How Can I Prepare My Pelvic Floor, To Avoid Problems After Delivery?
As you’re surrounded by the commotion over painting the nursery or planning the baby shower, it’s easy to overlook, as your due date approaches, one of the most important issues: your body. But would you enter into any other major physical event without stretching, working out, and getting yourself into shape?

Start Early. The best time to start practicing prevention is your first baby, since this pregnancy and delivery appears to carry the most potential risk of injury – and it’s the one during which you can probably do the most good. On the other hand, if your first pregnancy is already behind you, several pelvic floor problems do have the potential to worsen ‘from baby to baby’ – and you should be aware of all you can do to minimize this cumulative risk.

‘Kegel exercises’ can be used to strengthen the pelvic floor, and your first pregnancy is one of the best times in your life to learn about them. Not only because the need is so great – up to 70% of women will have some stress urinary incontinence during or after pregnancy – but also because the pelvic muscles are still at their greatest potential. Increasing their strength will make incontinence and pelvic floor problems less likely.

Perineal massage involves gentle stretching of the vaginal opening, using your fingers and a bit of lubrication. Two studies have suggested that perineal massage performed in late pregnancy may decrease the risk of perineal injury and pain afterwards.

Weight gain and fitness may influence the risk of pelvic floor injury, as being overweight means more stress on the pelvic floor muscles and nerves. Studies have shown that although women of all sizes may experience incontinence during pregnancy, long-term problems are more likely among women gaining a lot of weight, and those overweight before pregnancy began. Check with your obstetrician or midwife to determine your ‘ideal’ pregnancy weight goals, and the most appropriate diet and exercise routine. Posture and lifting habits, pelvic tilts, and ‘bracing’ of the pelvic floor, are among other helpful tips to learn about.

What’s The “Right” Way to Labor?
As your due date arrives, the flurry of plans, emotions, decisions and preparations all begin to revolve around one simple question … when will labor begin? But other key questions, in the midst of it all, may have been overlooked: How have you prepared for delivery? And after the final push, when the feedings and diaper changes begin, what will you do to ensure the most complete healing for your body? Events in the labor room that may seem predestined or inevitable, are in fact choices and decisions – and in preparing for labor, it’s essential that you understand and influence all that you can.

Relaxing in Early Labor. Tension within the pelvic floor muscles, due to pain or anxiety, can slow your progress during early labor. If you’ve already ‘found’ your levator muscles during pregnancy and built their strength with Kegel exercises, you should be better able to relax them during this stage.
Options for Pushing: Though much remains to be learned about the ‘best’ pushing methods for preventing pelvic floor injury, you should be aware of the basic options. Which Position? Many mothers of previous generations were invited to deliver only while lying on their backs. Nowadays, you may have the opportunity to push out your baby while lying down, sitting on a chair or stool, standing upright, or even soaking in a pool of warm water. Lying-down (‘lithotomy’) is the most common position, whereby the mother’s legs are held in a fully flexed and upward position during each contraction.

Many nurses, midwives and doctors recommend the squatting position, which may help to ‘open’ the pelvic outlet during birth. Although one study showed squatting to be associated with less perineal injury, anal sphincter injury and episiotomy, other studies have reported conflicting results. The sitting position has been advocated by some women, sometimes using a specialized birthing chair – which has been associated with quicker deliveries, but also greater risk of injury to the labia and perineum, and increased blood loss. The side-lying position may allow some women greater ability to slow the expulsion of the fetal head past the vaginal opening, potentially reducing the risk of injury resulting from a fast or uncontrolled birth. Indeed, one large study found that of all birth positions, side-lying was associated with the best odds of avoiding perineal injury.

Finally, although some studies have shown the standing position to result in a reduced need for forceps or vacuum assistance, other studies have associated this position with increased anal sphincter injury, labial injury and blood loss.

(Figure 5-2: Woman squatting with baby in pelvis)

When to Begin? Delayed pushing means resisting the urge to push for a period of time, even after the cervix is fully dilated, thereby allowing the fetus to ‘passively’ descend through the birth canal. Medical literature dating back to the 1950’s suggested that avoiding pushing appeared to result in lower risk of forceps delivery and injury to the perineum. More recent studies have confirmed that ‘difficult deliveries’, forceps and perineal injury may indeed be less likely among women who delay pushing, or push less forcefully.

How Long is Too Long? There was once a time when ‘prolonged labor’ meant a truly epic and dangerous struggle for mom, often lasting for several days. That period of time, we came to understand, introduced major risks for both mother and baby. But even today, defining the true ‘limits’ of normal labor remains a question. Will the length of labor influence the function of your bladder, bowel and pelvic floor later on? Long pushing stages have been associated with diminished pelvic nerve function afterwards, and increased risk of flatal incontinence (inability to control gas) and bladder dysfunction. Pushing longer than three hours warrants discussion with your doctor, to review the potential effects on the pelvic floor.

