://www.breastfeeding.com). Careful: Most books (& classes!) emphasize all the positives. Read on so you know what can go wrong – and how to avoid it!

**What I Wish I Had Known about Breastfeeding & Pumping…**

Reading many books may not help a woman succeed in getting breastmilk to her children, particularly when she has multiples to feed. Books tend to emphasize the positive, giving short shrift to the negative. Their authors want women to be excited about this important (and major) commitment. The following was my experience and may help round out the literature:

- Quite a few women find nursing very painful, for weeks, and some even for months. Breastfeeding books suggest just 1 week of soreness, maximum. If you’re sore longer than that, you’re doing something wrong and that something can be corrected. That’s false. A fair number of women lack the skin elasticity necessary for nursing and their bodies take a long time to adjust. Nursing and pumping for multiples is even tougher, putting more stress on the breast tissues. We should present truthful pain statistics, so that mothers-to-be can prepare themselves. Eventually, however, the pain should go away.

- Even though it looks like we’re enduring some Medieval torture device, pumping is not supposed to hurt. Pumping suction levels can be controlled (low suction levels are sufficient for those who can feel the stimulation and train themselves on such levels). And flanges and areolas can be lubricated (with olive oil). The newer hospital-grade pumps provide a full range of suction levels with precise pressure changes. Do not pump on a retail version that causes you pain. Rent the best pump you can. Even $60/month for 6 months is about the same as a new retail pump. Also, buy a pumping bra (with two holes in front), so your hands are free for breast compressions and massage and proper flange positioning (and for work and other necessary chores).

- Pain inhibits letdown. Do whatever you can to minimize that pain, particularly if you cannot afford to have you milk supply drop. If letdown is inhibited, breasts fill up, sending a signal to reduce production. Lubrication of pumping equipment, lanolin, petroleum, cortisone, and other salves can help tame superficial pain. Prompt treatment of thrush and mastitis are critical for deeper pain.

- Smaller-breasted women tend to have less milk-storage capacity, resulting in a need to nurse or express milk more often, in order to make the same amount of milk as fuller-breasted women. While large-breasted women may nurse/pump enough for their multiple babies 6 times a day, smaller-breasted women may find that it takes 8 to 12 times a day to meet multiples’ needs.

- While many women can pump exclusively and feed their multiples, many miss the positive pressure of a baby’s mouth. (A pump only provides suction, or negative pressure.) A combination of nursing and pumping may meet this need. Of course, the best nursers are
those trained exclusively on the breast for many weeks. So some frustration is in store for
women who start pumping more frequently than nursing early in the baby’s life.

- **Milk supply is compromised by many factors.** These include insufficient stimulation (such as waiting 5 or more hours between starts of feedings or pumpings), premature babies (who may not nurse too well until their due date), preemptive deliveries (rather than waiting for labor to begin on its own), pain (due to mastitis and thrush, lack of skin elasticity, poor baby latch, etc.), and excessive reliance on a pump. First-time mothers also are at somewhat higher risk, since mammary systems enlarge with each pregnancy.

- **If your babies are not nursing vigorously within one week,** you are not getting adequate stimulation to your breasts and should rent a high-grade pump right away to supplement the babies’ action and preserve your breastfeeding options. Your babies’ nursing will improve with time, but your milk supply can only be protected and “up-regulated” by adequate stimulation.

- **The first 6 weeks are critical** to establishing one’s milk supply and making a good nurser out of a (term) baby. If you have any reason to worry about milk supply, consider yourself attached to that baby (or babies) – and/or to that pump (if babies are in the NICU and/or unable to nurse). Nap with the babies, cuddle with them, be there for them when hungry. Take the time to get your mammary glands’ prolactin receptors up and running at needed levels of capacity. After 6 weeks or so, the window for receptor stimulation is ending; do not shortchange yourself during this key period.

- **If you experience low milk supply,** there are ways you may be able to meet your baby’s/babies’ needs: Double-pump every time (e.g., pump a second time, 30 to 45 minutes after your last pump), pump in the middle of the night (the babies may be sleeping, but milk production is very active), pump more frequently rather than for longer (try to not exceed 15 minutes of pump time, particularly if you experience any pain; many women increase supply by pumping every 2 hours for 2 days in a row), never go more than 4 hours between the starts of successive pumps, compress your breasts by hand during letdown to help fully drain the breasts, take domperidone (or Reglan) & More Milk Plus tincture and fenugreek with blessed thistle.

- **If babies balk at nursing,** walk them around while at the breast, to get them to latch on & stay latched (in a sling may be best). After a while, transition to a glider or any other position where you can keep “moving.” Keep the lights low. Nurse in the morning, when babies are most settled. Use a pacifier for a minute or so before re-offering the breast. (Many books suggest nursing during a warm bath with the baby; this may not be necessary.)

- **Unplug plugged ducts** by finger-manipulating mammary glands backward from the nipple (rather than forward/toward the nipple, as many books suggest). And be very alert for plugged ducts in the early weeks, when engorged. Lie on your back and feel around for any lumps in each breast. Also, if pumped volumes drop off on one breast, a plug has developed. Find it and root it out before mastitis and serious pain develop.

- **It takes two days** for your supply to demonstrate its response to altered demand. Do not assume your supply is unaffected by insufficient stimulation one day. Most women find the effects do not materialize for about 48 hours.

- **Finally, a top lactation consultant** can assist greatly in many issues that present themselves, even by phone at a moment’s notice without fee. Do not delay in getting assistance, particularly in the early weeks, when upregulation of milk volumes and mammary system calibration are critical to your long-term success as a nursing mother.
Some Great Reasons to Breastfeed:

Most women know that there are a multitude of health-related ways that their *children* benefit from breastmilk. Of course, the parents benefit greatly when their children are not ill. In addition to these benefits, there are a great many other ways in which the mother, and the father, benefit. Most of the benefits I could appreciate first-hand are listed below. There are many more, as noted at websites like [http://promom.org/101/index.html](http://promom.org/101/index.html); [http://www.breastfeedingonline.com/advantages.shtml](http://www.breastfeedingonline.com/advantages.shtml), & [http://www.kellymom.com/bf/start/prepare/bf-benefits.html](http://www.kellymom.com/bf/start/prepare/bf-benefits.html).

- Reduce the incidence of colic (colic is absolute hell, as you can imagine, & starts about 1 month after 40-week due date)
- Reduce the incidence of ear infections (which often result in antibiotic treatments [and I have student whose daughter may have lost her hearing due to a powerful antibiotic injection, as a result of an ear infection])
- Reduce the incidence of asthma, allergies & other health issues (e.g., Crohn’s disease)
- Provide 1 to 2 extra IQ points
- Get babies close to your heart beat & warm skin (which they crave ;-) )
- Calm the babies (the oxytocin in milk works wonders when delivered directly!)
- Keep the babies healthy (so that the entire family can focus on being happy, rather than wondering what is wrong with the babies & rushing off to see doctors and trying to get ill babies to sleep, take meds, etc.)
- Eliminate (or reduce, if also pumping) bottle-washing & -sanitizing chore (it's quite a production!)
- Save a fair amount of money (at least $125 per month for twins, perhaps on the order of $200/month)
- Allow mom & babies to go out with fewer (bottle) bags in tow
- Avoid formula, which tastes horrible. (No one would choose to drink the stuff. I don't know why babies tolerate it.)
- Shrink mother’s uterus and tummy size; allow mother to regain her prior weight.
- Avoid menstruation for many months (a year, in my case, as long as I was nursing/pumping at least twice a day)
- Reduce mother’s incidence of breast & ovarian cancer, as well as osteoporosis

Of course, breastfeeding is not simple for most of us. For many of us, it is very close to being the most difficult assignment we’ve faced. So the BIG issue becomes whether mom can handle being tied to her babies (or a pump) every few hours for months on end. It's a serious commitment & unlike anything many people have ever experienced. A good milk producer, however, can catch a break every once in a while (particularly after the critical 6-week calibration period). One woman I knew, for example, pumped for twins at whatever time she could find, pretty much, six times a day, and was able to keep up with her two very thirsty babies. Others do not have the same storage capacity or for other reasons cannot skip pump sessions.

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1 The first time our children became sick (at 10 months, when about 60% of their milk was breastmilk), they gave it to me & our nanny, and we both became very ill. It was truly horrible. And it was the first time I really could understand why many parents choose to have only one or two children.
I suspect many people who know about the benefits of breastmilk would suggest that 1 month be “mandatory”, if a woman is able to do it physically. 6 months is a great goal, so is 9 months. Beyond a year (just once or twice a day at that point) is helpful in protecting them from some infections and provides a mother-baby closeness that they desire (& many mothers also want).

AAP recommends babies be breastfed until 12 months or more. (6 months = key [KK])

Breastmilk-fed babies (whether via bottle or at breast directly) have, in the past, averaged IQs 3 to 8 points higher. Their immunities are also higher, though this has not been quantified that I have found. Colustrum is critical, and first month of nursing is more important than later months. Supposedly, any amount of breastmilk is better than none; however, formula can coat the stomach of a baby making some immunities & other goodies less likely to enter gut. In Africa, this has resulted in HIV-positive moms passing more HIV to babies. (KK)

Seton Breastfeeding Support Services 324-1000 + 1 + 17036#.

Consume an extra 500 cal/day/child (proteins & milk products) for exclusive breastfeeding (but can cut this a bit to drop weight, ~1 lb/week is safe) (O&M)  Note: KK feels additional cals are not much at beginning of nursing; the need goes up as the babies’ consumption goes up. So one may need just ~200 extra cals/day at beginning, and 500 later. (But 2 ozs 8 times a day at 20 cals/oz is 320 cals in your breastmilk for a newborn. So maybe 320 cals/day is needed early on? 😊)

You need lots of protein, calcium, iron & fats. Fish is good. Eat +500 cals/day while breastfeeding (vs. +300 during 3rd & 4th trimesters). (PP)  If you take medicine (e.g., to ease breast pain), 500 cal/day/child. Drink lots of water! (JOT)  WTE recommends no caffeine (& of course no alcohol) while pregnant, but says it’s okay to have ~2 cups of coffee per day while nursing & ~1-2 alcoholic drinks a week. (WTE) Alcohol is metabolized within 30 to 90 minutes, depending on one’s metabolism; so safe to nurse 2 hours after drinking, typically. (Baby 411)

Extra 500 cal/day. Exercise after nursing, & wear double bra. (PP)

Nutrient content of breastmilk is amazingly consistent & relatively independent of mother’s diet. Mom must eat well to avoid sabotaging own body & avoid fatigue. (ST)

Losing > 2 lbs/week after first 3 weeks of nursing is a problem. Milk production requires fat stores. So have 5 servings of milk per day, 3 of protein, 2 of Vitamin C, ~3-5 veggies + fruit (total), 6 grains, & 1-2 high-fat foods, per day. With twins being nursed, add protein, calcium & fluids. (WTE)

Seton NICU’s excellent lactation consultant, Valerie Mick, recommends the following: Pumping 8 times/day for 10-15 minutes each time. (Don’t pump more than 25 minutes. More frequent pumping is better than too-long pumping.) Hand-expressing a drop of milk & leaving on child’s upper lip to whet their appetite. Placing a finger above nipple (above where upper lip of child would be) so nipple angles up into child’s mouth, hitting the point where the hard palate joins the soft palate of the upper mouth, & getting most of the lower areola into the lower mouth, where maximum glandular stimulation occurs. Push/roll flesh of areola region into a baby’s latched mouth, to increase latch size & get baby lips flanged outward. Massage breast while feeding, to facilitate flow. Relax & breathe deeply when starting to pump, & think of baby; don’t cry, unless it’s happy crying. Watch a video of your child when pumping. Buy EvenFlow Comfy nipples to
best train babies for breast, since wide base & short nipple are much more like a woman’s breast. Try not to have too many servings of milk a day (~3 to 6 servings), since you may overload their systems, resulting in allergic reaction (& need to cut back dramatically, if not completely, on milk).

Don’t allow babies to sleep 4-5 hours (or more) at a stretch during the daytime. Babies need to nurse often in order to make good weight gains & sleep longer stretches at night. (HEA)

Wake baby every 2-3 hours to feed during daytime. (Seton)

Nurse the hungriest baby on the fullest breast, but do alternate too, so hungry baby keeps milk in both breasts up. (HEA)

Don’t stall the babies until your breasts feel like they’ve filled up. There is plenty of milk after 1.5-2 hours, but you can’t feel it. After the first week or so, you breasts won’t seem so full anymore, b/c the swelling (not the milk) has gone away. (HEA)

Twins stimulate a lot of milk, & missing a feeding can be quite painful. Pump or wake a baby to ease this, or risk pain & possible breast problems. (HEA)

Babies nurse best during their most alert times; when a young baby wakes up (!) on his own is when he will nurse best. (!) When you see a baby waking up, offer the breast. (HEA)

Quiet, alert times are best. Crying is a late hunger cue & babies may not nurse so well at this time. Do not use a pacifier as it may cause you to overlook subtle hunger cues. (Seton)

Alert the baby to initiate feedings, by partially undressing baby, talking to baby, changing diaper, stroking body, & holding baby upright. (Seton) Have dad massage baby’s head, to trigger sucking reflex.

Clues that babies are hungry include putting hands near mouth, opening their mouths, sucking motions during sleep, motor activity & blinking, eye movements under the lids, smiling & frowning. (HEA & Seton)

Let baby end the feeding. Satiety clues may include hands open, limbs relaxed, baby limp, eyes closed, less swallowing, and increased pauses in sucking. (Seton)

Frequent nursing makes more milk than longer feedings. Massage of breasts before & during pumping (& nursing pauses) increases flow & makes more milk. (Seton)

Many newborns cluster feed, with several feedings in a row & only ~45-60 minutes in between. Then, the newborn will take a long nap. Newborns need to eat at least 8 times per 24 hr period & at least once during the night. (Seton)

Babies that fall asleep or lose interest in nursing are probably an indication of poor nursing techniques. Can do a supplementary nursing system tube to them (so go through motion of nursing on breast while getting extra pumped milk in); also can try nipple shields. (CH)

Wounded nipple care: Lanolin is chap stick. Nice for lubrication, but not a medicine. Try daily cleansing with milk soap and water, rinsing after nursing, and some antibiotic cream. It's easy to pick up a staph infection when babies are teething. It also could have been a bacterial or viral diaper rash. Teething & fevers: Raji P writes “My pediatrician told me that they do not get a fever from cutting teeth, but that they very commonly pick up a virus or bacterial infection because they are putting even more stuff in their mouth to soothe the teething.”

Dads can & do help! They provide encouragement & support, water & pillows, backrubs & burping, …. Women with small breasts can & do produce just as much milk as others, but storage space is affected & thus such women may need to nurse or pump more often.
Breasts will nearly double in size during pregnancy & enlarge further for milk coming in, which typically occurs on the 3rd postpartum day. (BT)

New moms are often advised to nurse a singleton on each breast 10-15 min, but most infants nurse most vigorously at the beginning, getting ~2/3 of their milk then. Alternation of breasts ensures that more balance in demand on the breasts. Breastmilk fat content rises during feeding at a single breast, so it’s important to nurse first breast until well-drained (i.e., 10+ minutes) to give access to the rich, high-fat “hind milk.” When the baby starts to slow &/or doze, you can burp her, change her diaper & arouse her for the 2nd side. Let the baby stay there for as long as he/she wants. As babies get older & the milk ejection reflex (“let down”) gets well-conditioned, they will nurse more efficiently, taking the bulk of the feeding in ~4-7 minutes only per breast. If you’d like to try keeping them longer, to get the hind milk, you can. But if baby is not perhaps gaining enough weight, switch him/her to get to the easier-to-access & greater volume of milk in the 2nd breast. (BT)

Hind milk has more fat, & begins to show up in milk after ~2 minutes, and then increases with nursing duration. It has ~32 cal/oz. Foremilk has more lactose & water, & babies will need to nurse more frequently with this, since it only has 12 cal/oz. (CH)

Babies nurse every 3-4 hours; breast milk takes them less time to digest than formula. (YPA30)

Note: Other sources say newborns may feed at often as once per hour, esp. during cluster feeding periods.

Some sources suggest that babies need a LOT of milk (e.g., one source suggests 7 lb & 10 lb babies need ~20-24 & 28-34 oz of milk/day). And some babies do drink a lot of milk. JW’s babies supposedly drank 30 to 40 oz/day, while KK’s drank only 23 oz/day at 15 lbs (5 months of age). Yet the babies are not different in size. The fat content of different mother’s milk can vary, and hindmilk is richer than foremilk. Simply watch your babies’ growth, and check in with your pediatrician about feeding amounts. Your baby may be fine on 20 oz/day or less. (KK)

Formula stains clothing (!), so watch out for spitup. Can avoid spitup/loss of precious milk by burping baby halfway through feeding. (ST) Another source recommends burping 2-3 times per feeding to avoid gas reducing their milk consumption. BT recommends zapping breast milk, formula & spitup with stain stick & then soaking in cold water. Don’t wash in hot water (which will turn it brown). If it turns brown, try a non-chlorine bleach. Aged milk will turn brown & smell, so act fast! On couch or rug, squirt dish detergent mixed with cool water; if that doesn’t work, try a tsp of ammonia in 1 cup water (use gloves for this), or a carpet cleaner. (BT) The stair remover “Shout” works well for baby stains; simply spray on most stains right before dropping items into the washing machine. (For tougher stains, keep wet beforehand.) OxyClean is also a great product, for getting clothes white.

Formulas vary quite a bit. Not too many have DHA & ARA in them yet, though those have been found valuable for brain development (& both are present in breastmilk). Enfamil’s Lipil brand (1-800-baby-123) appears to be the best. Seton’s NICU used Similac Advance, which also has both, but in lesser quantities. KK’s call to Similac (1-800-515-7677) came up with 8 mg/100 cal of DHA & 21 mg/100 cal of ARA, vs. 17 & 34 in Lipil, which is what breastmilk from around the world averages (according to Lipil literature). Similac phone center staff suggest that their formula allows 50% better
calcium absorption than Lipil, however, thanks to their fat blend. American’s DHA & ARA levels are typically lower than those found elsewhere, due to different diets. If you’re not getting enough milk to come, increase your fluids & nutrition. Include wheat germ, nonalcoholic beer & Brewer’s yeast in your diet. (HT) Milk supply is low at the end of the day, with low fluids & fatigue setting in. Put up your feet & have a snack! (HT)

A mom that drinks milk while nursing may lead to colic, fussy babies, & spit ups. So watch this. Also, never give a baby cows milk during the first 12 months. It is too high in protein & salt, which strains their kidneys. (!) (HT) All cows milk products (milk, cheese, ice cream, butter…) are able to cause digestion problems for baby. (CH)

Keep back straight but relaxed as you offer the breast (vs. leaning over or back). Try several positions before leaving hospital. (Such variety can help prevent nipple soreness & clogged milk ducts.) Place 4 fingers underneath breast & thumb on top to present the nipple; make sure fingers are well behind areola so they don’t get in baby’s way. Tickle baby’s lower lip with the nipple, to get him to open mouth; when it’s open wide, quickly draw him to you, getting a lot of the breast into his mouth. Breastfeed on demand (e.g., when notice suckling motions or increased alertness of baby!!), & feed as long as baby desires. (BT, citing AAP’s breastfeeding book)

To feed a premature child, one must keep her awake (since she’s weak & will try to doze off); one can do this by unwrapping her clothes, rubbing the soles of her feet, stroking the throat under the child. Express some milk first, to allow the child to smell it, & apply warm breast compresses to increase the flow. Lie down with the baby to feed, before the child becomes too hungry & starts to fuss. You also can put a cut-tip plastic nipple over your own nipple, if a baby is getting too used to bottles. (GPSP) Also, you can try spoon feeding milk to avoid a bottle-vs-breast confusion. (HT)

Newborn suckling helps avoid painful breast engorgement. Most hospitals will take newborns away, until they get their temperatures up. But immediate bonding is very important! So you should have at least 20 minutes of this. (HT) Breastfeed within a few hours of birth to get the colostrum; normal breast milk comes at about 12 hours after birth. (YPA30)

Engorgement comes on ~3rd day after birth, & its swelling flattens the nipple, so may want to hand express or pump first, to get the nipple more grabbable for the baby. Washed green cabbage leaves can soften the nipple area too; just wear these inside your bra, with a hole for the nipple. They are anti-inflammatory, but can reduce milk supply if overused (watch for a tingly sensation). You also can use warm compresses (or warm shower) before feeding & cold compresses afterward, + massage while pumping. (CH) Cheryl Heynman has never heard of cabbage leaves being left on too long; ice & leaves want to reduce inflammation, else swollenness constricts glands. Cabbage helps with milkduct plugs, can do just in that quadrant, she wore overnight in bra & was gone. Lecithin is also helpful, if recurring over a long period of time. (CH)

Epidurals can affect baby’s response to breast. C-section babies have had less exposure to those drugs & thus may respond faster. Also, epidurals relax the nipple, so it may look flat right after birth. (CH)

St. David’s breastfeeding boutique employee (397-4104) said newborns nurse longer (e.g., up to 60 minutes, vs. down to 10 minutes for good suckers later on) b/c they are weaker, so one needs a more powerful pump if delivering earlier. She said suction is most important, versus cycles per minute; & Medela’s “high” suction is “medium” on a hospital-grade pump. (Babies suck at ~60 cycles/minute, but hospital grade pumps only
go up to ~50 cpm, & retail pumps are even lower, evidently.) However, AMOM’er Julie Ballengee said when she finally started using high suction (after ~10 months), she hurt her breasts immediately (they started bleeding) & she had to stop pumping altogether. (Julie had NO other problems the rest of the time & was a great pumper, never contracting yeast or cracked nipples.) Moreover, KK found that Seton’s hospital grade pumps were actually easier on/less aggressive on breasts, than Medela pump. So they were good for tender breasts, but not any better for strong pumping. One can actually be traumatized by excessive & imprecise suction pressure, causing great pain & an inability to continue pumping at such levels.  

** The lesson: Be CAREFUL with high suction, particularly on retail grade pumps. You need to have tough breasts to do it. And the pain may not start right away. Be ready to cut back immediately.

As milk comes in, your temperature will rise to ~100°F. If it goes to 104°, tell the doctor. (ST) Nipples need lots of stimulation the first couple weeks, in order to get milk supply going. You should be nursing or pumping with a hospital-grade pump (if mother of twins) every 3 hours for 10-15 minutes, in order to ensure adequate milk supply. (CH) Don’t let those nurses tell you to get a 5-hour nap if you’re not certain you’re going to be a big milk producer. Take a 4-hour nap at most once every one to two days, & be religious about pumping every 3 hours during the rest. (KK) CH feels higher sxn levels on pumps often make a big difference; sometimes no difference. Some people don’t do well with a pump. (CH)

Letdown is a tingly, semi-painful cramping (feels like glands are being stretched or torn [KK]) that occurs several times during a 20-30 min. nursing session. (YPA30) It only occurs for ~3 months; so you’ll need breast pads during that time. You can stop this process by squeezing nipples. (ST)

Simultaneous feeding of twins takes less time, but does require waking the twin. Feed at night in the hospital too, rather than letting nurses give formula. The nurses may want you to sleep, but it will result in painful breast engorgement. (HT) Tylenol is also helpful when feeling engorgement pain. (YPA30)

Twin moms often feed at same time & try to get on schedule, but can be hard. Probably best to switch the kids on breast, to avoid lopsided look. Burping often not needed with breastfed kids (b/c less air than in bottle) so try going without burping them at first. (JOT)

You can use a football hold with twins, or both parallel or crossed, tummies up or down. You can lie down with one, to nap at the same time. Pillows to prop babies are very important (not a “boppy” but a real nursing pillow is needed for twins). (JOT)

A football hold of both (with their legs back, under your arms) = relatively easy. Prop them up on a tray-like pillow, leaving your hands free. Or put 1 in a traditional front position & the other in the football hold. Feeding while lying down also is great, if you can do it. (HT)

A cradle hold is best, with hand around the baby’s neck (not the back of head), allowing the nostrils to come off & you to really be able to control their head. One can do a football position with cradle hold on two babies at once. (CH)

Nipple soreness peaks at ~day 10. Wash & expose to air & pure hydrous lanolin (no need to wash off) or breastmilk. Do not use soap, alcohol or petroleum jelly. (!) Nurse on less sore side first, so you’ll have more “let down” on the sore one & make it easier for babies to get milk there. You can wear special nipple protectors (~1/2 bubbles, such as tea sieves) to cover yourself up on top. (JOT) Dermatologist Dr. Mary Martinez says
lanolin, Vaseline, or aquaphor are fine on nipples & no need to wash unless excess still there.

Breast infections peak at ~6 weeks, 3 mo, & 6 mo. b/c moms often try to add new activities then, which causes them to lose sleep & get plugged ducts. Apply warm, wet compresses for <5 minutes prior to nursing or pumping (or apply cabbage leaves) & nurse frequently on that side to keep the milk low there. (JOT) Massage the clogged breast while nursing/pumping with it. (YPA30) Plugged ducts can be treated by massaging before & after nursing, warm compresses, & frequent nursing. (CH) See [http://www.kellymom.com/bf/concerns/mom/mastitis.html], [http://www.breastfeedingonline.com/22.html] & [http://www.breastfeedingbasics.com/html/breast_infections.htm] for more plugged duct info & ideas (e.g., nurse on all fours, with breast hanging down toward baby – as also suggested in Breastfeeding Multiples; use a soapy comb to massage it toward nipple while in hot shower). Note: You can best feel for a plugged duct when lying down flat on your back, much like for seeking cancer. Large breasts get in the way of feeling the mass when upright. Don’t massage toward the nipple, though many people may recommend that, fiddle around in that mass of ductwork & massage back, away from the nipple to get the milk to back up, reducing pressure on the plug. (KK) AMOMers also highly recommend lecithin (1 Tbl 3-4 times/day or 1-2 capsules (1200 mg each) 3-4 times/day, which helped Joanna W) & Phytolacca Decandra for plugged ducts, as well as a chiropractor for a permanent solution (Kimberly Mauldin Heinrich, at Mauldin & Heinrich) & perhaps even an acupuncturist for a less permanent solution (Kimberly Patterson, 322-9649).

Air your nipples in sunlight occasionally. (Babies’ butts aired in sunlight are also better!) Soggy pads lead to infections. Vitamin E and/or lanolin help prevent cracking. (HT) Air dry after every feeding; leave bra flaps down. Avoid all plastic bra liners. Avoid soap on nipples. (HEA)

Washable bra pads should be kept in a lingerie bag in the washing machine & dryer (to avoid ruining the machines). (ST)

Improper/insufficient “latch on” of babies to nipple + aerola can lead to reduced milk production & painful nursing, as baby works harder. Such pain can inhibit a let down, but so can infection. Infected nipples can lead to mastitis (which occurs in about 10% of lactating moms), with pain & flu-like symptoms. Don’t stop breastfeeding at this time, since that can result in abscesses, which are extremely painful localized pockets of pus. Continue breastfeeding or pumping (if nursing is too painful) from the affected side! If milk looks discolored or bloody, you can pump & discard. It’ll return to normal within a day or two. (BT)

To get child to latch on, tickle the upper lip (since baby will naturally tilt head upward to feed & thus nipple will end in the right spot) back & forth a bit. Wait for baby to open mouth wide & then bring baby to breast, tilting/pointing nipple upwards, towards roof of baby’s mouth (allowing them to get their tongues underneath & get a lot of the nipple inside). It’s important to get the chin up close, to keep the tongue in place. About 1” of aerola should be in baby’s mouth, esp. the underside for her tongue to optimally extract milk. Her lips should be “flanged” & visible/flipped outward, looking like fish lips (esp. the lower lip). Their tongue should be forward & working on the nipple. The chin should be pressed into the breast tissue, & the neck slightly extended, nose just touching the breast
(or slightly free). Neck will be slightly extended, so nose freer to breathe. Ears may wiggle, but dimples should not be sucked into cheeks. Swallowing/uh-uh sound will be more evident when milk comes in. You shouldn’t see much/any jaw movement, & it’s very hard to hear the soft sound of swallowing, but you can see the lower chin-neck area move up & down for the swallowing. (CH)

Will probably nurse 35 minutes per baby, but really as often as baby wants & for as long as baby wants. Should get 6-8 wet & 2-4 soiled (larger than a quarter coin size) every 24 hours after the first 6 days. Can tell if wetting diaper by inserting a toilet issue or Kleenex. (CH)

To break baby off breast, insert finger into mouth corner. (Keep a nail trimmed for this). Want to hear a “pop” before removing the child, to be sure she/he has let go (else it will be painful for your nipple). (CH) KK also inserts a formula bottle’s nipple, to break the latch & avoid sore nipples – and avoid hurting the child’s mouth with your finger.

Nurse every 1.5-3 hrs during first 2+ weeks (must wake baby every 3 hrs in 1st 2 weeks). Only if they’re doing well after 2 weeks can you let the feeding go more by their cues. To wake baby, remove clothing, tickle feet or forehead or back, use cool damp cloth on feet or forehead or upper body, talk or sing to baby. (CH)

Creating & Maintaining Adequate Milk Supply is Key: AMOMer D Monks writes that she “never went more than 3-4 hours at a time between nursings. It's important to establish a good milk supply, and if you get that full feeling, or are engorged, you've probably waited too long. Your breasts will sense the fullness, and they may not empty well, and that will trigger them to stop producing as much. My milk supply is only as good as the amount of feedings the day or two before! I have major issues with supply and I've learned how to avoid the "not enough milk" problem, but it's not easy! No, I don't get great sleep (she does sleep with them next to her & doesn’t change wet diapers, just dirty diapers at night), but as the babies get older, they become fairly efficient at extracting milk fast, and you have minimal interruption. For most of mine, by about 3-4 months old, they could be done nursing within 7-10 minutes.”

Baby cues including smacking sounds, mouth movement, hand at mouth, rooting reflex, sucking on fingers, transition from heavy to light sleep with increased eye movement & pre-cry grimacing, small fussing sounds. (CH)

Baby shouldn’t be able to bite, since tongue should be in the way. When baby teeth do come in, however, they are razor sharp, for a little bit (but they dull down pretty quickly). (CH)

Practice nursing in front of a mirror before going out in public, if you want to get a sense of what is visible. (CH)

Clogged ducts result in sore breast spots. Massage these while you nurse to avoid mastitis. (ST)

Mastitis can dramatically reduce one’s milk supply. So AMOM’ers recommend PUMPING a lot, in addition to nursing, to get supply back up. And drinking tons of water (some say even to the point of making yourself sick!). The other, standard methods women use are Fenugreek plus Blessed Thistle (taken together), sleep & avoiding caffeine. Also, acupuncturist (Kimberly Patterson, 322-9649) helped one AMOMer eliminate mastitis without drugs & Chiropractor (Kimberly Heinrich) did an adjustment on one’s clavicle/sternum/ribs, and she hasn’t had a single clogged duct since! It's incredible. If her baby skips a feeding, her ducts don't clog.
Pumping helps unclog ducts. Best to do every 3-4 hrs to avoid pain/engorgement. And lay down on your bed & feel for little “knots” in your breasts. If you notice milk drop on one of your breasts (when pumping, for example), you’ve got a plug starting – and NOW is the time to get rid of it (by fiddling around & massaging back AWAY from the nipple – not toward the nipple).

