# the People's Doctor

A MEDICAL NEWSLETTER FOR CONSUMERS
by Robert S. Mendelsohn, MD

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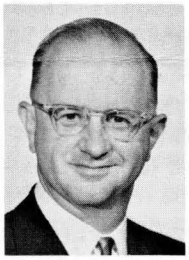
## Pregnancy & Childbirth



**Dr. Robert Mendelsohn**

Welcome to the first issue of The People's Doctor, a medical newsletter designed for consumers. Each month's issue will highlight a specific medical area (this month's issue features Pregnancy and Childbirth) and will contain a monthly guest column by Marian Tompson, President of La Leche League International.

I hope you will take advantage of the unique service this newsletter will provide -- to the extent that space permits -- your questions about the medical problems that trouble you most will be answered. Please send your questions to: The People's Doctor, 664 N. Michigan Ave., Suite 720, Chicago, Ill. 60611. I will be looking forward to hearing from you.

Q

How much weight should a pregnant woman gain? Can one be pregnant and on a diet at the same time?--Mrs. H.R.

A

*Weight Gain for Pregnant Women*

Dear Mrs. H.R.: Only a few years ago, women were warned not to gain more than 10 or 15 pounds during their pregnancies. Today many doctors restrict their pregnant patients' weight gains to 20 or 25 pounds. I feel both sets of numbers are arbitrary: It is not the amount of weight gain that is important; what is important is the quality (not quantity) of food consumed. Every pregnant woman should be on a proper diet--one that contains sufficient protein, vitamins, minerals and other essential nutrients. She should avoid junk foods that cause harm to her and her unborn child. On a proper diet, most women will gain weight. But some women who may have been overweight because of bad eating habits may lose weight if they eat the right foods during pregnancy--and properly so.

Tom Brewer, M.D., medical consultant to the book What Every Pregnant Woman Should Know: The Truth about Diet and Drugs in Pregnancy (Random House, $8.95), has demonstrated that a diet of high quality foods is the best insurance against giving birth to low birthweight babies. A well-nourished woman who gains 30 to 40 pounds will have a much better chance of delivering an eight-pound, rather than a five-pound, baby.

I'd advise you not to worry about the numbers on a scale, whether in your own bathroom or at the doctor's office. A wise doctor will take the same path: Even though it takes longer to tell a pregnant woman the elements of a good diet than to look at the number of pounds the nurse has written on the chart, the payoff for this extra time will be in healthier babies and healthier mothers.

Q

I am 30 years old and have been married for three years. For financial reasons, we just can't have children for another three years. That means I'll be pregnant at 33. My cousin tells me my chances of having a normal baby at that age aren't very good. My first reaction was "Hogwash," but then I realized I don't know anyone who had her first pregnancy at age 33. When I told my doctor, he just laughed. I am in excellent health, am very active, and have no weight problems. What is your opinion on late first pregnancies? --Mrs. R.D.

A

*Pregnancy at age 35*

Dear Mrs. R.D.: It is not easy to interpret the laughter of physicians, but my guess is that your doctor would agree with me that there is nothing risky about your becoming pregnant at age 33.

The question of a safe age for pregnancy has assumed monstrous proportions. When I was in medical school, it was considered dangerous to have babies after age 45; a few years later, the age was lowered to 40. About a decade later, it was taught that deformed children were more common when the mothers were over 35, and now your cousin, as well as many others, believes 32 to be the upper limit. At the same time, the numbers are narrowing at the opposite end as teenage pregnancies are increasingly discouraged. If the present trend continues, the woman who doesn't conceive between ages 25 and 25½ may well have missed the boat.

In my opinion, the crucial consideration is the reasoning behind the limitation of children below certain ages. Is it true that a woman's eggs become tired and worn-out? Did God make a mistake in establishing the age of menopause about 10 or 15 years too late to prevent the birth of deformed (primarily mongoloid) babies? And incidentally, why don't we ever hear about tired, worn-out sperm?

A study conducted at Johns Hopkins Hospital showed that the incidence of mongoloid children born to older women was closely related to the number of diagnostic and therapeutic medical and dental x-rays to which the woman had been exposed during her lifetime. Subsequent studies have backed up these findings.

The chance of your having a normal child is better than 99 per cent. While I never want to be in the position of counting the next person's money, I certainly hope you reevaluate your financial situation to see whether it isn't possible for you to become pregnant right now. Then, by age 33, you can be having your second child.

Q

When is it safe to get pregnant after going off the Pill?--S.S.

A

*Post-Pill Pregnancy*

Dear S.S.: Knowledge of the ill effects of the Pill after its discontinuance is accumulating at such a rapid rate that it may be necessary to have an entirely new category of disease called "post-Pill pathology."

Women typically discontinue birth control pills because they want to have a baby. But many women are disappointed because the incidence of sterility, usually temporary but sometimes permanent, may be as high as five per cent. I certainly hope women realize this before they opt for the Pill in the first place.

Doctors also have noticed an increased number of spontaneous abortions, due to abnormalities of genetic equipment in the fetus, occurring in women who became pregnant just after discontinuing the Pill.

No one knows exactly how long a waiting period is necessary for there to be no complications from the Pill. In the absence of scientific date, the best physicians I know recommend a post-Pill recovery period of at least six months.

Q What birth defects are associated with tranquilizers? I couldn't have been more than one week pregnant when I read the warnings about tranquilizers and birth defects in the newspapers, and I stopped taking Tranxene. Do I have anything to worry about?--Mrs. L.B.

A Dear Mrs. L.B.: The 1976 Physician's Desk Reference (which was prepared in 1975) says that animal experiments with Tranxene show no evidence of harm to the animal fetus. The manufacturer, Abbott Laboratories, adds that "The relevance to the human is not known" and also states that there is no experience with pregnant women who have received the drug.

*Birth Defects and Tranquilizers*

Let's take a look at some other tranquilizers. Haloperidol (Haldol, manufactured by McNeil) has been identified as a possible cause of serious limb deformities. A 19-year-old mother who took Haldol between the 25th and 37th day of pregnancy delivered a child with only a thumb and two fingers on each hand as well as deformities in other bones. The labeling information supplied at that time by McNeil stated only that "safe use in pregnancy has not been established." Valium, when taken during the first trimester of pregnancy, has been linked to cleft lip and cleft palate. Almost every other tranquilizer is presently under suspicion of causing birth defects.

Since you only took Tranxene for one week of your pregnancy, the odds that you did any damage to the fetus are miniscule. As a physician, I would like to reassure you that there is nothing to worry about.

But in your case and others I am angry that doctors are still prescribing powerful tranquilizers to women in their childbearing years without first at least asking if they might be pregnant. While Thalidomide's use did not extend into this country, if current practices continue, we could have a similar tragedy over here. It is the doctor's responsibility to determine whether a woman is pregnant before he prescribes either medication or treatment.

Q What birth defects are associated with X-rays? I realize you've answered questions on X-rays, but I've never seen you answer one about dental X-rays.

I was one month pregnant when I had my teeth X-rayed. At the time I wasn't sure I was pregnant, and I didn't know about ANY dangers relating to X-rays. Three were taken, but one didn't develop properly and had to be redone. I've been extremely worried about this, but everyone including my doctor says there's nothing to worry about. My mind would be put to rest if I knew what the percentages were, but I'm just ignored when I ask questions.

Why don't dentists ask if there's a possibility of pregnancy? I would have told him "yes," and I would have been spared a lot of worry. Please answer soon because I don't know how I'll make it through the next four months without knowing.--Detroit Reader

*Dental X-rays during Pregnancy*

Dear Detroit Reader: I am continually surprised that doctors advise people to worry about smoking too many cigarette and about eating too much food, yet try to assuage the patient's concerns about X-rays and drugs.

I have written about the dangers of routine dental X-rays, and I have plenty of letters from irate dentists to prove it. Perhaps your letter will help many dentists realize that it's not very difficult to ask that one little question, "Are you pregnant?" before aiming the X-ray machine.

There has been so little research on the question of X-rays during pregnancy that it is impossible to answer YOUR question on the chances of birth defects developing.

Since doctors recommend that their patients keep careful records of immunizations, I think it would be just as easy to advise patients to keep a record of every X-ray they have taken. Ideally, on each exposure, the radiologist would tell the patient the amount of irradiation administered and the conditions under which it was given (e.g., CAT scanner or conventional X-ray). Such a procedure might encourage both the patient and radiologist to ask, "Is this X-ray REALLY necessary?"

Your doctor has told you not to worry. Perhaps he can help by determining, through consultation with a wise radiologist, the amount of radiation you received from the dental X-rays. He could than take this data to an expert geneticist. This kind of approach may provide you with the reassurance you need during the remainder of your pregnancy.

There must be others like me who have more than one child of the same sex and would give anything for just one of the opposite sex. Sometime ago, I read about timing sexual relations so that one can control the sex of the fetus. Can you tell me at what time during a woman's cycle she has a greater chance of conceiving a female?--Mrs. M.K.

*Determining Baby's Sex*

Dear Mrs. M.K.: I have heard all kinds of advice about timing, positions and emotions during intercourse. Unfortunately, to my knowledge, none of these theories has been statistically or scientifically substantiated.

A prominent obstetrician who used to practice in the Chicago area would examine an expectant mother and then announce his prediction of the child's sex, emphasizing that he was writing it down so he could prove his crystal ball capabilities. On the paper, he always wrote the opposite of what he told the mother.

The doctor was always right; if the mother gave birth to the desired sex, who would ever refer to the paper? But if she delivered a boy instead of the girl the doctor had predicted verbally, he would produce his written prediction. Even if the mother remembered what he had told her, how could she challenge the written word of an esteemed physician?

Today, by a technique known as amniocentesis, it is possible to predict the sex of an unborn infant. Despite the salesmanship of some doctors who use this procedure, and despite its value in certain rare instances, no one knows the long-term effects of amniocentesis.

In our culture, it seems that whatever can be done will be done, regardless of value or lack thereof. I hope that, in spite of the

fact that we may be able to determine the sex of a fetus, we will refrain from using technology for technology's sake.

I'm sure that, whatever sex your baby turns out to be, you'll love it very much.

Q

Thank you for pointing out to American women the alternative of giving birth at home.

In 1953, 1955, and 1958, I had three children delivered at home in New York City through the Maternity Center, which unfortunately has since closed its doors. I had the best care-two nurses 24 hours a day while in labor, the blessings of dedicated midwives, an outstanding doctor, and the presence of my wonderful husband. This made our family so much closer, and my husband and I now advocate home childbirth whenever we have a chance. We just wish we could do more. What doctors or organizations can we contact to get this message across to American women?--Mrs. V.M.

A

*Childbirth at Home*

Dear Mrs. V.M.: An organization formed last year, the National Association of Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC) may be the group you are looking for. You can write to them at P. O. Box 1306, Chapel Hill, N.C. 27514.

While we are speaking of ways in which families can be brought closer together, permit me to recommend a new book, The Family Bed by Tine Thevenin (P.O. Box 16004, Minneapolis, Minn. 55416). This book describes the old practice, now being rediscovered by many young families, of taking children into bed with parents.

While some Americans regard breastfeeding as a minor sexual deviation, family bed-sharing is considered a major perversion. But those who are ready to reject conventional obstetric advice and have their babies at home may also be ready to reject standard psychiatric advice and use the same bed that kept the family together at childbirth as a headquarters for keeping the family together afterward.

Q

My obstetrician insists on doing an episiotomy for my first delivery. He says I'll have trouble when I'm older if I don't have one now. How does an episiotomy prevent problems later on?--M.T.

A

*Routine Episiotomy*

Dear M.T.: The routine episiotomy (an incision in the perineum designed to enlarge the opening through which the baby will pass) has become as American as apple pie. Yet the case for its value is extremely weak.

The book Our Bodies, Ourselves (Boston Women's Health Book Collective) contains a convincing argument against the automatic performance of episiotomies:

"Although episiotomies are done routinely in the United States, there is often no need for them. If the mother is unanesthetized, she will feel when to stop pushing and when to start easing her baby gently out. Her doctor can direct her. The vaginal opening can stretch to very wide proportions without tearing...We question the practice of administering episiotomies to all women before delivery."

Obstetricians seem to prefer a surgical incision to a spontaneous tear, although I know of no evidence showing that one heals better than the other. Episiotomies are also touted as leading to more sexual satisfaction when intercourse is resumed--obviously an assumption that is scientifically untested and unprovable.

In other countries, where sex is enjoyed certainly as much as it is in America, episiotomies are rare. In addition, I know quite a few women who have had their babies delivered at home by skilled American physicians who avoid episiotomies. The sex lives of these women seem to be quite satisfactory.

Your doctor's reference to "trouble later on" may be in relation to uterine prolapse, which obstetricians in this country believe is caused by stretching of pelvic floor muscles and vagina during delivery. Our Bodies, Ourselves suggests that prolapse can be avoided by exercise. You might want to ask your obstetrician if he agrees.

In a booklet called The Cultural Warping of Childbirth (International Childbirth Education Assn.) a prominent European professor of obstetrics and gynecology says, "Since all the physician can really do to affect the course of childbirth for the 95 per cent of mothers who are capable of giving birth without complication is to offer the mother pharmacological relief from discomfort or pain and to perform an episiotomy, there is probably an unconscious tendency for many professionals to see these practices as indispensable."

## *"Family Maternity Programs"*

**Q** I recently read that many hospitals are creating family maternity programs where fathers can stay with mothers during delivery and their children can visit afterwards. Isn't this the kind of change you've been advocating? How can we get more hospitals to do the same thing?--J.McK.

**A** Dear J.McK.: I can't blame you for assuming I would be in favor of "family centered" maternity programs in hospitals. After all, who can argue against humanizing some of the present inhuman hospital care? Yet I regret that the situation is not as simple as it seems. While I'm CONCERNED about the psychological implications of isolation which the hospitalized mother must contend with when she is separated from her husband and other close relatives, I'm ALARMED at the potentially life-threatening and disability-producing implications of many present-day hospital obstetric practices.

I refer specifically to the outrageously high number of Caesarean sections performed, as well as the general overuse of analgesic and anesthetic agents that so easily find their way through the placenta and into the infant's vulnerable brain cells. To address oneself solely to the psychological issues of separation while uncritically retaining stirrups, routine elective induction of labor, episiotomy, monitoring, epidurals, Demerol, intravenous fluids, multiple vaginal examinations, and forceps amounts to just so much window dressing. We need to do far more than just slap a coat of bright paint over the crumbling facade of modern-day hospital-based obstetric procedures.

**The People's Doctor Newsletter**
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# Another View

by Marian Tompson
President, La Leche League International

With seven children in our family, four of them married, we celebrate a lot of birthdays. But the most memorable by far during the past two years have been the actual births of our two granddaughters at our home.

Home deliveries are a growing phenomenon in the United States. Much of it reflects a growing concern with unacceptable hospital routines and some simply the desire to return childbirth to its proper place, in the bosom of the family.

When I started having babies in the early 50's, fetal monitors were unheard of, as were routine IV's or the threat of a Cesarean section if labor was prolonged. (I am especially grateful on the last count as our very first child was posterior, resulting in a 36-hour labor.)

The use of anesthetics and analgesics were routine. Father stayed in a waiting room during the birth, and mother and baby were separated after delivery. Even though my obstetrician agreed not to give me drugs so I could have the kind of natural delivery Grantly Dick-Read wrote about, I still found being separated from my husband and baby an unhappy experience.

Fortunately, after three babies, we met a doctor who attended home births, and the rest of our children were born at home. We were extremely lucky. Most couples those days didn't have choices when it came to having a baby.