Do Forceps and Vacuum Procedures Affect the Bladder and Pelvic Floor?
Even a perfectly routine, apparently uneventful vaginal delivery can have a detrimental impact on future pelvic floor function. But incontinence and pelvic floor problems are
even more common after deliveries assisted by a forceps or vacuum device. Women undergoing forceps delivery experience injuries to the anal sphincter visible by ultrasound in 80% of cases, are up to ten times more likely to report urinary incontinence, and also have weaker pelvic floor and anal muscle strength compared with those who had spontaneous vaginal birth. Several studies have indicated that the use of a ‘vacuum’ rather than forceps device may be associated with lower risk of injury to the perineum, anal sphincter and pelvic floor.

**Why Not Request a Cesarean Delivery, to Prevent Incontinence?**
Should women be permitted to accept the risks of cesarean in order to possibly reduce their risk of developing incontinence, prolapse, and pelvic floor problems later on? This is a topic being actively debated in women’s health – one surrounded by complex medical, economic and social questions. At the very least, women should have the option of informing themselves on different childbirth strategies, and learning about what the potential repercussions of these choices may be.

The risks of cesarean delivery need to be seriously considered. Although this operation under spinal or epidural anesthesia is safer today than at any time in the past, a cesarean section is an operation that carries potentially serious risks to both mother and baby – which need to be carefully discussed. The debate over ‘cesarean by choice’ is a perfectly legitimate one, so long as the potential hazards of this operation are never overlooked. The benefits of cesarean may include less urinary incontinence, anal injury, and pelvic floor injury – due to less nerve, muscle and tissue strain. Though not totally eliminated, stress urinary incontinence is far less common (up to 50% less) after cesarean compared with vaginal birth. Serious injuries to the anal sphincter are rare after cesareans that are performed before labor begins. Pelvic organ prolapse is also less common.

‘Cesareans for all’ obviously cannot be justified for the prevention of pelvic injury alone. Therefore, the challenge is to identify those women most at risk – and encouraging women to discuss their potential risk factors with their doctor or midwife. Also, it should be understood that not all cesareans are ‘equal’ in terms of their potential benefit. The most protective of all – the ones that most reliably help to avoid pelvic floor injuries – appear to be those performed in the first pregnancy, before labor ever begins. Cesareans performed after the onset of labor may be less protective.

Childbirth choices should be individualized. Each pregnancy is a unique combination of mother and baby, making each and every labor and delivery a singular event. As a result, a single obstetrical strategy, or an ‘ideal’ mode of delivery cannot be applied to all expectant women. In some cases, a prolonged labor, a forceps extraction, or an extensive perineal injury during vaginal birth may be more physically traumatic for both mother and baby than a cesarean section. For others, the exact opposite will be true.

**I’ve Had a Cesarean in the Past. What is the ‘best’ way to have my next baby?**
Vaginal birth after cesarean section (VBAC) has been an obstetrical topic mired in controversy. Up until the past few decades, VBAC was rarely attempted due to concern that the uterine scar might rupture under the forces of labor. But over the years, it became
clear that VBAC could succeed for most women who tried. In 1987, the National Institutes of Health delivered a statement actively promoting VBAC as a safe and desirable alternative.

More recently, new debates have arisen regarding VBAC – and over which women are the best candidates. The risk of pelvic floor injury, though often overlooked in this debate, may indeed be a factor worth considering – as higher rates of stress incontinence, sexual dysfunction and worse quality of life scores have been reported after VBAC compared to ‘repeat’ cesarean delivery. More research is needed to clarify the risks and benefits of VBAC from the maternal pelvic floor standpoint. The American College of Obstetricians and Gynecologists recently issued a statement stressing the importance of an individualized decision for each woman in each pregnancy, including those occurring after a prior cesarean.

**What Can Be Done After Delivery, To Prevent Pelvic Floor Problems?**

Despite a remarkable level of stress endured in the pelvic area during labor and delivery, most women devote little attention to their recovery afterwards. Although childbirth is a ‘natural’ event if ever there was one, the physical recuperation is substantial – especially if you’ve had a long labor, large laceration, or episiotomy. Right after childbirth, you can begin taking steps to rehabilitate your pelvic floor.

*Perineal healing* may be enhanced by proper hygiene, and sometimes icepacks as directed by your doctor or midwife.

*Kegel exercises* will help to restore pelvic floor muscle function during the postpartum period, before it is permanently lost. Well-toned levator muscles may help to prevent post-reproductive symptoms before they ever arise.

Good bowel habits and avoiding constipation are important for minimizing strain against the levator muscles, pelvic nerves, and any perineal stitches. Sensible work and play. Leaping into a full and strenuous routine may stress your pelvic area, before it has a chance to properly heal. Exercise, dietary and lifting habits should be reviewed.

*If Problems Persist ... Ask the Doctor.* A number of treatments – including physical therapy, non-surgical devices and behavioral training – can be used even during the postpartum period, if pelvic floor symptoms remain a bother despite self-remedies.