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Hope with a Heartbeat

With worry a constant companion, the author embarks on another pregnancy, post-stillbirth

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It can't happen again.

That's what my doctor told me. She said stillbirth is such a rare occurrence that it never happens twice.

I knew she was wrong. I'd seen the stories of women with multiple losses on online message boards. I'd read studies showing women who have had one stillbirth are at an increased risk for another.

Besides, if subsequent losses weren't possible, why designate women with a prior stillbirth as high risk or recommend increased fetal monitoring? Is it because no doctor wants to be blamed for overlooking something a second time around? Or is it because women with a loss begin to question the gap in knowledge in a system they trusted with the lives of their babies?

I didn't say anything to her. I didn't know how.

I knew my doctor said it to reassure me that this time my baby would live. She didn't want me to worry.

What she didn't realize, and what every parent who has lost a child knows to be the only hard-and-fast rule of a subsequent pregnancy, is that worry and doubt are as constant a companion as prenatal vitamins. Nothing a doctor says or does causes the worry.

It has been there since the first time I thought about getting pregnant again.

It will be there until I hold a living, breathing baby in my arms.

Nine months is a long time to wait to find out if this time it'll be different. It's hell. But hell with hope and a heartbeat.

There was no doubt I wanted to get pregnant again after my son Avery was stillborn in March 2005. Losing him was the worst thing that has ever happened to me, but the six months he was in my womb were also the most precious. His brief and unexpected visit changed the haphazard course of my life and gave it a resolute focus.

I needed to have a baby. It didn't matter that I was 36, single and without a clue as to how I was

going to make it happen.

My friend Stas encouraged me to wait a year and a day after Avery's death. Studies showed her advice had merit: Women who wait a year or longer to get pregnant after a loss experience less anxiety and depression. But as many as 60 percent of women become pregnant within a year of their loss. Most of the couples I met waited only a few months before trying again.

I wish I could say I decided to wait a year because I wanted to give myself a chance to heal.

I spent the months after Avery's death honoring his life. I attended support group meetings, went to candlelight vigils and talked about him to anyone who would listen. I tried to find out as much as I could about stillbirth -- despite a distinct lack of research and awareness -- and wrote a story about my experience in this magazine.

But the mother in me was just biding time until I could get pregnant again. I tracked my menstrual cycle like a mad scientist, asked my friend, Steve, to be a donor, read up on home-insemination methods and researched prenatal testing.

While doctors never figured out why Avery died, there were a few conditions that could have been contributing factors: circumvallate placenta and a peripheral cord insertion. Neither of them, the doctors said, usually resulted in a negative outcome and there was no reason to believe they would recur. The blood clot they found on my placenta might have been the result of a fall or from another condition.

Without knowing the cause of death, I found little comfort in my doctor's reassurance that I wouldn't have another stillbirth. Research on pregnancies after a loss wasn't comforting, either. One study found that only 25 percent of the subsequent pregnancies of women who had a loss after 10 weeks gestation resulted in a surviving infant. Another showed that women who had a stillbirth were five times more likely to have a subsequent stillbirth -- the recurrence of stillbirth almost tripled in black women compared to white women. But a small Australian study from 2001 found there was no increased risk of subsequent stillbirths. And while I had met many women with multiple miscarriages, none of the bereaved couples I met had more than one stillbirth.

Before I tried to get pregnant again, I asked for every blood test available to check certain protein and hormone levels -- including the one for thrombophilia, a blood-clotting disorder that has been linked to stillbirth. I requested a prescription of progesterone to take for two months once I got pregnant, because low levels of the hormone may lead to miscarriage. My doctor prescribed all of them without blinking. One test came back with a slightly elevated anti-phospholipid antibody, which if high enough could cause thrombophilia. My levels were low enough that the high-risk perinatologist I consulted thought treating it with aspirin was sufficient.

He was confident I had no reason to worry and I should go out and "make a baby."

Most bereaved parents have spent considerable time trying to find out what might have caused their loss. They take nothing for granted and don't assume everything will be different the second time.

