University Hospital Southampton NHS
NHS Foundation Trust

Antenatal care for women who are pregnant with twins or triplets

Contents

Introduction to multiple pregnancy

Women who are pregnant with more than one baby are described as having a multiple pregnancy.

Most multiple pregnancies are normal and healthy and therefore most of the advice given to women who are expecting one baby (a singleton pregnancy) is also relevant. However, there is an increased risk of complications for you and your babies which means you need to be monitored more closely during your pregnancy.

The information in this booklet refers to care provided by University Hospital Southampton NHS Foundation trust at the Princess Anne Hospital, and has been adapted from the NICE information for parents with multiple pregnancy, which is available at **http://www.nice.org.uk/nicemedia/live/13571/56427/56427.pdf**

Antenatal appointments during your pregnancy

While you are pregnant you will be offered a series of antenatal appointments with your midwife and in a consultant clinic to check on your health and the health of your babies.

The number of appointments and scans you are offered will depend on your individual situation, the chorionicity of your pregnancy and if you develop any complications.

The chorionicity of your pregnancy is usually confirmed by ultrasound scan at the same time, or soon after it is confirmed you are carrying more than one baby. It is therefore important that you read the section of this booklet entitled Understanding chorionicity and ask your midwife or a member of the fetal medicine team if you have any questions.

Mothers carrying triplets or monochorionic twins will usually be referred to one of the consultants in the fetal medicine unit for care during their pregnancy and will also receive care from a specialist midwife because their care may be more complicated.

Understanding chorionicity

As soon as it is confirmed you are carrying twins or triplets it is important to find out the 'chorionicity' of your pregnancy. This means finding out if your babies share a placenta (the afterbirth). Finding this out early is important because babies who share a placenta have a higher risk of health problems. If your babies share a placenta it means they are identical (monozygotic). This will be confirmed by an ultrasound scan. Most babies who do not share a placenta are non-identical (dizygotic), but it is still possible for them to be identical. This is because 30% of monozygotic twins do not share a placenta.

The chorionicity of twins

Twins can be either dichorionic or monochorionic:

- Dichorionic – each baby has a separate placenta and is inside a separate sac which has its own outer membrane, called a chorion.
- Monochorionic – the babies share a placenta and chorion (which means they are identical).

The chorionicity of triplets

For triplet pregnancies there are more possible combinations:

- Trichorionic – each baby has a separate placenta and chorion.
- Dichorionic – two of the three babies share a placenta and chorion and the third baby is separate.
- Monochorionic triplets – all three babies share a placenta and chorion.

Understanding amnionicity

It is possible for twins and triplets to share an amniotic sac as well as a placenta and chorion. These are the highest risk pregnancies but they are also very rare. If your babies share an amniotic sac you will be seen in our monochorionic twin clinic where there is experience of managing these pregnancies.

Your antenatal appointment and scan schedule

Twins	
Twins who share a placenta (monochorionic)	• A scan at between approximately 11 weeks and 13 weeks 6 days to estimate when your babies are due and to offer you a test to tell you if your babies are at are high or low risk for having Down's syndrome • A scan every two weeks from 14 weeks or from the diagnosis of them sharing a placenta, until delivery. • A detailed scan between 18 weeks and 20 weeks six days to look for anomalies in your babies (this scan will usually be timed to fit into one of your consultant clinic appointments).
Twins with separate placentas (dichorionic)	• A scan between approximately 11 weeks and 13 weeks 6 days to estimate when your babies are due and to offer you a test to tell you if you are high or low risk for the babies having Down's syndrome. • A detailed scan between 18 weeks and 20 weeks six days to look for anomalies in your babies (this scan may be timed to fit into one of your appointments with a doctor). • Appointments with a doctor and scans to measure growth at 28, 32 and 36 weeks.

Triplets	
Triplets where one placenta is shared by two or three of the babies (dichorionic or monochorionic)	• A scan at between approximately 11 weeks and 13 weeks 6 days to estimate when your babies are due and to offer you a test to tell you if your babies are at are high or low risk for having Down's syndrome • A scan every two weeks from 14 weeks or from the diagnosis of them sharing a placenta, until delivery. • A detailed scan between 18 weeks and 20 weeks six days to look for anomalies in your babies (this will usually be carried out in the fetal medicine unit).
Triplets with separate placentas (trichorionic)	• A scan between approximately 11 weeks and 13 weeks 6 days to estimate when your babies are due and to offer you a test to tell you if you are high or low risk for the babies having Down's syndrome. • A detailed scan between 18 weeks and 20 weeks six days to look for anomalies in your babies (this will usually be carried out in the fetal medicine unit) • Appointments with a doctor and scans to measure growth at 28, 32 and 36 weeks.