If you plan to supplement or pump, probably need to introduce bottle by week 3 or 4 (!), and have dad deliver it (mixed at first with breast milk at first). To bottle feed, CH recommends Avent nipples, & getting child’s lips around base. 1 hole = newborn nipple, 2 holes = for 1+ month, 3 holes for 3+ months, 4 holds for 6+ months. (CH)

Colic is more common from bottle-feeding, but some bottles reduce this more than others (e.g., Avent). Val Mick recommends EvenFlo’s comfy nipples, because much flatter base & shorter nipple, resembling human breast much better.

Thrush is VERY painful (often described as glass shards on one’s nipple) & comes from a candida yeast infection, given through baby’s mouth to your breast. It leads to cracked & burning nipples, deep shooting breast pains, vaginal yeast, & white patches on the inside of the baby’s cheeks & lips. Eating sugary (& yeasty) foods, taking antibiotics, getting inadequate rest, stress, allergies, and injury to the nipples from poor latch-on can also set the stage for an infection. Vegetable or olive oil on nipples before pumping helps a lot. Take ibuprofen & acidophilus. Venetian dye = purple & stains a lot, so not the greatest, if you can avoid that treatment. Diflucan, nystatin (not as good as diflucan, evidently & not as good as Gentian violet for many), dioxchlor, & other drugs/vitamins can help greatly – both mom & baby. See http://www.mothering.com/articles/new_baby/breastfeeding/breastfeed-thrush.html (Be sure to sterilize pacifiers & watch babies self-reinfection via thumb – though gentian violet can take care of that.) An AMOMer had great success apply Stoneyfield Farm yogurt like a lotion to child’s mouth with added Nature's Way Primodopholus (breaking open the capsules of primodopholus and added it to the yogurt and then stuffed it all in his mouth). It cleared up in about a week & her nipples didn't flare up at all. So much easier than gentian violet or anything else she has ever done with a baby. AMOMer EPG writes: Gentian violet is much more effective than nystatin for most women. It is a mess. It creates purple babies, purple moms, and purple everything. But it's cheap & widely available (but call first, because not everyone carries it). It's OTC but sometimes they have it behind the counter. Use a q-tip, not the applicator, to apply it, and don't double dip. And wear old clothes that you don't care if they stain. She wasn't able to kill the yeast with gentian violet, probably because of my diet and the fact the yeast was systemic for me. I had a lot more luck with Dioxychlor-DC3, a supplement at Whole Foods. It basically suffocates the yeast. If the nystatin doesn't clear it and you want to go the drug route, you can go on Diflucan. You need to get a 7-10 day prescription from your MD, not a one day supply (which is what you need for vaginal yeast & won’t take care of thrush). Diflucan works great for her, temporarily, but the yeast flares as soon as she stops. But it is a miracle for many.

AMOMer Elizabeth Pollard-Grayson wrote: Raynaud's (sensitivity to cold in the extremities) can cause intense nipple pain. Here's an article about it: http://www.lalecheleague.org/NB/NBJulAug99p120.html

La Leche League Amy O. leader suggested that fair-skinned, light-areola, light-haired women are more prone to pain from breastfeeding. New growth of breast tissue is painful. Too tight a bra can plug ducts. Also, fast walking may be too much for breast tissue. Try to walk at same time of day, so body doesn’t get a mixed signal (e.g., thinks it’s time to
pump, but tight bra will send restrictive measure). Best to get to nursing as much as possible; try to do an early morning feed that way, since more milk at that time. Pump is not as stimulating as nursing. Recommends ibuprofen for pain.

Lactation consultants highly rec’d by AMOM’ers include Special Additions’ Cheryl Heynmans at 280-5814 ($95 for home visit plus lots of phone call follow-up) & Mom’s Place Mary Anne. La Leche League’s Darien (458-6873) highly recommends Barbara Wilson Clay as the BEST lactation consultant in Austin & perhaps Texas: bwc@lactnews.com 292-7227 (has written books & is the most experienced one in town). $150 per visit (at home) plus lots of email follow-up, get prescription from Ob or pediatrician to seek reimbursement (twins are usually covered by insurance). KK called Barbara on 2/12/04 & heard that premature babies are much less likely to suffer from nipple confusion & will take a bottle, even after 1 or 2 months of exclusive bottle-feeding. Mom just needs to keep pumping, to keep milk supply up, & best to allow babies to nose around & lick, so they’re at the breast. (No need for feeding tube system; that’s mainly for adoptive moms to use.) Their tongues & strength levels are generally not up to the task of breastfeeding at first; just let them gain wait & get to their due date; they should be fine. Note: Seton’s NICU’s Valerie Mick is a very good lactation consultant that Barbara respects. Mary Ann Laverty’s lactation consultant friend is Tanya Phillips (301-3779 home, 560-3732 cell)

**Raising milk supply:** Tanya Phillips says suck is strongest from chin, so orient it that way to unplug/empty ducts. Breasts need to be stimulated 10-12 times/day to keep supply up. Pump is never as efficient as a baby, unless weak newborn. If mom were to just pump (on a retail grade pump, most likely?), she often can’t keep up supply to feed babies. If you take fenugreek that urine smells like maple syrup; need 12 capsules/day for it to work. Highly recommends breastfeedingonline.com. Jack Newman talks about fenugreek in his notes; domperidone or motilium are prescription drugs that are much more effective than Regalin. Pain is almost always a sign of a duct that’s getting too full. If stays too full for a while, bacteria will start to grow, causing mastitis. Massage while nursing or pumping. Massage while not doing that stimulates letdown but without being able to empty is not effective. An 8 lb baby really needs only 1.5 oz per feeding. So ours probably only need 0.75 oz, but every 1.5 to 2 hours. After 10 days, mothers need to empty their breasts well in order to keep the milk coming. She recommends pumping every couple hours during day, & then every 3 or 4 hrs at night. Raji P also recommends “drinking the hot barley drink called Pero (I got some at Cost Plus World Market). It is like instant coffee and I add creamer to it. This has helped me a lot!”

Breastfeeding results in a dryer vagina, so use KY/lubricating jelly for sexual intercourse. Also, keep a towel handy, since orgasm simulates letdown. (ST)

Babies who are extremely sleepy & ineffective nursers at first may be the result of a highly medicated birth. Jaundice in a newborn may be the result of ineffective or infrequent feedings. Newborns should be awakened every 1.5 to 3 hours (!!!**) to nurse during the first 2 weeks. Most women can trick themselves into thinking they have just given birth & can breastfeed, but pumping a lot (!). [CH – lactation consultant]

Babies are ready to nurse in the first hour after birth; then they have a long sleep phase. That phase may last up to as many as 8 hours, but hospitals will try to feed the sleepy babies every 3 hours, to keep them from dehydration & losing >10% of weight. (CH)
Breastfeeding twins simultaneously increases prolactin, thus increasing milk supply; it also helps the weaker baby feed, since the stronger sucker gets the let-down going. One should mix up the breasts across the 2 babies, since different breast produce different amounts of milk. (You can put a pin on your bra or bracelet on your wrist to help you remember who goes to which breast next.) (Lactation Consultant CH)

There’s a mothers Milk Bank for ~6-week early babies, because it’s much harder to express much at the start. It may be easier to hand-pump (rather than electrical pump) colostrum. Lots of nipple stimulation is important anyhow, even if nothing or very little is coming out in the early stages. Keep it up! It’ll get there. (CH)

Human milk helps clean out the meconium, reducing jaundice. Also helps prevent hypoglycemia, & reduces rates of breast cancer & osteoporosis. (CH)

Avoid bottles & pacifiers for several weeks, if possible, till babies are established at nursing. (CH)

Babies’ autoimmune systems take 5 years to become indept., so the normal human weaning age is 3-7 years (!). Nursing longer is better. (CH)

Don’t use underwire bras while nursing. Those plug ducts & cause infections. (CH)

Squeezing nipples won’t stop milk release; instead, use entire arm to pressure the entire nipple area. (CH)

Thanks to nursing, a baby will stay healthy & resist most infections the first 6 months. This situation changes in months 6 to 9, even with exclusive breastfeeding. (Dr. Guerrero & KK)

Growth Spurts & Nursing: These last for ~1-2 days. For many babies, growth spurts (when they’ll need more milk) occur around 10-14 days, and 4-6 weeks, 3 months, and ~5-6 months. (HEA) The breast may not seem as full during these periods, b/c the baby is stimulating them to make more milk. One should feed baby more often during these times. Frequent nursing makes more milk than longer feedings. Massage of breasts before & during pumping (& nursing) increases flow & makes more milk. (Seton)

Nursing & Constipation & Reflux:
Julie B writes: “There is a relationship between not having dirty diapers and the overactive letdown or foremilk/hindmilk imbalance. But, not sure where the constipation fits in or backing up. Overactive letdown, oversupply, and foremilk/hindmilk imbalance tend to go together. When a mother has too much milk, the baby ends up getting a lot of foremilk. The foremilk helps with hydration and wet diapers. The hindmilk helps with dirty diapers, because it is the heavier, fattier food. The foremilk has a lot of lactic acid in it, it seems. Anyway, when the baby breaks it down in his system, he ends up spitting up a lot, having a lot of gas and a lot of discomfort. See [http://www.users.qwest.net/~fsdebra1/refluxoal.html](http://www.users.qwest.net/~fsdebra1/refluxoal.html) for more details.” What Julie did to tackle this issue: “I've increased my fluid intake dramatically. I've also added much more juice than milk. The first day, I gave my baby some Prune juice, which he didn’t like. I also have paid more attention to my Over active letdown problem, particularly at night. I have been sticking with one side for a longer period at night and sticking with the 3 hour window during the day.”
Pumping:

Ad for Medela pump says it’s double, electric & offers an initial rapid rhythm for “let down” milk & then slower, deeper rhythm for most effective expression. [www.medela.com](http://www.medela.com), 1-800-435-8316. St. David’s has a breastfeeding boutique on 3rd floor (32nd Street, 10-4 M-F & 11-3 Sat, 397-4104), & they recommend a hospital grade pump for 50 cycles per minute frequency, b/c babies suck at ~60 cpm. Rental rates are $20+/week or $55+/month. Also recommend their Bravado sports bras for nursing, $33. KK rented top-of-the-line Symphony for $75/month = very precise.

Adjust a baby to use of a bottle before returning to work, but you don’t have to miss feedings! Give your baby just ~1-2 oz of milk 2-3 times/week, & have someone else give the bottle. (Seton) At work, wash your hands, minimize distractions, relax & think about baby. Start pumping at the lowest (!) suction level. Allow 20 minutes for a complete pumping. (Seton)

With bottles, may need to especially warm the milk, use fresh (rather than frozen) breast milk, sit on a bouncy ball while bouncing with them, turn the baby away from the person [so all she sees is bottle & hand], and/or start with a breast & then switch in the bottle nipple quickly, to get them to first take it. Note: Silicone has less of a taste than Latex. Many babies seem to finally take the Platex drop in nipples, but refuse the others. (AMOMers)

Apply heat to breast & massage prior to pumping to stimulate let-down. Interrupt pumping to massage again when flow of milk lessens, & then try pumping for a few more minutes. (Seton)

The best time to begin collecting breast milk at home is at feeding times, esp. early in the morning when breasts are full. Nurse the baby on one breast & then do a short pumping (~5 minutes) on the other breast. Then, you can nurse the baby on the pumped breast. (Seton)

Babies may need to nurse so often that you go crazy, so pumping can really help spread the feeding times our for you (according to AMOM’er Julie Ballengee), so you’re only nursing (plus pumping) every ~3 hours. Twins may feed at different times & babies may not drink enough each time, so you have milk to pump & they want it every hour or two.

Do not pump until 6 weeks so that you’ve fully developed your milk production (!). (JOT) Relaxation aids your let down (so get in a comfortable position & listen to music!). (JOT) Breast milk can be kept in fridge 3-5 days, freezer 3 months, deep freeze 6 months. Small portions (2-4 oz) are easier to thaw & less likely to be wasted. After milk is thawed, use it within 9 hours; do not refreeze. If baby doesn’t finish bottle, remainder should be used within one hour, or discarded. (Seton)

Don’t microwave breastmilk b/c it breaks down the natural milk chemistry & can create hot spots that burn baby’s mouth. (USA Baby) Note: Special Additions Lactation Consultant, Cheryl Heynman, says microwave won’t really break down anything in the milk (unless you super-heat it), but the hot spots are the reason behind no microwave. (CH)

Used Pumps: FDA says non-hospital-grade breastpumps, like toothbrushes, are labeled as single-user gadgets. Evidently, some droplets of milk can get through the tubes, back into the motor. Some viruses in breastmilk are HIV, HTLV-1, & CMV. So Medela & many lactation consultants recommend no one buy a used pump. Of course, HIV can hardly live on any nonhuman surface, & that’s probably true of the other viruses. Yeast is a more stubborn issue (according to a nurse’s website SGR visited). Yet Medela doesn’t recommend that women with yeast infections buy a new pump. So LM & Seton nurse
ST think it’s fine to get a used pump, esp. if you trust the prior owner quite a bit. Note: Commercial pump motors do slow down after a while. So that is the real limitation. Also, batteries go down, so best to buy a car power outlet, if you plan to pump on the road.

Pump rentals: Mothers of multiples generally need the higher-frequency (60 cycles/minute) of a hospital-grade pump to establish sufficient milk supply at the beginning. These cost ~$1000, but can be rented for ~$22/week & ~$55/month from Seton’s nursing boutique or Special Additions (on Lamar, near 38th).

KK’s notes on use of Medela Pump in Style (by AMOMer Julie B): Start on highest frequency (#5), and lowest (min) suction. After ~2 minutes, when milk is coming out, lower the frequency to 4 & raise the suction a bit (but not so it ever hurts), which will help produce more milk, after the let down. Eventually, go down to frequency 3 & go up to medium suction. (Julie never tried high suction till ~11 months, & then soon started pumping blood & had to give up pumping altogether!) Make sure nipple is centered in intake, so it stays comfortable & doesn’t rub against sides as it is pulled under pressure. If you are pumping a lot of milk (i.e., >4+ oz/breast per session), try to mix the fore & hind milk into a single bottle later, so that child gets both. (Julie would pump into bottles & then pour milk into baggies. Dr. Brown’s (& other) bottles will screw right in to the contraption too.) She washed the little white flaps only once a day, after pumping 8 times a day. (She had a weak boy with reflux problems & pumped for him, since he was rather weak at the start, never on the same timing as the girl & she could better monitor how much he was drinking if she pumped it first.) Use a Qtip each time at start, through top vent hole of intake, to avoid any tube condensation (which slows the pumping). Push or massage or apply pressure to your breast ducts under your breasts toward end of session, in order to stimulate more milk, from lower ducts. Can run pump with intake cups off to get rid of water vapor that may show up in tubing. Warm soapy water with hot rinse & air drying seemed to work fine, unless you have a very sick child & want to avoid any contamination of baby: you can then further sterilize the gear in a microwave sterilizer bag ($5 for set of 20 bags, with 5 uses each, with water in microwave for 3 minutes).

NOTE: The Pump in Style TRAUMATIZED KK’s breasts. It feels like vacuum cleaner relative to the more precise Medela Symphony. For those with very sensitive skin & who need to pump a lot, be certain to rent a top-of-the-line hospital-grade pump for as long as possible, to avoid trauma & maximize milk volumes. Do not let yourself get off to a bad start; you will not be able to recover after the calibration period. (You can always freeze extra milk for use later!) (KK)

JulieB somehow never needed to rent a hospital grade pump for her twins. But she had plenty of milk. (She could eventually pump 20 oz in the morning session!) And she never had to use any moisturizers on her nipples; she never had cracked nipples. But she didn’t use soap on her nipples, & she drank a lot of water (but didn’t eat particularly healthfully).

Nursing Amounts:
Birth to 6 months: American Academy of Pediatrics (AAP) recommends nursing 8-12 times/day, ~10-15 min on each breast (so ~20-30 min for twins, staying on single breast?). Most babies consume 2-3 oz/feeding, for a daily total of 2-3 oz for every pound they weigh. But their desires can go up & down, just like with adults. A good measure of whether child is getting enough is frequency of urination & satisfaction. Expect ~6-8
wet diapers/day & 3-4 with stool. Disposable diapers will feel dry, so drop ~1/4 cup of water into one, to get a sense of what a wet one should feel like. Also, weight gain is probably the most important factor in determining whether baby is eating properly. Some weight loss after birth is normal, but shouldn’t lose >10% of weight in first few days. Breastfed babies initially lose a bit more weight, b/c mother’s milk is coming in & she is learning to feed. Warning signs for newborns are feeding <10 min/nursing, <4 diapers/day, skin remains wrinkled beyond first week, &/or baby doesn’t develop rounded face by 3 weeks. (BT) Baby’s skin thickness & 30-100 billion neural connections mature only after birth. Math & music is responsible for keeping more of these neural connections, but often/typically left with only ~10% of these by one’s teenage years. (ST)

Baby should gain ~1 oz/day for first 3 months of life. In the first month, good signs for getting enough to eat are: 4+ yellow, seedy bowel movements; 6-8 wet diapers; & 8-12 feedings/day. Also, rhythmic suckling & audible swallowing, a mother’s sense of letdown or dripping milk, decrease in breast fullness, & apparent infant satisfaction. (BT)

If a baby doesn’t breastfeed well, bottles are not going to make it worse, most likely. There are exaggerated fears about even a single bottle. Bottles can supplement & help newborns gain appropriate weight. At the same time, it’s key that the mom pumps after feedings to increase her supply (for when the baby goes back to full-time nursing & bottles can contain breastmilk, if mother chooses). (BT)

Babies soon become efficient at feeding & can drain a breast in 5 minutes, but they may choose to linger. (HT)

At 4-6 months, baby’s interest in the world expands beyond feeding & may be distracted → Allow a bit of distraction & offer the breast again; also may need to nurse in a dark, quiet place. (BT)

Baby’s weight should double at about 4.5-5 months, though smaller babies may double earlier. Breastfed babies often grow fast in the first 3 months & then become lower-weight than their bottle-fed peers. (BT)

Wait at least 5 months to introduce solids, because they are messy, don’t get digested by a baby’s system & don’t help the babies sleep (as many believe). Wait till the children have some teeth & are clearly interested in food. One twin may be hungrier or more assertive; make both request food so 2nd twin doesn’t become passive. You can pre-chew or use a blender on whatever the family’s eating or while at a restaurant, but do not add sugar or salt. (HT)

6-12 Months: AAP recommends starting solids between 4 & 6 months, but no magic number exists & others encourage you to wait until baby has good head control & clearly interested in food. Breast milk should remain the major source of nutrition. AAP recommends ~50 cals/pound/day across milk & foods. (BT) Add ~1-2 foods per week. You can nurse before you give the food each time, to ensure that nursing continues. (HT)

Some AMOMers have noticed that their children start waking more at night when they add solids to the diet, since many jarred foods have much lower calorie density than milk. AMOMer Debra M doesn’t even introduce food until 8 months, and then goes right to table foods. She writes that gassiness & mess are two additional reasons to avoid solids beyond 6 months. (Note: Some experts suggest that waiting past 8 months can cause chewing & texture problems for the child.)
High chairs making feeding easier & bring child into mealtimes. Trays should be operable with one hand & preferably tilt away from child & have high rim, to keep child clean. (USA Baby)

By 1 year: By this time, child should be eating 4-8 Tbl of veggies & fruits, 4 servings of breads & cereals (where serving = ¼ slice of bread, 2 Tbl of rice or pasta or potatoes), 2 servings of meat (1 Tbl each). Once baby is weaned, he’ll begin drinking 16-24 oz of whole milk/day (2-3 8-oz glasses, or 4-6 4-oz baby glasses).

12-18 months: Parents should never enter a power struggle around eating with their kids. They will only lose. If child refuses the dinner the family has prepared, don’t offer an alternative. If there’s a really favorite food the child insists on (e.g., mac & cheese), you might serve a bit of it at a meal, along with what the rest of the family is eating. Leave the food for 20 minutes, & then pick it up.

Low-weight babies: From AMOM listserv responses on this question– Docs don’t worry if baby tracks the same percentile all along. To help with weight gain, one specialist suggested adding a scoop of formula to soft foods such as yogurt, applesauce, etc. She also wanted Janine F to give a lot of butter, which she found hard to do & didn’t find helped. The specialist also wanted here to give lots of avocados. Another doc recommended avocados as well. Another wrote that less milk may eventually be needed (giving just once a day, with juice & water at other times), b/c milk can be an appetite suppressant. “There is plenty of calcium in other foods, so they will get enough. But, if they have a big glass of milk with their dinner they are going to drink the glass of milk and feel full, and then not eat the meat, etc.” Also, less snacking means more consumption overall. You might feed them one or two really high fat meals a week, but in general it’s more important to instill healthy eating habits than to fatten them up. It will help increase their appetites at meal times to have no snacks in between meals, drink milk at one meal, juice and/or water at the other meals; and do not give them sodas.

More Nursing & Pumping Details:
Benefits of having at least some Breastmilk vs. 100% Formula: BWC writes: “In the developing countries, where many more infants are at risk for morbidity and mortality, some infants are hospitalized with diarrhea diseases that are pretty devastating. These illnesses (and they happen here, too, of course) can cause, as a sequelae, a condition called "sick gut syndrome." This means the gut is so irritated that the person can't absorb nutrients from their food. A treatment for this in the Third World is small "doses" of donor human milk to re-colonize the gut, to reduce inflammatory symptoms, and to help the child recover from malnutrition. Even two oz daily of human milk can often prevent death. In this country, we have donor human milk banks that provides milk that occasionally goes to sick older children and adults. The milk is used as a "cocktail" to help restore gut integrity in patients with colitis and to help immune-compromised organ recipients following transplantation. There is a lot of interest in human milk as a medicinal. The doses of milk to adults and older children are probably (in terms of a ratio) about like giving an infant from several ounces to about 3/4 of the daily nutrition. So we feel strongly that while the benefits of breast milk are clearly dose-dependant (i.e. the more the better,) some is clearly better than none in terms of advantages for the recipient. These adults and older children (past 6 months of age) clearly are getting other food substances, and the benefits still accrue. In infants under 6 mon. the "gold standard" for early nutrition is exclusive bfg, but the same "some is better than none" rule applies. Mixed feeding is
felt to be best avoided because the infantile gut of the exclusively bfed baby is protected from contaminated foods during the time when the child is still immunologically immature. In countries with clean water and hygienic food preparation standards, exposure to human milk substitutes is less likely to expose the child to pathogens. Exclusivity is promoted also due to risks of allergic sensitization, but there is controversy about the issue of allergy prevention. Some studies show clear benefits of early exclusive bf. Others seem to show that early exclusivity merely delays, not prevents, allergies in genetically susceptible individuals.”

Note: Immunity benefits decline between 6 & 9 months, & babies start to get runny noses & loose stools as they confront standard bugs that their parents are immune to during that time. (Dr. Guerrero, PD)

**Pump Suction Levels:** BWC writes “The research suggests that it takes about 30 sec to 2 min. (minimum range time) to induce a letdown (MER). The typical duration of a milk release is about 2 min. Then there typically is a trough period of about 7 min. after which there is build up to another peak, with a 2nd letdown. At no time is high pressure generally felt to be necessary to elicit letdown. The Symphony pump is designed to have a stimulation cycle (lighter and faster) and a release cycle (slower) to capture those diff. phases. Neither phase of sucking requires painful pressure levels, although some women prefer to hike the pressure or feel they get better vols with slightly more pressure during milk release. So yes, it would be useful to reduce the strain on your nipples to decrease the pressure levels during the troughs.”

**A good nursing book** is Bestfeeding, by M Renfrew and C. Fisher. Chloe Fisher is considered a global expert on positioning and latch. The book is lovely, readable, interesting, and the science is impeccable. Make sure to get the most recent edition. This is the book for mothers that I most often recommend. (BWC) Read the pages of Jack Newman MD at [www.breastfeedingonline.com](http://www.breastfeedingonline.com). Also, [www.kellymom.com](http://www.kellymom.com) is terrific! For latch Help, visit Diane Wiessinger IBCLC's website at [http://www.wiessinger.baka.com/bfing/index.html](http://www.wiessinger.baka.com/bfing/index.html).  

**Saving breastmilk for later:** BWC & Stanford’s top lactation doc both say to give now, fresh, rather than hold some back (& give formula in its place). BWC writes: “I would not freeze, but would focus on giving the maximum amount of breast milk now, while the babies are most immunologically immature. Babies achieve gut closure (the maturation of the gut lining) at about 90-120 days postpartum. The benefits of breastmilk during this time include delay of exposure, reduction of exposure, and enhancement of immune competency and improved growth factors. Consequently, as babies get older, they are designed to be able to tolerate not only other things like solid food, but all the dust bunnies, pill bugs, and dog kibble that a crawling baby experimentally tastes. So there is no such thing as a 'sealed' gut later on anyway.

**Freezing breastmilk:** BWC writes: Freezing does not significantly harm freshly pumped milk. Frozen, thawed milk is good for about 24 hrs. If you are going to pour it out of a larger container to make bottles during the course of a day, I would thaw it all in warm water, or overnight and then swirl gently (don't shake) to combine the separated fractions. Then pour off into your bottles and warm to wrist temp. If they leave a little in the bottles, they can be refrigerated and held until the next feeding, but probably not for longer.
**Cutting back on pumping & nursing:** BWC writes: It is hard to predict what your milk supply will do when you slow down a bit. I just think we will have to wait and see. I also think that even if/when you taper down on the pumping, you will still be making milk that gives the kids really important immunologic advantages even in small quantities.

**Weaning without Engorgement or Mastitis**
Some women produce so much milk that weaning is a long or painful process. Essentially, one will then want to pump a bit, to relieve the discomfort. In this way, the body slowly grows accustomed to the reduction in demand.

**Breast size & lactation:** Dr. Hartmann in Australia uses laser cameras & can tell milk storage capacity. The gist of his research seems to be that smaller breasts have less space to store milk and hence, while production capacity is similar to larger breasts, the smaller breast has to work harder to make and deliver these smaller volumes -- generally by delivering more frequently. 8 times per 24 hrs has always been described as the MINIMUM number of breasts stims/breast emptying times per 24 hrs. Many babies will feed closer to 12 times per 24 hrs in the new born phase -- often in clusters of feeds with a few longer sleep stretches. Hence the cultural taboos that evolved designed to keep mothers almost immobile for 6 weeks to 2 months so that the milk production could be stimulated adequately while the mother rested from her normal labors and laid around with the baby (or babies.)

If the swelling is around the shaft of the nipple, lubrication and shorter pump session durations are generally curative. Over long sessions contribute to swelling in the diameter of the nipple, friction abrasion on the shaft of the nipple, and pain. Generally a 12-15 min. session is desirable. You could do another in an hour if you want to push the stimulation.

**KK’s milk supply suggestions:** If you have serious milk supply issue, take domperidone (60 mg/day for twins, 30+ mg/day for singleton); compress breasts during & following letdown, to empty breasts; pump twice, one hour apart, for every time babies eat (& are not nursing); pump at night, whenever babies are sleeping & giving you a big break (e.g., a 5-hour break, which usually occurs after they are 2 or 3 months old); take lots of fenugreek with blessed thistle every few weeks, for at least a week at a time. Eat WHOLE-oat (not the quick kind!) oatmeal as often as you can for breakfast. Take a milliliter or two a day of More Milk Plus tincture from Whole Foods. Also, though it sounds odd & some people may disagree, I found that bottle-feeding, rather than nursing, seemed to ensure my babies got a higher ratio breastmilk to formula. This may be because: 1. there is less pain associated with pumping, particularly if milk supply is low (since some babies may attack an empty breast & one cannot control a baby’s mouth as easily as a pump), 2. bottles deliver milk more easily creating less of an appetite in the baby, 3. babies may not empty a breast, whereas one can observe milk delivery via a pump & keep pumping until dry, 4. I could pump at any time, and thus more frequently than my babies were nursing. However, I also found that I needed baby stimulation (at least a couple times a day) in order to pump a reasonable amount of milk. (Most mothers don’t need this. They get trained to a pump & do fine. But some of us really do need such advice! ☺ Nursing is rather enjoyable once the kids get good at it too. It took mine ~3 months to get there.)
AMOMer’s milk supply suggestions: Take fenugreek plus blessed thistle; Powerpump 10-10-10 (pump 10 min, rest 10, pump 10 min), Eat oatmeal every day, Drink plenty of water, Pump immediately after baby nurses, Pump every two hours while you are away, Nurse your baby every 2 hours, Nurse when baby shows interest, Pump on a regular schedule, Don't watch the milk, Add one or two additional sessions

I wish I had known about fenugreek while nursing my first two children. I was able to provide enough breast milk only with constant attention to my fluid level, fatigue level and availability for every 2 to 3 hour nursings day and night. Just as certain dairy cows produce better than others, I felt I was a poor milk producer. With my third child, a "tight baby," I had such severe pain with nursing that my milk production dropped below demand and could not catch up. I heard about fenugreek from Dr. Paul Fleiss and Dr. Carolyn Waters, and decided to try it. With fenugreek I was able to bring the milk supply up to demand. My milk supply dropped every time I missed a few doses, so I continued it until she was weaned. Currently I am nursing my fourth child, the second with the help of fenugreek. Soon after Alex, my fourth child, was born, I knew I had another "tight baby." This time I did not wait as long to start treatment. Alex is much easier to nurse when I take fenugreek. Without fenugreek, the baby has to keep the breasts drained nearly dry to keep up the supply. Any minor growth spurt or delayed feeding time causes the milk supply to drop significantly below demand, and requires two days of every 1 to 2 hour feedings to build back up. With fenugreek, there is enough milk even with every 3 to 4 hour feedings. Also, the flow is faster, which corrects some of the tight jaw response. With my busy lifestyle, I can allow myself to get tired now and then without having to nurse a baby continuously for the next two nights. With fenugreek, the breasts seem to increase production with only emptying. It is as if a new baseline is created. The milk response to fenugreek seems to be somewhat dose-dependent. Three capsules of ground fenugreek seeds bought at a local health food store and taken twice daily seems to be an adequate dose for me. Fifteen capsules taken all at once causes moderate engorgement about 36 hours later. Three capsules a day are not enough. The dose may need to be adjusted for each mother. Fenugreek’s mechanism of action seems to be related to its' propensity to increase sweat production. As you may remember, the breasts are modified sweat glands. I am one who almost never sweats and that may be why I am a poor milk producer. The sweat that is produced while taking fenugreek smells of maple syrup. If there is no sweet odor, the fenugreek dose is not high enough to affect milk production. Changes in fenugreek dosing affect milk production about 1 to 2 days after the change.