"I was hell bent on having things go right," said Sherry Page, whose daughter, dubbed MP (Mysterious Person), was stillborn with a true knot in her umbilical cord. "I was the most conscientious pregnant woman ever. ... I felt responsible for making sure nothing went wrong, which was a burden to some extent."

At 23 weeks pregnant, Tarra Lyons was on a trip with her husband, Dave Miles, when she noticed she had been leaking fluid for a few days. Lyons visited a local hospital and was examined and monitored for four hours. She was told it wasn't amniotic fluid and was sent home. By the time they got back to Berkeley, Lyons had a fever. Doctors discovered she had no amniotic fluid left. There was no way they could save her son Morgan. He was born alive at 1 pound and died less than two hours later.

"I was a high-risk pregnancy and I wasn't treated as such," Lyons said of the doctors at the first hospital she visited. She was later diagnosed with an incompetent cervix. After spending months researching her options and talking with other parents through online support groups, the 41-year-old believed getting a stitch called a cerclage to keep her cervix closed was her best course of action.

When she learned she was having twins, she was even more convinced it was the right thing to do. But her OB told her the procedure was unnecessary. She sought a second opinion and got a similar response.

"He had a preconceived idea that incompetent cervix was extremely rare and could not be the cause of the loss," Lyons said.

She started to doubt the doctors and the treatment she was getting. "I felt like they didn't care, like I was the only one who cared," Lyons said. "When I would point out the research, the doctors would say, 'Oh someone has been doing their homework.' And I thought, 'Yeah, but you're not.'"

Seeking a third opinion, she went to a well-known high-risk perinatologist in San Francisco who finally advocated the cerclage. He told her that common practice is to perform it only after at least two losses. He said while 25 percent of the cerclages performed might turn out to be unnecessary, he would rather do one that is unnecessary than not do one that is.

After doing the cerclage, the doctor told Lyons he was 100 percent convinced she had needed the procedure: Her cervix had already dilated, and "looked like I had had several kids."

"I had to trust my judgment, I had to listen to my intuition," Lyons said. "I am so glad I changed doctors and asked for another opinion." Her twins, Fiona and Pearson, were born healthy at 37

weeks in January.

Dr. Sarah Kye Price, a professor at the Virginia Commonwealth University School of Social Work, said mothers tend to become experts in whatever may have caused their loss.

Price found that 25 percent of women in the United States had one or more fetal deaths before having a live birth. "It is important for women to be self advocating. Ask a lot of questions and take charge of their experience and not see it as a weakness."

According to Richard K. Olsen, founder of the National Stillbirth Society, many potential pregnancy-saving procedures are not discussed with patients. Sometimes because doctors may not believe they will work; other times it's because insurance companies refuse to cover them. Olsen, whose daughter Camille was stillborn full-term with no known cause of death in 2000, claims that many stillbirths could be avoided if women were taught how to monitor their baby's activity and if ultrasound and non-stress testing were more widely made available to all women -- not just those deemed to have high-risk pregnancies.

"In the end it is the mothers of America coming together, not the medical community or the government, that is going to help us conquer stillbirth and start to reverse the appalling loss of life that devastates so many families," he said.

In April 2006, after taking every precaution I can imagine -- and waiting a year after Avery's death -- I made my third home-insemination attempt.

And it worked. As soon as the two blue lines showed up on the test strip, I called the dozen or so friends and family that make up my tribe, gushing excitedly at my luck.

But within days a nagging fear bubbled up. I worried that everything I did would end the pregnancy. Did the trash weigh less than 10 pounds or did I need a forklift to carry it? Could I repaint the spare room or would I give the fetus a birth defect? Could I fly?

I worried that my worry would somehow hurt the pregnancy. I couldn't bring myself to call the cells multiplying inside me a baby, because I didn't want to jinx it. So I called it the Bean.

I had read multiple studies that show a correlation between pregnancy loss and higher levels of anxiety and depression during subsequent pregnancies. So I knew I was normal. There was even research, including a study by Price, which said it wouldn't affect my ability to bond with the baby once it was born.