Your first appointment with the specialist team

At your first appointment your doctor or midwife should talk to you about what to expect during your pregnancy. This will include information about eating healthily during and after your pregnancy, planning where, when and how you will give birth to your babies (further information is given on page nine), how to spot signs of early labour and how to feed and care for your new babies.

Appointments later in pregnancy

The rest of your antenatal appointments should be tailored to your individual needs and your care plan. You will have more scans than women with a singleton pregnancy because this is the only way to check that babies in a multiple pregnancy are growing normally.

Advice about diet and lifestyle

There is no evidence that women with multiple pregnancies have greater nutritional needs than women expecting one baby, so you should follow the same advice about diet, lifestyle and nutritional supplements during your pregnancy as other pregnant women. However, you are more likely to need an iron supplement for treatment of anaemia later in pregnancy.

Screening and tests

Routine tests

The information about screening in this booklet is specific to multiple pregnancy; however, it is important for you to read the booklet entitled Screening tests for you and your baby as your midwife will also offer you the same screening for infections and medical conditions recommended for all pregnant women.

Early in your pregnancy you should be offered a number of tests to check on your health and the health of your babies. Your doctor or midwife should tell you about the purpose of any test you are offered, and explain what the results might mean. You do not have to have a particular test if you do not want it. However, the information from these tests may help your team provide you with the best care possible during your pregnancy. There may be difficult choices for you to make depending on the outcomes of the tests, particularly if the results show that you have a higher risk pregnancy. Your specialist team should offer you counselling and advice before and after each screening test.

If the screening shows there are any problems in your pregnancy, you may need to be referred to a specialist in fetal medicine who is experienced in caring for women with complications in multiple pregnancy.

Ultrasound scans

You should be offered a scan between approximately 11 weeks and 13 weeks 6 days to estimate when your babies are due. This maybe the first time you find out you are carrying more than one baby. The sonographer (person who performs ultrasound scans) will also confirm the chorionicity of your pregnancy. If you choose to have screening for Down's syndrome this scan also forms part of the screening test. If it is not possible to see the chorionicity of your pregnancy at your first scan you will be referred to a specialist as soon as possible to clarify this.

Screening for Down's syndrome

Early in your pregnancy you will be offered screening tests to check whether any of your babies are likely to have Down's syndrome. It can only indicate a possibility that a baby has Down's syndrome.

If you wish to have this done, it must be done at a scan performed between approximately 11 weeks and 14 weeks 1 day. If you wish to have screening and are not offered a scan within this time, please either contact your midwife or telephone the ultrasound department on 023 8120 6046. If you do not visit a healthcare professional until after you are 14 weeks pregnant we are unable to offer Down's syndrome screening.

The risk of Down's syndrome is calculated using a measurement of the baby's neck (taken during the ultrasound scan) and a blood sample from you. If your babies share a placenta (monochorionic) it may be possible only to work out their combined risk of Down's syndrome instead of each baby's risk.

- The risk of a chromosomal abnormality is higher in dichorionic multiple pregnancies than in singleton pregnancies.
- The chance of a 'false positive' result (where the test shows that a baby is at high risk of Down's syndrome but they are found not to have the condition) is higher in multiple pregnancies than in singleton pregnancies.

If the screening test shows either baby to be at increased risk of Down's syndrome, we will discuss with you the methods available to test the babies and the choices open to you for your pregnancy depending on those results. If you decide you wish to have further testing you will be referred to one of the consultants in the fetal medicine unit and offered an invasive test such as amniocentesis, where a needle is used to extract a sample of amniotic fluid from around the baby. Testing this sample will either rule out or confirm Down's syndrome. Remember choosing whether or not to have this test should be your decision: if you have any questions or concerns please speak to your fetal medicine specialist.

Anomaly Scan

During your second trimester (weeks 14 to 28 of your pregnancy) you will be offered another scan, the anomaly scan. This happens around 20 weeks and may last for up to 45 minutes. The purpose of the scan is to check for structural problems in your babies. Before deciding whether or not to have this scan you need to know what it can and cannot tell you. It is therefore important you read the booklet entitled Screening tests for you and your baby prior to this scan and ask your midwife or a member of the fetal medicine team if you have any questions.