Barbara Wilson-Clay, bwc@lactnews.com, www.lactnews.com Austin Lactation Associates 292-7227. Dry pumping (i.e, with no milk coming out) is more stressful than regular pumping, so avoid power pumping until one has tough, strong breasts; just keep prolactin receptors on by 8 times/day stimulation; pumping probably tougher on breasts/nipples than nursing (BWC)

Facilitating letdown: BWC writes “Syntocinon is synthetic oxytocin in a nose spray to facilitate letdown in mothers that are having problems getting the milk to start coming out & thus end up engorged. (Oxytocin response is hormonally stimulated by sucking or by thinking about the babies. Therefore release has somewhat of a psychosomatic nature, and can be depressed by stress, pain, anxiety.) Some of the new ultrasound lit. suggests that the let-down sensation of pins and needles may not be sensed when the milk supply is low. Typically the sensation of letdown
is poorly conditioned in new moms. I never felt anything until 3 months postpartum with my first. It tends to become better conditioned over time.)

BWC wrote: Nipple irritation results in delayed letdown, creating the phenomenon of "dry pumping" as well as "dry nursing". In the former case, if unlubricated, the dry breast is subject to more frictional abrasion. In the latter, babies will tug and exert over-zealous negative pressure trying to get a flow rate. This was elucidated by a brilliant lactation physiologist, Mike Woolridge. He has described the phenomenon of "primary sore nipples", an aspect of which is the suction trauma caused when hungry babies suck on an essentially empty breast. So heal the nipples first, while using meds to bring back milk supply. A more ample milk supply discourages tugging and excessive suction, allowing for nursing. Avoid stress to the nipples so we can calm the dermatitis, relieve your pain, improve your let-down, and get your babies back to breast comfortably. Work on milk supply with gentle, frequent pumpings on reasonable pressure settings, using lubricated flanges. If you do decide to breastfeed, do this when the babies are full, not hungry, so that their comfort sucking won't worsen your breast and nipple pain. Instead of 30 min nursing sessions, why not try shorter, more frequent nursings. They nursings don't always have to be scheduled. They don't even necessarily have to be at the same time as the bottle feeds. Sometimes, bottle feeding slightly smaller volumes (say 60 ml) and then an hour later putting baby to breast might be useful. Note that pain is NOT just a matter of time (e.g., over several days of poor latching). It typically is mechanically triggered: either by pinch trauma or irritation that contributes to dermatitis. No need to push pump to uncomfortable suction level; research on pressure vols was published last year in the Journal of Human Research, and it affirms that pumping at comfortable levels (even though this is subjective and varies from mom to mom) is adequate and does not appreciably change volumes).

There is some written material that pertains to "left-/right-handedness" & mastitis (not milk volume) by a British researcher named Sally Inch. The conclusion was that while an interesting speculation, no evidence supports the idea that handedness influences or is associated with mastitis occurrence on the predominate side. There is plenty of systematic observation that most women are not symmetrical and that often one breast produces more than the other. Interestingly, this can vary by pregnancy, with the lesser performing breast being the better performer next time. So no one really understands this between-breasts variation in performance.

**Domperidone** is manufactured in Canada but has not yet gone through FDA approval for lactation use in the US. The FDA cracked down on its distribution in June 2004, since they don't want Canadian pharmaceuticals to profit. BWC writes "The drug is widely available in Canada and other countries. It raises prolactin levels, and is often used to help increase mothers' milk supply, especially those women pumping milk for their premature or low birth weight baby. Dr. Jack Newman, a well-known Canadian pediatrician, describes his reasons for prescribing Domperidone at [http://www.bflrc.com/newman/breastfeeding/domperid.htm](http://www.bflrc.com/newman/breastfeeding/domperid.htm). Dr. Thomas Hale, well-known pharmacist and author of "Medications and Mothers' Milk," posted this commentary on his web site on June 8: [http://neonatal.ama.ttuhsc.edu/lact/html/fda_warning_on_domperidone.html](http://neonatal.ama.ttuhsc.edu/lact/html/fda_warning_on_domperidone.html). The American Academy of Pediatrics' Committee on Drugs published "The Transfer of Drugs and Other Chemicals Into Human Milk" in PEDIATRICS Vol. 108 No. 3 September 2001, pp. 776-789.
Domperidone is listed in "TABLE 6: Maternal Medication Usually Compatible With Breastfeeding" [http://aappolicy.aappublications.org/cgi/content/full/pediatrics%3b108/3/776]. Domperidone has a low profile of side-effects. They are listed in Hale, T: Medications and Mothers Milk 2002 as: "Dry mouth, skin rash, itching, headache, thirst, abdominal cramps, diarrhea, drowsiness. Seizures have occurred rarely." pg 231. I have seen one case of skin rash in the 4 yrs that I have been recommending the drug. The alternative drug, Reglan (metoclopramide) had may central nervous side effects. Domeperidone is used over the counter in much of the world as an antacid (like prevacid, etc.). People take it for years on end.

The efficacy of domperidone is good. There is a randomized, placebo controlled study (da Silva, 2001) on this drug that demonstrates an increase in milk vols from 112.8 to 162.2 ml/day in a group of mothers of premature infants. How this data would be best extrapolated to your situation is unclear. We know the drug works on most women, but individual variation and the specifics of each situation are key. For instance, if there was a long period of milk suppression secondary to maternal infection, there could be factors that domperidone couldn't overcome. If milk supply initially was poorly calibrated, there might be lack of potential target receptor cells that are still turned "on". In the case of twins, where there is the need for twice as much milk, and there is twice the stress on the mom's body, twice the fatigue, etc. well, I guess there is no way to give odds. I continue to be hopeful based on my experience watching other mothers in this situation have steady elevations in production. What my experience tells me is that many women recover well. How this plays out in individual situations has so many variables that it just isn't possible to predict. In general, women improve.

----- Original Message ----- 
From: Jack Newman drjacknewman@sympatico.ca
Sent: Saturday, June 19, 2004 6:25 AM (to BWC, who forwarded to KMK)
Subject: domperidone

Hi all,

The FDA's ombudsman's response to non physicians who have written about domperidone has not been satisfactory. At least not the ones I have been forwarded. He is dismissive and suggests that there is real danger to the baby, getting it through the milk, an absurdity if ever there was one. If you are an American, write your congressman/senator about this insane step the FDA has taken, and get your patients who are on domperidone to do the same.

Here, below, is my take on this question.

I am very concerned about the warning about domperidone which was issued by the Federal Drug Administration in the US on June 7, 2004. It warns breastfeeding mothers about getting domperidone to enhance milk supply because it conceivably can cause cardiac arrhythmias.

The FDA has basically come up with a political statement. They seem ticked off because people were going around their recommendations. The deaths (and I believe there were two) occurred with intravenous domperidone, which is never used any more and has never been used for enhancing milk supply. It is likely that if this drug was given intravenously, that the patients were sick with other problems as well, a confounding variable. Furthermore, unlike what the FDA has led people to believe, perhaps unintentionally, these are not new cases, but 2 decades old.
Why didn't they mention metoclopramide in their warning, which is far more dangerous (it can cause severe depression in oral doses, which domperidone does not), and is also being used off label to increase milk supply, but which, on the other hand is available and approved for gastric motility problems in the US? Can it be that they are not concerned about the danger but rather the threat to their authority?

Why didn't they mention the danger to diabetics, if they are so concerned, for whom some endocrinologists in the US are prescribing domperidone for gastric paresis? Why specifically for breastfeeding women? Why not specifically for diabetics who are at much greater risk of cardiac arrhythmias than women of reproductive age?

Why did this warning come out exactly on the day that the National Breastfeeding Campaign was to begin in the US?

I have used domperidone, in infants (for spitting up) but mostly to increase milk supply in women, probably well over 1000 women, without any more than mild headache, occasional menstrual irregularities and mild abdominal cramping as side effects. I cannot say the same for metoclopramide which I saw causing severe CNS side effects, aside from depression.

I have personally seen two children die of Stevens-Johnson Syndrome after taking Septra. If I have seen two, how many have actually occurred in the US and Canada? Why no such warnings on Septra? I have, as a medical resident, seen at least one person die and several get severely ill after taking ASA, from gastric bleeding. In overdose, many children have died and many have become seriously ill over the years because of ASA. Why no such warning on aspirin?

The issue comes up about providing a drug for women in good health and that we should not be treating healthy women with a drug. I disagree. With all the talk about preventive medicine, when it actually comes down to trying to prevent illness, it is all lip service. The data are clear. Breastfeeding decreases the risk of breast cancer in the mother. It decreases the risk of diabetes (type I and II), obesity, hypertension, high LDL/HDL levels, otitis media, asthma, and allergies, gastroenteritis, and in premature babies, necrotizing enterocolitis. The first 4 of these are all risk factors for atherosclerosis, the most significant degenerative disease in affluent societies and the biggest killer. The data are fairly clear that breastfeeding results in better cognitive development in children. The data are less clear, but suggestive, that breastfeeding decreases the risk of certain cancers in children (Hodgkin's and non-Hodgkin's lymphoma, breast cancer in later life), multiple sclerosis and inflammatory bowel disease.

Thus, we should do all that is reasonable to maintain and increase the success of women who are breastfeeding. If this means that, in some cases, we use a drug that, in my experience of well over 1000 women, is safe, with only minor side effects, we should have that option. Of course, there is no such thing as a drug which never causes side effects, and there are probably very few approved drugs (yes, even approved drugs) out there that haven't killed someone, but if one weighs the risk against the benefits, domperidone can do much good. I will continue to prescribe domperidone to women when I feel it will be useful. It's a shame, though, for women in the US to be deprived of this drug. The FDA says that it will monitor the border to make sure none gets through. Good for them. With heroine and cocaine getting through like a sieve, it's great that the US can now be sure that their borders are safe against an influx of the dreaded domperidone. What a waste of manpower! What a waste!

Jack Newman, MD, FRCPC

**Bad Taste to the Milk**

BWC feels it often could be a supplement the mom is taking. (Note: Iron supplements for the mom don't really do anything for iron in the milk. Preemies need extra iron, so this is obtained via a liquid vitamin added to the bottle daily.) Nursing within 30 minutes of intense exercise can add some bad-tasting lactic acid at the start of the feed. Overexposure to light (light-induced...
oxidation: http://www.foodsci.cornell.edu/mqip/SENSORYweb.doc), can be a problem. Overwashing with soap (as in KK’s case?) → use a Whole Foods soap & use a lot less of it & rinse in very cold water. Saponification (soapy taste) also higher in some women, so milk must be scalded within 8 hours of pumping & stored in glass jars so that babies won’t reject it. (The scalding halts the chemical process that too much lipase produces.) You do lose some nutrients from the heating, but milk is remarkably heat stable. (BWC) AMOMer Joanna S had this issue, & writes: I read up on the chemical reaction and how the overproduction of lipase causes a chem. reaction to the lipids, creating the soaplike smell. We were able to remedy it by pumping and then scalding the milk and freezing it in glass jars (the ones used for canning). It worked beautifully and although it's another step, it didn't take too long. I'd pump and save it from the day if needed and then scald it (heat it until it forms a very light film not quite boiling) then just pour it in glass containers and freeze. My breast milk went bad in the fridge too if I left it for longer than about 8 hours.

Miscellaneous (from BWC)
From BWC: Direct observation is the LEAST likely way to effectively assess infant intake. It seldom correlates with what is actually happening. Weighings before & after nursing are the only way to reliably track this. (BWC) KMK also felt it was very difficult to gauge, & felt that the only way to be sure a baby took away a lot was to nurse ~45 minutes.

Small breast size is related to storage capacity, not production capability. Both small and large breasted women are capable of making similar amounts of milk on a 24 hr basis (according to Hartmann's work). However, milk storage capacity is different, with larger breasted women being able to store more milk during feed intervals. They typically don't have to feed as often.

Don't confuse pumping pressure/suction levels with efficacy. There is no correlation and with skin as sensitive as yours has proven to be, you are perhaps still experiencing vasospasm as the result of that sensitivity. This is painful. Heat provides some relief.

Just 5 mm nipples are fine in terms of length. They are not more subject to wear & tear by not reaching the back of the babies’ throats. (BWC)

I would not worry about scrubbing off the cortisone, as that may create more irritation than the application of the meds can compensate for. Use it two times a day, as your derm suggested. A light coat will absorb into your skin, leaving a slight residue that a quick dip and swish should more than adequately remove. Try to apply it prior to longest sleep stretch. The work of the cortisone is to reduce inflammation. It is not a lubricant or moisture barrier. For dermatitis relief, the lanolin or aquaphor or Emla is best and can be used after each feed for the relief of the irritation you still easily feel if the still-healing (or at least still easily inflamed and irritated skin) gets too stressed.

The vocabulary of latch is constantly evolving to try to keep track of what we are learning about anatomy and physiology of lactation secondary to new visualization technologies. Therefore, old language such as RAM (which I have never liked) often creates a distorted view of what teachers are trying to communicate. It signifies a quick drawing towards the mother of the baby's body. It often translates in practice to pushing on the crown of the head, burying baby's face and nose
into the breast, and a rather aggressive approach to what is in reality a quieter and more cooperative maneuver. When infants have a breast in their mouths they draw it into a shape much like a goat's teat: It is elongated nipple with underlying breast tissue. The baby must compress the teat with tongue and lower jaw, pressing it up against the hard palate and squeezing (much like rolling dough upon a table top.) The piston and peristaltic action of the jaw and tongue squeeze milk out of the teat and propel it to the rear of the mouth for swallowing. (We have ultrasound of this action.) So you will see evidence of the area having been compressed. The dramatic, painful and acute angle of the lower aspect of the nipple indicates that the lower jaw is compressing only the nipple rather than the base of the elongated teat (which doesn't produce either the sensation of pain or evidence of acute nipple distortion). See attached photos.

Positioning is a manual skill for you; latch is a manual skill for the babies. In general, if the mom lines up the baby and provides adequate support, the baby can latch on with no assistance. This is not typically true for the premature, but is for the older baby. When latched, the prioritization of the position of the chin (digging into the breast) rather than the nose (which should be well tipped away) is going to help place the lower jaw compression in a comfortable location. This will minimize the Nuk-inization (if you will) of the nipple.

Below is something BWC was working on for a workshop for the Dept. of Health/WIC to train their bfg support staff: We no longer say: · Center the nipple.· Cover all the areola.· RAM the baby in with the nose touching the breast. · Push the breast into the baby's mouth. Instead, today, we emphasize covering all the lower portion of the areola. We want the baby off-center on the areolar "target." This re-locates the jaw compressions over the round part of the breast. We do NOT want the baby's jaws closing on the shaft of the nipple, pinching the nipple into a shape like a new tube of lipstick (i.e., sloped, which one can see when the baby is delatched). Help the mother line up the baby so that the round part of the breast below the nipple is touching the baby's lips. The nipple should be touching the baby's nose. Wait until the baby opens wide and tips back the head to reach for the nipple. When baby opens wide as a yawn, draw the baby in with pressure on the hips and at the shoulders (not on the head). Once the baby is latched, the mother should see some areola showing above the upper lip of the baby. The chin should be denting into the breast. The nose should be tipped away from the breast. A mother should be able to look into her baby's eyes while nursing. This positioning improves sucking efficiency reduces nipple pain, improves infant breathing and swallowing, and improves mutual gazing opportunity (enhancing bonding.)

Syntocinon is synthetic oxytocin, delivered via nasal spray to help a woman letdown right away. Oxytocin response is hormonally stimulated by sucking (nipple stimulation of the 4th intracostal nerve) or by thinking about the babies. Therefore release has somewhat of a psychosomatic nature, and can be depressed by stress, pain, anxiety. Sometimes people get the nose spray, but it typically is used to help profoundly engorged moms (impacted) release. Some of the new ultrasound lit. suggests that the sensation (pins and needles) may not be sensed when the milk supply is low and there is less dilation of the ducts by large vols of unreleased milk. Typically the sensation of letdown is poorly conditioned in new moms. I never felt anything until 3 months postpartum with my first. It tends to become better conditioned over time. Not feeling it does not mean you aren't having it. I suspect the lack of sensation in your case does not result from not having one, but still from the low milk production. (BWC)
Great book on Breastfeeding is “Bestfeeding”, by M Renfrew and C. Fisher. The book is lovely, readable, interesting, and the science is impeccable. Make sure to get the most recent edition. (BWC)

Swimming with the Vaseline/Aquaphor ought to protect your nipples from the worst affects of chlorine exposure. Generally speaking, chlorine exposure is to be avoided in moms with eczema/dermatitis during outbreaks. However, if it doesn't bother you (i.e. get worse) and the barrier moisturizers do their job effectively, I don't have a problem.

There are several studies that link mild to moderate exercise with slightly increased lactation performance in well-nourished women. So I don't think exercise per se is an issue. You want to wear a supportive bra, protect your nipples from the effect of rubbing on a bra or pad when sweaty (maybe lubricate prior to exercise.

There are no studies that point directly to the issue of 35 wks gestation reducing milk supply, however we do know that the breasts keep developing all through pregnancy and even beyond! Lactation itself creates mammary gland growth. More to the point, 35 weekers are always weak feeders and it appears to be more difficult for women to initiate lactation when only pumping or when over-relying on weakly feeding babies. In general, what is called "insurance" pumping is instituted to protect lactation capacity until the babies are bigger. There is a potential negative effect on the mother with regard to the c-section (using up metabolic energy while she heals) and moms of twins bleed from two placental sites, so there is often more blood loss which sometimes also negatively impacts lactation performance. Finally, a symptom of mastitis is always reduced supply. I am encouraged that the milk supply is rebounding some. Two weeks is about the time frame for expecting the domperidone and herbs to begin to take effect, and there are certainly mothers who continue to see increases past this point.

Diet suggestions: prolactin spikes when insulin spikes. Therefore, try to eat a protein/carb snack right before pumping. When the nipples feel fully healed, putting the babies back on (well positioned) may enhance your milk release.

I don't have an answer about the appearance of your milk (with regard to your sense that it doesn't contain much fat.) The one way (only way I've ever read) of manipulating fat content is to decrease the feed interval. This means that by pumping more frequently, the fat content of the milk at the next feed should be higher. Also, the type of dietary fat ingested by the woman is reflected in her milk. Perhaps not so much in terms of content as type (i.e. polyunsaturated vs saturated). Whether this translates to higher cal milk or not is not a question I think anyone has a specific answer for. Malnourished women have to be VERY depleted for their milk to be appreciably different than well-nourished women, but too rapid weight loss may be an issue in women who also are dealing with recovery from c-section, blood loss, and infection.

If we don't cure the nipple irritation, you will continue to be plagued by delayed letdown. The delayed letdown creates the phenomenon of "dry pumping" as well as "dry nursing". In the former case, if unlubricated, the dry breast is subject to more frictional abrasion. In the latter, babies will tug and exert over-zealous negative pressure trying to get a flow rate. This was
elucidated by a brilliant lactation physiologist, Mike Woolridge, PhD, whose name will come up if you Google. He wrote a series of papers in the mid-80's, one of which described the phenomenon of "primary sore nipples", an aspect of which is the suction trauma caused when hungry babies suck on an essentially empty breast.

My strategy in managing your case is to heal the nipples first. We are simultaneously working on improving milk flow by increasing supply with the meds and gentle pumping. The plan is to try to get these parallel lines to converge about a week in the future when you have healed nipples that can tolerate nursing, and a more ample milk supply that discourages tugging and excessive suction creation by the babies. I know you are anxious, but rushing things may delay rather than enable resolution of these problems.

Avoid stress to the nipples so we can calm the dermatitis, relieve your pain, improve your let-down, and get your babies back to breast comfortably.

Work on milk supply with gentle, frequent pumpings on reasonable pressure settings, using lubricated flanges.

If you do decide to breastfeed, do this when the babies are full, not hungry, so that their comfort sucking won't worsen your breast and nipple pain.

BWC writes “Montgomery's glands are small sebaceous glands that look like tiny bumps on the surface of the areola. They can enlarge some during preg. and lactation, and often are subject to irritation if there is a lot of pumping going on (since flanges can rub on them.) Often a child will inadvertently scratch one, or one gets rubbed raw, resulting in an opportunity for a localized infection to occur. The result is rather like a small pimple or boil. The best plan would be to use a gentle regimen of soap and water cleansing (mild, non-perfumed soap) once a day. Then apply a thin coat of Bactroban (prescription) or Polysporin (over-the-counter) several times a day to deal with the infection. Try to be careful when positioning the pump flange to avoid friction trauma. It can be useful to put a small, round band-aid over the place during pumping or nursing if the kids pick at the spot or the flange rubs on it.”

BWC: Barbara Wilson-Clay, bwc@lactnews.com, www.lactnews.com Austin Lactation Associates 292-7227; dry pumping more stressful than regular pumping, so avoid power pumping until strong breasts; just keep prolactin receptors on by 8 times/day stimulation; pumping probably tougher on breasts/nipples than baby (BWC)

Oil before pump, lanolin after pump (unless have yeast, in which case must dry out so don’t seal). (VM)

Dip breast in water & swish off Emla (numbing agent) & cortisone (steroid) & pat dry with cotton (avoid paper/wood products) = conservative/cautious. If babies ingest too much steroid a couple babies have developed “moonface” from using high dosages for months. I shouldn’t have any problem. Brief exposure to water okay; not long exposure.

Read the pages of Jack Newman MD at www.breastfeedingonline.com. These pages are very helpful, and have some excellent descriptions, instructions, and diagrams on latch, sore nipples, milk supply, and effective breastfeeding.

Come and "chat" with us, on our weekly live free chats, Wednesdays at 9 pm EST. See www.medela.com for the easy instructions. Mary Bibb, IBCLC, helps me in our chats, and we have had a lot of moms come and "talk" to us. Just send us your AIM nickname (see our website for details), and be online Wednesday at 9 PM EST. We will page you into the chat room. against the valve), you can purchase new ones (very inexpensive) by calling Medela Customer Service at 1-800-435-8316 during business hours, CST USA.

Before babies weigh 10 pounds (4.5 Kilograms), approximately, and while they are still in the early days, and "especially if they are playing catch-up with growth," they may take 2.5 ounces (75 ccs) of milk per pound of body weight per day. After the first few weeks or so, after babies are about 10 lbs., until they begin solids around the middle of the first year, they take on about 570-900 cc of milk per day, or 19-30 oz of milk per day, according to recent research. This amount does not increase or decrease much, even as baby approaches 6 months or so, and is fairly consistent from mother to mother. Split into 8 feedings per day, this is about 3-4 oz of milk per feeding. Babies will often take more milk out of a bottle, however, because they are trying to satisfy needs for food, sucking, and closeness. Because they are sucking for comfort, and because bottles offered contain fluids, babies who get bottles cannot help but consume large amounts of milk while sucking. Babies continue to need about 19-30 ounces of milk per day until they start solids, regardless of their weight. Babies do not need more milk as they grow towards their 6-month birth date, despite popular belief. They may TAKE more from a bottle, as they get older, but their nutritional needs remain fairly constant.

Try pumping and/or breastfeeding if you wake in the night. Some moms keep their pumps by the bed, and just pump for a bit if they wake, keeping the milk at room temperature up to 6 hours, refrigerating it in the morning. These few peaceful quiet moments can be quite effective to fit in a short extra milk pumping session. It can be an excellent time to pump briefly, especially because prolactin levels are highest at night.

Listen to a tape of music, via headphones, which you listen to at home while nursing your baby, in order to relax and encourage a milk-ejection reflex, or let-down. Keeping yourself warm and your shoulders covered also helps. It is not uncommon to get more milk from one breast than the other, or at one time of day over another. Most right-handed mothers produce more milk in the left breast and vice-versa, but this is not always the case.

Hypothyroidism is an often-undiagnosed problem in new mothers. Once again, once the mother is on proper medication levels, a full milk supply is usually achieved.

Hormonal problems can cause insufficient supply. One recent article described the breastfeeding experiences of two women with gestational ovarian theca lutein cysts, who were found to have abnormally high testosterone levels and a delay in the initiation of their milk production. When their babies were 3 weeks old, their milk supplies finally increased when their testosterone fell to more normal levels.

Try using an eyedropper to drip milk down the breast while trying to latch the baby on. This will help to give the baby the idea of where milk is supposed to come from.
Babies can get really used to a bottle, and sucking at that, which is really different than sucking at the breast. You can use an eyedropper, a syringe, a cup (small medicine cup, paper bathroom cup, sippee cup or a shot glass work well) or a spoon. This is an important step in getting her to the breast. In many countries, bottles are never used when the baby is separated from the mother, but rather one of the above things.

Good time to try breastfeeding are when the baby is sleepy, either just going to sleep or just waking up. Nighttime feedings are also a great time for this, as the baby may be too sleepy to realize that he or she is trying something new.

Go to www.breastfeedingonline.com and click Dr. Jack Newman's articles. He has an outstanding article there called, "When latching..." which would be very helpful to you. For the next 24 hours or more, take the baby to bed with you, getting up only to eat and go to the bathroom (and maybe someone could bring you room service!). This suggestion has worked for many mothers and babies with latch on problems. I realize that this is more difficult to do when you have older children (I have six myself, so I can definitely understand), but try to get help to watch the older ones. For information on safe sleep, please see: http://www.askdrsears.com/html/7/T070100.asp

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There is one Australian paper in the literature on the efficacy of acupuncture in increasing milk production, and I've seen a couple of cases where it seemed to help. (BWC)

Pump in Style not appropriate for establishing milk supply for me/twin mom. Try Symphony. use olive oil.

AMOM’s Tina Roberts got Katja to offer to come by & see twins nursing, 479-6453, lives pretty central, suggested possibility of some hand expression if pumps & flanges are too painful (but wrist does tire after 15 minutes).

Yeast Infections/Thrush while Breastfeeding:
CH notes that shiny nipples may indicate a yeast infxn. Rinse nipples with baking soda rinse (1/2 tsp + 1 cup warm water & dip nipple in it or cotton ball & pat dry & air dry) = soothing & mild form of attack on yeast. (Vinegar can also be used, but may sting tender nipples.) Athlete’s food lotrimin is for normal skin; vs. vaginal mucus membrane, can do “triple nipple ointment” has antibacterial, antifungal + steroid helps, has to be compounded at People’s Pharmacy. Do baking soda overnight + try lotrimin in morning if not feeling better [at least ½ hour before pump/nurse & rinse & dry off before nurse/pump]. Use it as a diagnostic tool for yeast infxn. Pumping should not be painful; it should be comfortable. Yeast happens; attacks compromised skin. Just
use olive oil; get away from aquaphor & lanolin. If pumping gets comfy again, maybe pump every 2 hours for 48 hour period to get milk supply up & then go back to every 3 hours. The baby’s latch on is typically uncomfy for first 2 to 4 weeks; but shouldn’t be uncomfy while nursing. If starts getting painful during nursing, then likely it’s thrush. To latch: Pinch the nipple from both sides & sandwich it in, while pushing bottom lip down. Don’t use fermented vinegar (like apple cider); use white vinegar. (But that’s not as strong as lotrimin, but can wash it off with vinegar. And use after pumping.) If feel much better, then yeast & call Ob for antifungal topical or diflucan orally. (Note: diflucan very strong, so don’t give to baby. Probably best to try to get away with something topical, e.g. triple nipple ointment or Lotrimin. Nisteten doesn’t always work. Violet tends to be effective. No yogurt into their mouths. Infant acidophilus is an excellent idea, but still controversy. Sterilize bottles once a day for thrush. A lot of mastitis can be related back to yeast infxn. The emptier the breast the better, but don’t want to wait long break b/c FIL impedes lactation. Don’t go longer than 3 hours. Even after ½ hour should get another letdown, but shouldn’t get as much as last time pumped. Massage while pumping or nursing is very helpful, same with breast compression, back end of breast. Moving the flange helpful, tilting. Can go deep but not too long. Take ibuprofen, & okay to do massage to cover up for pain. Australian doc says pump avg of 1 oz per hour. So can pump more often, but can’t expect to get much more than 1 oz/hour of wait time.

Yeast Infections (from http://www.breastfeedingonline.com/yeast.shtml): The pain caused by a Candidal infection: 1. Is often burning in nature, rather than the sharp, stabbing or pinching pain associated with other causes. Burning pain may be due to other causes, however, and pain due to a Candidal infection does not necessarily burn. 2. Frequently lasts throughout the feeding, and occasionally continues after the feeding has ended. This is in contrast to the pain due to other causes that usually hurts most when the baby latches on, and gradually improves as the baby sucks. 3. May radiate into the mother's armpit or into her back. 4. May cause no change in appearance of the mother's nipples or areolas, though there may be redness, or some scaling, or the skin of the areola may be smooth and shiny and the nipple may crack. 5. Not uncommonly will begin after a period of pain free nursing. This characteristic alone is reason enough to try treatment for Candida. However, milk blisters on the nipple also may cause nipple pain after a period of pain free nursing as may eczema or other skin condition. 5. May be associated with recent use of antibiotics by the baby or mother, but not necessarily. 6. May be quite severe, may or may not be itchy. 7. May occur only in the breast. This pain is often described as "shooting," or "burning" in nature, and is often worse after the feeding is over. It is often said to be worse at night. At the same time, the breast appears or feels normal. This is not mastitis and there is no reason to treat with antibiotics. On the contrary, antibiotics may make the problem worse. We always have yeast and bacteria in our gastro-intestinal and vaginal tracts. In a healthy state they are in balance, and both are essential for health. However with a yeast overgrowth, the yeast overpopulates our systems and we have what we call a "yeast infection." This overgrowth can be on your nipples and in your milk ducts in your breasts, as well as in your baby's mouth and gastro-intestinal tract. It causes sore nipples and can cause intraductal pain in your breasts (burning, shooting pain during and after feedings). In your baby, a white tongue can be an early sign of oral yeast (thrush). If not treated, it will progress to patches of white on tongue and cheeks. It causes a sore throat and tongue and, sometimes red, sore skin in the diaper area, along with irritability and excessive gas. A baby with a sore mouth from yeast will often not feed well, coming off and on throughout the feeding or feeding in a way that hurts your nipples i.e. clicking or nipple compression.
After feeding, Rinse nipples with solution of 1 T. white, distilled vinegar in 1 C. water. Pat dry and apply antifungal cream (Nystatin ointment or Lotrimin AF or Jack Newman's All Purpose Nipple Ointment. Expose your nipples to air whenever you can.

Take 6 capsules of acidophilus (store in fridge) evenly spaced throughout the day. Refrigerated capsule forms can be found in health-food stores. I recommend Nature's Way Primidophilus with Bifidus. Other reliable brands are DDS and Florjen.

