

# Information for you

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## Multiple pregnancy: having more than one baby

### About this information

Finding out you are having twins, triplets or even quadruplets can be exciting, but it may also bring worries and concerns for you, your partner and family members. If you are expecting more than one baby, it is important that you are well prepared for the changes that will take place both during your pregnancy and after the babies' birth.

This information is for you if you know you are carrying more than one baby. It tells you about:

- the different types of multiple pregnancy
- what it means for you and your babies
- the care you will receive while you are pregnant
- the options for birth so that you can make an informed choice.

This leaflet provides an overview of multiple pregnancy: it focuses mainly on twins but it is relevant to any pregnancy where more than one baby is expected. Further information and support is available from your midwife and obstetrician and from the multiple-pregnancy organisations listed at the end of the leaflet.

### What is a multiple pregnancy?

A 'multiple pregnancy' is the term used when you are expecting two or more babies at the same time. It occurs in about one in 80 pregnancies. Fertility treatment increases the chances of multiple pregnancy.

### What are the different kinds of multiple pregnancy?

At your early ultrasound scan which confirms whether you are carrying twins or triplets, it is important to find out the 'chorionicity' of your pregnancy. This is to help identify whether your babies share a placenta and it is important because babies who share a placenta have a higher risk of complications.

Twins can be:

- dichorionic diamniotic (DCDA) – if two eggs are fertilised or if one egg splits soon after fertilisation, each baby has its own placenta with its own outer membrane called a 'chorion' and its own amniotic sac
- monochorionic diamniotic (MCDA) – if the fertilised egg splits a little later, the babies share a placenta and chorion but they each have their own amniotic sac; these babies are always identical
- monochorionic monoamniotic (MCMA) – much less commonly, the fertilised egg splits later still and the babies share the placenta and chorion and are inside the same amniotic sac; these babies are always identical; this is rare and carries additional risks.

Similarly, triplets can be 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), or monochorionic (all three babies share a placenta and chorion).

If your babies share a placenta, they are identical or 'monozygotic'. Most babies who do not share a placenta are non-identical or 'dizygotic'. However, it is possible for babies not sharing a placenta to be identical as well. This is because nearly a third of monozygotic or identical twins will each have their own placenta and hence will have the same appearance on ultrasound scans as the DCDA (non-identical or dizygotic) twins.

## What does a multiple pregnancy mean for my babies and me?

Most women who have a multiple pregnancy have healthy pregnancies and healthy babies. However, complications are more common in multiple pregnancy and having extra care during your pregnancy including more ultrasound scans reduces these risks to you and your babies.

### For you

Minor problems that many pregnant women experience, such as morning sickness, heartburn, swollen ankles, varicose veins, backache and tiredness, are more common in multiple pregnancies. They get better naturally after the babies are born.

Any problems that arise in any pregnancy are more common with twins and include:

- anaemia – this is usually caused by a shortage of iron because developing babies use up a lot of iron
- pre-eclampsia – a condition that causes high blood pressure and protein in your urine; for further information, see the RCOG patient information *Pre-eclampsia* ([www.rcog.org.uk/en/patients/patient-leaflets/pre-eclampsia](http://www.rcog.org.uk/en/patients/patient-leaflets/pre-eclampsia))
- a higher chance of bleeding more heavily than normal after the birth – doctors and midwives are trained to deal with these situations; for more information, see the RCOG patient information *Heavy bleeding after birth (postpartum haemorrhage)* ([www.rcog.org.uk/en/patients/patient-leaflets/heavy-bleeding-after-birth-postpartum-haemorrhage](http://www.rcog.org.uk/en/patients/patient-leaflets/heavy-bleeding-after-birth-postpartum-haemorrhage))
- a higher chance of needing a caesarean section or assisted vaginal delivery to deliver your babies.

### For your babies

#### Prematurity

You are more likely to have your babies early if you are expecting twins or triplets:

- about 60 in 100 sets of twins will be born spontaneously before 37 weeks of pregnancy
- about 75 in 100 sets of triplets will be born spontaneously before 35 weeks
- in comparison, only about 10 in 100 women who are pregnant with one baby will give birth before 37 weeks.

Babies born earlier than 37 weeks of pregnancy have an increased risk of problems, particularly with breathing, feeding and infection. The earlier your babies are born, the more likely this is to be the case. They may need to be looked after in a neonatal unit. You will be supported to spend as much time as you can with them and you will be encouraged to breastfeed. For more information, see the RCOG patient information *Premature labour* ([www.rcog.org.uk/en/patients/patient-leaflets/premature-labour](http://www.rcog.org.uk/en/patients/patient-leaflets/premature-labour)).

Having a baby born early can be worrying and distressing for parents. Your babies are more likely to need special care after birth. Your doctor or midwife will be happy to talk to you about this and can give you information about support groups that you might find helpful.

## **Problems with growth**

Having twins increases the chance of the placenta not working as well as it should. This can affect the babies' growth and wellbeing.