"We know that there is increased anxiety, but it speaks to the resilience that makes parents able to attach and parent once the baby is born," said Price. "Older studies decades ago were critical of parents feeling depressed or anxious after a loss and that it would be harmful but they were based

only on theory and isolated case studies."

I felt guilty that I wasn't enjoying the pregnancy. I felt bad that I was cheating the Bean of the love and excitement I felt when I was carrying Avery. The main thing I felt was desperation. I was convinced I was going to miscarry. I found myself begging the Bean to hold on. I finally reached week eight and Stas came with me to the OB's office for my first prenatal visit. The last time I was in that room was to see why Avery wasn't moving. I told Stas I was fine, but a part of me wasn't.

When my doctor, Dr. Jane Fang, walked in, the first thing she said was, "I'm sorry if this is uncomfortable for you. I know that the last time you were in here was when Avery died." She seemed to understand this was a dual pregnancy for me: One filled with fervent hope and the other with persistent regret.

She prepped me for the ultrasound and I turned away from the screen.

"I need you to look first to make sure everything is OK," I said, through the lump in my throat.

She turned on the monitor and within seconds said, "Yup, there's a baby in there. Everything looks great." Tears of relief dripped on the table as I turned back to see the proof for myself.

A fuzzy little bean with a heartbeat.

Getting through the uncertainty of the first trimester was a brutal test of endurance. I started going to a monthly support group for subsequent pregnancies. It felt like there were unexpected landmines and bittersweet reminders of what I lost and what I could still lose every day.

"It's about the intersection of grieving one baby while growing another baby and how confusing that can be," said Cherie Golant, a licensed clinical social worker who facilitates the Pregnancy After a Loss support group at California Pacific Medical Center in San Francisco. Golant, whose first child, Julia, was stillborn at 35 weeks, started the group after her subsequent child, Rose, was born. "Parents are afraid of losing another baby from the same thing happening and they may have learned about other ways for babies to die that they become afraid of. Many parents are afraid to have hope that their new baby will come home."

After Angelica Zab's first child, Daniel, was born alive, she lost three subsequent pregnancies in the first trimester. When her fourth pregnancy with her daughter Isabel, now 4 months old, made it into the second trimester, Zab was a wreck.

"I remember throwing the first ultrasound picture in the trash," the 41-year-old Berkeley mom said. "I didn't want to love her because of my fear of losing her, or anything going wrong. Being pregnant with Isabel felt to me like 'March of the Penguins.' I identified with what they go through to have their babies, so precarious, so hard and so many times, so tragic."

One doctor told Zab, "Don't worry, you'll be fine. Lightning doesn't strike twice in the same place."

"I thought to myself, 'Well, I think lightning has stricken many times already in the same place,' " Zab said. "She didn't understand what I was going through and that was painful and frustrating."

Price said that most women have mixed feelings about being pregnant again.

"They want to say 'I'm pregnant,' but they know it doesn't mean that they are going to have a live baby," Price said. "And that produces a lot of anxiety. Most women feel like they will overburden their doctors and their worry will cause problems for the baby. Once bitten twice shy. They want to protect themselves and not get too attached or too hopeful, but they want to enjoy it, too. To get past that milestone of loss in the last pregnancy."

Amy Abbey found solace in support groups and needed to talk about the ups and downs of being pregnant again. After losing her first baby, Solomon, at 19.5 weeks, as well as losing her second pregnancy, Abbey said she "was in the loss world and trying to climb back to normality, not realizing the normality I knew would never be mine again."

When she got pregnant for the third time, she didn't want to trust it.

"Emotionally I was a wreck, very low functioning yet still getting through my days," Abbey said. "I did not believe -- until I heard Alison cry -- that I would give birth to a living child."

Abbey had another son, Adam, and decided to compile a book of subsequent pregnancy stories called, "Journeys: Pregnancy After Loss," to give others hope that "there is a light at the end of this tunnel, even if you can't see it."

"I will never be the same," said Abbey. "Alison and Adam, and life in general, have restored happiness and wonder for me. But deep in my core, there is a level of joy I am still too cautious to experience." Page said that people like to believe that because you've had another child, "you've gotten over it."