Monitoring for intrauterine growth restriction

The subsequent growth scans normally last for up to 30 minutes. The purpose of these scans is to check that your babies are growing normally and look for intrauterine growth restriction.

Intrauterine growth restriction means that your unborn baby is smaller than expected for its age. This may lead to problems for the baby, including increasing the risk of stillbirth. To monitor for it, your babies are measured at every ultrasound scan you have after 20 weeks, looking at the size of the head, the abdomen and femur (thigh) length. If any of your babies develop intrauterine growth restriction you will be seen by a doctor to discuss how this will be monitored and managed.

Monitoring for twin-to-twin transfusion syndrome

Twin-to-twin transfusion syndrome (TTTS) only occurs in monochorionic pregnancies. It is most likely to occur between 14 and 24 weeks of pregnancy, although it may develop later. It happens when problems in the blood vessels in the shared placenta lead to an unbalanced flow of blood between the babies. This can cause serious complications in both babies. If your pregnancy is monochorionic you will be monitored for signs of TTTS through regular scans looking at growth and the amount of fluid around each baby. If there are any concerns your doctor will discuss with you how this might be managed.

Despite regular scans twin-to-twin transfusion can sometimes develop unusually fast in between scans. When this happens the mother may be aware that her womb has suddenly increased in size and become very tense and painful, because there is greatly increased fluid in one sac. **If you are concerned this may be happening you should contact the obstetric day unit on 023 8120 6303 or the labour ward on 023 8120 6002 and ask to be seen urgently.** The only way to check the fluid around the babies is by scan and you must have a scan before being allowed home.

Your health during pregnancy

As you will be carrying more than one baby, it is likely the milder complaints of pregnancy such as nausea, heartburn or indigestion, aches and pains and swollen feet will be worse. There are some things that are more important to be aware of though:

Anaemia

Anaemia is often caused by a lack of iron and is more common in multiple pregnancies than in singleton pregnancies. An iron rich diet will help maintain your iron levels, however, you should be offered an extra blood test for anaemia between 20 and 24 weeks, with a repeat test at 28 weeks. You may be advised to take an iron supplement if you are anaemic which can cause also cause constipation. This can be managed by ensuring you drink plenty of fluids or if necessary through changing the type of iron supplement taken. It is therefore important to discuss this with your midwife or doctor if iron supplementation is recommended.

Pre-eclampsia

Pre-eclampsia (PET) is a type of high blood pressure that only happens in pregnancy and can cause complications for you and your babies. Women carrying more than one baby are at a higher risk of developing PET. The risk is also higher if any of the following apply:

- This is your first pregnancy
- You are aged 40 or older
- Your last pregnancy was more than ten years ago
- You are very overweight (your BMI is over 35)
- You have a family history of pre-eclampsia.

At each antenatal appointment your blood pressure is checked and your urine checked for the presence of protein (a sign of PET). Symptoms also include nausea or vomiting, epigastric (upper abdominal) pain, swelling of the hands or face, severe headache and affected vision. PET is more common in the third trimester, but it is important to speak to your midwife or doctor if you have any concerns. Medication may be needed to treat the raised blood pressure and in serious cases, it may be necessary to induce labour early or perform a caesarean section as delivering the babies is the cure for PET.

Your blood pressure also can become raised after you have had your babies and you will therefore be monitored closely.

Premature delivery

No intervention has been shown to prevent preterm labour and birth in twin pregnancies. Bed rest, cervical cerclage and progesterone treatment have not been shown to be helpful.

Mothers carrying more than one baby are more likely to have labour start early. Sometimes it occurs so early that the babies' health may be affected. If you develop painful regular contractions in your womb you should contact the obstetric day unit on 023 8120 6303 or the labour ward on 023 8120 6002 and ask to be seen urgently. Sometimes it is possible to stop premature labour or, if it cannot be stopped, you can be given treatment to prepare the babies for early delivery.

Planning your birth

Early in your third trimester (from 28 weeks) your doctor and midwife should start talking to you about when and how you may give birth to your babies. Women with multiple pregnancies usually go into labour earlier than women with singleton pregnancies, and babies who are born early (before 36 weeks) are more likely to need care in a baby unit.

Every multiple birth is unique and will depend on a number of factors, for example you and your babies' wellbeing, their position in the uterus, any previous pregnancies you have had and your hopes and expectations. In some cases a caesarean is recommended but in the majority of cases a vaginal birth is possible.

Twins

With monochorionic twins, if the pregnancy has been uncomplicated your doctor would aim to deliver you between 36 and 37 weeks. Dichorionic twins are delivered from 38 weeks if spontaneous labour does not occur.