## **Twin-to-twin transfusion syndrome (TTTS)**

Twins sharing a placenta (monochorionic pregnancies) also share the blood supply. In around 15 in 100 monochorionic twin pregnancies, the blood flow may be unbalanced. We call this twin-to-twin transfusion syndrome (TTTS). One baby, the 'donor', receives too little blood and has a low blood pressure while the other baby, the 'recipient', receives too much blood and has a high blood pressure. You will be monitored with frequent scans for signs of TTTS. It can be mild and may not require any treatment, or it can be serious, in which case you will be offered treatment in a hospital with specialist expertise.

## **What extra care will I need during pregnancy?**

You will be under the care of a specialist healthcare team and will be advised to have your babies in a consultant-led maternity unit that has a neonatal unit. Your team will usually include an obstetrician and a midwife who specialises in multiple pregnancies.

Having a multiple pregnancy means that you will need more visits to the antenatal clinic at your hospital. You will be offered extra ultrasound scans to monitor your babies' growth more closely.

- For twin pregnancies where the babies each have their own placenta (dichorionic), this will mean having an ultrasound scan about every 4 weeks.
- If your babies share a placenta (monochorionic), your pregnancy will be monitored more closely, with scans offered every 2 weeks from 16 weeks of pregnancy onwards.
- You may be advised to take iron tablets and folic acid each day throughout your pregnancy.
- If you are having twins and have any other risk factors for pre-eclampsia, you may be advised to take low-dose aspirin from 12 weeks of pregnancy onwards to reduce the risk.

## **Can I still have screening for Down syndrome and other abnormalities?**

Like all women, you will be offered a scan at about 12–14 weeks to screen for chromosomal conditions such as Down syndrome. Even in multiple pregnancies, blood tests taken at the same time can be combined with the scan results to assess the risk of one or both of your babies having a chromosome problem; for further information, refer to the UK National Screening Committee ([www.gov.uk/topic/population-screening-programmes/fetal-anomaly](http://www.gov.uk/topic/population-screening-programmes/fetal-anomaly)).

You will also be offered another scan at around 20 weeks to look at your babies' development. The chance of these tests finding a problem is slightly higher than if you were pregnant with only one baby. Your specialist team will be able to offer you advice if the screening shows any problems with your pregnancy.

## Advice and information

During your pregnancy your doctors and midwives will give you information and advice about:

- planning the birth, including timing and types of birth and pain relief
- looking after your babies following birth
- care for you after your babies are born, including contraception.

## Where should I have my babies?

You will be advised to give birth in a consultant-led maternity unit so that you can get help from doctors if needed. This may be at your local unit or at a more specialist unit depending on how your pregnancy progresses and when your labour begins.

## When should my babies be born?

You may go into labour early with multiple pregnancy. Even if you don't, you will probably be advised to have your babies before your due date (elective birth). This is done either by having labour started off (induced) or by having a caesarean section.

The exact timing of delivery for multiple pregnancy depends on individual circumstances; however, if your pregnancy has been uncomplicated, it is advised that you should be offered elective birth from:

- 37 weeks of pregnancy if you are carrying dichorionic twins (babies having separate placentas)
- 36 weeks if you are carrying monochorionic twins (babies sharing a placenta)
- 35 weeks if you are carrying triplets.

If you have any concerns about having your babies born at these recommended times, you should talk to your healthcare professional, as continuing the pregnancy beyond these dates increases the risk of harm to your babies.

## How will I have my babies?

You will be able to discuss your birth plan with your midwife and obstetrician. Your decision whether to have a vaginal birth or a caesarean section will depend on several factors including the position of the placenta(s), how the babies are growing and whether you have had a previous caesarean section.

## Twins

If the baby nearest to the neck of the womb (often called the presenting twin) is head-down and you have no other complications then you should be able to have a vaginal birth if you wish. The position of your second twin can change after the first baby is born and should not influence how you choose to give birth.

If the baby nearest to the neck of the womb (cervix) is bottom-down (breech) towards the end of the pregnancy, a caesarean section is usually recommended.

Both vaginal birth and caesarean section have benefits and risks, and it is important to consider the options carefully and to talk about your individual situation with your healthcare professionals.

If you have decided to have a caesarean section but go into labour naturally, you should go straight to hospital. The operation will be done as soon as possible. However, occasionally labour may be too advanced and it may be safer for you and your babies if they are born vaginally. If you go into labour very early in the pregnancy, you may be advised that it would be better for your twins to be born vaginally.

## Triplets, quadruplets and monoamniotic twins

These babies are usually delivered by caesarean section unless you are in very premature labour or you give birth to the first baby very quickly.

Your own preference is important and you should be given enough time to consider all of the relevant information before deciding what suits you best.

## Labour and birth

Monitoring your babies' heartbeats during labour is recommended as it shows how well they are coping; however, it may make it less easy for you to move around. Your first baby's heartbeat may be monitored by applying a clip onto your baby's head via your vagina.