"It takes a long time to heal," Page said. "Other children do not replace the missing one. MP is still very present, albeit in a softer, more distant way than she was in the early years. She is still a part of the family and will always be."

Somehow I made it past the miscarriage "danger zone" and into week 14. It became a little easier to breathe. I marked a month off the calendar until the 19-week ultrasound. My friend Anna called dibs on the appointment before I was even pregnant. She had come with me to Avery's midterm sonogram, and wanted to be there for the Bean's.

"That's the sex one, right?" she asked. She wanted to be the first one of the tribe to know the Bean's

gender.

I saw Dr. Peter Callen, the same radiologist that examined Avery. He had discovered the circumvallate placenta and peripheral cord insertion but as per hospital policy, he could only tell my doctor. Because they weren't usually associated with a negative outcome, my doctor didn't tell me because she didn't want to worry me unnecessarily.

This time I made sure he was allowed to tell me everything on the spot -- good, bad and ugly.

It was a brief conversation.

"Everything looks good," he said.

And the Bean was a boy.

I was showing halfway through the second trimester and started getting "The Question" from strangers.

"Is this your first?"

"No," I told them. "My first was stillborn."

Some said, "Oh, I'm sorry." Others just said, "Oh."

Many more than I expected said nothing at all.

I was stuck. The baby that was nothing but ashes in a small cobalt bottle on my mantel was more real and alive for me than the baby in my belly.

"Just because you love this baby doesn't mean you don't love Avery," Dr. Donna Wiggins said to me during a monthly check up. She was the doctor on call who delivered Avery and called him an angel. "When my second child was born, it didn't mean I loved my first one any less."

A few weeks before the point in my pregnancy when I lost Avery, Stas took me into a Pottery Barn Kids and said we should register. I thought it was too early to buy anything. She didn't want me to cheat myself out of the experience and joy of being pregnant.

I never shopped for Avery. He died before anyone could plan a shower for him. I wasn't ready to make a list of baby things. I wasn't convinced the Bean was ever going to need them.

But some part of me wanted to believe, wanted to be normal. A week later at a Giants game, I made my first purchase: Black and orange booties.

When the week finally arrived when I lost Avery, I found myself at a Support After Neonatal Death (SAND) group meeting. I had agreed to go with a co-worker who had just hit her two-year anniversary of the stillbirth of her son, Matthew -- something she hadn't told any of her new friends or peers about.

Even after two years, her tears flowed fast and frequently as we listened to stories of other parents whose losses were more recent, yet seemingly no less raw, than hers.

When it was my turn, I felt guilty talking about being pregnant -- especially as several couples in the room faced fertility challenges getting pregnant with the children they lost. So I avoided talking about it, instead focusing on Avery. I talked about the year after his death and the gift bags that a few other SAND couples and I made for newly bereaved parents. We filled them with disposable cameras, small hand knit hats and suggestions for how to say goodbye to their babies before leaving the hospital.

The couple across from me said they got one of the bags when their son was stillborn just a few weeks earlier. Without it, they said, they would never have thought to hold him or take pictures. They were grateful.

But I was grateful that Avery's death helped another couple get through the hardest day of their lives.

Before I knew it, I was in the third trimester and uncharted territory. The Bean's movements were more pronounced. The four dimensional images of his face made him look like a real baby, not just a bony alien. I suddenly found myself wanting desperately to hold him and beginning to believe it was possible.

At 29 weeks, I traveled to New Orleans to see Dr. Jason Collins with the Pregnancy Institute. He has been conducting a study on the presence of cord-related anomalies in subsequent pregnancies of women who had some kind of cord-related complication in their previous losses. In his first test group, 21 of the 25 women presented with some kind of cord issue at 28 weeks. All delivered by 37 weeks, 14 of them with the presence of a cord anomaly and two that resulted in emergency C-sections. While stillbirth advocates laud his work, members of the medical community are more critical of his findings because he hasn't used a control group -- something he said he is in the process of doing now.

