# REPRODUCTION CHOICES

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Family planning is an important health consideration for all of us. The decision of whether or not we have children greatly impacts our lives. In recent years, advances in the medical field have made childbirth safer and easier; but new technologies have also provided more, and sometimes difficult, choices.

If you have decided not to have children for whatever reason, whether it is a transient or permanent decision, some precautions must be taken to prevent pregnancy. Abstinence is the only 100% foolproof birth control method, so it is imperative to learn the benefits and limitations of various birth control methods.

Contraception methods are numerous. Each has its own accidental pregnancy rate and complications. By chance alone, 85% of couples who practice no means of birth control will become pregnant within a year. The accidental pregnancy rate with spermicides, rhythm, withdrawal, cervical cap, sponge and diaphragm is 10% to 20%. Ninety-seven percent effectiveness is seen with the pill and IUD, while condoms are less effective. New methods of birth control include hormone injections, implants and sterilization. Their effectiveness is 99%, or greater but may have unwanted side effects.

Choosing a contraceptive is an important decision, but it also needs to be a practical one. An ineffective method results in an unwanted pregnancy. An unsafe method may result in serious medical complications. If a method does not fit one's lifestyle, it is not used. For example, if one has disproportionately short arms, a diaphragm, sponge, or cervical cap would probably not be feasible.

Other factors must also be considered. There are some reports which state that individuals with achondroplasia have a tendency to develop fibroids. If one's physician finds this problem, it would be reasonable to refrain from using birth control pills, since the estrogen in the pill may increase the growth of the fibroids. Birth control pills may exaggerate menstrual complications such as edema; but, they may actually help cramps, decrease flow, and lessen mood swings. Premature menopause has been reported in women with achondroplasia, epiphyseal dysplasia, and in women with a family history of premature menopause. Therefore, undue delay in childbearing may not be a good choice for these women. Individuals with cartilage hypoplasia and pseudoachondroplasia may have longer menstrual cycles, and getting pregnant may require the help of a specialist to determine their fertile periods.

If one decides to have children, genetic concerns need to be addressed. If one's spouse also has a chondrodystrophy, the chance of having a child with short stature may be as high as 75%. Prenatal diagnosis through ultrasound is available for a number of disproportionate short statures and usually requires ultrasounds at 12, 16, 20, 24 and 32 weeks. Preconception evaluation and counseling should be considered, so questions regarding genetics labor, delivery can be answered in an unhurried and unpressured situation.

Termination of a pregnancy is also an option. However, it is <u>not</u> a requirement for utilization of prenatal diagnosis, since the knowledge of a problem in the fetus helps to prepare the best possible obstetrical management for the mother and the child.

Complications reported in pregnancies with chondrodystrophies include increased lordosis, back pain, spinal cord and nerve root compression due to increased weight, and excess swelling from fluid retention. Breathing difficulties often occur during pregnancy, especially in the latter part of it, in individuals with severe scoliosis, spondyloepiphyseal dysplasia, achondroplasia, Vitamin D-resistant rickets, and other short-limb dwarfism. This has prompted the recommendation of breathing tests (pulmonary function) prior to pregnancy.

Cesarean delivery is usually necessary due to the pelvic configuration in most people with disproportionate short stature, and also due to a large fetal head in achondroplasia. General anesthesia may be required in anybody with an unusual spine (as in achondroplasia and most spondyloepiphyseal dysplasias), but- this should be determined by the physician. Slippage of C1, C2 spines may occur, and therefore evaluation <u>prior</u> to anesthesia is important. If there is utilization of general anesthesia, special care for the baby may be required to avoid complications from sedation.

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Proper preparation is essential, so choose an Obstetrician-Gynecologist who is knowledgeable, or one willing to learn. For example, a knowledgeable obstetrician can speak to an anesthesiologist prior to delivery, so everyone involved in the delivery understands the necessity of general anesthesia. If the on-call anesthesiologist knows about the complications, it will avoid delays and problems at delivery.

While the above problems are well recognized, it must be remembered that there is a tendency in medicine to discuss the "worst" cases and report those in the journals. Do not become alarmed. Each individual's circumstance is different and may require less or more medical treatment and supervision.

Not to be dismissed is the fact that some individuals may not wish to, or be able to, experience childbirth. Adoption is an option. Moreover, the

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Adoption Committee of LPA is a wonderful resource. Whether one "delivers" or adopts, a significant portion of bonding to a child takes place after birth. For those who wish to give love and care to a child or infant on a short-term basis, foster care is ideal, and it provides a much needed service. It takes a special human being to help and care for a needy child on a nonpermanent basis.

Remember that most individuals with short stature do have positive birth experiences and healthy children. Moreover, individuals who make the choice not to have children, also have fulfilling and rewarding lives.◆