You may wish to have an epidural for pain relief. This can be helpful if any complications arise and your babies need to be delivered by caesarean section, forceps or suction cup (vacuum/ventouse). It is not essential and the alternatives should be discussed with you.

After your first baby is born, the cord will be clamped and cut in the usual way but the placenta will stay inside the womb until your second baby has been born.

Your midwives and doctors will check whether your second baby is coming head-first or bottom-first by feeling your tummy, doing an internal examination and by carrying out an ultrasound scan. As your second baby comes down the birth canal, the second bag of waters may be broken. A normal birth usually follows within about 30 minutes to an hour.

Although it is uncommon for the first twin to be born vaginally and the second to be born by caesarean section, it can occur if the second baby needs to be delivered urgently and/or a vaginal birth would be unsafe. This can happen in anywhere between two and ten in 100 vaginal twin births.

The delivery room may seem crowded when your twins are being born. There will be at least one midwife but two are often present. An obstetrician will be in the delivery room or close at hand. Doctors and nurses specialising in the care of newborn babies may also be present and an anaesthetist might be there to make sure that your pain is controlled. The staff can help you and answer any questions you have.

## Breastfeeding

Breast milk is best for newborn babies and your body should produce enough milk for your babies. If you encounter difficulties, your midwives will offer you the advice and support you need.

## How will I cope with two babies at once?

Twins often come early and you will have a bigger bump than if you were having just one baby. You might consider stopping work early, possibly at around 28 weeks.

When the babies are born, it will be a very busy time for any household but it is made much easier if you are supported and accept help when it is offered. Establishing a routine as early as possible will help. Look out for activities and support groups in your local area.

## Key points

- Multiple pregnancy occurs in about one in 80 pregnancies.
- While most women with multiple pregnancies will have a healthy pregnancy and healthy babies, complications are more common.
- Extra antenatal checks and ultrasound scans to monitor your babies will be offered.
- You are more likely to have your babies early if you have a multiple pregnancy.
- You will be advised to give birth in a consultant-led maternity unit.
- Your midwives and local support groups can provide you with advice and support after your babies are born.

## Further information

Twins & Multiple Births Association (TAMBA): [www.tamba.org.uk](http://www.tamba.org.uk)

The Multiple Births Foundation: [www.multiplebirths.org.uk](http://www.multiplebirths.org.uk)

National Institute for Health and Care Excellence (NICE): *Multiple pregnancy: Antenatal care for twin and triplet pregnancies*: [www.nice.org.uk/guidance/cg129/informationforpublic](http://www.nice.org.uk/guidance/cg129/informationforpublic)

UK National Screening Committee: [www.gov.uk/topic/population-screening-programmes/fetal-anomaly](http://www.gov.uk/topic/population-screening-programmes/fetal-anomaly)

## Making a choice

### Shared Decision Making

If you are asked to make a choice, you may have lots of questions that you want to ask. You may also want to talk over your options with your family or friends. It can help to write a list of the questions you want answered and take it to your appointment.



#### Ask 3 Questions

**To begin with, try to make sure you get the answers to three key questions if you are asked to make a choice about your healthcare.**

1. What are my options?
2. What are the pros and cons of each option for me?
3. How do I get support to help me make a decision that is right for me?

\* Ask 3 Questions is based on Shepherd HL, et al. Three questions that patients can ask to improve the quality of information physicians give about treatment options: A cross-over trial. *Patient Education and Counselling*, 2011;84: 379-85

## Sources and acknowledgements

This information has been developed by the RCOG Patient Information Committee. It is based on the NICE clinical guideline *Multiple pregnancy: Antenatal care for twin and triplet pregnancies*, which you can find online at: [www.nice.org.uk/guidance/cgl29](http://www.nice.org.uk/guidance/cgl29), and the RCOG Green-top guideline *Management of monochorionic twin pregnancy*, which you can find online at: [www.rcog.org.uk/guidelines-research-services/guidelines/gtg51](http://www.rcog.org.uk/guidelines-research-services/guidelines/gtg51). The guidelines contain full lists of the sources of evidence used.

This leaflet was reviewed before publication by women attending clinics in Birmingham, Liverpool and Newcastle Upon Tyne, by the RCOG Women's Network and by the RCOG Women's Voices Involvement Panel.

The RCOG produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. This means that RCOG guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management.

A glossary of all medical terms is available on the RCOG website at: [www.rcog.org.uk/en/patients/medical-terms](http://www.rcog.org.uk/en/patients/medical-terms).

### A final note

The Royal College of Obstetricians and Gynaecologists produces patient information for the public. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of the clinical data presented and the diagnostic and treatment options available. Departure from the local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.

All RCOG guidelines are subject to review and both minor and major amendments on an ongoing basis. Please always visit [www.rcog.org.uk](http://www.rcog.org.uk) for the most up-to-date version of this guideline.