At first I thought flying to New Orleans a year after Katrina and drinking the water presented more of a risk to the pregnancy than the condition of the cord. Everything had been perfect so far. This time I knew my doctors hadn't knowingly kept anything from me.

Halfway through the exam after a half an hour of fetal monitoring, Collins looked at the strip and said, "I think you will be surprised at what I have found." Using an ultrasound, he showed me

where the umbilical cord was wrapped around the Bean's neck. A pattern that looked like a "w" on the strip indicated to him that the cord was being compressed. The ultrasound showed him why.

Collins wasn't worried because everything else looked fine. He showed me how to use the home-monitoring equipment so I could view the Bean's heart rate and my contractions and how to send the readouts to his BlackBerry.

At first I didn't know what to do with this information. I had thought everything was perfect. My friend Kala, who was the labor and delivery nurse for Avery's birth, reassured me that nuchal cords are common in healthy births and she didn't want me to worry. I knew she was right, but I had also met countless parents who had been told that their babies died because of a cord accident.

"Without Dr. Collins and the home fetal monitor, I don't know if I would have made it through the pregnancy," said Dana Fang, whose first child, Olivia, was stillborn with a longer than normal cord wrapped four times around the baby's leg with a true knot. Although the OB nurse from San Diego knew she wanted to try again, she didn't realize how emotionally challenging it would be to be pregnant just three months after her loss. "Not only did I fear she would die, I was still grieving the stillbirth of my first child," Fang said. When she was 28 weeks pregnant, Fang traveled to New Orleans to be evaluated by Collins. He found the cord was wrapped around her subsequent baby's neck and the cord had a marginal insertion, near the edge of the placenta instead of in the middle where it normally would be. "I couldn't believe it, considering my first baby died from a cord accident," she said. "But I felt at ease knowing that Dr. Collins was evaluating (the strip) every night."

When she was 34 weeks, Collins told her she would need to be delivered soon. She was having frequent contractions and cord-compression variables. "I was in pain and I just didn't like what was going on. As an OB nurse, I knew what I was seeing," said Fang. While her treating physician listened to her concerns, doctors wouldn't deliver her without a reason to believe it was necessary.

"Within a week, my fluid level dropped from 19 to 0 and I needed an urgent Cesarean section," Fang said. Her daughter Camille was born healthy in October.

I found myself asking anyone who would listen: If we can see cord complications like Fang's and mine at 28 weeks when a baby is considered viable -- if we can monitor pregnancies with these potential danger signs -- why aren't later-term ultrasounds standard medical procedure? Couldn't the majority of deaths related to cord accidents be avoided if there was more monitoring?

Collins thinks so. "We have to change the way we treat the third trimester," he said. "We look for club foot and cleft palate, which each affect 1 in 1,000 babies and aren't fatal. But we don't look for cord problems, which account for as many as 20 percent of fetal deaths."

But Dr. Julian Parer of the University of California San Francisco said that because there has been

so little research on the role of umbilical cords in fetal deaths, there is no evidence that umbilical anomalies are the cause of death. Thirty percent of all babies are born healthy, despite having the cord wrapped around the neck or some other squeezable place.

"There is a prevalence of doctors using the cord around the neck as a reason for the death, which is erroneous at best since we can't actually tell if that was the cause unless the babies are being monitored at the time of death," said Parer, an OB-GYN who specializes in maternal-fetal medicine and high-risk pregnancies.

So if the Page and Fang babies didn't die from a cord accident, what did they die from?

Parer grants that there have been no studies to prove that cord anomalies are not the cause of death, either.

A five-year, \$15 million research project co-led by Dr. Uma Reddy with the National Institute of Child Health and Human Development at the National Institutes of Health is attempting to address the lack of research into the causes of stillbirth. The presence of cord entanglements or anomalies will be documented, but Reddy said the deaths won't be attributed to a cord accident, "unless there is evidence of cessation of blood flow or lack of oxygen in the brain."

At a conference of the Society of Fetal Maternal Medicine in San Francisco last month, Reddy reported that a recent study showed that women with a prior stillbirth were five times more likely to have a subsequent stillbirth. Unfortunately, she said, current research and testing are still far from making conclusive recommendations for prevention.

"The hope is that in the future we can combine various (risk) markers together to be able to better understand, to help evaluate all pregnancies and tell which babies are at risk," she said.

How can some doctors tell their patients that recurrent stillbirths don't happen when there isn't research that says they don't and more than a few studies indicating that there is an increased possibility that some women will have a subsequent loss?

Dr. Robert Silver of the Department of Obstetrics and Gynecology at the University of Utah, Salt Lake City, said the recurrence risk for fetal deaths has not been well studied, and reliable numbers are often unavailable. But a study he co-authored in September 2004 showed that out of 230 women who had at least two pregnancies -- one resulting in a loss at 10 weeks gestation or longer -- fewer than 25 percent of their next pregnancies resulted in a live birth. Both Silver and Collins believe their studies point out glaring gaps in knowledge in obstetric medicine. And they concur that the way the third trimester is monitored -- in all women -- should be re-evaluated.

Parer said an increased scrutiny in otherwise normal pregnancies could have a negative effect. Once a nuchal cord or similar condition is spotted in a baby with no other negative symptoms, then

doctors are obligated to act on the information by more closely monitoring the pregnancy.

"That can lead to an increase in interventions like early inductions or C-sections in otherwise healthy pregnancies," Parer said. "Anytime we intervene there is an increased risk of something going wrong. And we don't know in how many of them the intervention is worthwhile and how many were unnecessary. We have a responsibility to the patient with a loss, but we have a responsibility to normal women as well."

A postal survey of Australian obstetricians in August 2006 showed that 87 percent prescribed additional third trimester ultrasounds for patients with a loss. Even without complications in subsequent pregnancies, the babies were more like to be delivered early. Elective induction was recommended by 93 percent of the respondents, and elective Cesarean deliveries by 35 percent.

If recurrent stillbirth rates are so low as to be too insignificant to raise alarm, could it be because the subsequent pregnancies are so closely monitored that increased interventions prevent fetal demise?

All three doctors agree that is one possible explanation.

Parer grants that some, like Collins, believe that if even one baby is saved by the increased monitoring that the risk is worth it. But Parer believes more research needs to be done.

"I think the research Dr. Collins is doing is fantastic," Parer said, "but he's putting advocacy before the data."

Golant said that most parents with a loss will choose, if they are able, to have more monitoring in the subsequent pregnancies. "They have an increased need for information and a perception of having control even if it is possible it will increase their anxiety levels," she said. "But ultimately parents are relieved to know as much as they can about their baby in utero."

The reporter in me understands the importance of critically evaluating research that suggests making major changes in medical protocol. And yet the informed mother in me feels as if much of what is standard practice hasn't always been based on research. Collins is asking the very questions those of us who have lost children have asked. Why not use the technology available to find out all we can about our pregnancies and allow us to decide what to do with it before we lose our babies?

To me, being able to see the Bean's heart beating every night was worth the risk of causing an unnecessary intervention. Especially as it could alert me when an intervention might be necessary.

With each strip, I became more confident that he would make it -- despite his nuchal cord.

Maybe it was his constant tossing around in my womb. I'd been counting his kicks since I hit 27

weeks, and they were regular and strong.

According to the Maternal Observations and Memories of Stillbirth study in 2005 of approximately 5,000 women, 50 percent felt a gradual decrease in fetal movement several days before their babies died, and 56 percent reported that it was their first reason to think something was wrong. One of the study's authors, Dr. Frederick Froen, said that reduced movement is associated with adverse pregnancy outcomes in both high- and low-risk pregnancies. I felt a dramatic decrease in Avery's movements for several days before he died. I just thought he was going through a resting phase and no one had mentioned kick counting because it was too early. At 24 weeks there wasn't anything they could do to save him. (To read more about kick counting, visit www.sfgate.com.)

Luckily, the Bean continued to do gymnastics in my belly.

Slowly, my worry shifted to the more mundane things that other pregnant women obsess about: How do I get ready for a baby?

He was going to need clothes and diapers and a crib and breast milk.

I didn't have any idea how to go from being pregnant to giving birth and having a baby. After taking everything one day at a time and taking nothing for granted, now I had to believe that my son would be born. Weeks that dragged at a snail's pace in the beginning were now speeding by too fast.

In November, my friends hosted a shower, and parents of eight stillborn babies shared their best wishes for his safe arrival. In December, 12 of my close female friends gathered for a blessing ritual to help prepare me to go through labor. I told them his name.

Quinn.

I visualized Quinn's birth. I saw his head come out -- without the cord around his neck. The doctor put him on my chest. I saw his hand around my fingers. I felt his head under my chin. He was perfect.

Collins wanted me to induce at 36 weeks. There were days when I felt as if my womb was not the safest place for him to be and that bringing him out sooner would be better.

But the weekly non-stress tests -- where a nurse monitors his movements and heart rate for a half an hour -- and the home monitor I strapped on more than once to calm a midday panic attack, made the last month a more calm experience than the entire pregnancy.

The closer I got to 36 weeks, the more I didn't want to be induced. He was doing fine and there were no indications of distress. I told Collins I wanted to wait.

After finding out Quinn was 6 pounds at 34 weeks, Fang worried his large size might cause his

shoulder to get caught on my pubic bone during delivery. With a nuchal cord, the potential complication could be even more serious. She suggested inducing at 37 weeks. Despite all the technical reassurances that he was fine, I couldn't help asking, "What if deciding to wait kills him?"

We set the induction for Dec. 12, a few days before Quinn reached 38 weeks. "This is going to be a very different birth than Avery's, Suzanne," said Sam, my friend and labor coach. "This time you will have a living baby working with you to be born. You need to talk to him and tell him what you are afraid of and tell him what's happening so he can help you."

We were supposed to arrive at the hospital at 6 p.m. on Mon., Dec. 11, for a course of cervidel to soften my cervix before the next day's induction. But OB triage was packed, and they told me there were no beds for me.

It was two weeks before Christmas, the baby was an immaculate conception and there was no room at the inn. The universe has a sense of humor.

A large room finally opened up and a caravan of six shepherds settled in for the night.

At 1 a.m., a nurse administered the cervidel and the small pre-labor contractions I'd been having for a week picked up speed and intensity. Stas and Sam, both of whom had coached me through Avery's delivery, were with me through every one.

I walked through most of the early labor. I passed the nursery, a place I avoided at all costs when I walked through my labor with Avery. Right near the window was a small newborn under a heat lamp. I watched his chest rise and fall.

Despite the months of telling myself not to get my hopes up, to not get duped again, I realized that my desire to have a baby had been strong enough to get me through the worst nightmares of what could happen. My dream was so close to finally coming true.

After 20 or so hours of labor, my doctor said, "OK, you are ready to push."

All of a sudden the room erupted. My mom and her partner Jen bolted out of bed, Quinn's dads, Steve and his partner Pablo, came back in a rush with coffee, Sam moved furniture out of the way, Anna, Rosa and my roommate Kai, all flipped open their cell phones to update the rest of the tribe. Within half an hour, there were 13 people around the bed.

I could start pushing. That meant he was coming.

Everything happened so fast as the contractions picked up intensity. "Sing something, something everybody knows," I shouted between contractions.

Steve started singing "Row Row Row Your Boat" and the whole room joined in for several rounds.

Then he pulled out his laptop and played "The Mighty Quinn."

"Everybody's in despair, every girl and boy

But when Quinn the Eskimo gets here

Everybody's gonna jump for joy

Come all without, come all within

You'll not see nothing like the Mighty Quinn"

I pushed as hard as I could past illogical pain and I saw and felt his head slip free. I heard the "oohhhhs" from the tribe and with one more push his body slid out -- with no cord around his neck.