Eat a lot of garlic or take odorless garlic capsules to boost your immune system and help in reducing the yeast overgrowth. 6 tabs of Kwai brand or 4 capsules of Kyolic brand garlic spaced throughout the day. (I prefer Kyolic.) Kwai and Kyolic brand garlic is found in most pharmacies.

Another outstanding immune-system booster is Echinacea. Get a good product in a health food store and take 3-4 capsules a day. Nature's Way is a reliable company which makes Echinacea in capsule form. Take Echinacea for 10 days, then off 3 days, resuming for 10 days, etc. It is a booster and if taken steadily it looses some of its boosting capabilities. Reduce sugar to a minimum and use no artificial sweeteners. You can eat some fruits and natural fruit juices, but they will best be consumed with other non-sweet foods. Avoid sugar-added fruit juices. Herbal teas and water are a good choice of drink. Any refined carbohydrates that you eat (breads etc.) will be best eaten with other foods--vegetables and meats--so that they will not feed the yeast.

Eliminate milk products until two weeks after all symptoms are gone. (Dairy products do not include eggs or mayonnaise, but products that come from cow's milk.) You can eat plain yogurt (no sweetened or fruit-added ones) with live acidophilus bacteria if you are certain that there is not a dairy sensitivity in your baby or yourself.

After each feeding (or every 3 hours) apply antifungal (Nystatin) solution to mouth, gently rubbing it around to cheeks and gums with a finger. The bottle instructions recommend applying every 6 hours, but since yeast grows back in 1 1/2 hours, it will be more effective if you give half the dosage every 3 hours. Don't skip nighttime. Some mothers are reluctant to wake a sleeping baby after the feeding to give the antifungal, so it can be given before feeding as well.

Infant Diflucan is very effective in treating yeast overgrowth (thrush). If using infant Diflucan, use as directed. (Many moms are saved by this drug.)

Three times a day, open a capsule of acidophilus/bifidus, sprinkle 1/3 of the contents on wet finger and let baby suck finger. This healthful bacteria will begin the re-balancing of your baby's GI tract. For simplicity, open 4-5 capsules of the acidophilus/bifidus and empty the capsules into an airtight container. Keep tightly covered in the refrigerator. Three times a day, wet your finger, touch the powder and let you baby suck your finger.

Rinse with each diaper change with vinegar/water solution (1T. white, distilled vinegar/1C. water.) Apply antifungal ointment. Do not use baby wipes, as they nurture the yeast. Use clear water for clean-up of bm, then rinse with the vinegar solution.

The following should be continued for 2 weeks after all yeast symptoms are gone:

White vinegar rinse for nipples; Antifungal cream; Acidophilus for mom and baby; Garlic and/or Echinacea; Vinegar rinse for diaper area; Nystatin or Lotrimin ointment for diaper area, or if you run out, Desitin or Balm-X (zinc oxide) will do.

Avoid the use of anti-bacterial soaps, which destroy healthful bacteria. Also if your water is chlorinated, fill a pitcher with water and let it sit for 12 hours lightly covered and the chlorine will be dissipated. The chlorine may reduce some of the bacteria that your are trying to restore.
This treatment plan seems very complex, but after a few days it will seem simpler, especially when you are feeling better because of all of your efforts. Sunlight is a good treatment for yeast overgrowth. Sunlight on nipples and baby's diaper area is helpful, but even a walk in the sun or sitting in an sunny window helps also.

It may NOT be thrush (2nd story at http://www.breastfeedingonline.com/stories.shtml): After months of trying everything she had heard of, she was referred to a dermatologist who said my problem was eczema. If I had a thrush problem at all, it was probably burnt off my breasts with one of the million remedies I tried. I'm not fair haired or particularly fair skinned, and I had not had rashes or eczema in the past, except a very mild, small, strange patch on my face early in pregnancy that disappeared almost as quickly as it appeared. The dermatologist prescribed Aclovate ointment, .05% for a week. 4-5 days into the treatment I was still in pain and ready to give this up as another failed treatment. However, I stuck to it for a week and poof! The pain disappeared

LLL’s leader Darien (458-6873) recommends dermatologist Dr. Alise Curry (459-4869, 8240 N MoPac, Balcones Dermatology, Ste. 350). Tuesday 6th 10 am. (NW corner of Steck, in Wilshire Homes parking lot, in Fidelity Natl Title building, north of Luby’s)

C Villareal-Hughes (mother of triplets) writes: If you are pumping at least 3 oz every 3 hours then you can begin to relax and try 3 1/2 hour and see if you are able to pump 3 1/2 oz. if so, then go 4 hours and see if you pump out 4 oz. and so on but don't go any longer than 4 -6 hours! You can get away with this only at night (and occasionally during the day) but if your productions seems to dwindle, much more frequently again and take Mothers Milk Tea in combination with the Blessed Thistle and Fenugreek. Actually, I did all three! I basically pumped about every 4 hours and every 6 at night.

Feeding on schedule: I nursed my first child on demand but believe me, with multiples the only thing that really makes sense it to stick to a schedule. I'm a child development teacher and doing this actually is supposed to increase brain development (has to do with neurological processing of putting things in order. But at about 8 weeks you can start adjusting their schedule. And, even though you will adjust the schedule, you must also adjust the milk portions you give. At first you when you adjust feedings to 3 1/2 hours you will give them 3 1/2 oz (make them finish them even if it's 30 minutes -1hr later) and then when you move to 4 hours, you'll start giving 4 oz. The American Academy of Pediatrics suggests no more than 24 oz a day. Later on the babies will begin to want more milk to help themselves sleep through the night and then the feedings will even out to again the 24 oz. Yes, go ahead and nurse when you want. I usually did it only at night before the 11 feeding. I always pumped and bottle fed because that way I was certain to know the intake they were getting. That's not important for a singleton but it's absolutely imperative for multiples to thrive.

AFTER THE BABY ARRIVES:
Breast engorgement begins ~3 days after birth & will be painful. You'll also experience 2-4 weeks of vaginal discharge, so wear pads. Sex is typically possible 2-4 weeks after delivery; use condoms to avoid pregnancy (since nursing is not a guarantee). (YPA30) Begin exercises right after the birth! Deep breathing + pelvic tilts (with bent knees) + ab tightening + pelvic floor kegels + leg tensing & relaxing = the minimum for c-section
births. For those without c-sections, start curl ups, deep pressure massage of the stomach, breast feeding (to get uterus to return to its original size), bend & straighten, pelvic lift while twisting both ways, reach to knees, do curls + come up diagonally on them. (HT)
For exercise, jump rope, dance, swim, run…. Eat well (broccoli, carrots, cabbage, collard greens, skim milk, yogurt, sweet potatoes, oat cereals, dried beans, cantelope, spinach, olive oil, salmon, tuna, brewer’s years in powder to mix in shakes with vanilla, OJ concentrate & milk, nuts + seeds. Eating carbonated drinks + fruit → faster update of potassium so you get energy quicker! Caffeine reduces absorption of iron & several vitamin types! ☺
(JOT)
In this “fourth trimester”, exercise (it’ll reduce stress & make it easier for you to nurse!) & breastfeed & get away from the house at least once a day. Do exercise after you nurse so you don’t have engorged breasts (while exercising). You’ll probably also need to wear a double exercise bra. (PP)
Demand a lactation consultant & a physical therapist in the hospital. (HT) Get help before 4 weeks go by, if things aren’t going great. Milk production gets programmed in first 6 weeks & cannot be reprogrammed after that. (BWC)
Babies should be tested for PKU (for milk intolerance leading to retardation), hypothyroidism (leading to slow growth), galactosemia (baby can’t absorb sugars), sickle cell & other hemoglobin diseases. (State of California health leaflet).
Wear a backpack (rather than carrying things over 1 shoulder). (BT) Carry the babies in slings/on your body, if possible, & move them front to back after the first few weeks. Bring a blanket for the shopping car, to put them in. (HT) Slings are better for babies than Baby Bjorns, etc., because don’t spread their legs. Slings can handle up to 30 lbs total, so can carry 2 babies at once. (CH)
Postpartum depression = 5 times more likely in mothers of twins!! 76% of such moms are constantly exhausted (vs. just 8% of singleton moms). C-sections → long recovery (4-6 weeks [YPA30]) → depression more common. Get a break from the babies ASAP, as often as possible, & go outside with the babies. (HT)
Exercise: Mothers who walk with their babies tend to take off weight faster than those who exercise when babies are asleep, perhaps because easier to keep up a team activity. Also, short bouts of activity are as effective as one long session (& may be even more effective). Every minute of exercise beyond 30 min releases fat from cells & they actually shrink. But beyond 60 minutes may cause fat cells to go into defensive mode. Dance gently with your infant. There are exercise videos for kids (e.g., Elmocize & Sesame Street Get Up & Dance) that you can do with them too. (BT)
Relax by holding deep breath ~6 secs while tensing & letting out as you go limp. (JOT)
Sleeping of babies: Babies sleep better in warmer environments (~88-90°F !). Wet diapers are too cool. Swaddling is great (or skin-to-skin or close baby-carrier-to-parent’s-body contact). Solid foods before 3-6 months are NOT helpful for sleeping (there’s no connection that has been found), is not easy to do (quite messy in fact), can create a tummy ache for babies, & may lead to allergies &/or obesity later. (JOT)
Play some soft music when 1 baby shows signs of sleepiness, then both will begin to associate music with sleep time. (ST)
Crying is higher in evening → use rocking & swaddling, carry one on front & one on back, promote sucking of thumbs & pacifiers or your pinky, play white noise for them (e.g., vaporizer, vacuum, rhythmic music). You can let them cry hard for ~1.5 minutes, but
after that, you should probably get to them, allowing them to be more confident later in life. ☺ (JOT)

Dr. Karp’s Happiest Baby on the Block 5 patented steps to calm a fussing baby (by mimicking womb during the baby’s “fourth trimester”): Swaddle, then hold baby on side or stomach in one’s arms, loudly shush into baby’s ear, swinging/jiggle baby (while supporting head & neck) like shivering, plus (non-nutritive) sucking. **Swaddling, sshsing, sucking, side lying, and swinging.**

If baby is crying a lot, feed baby more slowly & burp baby often; offer a pacifier; avoid onions, beans, tea, cola & coffee if nursing; check for signs of illness (like a fever or swollen gums); swaddle baby in soft, warm blanket; turn on music, vacuum cleaner, clothes dryer, … Let water run in tub for few minutes. Take a break, with baby in crib & checking him/her every 5-10 minutes. Never shake a baby; their brains will be damaged. (Seton)

Thumbsucking: [http://www.aboutourkids.org/articles/thumbsucking.html](http://www.aboutourkids.org/articles/thumbsucking.html) vs. Pacifiers: Many parents like thumbs b/c the child can self-pacify (in the middle of the night too!), vs. needing someone to find his/her pacifier. However, a thumb is hard to lose when it’s time to get rid of pacifiers, and some people feel excessive thumb sucking can result in poor tooth alignment (& a need for braces). Some children will naturally gravitate to their thumbs, while others will love a pacifier. AMOMer Julie B writes that by 18 months of age the pediatrician recommended that the children be finished with pacifiers, since they may have them in too long at night. (They use them only at nap & bed times.) He suggested a gradual approach - cutting one third of the pacifier tip off every 4 days or so, which Julie made even more gradual. Other parents find that telling how pacifiers need to be “sent away” to pacifier land works. (Our daughter went with her thumb, while our son went with a pacifier. When we cut off the tip at 9 months of age, he could only suck air through the empty shaft & immediately stopped wanting pacifiers. He remained somewhat orally fixated, however, sucking on bottle nipples & other objects more than his sister.)

New mothers typically cry too! Once or more a day! For sadness, joy, fatigue…. It’s cathartic. (JOT)

Rituals: These are important. AMOM speaker said that these are not routines. They are about connecting with your child & thus require the parents “be in the moment”, with their child, actively experiencing the ritual (vs. thinking about what they’ll be making for dinner, for example!). Note that rituals do not have to be daily. A fun ritual with older children, for example, is having a tradition on each other’s birthday, where you make pancakes in bed on their birthday. Rituals are key for young minds; they increase the dopamine levels in the brain, adding to an ability to focus one’s attention later in life. (AMOM speaker, 9/03)

Babies love repetition. They want to see the same kid shows, they don’t mind banging on pots as you make dinner night after night. (BT)

Taking Babies Outdoors: Dress them in one more layer than you’re wearing. If she’s eating solids, it’s fine for her to drink 2-4 oz/day of water. (only??) Get sunglasses for babies with 99+% UV protection. SPF 15+ for babies > 6 months of age (& can use small amounts of exposed skin of younger babies). Pat insect repellant onto clothing; don’t
apply directly to her hands. *Wash* their skin with soap & water once you’re back indoors. *Mosquito netting on stroller can help.*

Ezzo & Buckman’s *Babywise* book has the following recommendations: The family should not become baby-centered; it should remain family centered. You are their parent; they need your leadership & direction and support. You are responsible for their training to become independent individuals. Attachment parenting is overrated; it can create an unhealthy dependence. Your child needs to learn to become independent. Also, feeding on demand is not healthy, for anyone. The children end up with wild eating schedules, that are rather arbitrary, negatively impacting their digestion. Provide regularity, calming the child & helping their metabolism. When they are infants, aim to feed them 2.5 hours after the *end* of the last meal. (E&B)

**Baby Sleep Tips**

By 3 months, babies sleep 4-6 hours at a stretch during nighttime. (Mila’s triplets, who were on a strict schedule, started doing 6 hours at 2 months.) And between 4 & 6 months, most will sleep from ~midnight to dawn. (BT)

Tiny stomachs can only hold so much. Solids before 6 months won’t help sleep duration. Try a soothing massage, warm bath, feeding, or lullaby; soon such rituals will become associated with sleep. And be ready to evolve your rituals, as your child evolves. Many babies like the vibration of the deeper male voice & rocking, with the child nestled in the neck area. May place baby in sling & wear around house for ~30 minutes before bedtime. If necessary, slow drive around the neighborhood may also do it. (BT)

Sling recommendations: Julia T writes that she loves the SlingEZee for padded & Maya Wrap for unpadded: “There's a whole big padded vs. unpadded debate; my position is, for a smaller baby in the winter, a padded sling is better, and for a larger baby in the summer, an unpadded one is a lot more comfortable. Additionally, the unpadded one is a lot easier to stuff into a diaper bag.”

Ideal sleep temperature for babies is 70 degrees (!). Major developmental milestones may cause a baby to wake up at night (e.g., trying to crawl in crib). New chemicals/fabrics may also cause distress.

AMOMer Debra M (mother of 12 & wife of ObGyn) writes that “Yes, I sleep with them right next to me. We have a king sized bed and dad pretty much stays on his side facing away from us. I start out with them on their side, just with a blanket over them with the baby facing away from me right next to my tummy/breast area (I'm on my side). When it's time to eat, (I don't do diapers unless they poop), I just turn the babe over and latch on and go back to sleep. (if they can be trusted to eat, and not go back to sleep too soon). I don't move them away after that, they just pull off and stay fairly close, but sleeping. Sometimes, if I wake up hot, or something, I move them away and lay them either on their side or tummy. (I know, a no-no in the pediatric world). My little guys have all been tummy sleepers. The back/side thing only lasts a short time, and then they start to fuss. Tummy sleepers sleep better, burp better, and fuss less. Once my babies can pick up their heads and move well, I've felt comfortable with them on their tummies, but keep blankets and things away from the face. If they are next to me, though, facing me, there's all kinds
of stuff in their face! All I can say is that I've never had a problem, and there was an article I read in "Mothering" about co-sleeping, and there has never been a SIDS death or an injury-related death of a baby while co-sleeping with a parent unless alcohol/drugs were involved. That's a pretty good statistic. They suggested that the baby, while next to mom, develops a "rhythm" like mom, and my breathing/heart/warmth, keeps them on track. I know when I sleep with my babies I have a certain level of awareness that they are there and can respond to them fairly quickly. You just sense that they are there. Sort of like when you're sleeping on the couch with the lights and TV on and then someone turns them off and you wake up.”

AMOMers write: Once a child can flip him/herself (e.g., at 4 months), SIDS is no longer an issue really. So lying on one’s stomach (where baby can more easily find his/her thumb & calm him/herself) is fine.

Ezzo & Buckman’s Babywise has the following key recommendations for parents of newborns: The family should not become baby-centered; it should remain family centered. Do not sacrifice your spousal love & life to attend to the baby with every perceived need that is exhibited. This is not healthy for anyone. You are responsible for their training to become independent individuals. Attachment parenting is overrated; it can create an unhealthy dependence. Your child needs to learn to become independent. Provide regularity, calming the child & helping their metabolism. When they are infants, aim to feed them 2.5 hours after the *end* of the last meal. A healthy term baby should be able to establish an 8-hour period of uninterrupted sleep by 8 weeks if meals during the daytime are kept regular. (E&B)

SIDS: Sudden infant death syndrome (SIDS) comes from a child’s evidently forgetting to breathe, much like apnea. Yet it only seems to happen between 1 & 6 months, and is most likely to happen (90% of cases?) between 2 & 4 months of age, perhaps because newborns don’t sleep long enough to get into deep sleep (REM mode) in their first month, & at 3+ months children can shift themselves if they have trouble breathing. Keeping a child on his/her back, or side (if reflux is an issue), until he/she learns to roll over on his/her own, without blankets & toys is key & has reduced SIDS incidence ~50%. Dr. Sears found that breastfeeding, co-sleeping, & avoiding overheating of child seem to help, in reducing the likelihood of apnea & thus SIDS. Pre-term infants & males are at higher risk of SIDS. (Sears) Some docs may recommend stomach sleeping for reflux babies, interestingly. No blankets, no pillows, use a firm mattress, dress child in only 1 more layer than you have on. But do give some tummy-time during day, since back-sleeping can flatten the head, delay motor milestones like crawling or rolling, and weaken upper arms. Alternate the way you place your child into crib each week, so she won’t always turn in same direction to observe others in the room. (BT)

Key Tips from AAP: 1. Vary sleeping position of child in crib, putting head to different sides. Move crib to different parts of room, so he/she will turn head in different directions to see. 2. Provide tummy time when he’s awake, to build muscles. 3. Limit time in infant car seat, swings, carriers, etc., where the back of the head rests against them.

KK recommends crib “wedges” on either side of child, allowing you to place them on their different sides (avoiding head flattening). These wedges can also be tightly rolled blankets when children are little & unable to push them away; don’t put above the chest, however, so they stay clear of the face; they also feel a bit like the child is being held,
which enhances development. Also, a slight wedge underneath the crib sheet provides a nice angle to facilitate digestion & avoid spit up (& is often prescribed when a child develops reflux). They're from Safety First and were recommended by Sandra A's neonatologist for proper positioning of the babies for sleep. They elevate one end of the crib slightly and make breathing easier. They're also excellent for when your little ones are congested.

**Sleep Enhancement:** Babies whose parents massage them develop patterns of rest & activity that are more in sync with moms & dads. Those who don’t get bedtime massages are often awake a midnight. Massage can increase melatonin, promoting sleep. Rub their back in a circular, slow, rhythmic motion, using a baby-safe oil (e.g., almond oil). KK massaged twice a week, right before their baths & they grew to really enjoy it.

**Dr. Luke's recommendations:**
1. Ease your babies to similar schedules. When one is hungry, feed the other, event at night. (2) By 3 months, 1 or both may be ready to sleep 5-6 hrs. Let the non-crying baby sleep. If she wakes up within 20 min of the other, go back to feeding them together for a couple weeks. To keep similar naptimes, tire out the energetic one & keep awake the sleepy one. (3) Use a bedtime routine, e.g., bath, bottle & bed. PJs, rocking, reading, soothing song. Let them watch as you ready the room, closing the shades, etc. (4) Make sure their diapers & pjs are in great shape & won’t bother them. Burp them so no belches wake them. If their hands are cold, add a blanket. If neck is damp, remove some clothes. Use crib bumper cushions to avoid an arm or leg stuck in slats. (5) You will need to feed them at least once at night; baby stomachs can only handle 3-4 hours. But keep nighttime feedings mellow: in their room, don’t change their environment; quiet; little talk; minimal lighting. (6) Within 1 week (!) of birth, most infants have one long stretch of sleep (3-5 hrs) & you need to make sure this occurs at night. Make clear the daytime is playtime. Rouse them in morning with a special routine of opening curtains, loud music/voice, etc. Make daytime feedings fun & social. Sing or talk as they nurse. Don’t leave them in their crib after feeding them. Entertain them with a game & dance. Shower with them nearby. Keep nursery well lit at nap time. Shades up! Noises on. Cut short too-long naps. No more than 3 hr/daytime nape. Pick up baby, path, change diaper, take off clothes, rub chin, tickle. If you can’t rouse the baby, allow him to stay another 15 min in deep sleep. (7) Preemies take longer to reach the sleep-through-night stage. Instead of doing this at 3-4 months, it'll take ~5-7 months. Once they weight 9 lbs, feedings every 3-4 hrs okay, but more before then. Preemies are often used to the hospital schedule (quiet days & active nights [such as baths]) → parents need to reverse this. In the hospital, the lights may have always been on. So you may need more noise & light at home.

One AMOM mom has had great success keeping babies swaddled (in big 30"-40" swaddling blankets, not small ones they use at the hospital) till 6 months & beyond. Another “recommends the book 'Babwise.' It's a controversial book, but I think there's some good info. in it. The book discusses keeping your baby awake during the day after a feeding so that they'll be more apt to sleep at night. There's also advice on when to feed your baby, but I didn't follow that. I followed the routine that the NICU had them on. One thing that helped us (which other books will tell you not to do) was to let our kids fall asleep in the swing. Then we'd just transfer them to the crib. Also, pacifiers – as used in the NICU. Just know you'll have to break them from that habit at a later date.” Others recommended Healthy Sleep Habits, Happy Child (which has to do with getting them lots of sleep & using rather strict sleep schedules, I believe) & Baby
Whisperer. Childwise advocates corporal punishment. “Swaddling seemed to work for us, but we were still doing it at 4 months and decided it was time to stop b/c it didn’t seem to work that well. Almost immediately, they started to sleep better, in conjunction with some sleep training. I think we just swaddled too long.” “Like many of the others, we used tight swaddling in order to get our twins to sleep longer when they were little. It definitely helped. However, I have read that the tight swaddling can affect the development of the hip joints. So, we did the tight swaddling at night only, so that we could get more sleep. This may also help with the recognition of day vs. night sleep.” “Some other things for day v night sleep. Keep the routines a little bit different. For night time, as others have suggested, dim the lights. Also, you may want to use a mobile in the crib for naps and a cd of lullabies for night, or something like that. Our twins are 9 months old now, and we do the same routine for naps and night now, but at first we tried to make things different. Once they got used to naps, we started doing the same thing for both.” (AMOMer loves the Symphony in Motion Mobile [remote operation, 15 min of play time, $50] & crib Aquarium [$27 at Babies R Us, calms kids in crib for several minutes].

“Ferberizing” = **Progressive Waiting** (see, e.g., http://www.babycenter.com/refcap/7755.html): After 5 months of age, children may be reading for learning to get selves to sleep. After a soothing pre-bedtime routine, place child in crib while still awake & leave. If starts crying, wait a few minutes & then go in. Stay about 1-5 minutes soothing her with gentle, dull talk & massage. Don’t pick her up or feed her. Wait longer the next time & use similar techniques. If she wakes up in the middle of the night, try the same routine. Lengthen the intervals between visits as the nights progress. Be consistent. (BT)

Sleeping & night nursing suggestions from an AMOM’er:

We wanted to keep the kids in the same bed for as long as possible. And we had planned to keep them in the same room until they were two if we could. We have definitely changed our thoughts on that. We will probably keep them separate from here on out. When they were younger, Jack could sleep through Grace’s crying, but Grace couldn’t sleep through Jack's. That has never improved. In fact, neither one will sleep through the other crying anymore. Apparently, as they grow older, they are more prone to actual waking up from noises in general. I have heard that you can train them to get used to each other... but it never happened for us.

Another wrote “Our boys slept in the same crib for about 1 month. About the time, they started to sleep with their arms wide apart, so they kept hitting the other in the head and therefore waking him up. I wanted to separate them, but my husband liked how cute they looked sleeping together, but I won that battle. it totally helped. As for the crying, it is probably a good thing that they both wake up at the same time at night. If you are the only one waking up, try nursing one and using a bottle for the other, and switch each time. It will save little time. I know in the beginning it’s tough, but getting them on the same schedule will be a wonderful later on. Our boys took pacifiers, so we would just give one to him while we fed the other. We then started working on the sleeping through the night thing and those pacifiers saved us. every time they woke up, we would give them a pacifier first a couple of times (usually about 30 min) and they soon learned to sleep instead of waking up to want to eat. (of course you will want to wait until they are a little bigger) We also learned that if they had pitch blackness in their room, when they did wake up, there was no stimulation for them, so they would go back to sleep. They now want to go to bed at 7:00 pm. and don't want to wake up until 7:30 in the morning. We LOVE that because my husband and I now have some time for ourselves. Anyways, I would definitely put
them in separate cribs, if not just for a week to try it out. As for the crying and waking the other up, they will start to get used to it and sleep right through it.”

Another: “Ours slept in the same crib for about 4 to 5 months, in our room. (Like yours, they didn't seem to care that there were together.) Then, we moved a second crib into our room and we all slept there until 3 weeks ago when we moved into a new house (a one story home). They are sharing a room now and it's working out great. Mine went through stages where they would sleep through each other's cries, or not. For the most part, and for the past several months, it hasn't bothered them. You asked if this was the permanent state of affairs and all I can say is that so far, nothing is permanent - the good and the bad! They go through so many stages that things change constantly. Good news and bad, I suppose! So keep trying different things to help them sleep. As they go through stages, new things will work for you. Also, do they take pacifiers? My daughter did, and then my son started taking one at 6 months and boy, did things improved after that!! As for nursing, I nursed mine for 10 months and for the most part, nursed them separately. I too found it difficult to tandem nurse but did it when I had to, and then only with a very large nursing pillow. I assigned each baby a breast and that was that. Yes, I felt like I was nursing someone ALL THE TIME but looking back, it was the right thing to do for me and my twins. Only when I could finally get my son to take a bottle did I wean them and we were all ready by that time.”

JB says children in same crib till ~3 months, when one started rolling over & hitting the other, waking him up. Hers couldn’t really cuddle since, due to reflux, she had them propped onto their sides with pillows from the start. She writes: Up until 6 weeks, we woke the babies up every 3 hours to feed them. We would do one baby at a time... do one diaper, feed, back down - and then wake the other. As we approached 6 weeks, we gradually increased to every 4 hours. By 8 weeks, we were just responding whenever we heard a baby. Like I mentioned earlier, we would jump at the first sound over the monitor and grab the crying baby, change diaper, feed and put back down. When both would wake up, my husband and I would both get up to take care of them. (But, we did bottle feed breast milk to them at night, so that made it possible for us to both feed them). It did mean that we both got up - but we were up for a shorter amount of time and we kept the kids on the same schedule.

Having them eat at the same time during the night helped keep them on the same schedule during the day too - which made life so much easier for me when I didn't have anyone around to help me. I had a double breastfeeding pillow. Once I was able to feed two babies at once, I was able to feed for 45 minutes out of every 3 hours, rather than 1 1/2 hours out of every 3 hours!

Sleep issues: Dr. Pantley’s “No Cry Sleep Solution” (for infants) has worked well for many families that are interested in co-sleeping. Dr. Pantley has a new book out for toddlers and preschoolers, with excerpts at http://www.pantley.com/elizabeth/.

You can read excerpts of the book at:
http://www.pantley.com/elizabeth/content/excerpts/preventingsleep.htm

And you can also read interviews with her "test mommies" group at:
http://www.pantley.com/elizabeth/content/interviews/testmommies.htm

Cribs: Mattresses should allow no more than 2 finger widths to crib & preferably have square corners. Bumpers should be removed when child can stand up.
Mothers of multiples should **watch out for (Congenital Muscular) Torticollis**: Unfortunately, this is much more common in “cramped” pregnancies – and thus multiples (especially the presenting baby, whose head may be up against the pelvis for many months). It also results from injuries occurring during birth. It is KEY that this be diagnosed AND treated in the FIRST 6 MONTHS of life. Some key signs: one side of the child’s face is farther back than the other, head is tilted, ears aren’t aligned, the head doesn’t look oval from above, there are various flat spots, an eye doesn’t track correctly, or there is an inability to turn head to both sides all the way or look to both sides, etc. Doctors & parents & nurses should be looking for this early on. Exercises are key – such as holding the head & making the child turn fully in both directions. Some AMOMers’ experiences: “If your baby cannot or does not track from either side to midline and back out by two or three months of age, point it out to your pedi, then fight like mad with the insurance co to get PT paid for. The largest % head growth occurs between 4-6 months, so that is when the most damage can be done.” “We have seen loads of specialists. We learned that the helmet would not have fixed the asymmetry of his face-- we just went through that with Dr. Patricia Aronin, a pedi Neurosurgeon, this week. The helmet would have fixed the flat spot on the back of his head, but not the fact that half of the face seems farther back than the other half. That is caused by the sternocleomastoid (sp?) muscle being too tight. Loosening it will help his face become more symmetrical. Before they are 18 months old, this can usually be done with PT. However, it can be fixed after 18 months with surgery to release that muscle. We are trying to avoid that now by going to PT twice a week and doing exercised at home. Riley's orthopedic surgeon, Jay Shapiro, will be the one doing the surgery if we get that far. He is wonderful. We have been very lucky to have a very agressive pediatrician-- Michael Ward with ARC. He is FANTASTIC. Dr. Aronin, the neurosurgeon, also recomended that we see a pediatice ophthalmologist to get Riley's eye muscles tested-- apparently, a weakness in eye muscles on one side will cause a child to tilt their head to try to balance things out. Its not likely a proble for her, but since we've come this far-- might as well make sure there is nothing else going on.” Because of the neck movement issues, there is a link between torticollis and reflux. It may not be manifesting itself but can be diagnosed in other ways.” Note: Look up the term “Plagiocephaly” as well, for more info on this important topic.

**Child Development:**
Up to 20% of babies exhibit rhythmic head banging as a self-soothing mechanism. (BT) Can catch autism is baby isn’t smiling back when you smile (around 4 months) or using gestures such as pointing (at 12 months).

Communicating with your baby: Sign language can be very helpful (www.kindersigns.com, www.sign2me.com) One reader of BT magazine wrote in to say that her child learned 50 signs. They started when she was 10 months old, & she started signing back within 1 month. Videos on this at http://www.sayitvideos.com/index.htm (rec’d by AMOMer).