But today childbirth is in a state of transition. There are choices to be had and decisions to be made. Remember, an uninformed choice is no choice at all. So if you're expecting a baby or just anticipating expecting one, talk to other couples who've had good birth experiences. Do some reading on the subject. An excellent up-to-date collection of articles can be found in the two-volume set 21st CENTURY OBSTETRICS NOW! edited by Lee and David Stewart and available for $9.00 a set from NAPSAC, P.O.Box 1307, Chapel Hill, NC 27514.

When it comes to choosing a doctor, interview not only the doctors but also patients who have gone to them. That's the only way to make sure a doctor practices what he preaches. Find out if he routinely restricts weight gain, does episiotomies, uses fetal monitors, or IV's during labor and anesthetics or analgesics during delivery. What is the percentage of breast-feeding mothers in his practice, and what is his C-section rate? Does he make you feel good about being pregnant?

If delivering in a hospital, you'll want to know that hospital's C-section rate also, and if fathers can be present during labor and birth, if breastfeeding is allowed in the delivery room, and if rooming-in is available.

It's funny about rooming in. Quite often hospitals will insist that they would like to have it available but that it just isn't possible without redesigning the building at great expense.

Well, earlier this year I visited the Royal Women's Hospital in Melbourne, Australia. In this hospital where 7,000 babies are delivered each year to mostly middle and low-income families, rooming-in is mandatory. Most mothers and babies are in four-bed wards, and because the entire family is allowed to visit, "it sometimes seems like there are hundreds of people on the floor," one nurse explained. But they have had no problems with cross-infection. In fact, it was to combat a severe infection in the central nursery that rooming-in first became the rule in 1948.

Investigate childbirth preparation classes to see if there is one that will meet your needs. These are not to be confused with the prenatal classes given at some hospitals, which often do little but reflect their particular brand of obstetrical management. Attend La Leche League meetings. If there isn't a group in your area, write to the headquarters (9616 Minneapolis Avenue, Franklin Park, Il 60131) for personal help and information. Besides telling you everything you want to know about breastfeeding, La Leche League meetings are just naturally good sources of information about doctors, hospitals, and most other things having to do with childbirth in your own community. If you're going to have the baby at home, I would suggest that you include not only a medical attendant but also a friend or relative who has had children herself. I think you'll find her sensitivity to what's going on and the kind of help needed at the moment a real help in achieving a relaxed labor and delivery.

There's a lot to think about but after all no one will benefit more from the choices we make than we and our own children.

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In a study supported by the National Institutes of Health, researchers at the University of Chicago have found that abnormalities of the reproductive system can occur in the male offspring of women who took diethylstilbestrol (DES) during pregnancy. Additional information on these studies may be obtained by writing to the Office of Research Reporting, NICHD, Bldg. 31, Room 2A3A, National Institutes of Health, Bethesda, Md. 20014. (JAMA, August 8, 1977)

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Patients taking the drug Sansert, which is indicated exclusively for the prevention of vascular headaches, should report the following symptoms immediately to their doctor: Cold, numb, and painful hands and feet, leg cramps when walking or any kind of girdle, flank, or chest pain. Drug administration should not exceed six months, and dosage should be reduced gradually during the last two to three weeks of each treatment course. For further information, write to William F. Westlin, M.D., Director of Medical Services Dept., Sandoz Pharmaceuticals, East Hanover, N. J. 07936. (From a letter to physicians dated February 14, 1977)

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Reye's Syndrome is now considered by some to be among the 10 major causes of death in children. The Food and Drug Administration's Neurologic Drugs Advisory committee has just concluded, on the basis of present data, that antiemetics (drugs that stop nausea and vomiting), aspirin and acetaminophen may be causally related to Reye's Syndrome. Particular concern was expressed about antiemetics such as phenothiazines (Compazine) and trimethobenzamide (Tigan) prescribed for minor problems in young children. (Clinical Pediatrics, August 1977)