Immediately, Fang handed me my beautiful baby and I put him on my chest. I felt his hand on my fingers, his wet head under my chin. Seconds of silence pass before his cries filled the room. He was alive and breathing and perfect. Just like I imagined -- and so much more amazing than I ever let myself believe.

The room let out a sigh of relief as someone led the crowd in a round of "Happy Birthday."

Quinn Adam Pullen was born at 9:20 a.m., Wed., Dec. 13, at 8 pounds, 20 1/2 inches. In the few quiet moments I found myself alone, I thanked his older brother Avery for making him possible and for making me a better mother.

The past nine months, and the year before it, were part of an agonizing and hopeful journey I'm not sure I was ready to take; but am not sorry I did. This time I got the prize at the end and didn't have to give him back.

The facts

Twenty-five percent of mothers in 2001 in the United States had one or more fetal deaths before having a live birth. (Price, Maternal and Child Health Journal, Nov. 2006)

In the United States, 15 to 20 percent of all known pregnancies end in miscarriage and one in every 150 births results in a stillbirth. Most researchers believe these numbers would be higher if not for inconsistencies in data reporting and collection. (Centers for Disease Control)

Women who have had a stillbirth have a five times greater risk of a subsequent stillbirth; recurrence of stillbirth is almost tripled in blacks as compared to whites. (Sharma, et al, Obstetrics and Gynecology, Feb. 2006)

Of women who had a fetal death of 10 weeks gestation or longer, fewer than 25 percent of their next pregnancies ended in a live birth; 44 percent miscarried. (Frias, et al, American College of Obstetricians and Gynecologists, Sept. 2004)

In more than half of recurrent stillbirths, the cause of death was the same. (Maternal Observations and Memories of Stillbirth study, Robson et al; 2005)

Women who have had a stillbirth experience higher levels of depression and anxiety during pregnancy. (Hughes, et al, British Medical Journal, June 1999)

Resources

Support groups

SPALS - Subsequent Pregnancy After a Loss Support- An online member support and resource group, www.spals.com

PAM - Pregnancy After Miscarriage- Chat rooms, forums and mailing lists for those who are pregnant, trying to get pregnant or have had a baby after a loss; www.pamsupport.org.

Pregnancy After Loss - San Francisco support group. Call Cherie Golant; (415) 600-2229, e-mail cpmcnewborn@sutterhealth.org.

SHARE - Pregnancy and Infant Loss Support Group - Online and local support after a loss, including monthly meetings for subsequent pregnancies; www.nationalshareoffice.com. In Sacramento; www.sharingparents.org.

HAND -- Helping After Neonatal Death - Newsletter, bulletin boards and links for local and statewide support groups and resources; www.handonline.org.

Compassionate Friends - www.compassionatefriends.com.

A Heartbreaking Choice - Resources, stories and support for those who have terminated pregnancies due to genetic abnormalities; www.heartbreakingchoice.com.

Organizations

National Stillbirth Society - Nonprofit parent-based group focused on raising awareness and preventing stillbirths through advocacy, education and activism; www.stillnomore.org.

International Stillbirth Alliance- Nonprofit coalition of stillbirth groups focused on research and awareness; www.stillbirthalliance.org.

First Candle/SIDS Alliance - National network of healthcare providers, parents, caregivers and researchers working on infant mortality. Online resources, links to research and bereavement guidelines; (800) 221-7437, www.firstcandle.org.

M.I.S.S. Foundation/Missing Angels Bill - International nonprofit organization offering support, educational programs and legislative action; (888)455-6477, www.missfoundation.org. Nationwide campaign to pass the Missing Angels Bill, a state-by-state push to issue modified birth certificates for stillbirths; www.missingangelsbill.org.

Missing Grace Foundation- Resources and support for pregnancy loss, infant loss, infertility or adoption; (763) 497-0709, www.missinggrace.org.

BabyKick Alliance- Kick counting information, resources and newsletter; www.babykickalliance.org.

The Centering Corporation - Grief resources, books and materials; (402) 553-1200, www.centering.org.

<http://sfgate.com/cgi-bin/article.cgi?f=/c/a/2007/03/25/CMSUZANNE25.DTL>

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