**Austism & MMR Shots:**
Julie B writes “Apparently the MMR is all live viruses. The theory is that some children are more genetically prone to contracting a perpetual case of low level measles, because they are getting 3 live viruses at one time. This low level measles impacts the child’s brain development and results in autism.” Raji writes “My pediatrician friends has attended a lot of conferences on autism. She says that though there is no conclusive evidence either way, there is a HUGE CAMP
of doctors and researchers who swear up and down that it is the combined MMR shot that is responsible for the rise in cases of autism and that the separate shots pose no risks. She said that if she had children she would give them separate shots. She also said that there is no hurry to give the shots, by 24m is sufficient, and the later, the better (rather than the 12 m when many PDs give it).”

**Achieving Baby Confidence:**
1. Be responsive. Boost baby’s confidence by responding to their cues. If left to cry it out, they won’t trust their caregivers & resources. Being responsive won’t mean clingy, spoiled kids. Meet their needs early on. 2. Be mellow yet aware. Don’t hover or swoop in too quickly: overprotection leads to anxiety on child’s (& parent’s) part. Catch their eye, shrugging your shoulders & smiling to let them know they’re going to be all right & can handle whatever it is they’re getting into. 3. Carry baby in sling, making them feel like VIPs. 4. Facilitate their new, difficult activities rather than making the conditions too easy or rescuing them. Help them to get through their adventures. 5. Be confident yourself. Babies are very sensitive to your mood. If you’ve had it, hand the baby off & take a walk; get a break. 6. Frame your baby’s trying behaviors in positive terms: Babies who get into everything are not menaces but curious & inquisitive. Those who sleep little are alert & aware. Those who are fussy are smart enough to ask for what they need. 7. Play with your baby as much as possible. Let him/her know they are worth your time. But let them set the pace (don’t overwhelm with an adult agenda, circumventing their natural learning process); let the fun build gradually. (BT)

**Baby Illness:**
Never give aspirin to children under 12 years (!) of age. Can lead to Reyes Syndrome. Infant acetaminophen or infant ibuprofen can be given after 3 months of age. (BT)

Good news: Battling bacteria & viruses will mean your child is more able to shake them off when he’s older! (BT)

Colds: Thick, greenish discharge from nose is very common in children with colds & isn’t a sign of a bacterial infection, as it would be in adults. But colds can quickly become more serious in infants, so be sure to check infants for fever. Get a child lots of rest & fluids & acetaminophen or ibuprofen (but never aspirin). Bulb syringe to suction mucus (or blow into a tissue, if able). (BT)

Fever: No medicine needed if fever under 103 degrees, unless she’s very uncomfortable & physician recommends it. A fever isn’t an illness & can help body fight infection. Dress your child in light pajamas & give her fluids to ease the fever. (BT) Don’t bundle a feverish baby; that only keeps heat in. (AB)

Ear Infections: If ear is red or child tugs at it, it is most likely an ear infection. Tiny Eustachian tubes allow fluid to build up & press against eardrum, causing pain. Tubes can be blocked while drinking from a bottle while lying down & a small amount of milk flows from throat back into ears. So they may cry more during feedings. Apply a warm towel to achy ear or prop head up on a few pillows to relieve pressure. Most ear infections in children are viral, so antibiotics are ineffective. (BT) An AMOMer’s pediatrician recommends Primadophilus Children at the Natural Food section when the kids are on antibiotics, to replenish the good bacteria that help with digestion (which helps prevent, e.g., diarrhea from antibiotics -> severe diaper rash immediately – watch out for this!).
Ear Infections & Compromised Hearing: AMOMer Paulina M writes: My daughter had 5 ear infections in 5 months and the pediatrician was wanting to wait longer with the ENT visit. I could tell by then that Eva stopped learning new words and was irritated all the time. So I went to see an ENT (Eva was 22 mos then) and a hearing test proved that she could BARELY hear as her ears were full and the ear drums were not moving much. She had the ear tubes put in a month later (due to long waiting list to the Children's Hospital). Please please don't wait with checking your child's ears. Eva's speech, comfort and personality were compromised because we waited. She is recovering but slowly and her speech suffered badly. Another AMOMer says her PD sends to an ENT if have 6 ear infections in 12 months. Dr. Nowlin is a favorite Austin ENT among AMOMers.

Tummy Troubles: Vomiting & diarrhea in an otherwise healthy child is usually no cause for alarm. But, if accompanied by bellyache & fewer, she may have gastroenteritis. Watch out for dehydration (dry mouth, sunken eyes, scant urine & lack of tears in a baby over 8 months). Rehydrate, & if it’s a mild case, give plain foods, like rice, cereal, jarred baby food. Avoid too much juice. (BT)

Bedtime Vomiting: Don’t feed a child too late at night, & milk (esp. whole milk/high-fat) can be quite hard to digest. Keep the child calm & spend quality time with them before putting them to bed, perhaps getting them used to their bedroom for some time first, by reading & playing. Some have found their children suffer from allergies, which is causing the vomiting; consider removing apples (due to pectin). Others have found meats & diced veggies cause digestive problems (i.e., pain). BRAT diet (bananas, rice, applesauce, & toast or crackers) is also a good way to calm a stomach; so try that for several days. Congestion & post-nasal drip-related vomiting, from allergens or illness, is also a potential cause. Reflux, which can come on late (e.g., at 1 year of age) is also something to consider; have your PD look for acid-related issues in the esophagus. Keep the child hydrated; dehydration can become very dangerous (and require a stay in the hospital).

Diarrhea can lead to serious diaper rash, to the point of bleeding & blistering. Be wary of this, & change wet diapers on toddlers right away. The associated pain of such rashes will cause lots of crying & babies will cringe when touched. Do not use wipes, which spread bacteria. Clean thoroughly (under running water for example) & pat dry. Wetness (from diarrhea or warm diapers in the summertime) breeds yeast, which can lead to VERY red bottoms. As on nursing-related yeast infections, baking soda neutralizes the pH & Lotrimin AF (or nystatin) attacks the yeast fungus. Avoid sugars & give more yogurt (supplemented with live cultures, like dry primadophilus added to foods). Give kids “sitz baths” in ~2 Tbl. baking soda. Live aloe may help diaper rashes. Petroleum products (like Vaseline & even A&D ointment are great barriers for the diaper area. Caldecene powder, if you can find it, is a great old-time diaper powder. Many people love Dr. Smith’s diaper cream, which is pricey – but still a LOT less expensive than the “gold standard” (which didn’t work miracles for us) called “Happy Hiney” & compounded by Peoples Pharmacy & NuCara (for over $30/oz!). Diarrhea calls for a BRAT diet of bananas, rice (or rice cereal), apple sauce, & toast.

Urinary Tract Infections (UTIs) are very common in young children, esp. girls because urethras are short & close to anus. UTI will cause fewer, lower ad pain, & painful urination. You
may notice unpleasant odor or blood in urine. Will respond to antibiotics. Also, apply hot-water bottle (wrapped in a towel) to her abdomen & have her avoid bubble baths & perfumed soaps (which can irritate genitals). Have her drink lots of water, to flush out bladder bacteria. (BT)

Can alternate medicines, for same illness, in order to be able to give more frequently. Of course, be very careful to avoid overdose. (BT)

Most children’s ear infections (~90%) are viral, and behind tympanic membrane, so cannot treat with antibiotics (which increase odds of developing asthma). (ST) Best you can do is keep the Eustachian tubes drained via Sudafed. (Is that safe for young children?)

OTC cold & flu medicines do nothing to solve the problem, but will help a child sleep better – so give at night (not during day, when productive coughing helps speed up recovery). (AB) AMOMer highly recommends Children's PediaCare Nightrest Cough and Cold for kids with runny noses, coughs, or congestion (reducing the dosage for your age child); it really helps them sleep!

Giving Medicine to a Baby (AB): Pharmacist can add flavor enhancers (such as FLAVORx) or you can hide it in chocolate syrup or pudding or juice or applesauce (not honey, which can cause botulism [from spores in the honey] in children under 1 year of age). Can also pulverize chewables & mix into ice cream. Squirt medicine using a plastic syringe (giving you more control & speed than a dropper), aim for the inside of the cheek (not the back of the mouth), give half dose at a time if you like, can put medicine into a special dispensing pacifier, dangle a toy over infant’s head so she looks up & will keep medicine inside, swaddle the baby to keep arms from flailing, blow on the child’s face after giving to make him/her swallow, say the word “medicine” with the same excitement you say “chocolate”, can numb child’s tongue with ice cube or Popsicle first. Avoid adding it to milk, since child may detect it & refuse next feeding. Give a toddler some control, by asking the order of activities (e.g., read book first or second?). Pretend to give to a doll first (esp. with shots, for example), & then to child. Offer a reward, like a video or some juice. (AB) AMOMer writes that she cuddles with a pacifier, pulls the pacifier out, quickly squirts a little medicine in and then pops the pacifier right back in.

Keep your baby’s nose clear with saline nasal drops (Pediamist seems to work best, since it gets deep inside!), suctioned out via an aspirator (if you use the regular nasal drops). In winter months, run a warm shower & let baby inhale steam, or use cool-mist vaporizer in room at night. (BT)

Stomach viruses: Can cause a day or two of vomiting &/or diarrhea. Offer clear liquids the first day, and bland food the following day or two. Rotavirus is a more serious stomach bug, and can lead to severe vomiting at the start & a week of diarrhea, and thus dehydration. By age 2, 75% of kids have been infected. Dry lips, non-wet diapers, no tears, sunken appearance around eyes, & lethargy suggest dehydration. Give regular sips of Pedialyte. If child has just vomited, resist urge to give something immediately, and wait till can stomach more. (AB)

AMORs suggest: Tylenol (for viral fevers) & other drugs often come in a suppository form, which is very helpful when babies cannot keep anything down. Motrin can upset the stomach. Also, for diarrhea - Imodium (there are chewable tablets and liquid available), for Vomiting - Phenergan (a prescription drug that comes as a suppository [so that you won't throw it up] – works wonderfully & causes the patient to get some sleep – but some doctors won't prescribe it). Clear liquids the first 24 hours (popsicles, jello - liquid jello makes a good drink when it's warm, broth, coke or sprite and don't buy the HEB brands since they are really tough on
the stomach). Next you can introduce bananas, rice, applesauce (the peel of an apple has an enzyme that aggravates diarrhea and applesauce doesn't use the peel so it's OK) and toast (no butter). Avoid juice or fruit. Small babies can drink a soy-based milk, such as Isomil with no problem.

**Hand foot and mouth disease** (HFM) is very common these days, and painful for the children. AMOMer Julie B writes: “the incubation period for coxsackie virus (hand foot and mouth disease and herpangina) is ~3-7 days. During this time and before the bumps appear, the child is most contagious. Based on timing, we think they got the virus at Radijazz or the grocery store. Those are the only places we went where the kids were touching things and could have picked something up from the equipment at Radijazz or from the steering wheels on the shopping carts. Watch your kids for any symptoms of the virus... fever, little bumps in and around mouth, hands, and feet. The bumps may also appear on the torso or diaper area. It is unusual for them to show up elsewhere, but sometime the bumps also show up on the arms and legs. Since it is a virus, there really isn't much you can do. But, you should keep an eye on the fever. Watch out for dehydration, since the children often have a lack of appetite because of the sores in the mouth and throat. Also, wash hands lots after touching any utensils, cups, etc. that the kids use. See BabyCenter website: [http://www.babycenter.com/refcap/11433.html](http://www.babycenter.com/refcap/11433.html).” Another writes: “The Maalox/benadryl worked well for us. We didn't have the diaper rash, but I would use diaper cream on that unless the Dr. says otherwise. Mine didn't have much appetite through it all due to the soreness in their mouths. I tried to give them the Maalox/Benadryl and Tylenol or Motrin near meal time to dull the pain. I was most worried about dehydration because they didn't want to drink anything either. The Dr. wasn't worried about the lack of eating ... just keeping the fluids up.”

**CPR & First Aid:**

Choking: Five 5 back blows between shoulder blades, with child’s head lower than chest. Then, 5 chest thrusts with just 2 fingers on center of breastbone, just below nipple line, for a dip of ½ to 1 inch. Repeat blows & thrusts until object is coughed up or baby begins to breathe. If baby becomes unconscious, deliver 2 rescue breaths; if air doesn’t go in first time, tip head back further & try. If air still won’t go in, look for a foreign object; if one is visible, use little finger to try to remove it. If chest doesn’t rise, continue 5 chest compressions + rescue breath. If airway clears, give a breath & check for breathing & circulation. (BT)

CPR: Place baby on firm, flat surface. Open airway, keeping 1 hand on forehead. Give 5 chest thrusts, with 2 fingers (in center of breastbone, just below nipple line), depressing chest ½-1”, at rate of 100 times per minute (3 secs to deliver 5 compressions). After 5 compressions, given 1 rescue breath. Continue cycle for 1 minute & then check for pulse. If pulse returns, can continue rescue breaths, until breathing returns. (BT)

Cuts: Apply pressure to the wound for >60 seconds. If no bandaids are available, toothpaste will protect the area while allowing it to air, and will flake off, leaving a clean scab. (Austin’s Green Issue magazine)

Burns: Flush with cool water (a lot if chemical burn), loosely cover burn with gauze dressing (no ointment on a significant burn, since it can seal in the heat). (BT) Place honey on the
burn for 10-15 minutes (vitamin B cuts pain & stops blistering); juicy potato also helps. (Austin’s Green Design magazine)

Stings & Bites: Either mustard, pickles or onions (separately) for 10 minutes, to cut pain & swelling. Itching from mosquito bites cut by unseasoned meat tenderizer mixed with water (breaks down the proteins that insects leave in the skin). Salt water, diluted ammonia or liquid soap will also alleviate the irritation. For tick bites, can use lighted match (to coax tick out) or drop of gasoline or alcohol on the area for 10 min (to irritate the tick). Can suffocate by covering with nail polish for 24 hrs. Then, use tweezers to pull it out. (Austin’s Green Design mag)

Sunburns: Aloe vera, or a lot of vinegar and then sour cream rubbed in on top. Once cream dissolves into vinegar, wash off. Red color remains, typically, but heat & pain should be gone. (Austin’s Green Issue mag)

Splinters: piece of tape pressed on any exposed part can be pulled away slowly. Else, let a bit of glue dry over it, and then peel off.

Poisoning: Do not use Ipetac any more (unless instructed to by the Poison Control Center). Save some of the vomit for analysis by doctors. (BT)

Poison Ivy: White shoe polish contains clay & zinc, which are similar to calamine lotion. Warm baths or oatmeal also help.

Bruises & bumps: Cold compress or frozen spoon or ice can decrease pain & swelling & further bleeding. (BT) If kids refuse the cold approach, wet a cloth with vinegar & hold on to bump for 5-10 minutes. Acetic acid minimizes the swelling. For a bruise, many feel that the inside of a ripe banana peel & sleep with it overnight will work fine. (Austin’s Green Issue mag)

Object in Eye: Angry flush for at least 15 minutes (!), do not try to move, cover with a paper cup & seek medical care. (BT)

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**Baby Reflux:**

JBallengee says children in same crib till ~3 months, when one started rolling over & hitting the other, waking him up. Hers couldn’t really cuddle since, due to reflux, she had them propped onto their sides with pillows from the start.

Another AMOMer loved how her reflux baby would sleep so well in a car seat. They kept them in that sleep position for as long as possible.

Ute Ewe suggests “Don't let them put him on Reglan. It's supposed to empty his stomach faster into his intestines but the side effects are really bad.” Susan A writes: “if your child is still screaming after meds, you may want to have him/her check for a milk protein allergy (they do this by checking stool samples) or a UTI. My child that dealt with reflux for 17 months (on Prilosec & Bethanacol suspension) also had a milk protein allergy. We had to switch from my breast milk and several different other formulas until we found the right one for her (Neocate), which we had to special order through the pharmacy. It was the magic formula along with her meds that finally saw us through the roughest times (ie: screaming all night!!).” Many AMOMers recommend Dr Zweiner for reflux. One recommends giving Prevacid at night, even if the child improves; and she cut almost all foods from her diet (& lived largely on chicken).
Reflux – Medications & Insurance Coverage:

Julie B wrote: “Our insurer [Blue Cross] initially said they would not cover the compounding of meds. Then I explained that he was an infant (at the time only 3 weeks old). After I mentioned that she did some research and said they would pay for it at $40 copay. This same insurance company only requires a $10 copay if we get the Omeprazole compounded instead of the Prilosec or Prevacid. So, we gave that a shot and it worked!”

Julie B increased meds for short periods when “we saw a resurgence of symptoms.... increased vomiting, increased pulling away from the breast, back arching, screaming for burps, etc.” One of her children failed to thrive/gain weight with reflux, while the second gained substantial weight (which is a bit unusual). Some refluxers will eat for comfort & very frequently, since milk is a natural antacid. (This can lead to too much foremilk & constipation, as described in the nursing section.) Antibiotics may bring the reflux back on in full force, since it kills the good bacteria in the stomach too. Julie B has had two kids on Zantac, which has an overwhelming peppermint taste to it (& is expensive). One had no problem with it. The other is averse to all of his reflux meds. She writes: “In 2003 it was the standard protocol to start reflux babies on Zantac and if needed Reglan. Texas Children's in Houston has revised that policy and goes with Prevacid (or Prilosec or Omeprazole, which is a generic Prilosec) and if needed Bethanechol. Zantac and Prevacid/Prilosec work differently to reduce the amount of acid in the stomach. They can even both be taken without risk of overdose, because the medications act on the body through a different process. The Zantac is almost like an antihistamine in the way it acts in the body and it basically reduces the acidity of the acid produced in the stomach. It can be effective in mild reflux cases. However, Peds have found that the Zantac Reglan treatment is largely ineffective for most cases of reflux. Prevacid and Prilosec are Proton Pump Inhibitors. They actually stop the body from producing most stomach acid in the first place. This has been found to be highly effective. Side effects are rare and to prevent the body from over producing acid, to make up for the pumps being shut down, you wean a child gradually off the medication. That way the body has time to adjust to producing regular amounts of acid. Most children/babies react to Prevacid or Prilosec the same. However, as they are slightly different drugs, some will find that one is more effective than the other. It can take up to a week for the drug to kick in and be effective. Prevacid, Prilosec, and Zantac are not actually reflux medications. That is, they are not designed to stop or even reduce the vomiting. However, this frequently is a side effect of the medication. When the child throws up and the stomach fluids are acidic, it continues to damage the esophagus and the sphincter. They have found that over time with the decrease in acid, the throat heals and the reflux is diminished. Reglan and Bethanechol are actual reflux drugs that are used to help push the food through the digestive system. They also help to tighten/strengthen the sphincter in the esophagus (not sure I am using the correct terminology here) - but basically what they do is to help keep the top of the esophagus closed so that when a child burps or pushes out a dirty diaper, or just has some acid reflux, the sphincter does not remain open and less/no food comes back out. Reglan and Bethanechol are used less frequently, as there are potential long lasting side effects. One other thing to keep in mind with reflux meds is the dosage and weight of the child. Pediatricians typically give a very low end dose. We started with low doses on both kids and eventually had to see Ped GIs to get the mid-dosage for the doses to be effective. Pediatricians are not GI docs and both of our Peds were not comfortable with higher doses without a referral to Ped GI. Also, once the child is on meds, they may begin to increase weight
fairly rapidly, or if the child is an infant - they are likely growing quickly. Meds may need to be increase as frequently as weekly to keep up with weight gain.”

Cleaning Baby + Skin Rashes:
Don’t immerse in water until cord falls off, a week or two after birth. Just wash face, hands & bottom. (BT)
Test water temperature with elbow. (BT)
Use cotton balls/pads to clean eyes, ears, nose & face. Wipe eyelids from inside to outside, using a different cotton ball for each. (BT)
You can expect ~200 diapers/week with twins. (!!) Cloth diapers require 2 cycles of wash, & do not use bleach in the first cycle (since it will mix with the urine & lead to diaper rash). (HT) Note: KK aimed for just 8-10 changings/day, per child, or less than 140 diapers per week total.
Blow-dry (on low setting) the bottoms of babies to reduce rash likelihood, or put them in the sun, with some castor oil. (AMOM & HT)
Baby skin is very sensitive & takes ~9 whole months to develop in womb. It also may be much more absorbent than an adult’s (experts are still arguing on this one). Don’t dip baby in tub until umbilical stump falls off. Until then, a gentle sponge bath on the bottom & genitals is plenty. After that, go easy on the soap! Save it for the end of the bath, when baby isn’t sitting in soapy water, & choose mild & fragrance-free products, to minimize skin rash & irritation. Whatever product you do choose, stick with it! – to avoid baby’s exposure to chemicals. If baby is particularly sensitive to soaps, might wash her clothes with Dreft or other formula that rinses thoroughly. (BT)
Peak period of skin rashes occurs at crawling stage – from 9-12 mos. Best advice: Keep your baby dry! Keep her changed & avoid the pre-treated wipes, in favor of a washcloth. Change her 8+ times/day & apply a protective cream (such as Desitin or Balmex, which are zinc-oxide based, or A+D petroleum-based products). Don’t use baby powder; it decreases friction & does not help. Avoid talc altogether, since it can be inhaled. Instead, choose a product from cornstarch.
Don’t use sunscreen on skin of a baby < 6 months; after that, use SPF 15 or higher, even if she’s in the shade (due to reflected rays). (BT)
RASH types: Cradle Cap – yellowish & greasy scales on head, rub with oil to loosen scales or a cortisone cream or shampoo may be prescribed. An AMOMer recommends Mustela shampoo, since it has a salicylic acid. Washing hair daily also helped her kids (contrary to some common advice one may read).
Diaper Rash – Chapped red spots & patches in diaper area from urine or stool or diarrhea → change diapers often, bath them, apply ointment & let go bare bottomed. Several AMOM’ers love Dr. Smith’s rash cream. Live-plant ALOE works great sometimes! (The bottled stuff is just really a moisturizer, since the plant chemicals deteriorate.) Annette Perrone uses vitamin E capsules (pricking with a pin to release the oil over the baby’s skin). “Happy Hiney” can be compounded at People’s Pharmacy or NuCara, but it’s very expensive ($>30/oz!) & didn’t work so great for us. One AMOM was prescribed Cholestyr/Aquaphor 10%, which worked great. (Seton NICU uses Boudro’s Butt paste, which seems a bit better than other standard diaper rash barrier creams.) Note:
Diarreha can lead to serious diaper rash, to the point of bleeding & blistering. Be wary of this, & change wet diapers on toddlers right away. The associated pain of such rashes will cause lots of crying & babies will cringe when touched. Do not use wipes, which spread bacteria. Clean thoroughly (under running water for example) & pat dry. Wetness (from diarrhea or warm diapers in the summertime) breeds yeast, which can lead to VERY red bottoms. As on nursing-related yeast infections, baking soda neutralizes the pH & Lotrimin AF (or nystatin) attacks the yeast fungus. Avoid sugars & give more yogurt (supplemented with live cultures, like dry primadopholus added to foods). Give kids “sitz baths” in ~2 Tbl. baking soda. Live aloe may help diaper & other rashes. Petroleum products (like Vaseline & even A&D ointment are great barriers for the diaper area. Caldecene powder, if you can find it, is a great old-time diaper powder. Many people love Dr. Smith’s diaper cream, which is pricey – but still a LOT less expensive than the “gold standard” (which didn’t work miracles for us) called “Happy Hiney” & compounded by Peoples Pharmacy & NuCara (for over $30/oz!). Diarrhea calls for a BRAT diet of bananas, rice (or rice cereal), apple sauce, and toast. (KK)

Eczema – dry reddish patches on cheeks, arms & legs, which may get scaly (often due to food allergies, like egg & cow-milk-based formulas) → avoid soaps & harsh detergents, treat dryness with a moisturizer (or prescribed steroidal cream, like hydrocortisone, right away). Unfortunately, about 10% of babies suffer from this & about 75% of those who do will develop asthma or allergies. 😞

Hives – itchy raised, red welts surrounded by white halos → cool compresses & calamine lotion & perhaps prescribed Benadryl. Infant Acne – Red pimples on cheeks & forehead due to maternal hormones → cannot treat; it’ll go away.

Milia – Tiny white or yellow spots on face or near genitals due to dead skin cells & trapped sebum → No treatment.

Prickly Heat – Small red pimples or clear blisters on chest & back due to blocked sweat glands → cool compresses & loose, cool clothing + calamine lotion for itching (or prescribed cortisone cream).

Yeast Infection – Red splotches with tiny red bumps on edges in skin folds of diaper area due to yeast organisms → Keep dry & change diapers often, with prescribed cream like Lotrimin AF. (BT) Don’t use A&D ointment on this [which works for traditional diaper rash], as it will fester. Lotrimin AF may work very quickly. (AMOM)

Many lotions contain aloe, vitamin E, etc., which are irritants to sensitive folks; one AMOMer has found that only Nutraderm works for her. She also treats patches of eczema right away with a cortisone, 2-3 times that first day (& it’s gone by the next day, usually). Don’t put both lotion & cortisone on. And don’t overuse cortisone after spot is gone, since it weakens the skin. But do be aggressive when you first see it! It can become an oozing mess.

Diaper Rashes: Kara K loves simple cornstarch (which comes in a powder dispenser, for the purpose of baby diaper changes); it’s very inexpensive & seems to work where all the creams fail. If the rash is blistering or bleeding, a cream is needed. AMOM’ers Debra M & Kathina A swear by Walgreen’s Dyprotex, but that does have zinc (which doctors try to get parents to avoid, since too much in the air is bad for babies’ lungs). Many parents love Aquaphor, when no rash is present. (One can get it in a tub form at Babies R Us or
elsewhere, which lasts a lot longer & is a lot less expensive than the standard tubes.)

Washing (& drying) a baby’s bottom is very important to stopping a severe rash, in
addition to cream or other treatments. Many things don’t appear to work for certain
babies, but different mothers have success with 2 or more of the following: A&D
ointment, baking soda baths, Neosporin, baby powder, live aloe.

Baby Marks: Strawberry Mark = raised, spongy red growth (hemangioma) which appears in first
few weeks & expands; will fade by age 9 w/o any scars. Stork Bites = dark pink spots on
back of neck, forehead or eyelids due to dilated blood vessels, which usually disappear
within a year except on neck, which often are permanent.

Rickets are a soft-bone disease due to insufficient Vitamin D. Human milk (nursing) has only
small amounts of this vitamin, so AAP has recently rec’d giving all infants a supplement
of D, before they’re 2 months old (at least 200 IU/day) via a dropper (which some babies
will have a hard time getting adjusted to, at least in first month). Though sun exposure
helps, keep babies under 6 months out of direct sunlight. (BT) ST believes all one needs
is sunlight exposure ~30 min/day.

Baby Dental Care: Putting baby to bed with milk bottle leads to tooth decay. (Put to bed with
water bottle, if you wish.) 40% of kids have decay by the time they enter kindergarten.
Baby teeth are indeed temporary but important; cavities there, besides causing pain,
increase risk of decay in adult teeth. Allow fruit juices only with meals, if you can, &
allow no more than 4-8 oz of juice/day (!). Do not share your utensils with babies or use
your own mouth on their pacifiers, bottles, etc. Xylitol in gums helps reduce their tooth
decay, if you want them chewing gum. Clean baby mouth with damp cloth after
feedings. When teeth start to come in (around 6 months), brush them twice/day & begin
flossing when teeth touch one another. (Note: We only brushed once a day, with a little
finger-cap brush & flouride-free gel, after the babies reached ~12 months of age.)

Chicken pox: AMOM’ers wrtie: “Getting chicken pox when you're young is a good thing.
Getting a full blown case is much better immunity than the vaccine. Especially in a baby, when
they can't really scratch the pox. Both my girls were vaccinated when they were one and both
got the cp by the time they were 4. If it was a milder case, you could have fooled me! One thing
that worked great for them at that age was putting them naked in the bathtub and letting them
"paint" calamine lotion on their pox with a water color brush.”

Baby Allergies:
May be able to reduce baby allergy risk by: (1) covering crib mattress with vinyl-backed
dustproof zipper casing & washing sheets 10+ min/week in hot water & drying at highest
setting; (2) washing stuffed animals weekly in hot water or putting in sealed plastic bag
& leaving overnight in freezer (!); (3) cleaning household surfaces with diluted bleach,
ammonia-based cleaner, or antifungal spray & by running A/C, and avoiding humidifiers
& vaporizers (to reduce molds); (4) cleaning any humidifier or vaporizer weekly (for
molds); (5) bathe any pets regularly (recent research suggests that pets in first year of life
may help reduce allergies); (6) breastfeed, of course! (BT)

Peanut allergies are on the rise, & no one is sure why. It effects include eczema & other skin
rashes, swollen lips, shortness of breath & wheezing. If your family has a high allergy
history, you can avoid peanuts during pregnancy. And, while breastfeeding, avoid other
tree-grown nuts (such as walnuts, almonds, hazelnuts, pecans & cashews), fish, eggs & cow’s milk. (BT)

If a child shows allergy symptoms (e.g., itchy rashes) when nursing, moms should avoid milk, eggs, fish, peanuts & tree nuts. In a family with a history of food allergies, babies should avoid cow & soy milks until 1 year of age. At 2 years, one can give eggs & at 3 nuts & fish. Nut & fish allergies usually last a lifetime, but milk allergies often lessen later in life. (Newsweek 6/9/03)

Avoid cows milk before baby is 1. Her intestinal lining may not be fully mature, & you run the risk of allergies. (BT)

Avoid shark, swordfish, king mackerel, & tilefish, due to mercury content. Tofu is a good meat substitute to get your child used to as well. (BT)

Allergies manifest themselves in runny noses, coughs, wheezes, rashes, vomit, & diarrhea. (JOT)

Colic: Uncontrollable, endless crying. Generally subsides around 4 months. May be due to gastroesophageal reflux (GES), allergies or environmental sensitivity. To address the first of these, try a formula thickened with finely ground rice cereal, since it’ll stay in stomach better, & feed at least every 3 hours. There is a special, very dense formula that exists too. Mylanta drops can help reduce gas. For allergies, hypoallergenic formulas like Alimentum or Nutramigen may be easier to digest. Coffee, chocolate or broccoli & cauliflower may be the culprits. To address the environment, some babies need dimmed light & silence, others like motion of a swing or car ride. Swaddling & close snuggling may help. Change hold positions frequently, to ease tummy pressure. You will need many breaks from baby duty. E Buller found that putting her son on his stomach helped a lot, as did giving him lacto-acidophilus capsules’ powder in his bottle.

Dr. Sears’s 36 TIME-TESTED BABY-CALMERS (lots of good anti-fuss info at http://www.askdrsears.com/html/5/T051200.asp#T051207): wearing baby in a sling, Dancing with baby, Swinging baby, car rides, Pushing baby in a carriage, Taking a walk., Bouncing on a trampoline, Nursing while walking with baby, Draping baby over a beach ball, Comfort sucking: nursing, pacifiers, sucking on the move, Music, tapes of womb sounds, heartbeats, Echo baby's cry, Tape recordings of baby's own cries, Tick-tock of clock or pendulum swing of grandfather clock, Singing lullabies, vibrating, humming gadgets wrapped in diaper or blanket, Running water, Tape of environmental sounds, metronome, Ceiling fan; bathroom fan, Sounds of vacuum cleaner, dishwasher, washer-dryer, air conditioner; Show baby your "silly face"; Magic mirror Fire in fireplace; Gazing at traffic, Watching parent on exercise machine, Watching television or video, Infant massage, neck nestle, A warm bath together, eliminating bothersome foods from mother's diet if breastfeeding, or changing formula, Slowing down mother's lifestyle and changing her expectations, Creating the most peaceful home environment.