If labour does not happen spontaneously when your babies are due you may be offered an induction of labour. The aim is to start your labour artificially and may involve using a vaginal pessary to soften the cervix and start contractions, or by breaking the waters around the first baby if the cervix is already starting to dilate. A hormone drip (Syntocinon) may be recommended to improve the frequency of your contractions. The aim is to have four contractions every ten minutes in established labour to dilate the cervix.

If the first baby is cephalic (head down) then a vaginal birth is possible. In labour this baby can dilate the cervix to fully dilated (10cm) and be delivered, allowing the second baby to then follow if they are breech (bottom down) or cephalic.

We recommend you labouring on the labour ward. During labour, the heartbeats of both babies will be recorded as well as the timing of the contractions with continuous fetal monitoring.

For twin pregnancies we recommend using an epidural for analgesia once you are in established labour. During the second stage of labour (when you are fully dilated and actively pushing) there is a higher risk of intervention (an episiotomy, an instrument to assist delivery – ventouse or forceps - or caesarean section). Occasionally this needs to be performed urgently or rapidly and an epidural takes time to put in and work. A fully effective epidural especially in the second stage of labour reduces the risk of needing a general anaesthetic if an operative delivery is required urgently. 30 to 40% of our twin pregnancies need a caesarean section in labour for suspected distress of one or both babies or failure of the cervix to dilate. This operation can be performed using the epidural as the anaesthetic.

When your cervix is fully dilated we usually transfer you to the operating theatre. This is because of the increased likelihood of you needing help to deliver one or both of your babies. It is important that you are aware that in three to five percent of twin labours there is chance of your second baby being born by caesarean section even if you are able to give birth to your first baby vaginally. The theatre room is better equipped for this and is larger allowing more staff to be present to look after you and each of your babies when they arrive. In addition to the obstetric doctors and your midwife, the neonatologists and anaesthetists are usually present in theatre when you give birth so they can respond quickly if any problems arise.

After the first baby is born, the doctor or midwife feels the position of the second baby and if necessary will attempt to move it into a cephalic (head down) position. This can sometimes be done externally, but it may be necessary to turn the baby internally, or assist the birth of your baby in a feet first position.

Sometimes the contractions decrease or stop after the first baby has been delivered. The same hormone drip used to induce labour can be used to promote contractions. The baby's heartbeat will continue to be monitored and if needed, delivery may need assistance. In general we aim to deliver the second twin within 60 minutes after your first baby.

Delivery of the placenta is the final stage. Natural delivery of the placenta can take up to an hour and is not recommended in multiple pregnancy due to the increased risk of bleeding with the larger placenta(s). An 'active' third stage is achieved through an injection of syntocinon to contract the uterus and expel the placenta. You may need to have an infusion of syntocinon in to a vein after delivery of your babies to help keep your uterus contracted and help reduce blood loss.

If the first twin is breech or transverse (lying sideways across your womb) aiming for a vaginal delivery is more risky for the baby. Your doctor will suggest a planned (elective) caesarean section and discuss this with you. Your babies will change position through the pregnancy but will tend to stay in the position they are in from 34 weeks.

Triplets

Triplet pregnancies are usually delivered by caesarean section and the timing is considered individually depending on the well-being of the mother and babies.

Elective caesarean section

Your doctor or midwife will explain all the risks and benefits of the possible options when planning your delivery.

If you are having an elective caesarean section your midwife will talk to you about this. When the date is set, you will be seen a few days before you are due to come in to be reviewed by the anaesthetist and have a blood test.

On the day of the caesarean you will be seen by a doctor. Usually this will be one of the doctors who will be doing the operation. They will talk through the procedure with you again and complete a consent form with you.

Further information

The organisations below can provide more information and support for women with multiple pregnancy:

Multiple Births Foundation
020 3313 3519
www.multiplebirths.org.uk

Twins and Multiple Births Association (TAMBA)
0800 138 0509
www.tamba.org.uk

National Childbirth Trust
0300 33 00 772
www.nct.org.uk

National Institute for Health and Clinical Excellence, clinical guideline 129, Issue date: September 2011: Antenatal care for women who are pregnant with twins or triplets http://www.nice.org.uk/nicemedia/live/13571/56427/56427.pdf

If you need a translation of this document, an interpreter or a version in large print, Braille or on audio tape, please telephone 023 8120 4688 for help.

www.uhs.nhs.uk

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