**Feeding Babies Food:**

Babies do not need a wide variety of food before 12 months. At 5-6 months, add rice cereal or banana, once/day. And be sure to **nurse before giving food.** At 7-8 mo., give pureed veggies & fruit (but no seasoning) & cooked egg yolk (not whites). At 8-9 months, pureed meats & yogurt are good. After 1 year, scrambled eggs, cooked noodles, peas,
cottage cheese (large curd) … = finger foods, so they feed themselves! If you do use a spoon, use just 1 for twins. It’s much saner that way. (JOT)

Give food toward end of day, if nursing, b/c milk supplies will be lower then & your baby may be more eager to eat. Otherwise, offer new foods in morning, when babies tend to be hungriest. (BT)

Recommend 630 cals/day from 4-6 months, 740 from 7-11 months, 950/day from 1 to 2 years of age. Avg US baby gets ~10-30% more → weight problems. (AB)

Avoid juice, until 6+ months. Don’t start cows milk until 12 months, & then only full-fat variety through their toddler years. (AB)

Used to be physicians advised rice cereal at 6 wks, but it’s much wiser to wait. At ~6+ months, babies are physically ready. You will know this b/c they will reach for your food or follow your fork with their eyes. Use your fingertip as baby’s first spoon. Favorite firsts are mashed bananas (its sweetness is similar to breast milk), mashed cooked pears, iron-fortified rice or barely cereal (b/c it’s gluten-free, rice if more friendly to maturing intestines than wheat), applesauce, mashed cooked carrots, mashed sweet potatoes, pureed peas & green beans. Most nutritious of early foods may be the mashed avocado. (High folate & phosphorus.) (BT)

It is possible to start some foods earlier! Mother of triplets CVH writes: “I started so much earlier with my triplets, mainly my son who seemed to be colicky but was really just hungry. Both he and Heather had a high metabolism so they needed something more than just breastmilk at 12 weeks of age. The cereal in the bottle did was a huge help. Dr. Smith's sells the "thicker liquids" nipples and you should always start off really thin and add up to more. But don’t let your kids take it to bed where they can choke. Also, with solids, it helps to give multiples a little finger food before hand-feeding them one at a time so they don't feel neglected.”

Wait 3-5 days before introducing another food, to see if develops red rash on face or bottom, diarrhea, runny nose, colicky ab pain. Breast milk should remain the primary source of nutrition for first year. (BT)

Around 9 months, can begin finger foods like rice cake pieces, O-shaped cereals, egg yolk crumbled, cooked noodles & small pieces of cooked fruit or soft ripe avocado. Between 9 & 12 months, babies become enthralled with poking at food; this stage will pass. Also during this time, baby may enjoy the variety of a cup. Start with water or breast milk/formula. Consider juice only as a vehicle for delivering extra water, which your baby needs once she starts eating a lot of solids. (BT)

Teething biscuits help soothe sore gums. Avoid raw fruits & veggies, nuts, seeds, grapes, hot dogs, meat chunks & other choking hazards. (BT)

Also, between 9 & 12 months, serve foods rich in vitamin C to get iron in other foods to absorb better (e.g., spaghetti with meat + tomato sauce). (BT)

12-24 months: Most chubby babies go through a natural leaning phases, between ages 1 & 2. Look out for saturated fats (listed as “partially hydro. oils”) in some cereals, crackers & fast foods. Best fats = Omega 3, in oily fish. Get baby used to salmon by camouflaging with applesauce (!). (BT)

24+ months: 2 year olds are picky eaters b/c they aren’t growing as fast. Encourage them to try new foods by (1) creating a “nibble tray” (using an ice cube or muffin tin with bite-size portions of colorful, nutritious foods in each compartments), (2) making mini-meals (i.e., frequent, small healthy sit-down snacks), (3) top off new or less desired foods with
familiar favorites like yogurt, melted cheese, or applesauce. It may take 10-15 exposures until child accepts new food. (BT) Allow them to help make their own foods, like decorating a minipizza with veggies, so that they’re more likely to eat the veggies. Can also mash broccoli into potatoes, & teach children their colors with veggies. Research shows may take 10-15 times. (AB)

Avoid the following for the first 8-12 months: egg whites, citrus (!), berries, mushrooms, peas (!), shellfish, raisins (!), fruit skin, whole grains (!), cereal flakes, corn (!), cinnamon, artificial colors, nuts & chocolate. No cow’s milk until age 1, except for *yogurts, with live cultures.* (JOT)

Be sure not to force feed! Obesity prevention requires that the child learn to control her own food portions. If she doesn’t want it, don’t push it. But, to get her excited, you can exaggerate your enjoyment of it, & to help her get it off spoon, you can lift it upward as you draw it out of her mouth. (BT) Babies born over 9 lbs or under 5 lbs have an increased risk of being overweight later on. Nursing & delaying solids help protect your child against obesity. Help baby learn to cue him/herself for hunger, rather than forcing food or a bottle upon them. Offer a variety of baby foods, since preferences are formed in the first few years. (AB)

Babies are ready for solids after they have doubled their birthweight & weigh at least 13 lbs & seem hungry after 8-10 nursings/day (or 32 oz formula/day) & are able to lift and support head.

Gerber’s Recommendations on Starting Solids: Start with 1 Tbl of single-grain cereal (rice, oatmeal or barley cereal), mixed with 4 Tbl breast milk or formula or water. Decrease fluid as baby gets used to consistency. Try to get fortified cereals for iron. Start a new food in the morning so you’ll know it if doesn’t agree with baby by evening. Add only 1 new food at a time, for 3 to 5 days in a row, before starting another. First foods: Fruits & veggies can be added when baby pushes self up with straight elbows & sits with help. Add 1/4 jar per day for first couple days [where jar ~2.5 oz] & then ½ jar & then 1 jar/day by end of 4-day period. Veggies & Fruits = pureed green beans, peas, carrots, sweet potatoes, squash, applesauce, peaches, prunes, bananas, pears. NO sugar, salt, egg, milk, wheat or citrus. (See Gerber foods for the first 2 years sheet for more advanced foods, like broccoli, pasta, apples.)

Constipation: Some babies have a real hard time at various times during their first year, even throwing up due to constipation. Prune juice mixed in milk usually does the trick. (Many doctors like to avoid suppositories, since they worry the child will get too used to it. So use in moderation.) Prescription Miralax can be a lifesaver for those who cannot get rid of this problem. (It is not absorbed in the bloodstream.) Lactulose is also very valued by at least one AMOMer. Note: Most kids are fine going several days without pooping, however. So it usually bothers the parents more than the kids. AMOMer Julie B learned it was her active letdown reflex releasing too much foremilk into her reflux-prone baby (who didn’t like to overeat & thus was always getting foremilk) that lead to a lot of wet diapers – but not many poopy ones! She had to focus on sticking to a single breast every 3 hours to ensure he got enough of the denser hind milk, and thus enough fat to get rid of those poops.

Physical Milestones: The average baby (which doesn’t actually exist!) usually begins moving objects from hand to another at ~5 months & plays pat-a-cake at ~9 months. The pincer grasp
usually kicks in around 11.5 months. By about 13 months, the average baby can stack 2 blocks, and by 14 months scribble with a crayon. The average baby will be crawling at 7-8 months, walking with support at 9-11 months, and begins to walk on his/her own just before the first birthday. Walking up stairs & jumping occur at 16 months & 2 years, for the average toddler. There is great variation. Chubbier babies have a harder time, as do those with less muscle tone. Most children can say their first words around their first birthday. By 18 months, babies should say at least 10 words & may understand 50 or more. 18 months also marks the start of a language explosion; they may acquire as many as 8 words daily! (AB)

**TODDLERS**

Toddlers are into everything! Help them to find safe ways to experiment by keeping tempting objects out of sight, giving them a place to make messes, choosing your battles (e.g., only with really dangerous items should you step in strongly), focusing on safety (not showing them who is boss – you’ll waste your energy & patience this way & they won’t know what real problems are), applauding their curiosity & letting them experience they joy of discovery. This inquisitiveness & physical activity will hold them in great stead one day! (BT)

In Austin, a weekly email of kid-oriented events, many of which are free, comes from MrJohnny & Sharon www.mrjohnny.com (512) 494-1411; write to get on their list. Similarly, check out www.kidevents.com (for low-cost movies & so on).

Toddlers also experience a lot of frustration. They will cry often & need reassurance as they set out on their own. Watch for signs that they need some assistance or support. Encourage them to say they are sad, rather than crying, & don’t ask too much. Reward with a quick hug & some praise (not a cookie☺). (BT)

Toddlers may balk at nap times. “Crib tents” are something highly recommended by AMOM’ers, to keep the kids in the crib. (Pretend they are camping; they like that analogy.) To keep kids sleeping longer, tell them to “close their eyes & go back to sleep; no crying. If you sleep a looong time, we’ll get you a pretzel (or raisin or other incentive) when you wake up!”

**How to Discipline a Child**

From the Book “SOS”, authored by Lyn Clark (highly recommended by UT professor of ed psych, married to another UT ed psych professor & mothere to two young children)

This short book explains the following:
- **Active Ignoring** of bad behavior (including whining) is key. NO attention should be given the child. But praise all good behavior – like their sharing, cooperating, using their words to discuss problems, use of their regular voice, etc.
- Many children seek the attention of the parent, so no attention is a very valuable penalty. One way to make such children feel very good is to watch them & narrate what they are doing. (This is called “child’s game”, and there’s no direction from the parent, really. The child leads the activity, and the parent simply describes what he/she is doing, which makes the child feel like the center of attention.)
• Stay unemotional. No pointless threats, no yelling. But you can be pointed & stern, and clearly explain why what the child did was wrong (e.g., explain its repercussions – like throwing a hard toy could damage the walls). Be brief & calm; don’t give thea child extra attention.
• Don’t say “good girl/boy”; it’s more effective to explain why their behavior is helpful.
• Don’t tell a child that he/she is mean or naughty or a bad child; say that what they did was mean or naughty.
• Model the behavior you seek. (Pretend you’re a kid & share nicely.)
• Have fun/give a reward after they complete an unpleasant task (e.g., clean up), not before.
• Try to allow for natural, logical consequences, where feasible. For example, no sweets until a child resumes his/her toothbrushing regularly, or have a friend leave is the child isn’t nice to him/her. For other types of behavior, you can have a penalty (e.g., chores).
• Keeping tally marks of specific bad behavior, visibly, will help a child stop.
• If two kids are fighting, put both in time out to that they stay motivated to solve their own problems, and you don’t have to worry about punishing the wrong child.
• If they are fighting over a toy, you can put the toy into timeout! This will help them learn to share.
• If child has a very bad behavior that is tough to train out of him/her, pick a weekend & be prepared for misery: taking the child back to time out every time he/she misbehaves (even 100+ times), in order to clear him/her of that behavior. You won’t have much fun that weekend, but Monday will be a lot better! Children tend to be a lot happier once they know there are boundaries (and they are clear on what these are).
• If you need them to cleanup, try using a timer for 10 minutes & tell them that whatever’s not in its place in that time goes into a “Sunday Box”, which will not be available again until that time.
• A “job jar” is also a neat idea, for kids 10+ year olds, when they misbehave (rather than grounding them, for example). This way jobs get done, and the child has control over the response, rather than sitting around moping (& tying up the entire family’s activities while he/she is grounded).
• With many types of activity you want done, try “race the timer” (like get ready for bed) with a reward &/or praise if they beat the timer (but no punishment if they don’t).
• With dangerous behaviors (e.g., crossing a street unaccompanied or hitting another with a heavy object), be sure the child explains what he did that was wrong & hopefully some alternative behavior options for use in similar future situations.
• Communicate your expectations to your kids before having to punish them, so they know what the punishment is. They will feel it’s more justified/fair, if they know what to expect.
• If they wet the bed after age 5, give points for dry nights. On wet nights, have them clean up the bed & shower off. If it continues, a wetness sensor/alarm for the bed could be very helpful.
• Tell child ahead of time what the penalty will be. Use mild punishment, but use it consistently (every time).
• Consistency is very important, since children are like gamblers in Las Vegas: once they win a bit of money, they will go back to the crap tables as many times as needed in order to finally win again. They will try & try until they “break” the parent; it’s a bit thrilling for them, to
finally “win” – even if it takes 20 attempts to discover inconsistency in their parent, where
the behavior is allowed to ‘slide’ by.
• Of course, timeout is a very common penalty, and it is explained below.

Timeouts (from the book SOS, by Lyn Clark):
• Explain about timeouts when both of you are relaxed. Tell him/her that you love them, but
his/her behavior’s causing a problem. Maybe demonstrate it with a doll.
• Send the child to time out within 10 seconds & with fewer than 10 words.
• Don’t threaten a time out; use it. And use it immediately, unless you’re at a public place
where you may prefer the option of telling the child that he/she will get time out back at
home if he/she doesn’t stop the behavior. But you can always put on a bench, in car seat,
etc., as a time out. It’s typically very effective because they want to engage in the out-of-
home activities.
• Use hand gestures to send an older child to timeout; but take a toddler to time out.
• You can use a timer for timeouts, from age 2 through 12, but use it immediately (within 10
secs.) & ideally it should be audible while ticking (to avoid a child who keeps coming out,
unsure of when the timeout will end).
• When the child comes out, ask him/her “Why were you in time out?” and confirm his/her
answer. Be sure he/she can tell you why he/she was in time out before he can head onto a
difference activity.
• Don’t give a timeout if you haven’t seen the offending behavior, or just because the child is
pouting & in a bad mood, or didn’t do his/her chores/pick up toys. (Using active ignoring
when he/she is pouting.)
• Don’t do a timeout in order to get a child to do a chore. (Instead, use a reward, or, with older
kids, a “contract.”)
• Don’t give timeouts for all bad behaviors. Pikc a couple target behaviors with your spouse &
work on these.

Tokens & Point Systems (SOS) –
• Tokens are for kids 4 to 5 years of age, and Point Systems are for children 6+.
• Tokens are stickers or poker chips, etc., for child to keep in a safe place.
• Create a table of desired behaviors, and points/tokens they can earn.
• Rewards are ice cream, lollipops, trip to McDonalds, ordering pizza, staying up later –
whatever the child is most excited about (& each requiring a different # of points or tokens).
• Don’t ever take away tokens/points. Use timeouts for that (or another response).

Contracts – for kids over 12 years of age
• Contracts are negotiated with the child, and signed by all parties, so that child is aware of
responsibilities, in order to enjoy a privilege (e.g., midnight curfew, use of car, keeping a pet
inside, etc.). (SOS)

Discipline & Time outs: AMOMer Julie B does the following with her 18-month-olds: Remove
the child, briefly, from the toy or situation and gently place them face down on the carpet in a
corner or next to the wall. As I put them down, I say "crayons stay on the table" or whatever the
proper action is. For some reason they hate even this brief removal. They will cry and then get
back up and come back to the situation. Then I say, for example "Are you ready to try again? Here is a crayon to use on the paper." They are really only removed for a few seconds - but apparently this does it for them. -With something a little more safety issue-ish, we've been a little bit firmer. So, they get one warning. If they didn't stop or did it again, we said, "Little boys/girls who don't know how to be safe on the balcony, have to go inside." Then, (this part was absolute torture for me!) we put the offender just inside the door (which is glass). Then I shut the door, paid lots of attention to the other baby, and the offender stood at the window sobbing. In less than a minute, I would open the door and ask if they were ready to try again. Then as they came out, I would pat the balcony floor and say, feet stay on the floor. Grace now pats the balcony floor on a regular basis! -For time-outs, I have heard that it is not a good idea to use an area that they still get to be part of the action (like hear the television, or interact with other kids). I read that the laundry room or a powder room (Making sure room is totally baby proofed and damage proofed) is a good idea. That way, they are close by and someplace that they can't have fun. An alternative is to use a pack and play that is no longer used to sleep in, so that they are confined and safe. I also have heard, 1 minute for each year of age and not to start using before age 2. Using a timer with a bell or a sand timer they can watch was another suggestion - this allows them to see the time counting down, since young children have little concept of time. Do not start the timer until the child is behaving. If the child messes up the room (e.g. ripping roll of toilet paper) they have to clean it up and THEN do the time. – Elizabeth L. writes: Time-Outs are only effective if they're quick, consistent and occur immediately after the offense. The point is just for them to learn that, consistently, if you stop doing something or you'll put them in time-out, it will happen. - You should keep time-out's "unemotional." Remain calm when putting them in time-out, carry them to time-out quickly and kind of holding them away from you & facing outwards (so the "ride" there isn't enjoyable - with basically a free snuggle from mom.) Then, don't interact with them while they're there because they end up just getting more attention. Just ignore them for the 45 seconds or so, lavish attention on the other child, then turn around to go get them out. If you do it quickly enough, you can probably get back to your other child before he/she wanders over to see what's going on. And if the time-out is short enough, you don't get into a battle about keeping them there. Things we've learned: - If they start fussing, protesting, etc, as we put them in - we just ignore it and set them down as quickly as possible. We try not to get engaged with them over going to time-out or it defeats the purpose and suddenly we're battling over time-out, not just a location. That way if we're not at home, we can still use time-out. It's basically just being removed from the fun for under a minute. For instance, yesterday I set Chloe down on the grass away from where we were playing. It worked.

**Biting:** Our son bit a lot, for a year or so (1.5 to 2.5 years old, probably). We would say “kiss, kiss” as he went in to bite, and often he’d turn to kissing. Many people feel that only the child’s being bitten back gets him/her to understand the pain he/she is causing. Thus, I also pulled his lower hair, which seemed to protect me from much of his biting (but was a technique greatly disliked by my spouse). He continued to bite my husband & nanny (& his sister) a lot, and I think they didn’t discipline him enough (simply taking the biting & saying Ow). AMOM’ers also recommend (1) letting go of the child right then & there, and walking away saying “Ow, ow,
ow!

(2) giving him/her something else to bite, (3) reading a book about biting (which describes how apples are for biting, but not your sister, etc.; it asks questions like, “is your mommy for biting?”), so everyone says NOOOO, and it ends by letting the child know he/she can bite the book itself, which is a bit fun.

**Make Your Own (Edible) Play Dough** (since little kids may like to eat the stuff!)

Recipe #1: 1 cup flour 1/2 cup salt 2 Tablespoons cream of tartar 1 cup water 1 Tablespoon vegetable oil; a few drops of food color, peppermint extract or lemon oil

Sift dry ingredients together in a sauce pan. Add liquid ingredients and cook over medium heat until the mixture pulls apart from the sides of the pan, approximately 3 to 4 minutes. Knead dough. Store in an airtight container.

Recipe #2: 1 cup flour 1/2 cup salt 2 Tablespoons cream of tartar one package of unsweetened Koolaid 2 Tablespoons vegetable oil 1 cup water

Follow the steps in recipe #1. The koolaid gives the play dough a vibrant color and a semi-fruity flavor, if you want to taste it.

Recipe #3: 1 1/2 cups flour 1 cup salt 3/4 cup boiling water

Mix the ingredients, knead once or twice. Refrigerate until cold. This recipe makes dough that is great for sculpting or molding. Leave creation out until dry, then paint.

Birthday Party Entertainment: [http://www.threeringservice.com/](http://www.threeringservice.com/) (has every character you can think of)

**Things to do with toddlers**: [http://www.twinslist.org/toddler.htm](http://www.twinslist.org/toddler.htm) (e.g., macaroni & string for necklaces, paper plates & washable finger paints, super-soapy water & sieves,


**Homeschooling**: Here’s what preschoolers need to learn -- [http://www.worldbook.com/wc/browse?id=pa/tcs//psl/course_study_curra.htm](http://www.worldbook.com/wc/browse?id=pa/tcs//psl/course_study_curra.htm)

**Websites for materials: toddler/preschooler to learn.** Here's some good ones:

- **Starfall** - this is one of my new favorites. It is a learn to read website which has free online games, stories, and activities. It goes through 4 levels - ABCs/Let's Get Ready to Read, Learn to Read, It's Fun to Read and I'm Reading. My kindergarten boys are working through the learn to read section and really picking it up fast. You can also order writing journals and books at very low cost that you can use with the website or separately. [http://www.starfall.com](http://www.starfall.com)

- **Between the Lions** (PBS show) - includes games and materials from the show including the literacy curriculum aimed at children ages 4-7 [http://pbskids.org/lions](http://pbskids.org/lions)

- **Mrs. Alphabet** - has advice, tips, activities and games about teaching the alphabet, phonics, beginning reading, math & more. They have a free newsletter & links to other sites too. [http://mrsalphabet.com](http://mrsalphabet.com)

- **Reading Rockets** - lots of info on helping your child learn to read, including a screening test to help determine if your child is on track for learning how to read. [http://www.readingrockets.org](http://www.readingrockets.org)
Suggestions for FLYING with Toddlers:

Flying was one of the most stressful situations we faced. For those of you with somewhat "unruly" toddlers on your hands &/or those with ear pain (like our 17-month-olds), here are our recommendations:

• Travel (very) early or (rather) late in the day, so that travel lines up with normal sleepiness.
• Kids & one parent do well to board last. Have one of the parents get those car seats on before the kiddos arrive. He/she can come back out to help get the kids on board, if you like. (We always approach the aircraft with our twin stroller & hand that off last, along with any car seats we are unable to use on board.)
• Consider giving Tylenol or Benadryl (or both, I've heard). The Benadryl may not be helpful at all unless given during what is normally a sleepy time for the child. (We tried it for a 5 pm flight & failed rather miserably. Simply Tylenol helped last night, perhaps easing some of the ear pain both our kids sense.) A decongestant (Triaminic) may also work well for ear pressure pain.
• Do whatever you can to get each child in a seat next to you (preferably a car seat), rather than on your lap. We have never bought seats for our kiddos, but we have almost always been given 2 extra seats by watching plane seat availability closely & letting the gate agents & others know that we really wanted those extra seats. This request is made at the time of the reservation & is carried out at the gate, if feasible. We often start with aisle seats for ourselves, & hope to get a free spot next to us. We have convinced the window seaters to switch with us, so we could get our car seats on board. The American Airlines staff permitted us to do this. (They all want everyone's kids in car seats, from what I can tell. But they often don't want to ask folks to move around for a couple of "lap babies", which I certainly understand.)
• Consider getting a window seat for each toddler (these are required with a car seat, typically), so that he/she is "confined" & is less inclined to wander or disrupt life on both sides of the aisle. If you have a car seat, I'd try to get the bulkhead location (so that you have a bit more space to move around, but the child is still confined). Of course, these are only available at the time of travel, & typically only at the gate.
• Carry bags & little containers of things for kids to explore/stick their hands into. Of course, bring lots of items that the kids love. Distraction is key to keeping toddlers from screaming. What a marathon!
• Don’t be afraid to sit many rows apart from your spouse & the other child, if you think you may be "interacting" too much -- & the kiddos may be picking up on each other's stress (& your own). Two on two can be a lot more confusing/complex than one on ones. You can pass things back & forth by walking down the aisle very briefly.
• If your kids are like ours, they experience lots of descent-related ear pain (& some ascent-related discomfort). If they can sleep through much of this, you may be in good shape, as we finally were last night. If they're awake, have bottles of milk (with nipples, if they like that), Cheerios, grapes, & whatever else they adore for the pressure-equilibration. (I'm afraid constant swallowing still doesn't save our kids from some discomfort. But it remains key, if they're awake.)
Note: Vacations can be a great time to introduce changes (e.g., sippy cups instead of bottles, giving up a pacifier, crib to toddler bed).

**Baby & Toddler Shoes:** Robeez-like shoes for just $11/pair [http://stores.ebay.com/Shoes-Zoo](http://stores.ebay.com/Shoes-Zoo). Preschoolian.com shoes (on-line) are terrific & can get 40% discount when have twins & buying two pairs.

**10 Tips for Growing Creative, Capable Kids** (from joywithchildren.com)

- Say "Yes!" to children in as many ways as you can.
- Play with them. It's good for you and them.
- Be authentically yourself. Tell them how you feel.
- Pay attention to what they are feeling.
- Go on fun adventures together!
- Listen to children. They need it, and you will learn much.
- Be clear when you need to say "No".
- Open your heart to loving them. It will nurture both of you.
- Enjoy them as fully as you can. Life and time do not stand still.

Also: Praise them! Read about the Relative Age Effect (in sports & other success stories) below.

**Ezzo & Buckman’s Babywise** has the following recommendations: The family should not become baby-centered; it should remain **family centered**. Do not sacrifice your spousal love & life to attend to the baby with every perceived need that is exhibited. This is not healthy for anyone. Make sure you have time for yourselves. Children do crave & need to know that their parents love one another. As the children get a bit older, this may mean having ~15 minutes of "couch time" where they can see you buy are not allowed to interrupt you as you sit with your partner. Also, do not succumb to a "democratic" approach to your children where they are your equal or friend. You are their parent; they need your leadership & direction and support. You are responsible for their training to become independent individuals. Attachment parenting is overrated; it can create an unhealthy dependence. Your child needs to learn to become independent.

The recently studied **"relative age effect"** is where coaches & family perceive older children (e.g., those born in January or February, when league divisions are formed based on calendar year of birth) as "better" athletically (& intellectually), thus giving such children the advantage of praise & faith in their apparently exceptional abilities. (See, e.g., [http://www.socialproblemindex.ualberta.ca/relage.htm](http://www.socialproblemindex.ualberta.ca/relage.htm).) Evidently, this relative age effect plays out in many areas (e.g., business leadership & suicidality). The moral of the story is that positive support of one's children, by all around them, begets top performances. (In addition, practice makes perfect, and doing something one loves facilitates the hard practice that enables the expert performance.)

**Toddler Tantraums:**
AMOM’er Julie B writes that she sends a child to corner, if she/he is misbehaving. “However, if he/she won't go into the corner, then it’s time for “time out”, in his/her bedroom. If she is screaming, or pitches a fit in public she/he has to go to her/his room. Fighting, they both go into the corner. Not listening - corner. Other than that, we do logical consequences. If they are playing with the toy wrong, we take toy away. Fighting over toy, take toy away. Don't nap - to bed early. Etc. If the logical consequence results in a fit, they go to the corner. I also try to be very sympathetic. We often talk about taking a breath to calm down. I regularly stop Jack as he is about to melt down and walk him through what he needs to say and do. We also talk about better ways to handle things, even when they end up having to go in the corner. If they have hurt someone else (like kicking/fighting) then they have to apologize when they come out of the corner and life goes on as if nothing happened. When Daddy comes home, I only bring up the good things they did. That is not to say that I haven't flown off the handle. When I yell - I put myself in the corner too - if they aren't allowed to do it/say it, neither am I. I also apologize to them when I haven't handled things correctly. (My husband does not apologize to them for yelling, but they seem to manage that just fine.)"

The Value of Consistency:

Consistent Discipline—Never Easy, But Always Worth It!

By Diane Sonntag (elem school teacher)

"Ouch!" I yelled as I tripped over my three-year-old daughter's doll stroller. As I glared at the offending toy, I called, "Julia, you need to come get this stroller and take it into your room." I waited a moment. Nothing. I could hear her playing in her room, so I was sure she'd heard me. I sighed and called again. "Julia, I just tripped over your doll stroller. You need to come and pick it up or I'm going to take it and you won't get it back until tomorrow." Her eyes wide, she darted out of her room and quickly pushed the stroller into her bedroom. "Sorry, Mommy," she said as she went.

Why did she do as I asked promptly and without argument? Because she knew that I meant what I said. I warned her that I was about to take away one of her favorite toys, and she knew that I would follow through. She knew because I had done it before.

Dr. Sal Severe, PhD, author of How to Behave So Your Preschooler Will Too!, says, "You want to build a reputation with your kids that when you say something, you mean it." In other words, be consistent with your discipline.

Why is consistency so important to young children? "Consistency is the glue that sticks together for kids. It teaches them that their behavior has an outcome," says Dr. Severe. They learn the cause and effect relationship: When I act like this, this is what happens.

Good or bad, my behavior produces a result. But when discipline is inconsistent, children do not learn about cause and effect because the effect of their behavior keeps changing. "Inconsistency teaches children to take chances. They think, 'Maybe I'll get away with it this time,'" explains Dr. Severe. When kids do not know what to expect from their parents, it's almost a guarantee that they will test the limits every chance they get.

Many parents use the words "discipline" and "punishment" almost interchangeably. Dr. Severe says that the two are very different. "Discipline is everything we do to teach kids to think for themselves and to make good choices," he says. "Punishment is only one small part of discipline. Punishment lets the child know that they made a bad choice."
"Discipline should focus on the connection between what the child did and how they should feel about their behavior," says Dr. Severe. When your child behaves well, you should say something like, "You shared your toys with your brother. That was so nice of you. You should feel very proud of yourself!" When your child does something wrong, say, "I'm sorry you hit your sister. We use nice touches in our house. Now you have to go to time-out. I hope you'll make a different choice next time."
Dr. Severe says, "Consistency is the foundation of good discipline. It is part of everything we do with kids." So how do we ensure that we are disciplining consistently? Follow these tips from Dr. Severe.

Practice proactive parenting.
Proactive parenting means trying to prevent misbehavior in the first place. "Tell your child ahead of time about the expectations," says Dr. Severe. It is easier to let your child know up front how you want him to behave than to deal with misbehavior later. Dr. Severe calls this the "Smokey the Bear Philosophy." It is easier to prevent forest fires than to put them out.

But be reactive, too.
Reactive parenting means handling the misconduct as it is happening. "How you handle misbehavior will determine whether or not it will happen again in the future," says Dr. Severe. Having a consistent and immediate consequence to a child's misbehavior will go a long way toward extinguishing that behavior.

Develop behavior cues with your child.
"Give your child an indicator that now is the time they need to behave," says Dr. Severe. Many parents count as a warning to their children. The kids know that they better be doing the right thing by the time Mom says "three." Dr. Severe also encourages parents to give their child one warning and then a moment to think about their choice. Saying, "I hope you make the right choice" can act as a cue to your child that the wrong choice will have a consequence. But one warning is all it should take, cautions Dr. Severe. Any more than that, and your child will realize that you don't really mean what you say.
Another effective behavior cue is asking your child a question. In his book, Dr. Severe describes how a parent should handle interruptions when he or she is on the telephone. Calmly say to the child, "What's on my ear?" This question acts as a reminder to the child that Mom or Dad is on the phone and he should wait a few minutes. Other questions that can act as behavior cues are "What is our rule about that?" or "What did I ask you to do?" One that works well for me is "Who is the boss at our house?" My children know the right answer is "Mommy and Daddy," and saying it acts as a reminder that they need to do as we ask.

Focus on the positive.
Every time you comment on your child's behavior, you are encouraging him to repeat that behavior. If your child picks up his toys and you thank him for being helpful, he is much more likely to be helpful in the future. You are teaching him good behavior just by paying him a compliment. Be sure to catch your kids being good!

Let your child know what matters most to you.
Explain to your child that it is your job as her parent to teach her how to behave. Tell her that you love her and you want only the best for her, and part of that is learning good behavior. If your child throws a kicking-and-screaming temper tantrum at the supermarket, leave the store immediately.

Dr. Severe says, "Let kids know that their behavior is more important than anything else. Tell him, 'My job is to teach you how to behave. I can finish the shopping later. You are my job.'" This tells your child that you love him, but also that you take his misbehavior very seriously.

Be aware of your mood—and your child's. Being consistent with discipline can be challenging even on a good day. On a bad day, it can be downright difficult. When you've had a hard day and you know that your tolerance level is not at its best, remember that disciplining based on your mood can be very confusing to children. Try to keep the basic rules the same, no matter how you are feeling at the time. Also, consider your child's mood. "Kids accept your guidance more readily on good days," says Dr. Severe.

Remember to let your kids be kids. Dr. Severe says, "The biggest mistake parents make is to punish the annoying, attention-getting things, rather than just the deliberate misconduct." Many preschool behaviors, while annoying to us as adults, are not actual misbehavior, but just a three-year-old being three. Talking incessantly, being messy, and not sitting still are behaviors that might fall into this category.

Reward your children when they make good choices. A popular saying at my house is, "When you act good, good things happen." My children understand that good behavior will often be rewarded in some way. Being cooperative at the grocery store means that they'll get to choose what cereal we buy on that trip. Being polite during a meal in a restaurant will usually earn them dessert or an extra book at bedtime that night. On the other hand, misbehavior will result in a time-out or the loss of a privilege. My kids know that their behavior determines what happens to them. Through their behavior, they choose either a reward or a consequence, and they are learning to choose their destiny wisely.

POTTY TRAINING
50% of children around world are trained by 1 year of age; convenience & affordability of disposable diapers makes this age much higher in the U.S. (NYTimes 5/4/04) NYTimes Jane Brody & Dr. James Schmitt recommend the following: PREPARE the child. Don't hit them cold with training. Start talking about pee & poop by 18 months, praising the child for using the diaper & having him/her request to get it change, so that he/she learns to prefer dry over wet. At 21 months, start talking about the potty & toilet. Encourage them to sit on potty while clothed, reading stories & such. At age 2, read potty training books & watch videos, have child put a doll or toy on the potty & buy some special underwear, introducing it as a privilege. Praise successful deposits in the potty & try to recognize signals for elimination, saying “the poop/pee wants to come out; let’s find the potty.” Definitely let them run around without clothes from the waist down for a week, if you can. Go outside & let them try to eliminate into little cans or potties. Allow the children to learn by trial and error – on her/his own, refraining from
reminders & practice runs. Easily stretched elastic waist clothes will also be key after the first week. Avoid overdoing reminders, since they antagonize a toddler & result in a power struggle.

See, for example: http://www.pottytrainingconcepts.com/

Many children are “ready” for potty-training at 18 months (& many of us began our training at that age), but it’s hard to do. Thus, it seems most parents are now waiting until 30 months or so, when the child is clearly ready so training is easier (& faster).

Many AMOM’ers have had problems getting a kid to stick with the toilet for pooping. They won out eventually by making the child go back to diapers, offering chocolate as prize. They recommend positive reinforcement (sticker charts, potty parties) & making sure the child doesn’t have a constipation problem before they start the training. One recommended waiting until 3 years of age, to make it so much easier. To make sure it’s not painful (which can make them stop pooping for ~3 days!), you can try to increase their fiber (e.g., apples, pears, prescription Miralax). Kids should poop every day; try to find the same time. If their stomach starts looking big, they’ve got a big poop coming. There’s a potty-related video by Bear in the Big Blue House. Some kids really like the book Once Upon A Potty, & there is a popular Sesame Street book called No More Diapers. Can bring potty chair in the car, to make sure you catch the opportunity (& just line it with a holeless trash bag, to clean quickly). Charts for kids to use with Potty training, chorese, etc.: http://www.dltk-cards.com/chart/

Potty training is much easier the longer you wait. Sometime between 2 & 3 years of age, they’ll (probably) show they’re ready. They should have dry nighttimes by the time they are 3.5 years old. (APT)

AMOMer Joanna B writes “We did the chart thing after a while of just getting used to the potty and the whole routine. We watched potty videos, sat on their potties in the living room while watching the videos, and read potty books. This is when they did most of their trying as opposed to producing. We used lavish praise for trying (but no rewards, to avoid confusion). We started with stickers for going pee, flushing, washing hands. This was in a chart in the back of their potty book It's Potty Time. When that chart was filled we made our own charts on paper. When Bella was pretty much using the potty all the time, she started withholding her bm's. That's when we started giving m&m's for pooping on the potty. This was a big thing because they really had not had a lot of candy before then.”

Potty training can take a year (!), but many people find their kids pick it up within a few weeks (at least daytime pottyng; nighttime takes longer). Some parents never let them wet the ground, but the fastest way is to make sure they know what they’re doing is by letting them sense it regularly – by seeing it (e.g., naked outside every day for a week) &/or feeling it (with Gerber padded panties or Feel & Learn diapers). Of course, absorbent diapers hamper this & delay training (but keep floors pee free ;-) ). Some parents put their kids on the potty every hour for 5 to 10 minutes. Some really try to guess their pee schedule. It can be very helpful to have good books by the potty, an incentive (e.g., a cracker for when they sit down or pee) & an older child regularly showing them what to do. In terms of videos, an AMOM’ers friend recommended "It's Potty Time”, while "I Can Go Potty” looks like it has a real kid on a real potty. Videos can be very helpful for visual learners. Rewards are important. “Kandoo wipes” are great for kids cleaning themselves. Boys will often verbalize that they are peeing/pooping, well before girls; but it is the girls who tend to train much earlier (even a year ahead of their twin brothers).
AMOMer Debra M, mother of 14, suggests that waiting until 3 years old or so is just fine. Child-initiated pottying is completely different from having to ask the child every 30 minutes about his/her need to potty (or every 60 minutes, once they get a bit older). After trying to train for 3 weeks at age 18 months, I tend to agree: a parent's having to always ask & schedule activities around a child's potty use (as Johanne Cesar suggests) is not "being trained". Until a set of psychologists tells me that we are hampering our children's development, holding off sounds very reasonable. Debra never used potty chairs (since she’d much prefer to change a diaper than a potty chair). Only her 2nd son trained early (at 2.5 years old); others were at least 3. Debra writes: “I think potty training is teaching the kids to use the potty, not us watching body language, taking them every 30 minutes, or always asking them "do you need to go potty?", in essence, training yourself to clue in to their body language and then acting on it. I have seen other friends teach pottying, and they were actually very annoying to be around, because they didn't let the kids alone about it. The children turned a deaf ear to the parent and the parent got frustrated, and things just went downhill. I think if you start too early, it is a source of frustration for both kids and parents. I do, on the other hand, recognize that 3+ is on the late end, but it is very matter of fact at that time. The kid is logical, they know how it happens, how to not make it happen, etc., and can hold it if necessary. They tell me when they have to go potty, I don't ask past the 3 weeks. They are usually sick of us asking by then! We always attach an end reward, a trip to the store, a special toy, etc. when they can go to the potty by themselves. Night wetting will be an issue for at least another year or so, if he continues as my other sons have.” When our mothers were raising us, they did not leave the house & it was relatively easy to get a child to a potty regularly. It doesn’t make much sense in today’s activity-filled schedules. “At any rate, even if you wait a few months and try again if you think they are ready, it's all fresh again to them. Sometimes a break helps them focus when you retry again.”

AMOMer Julie B did not research potty-training but noticed a lot of interest at age 18 months (as have other AMOMers). But it wasn’t until 2.5 years of age that she started setting them down in the evenings, after their daily bath & right before bedtime, for them to produce. She gives them only the choice of the location: One child would choose the potty & the other the toilet. They don’t get liquids after dinnertime. Her daughter will sometimes strip off & pee during the daytime, for which she gets stickers & other rewards. She tells them how they must have a diaper on if they are on the carpet, & how they shouldn’t pee/poop in their pull-ups, but it’s okay if they do.

Another AMOMer’s (Patty T’s) son trained almost 9 months before his twin sister (at 2 years of age). He loved reading books on his potty & actually poop-trained before pee-training. It became a bit of a battle with her daughter & one day she exploded yelling after an accident. This is what finally got her daughter to train, oddly enough. But her daughter did night-train earlier than her son. Potty videos & books really seemed to help with her son.

Another AMOMer suggested that many of her friends have found that 3 is the “magic age” for boys.

See [http://www.thepottytrainer.com/minicourse/lessons.html](http://www.thepottytrainer.com/minicourse/lessons.html) for several of Johanne’s insights into training. Key insights: (1) You can start before age 2; kids are much smarter than we give them credit for. (2) Be consistent. This is the number one reason parents fail at training. Consistency in language used for using the potty, expectations about potty time, timing sleep & wake periods, other life activities. (3) You are the boss; show them tough love, & they will respond. (4) There will be accidents. Do not allow these to become regressions in training (which take longer to overcome). Avoid the situations that prompt accidents, in order to avoid regressions.

Key Tips from Johanne Cesar’s FAQ:
1. Training can very well begin training before age 2 (but the author waits until exactly 2 years old with her boys). Kids are definitely smart enough, even if they cannot talk about it. The average girl can be well trained by 20 months, but the average boy typically can't be fully trained before 24 months. (Note: The author has trained over 300 kids & her rule of thumb is to start training at 24 months, their 2nd birthday.) Start before age 2.5, when children can become quite negative & emotional about training.
2. Setting a timer for every 20 to 30 minutes & placing them on the potty as a *celebration* of the timer's going off can be very effective. (You can blow whistles & noisemakers as part of the celebration! :-) ) It has to be frequent. Otherwise, accidents will happen.
3. Only 1 to 3 minutes of potty time at first. One doesn't want them to resent it.
4. No diapers & no training pants while kids are awake.
5. Everyone (including grandparents :-) ) should be using the same language. Pee-pee (written as "pi-pi" in Spanish) should be distinct from poo-poo (po-po in Spanish). The toilets should be called "potties". Don’t confuse the child; don’t add new terms, & don’t say “potty” when you really mean “pee” (or “poo”). Potty is the object they sit on, but pee & poo are what they do. (They do not “go potty”.)
6. We will get frustrated with the kids. Have a plan ready for how to handle that stress when it arrives (e.g., singing a tune, getting a cup of water, closing one's eyes & breathing deeply a couple times).
7. It's best to get the kids used to the potty in a non-threatening environment, weeks before actually starting potty training. If they balk at the potty, perhaps use a different word & activity (e.g., "let's watch TeleTubbies" on the TV & then sit them on their potties, so they get used to it).
8. Do not limit fluids during the day. (In fact, more fluids can be helpful in the process.) But do limit fluids before bedtime if you are wanting them to wake up dry (which is part of potty training).
9. Of course, always be very upbeat -- especially about time to sit on the potty.
10. Do not wait for children to come tell you that they have to pee. By then it is probably too late, since children tend to wait until it's urgent. Get them to go to the potty at specific times, in advance of being in an urgent situation. The goal is that they wait until it's time. They get used to using the potty proactively, rather than reactively. Even 6 year olds still have to be reminded to take bathroom breaks when they are playing.
11. Training on the regular toilet, without an insert, is simpler in the long run. But, if you have the room & time to deal with a potty &/or toilet insert, than you can do that. But don't be afraid to train on the big toilet.
12. Show them your use of the toilet whenever you can, & put their potty next to yours so you can use them together.
13. If a child is refusing to train, you can try to make him/her clean out his/her own underwear, which they usually dislike very much. This is usually sufficient incentive.
15. If a child is averse to pooping, take him to pee (don't use the word poop) & he'll have a very hard time avoiding the pooping while he's there.
16. Boys should sit down because so many have lousy aim, even as adults (!). (Moreover, they pay poop at the same time, which is very tough to clean up.) I find this hard to believe, but I guess we'll have to see how Braden develops his aim. ;-
17. What are signs that a child has to go? Standing still & quiet, holding him/herself, hiding in a corner, squeezing their legs together, shifting weight fast, talking & breathing fast.
18. When you go out, be sure you know where the bathrooms are. Go to the bathroom at the start of the visit. And avoid liquids for a full hour before your activity begins. Have a child eat first & then drink so that the food absorbs some of the liquid.

Johanne’s Example Lesson 1 of 5 - September 12, 2005

In today's lesson, I am covering what I believe to be the biggest mistake a parent can make when it comes to potty training: waiting too long. Some people believe they should wait to start potty training until the child tells them or gives signs of readiness. Most psychologists and members of the medical field come from this school of thought. Remember, these are the same people that believe you should never say no to a child. As a parent, you know how unrealistic that is. There is a specific day you should begin potty training, which I reveal on page 32 of my book, "Potty Training Made Easy, Simple & Fast." If you have not gotten your copy yet make sure you click on this link and get it today.

You don’t have to force the child to use the potty when they are not physically ready. In the book we discuss the sphincter muscles and what roles they play in your child’s ability to use the potty. Even though they might not immediately start using it, it is perfectly okay to introduce the potty early so your child gets used to it. If you are making an early introduction to the potty, however, remember to not force your child to go. This could backfire. You can get a few techniques on how to properly do this in the book.

Things are no different for you than they are for your child. Think of the last time you decided to do something new. Did you wait until you knew how to do this activity already, or did you get started and learn as you went along? I would think you got started and learned as you went along. Think about this: by the time your child tells you they want to go potty, they are already potty trained. Why would they want you to potty train them at this point? They already know how.

Now, I am not a psychologist so I can’t give you all the psychological positives or negatives for waiting. I am, however, a parent of three and I can give you the financial benefits of having a fully potty trained child. Between diapers and clothes I’ve thrown away, I would say the
monthly cost of not being potty trained is $150. So this is how much you’d save each and every month by having your child potty trained as early as possible and not waiting.

Study Up On Potty Training (from http://www.pull-ups.com/na/wtg/articles/start/special/suopt.asp): What's "normal" when it comes to potty training? Should it take a month? A year? Key Findings of a major survey (300 kids for many, many weeks): Every child progresses at his/her own pace. Potty training takes an average of 8 months. The average age for completion is 34 months for girls and 37.5 months for boys. The typical age for the start of potty training is 24 months. Switching back into diapers after you have moved to training pants may actually slow potty training progress. When it comes to success, things like temperament, development, use of daycare, previous toilet training experience or having an older sibling around actually have no impact on progress.

The study found techniques that are not effective: Making your child sit on the potty for long periods of time  Use of force, spanking; Running water while seated on the toilet or potty

Readiness: This is the time to start teaching potty training basics, checking for interest and creating it with potty training books or videos. This is the perfect time to take your child on a shopping trip for potty training tools. (Average age: 24-27 months)

Routine Building Once your child shows two or more signs of readiness, begin coaching your child with familiar potty routines. Moving your child out of diapers is an important step in this stage.

Routines include:  Reminders to go to the potty  A trip to the toilet at certain times  Rewarding successes. (Average age: 27-30 months)

Completion Encourage independence by teaching skills such as wiping and hand washing. At this stage, your child begins to remember to go potty on his or her own. (Average age: 30-36 months)

Reminders + Praise = Key

Transitioning from cribs to toddler beds: These means kids can get out, and they do. Multiples sharing a room will play with one another (hiding in closet to keep the noise down, so you’re unaware). The novelty will wear off after a month or so; with consistent discipline (e.g., removing a toy or cutting out dessert each time they get out of bed, & if they don’t nap having them go to bed right after dinner to make up for the lost sleep time), you can have them napping & sleeping again (or at least enjoying “quiet time”). Try keeping toys out of their room as well. (Just allow books, for example.) Most AMOMers seem to transition their kids to toddler beds at age 3. Most say WAIT as long as you possibly can! (You will lose tons of sleep trying to get the kids to stay in their beds.) Door knob covers may be needed to stop kids from leaving their rooms; for lever-type door knobs, you may be able to use those at http://www.onestepahead.com/product/67184/207756/117.html (but they require a visible screw hole).

At 18 months of age, kids tend to be quite negative, and again at 2.5 years of age. (They say “no” a lot, have nightmares, perform tantrums & act clingy.) (APT)
Nightmares: AMOMer Susan A recommends ‘pulling out "magic sprinkle dust" from my pocket and give it to her to put into her pocket (actually, the pretend pocket in her pj's). We'd also sprinkle it all around her bed. I told her if she had a bad dream in the middle of the night, that she should simply pull out the magic sprinkle dust and throw it on the scary monster/thing and tell it to go away. For some reason, she seemed to buy into this and it comforted her. I think it gave her some sort of control over the scary things in her dreams.’ Most AMOM’ers recommend being nice to the child, and re-tucking him/her in quickly. But at least a couple have had the “stern” dad-goes-in-and-tells-the-child-that-he/she-must-go-back-to-sleep approach work fine, after a few nights. Debra M suggests that mom is the one they want until age 3 or 4 (& then it may be only dad they want) & that putting a stuffed animal as a “sentry” in the crib (& a night light) can help. A sticker chart for staying in bed all night (much like potty training) can help a great deal too.

Hair cuts: First haircuts can be a bit traumatic (esp. for boys, who get these at a younger age). You can do this at home, while child is watching a video. (AMOM)

Napping: Typically 2 naps/day till ~15-18 months old & then phase out the midmorning nap. (APT) AMOMer Julie B types the following from Dr. Weissbluth’s Healthy Sleep Habits Happy Child book: If a child misses a nap one day (due to a special event, for example), may need re-training. The more rested the child is, the quicker you'll see improvement. A very tired child might require several days of training before he/she relearns how to nap. “Between 22-36 months, most children still need to nap. The average amount of daytime sleep at 36 months is about 2 hours. But there is much individual variation; the range is from 1 - 3 1/2 hours. If your child is at either extreme of this range, ask whether he/she appears well rested at all times. The majority (80%) of children between the ages of 2 and 3 years have a nap length in a narrower band, between 1 1/2 & 2 hours. The model nap duration is 2 hours between 2 and 6 years. The stability of the 2 hour nap over different ages is another argument for a strong biological influence over sleep, but it does not necessarily mean that your child needs a 2-hour nap. Some children need less and some need more daytime sleep.” Julie B feels that it’s harder to put a tired child to bed, so she preferred an earlier bed time, because the children were much more docile then. And they seemed to sleep in later that way. Various AMOMers say to stick to your guns – hang in there, and the child will learn that you mean business & follow your lead. Some have let their kids give up naps at age 3 (because they weren’t falling asleep at night for an hour or so).

Phase toys in & out, on a rotation, quietly, so that they think they’re new. You can give them brushes & water to “paint” the sidewalk, and big cardboard boxes to make houses with. (APT)

Learning to read: An AMOMer writes that she has heard a lot of homeschoolers recommend the book "Teach Your Child to Read in 100 Easy Lessons." The lessons are short, like 20 minutes a day. Here is their website: http://www.startreading.com/. Another one she has heard recommended is Phonics Pathways: http://www.dorbooks.com/phonics.html. Others mentioned www.starfall.com & http://www.literacycenter.net/lessonview_en.htm#.

American Way mag. article suggests that parents should play word games with children. These include (1) giving 2 simple words that rhyme or start with the same sound & asking child to do
the same, (2) saying a compound word [e.g., seashell] & asking child to repeat back without one
of the words, (3) saying a word one sound at a time [e.g., c/a/t] & ask child to say back “fast”
[cat], open book, (4) having a child point to “things that can be read” on each page [i.e. words].

Educational DVD recommendations by AMOM’ers: One can get the DVD package of bott.
Letter Factory and Word Factory at Sam's Club for $15 or Walmart sells them individually for
$10 each. The Richard Scarry ABC Video is great too. And there is a Richard Scarry
Number/Counting Video.

**Toddler Eating**

AMOM’ers find that one can get children to eat almost anything by letting them use toothpicks.
“They also like to eat more if it's in a fun shape or design (use cookie cutters on a turkey
sandwich, or make a smiley face on pizza out of veggies). We call broccoli "trees", and when we
have dinosaur-shaped pasta I mix in different veggies and cheese, and tell them "the dinosaurs in
your tummy need something green to eat - they like trees - feed them a broccoli tree" and these
silly kinds of games work sometimes.” For added protein, one can always try adding a soy
protein powder to various foods. (Wait on peanut butter until after age 3 if there is an allergy
history in the family (doesn't necessarily have to be a peanut allergy, just allergy). Also, beans
plus a carbohydrate.”

Dips are also a big favorite with toddlers. Make sure toddlers eat 5+ servings of fruits & veggies
per day. Baked sweet-potato fries & veggies with dip are good. Keep portion sizes small to help
avoid obesity. A good rule of thum is 1 Tbl of each food for each year of age. 3 meals & 2
snacks/day, 3 to 4 hrs apart. (AB)

Avoiding obesity: A child who grazes throughout the day can lose the ability to sense real
hunger. May need to expose to a new food 15 times before accepting it. In terms of juice, 1 4-6
oz serving/day is plenty for kids under age 3. Allow plenty of active play time (rather than just
stroller time), minimize TV time, & get a pet. (AB)

*Toddler snack* from Farrar S: 1/4 c vegetable oil 1/2 c applesauce 1 c sugar 1.5 c flour (wheat is
fine) 1 tsp baking soda 1 tsp baking powder 1 tsp cinnamon 1/2 tsp salt 2 eggs 1 c grated raw
carrots. Mix 1st 9 ingredients in large bowl. Fold in carrots. Pour into greased 9x5x3 loaf pan
and bake at 350 for 50-60 minutes. Let cool 5 minutes before removing from pan.

**Starting School & Separating Twins:**

http://www.apples4theteacher.com/resources/modules.php?op=modload&name=News&file=article&sid=74
& http://www.twinsmagazine.com/schooldays/preschool.shtml

**Toddler Activity Ideas:**

http://www.twinslist.org/toddler.htm & http://www-
personal.engin.umich.edu/~ajdrake/toddler/open.htm

**Sites for children learning Spanish:**
Miscellaneous Topics:

Returning to Work: Developmentally, 10-15 months is the WORST time b/c the kids are taking some major steps towards independence. At preschool age is best, next best is BEFORE 6 months, or even 3 months, so that they can form good bonds with a caregiver. (JOT)

Finances & Injury: Get a durable Power of Attorney for spouse to make decisions in case you’re incapacitated, to avoid having to determine guardian in court. Leave 3 times household’s monthly expenses to newborn, in case something happens to parents. Write will via www.nolo.com + attorney if needed. Consider putting some money into a tax-free state-sponsored section 529 plan for college (after making sure your retirement is adequately covered). (BT)

Oral contraceptives not only protect from pelvic infections & reduce rates of ovarian cancer & anemia, they also protect against endometriosis (which can delay &/or stall pregnancy). (BT)


Diaper wipes recipe (has worked great for several AMOM’ers):
Use a pop on lid Rubbermaid 12 cup round container. (the bottom says 12 cup). Use Bounty select a size roll paper towels. (I've used the multi pack but the rolls are smaller so the wipes are too wet it seems.) Cut the roll in half with very sharp knife (or electric knife, if you have one). Place the 1/2 roll cut side down in container. Mix together 2 cups warm water, 2 T baby oil and 2 T Johnson's baby bath moisturizing (yellow container with green pump top). Stir and slowly pour over paper towels from the center out. Once wet, pull out inside frame and the first towel will follow.

Stain removal: http://www.textileaffairs.com/stains.htm & http://www.ianr.unl.edu/pubs/textiles/g922.htm. For red carpet stains and grape juice stains, try Oxyclean! Poop, like formula & milk, is protein-based & will turn brown. Thus, again: Don’t use hot water. Instead, scrape, soak in lukewarm water mixed with liquid detergent & 1 tsp of ammonia. After ~20 minutes, douse in an enzyme pre-soak solution like Biz until ready to put in laundry. If you’re not at home when poop happens, pre-treat with a stain stick & soak when get home. Urine should be rinsed & then items put in the washer. On the carpet or couch, use a cup of vinegar in a cup of lukewarm water to fight it. Ink: turn stain side down on to paper towel & encircle opposite side with rubbing alcohol & then directly on the stain. Crayons: On the wall, soften with a hair dryer on low setting, spritz with all purpose cleaner or WD40 (!) & wipe off with a rag. On clothing, Crayola recommends WD40 again, wiping off with a cloth, & then washing. (BT) (see Crayola.com site: Place the stained surface down on pad of paper towels, spray with WD-40, let stand a few minutes, turn fabric over and spray the other side. Apply
liquid dishwashing detergent and work into the stained area, replacing towelling as it absorbs the stain. Wash in hot water with laundry detergent and bleach for about 12 minutes (use heavy soiled setting if there is no minute timer on your machine) and rinse in warm water. To clean the drum of your dryer to remove any remaining wax residue. Spray a soft cloth with WD-40, and wipe the drum. Run a load of dry rags through a drying cycle to ensure that your drum is clean.) Note: AMOMer Julie B loves the washable crayons that are out there now.

For Ballpoint pen on leather: Kristi H writes “I use straight rubbing alcohol on a cotton ball to remove a ball point pen "art" from my leather recliner and couch. Just don't rub to much or the color of the leather WILL start to fade out!” (Joanna B writes that neither hair spray nor rubbing alcohol helped her.)

Note: KK recommends simply soaking items after they get dirtied (in regular water, is fine), & then spraying on Spray & Wash 10+ minutes before throwing into the washer. Also, for tough food stains (e.g., berries), a dish detergent (e.g., Cascade) can help a lot more than more traditional anti-stain devices. If the stain doesn’t come out, allow item to air dry & try again on next washing round.


Mosquitos: Most people really love AVON’s Skin So Soft (no DEET & quite safe). Julia T writes “The Skin-So-Soft didn't work as well for anyone in my family as the garlic pills do.” Don’t use fabric softeners (as anti-mosquito skin wipes or even for laundry); they are quite toxic. “Mosquito Magnet” machines cost ~$300 & should be run 24/7 but seem to work well; the problem is that they require one burn propane non-stop, which is not a totally innocuous substance. The CDC seems to be a big fan of <10% DEET sprays, but Elizabeth P-G & others won’t let their kids wear any DEET. (But don’t spray it directly on them. Spray your hand & rub on them, even just their clothing.) Letting kids get bitten is also probably quite safe. The West Nile virus & such are very rare, and do not kill hardly anyone. A combo of essential oils at Whole Foods etc. (e.g., [http://www.buzzoff.us/home.asp](http://www.buzzoff.us/home.asp)) seems to work all right, but smells big time (much like a DEET spray) & you’ll feel like you need to wash it off after coming indoors.

KIDS EAT FREE LOCATIONS IN AUSTIN:
Mondays
Margaritas – kids eat free all day
Hangtown Grill – kids eat free all day
Gattiland – moms eat free
TGI Friday’s – kids eat free and get free animal balloons
Texadelphia South – kids eat free
Zuzu – kids free after 6:00 p.m.

Tuesday
Central Market – kids eat, with purchase of adult entrée
Spaghetti Warehouse – kids eat free at night
Fazoli’s – kids eat for $0.99 from 5:00 – 8:00 p.m.
Kerbey Lane – kids eat free all day
Denny's – kids eat free from 4:00 – 10:00 p.m.
Chick-fil-A – kids eat free after 5:00 p.m.
Bennigan’s – kids eat free after 5:00 p.m.
Zuzu – kids eat free after 6:00 p.m.
Wednesday
Luby's – kids eat free after 4:30 p.m.
EZ's – kids eat free all day
Moe's Southwest Grill – kids eat free after 5:00 p.m.
Central Market – kids eat free after 5:00 p.m.
Zen – kids eat free after 5:00 p.m.

Saturday
Luby's – kids eat free all day
Texas Land & Cattle – kids eat free from 11:00 a.m. – 4:00 p.m.

Sunday
Souper Salad – kids aged 3-5 eat for $0.50; kids aged 6-12 eat for $0.99
Zen – kids eat free all day
Texadelphia – kids eat free at certain locations

All Week
IHOP – all kids eat free from 4:00 – 10:00 p.m.
Cici’s Pizza – kids under 3 eat free
Fresh Choice – kids aged 2 and under eat free; kids aged 3-5 eat for $.99; kids aged 6-8 eat for $2.99
Denny's – kids eat free on their birthday
Pizza Hut's lunch buffet – kids eat free
Applebee's – kids eat free with all As on their report card

GETTING PREGNANT
Ovulation typically 14 day before next period. LH surge ~12 hr before ovulation.
Use of Ovulation Kits to predict cycle: AMOM’ers recommend the ClearBlue Easy or First Response (which is expensive). One gal writes that she used the Answer (inexpensive) once and missed a cycle because of a false read.

Also, make sure you are taking them when you wake up. My doc told me that you do not want to have consumed massive amounts of water prior to taking the test or you could dilute the results.
The vagina leads to the cervix, which only opens during ovulation (to let sperm in!) and at birth. (Blood escapes at other times.) (O&M)
Orgasms may help sperm travel. And cough expectorants (taken midcycle) can thin overly-thick mucus in the cervix, helping sperm navigate. (O&M)
Men need good nutrition & exercise too. Reduce caffeine (except before intercourse, when it can help sperm travel).

2+ years in between pregnancies/children is best, for the mother’s & child’s nutritional needs to be met. (GPSP)
Cell requires 46 chromosomes: 23 from mom & 23 from dad.
Women born with ~500,000 eggs. Ripest/best are released earlier; a woman in her 30s & 40s is left with the least viable eggs. (AB)

The reason your doctor recommended making love every other day is because it takes about 48 hours for the sperm count to build up to their most fertile levels. The more sperm, the higher the chance for conception. You want the highest count of the most mature sperm to maximize the chances of fertilization.
Sperm: 600 M sperm/avg ejaculate (BT says 350 M, & GPSP says only 60 M!), but only 200 sperm make it to the average egg!! These sperm are good for up to 3 days (up to 5 days, sometimes, says BT). It requires ~1-2 to replace the released sperm. Boxers or briefs are fine; there's no effect on sperm temperature due to underwear type. (O&M) Grogoro suggested loose underwear & father cutting back on caffeine.

IVF & Freezing: Eggs are far more fragile than embryos, so usually don’t freeze those. (O&M)

Miscarriage
15% of births are miscarried at ages < 35, 22% if < 40. Fewer than 1% of methods have 2 successive miscarriages. A first trimester spontaneous miscarriage is typically due to a non-viable fetus. One can wait a couple cycles & try again. (O&M) Recurring miscarriages can be a symptom of an immune system issue, according to maverick & beloved (and now deceased) Dr. Alan Beer (http://www.repro-med.net/). Immune therapy can include things like Baby Aspirin, Lovenox, Heparin, & IVIG (according to AMOM’er Raji R.).

30% of pregnancies miscarry. (!) (PP) 15-20% miscarry. (GPSP)
½ of first-trimester miscarriages = due to chromosomal abnormality. (YPA30)
Ectopic pregnancies are caught by a 5-8 week ultrasound, which is good. (O&M)
Infections = a problem with pregnant women & may lead to miscarriage. These occur in the urinary tract, & can be reduced by increasing one’s acidity, via Vitamin C supplements & cranberry juice + lots of water + frequent urination + cotton underpants & washing up after sex + urinating regularly, or when needed, rather than waiting. (GPSP)
25-50% of women spot at some point during their pregnancy, often between weeks 9 & 12. Call your physician &, if this happens in the last 20 weeks of pregnancy, go to an emergency room. (GPSP)
D&C = dilation & cutterage, performed after miscarriage (if not all placenta removed, in first-trimester abortion). (GPSP)
Still birth = after ~4 months of pregnancy. (ok?) Neonatal death = within 4 weeks of birth, & often occurs because lungs are not strong enough. (GPSP)
The chance of a miscarriage happening in any pregnancy is about 15%. The majority of miscarriages are caused by the sperm and egg failing to join together properly. If you study the genetic makeup of most fetuses that are miscarried, they are abnormal. The good news is that if one suffers a miscarriage, the odds are the same 15% of suffering a miscarriage in the second pregnancy. And even if a woman has gone through three miscarriages, the odds are 75% that she will carry a healthy pregnancy on the fourth attempt.

Some Terminology:
Embryo = implanted fertilized egg in lining, until 8 weeks (PP) 10 weeks (YP)
Embryonic period = most important in many ways, b/c most can go wrong developmentally then. (YP) = first 10 weeks
Fetus = after 8 weeks of gestation (PP)
Newborn = 1st month postpartum (BT)
MISCELLANEOUS TOPICS

Shopping for Kids:

Austin Consignment Stores:

Bright Kids (2501 W Parmer Lane, near HEB) brand-new one; supposed to be very good (Melissa Heiner)

Between Friends – Mesa (between Spicewood Springs & Shoal Creek) – bit overpriced on clothing (not so much on equipment), but great shape (Melissa Heiner)

Rock-a-Bye Baby: off of 183 & Braker (west side of 183, near HEB & north of McD’s) – best prices & do get cribs & dressers (also can be put on a “wish list” for large items that may come in later) (Melissa Heiner)

Pumpkin Patch – Anderson Lane & Burnet, clothing seems too worn, but can sometimes get good equipment (Melissa Heiner)

Preemie Lending Closet by AMOM: When needed, borrow preemie clothes from & return to Windflower Waters 258-3042, groups@planetography.com. Best place to buy preemie clothes is “Miniwear” at Babies R Us, hanging in bags of 3 per package. Usually at home (esp Tues & Thurs), working, Oak Knoll & 183: 7407 Attar Cove (183N, L on Oak Knoll, past Jollyville Rd, then take 4th right turn = Woodcrest (but hard to see sign); ~1/2 mile as road changes name & on left 1 block before end is Attar Cove, very back of the cul de sac.

AMOM – twice yearly sale (October & April, Friday night for members & Sat. morning for public), lots of twin used items.

Nursing Pillow for Twins: NurseEz Twin Pillos $44 (buckles around waist, at www.twinconnection.com). One AMOM writes “I highly recommend the pillow from www.doubleblessings.com. It has a big surface area tilted toward you, holding the babies in position and leaving your hands free to read or eat or whatever.”

Austin Discount Diapers: 821-3342, free delivery of size 1 (5-12 lbs) $24/150 & $40/300, vs. size 2 (8-14 lbs) $24/130 & $40/260, etc. (brand-name diapers, evidently?) [Note: Costco seems to have 228 Huggies diapers for $25 (size 1-2) & 128 for $25 (size 3), though not free delivery.]

Austin Donations of baby gear: “Marywood is a great program that houses and works with pregnant women. They are located at 24th street a block down from Guadalupe.”

Twin Stroller Recommendations (from AMOMers & friends):

Definitely will need umbrella strollers; these are great.

Can’t use jogging stroller until after 3 months or more, when babies able to control necks. So hold off on buying this a bit. Also, you may choose to run when someone else has the baby, & just walk with the babies. So you may not really need a jogging stroller that badly. You also could run with someone else, & get two single jog strollers.

Jog strollers rarely fit in vehicles (or stores), even SUVs, & typically need to take off front wheel to do this. (So hopefully that comes off easily.) Some people use a bike rack on the back of their car to carry these places. The Schwinn Safari TT double jogger is great (& rare), b/c it has a front wheel that either locks or swivels (& telescoping handle, for tall dads). The wheel mechanism is very important/helpful. Also important are big wheels – 20”, if you can get it (to make pushing so much easier, even up hills).
Julie Ballengee has a Kelty brand, & the handles are high for her husband. “Outside of being very wide (we have to fold it down to get it through our doorways) it is awesome. It is very easy to take the wheels off and to fold up to put in the car. If we weren't in an apt, I wouldn't mind how wide it is either.” AMOMer Jenny Dingler-Brown got the Dreamer Design Ditto and absolutely loves it. She purchased it over the web from www.bicycle-source.com and they put it all together. All one has to do is snap on the wheels. It's like pushing air, very smooth.

Many AMOMers love their inline (Graco) Duogliders, with snappable bases. But these cannot be used on hike/bike trails & wheels may wobble when walking fast on the road. (KK has used hers jogging on paved roads, however, without incident.) They have stadium seating, so back kid can still see, generally. The Eddie Bauer allows kids to face each other in the stroller seats, which Julie Ballengee would have preferred, if she had known about it. Molly Kohler wrote that she thinks the side-by-side is quite a bit easier to maneuver than an in-line!
One women really enjoyed her inline Peg Perego Twin Tender stroller, but couldn’t maneuver after kids hit 40 lbs (around 4 years of age). There is supposedly a very nice, lightweight Peg Perego, dbl tandem, where both seats turn around and lay down.
A side-by-side stroller may not be able to handle two infant seats.
Interestingly, a couple folks suggested that we can use infant seats ~9 to 12 months or more, even for big (90 percentile) kids.
Almost all snap-in strollers require same brand of car seat. But BabyTrend Caravan Lite Stroller allows both Graco & Evenflow seats. These sell for $190+ on-line, new.

* JOT recommends Twin Matey carrier.

**Clothes Shopping for Moms**

Little Pea in the Pod – on US 290
Motherwear catalog (1800-950-2500) → Terrific nursing clothes; in Austin there’s Special Edition (more trendy than Motherwear)
Ebay → Medela pumps (Cynthia Kinnas has their In Style pump) etc.
San Marcos’ Old Navy & Gap outlets have ~20 maternity items each. Motherhood Maternity (near Gap) has many items. Large women’s clothing & stretchy casual tops + elastic pants can be found at Dress Barn (30 day returns, to any Dress Barn, with tags).
Round Rock has an Old Navy with Maternity section just north of 79 & 620, at ?? Shopping Center.
Target is good.
KK found lots of maternity items (used) at the Junior League’s resale shop (on Burnet).
AMOM has a preemie-clothes lending closet, via Wildflower Waters (258-3042, groups@planetography.com, 7407 Attar Cove).

**House Cleaners:**

AMOMers just love Terri & Donnie Bruce at 385-4276. But they don’t do such a good job on the 4th+ visits, unfortunately.
Linda Godinez recommends Rose Bocanegra 577-4158: “She has been helping me for years and works before, during and after holidays! She does a great job, just tell her your needs.”

Another AMOMer has a great cleaning lady named Martha. She speaks only Spanish, but you can leave her a message at 933-9766 and her daughter Linda can translate for her.
Handyman, Carpenter, Electricians, Painters, Gutters, Gardeners:

Handyman: AMOMer Monica S says her father does it all and has lots of references as well. His name is Freddy Garcia and his cell. # is 751-0525.

Handyman: Raji P highly recommends Vicente Jaimes 796-9034 (cell) & 478-4949 (home): “Awesome handyman, can fix anything, does great painting, and all around very reliable, wonderful guy. Have known the family for years – highly recommend him for any and all jobs. He is extremely affordable. Tell him I referred you to get ultra-special treatment. :-)”


Painter: AMOMer Linda G writes: I just had my house painted outside and inside. The painters did an exceptional job. Call Robert Andre, of Andre Painting-- 636-6920. Very nice and extremely reasonable considering the quality of work we received. He charges either by the job or by the hour ($15/hr). Also does drywall and light carpentry. It took him less than 2 hours to paint my bedroom-- I paid him $30. AMOMer Shannon Calhoun’s father, Ron Davis 453-7198. AMOMer Jill Stachura loves Gilbert cell phone: 554-4378; very reasonable, neat & clean; does all by hand, including ceilings; some rooms twice (when she changed her mind on paint colors).

Gutter work on house: AMOM’er Lorie R highly recommends Direct Gutter Services 692-9150 (David Alcocer--my husband's cousin).

Gardeners: Alexis B writes “Keith Canada – extremely hard working and very picky about his work!! 423-1619.”

Custom Blinds: Joanna B & Christiane S write that Chris Mendenhall with Custom Touch is great 837-6828 (less $ than Home Depot & very personal service). Raji P got a good price (thanks to good timing) from Budget Blinds. Free estimates and free installation. Ron Putman: 947-7194.

Chiropractors: Catherine Antolak, DC First Chiropractic 9037 Research Blvd # 250 339-9727

Child Care

Nanny taxes: Pay via www.paycycle.com, (allows one to enter take-home pay and then calculates the taxes I need to pay since I am paying both the employee and employer tax. It does all the paperwork, and emails me reminders when I need to pay quarterly (state) and annual (federal) taxes. I just! print it out, write the checks and send it in!)

Steve says one can just pay federal nanny taxes with one’s own annual return (but be sure to not over withhold during the year, or be subject to fines on over withholdings). To pay the Texas nanny taxes in one lump sum (which should be less than ~$200/year), need to alert Texas authorities before ~Dec. 20th of the year before you hire the nanny. Otherwise, technically, those are supposed to be paid quarterly.

www.breedlove-online.com = a great website for nanny taxes too; takes care of everything for lots of our friends for $100 sign-up fee & ~$400/year. (payroll@breedlove-online.com)
Nanny Health Care: MAL joined the Nat'l Assoc for Self-Employed persons (NASE) for a nominal amount & then was able to purchase their Mega Health & Life Insurance plan, covering medical, dental & life. For her (with a history of asthma, high blood pressure & some other pre-existing conditions), it's $263/month. It'd be quite a lot lower for someone without those conditions. (perhaps even just $150/month)

Babies feel much more secure with sitters who are sure of themselves, while bathing, feeding, & putting them to sleep. Thus, it’s best that the sitter know the child. (BT)
If you have a hard time leaving the child, take shorter outings at first. Also, be prepared for the child to not be too happy to see you when you return. They can be aloof & coy, as a way to cope! (BT)

Night Nurses
Kate Hersch & co. recommend Sandy Silver (best night nurse in town; LBJ’s daughter bid highest for her) = $15/h for twins, suggested coming over before babies arrive to help “set up” the sleeping environment (& give us some tips, I imagine!), as well as after “family leaves”: 474-2433 (home) & 217-0307 (cell phone)
Dr. Berry’s nurse Erin had twins 2 years ago & used Sue Monks: 335-4251, $12/hour + 25 cts/mile from Anderson Mill Rd up north on 183. However, KK has heard two complaints about Sue Monks, re. dangerous situation for family & cancelling on a job.
Judy Adams = night nurse who showed up at AMOM mtg in Sept. 03: $300/24 hr, $175/12 hr, $15/hr (4 hr minimum); 415-3002 (lives on Slaughter)
AMOMers list the following night nurses: Carolyn Notario 512-252-7561 or 789-6107; Hannah Brown hannahpage2000@yahoo.com, Jennifer Graham 246-1327, Mary Boaz 601-3230, 965-2409, Lanell Coultas 459-3088, 663-9320, personal chef: Gigi Maris 371-3696 cmaris@austin.rr.com, Monika Stone 444-5686, 925-8354, Kathryn Smith 328-4111, Liz Vazquez 821-0601, 636-0659
Doulas: Catherine Lewis 360-4341 & 784-7894 (also provides child care, evenings & daytime)

Daycare Details:
Visit the center. Check infant-teacher ratio; ask if any babies are absent that day & include them in your count. Determine whether the environment is being modified to aid development, by rotating toys & babies among areas; is there a curriculum? Is there a quiet, private place for nursing? How’s the shade outside? What are the safety procedures? How often are evacuation drills? Are infants ever put to sleep on their backs? Are inside doors locked at all times? How do visitors gain admittance? How are prospective employees screened?
Car Seats:
See http://www.car-safety.org/index.html for great info on seating children safely, and the safest vehicles to buy. (See also http://www.txdot.state.tx.us/trafficsafety/road_tips/child_safety.htm for details of Texas laws on car seats.)
Free inspections in Austin via Brakenridge’s Safe Kids Coalition (2nd & 4th Weds of each month, by appt only) 324-8470 & TDH’s Safe Riders 1-800-252-8255 (www.tdh.state.tx.us/injury/safe).
Keep them rear facing as long as you can, well past 1 year/20 lbs: http://www.cpsafety.com/articles/stayrearfacing.aspx.
To figure out car seat/car compatibility, see http://www.carseatdata.org/.

Raji P writes that emergency-stop vs. standard-stop belts can pose a problem for seat installation (requiring special buckles). Get your vehicle inspected at Children’s Hospital of Austin by trained installers.
Straps should be snug on child, with no more than 1 finger-width between collarbone & shoulder harness. Harness clip should always be at the level of the child’s armpit. (USA Baby)
Straps should tie in BELOW child’s shoulder when rear facing, but above shoulder when forward facing! (Britax brochures & AMOM listserv)
Children under 20 lbs & under 1 year of age must ride rear facing, but can often keep them this way until ~30 lbs. Law also requires children in car seats until age 4 (or ~36? lbs), but recommended that child be 8 years old, 80 lbs, or 4’9” before sitting in a regular car seat. (USA Baby)
Keep children backward facing as long as possible (age 2 or 3); legs can be bent, no problem. Backward facing is a much safer position for the majority of crashes (except when being rear-ended).
One problem with forward facing (besides being more dangerous) is that on-coming car lights at night wake up sleeping children. However, children can watch a central video screen that way, which can make long rides much easier.
Most parents are paying $200+ for Britax car seats (after their children outgrow the infant seats, which lock into the Duoglider strollers). These are very large (& thus cannot/should not be taken out of the car), but they have the best ratings for side-impact protection (& tend to have straps that will not twist). See http://www.britaxusa.net/support/default.aspx.

Videos to Rent:
Baby Ward, TLC, Maternity Ward (has fair # of multiple births, from Cable TV), Bill Cosby’s parenting comedy routines

UT Family Leave Policy

DOCTOR RECOMMENDATIONS

Obstetricians & Perinatologists
Suggestions from AMOM’s D Monks (married to Ob Dr. Brian Monks, with 12 kids): Breech babies: Often can turn the 2nd one, if breech, for a vaginal delivery on both. But Dr.
Binford said 50% of those tries still results in c-section, & it’s stressful for child, so recommends a c-section (as does Dr. Grogono).

Debra M. recommends Drs. Binford & Seeker for multiples. A couple AMOMers have had issues with Dr. Binford.

Many recommend perinatologist Dr. Berry, rather than Dr. Harstead. Both are highly respected, and knowledgeable. Debra M says Dr. Berry is very aggressive with keeping the babies inside. Perinatologists are esp important with pre-term labor, since they are able to make sound drug & hospitalization decisions/suggestions to Ob. (A lot of Obs have no idea about such things. And many will, for example, induce within 24 hrs of water breaking. In reality, one can spend weeks in the hospital after such an event, loaded up on antibiotics & steroids [for their lung development], leading to the best results with baby development.) Dr. Berry &/or Dr. Monks gives monitors to all mothers of triplets & some twins. D Monks feels the mothers are not “stressed” by these (as Dr. Grogono suggested a mother would be); they are happy. They do a 1-hour screen in the morning & in the evening & speak with a nurse every day. They start doing this sometime after 24 weeks, because the kids are more salvable by this age, & drugs can stop the contractions. Dr. Berry does do nuchal translucency tests, and then, afterward, amnio.

Dr. Harstead has twins expert RN Laura Menzies in his practice, whom many AMOM’ers swear by (thanks to her regular visits, cervical checks, extensive knowledge, etc.).

**Pediatricians:**

AMOM’ers love the following PDs:

- Dr. Louis (central, near Seton)
- Elizabeth Bartlett (2222 & Jester Estates)
- Dr. Dan Terwelp (on Far West, doctordanonline.com. Great nurses too)
- Dr. Elizabeth Reedy (“fantastic”, mother of teenage b/g twins, by Seton NW)
- Dr. Mary Marvin Johnson (by Seton NW)
- Dr. Michael Ward of ARC. (a “gem” & a father of twins)
- Dr. Juan Guerrero (Far West, ADC, with weekend hours & sick/well waiting rooms)
- Dr. Bayer 458-6717 (central)
- Dr. Ari Brown (who wrote Baby 411 – a great book!, but practices at a big place that’s a bit of a zoo & not well maintained, though it is central).

Podiatrist: AMOMer’s husband Rick Warpula, owns Austin Family Foot Care located on 1600 W. 38th St.

Pediatric Cardiologist: Dr. Shapiro comes most highly recommended by AMOM’ers.

For ADD/ADHD: Deb M. recommends Kevin McFarley, MD, PhD. “He is a psychiatrist with a PhD in Education, I believe. He is very well known for educational diagnostics and his reputation is well respected. If he recommends meds, then I would try it, as he is pretty conservative about that. I think so many people are using meds as a behavior issue, not a learning issue and that is where it is helpful to have him diagnose the problem, not just guess about it. He is on Bee Caves Rd, just west of Walsh Tarlton.”

Pediatric Neurologist: Everyone on AMOM highly recommends Dr. Ghodsi.
Pediatric ENT (for removal of tonsils, for example): Drs. Nowlin, Sawyer & Fyfe are reported to be good by AMOMers

**Dentists:** AMOMer S. Aguillon writes “Dr. Sherwood is is FABULOUS with the kids and his office is central (across from Seton Hospital). … They have computers in each room that show movies while the kids are waiting. They have fun fish tanks near the X-ray machine to distract the kids, and a great waiting room with lots of toys/books, etc. He's got three kids himself and is just great with ours.” 1111 West 34th Street Suite 204 454-6936

**Dental Care & Milk Consumption:**
Supposedly, the AAP recommends that after 15 mo. babies have only 12 oz/day of milk to get other proteins & nutrients (biggest complication is decrease in iron). American Dental Assoc doesn't have strong stand on that but does want switch to cups by 15 mos to keep mouth cleaner & facilitate the move away from sucking (on thumb or pacifier) since those habits can be hard to break & cause some later issues. Our dentist thinks it's fine if they are only taking ~1 nipped bottle per day of milk up to 2 years. And he said 98% (!) of cases with poor dental plate development return to normal dental plate once the stimulus is removed; the body is very forgiving at an early age.

In terms of sucking, our dentist said a kid can suck thumb up until age 6 before they start removing the thumb via a retainer in the mouth. Also, as we are doing right now, he recommends cleaning their gums via massage. We might want to change last bottle of day from milk to water, so can get teeth clean & still give them something to suck on at bedtime. Sucking will give them comfort. Milk causes a lot of cavities as teeth are erupting.

The # of teeth one can expect, on average: 8 teeth at 15 mos; a second set of molars at about 18 mos; with 20 teeth by age 2.5 years. Girls usually get their teeth before boys.

**Physical Therapy (for pregnant moms in pain):**
Pain Mgmt Specialists (who seem to mainly rely on drugs that pregnant gals cannot have) covered by Humana: Mark White (whom Helen Maidment likes very much) 795-9977 (4807 Spicewood Springs Rd, NW of MoPac, ½ mile past Mesa on left, in Steelhouse Canyon office park, with Caldwell Bankers), Michael Malizzo (who has left TX for NM), Robert Wills & James Stonecipher (whom she doesn’t know), Lowell Haro & Ray Ximenes (whom she’s not crazy about). Unfortunately, these guys can only really do osteopathic manipulation & some PT, for pregnant gals, according to White’s assistant. And White’s calendar is booked 4 weeks ahead.

Laura Menzies recommends: Kathryn Smathers - aquatic physical therapist out at The Hills Fitness Center on Bee Caves. 512-328-8950. info@newdimensionspt.com. www.newdimensionspt.com. $180 for initial evaluation, $150 for follow-up sessions.

But HMOs usually have clinics for PTs, so Smathers was not covered at all.


Yoga Yoga prenatal instructor recommends Family Therapeutics' Nancy Foreman, RMT, CIMI -- 763-1821 & Cindy Foreman, RMT, CIMI -- 821-0255
Lactation Consultants:

Special Additions’ Cheryl Heymans at 280-5814 (very practical & knowledgeable; down-to-earth; kind; about $90 for a home visit [including a follow-up visit at Special Addition])

Barbara Wilson Clay is the most well-known lactation consultant in Austin & perhaps Texas: 292-7227  bwc@lactnews.com (has written books & is the most experienced one in town). $150 per visit (at home), get prescription from Ob or pediatrician to seek reimbursement (twins sometimes are covered by insurance). Feels yeast is grossly over-diagnosed. Fan of natural latch (vs. RAM method).

Raji P recommends Cathy Clark 873-0700.

Seton’s NICU’s Valerie Mick is a very good lactation consultant that Barbara Wilson-Clay respects highly.

AMOM’s Tina Roberts got Katja to offer to come by & see twins nursing, 479-6453, lives pretty central, suggested possibility of some hand expression if pumps & flanges are too painful (but wrist does tire after 15 minutes).

Dawn Martin 474-0179 dmartin36@austin.rr.com (rec’d along with Clay & Heynman by La Leche League’s Darien, 458-6873 & by AMOMer EPG)

Mary Ann Laverty’s lactation consultant friend is Tanya Phillips (301-3779 home, 560-3732 cell)

Cynthia Kinnas used Julie Moroney (RN & lac consultant) @ Baby Joy, 301-0299

AMOM’s Tina Roberts (263-7275) is a twin breastfeeding mom & La Leche Leaguer who used to be willing to come to one’s home & help a mom establish correct breastfeeding.


Lamaze & Childbirthing classes:

Sarah Trimmier, RN:  916-0784, gaiahouse@earthlink.net. 408 Wood Bine Dr. Austin 78745, “To Have & To Hold Intensive” class. A Seton Labor & Delivery nurse who lost her twins at 24 weeks & is on a mission to help the rest of us, particular parents of multiples. Excellent set of classes!

Lamaze is the oldest method, where one relaxes & breathes in order to push most effectively. Bradley is similar but for delivery without an epidural. (YPA30) Bradley Way is focused on relaxing & refusing drugs with dad actively involved in helping mom relax while massaging back & stomach as desired. Helps avoid forceps, episiotomies, etc. (Bradley)

Massage:

Yoga Yoga’s prenatal instructor Meg (who has had a baby) recommends Nancy & Cindy Foreman who specialize in preg massages & call their business “Family Therapeutics” & will come to your home. 763-1821 (Nancy) & 821-0255 (Cindy).

Do not do deep-tissue massage during pregnancy. (ST & other sources)

Resources for Stay at Home Dads:

Good websites: http://austin-sahds.tripod.com/ & http://groups.yahoo.com/group/Austin-SAHDs/
Things to Do with Kids in Austin (particularly during the summertime)…

**Krause Springs**- I love this place, it’s great on a hot day! Be sure to pack a picnic. Visit: [www.texasoutside.com/kraussprings.htm](http://www.texasoutside.com/kraussprings.htm)

**Mount Bonnell**- A nice little hike up 106 stairs, pretty neat. At western edge of city over looking Lake Austin; Mt. Bonnell features dramatic views of the city and Hill Country. Mt. Bonnell Rd. reached via West 35th and Old Bull Creek Rd

**Treaty Oak**- Check out a children’s book about treaty oak from the library and then go visit this amazing and historical tree.

**Picnic at the State Capital**- Tour the capital, then picnic on the grounds. Bring extra for the friendly squirrels.

**Zilker Botanical Gardens**- Austin Area Garden Center is a free, beautiful showcase of flowers, shrubs and trees. One of the crown jewels in the Center is the Japanese Garden. There is also a pioneer log cabin furnished in the frontier style. Tours of dinosaur tracks found at **Zilker Botanical Gardens** offered every Sat., May - Thanksgiving weekend. Hours: May - June 11 a.m. - 1 p.m; otherwise, 9 -11 a.m. For information call 512/477-8672.

**Austin Nature Center** – Exhibits of science, natural history and botany. A living nature museum with resident injured and/or orphaned native wildlife, a Birds of Prey aviary, and the Eco-Detective Trail and more. Open Mon. - Sat. 9 a.m. - 5 p.m.; Sun. 12 - 5 p.m. Located at 301 Nature Center Drive. (512) 327-8181. **This is a must visit !**

**Zilker Park and Train**- super, kid friendly, park. Take a train ride for a nominal fee. When the ride is done, get an ice cream cone at the concession stand (total kid day).

**Barton Springs**- In **Zilker Park**, just off Barton Springs Road. Barton Springs Pool is one of Austin's famous landmarks and easily the most popular swimming hole in the city. Spring fed and over 900 feet long, the pool was formed when Barton Creek was dammed up, so it has a natural rock and gravel bottom. The water temperature averages 68 degrees F’ throughout the year…burrree.

Cheap or free movies throughout the summer. Great on the pocket book and a super way to get out of the heat- visit local moviehouse sites & link to “special screenings” (targeting kids)

**Bike the Veloway**- This popular park in south Austin has a 3.1 mile surface that is great for biking and in-line skating. For information, call 512/480-9821.

**Wildflower Center and café**- Especially colorful during spring. Visitors receive information on plants native to their region or home state. Open Tues. - Sun. 9 a.m. - 6 p.m. Located in southwest Austin; from I-35 take Slaughter Lane Exit 277 west to Loop 1; go south 8 miles and turn left onto La Cross Ave. Address is 4801 La Cross. For information, call 512/292-4200. *(Stay for a bite at their yummy café!)*
Hamilton Pool- Swimming hole and nature trails along the creek. Swimming is allowed only when the water quality meets safe standards. (We’ve been 3 times and have yet to swim; it’s awesome though!) Water quality is monitored regularly. Hamilton Pool Preserve is located about 30 miles west of Austin on FM 3238. From SH 71/U.S. 290 junction in southwest Austin, take SH 71 about 8 1/2 miles to FM 3238 (Hamilton Pool Road). Turn left and travel about 13 miles to the preserve. The entrance to the 232-acre preserve is on the right. For information, call 264-2740.

Town Lake - Hike/walk/bike the trails; bring old bread to feed the ducks, turtles, and fish.

Symphony Square- outdoor concerts, visit:  www.austinsymphony.org/symphony/square.

Governor’s Mansion tours - Dignified white-columned mansion built in 1856. The governor and his family occupy a private second floor apartment. Elegant rooms and furnishings may be seen on public tours, Mon. - Fri., every 20 minutes, 10 to 11:40 a.m. Groups and official functions control schedule. The mansion is located at 1010 Colorado St. For information, call 463-5518.

Picnic at Rose Park during the Juneteenth celebration- (June) Call 472-6838 or visit: www.ci.austin.tx.us/parks/pgjuneteenth.htm

Go kayaking, sculling, paddle boating or canoeing on Town Lake- For information on the two locations, visit http://www.rowingdock.com or call 478-0098.

Take a hike on Barton creek nature preserve- visit: www.nature.org/wherewework/northamerica/states/texas/preserves/art6418.html

Spend the morning/afternoon at the downtown, Westlake, or Travis county farmer’s market- For information of the last of these, call 454-1002.

Emma Long Metropolitan park – Great sandy beach for the kids, rugged mountain bike trails, swimming, fishing and camping; small admission fee. For information, call 346-1831- (Always a blast here!)

Old Bakery & Emporium- Built as bakery by Swedish immigrant Charles Lundberg in 1876, it is now a craft shop selling handicrafts and baked goods by senior citizens. Open Mon. - Fri. 9 a.m. - 4 p.m. in the Summer 10 a.m. - 3 p.m on Saturdays in Dec. It is located at 1006 Congress.

Visit the LBJ museum - Archives and museum relating to LBJ and the office of presidency in general; colorful highlights of political campaigns. Exhibits include gifts from foreign heads of state, a moon rock, replica of Oval Office and changing exhibits. This is a cool place! Open daily 9 a.m. - 5 p.m. Located at 2313 Red River St. For information, call 482-5137

Outdoor theater performances at Zilker - Free Zilker Hillside Theater presents shows under the stars, early June - Aug. Call 397-1463 for information.- Bring a blanket and some food and enjoy!
REFERENCES:
(PP) Prenatal Prescription. YEAR???? (says not to exercise with twins!!)
(BT) Babytalk Magazines
(AB) American Baby Magazines
(AMOM) Austin Mothers of Multiples Club. (Newsletters, listserv, & meetings)
(YPA30) Your Pregnancy After 30. GB Curtis. 1996.
(HEA) Breast Feeding your Twins. Health Education Associates. (no year)
(Seton) Seton Hospital pamphlets.
(SOS) SOS, by Lyn Clark (provided by UT professor of ed psych, and mom to two youngsters)
(ST) Sarah Trimmier, RN at Seton’s Labor & Delivery, Lamaze class for parents of multiples.
(LM) Laura Menzies, RN at Texas Perinatal Group, leads “Twins Program”, monitoring mothers of multiples weekly (for cervical check) from week 22 to week 34.
(USA Baby) What you should know about … handouts
(Luke) When You’re Expecting Twins, Triplets or Quads.
(Bradley) McCutcheon’s Natural Childbirth the Bradley Way. 1996’s 2nd Ed. (quite dated, mostly from the 1984 version; but great pictures & interesting info, esp. re. episiotomies & nursing)
(KK) Kara Kockelman 😊
(CH) Special Additions Lactation Consultant, Cheryl Heymans, 280-5814.
(Sears) Dr. W. Sears’ SIDS book. 1995.
(BWC) Barbara Wilson-Clay. Best lactation consultant in Austin & perhaps Texas.
(E&B) Babywise by Gary Ezzo and Robert Bucknam, MD (a controversial book since many mis-read its suggestions for limits on feeding intervals as being very strict; however, it does suggest formula supplements in some cases, when a proper latch & improved nursing technique is the needed solution)

Baby Names: