



EXPECTING TWINS, TRIPLETS OR MORE?
**THE HEALTHY MULTIPLE
PREGNANCY GUIDE**

BY DR ERIKA MCASLAN FRASER

Tamba
TWINS & MULTIPLE BIRTHS ASSOCIATION

COVID-19 UPDATE

MIDWIFE AND MATERNITY TEAM

During the Covid-19 pandemic, it is very important that if you have any questions or concerns about yourself or your babies at any time, you contact your midwife or maternity team.

NHS

The current NHS England and NHS Improvement campaign 'Help Us, Help You' is a reminder to all pregnant women about the importance of attending check-ups, contacting their midwife or maternity team when something doesn't feel right and gives reassurance that the NHS is here to see you safely.

RCOG

The RCOG (Royal College of Obstetricians and Gynaecologists) [website](#) is a great source of information regarding pregnancy during Covid-19.

BLISS

Bliss is the leading UK charity for babies born premature or sick and supports families with babies in neonatal care. It has some excellent information on care during the Covid-19 pandemic on its [website](#).

GOVERNMENT GUIDANCE

As Covid-19 guidance and restrictions differ throughout England, Scotland, Wales and Northern Ireland please make sure you follow the guidance relating to where you live at www.gov.uk/coronavirus.

Follow the latest government guidance and avoid anyone displaying symptoms of coronavirus.

Pay particular attention to social distancing from 28 weeks of pregnancy.

Wear a face mask if going anywhere outside your home.

Keep mobile and hydrated and eat a healthy balanced diet.

Attend all of your pregnancy scans and appointments unless advised otherwise and contact your midwife or maternity team if you have any concerns about your well being or that of your babies.

TWINS TRUST

If you have any questions or concerns that are not covered here please contact us. For hospital care related enquiries please email maternityengagement@twintrust.org.

For help and support once your babies have arrived email support-team@twintrust.org.

You can also call our free support service, Twinline, on 0800 138 0509 or email asktwinline@twintrust.org.



Thank you to the National Lottery Community Fund for funding additional information relating to COVID-19.

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For questions or advice outside of your appointments, record your health team contacts here

Name.....
Ward.....
Telephone number.....
Days and hours of work.....

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Name.....
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Days and hours of work.....

Introduction

Congratulations! Discovering you are expecting more than one baby can be one of the most exciting, surprising and (quite frankly) terrifying experiences many parents will have. You are at the start of a roller-coaster ride full of amazing highs, lows, twists and turns. It is normal to feel concerned, but try to enjoy the journey. You are in good company, as each year there are over 10,000 multiple births in the UK. This guide aims to reassure you that women regularly give birth to healthy, happy multiple babies and you can too.

Although you may be treated as 'high risk', you should always keep in mind that having more than one baby is a natural process. The label of 'high risk' does not mean that you will experience complications, only that doctors need to monitor you more carefully. Many mothers find this extra level of antenatal care reassuring as it gives them a chance to ask questions and discuss how their pregnancy is progressing.

This guide to multiple pregnancies follows on from the 2008 and 2011 Tamba Health & Lifestyle Surveys which collected the views of more than 2,000 mothers of twins and triplets. The survey highlighted the need for an easy-to-use pregnancy guide, with tailored advice on antenatal care, nutrition, lifestyle, pregnancy complications, and preparing for your babies.

Pregnancy books, particularly those for multiple pregnancies, may be daunting when read cover to cover. Sections on complications and pregnancy complaints can be enough to overwhelm even the most confident women, but rest assured that statistically these conditions are still rare. Feel free to dip into this booklet, using the information provided as a handy reference tool to complement your antenatal care. If you have any concerns about medical issues relating to your pregnancy or birth, you should always seek advice from your midwife or doctor. We hope it will be a useful resource for you and help give you the best possible pregnancy outcome: healthy mother and babies.

Keith Reed, CEO Tamba

SECTION ONE

PREGNANCY: HOW ARE MULTIPLES FORMED?

HOW COME I'M EXPECTING MORE THAN ONE?

All naturally conceived pregnancies start in the same way:

- The mother produces an egg (or ovum) which is released into the fallopian tubes
- One of the father's sperm fertilises the egg.
- The fertilised egg (or zygote) develops into an embryo.



SO WHAT IS DIFFERENT ABOUT A MULTIPLE PREGNANCY?

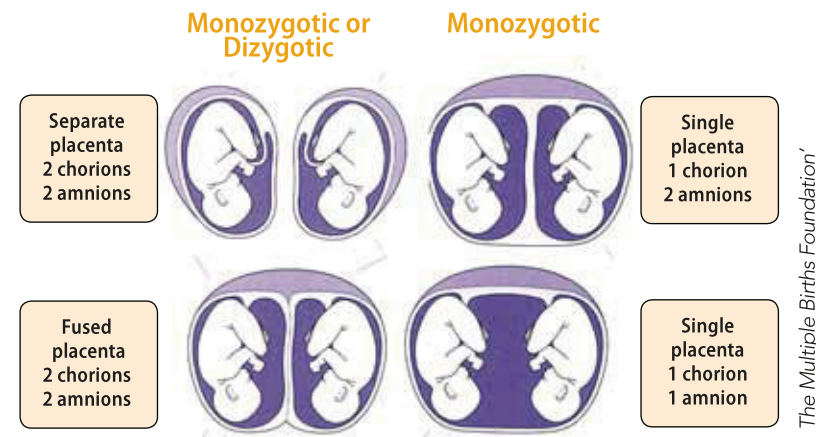
For the sake of simplicity, the following explanation refers to twins. Triplets and higher multiples are formed in a similar way – but a combinations of these events may occur, resulting (for example) in a set of triplets where two are identical and one is not.

Sometimes a woman produces more than one egg at a time. If each egg is fertilised by a different sperm, then she conceives non-identical twins (also known as fraternal or dizygotic twins). The babies are no more alike or non-alike than any other brothers or sisters.

Each twin has its own placenta and its own amniotic sac and for this reason they are described as dichorionic diamniotic twins (two placentas and two sacs). It may look on the scan as if the twins share one placenta, but in fact the two placentas remain separate even if they have grown to lie closely together.

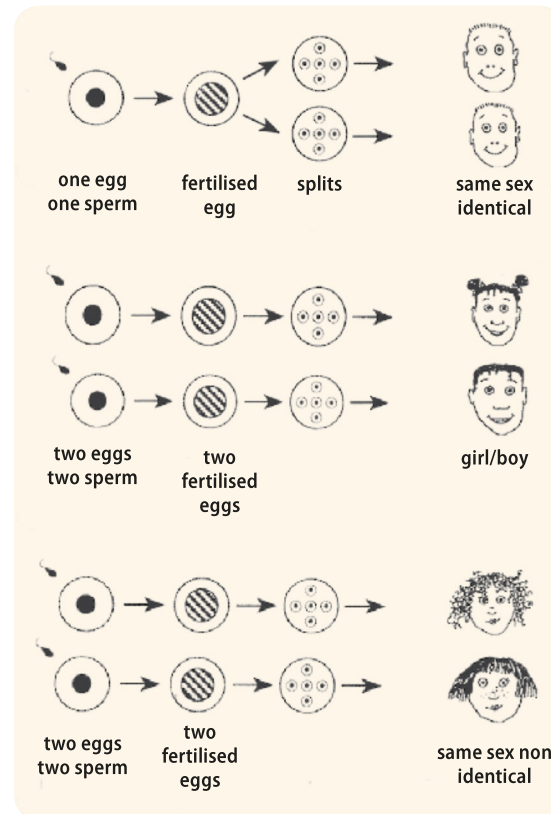
In about one-third of all multiple births, a single egg is fertilised then splits into two. This process creates identical or monozygotic twins. Identical twins have the same genes and physical features as each other, and are of the same sex. Characteristics such as size or personality depend on other factors as well as genes, so may be different. If the division, or splitting, occurs soon after fertilisation, the resulting two embryos will each have their own placenta and their own sac and will be described as dichorionic diamniotic twins, the same as when two eggs are fertilised separately (see above). They will be identical though. If the division occurs later, they will still have their own sac, but they will share a placenta (monochorionic diamniotic). Much less commonly, the division occurs later and the twins share both a placenta and an amniotic sac (monochorionic monoamniotic twins). Very rarely, the splitting of the fertilised egg occurs very late, and incompletely, resulting in conjoined ('Siamese') twins.

PLACENTATION OF TWINS



IDENTICAL OR NON-IDENTICAL?

Hospitals refer to twin pregnancies most commonly by the number of placentas, and this is usually determined by an ultrasound scan before 15 weeks gestation. All monochorionic twins (one shared placenta) are identical. They will be of the same sex. Twins with separate placentas (dichorionic) are more confusing. Although most of them are non-identical (fraternal), a smaller proportion are, in fact, identical too and you may only find out after birth if they are identical or not, and this sometimes requires a genetic test. If one is a boy, and one is a girl, you can be confident that they are non-identical! Beware; some medical professionals still think that two placentas means non-identical twins. You now know that this is not always the case!



WHY ME?

Many factors make a multiple pregnancy more likely:

- A woman is more likely to have a multiple pregnancy if there is a history of having twins on her mother's side i.e. mother, sisters, aunts, grandmother. There is a lot of information to support this, but the influence of family history on the father's side is far less evident.
- If you have already had one set of non-identical twins, triplets or more, then your next pregnancy is five times more likely to be a multiple pregnancy.
- Multiple pregnancies are more common in older mothers.
- The more previous pregnancies you have had, the greater the likelihood of a multiple pregnancy.
- Although the incidence of identical twins is roughly the same in all races and in all areas of the world, some races have a much higher incidence of fraternal twinning than others. The highest rates of twinning are among Nigerians, and the lowest among Japanese.
- Fertility treatments to help women to ovulate can result in the production of more than one egg and result in multiple pregnancy. With IVF, it depends on the number of embryos transferred and new guidelines aim to reduce the incidence of multiple pregnancies through single embryo transfer for women most likely to have multiple pregnancy.

"I was thrilled when they told me. Absolutely thrilled. It was days before my feet touched the ground"



"It's amazing. None of the risk factors apply to me. I'm just lucky I suppose"

HOW IS A MULTIPLE PREGNANCY DIAGNOSED?

A multiple pregnancy may be suspected from the size of the abdomen (being large for dates) or severe morning sickness, and is usually confirmed by an ultrasound scan.

HOW COMMON ARE MULTIPLE BIRTHS?

The incidence of multiple births has been increasing since 1980, when one birth in 100 was a twin birth. The latest figures from 2010 reveal that there is now one set of twins for every 62 live births. The increase may be due to a number of factors, for example, the use of fertility drugs, assisted conception techniques, increased maternal age and advances in neonatal care for preterm babies.

Higher order multiples are less common, with about one in 5,000 births being a triplet birth and one in 150,000 a quad+ birth.

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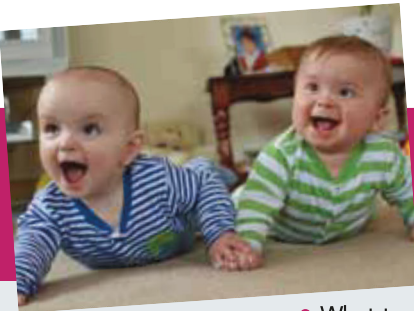
www.angelcareuk.co.uk



SECTION TWO

YOUR ANTENATAL CARE: WHAT TO EXPECT?

Finding out that you are pregnant with twins or more may come as a big surprise. No doubt, you will be full of questions about what to expect and how your health professionals can best support you with a healthy pregnancy and birth. This section aims to help you understand what your antenatal care will involve and how to get the best out of it.



WHAT ROUTINE TESTS SHOULD I EXPECT?

Routine tests vary from hospital to hospital, so it is important to seek clarification from your doctor about what your antenatal care will involve. You are likely to have your first antenatal appointment at around 11-14 weeks, involving checking your height, weight, blood pressure, urine sample, and blood sample. You will also be offered a routine ultrasound scan and this may be the first time you discover you are expecting

CONGRATULATIONS!

You're expecting more than one baby! Questions to ask at your antenatal check-ups

- What is the hospital procedure for multiple births?
- How will my antenatal care be arranged? Who will be looking after me? (obstetrician/midwife?) How often will I be seen? And where?
- Who will be there for the birth of my babies?
- What antenatal tests will I be having and what risks (if any) do they carry?
- What type of foods should I be eating and how much?
- What exercise / sports can I do? And what should I stop doing?
- Can I go on holiday overseas and which vaccinations can I have?
- When should I stop travelling?
- Does the hospital offer any multiple-specific antenatal classes?
- What level of neonatal care is available in case the babies are born early and are there any tours available?
- Do you have any advice on how to feed my babies? Are there any midwives or other staff who specialise in supporting mothers of multiples with breastfeeding?
- Who should I contact if I have questions or would like advice outside of my check-ups?

YOUR ANTENATAL CARE:

Tips for making the most of your check-ups

- Ask if the hospital has a midwife/doctor or specialist team for multiple births and ask for your antenatal care to be with them.
- Do not feel hurried or rushed through your appointments; ask for extra time to discuss issues that concern you. Remember that all the extra hormones can make you feel emotional and it is ok to feel overwhelmed or upset.
- Make a list of questions or things you need to discuss beforehand
- Your employer is legally obliged to give you time off work to attend antenatal appointments and parent education classes. Except for the first appointment, your employer may request to see a certificate from a registered medical practitioner, midwife or health visitor confirming the pregnancy as well as an appointment card. The entitlement to paid time off for antenatal appointments applies regardless of the employee's length of service.
- Mention all symptoms you are experiencing, even if you think they are probably normal during pregnancy. Your health professional will be able to put your mind at rest
- or investigate further if need be.
- If you are not happy with the care given by your health professionals, ask to speak with another doctor/midwife. All hospitals should have complaints procedures or contact Tamba.
- Bring something to eat, drink and read as there will be times when you have to wait around. If you have young children with you, bring a little bag full of small picture books, colouring in books and crayons, toys and snacks for them.
- Remember your hospital notes.

multiples! Although government guidelines now recommend that women expecting multiples access care at around 8-10 weeks, many women will not know they are having twins until they have their first scan at 11-14 weeks.

Multiple pregnancies tend to be medically managed to a greater extent than singleton pregnancies. You will have several more antenatal appointments during the course of your pregnancy, although the number and frequency will vary according to hospital procedure, how many babies you are having, and how your pregnancy is progressing.

Further information can be found in the clinical guidelines for multiple pregnancy, produced by the National Institute for Clinical Excellence (NICE).

You are also likely to have more frequent appointments if you are expecting monochorionic twins (or higher order multiples), due to the risk of Twin-to-twin Transfusion Syndrome (TTTS) which occurs in about 10-15% of identical twins who share a placenta (monochorionic twins). There is also a 10-15% risk of selective growth restriction in monochorionic twins. Section 5 explains further about TTTS and growth restriction.

WHICH HEALTHCARE PROFESSIONALS WILL LOOK AFTER ME DURING PREGNANCY?

Most pregnant women of multiples have all their check-ups at their hospital; others have mixed care at their doctor's surgery or local health centre. Clinical care should be provided by a core team of named specialist obstetricians, specialist midwives and ultrasonographers, all of whom have experience and knowledge of managing twin and triplet pregnancies. If necessary, you will be referred to other health professionals, for example a physiotherapist for backache or pelvic pain.

Your core healthcare team should offer information and advice, as well as emotional support, on:

- **antenatal and postnatal mental health and wellbeing**
- **antenatal nutrition**
- **the risks, symptoms and signs of preterm labour and the potential need for corticosteroids to help your babies' lungs mature before birth**
- **likely timing and possible methods of delivery**
- **breastfeeding**
- **parenting.**

HOW OFTEN WILL I RECEIVE ULTRASOUND SCANS?

Ultrasound scans are used to check the babies' growth, health and position. Unlike singleton pregnancies, examination of the pregnant abdomen alone is not enough to assess fetal growth and therefore scans are used more frequently in multiple pregnancies.



It can be reassuring for parents to see their growing babies. You are likely to have several ultrasound scans during your pregnancy. The first scan usually occurs at the end of the first trimester (pregnancy is typically divided into three periods, or trimesters, each of approximately 3 months). The first ultrasound scan at 10-14 weeks is to confirm the number of fetuses, how many placentas there are, and whether they are in separate chorionic and amniotic sacs.

Your sonographer will also be checking to see if the babies share a placenta (referred to as monochorionic) as these babies are at risk of complications, such as Twin to Twin Transfusion Syndrome (see Section 5). Twins sharing the same gestational sac (monoamniotic) are at risk of the cords becoming entangled and you will be monitored closely, as in some cases cord entanglement can cause problems.

At 18-22 weeks an anomaly scan is offered to check your babies are developing normally. The scan looks for any abnormalities in the babies' structural development and growth, and checks the position of the placenta. You

IT CAN BE REASSURING FOR PARENTS TO SEE THEIR GROWING BABIES. YOU ARE LIKELY TO HAVE SEVERAL ULTRASOUND SCANS DURING YOUR PREGNANCY

are likely to have several more ultrasound scans during the third trimester to check how the babies are growing and their relative positions. The frequency and timing of these ultrasound scans will vary according to the number of babies, whether the babies share a placenta or not, hospital procedure and whether anything arises in your pregnancy that needs to be monitored regularly through ultrasound scans. National guidelines recommend that dichorionic twins should be scanned every four weeks, from 20 weeks gestation. Monochorionic twins are usually scanned fortnightly from 16 weeks gestation. At about 34 weeks the position of the leading twin will help to determine the options for mode of delivery, taking other factors into account (for example, how delivered previously, if not first pregnancy).

WHAT SCREENING AND DIAGNOSTIC TESTS WILL I BE OFFERED?

As part of your antenatal care you will be offered a number of specialist screening and diagnostic tests to check for abnormalities in your fetuses (screening tests predict the likelihood of these

complications, whereas diagnostic tests can confirm them). Some tests (including blood and urine tests) are offered routinely to all pregnant women, whereas others will only be offered to those women perceived to be at high risk.

The screening test routinely offered in the first trimester is for Down's syndrome, which for a twin pregnancy is a nuchal translucency scan alone or with a blood test when it is referred to as the "combined test". The nuchal translucency scan is done at 11-14 weeks and involves measuring the thickness of the fetuses' necks (the amount of fluid lying under the skin at the back of the neck). The detection rate of Down's syndrome is around 65-70%. The test sometimes gives 'false positive' results, particularly in twin and triplet pregnancies, meaning that the test results are misleading and the baby is fine. This ultrasound scan carries no risk to the fetuses, but is not a diagnostic test so will only indicate whether there is a high (e.g. 1:50) or low (e.g. 1:5000) chance of each baby having Down's syndrome.

If this screening is positive, you will be given information about diagnostic tests. These are an amniocentesis where a sample of amniotic fluid is used or Chorionic Villus Sampling (CVS) where a small piece of placental tissue is taken and in both cases the fetal cells will be examined to tell whether the chromosomes are normal. You may need to go to a specialist hospital to discuss your options further, as these tests are more complex for multiple pregnancies and typically involve inserting instruments into the uterus, carrying a small risk of miscarriage. Each hospital should be able to tell you the risk for

each procedure to help you make the decision whether to go ahead.

These tests can be reassuring and could rule out some genetic defects. However, they vary in their reliability (screening vs. diagnostic) and some carry small risks. You may wish to discuss with your partner whether you want to have the tests and what you would do with the information. If you find out one or more baby has some kind of abnormality, how will you proceed? Are the risks of the tests worth taking? You should be given all this information and offered counselling to help you decide whether to continue with the pregnancy or whether to terminate the affected baby or the whole pregnancy. It may also be helpful to know about possible abnormalities to prepare for a baby with special needs. The options can be discussed with your Consultant and/or Specialist Midwife in the Multiple Pregnancy Clinic or Fetal Medicine Specialist if your unit has one.

Tests for other rare genetic conditions, such as Tay Sachs and Cystic Fibrosis may be offered depending upon individual factors such as family history.

WHAT ANTENATAL CLASSES DO I NEED?

Antenatal classes are a great opportunity for you to meet other mothers at the same stage of their pregnancies and ask questions about delivery and care of your babies. Often a representative of the local twins club will be there to give a personal account of looking after multiples. Your midwife should be able to tell you if the hospital runs antenatal classes or talks for multiple pregnancies.

Unfortunately, not all hospitals offer multiple-specific classes. Tamba



offers specialist multiple birth classes (preparing for parenthood, antenatal classes for first time and second time parents, and breastfeeding classes), as well as a range of booklets to help you prepare for parenthood.

The Multiple Births Foundation also holds prenatal meetings in London for parents and grandparents expecting a multiple birth.

NHS antenatal classes that are not tailored to multiple pregnancies are also a useful preparation for birth and parenthood. Don't be surprised if everyone else in your antenatal class is expecting just one baby and don't let this limit your participation. If you have questions, ask them – if necessary, after the session has finished.

Because your babies are more likely to be born sooner than in a singleton pregnancy, make sure that you have time to complete the classes. If you are expecting twins, it is advisable to start at around 24 weeks and aim to complete the course by the 34th week of pregnancy. If you are expecting triplets or more, complete the course by the 30th week of pregnancy. If your partner intends being present at the birth, it is a good idea for him to attend antenatal classes with you.

SECTION THREE NUTRITION & LIFESTYLE

Eating healthy, balanced meals during your pregnancy is one of the most important things you can do to give your babies the best start in life. The following section provides advice on good nutrition and lifestyle tips for multiple pregnancies.

HOW MUCH SHOULD I EAT?

You should expect to put on more weight than a mother expecting only one baby. Part of this extra weight is due to the additional babies, but also their placentas, amniotic fluid (the liquid protecting and surrounding the babies) and additional maternal body fluid. How much extra weight is enough though? In the UK, there has not been much research conducted on nutrition in multiple pregnancies and current government guidelines are that women with twin and triplet pregnancies should follow the same advice on diet, lifestyle and nutritional supplements as a woman expecting only one baby.



If you are concerned about weight gain, especially if you are underweight or significantly overweight, please discuss your progress at your antenatal appointments. You may be referred to a dietician if necessary. However, do not get too worried about precise measurements of weight gain. If you eat a well-balanced diet containing a variety of different food groups on a regular basis, you will gradually gain weight and provide the best possible start for your unborn babies.

WHAT SHOULD I EAT?

Eating the right balance of foods is important for a healthy pregnancy and knowing what to eat and drink, as well as what to avoid, can help improve your babies' growth and development. Try to avoid foods with empty calories (for example, sugary snacks, fizzy drinks, white bread and cakes), which can give you feelings of 'highs' and 'lows'. Instead, aim to eat healthy slow-burning foods to keep your blood sugar levels stable and satisfy you for longer. Examples of slow-burning foods include: whole grain breads and crackers, vegetables, beans, brown rice, oats, and whole grain pasta.

WHAT EXERCISE CAN I DO?

You can continue with gentle exercise, which is an excellent way of easing tension, helping maintain good muscle tone and cope with labour.

DOS AND DON'TS OF HEALTHY EATING DURING PREGNANCY

DO ✓



- Graze: eat lots of small meals if you can't face three large meals
- Get enough protein by putting bits of chicken, lean meat, fish, cheese, eggs or pulses into salads
- Keep it simple – the best quality food is in its unprocessed fresh state.
- Carry around lots of

healthy snacks to keep your energy levels high (e.g. flapjacks, dried fruit, cereal bars and bananas)

- Take food to bed with you if you need something to nibble on when you wake up during the night
- Check with your doctor or midwife if you want to take vitamins in tablet form - there are several pregnancy-formulated multivitamins which also contain the recommended levels of folic acid (400 micrograms for the first 12 weeks)
- Get enough iron in your diet. Good sources of iron include: dark green vegetables, red meat,

fortified breakfast cereals, wholemeal bread, and pulses. If the iron level in your blood becomes low, your doctor or midwife will advise you to take iron supplements (see Section 5 on anaemia).

- Ensure you have enough Vitamin D from eggs, meat, oily fish, vitamin-D fortified margarine or breakfast cereal. Talk to your midwife/doctor to see if you are at risk of Vitamin D deficiency (especially if your family origin is South Asian, Caribbean, African or Middle Eastern, if you stay indoors a lot or if you have a diet low in Vitamin D).

DON'T ✗



- Eat raw eggs, unpasteurised milk, raw poultry and raw meat, as they may contain salmonella
- Take Vitamin A supplements or foods rich in Vitamin A (e.g. liver or pâté)

- Eat soft mould ripened cheese, such as Camembert, Brie and blue-veined cheese as they may put you at risk of bacteria called listeria

- Eat unwashed raw fruit and vegetables, raw or uncooked meat and unpasteurised goats' milk or goats' cheese, which may put you at risk of toxoplasmosis (a parasitic disease which can be harmful to pregnant women)

- Eat more than two portions of oily fish a week (e.g. fresh tuna, mackerel,

sardines and trout) because they may contain harmful pollutants

- Drink too much caffeine which is commonly found in tea, coffee, cola and some energy drinks as high levels of caffeine can result in babies having a low birth weight, or even miscarriage. 300mg a day is the recommended limit (3 mugs of coffee; 6 cups of tea; 8 cans of cola). Coffee and tea also contain compounds called phenols, which interfere with your body's ability to absorb iron (an essential nutrient for pregnant women).



Recommended activities include low-impact activities, such as swimming, yoga, walking, aquanatal classes, pilates, tai-chi and dancing. It is important to begin your routine at a slow pace and stop exercising if you suffer any pain, cramping or shortness of breath. Talk to your doctor/ midwife if you are at all unsure.

Some exercise activities should be avoided as you get larger due to the possibility of falls or problems with balancing due to your changing centre of gravity, for example skiing, surfing, cycling or riding horses. Also avoid sports involving physical contact that may involve knocks, such as hockey, netball or boxing.

CAN I SMOKE?

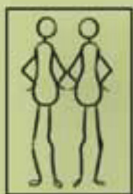
Pregnant women are strongly advised not to smoke or take drugs during pregnancy, because of the risk of having babies with low birthweight and preterm birth. Your healthcare team can offer you advice and support with stopping smoking, including the risks and benefits of nicotine replacement therapy. For example, recent government guidelines advise pregnant women using nicotine patches to remove them before going to bed.

CAN I DRINK ALCOHOL?

Pregnant women and women planning a pregnancy are advised to avoid drinking alcohol in the first three months of pregnancy if possible because it may be associated with an increased risk of miscarriage.

If you choose to drink alcohol during pregnancy, the government guidelines are no more than 1 to 2 UK units once or twice a week (1 unit equals half a pint of ordinary strength lager or beer, or one shot [25 ml] of spirits. One small [125 ml] glass of wine is equal to 1.5 UK units). Although there is uncertainty regarding a safe level of alcohol consumption in pregnancy, at this low level there is no evidence of harm to the unborn baby.

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WHAT OTHER LIFESTYLE TIPS WILL HELP ME HAVE A HEALTHY PREGNANCY?

You can also take care of yourself and your babies by doing the following:

- Drink lots of fluid, ideally eight large glasses a day. Dehydration has been linked to an increased risk of premature contractions, so it is important to drink water or fruit juices, especially during hot weather.
- Try to rest and get as much sleep as possible. You may need to adjust your sleeping position as your stomach gets larger, for example sleeping on your side with your upper leg bent at the knee and resting on pillows. If you are finding it difficult to sleep due to indigestion, try sleeping semi-upright with pillows

● Regularly do your pelvic floor exercises to minimise the risk of a prolapsed uterus later in life and help your pelvic floor to get back to normal after the babies are born. Physiotherapists recommend tightening the muscles around your vagina and anus, as if you are stopping the flow of urine. Count to five, before releasing the muscles and relaxing. Repeat the exercises in sets of 5-10 at least five times a day. Speak to a midwife if you're unsure how to do these.

● Look after your emotional well-being as well as your physical health. If you are feeling stressed or anxious, talk to family members, friends or your doctor / midwife. Tamba also has a freephone helpline called Twinline (0800 138 0509), which is a confidential listening service

“LOOK AFTER YOUR EMOTIONAL WELL-BEING AS WELL AS YOUR PHYSICAL HEALTH”

propped up behind you. If you are still finding it difficult due to heartburn, discuss it with your doctor or midwife.

and open every day of the year from 10am-1pm and 7pm to 10pm. It is staffed by trained volunteers who are themselves parents of multiples and can answer questions on many topics or listen to your concerns.



● Sexual activity – there is no evidence this is harmful whilst pregnant. Ask your doctor/midwife for advice if you are unsure.

● Wear a three-point seat belt above and below your bump, not over it, when travelling by car/coach.

SECTION FOUR COPING WITH COMMON SYMPTOMS

Your body will go through an amazing journey to carry and deliver your babies and it is not unusual to experience some aches, pains and discomfort along the way. This is natural and more often than not, these complaints do not pose a serious risk to mother or babies. If you are at all concerned, discuss the symptoms with your doctor and they will be able to reassure you or investigate further.



MORNING SICKNESS: coping with the nausea

- Little nibbles of dry biscuits, especially those made of ginger
- Travel sickness bands
- Don't brush your teeth for 20-30 minutes after vomiting, because stomach acids temporarily cover the tooth surface
- Different foods may trigger feelings of nausea for different women – try keeping a diary of what you eat, when and feelings of sickness. Common culprits are: strong smelling foods; oily and spicy foods.
- Foods rich in zinc have been found to be effective in combating morning sickness, for example dairy products, meat, eggs, fish, ginger, maize, nuts and pulses.

NAUSEA

Contrary to its name, morning sickness occurs at all times of the day, but especially when you have not eaten for a while (hence why it is more common in the morning). The main cause is low blood sugar, so try to eat little and often. Morning sickness has also been linked to higher levels of the pregnancy hormone hCG (human chorionic gonadotrophin) and is therefore more common in multiple pregnancies.

The nausea usually subsides by Week 14, but some women continue to feel nauseous throughout their pregnancy. If nausea continues to be a problem, see your consultant/doctor. In its most severe form (hyperemesis gravidarum), vomiting can be dangerous for you and your babies. If you vomit for more than three times a day for three days, contact your doctor or midwife. Hyperemesis can

deplete you of important minerals and fluid, leading to dehydration and low blood pressure. You may be admitted to hospital for a short time to control the nausea and give you intravenous fluids until the vomiting is under control by prescribing anti-nausea medication.

PILES / HAEMORRHOIDS

Piles are dilated rectal veins that can sometimes protrude through the anus. They are caused by the pressure of the babies, obstructing blood flow back to your heart and causing blood to pool and veins to dilate to accommodate the damned-up blood. Piles are not dangerous, but can be uncomfortable and bleed during a bowel movement. Try to avoid constipation by eating sufficient fibre and increase your fluid intake. Your doctor may also be able to prescribe medication to prevent irritation and muscle spasm pain. External creams are also available. Swollen vulval/vaginal veins are also common in multiple pregnancies.

VARICOSE VEINS

Varicose veins are swollen veins just below the skin. They can become more uncomfortable towards the end of your pregnancy and your doctor may be able to prescribe pregnancy support tights and socks. Shoes with a small heel (not flat and not too high) can reduce the onset of varicose veins. It also helps to put your feet up and avoid standing still for long periods of time.

HEARTBURN AND INDIGESTION

Heartburn and indigestion are caused by pressure on the stomach from a large

HEARTBURN AND INDIGESTION: coping with the nausea

- A glass of milk before you go to bed – alkaline antacid foods such as yoghurt, milk and ice cream can neutralise stomach acid
- Sleep upright, for example propped up with pillows. Alternatively, put a couple of books under your bed at the head end, so that it is raised by several inches
- Eat little and often – indigestion often feels worse when you are hungry
- Avoid foods that set off indigestion, such as cheese, spicy foods, tomatoes, chocolate and alcohol
- Some women swear by gentle exercise, e.g. yoga (try stretching your arms above your head to elongate your upper body and relieve the symptoms of heartburn)
- Hot drinks, especially peppermint, ginger and fruit teas
- Gaviscon, which you can get free on prescription from your health professional, TUMS and Remegel tablets
- If severe, medication can be prescribed.

uterus, forcing stomach acid to flow up into the oesophagus (gullet) and causing a burning sensation. In multiple pregnancies, the pressure on the stomach is quite intense and you may experience heartburn and indigestion. Increased hormones, such as progesterone, can also cause heartburn by relaxing the muscles at the entrance to the stomach and letting stomach acid flow back up.

BACKACHE

Pain in your lower back is common for pregnant mothers, especially those expecting twins, triplets or more. The hormone relaxin softens and stretches your ligaments to prepare you for labour, but also makes minor aches and pains more likely. Your back muscles will be working hard to support the increased weight you are carrying around, often causing lower back pain.

Ways to ease backache include maintaining good posture and being careful when bending, lifting and carrying. A firm mattress and pregnancy pillow can help relieve back pain while sleeping. Your midwife may be able to give some advice and a support bandage or refer you to a physiotherapist who can prescribe a support belt to lift and distribute the weight of the babies, reducing pressure and lower back pain. If suffering with backache, ask your doctor/midwife to be referred to an Obstetric Physiotherapist if needed. Some hospitals offer a routine session with a physiotherapist, so do take advantage if so.

PELVIC GIRDLE PAIN

Pelvic Girdle Pain is a condition caused by excessive movement of the two bones that connect to form your pelvis, causing pain and/or discomfort. As mentioned above, during pregnancy, your body produces the hormone relaxin, which loosens the ligaments holding the bones in your pelvis together. Women expecting more than one baby are more likely to suffer from Pelvic Girdle Pain, due to the extra hormones produced and the extra weight of your babies pressing down on

“YOUR BODY WILL GO THROUGH AN AMAZING JOURNEY TO CARRY AND DELIVER YOUR BABIES”



these bones. Your doctor/midwife can refer you to an Obstetric Physiotherapist, who can help by advising you on correct posture and pelvic tilt exercises, as well as recommending a support girdle if necessary.

INSOMNIA

Many pregnant women find sleep disturbed by common symptoms such as nausea, heartburn, restless leg syndrome, itchiness and anxiety. Sleeping tablets are not recommended. Instead try to identify and address the symptoms causing you to lose sleep. Women expecting multiples can find the increased pressure on the bladder means several night-time visits to the bathroom. Drink lots of fluid during the day, but stop drinking an hour before

you go to bed and empty your bladder immediately before sleep. You may also be kept awake by babies moving and kicking you throughout the night. Unfortunately there is nothing to prevent this except to make yourself comfortable, for example, listen to music, read a good book, watch television and have a warm bath before bed.

SWOLLEN FEET

During pregnancy, more fluid and blood circulates around your body than usual. Due to gravity, some of that extra fluid remains in your feet, leading

“MORE OFTEN THAN NOT, THESE COMPLAINTS DO NOT POSE A SERIOUS RISK TO MOTHER OR BABIES”

to swelling. If you are experiencing swelling in your feet, try to sit down regularly and raise your feet up. You may also suffer from painful knee joints because of the increase of the hormone relaxin, so try to rest and support your knees when possible. Gentle exercise can also help disperse fluids that have settled in your feet, for example walking around or aqua-aerobics. It also helps to avoid tight fitting socks, stockings and shoes. Although swelling is normal, if it appears suddenly and is accompanied by swelling in your hands and/or face it may be a sign of pre-eclampsia (see complications in the next section). You should notify your doctor/midwife who will be able to check your blood pressure and rule out or refer you to the hospital to monitor for the pre-eclampsia.

CARPAL TUNNEL SYNDROME

Body fluid can also accumulate in your wrist joints in an area called the carpal tunnel – a band of tissue which protects the carpal nerves that pass from the arm to the hands and fingers. The excess fluid applies pressure on the nerves, causing a tingling feeling in the fingers, a sensation like pins and needles. You may also feel numbness, weakness and in extreme cases, carpal tunnel syndrome can be very painful and affect the whole hand and forearm. The pain and discomfort tends to be worse at night, due to fluid building up during the day, so try

sleeping with your hands raised on a pillow. It can also help to gently stretch your hand above your head and wiggle your fingers. However, do speak to your midwife or doctor if you continue to suffer from carpal tunnel syndrome.



SECTION FIVE COMPLICATIONS: WHAT TO LOOK OUT FOR

Most mothers have healthy multiple pregnancies, despite the high-risk category, so it is important not to panic unduly about the complications outlined in this section. Each of the complications is still relatively rare, but does need medical attention and monitoring. If you suspect you are experiencing any of the symptoms, please do contact your doctor immediately. However, many of the complications can only be picked up at your antenatal appointments through scans/urine/blood pressure tests, so it is important to attend them regularly.

ANAEMIA

Anaemia is common in pregnant women, especially during multiple pregnancies as your babies absorb nutrients from your blood. It occurs when there is a decline in the concentration of red blood cells and, with them, haemoglobin. Symptoms include feeling tired, looking pale, short of breath, and fainting. Mild anaemia is not harmful to your babies and it is estimated to be present in up to 80% of pregnant women.

A diet rich in iron is the ideal way to keep your haemoglobin levels up. Good sources of iron are wholemeal bread, red meat and game, baked beans, dark green vegetables, lentils, and breakfast cereals fortified with iron. As part of your



routine antenatal care, your blood tests at 20-24 weeks should reveal whether you need to take iron supplements. There are several varieties of iron tablets, some of which can leave you feeling constipated. Your doctor/midwife should be able to recommend one that is less likely to leave you constipated. You can also help prevent constipation by eating plenty of fibre (fruit, wholegrain cereals, green leafy vegetables) and drinking lots of fluids. If haemoglobin levels do not rise, your doctors/midwife may do further blood tests to check for rarer causes of anaemia.

PRE-ECLAMPSIA

Pre-eclampsia is a condition particular to pregnancy, characterised by a rise in blood pressure (hypertension) and/or protein being present in the urine (proteinuria). Regular monitoring of blood pressure and urine by your doctor or midwife is essential for detecting pre-

eclampsia, especially during the third trimester. It may be associated with symptoms include such as swelling of the face, sudden swelling or puffiness of the ankles and hands, severe headaches, visual disturbances and, in more severe cases, pain in the upper abdomen, and vomiting. If you suffer from any of these symptoms, please contact your healthcare team immediately as pre-eclampsia can develop into eclampsia, a dangerous condition for both mothers and babies.

Mums-to-be who are at risk of developing hypertension during pregnancy, which includes the condition pre-eclampsia, are advised to take a small amount of aspirin every day to ward off the condition. Recent government guidelines on multiple pregnancies recommend that women take 75mg of aspirin daily from 12 weeks until the birth of the babies if they have one or more of the following risk factors for hypertension:

- **first pregnancy**
- **age 40 years or older**
- **pregnancy interval of more than 10 years**
- **BMI of 35 kg/m² or more at first visit**
- **Family history of pre-eclampsia.**

Hospitalisation may be necessary to ensure complete bed-rest and to

administer drugs to reduce blood pressure. In the most serious cases, it may be necessary to induce labour early or perform a caesarean section, in which case you will be given a steroid injection to help speed up the babies' lung development. This is usually given up to 36 weeks. After the babies are born, the symptoms should go away, but your blood pressure may be monitored for any signs of eclampsia for up to six weeks. The support group Action on Pre-eclampsia (APEC) is a useful organisation for anyone experiencing pre-eclampsia (www.apec.org.uk).

PRETERM LABOUR

The most common gestation for the onset of labour in twin pregnancies is approximately 37 weeks. However, labour may occur earlier than this, particularly with multiple births. The signs and symptoms of preterm labour are regular contractions of the womb, building up in strength and frequency, sometimes with passage of the mucous plug ('show') or breaking of the waters. Premature contractions are a common occurrence in pregnancy, particularly with twins and triplets, and in most cases they are not a sign of preterm labour. However, it can be very difficult to determine if labour is imminent or not and if you experience these symptoms you should inform a health

MANY OF THE COMPLICATIONS CAN ONLY BE PICKED UP AT YOUR ANTENATAL APPOINTMENTS THROUGH SCANS/URINE/BLOOD PRESSURE TESTS, SO IT IS IMPORTANT TO ATTEND THEM REGULARLY

care professional immediately. It is likely that you will be advised to go to hospital. Although it is difficult to stop true premature labour, it can sometimes be delayed, giving time to prepare the babies for an early birth.

GROWTH RESTRICTION

Most twins and triplets grow normally in the womb, although they do tend to be a little smaller than singleton babies. In all pregnancies however, there is a risk that the placenta(s) will not keep pace with the needs of the growing baby and that this will cause their growth to slow down. This can put the baby, or babies, at risk if it goes unrecognised. Fetal growth restriction is more common in twin pregnancies and even more so in triplets and higher order multiples. Regular ultrasound scans will be offered to you to monitor the growth of your unborn babies. Premature delivery is sometimes recommended if one or more of your babies is very small.

GESTATIONAL DIABETES

Gestational diabetes is diagnosed when elevated blood sugar levels occur during pregnancy. Insulin is the hormone produced by our bodies that helps to keep blood sugar levels stable. Different hormones, produced by the placenta, partially block the action of the mothers' insulin and in some women this causes the blood sugar levels to rise beyond a threshold at which point gestational diabetes is diagnosed. Symptoms include feeling very hungry or thirsty, needing to pass urine frequently, tiredness and blurred vision. However, it is not always easy

for pregnant women to notice the symptoms, so it is important to take a urine sample to all your antenatal appointments so your doctor can check for sugar in your urine (glycosuria). Glycosuria is a common finding during pregnancy, even in the absence of diabetes, however if gestational diabetes is suspected, a glucose tolerance test is given during the second or third trimester to test for the disease. This involves fasting overnight and having two bloods the following morning, the second one after having

“**MOST TWINS AND TRIPLETS GROW NORMALLY IN THE WOMB, ALTHOUGH THEY DO TEND TO BE A LITTLE SMALLER THAN SINGLETON BABIES**”

taken a very sweet drink. This test is also recommended to women who have an increased risk of developing gestational diabetes, such as those with a family history. Gestational diabetes should not pose any threat to mother and babies once it is detected and treated. The risk is that if left untreated and undetected, excess blood sugar can cause the babies to grow very large, increasing the incidence of difficult labours, assisted deliveries and caesareans. Following delivery, the babies may go to neonatal care to be observed and their blood sugar levels monitored and providing all is well, they should soon be with you. Treatment for gestational diabetes

is the same as pre-existing diabetes: dietary changes (more protein, less carbohydrates); close monitoring of blood sugar levels; and possibly treatment with tablets (metformin) or insulin injections for the rest of your pregnancy. You may also be seen by an Endocrinologist (doctor who has an interest in diabetes), diabetes nurse, dietician and specialist midwife regarding treatment and management.

VAGINAL BLEEDING

Bleeding or 'spotting' can be extremely worrying for pregnant mothers, but it is surprisingly common in the first trimester. The 2011 Tamba survey found 1 in 4 mothers of multiples had experienced vaginal bleeding during their pregnancy. Indeed, some women have irregular 'spotting' throughout their pregnancies with no negative impact on their babies. However, if you experience vaginal bleeding, it is important to notify your doctor/midwife. In early pregnancy, bleeding may be an indication of an ectopic pregnancy or that you are likely to miscarry one or all babies. Later in your pregnancy, bleeding could mean that the placenta is separating from the uterus (abruptio placentae) or partially covering the cervix (placenta praevia). Both conditions require immediate medical attention, although your early scans should have ruled out a low lying placenta / placenta praevia.

OBSTETRIC CHOLESTASIS

This is a liver condition where the normal flow of bile is impaired in a pregnant woman's body. Cholestasis means there is a build-up of bile salts in the blood. It occurs in approximately 1 in 100

OBSTETRIC CHOLESTASIS: coping with the itching

- Keeping cool by dressing in light, loose cotton clothes, avoiding humid conditions, lowering the thermostat in your house, taking cool showers and baths, and soaking your hands and feet in icy water before you go to sleep.
- Eat a healthy, balanced diet and cut down on fried and fatty foods to minimise the work your liver has to do. Avoid alcohol and drink lots of water.
- Relaxation techniques may help you sleep at night and take your mind off the itchiness
- Aqueous creams with menthol may also help symptoms of cholestasis
- Your doctor may prescribe Ursodeoxycholic Acid (known as Urso or UDCA), antihistamine tablets, and/or suggest maternal liver or gall bladder scans and regular monitoring (blood tests and ultrasounds)

(Although complementary remedies are available from registered homeopaths, check with health professionals first before using them and remember that remedies should not be a substitute for medical treatment)

pregnancies in the UK, although it is more common for women carrying twins and triplets, possibly due to the increase in hormone levels in multiple pregnancies.

The main symptom is severe itching often on the hands and feet. Other symptoms include: fatigue and sleep deprivation from itching; loss of appetite; dark urine

and/or pale stools (greyish in colour); and mild depression. Although obstetric cholestasis has been reported early in pregnancy, it is most common when hormone concentrations are at their highest levels in the third trimester.

It is quite common to experience some level of itchiness on your abdomen in your pregnancy, but if the symptoms are extreme, you should consult your doctor/midwife immediately. There is a small increased risk for infant stillbirth (near term), premature labour, fetal distress and haemorrhaging in both mother and babies.

Your doctor/midwife may do blood tests (e.g. bile acid test and liver function tests) and possibly an ultrasound test to check for gallstones blocking the flow of bile into the gut. If diagnosed, you will be regularly monitored and may be given medication to reduce the bile acids in the bloodstream. It may also be necessary to deliver the babies early to protect them and reduce risks. The itching should stop within 1-2 weeks of the birth. If you would like further information or support, please contact Obstetric Cholestasis Support Worldwide (see www.ocsupport.org.uk).

TWIN TO TWIN TRANSFUSION SYNDROME (TTTS)

This is a rare complication that occurs in approximately 1 in 7 twin pregnancies where the placenta is shared (monochorionic) and occurs as a result of the transfusion of blood from one twin (the donor) to the other (the recipient) through blood vessels in the shared placenta. The donor twin may become smaller and anaemic due to not having enough blood

“IF DIAGNOSED, HEALTH PROFESSIONALS WILL CONTINUE TO MONITOR YOUR PREGNANCY CAREFULLY WITH FREQUENT ULTRASOUND EXAMINATIONS”

supply. The recipient twin has a higher blood volume, which can strain the fetus's heart and lead to heart failure. The donor twin is also likely to have a decreased urinary output, leading to a lower than normal level of amniotic fluid, whereas the reverse is true for the recipient twin. The excess fluid in the recipient twin ('polyhydramnios') can be quite uncomfortable for the pregnant mother and pressure on the cervix can lead to ruptured membranes and early delivery.

During your first ultrasound scan, the sonographer will look to see if your twins are monochorionic (one chorionic membrane and shared placenta) and if so, your pregnancy will be closely monitored for signs of TTTS. Indications of TTTS include differences in the size of the twins' abdomens, estimated birth weights, amounts of amniotic fluid and bladder volumes. If diagnosed, health professionals will continue to monitor your pregnancy carefully with frequent ultrasound examinations. You may be referred to a Specialist Centre for laser ablation therapy, which separates the blood vessels in the placenta. Tamba's free booklet 'Twin to Twin Transfusion Syndrome: A Guide for Parents' can be downloaded from Tamba's website.

SECTION SIX PREPARING FOR BIRTH

HOW BIG WILL I GET?

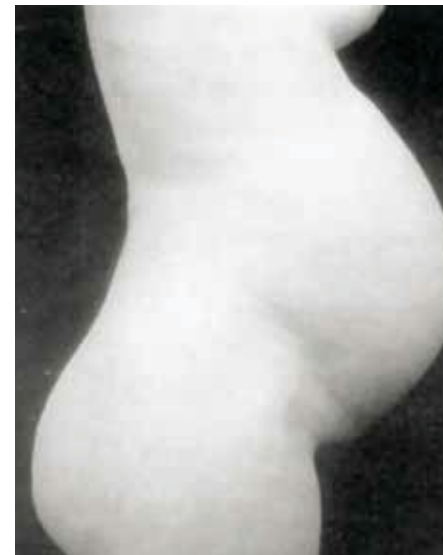
Expectant mothers vary in size, although the vast majority of women expecting multiples find that they are much bigger than those expecting a single baby.

You may find that you outgrow standard maternity clothes. Although you may not feel stylish, it won't last forever! The last few weeks of a multiple pregnancy can make you feel awkward, uncomfortable and ungainly – driving with a seatbelt and getting in and out of cars may become incredibly difficult, be prepared to do very little during those final weeks.

It is also sometimes the case that friends or family tell expectant mothers that “you don't look big enough to be having twins”.



A woman 35 weeks pregnant with one baby



A woman 35 weeks pregnant with twins



Although this is often said to make you feel better, it can sometimes have the opposite effect of making you worry that the babies are not growing well. If you have any worries about your babies' size, please speak to your doctor or midwife.

WHEN SHOULD I START MY MATERNITY LEAVE?

You can start maternity leave anytime from 11 weeks before the beginning of the week when your babies are due. For twins, this is from 29 weeks. If you are carrying more than two babies you may need to stop work even earlier than this. Remember that you may be very tired towards the end of your pregnancy, and that you may develop raised blood pressure or other health problems. Discuss your plans with your midwife and doctor and be prepared to change your mind as your pregnancy progresses.

If the multiple pregnancy affects your health so that you have to stop work before you are entitled to maternity benefits, you may be able to claim

“THERE IS NO ENTITLEMENT TO EXTRA MATERNITY OR PATERNITY LEAVE BECAUSE YOU ARE EXPECTING MULTIPLES”



sickness benefits instead.

There is no entitlement to extra maternity or paternity leave because you are expecting multiples. For up-to-date information on entitlements to parental leave and flexible working please consult www.direct.gov.uk

WHEN CAN I EXPECT THE BABIES TO BE BORN?

The average length of a pregnancy depends on how many babies you are expecting:

- A single baby usually arrives at around 40 weeks
- Twins usually arrive around 37 weeks
- Triplets usually arrive around 33 weeks
- Quadruplets usually arrive at around 31 weeks

With all multiple births, there is an increased risk of prematurity. You should be prepared for the possibility that your babies may come early and spend some time in neonatal care. About 60% of twin pregnancies result in delivery which can be spontaneous or induced before 37 weeks 0 days, and about 75% of triplet pregnancies before 35 weeks 0 days.

Neonatal units can sometimes be quite daunting places to begin with and you may think your babies look small and vulnerable amongst all the technology. It is a good idea to try to visit the neonatal unit on a hospital tour during your pregnancy to prepare yourself for the possibility that your babies may spend some time here. Some tips for coping emotionally and practically with your babies' stay in neonatal care are provided on the next page.

NEONATAL CARE AND PREMATURE BABIES:

Tips for coping

• Your babies will not be the only ones who feel fragile - recognise that you too will be dealing with complex emotions. Common feelings include guilt, anger, sadness and sometimes no emotions at all.

• It is possible to breastfeed premature babies, although you may have to express milk and feed it through a small tube into the nose or mouth.

• Skin to skin contact (also known as 'kangaroo' care) can calm babies and help develop a sense of attachment. It helps with breathing, heart rate and to speed up recovery. Tuck your baby (or babies) inside your shirt against your skin in the kangaroo position. Staff can help you as soon as the babies are well enough.

• Babies are also comforted by the smell

and sound of their mother. Talk to them quietly and calmly, and ask if you can leave a piece of cloth for the babies that you've kept close to your chest.

• Parents often feel better after talking to people whose babies are going through a similar situation. Some neonatal units run groups or coffee breaks where parents can chat to each other. You can also talk to Tamba's Twinline or BLISS's family support helpline, both of whom can provide support

• Visit the babies as often as you can, although it is natural to feel exhausted, upset or tied between older siblings or their healthy twin/triplets. Take some time out if you need to. Some parents find it helps

to take a photo of your babies to look at when you are away from them.

• Try not to become overwhelmed by issues affecting other people around you - you need to focus on your babies (that will be stressful enough as it is).

• Don't worry about asking for help at home, e.g. with shopping, babysitting and looking after babies, but ensure these are people you know or have been recommended.



The length of time in a neonatal unit will depend on how early the babies were born and whether there are any medical complications.

In 2011, Tamba and Bliss produced a free booklet 'Multiple Births – A Parents' Guide to Neonatal Guide', which can be downloaded from Tamba's website. For more information about what to expect on the neonatal unit, parents can ask for a copy of the Bliss Parent Information Guide.

HOW BIG ARE MY BABIES LIKELY TO BE?

The average weight of a baby at birth depends on the number of babies and the length of the pregnancy before delivery

- **Single babies average around 3.40kg (7.5lb) at 40 weeks**
- **Twins average 2.49kg (5.5lbs) at 37 weeks**
- **Triplets average 1.80kg (4lb) at 33 weeks**
- **Quadruplets average 1.40kg (3lb) at 31 weeks**

Your babies may weigh much the same as each other, or their weight may be very different.

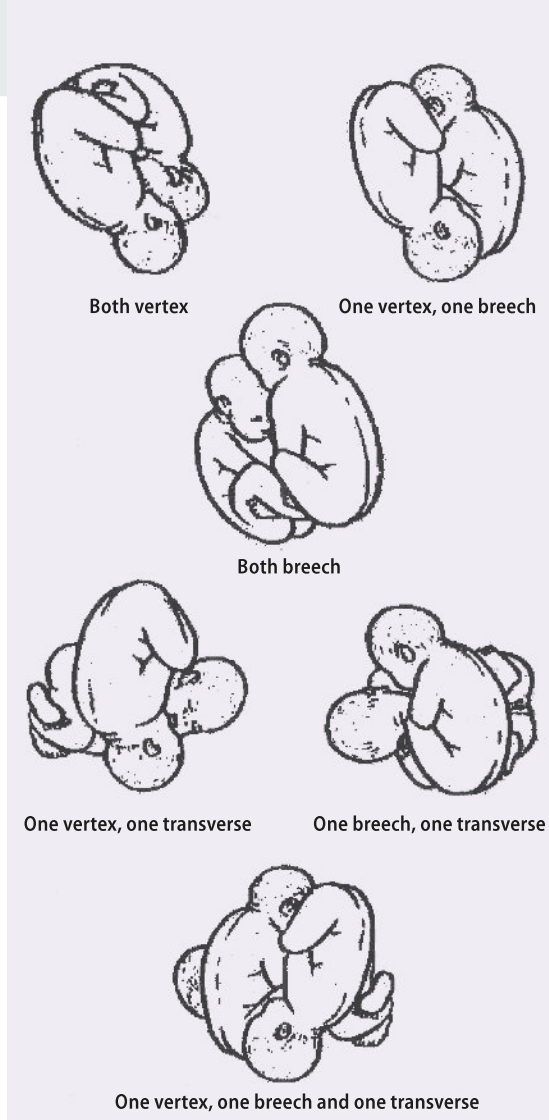
HOW ARE MY BABIES LIKELY TO ARRANGE THEMSELVES IN THE WOMB?

Twins can present themselves in the same ways as singletons, the main presentations being vertex (head down) and breech (bottom first).

The diagram shows the main combinations with which each presentation occurs. With triplets, it is common for the first baby to be lying transverse (across).

SHOULD I WRITE A BIRTH PLAN?

Some women find it helps to write a birth plan - a record of what you would like to happen during your labour and after your birth. Discussing your plan with your midwife will give you the chance to ask questions, learn about hospital



procedures for multiple births, and find out more about what will happen when you go into labour.

The NHS Choices website has further information about making a birth plan, for example: options for pain relief, positions for labour and birth, and looking after your babies after birth.

Though a birth plan can be helpful, please remember that labour and birth are unpredictable. You will need to be flexible and be prepared to do things differently if complications arise.

SECTION SEVEN

VAGINAL DELIVERY

WHAT ARE THE DIFFERENT STAGES OF LABOUR?

Vaginal deliveries consist of three stages of labour:

- **first stage (thinning and dilation of your cervix);**
- **second stage (pushing the babies out); and**
- **third stage (delivery of placentas).**

AM I IN LABOUR?

Every woman's experience of labour is unique, but understanding how to recognise labour and what the different stages involve is a good preparation for giving birth to your babies. You may experience some, all, or indeed none of the following signs of impending labour:

- The 'show' - a mucus plug sealing your cervix that may dislodge up to 12 days before labour. It is a sticky

substance, which may be pink, slightly brown or blood-tinged in colour

- 'Nesting instincts' - some women feel a sudden urge to clean the skirting boards!
- Braxton Hicks' contractions - weak, irregular, painless contractions which may become more frequent and intense as real labour approaches
- Engagement of one of the babies' heads in your pelvis up to 2-3 weeks before labour

You may want to discuss these symptoms with your doctor/midwife, but at this stage you do not need to be admitted to hospital.

Spontaneous breaking of your waters (amniotic fluid) can be another sign that labour is imminent and you should contact your hospital straight away if your waters break. Leaking of fluid may vary from a trickle to a gush and if you are uncertain whether your waters are breaking or the leaking fluid is urine, it is advisable to wear a sanitary pad and check with the hospital. They will probably advise you to come straight in, particularly if the fluid contains blood or meconium (your babies' first bowel movement, which is typically sticky, thick, and a dark green colour) or if you are experiencing strong, frequent contractions.



"The doctor said she needed to examine me before she could start. I told her I need to push. She asked me not to, as I was still wearing shorts and knickers!"

You will probably recognise the first stage of labour by painful contractions of the muscles of the uterus. It is best to contact the hospital as soon as your contractions begin and they can advise you when to come in. The contractions will become stronger and more regular as your cervix thins out and then dilates.

WHEN WILL I BE INDUCED?

It is not unusual for women to give birth to twins at 40 weeks or over. However, national recommendations specify that your obstetrician should offer elective birth (induction or caesarean section) from 36 weeks if you have monochorionic twins, 37 weeks if you have dichorionic twins and 35 weeks if you have triplets. If you choose to continue the pregnancy longer, your obstetrician should put in place a plan for weekly monitoring of the babies. It may be advisable to induce you before



these timing guidelines, if your babies' or your health would be at risk by continuing with the pregnancy.

Your doctor/midwife should explain fully the reasons for induction and how the procedure will happen. Typically labour is artificially started by a vaginal pessary or gel of prostaglandin, which softens the cervix. If labour has not started within 24 hours, it may be necessary to break your waters manually (slightly uncomfortable, but should not hurt). If contractions do not follow in the next few hours, you will be given oxytocin (also called Syntocinon) via an intravenous drip.

HOW WILL THE BIRTH BE MONITORED?

Regular monitoring of multiples during vaginal birth is standard practice. Fetal heart monitoring (CTG) is often used to assess your babies' heartbeats and the intensity and frequency of your contractions. Your midwife will strap a thick belt with small pads and sensors onto your abdomen. Although the monitors can be bulky, you should still be able to move into different positions with the help of your midwife. If the external monitors are not able to pick up the babies' heartbeats accurately, the first baby will be monitored internally using a fetal scalp electrode attached to the babies' scalp with a metal clip.

WHAT PAIN RELIEF WILL I BE OFFERED?

More often than not, labour is painful and it helps to know in advance what types of pain relief are available. Having a partner, friend or relative who can



or even depressed. You will not be given pethidine if you are close to giving birth because it might affect the babies' breathing and can interfere with breastfeeding. It can also make it difficult to push, and you might prefer to start with half a dose to see how it works for you.

- Epidurals involve painkilling drugs passed into the small of your back via a fine tube. The drugs are injected

“MORE OFTEN THAN NOT, LABOUR IS PAINFUL AND IT HELPS TO KNOW IN ADVANCE WHAT TYPES OF PAIN RELIEF ARE AVAILABLE”

support you and ensure you get the pain relief you need helps a lot. There are several different options for relieving the pain of labour:

- Gas and air (Entonox) – a mixture of oxygen and nitrous oxide gas – is breathed in through a mask or mouthpiece, which you can hold and control yourself. The gas takes about 15-20 seconds to work, so take slow, deep breaths as a contraction begins. Gas and air reduces the pain, but won't remove all the pain.
- Injections of pethidine or diamorphine can help you relax. It takes about 20 minutes to work and lasts between two to four hours. However, there are some side effects to be aware of; it may make you feel drowsy, dizzy, sick, forgetful, elated,

around the nerves that carry signals from the part of your body that feels pain when you're in labour, acting as a regional anaesthetic. Epidurals are the most effective form of pain relief during labour and can be topped-up by an experienced midwife, so you don't usually need to wait for an anaesthetist once the epidural is in place. It can also be topped up with stronger local anaesthetic if you need a caesarean section. You may be advised to have an epidural due to the higher risk of assisted delivery or emergency caesareans with multiple births. However, you may prefer not to have an epidural and it is worthwhile discussing alternative pain relief with your doctor/midwife during your antenatal appointments, giving you time to think about what might suit you and your babies.



● TENS machines can be effective in the early stages when many women experience low back pain. However, TENS are generally not such a good option for pain relief when contractions get longer, stronger and more frequent. If you wish to use TENS you will need to hire TENS equipment in the later months of your pregnancy and learn how to use it (ask your midwife to show you how it works).

WHAT HAPPENS DURING THE BABIES' DELIVERY (THE SECOND STAGE OF LABOUR)?

When you are fully dilated (10cm), you will be ready to push the baby out (the second stage of labour). Your hospital's policy might be to move you into the operating theatre for this stage, or your doctor and/or midwife may consider it necessary. The exact number of people in the room will depend on hospital procedure, but multiple births usually involve more health professionals. For example, there may be a midwife, an obstetrician, and two paediatricians – one for each baby. If you feel strongly

that you do not want lots of people present, you can ask for all non-essential staff to wait outside the room until they are needed.

It can take anything up to two hours to deliver the first baby. You may be encouraged to give birth on your back, but do discuss your options and hospital policy beforehand. With the support of your midwives, it is possible to deliver twins safely in different positions, for example standing, squatting or on all fours.

If the second stage is taking too long and there is a risk the babies are becoming distressed, your doctor may advise you to have an assisted delivery using forceps or ventouse (a vacuum device). It is generally not recommended that a ventouse is used on premature babies (of less than 34 weeks), because your babies' heads are too soft at this age. Both procedures usually (but not always) involve episiotomies (small cuts to the vaginal wall), which are usually performed under local anaesthetic if you haven't already had an epidural.

After the first baby is born, your doctors will feel the position of the second twin and if necessary attempt to manually move it into a vertex (head down) position. This can sometimes be done externally, but it may be necessary to do a breech extraction (pull baby out by the feet) or to turn the baby internally, which requires pain relief if you haven't already had it. The doctor may also undertake an ultrasound scan to confirm the position of the baby.

The time that elapses before the next baby is born may be as little as a few minutes and is usually within twenty minutes. If more than half an hour passes, your doctor may recommend speeding up the second baby's arrival using an intravenous hormone drip. You will be relieved to read that second babies are often delivered more quickly than the first, mainly because the tissues have been widened. While you are pushing the second twin out, your birth partner can put the first twin onto their chest (under their shirt) for warmth and bonding.

"I expected lots of medical staff, and chaos, but it was actually very relaxed with just my partner, two midwives and a registrar. Twin 1 was born at 5.48pm, weighing 6lb2. I started to panic, when I realised I had to go through it again, and was asking for "any kind of drugs!", but the midwife was lovely and reassured me everything was going perfectly, and I just had to listen to my body. At 6.04pm twin2 was born weighing 5lb12. I was handed both babies, and all the staff left, to give me and my partner some alone time.



AFTER THE FIRST BABY IS BORN, YOUR DOCTORS WILL FEEL THE POSITION OF THE SECOND TWIN AND IF NECESSARY ATTEMPT TO MANUALLY MOVE IT INTO A VERTEX (HEAD DOWN) POSITION

It was magical, and couldn't have gone any better. I was so worried before the birth as all you hear is the horror stories, but my twin birth was amazing, and I feel truly blessed."

HOW WILL THE PLACENTAS BE DELIVERED (THE THIRD AND FINAL STAGE OF LABOUR)?

You will be given the opportunity to cuddle your babies before the third and final stage of labour. Natural delivery of the placenta can take up to an hour and is generally not recommended due to an increased risk of bleeding with the larger placenta(s). Therefore your doctor/midwife may recommend that you have an injection of a drug (Syntocinon or Syntometrine) to contract the uterus and expel the placenta in under ten minutes. This means you don't need to push and there will be less risk of blood loss, which tends to be greater in multiple births because the placenta(s) are attached to a larger area of uterine wall.

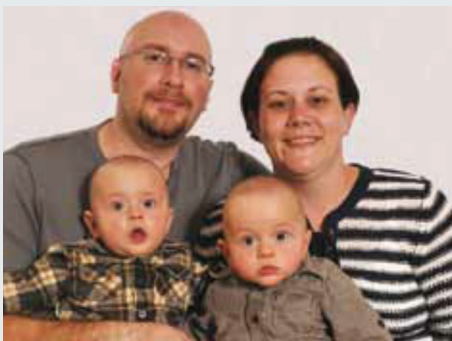
BIRTH STORY

OF THOMAS AND BENJAMIN

After let's just say not a brilliant pregnancy with sickness, pelvic pain, fortnightly scans for Twin To Twin Transfusion Syndrome (TTTS), etc by 32 weeks I was begging all the health professionals to get the boys out of me as I was HUGE and hardly able to move!

At our 34 week appointment with our consultant he noted that my blood pressure was slightly raised and I had protein in my urine and asked me to go to hospital for overnight observation. The following morning, the on duty consultant appeared at my bedside at 9am and said my blood tests showed that my blood platelets were very low and that my kidneys were failing. So to be on the safe side, for me more than the boys, they were being delivered "one way or another within 12 hours". You can imagine the panicked phone call my husband received just minutes later! I had a scan and both boys were still head down although the twin 1 and 2 reference had been changed as twin 2 had moved down.

"I WAS BEGGING ALL THE HEALTH PROFESSIONALS TO GET THE BOYS OUT OF ME AS I WAS HUGE AND HARDLY ABLE TO MOVE!"



When my husband, Leo, arrived at the hospital I was taken up to the delivery suite. We had a large delivery room given the need for 2 resuscitators, and the number of medical professionals who would be present – midwife, assistant midwives, consultant, Neo Natal Team on standby. In the end there were 15 people in the room besides me and my husband.

My waters were manually broken at 1:30pm. I had no hormone drips, given that I had been in pre-term labour on and off for the 2 weeks prior to this, so by breaking my waters it was hoped that that would be the gentle push to get my body going and it was. By 4pm I was already 6 cm dilated. I felt each contraction until then getting stronger, longer and more frequent. I was given an epidural in case a c-section was needed at any point. The pain all melted away. There were then a few peaceful hours with limited discomfort before

7pm when I was told I was fully dilated and the team were assembling ready for me to start pushing at about 8pm. By 7:45pm my body took over and I began pushing. I remember telling everyone I wasn't having these babies I just needed a poo to which all the midwives reassured me that these babies were coming.

Halfway through my umpteenth "I can't do this anymore" after what felt like pushing forever, but was in fact 20 mins, at 8:08pm suddenly Thomas Stephen was placed on my chest as red as a lobster. He was taken to Neo Natal to

appeared ghostly white and placed on the resuscitator immediately. It was a few minutes before we heard him cry as we found out later he had stopped breathing and needed resuscitating. He was then taken to Neo Natal followed by Leo while I was sewn up.

It was then explained to me the reason for their colour difference – Twin to Twin Transfusion Syndrome. Thomas (5lb 2oz) had received all the haemoglobin and Benjamin (4lb 5oz) very little requiring a blood transfusion instantly after birth. They were both in incubators in the Neo Natal unit on monitors and drips.

"THEY ARE NOW HAPPY THRIVING LITTLE BOYS AND THE STRESS OF THE PREGNANCY, THE BIRTH AND NEO NATAL TIME SEEM A DISTANT MEMORY"

be checked out. The medical team had grabbed my tummy to stop twin 2 from turning and scanned me to ensure he was still head down. He showed some signs of distress so we agreed to a forceps delivery. I had an episiotomy and at 8:24pm Benjamin Peter

Due to being on a drip for fluids and a catheter myself it was 5 hours before Leo was able to wheel me to see them. The longest 5 hours of my life. Leo was flitting between me and them keeping me up to date on what was happening.

My stitches from the episiotomy dissolved after 2 weeks, my bleeding stopped after 3 and generally I was back to normal within a month of having the boys.

After 3 weeks, the boys came home to meet their grandparents and their two dogs! At 5 months they are now happy thriving little boys and the stress of the pregnancy, the birth and Neo Natal time seem a distant memory."

DAWN MORSE



SECTION EIGHT CAESAREAN SECTIONS

WHY MIGHT I NEED A CAESAREAN SECTION?

In the UK more than half of twin babies and almost all triplets and quads are born by caesarean. You may decide you want a caesarean (elective), or your doctor may advise you to have one (planned) during pregnancy because of the babies' position, a previous caesarean section, difficult vaginal delivery or previous history. A caesarean section will usually be recommended if the first baby is lying in the breech position (feet, knees or buttocks first) or transverse lie position (when the baby's body lies sideways across your uterus). A planned caesarean will also be necessary in the case of placenta praevia (when the placenta covers the cervix).

The need for a caesarean section in labour (emergency) may be prompted by a number of possible scenarios: your babies moving into difficult positions; concerns regarding fetal well being; a compressed or prolapsed umbilical cord (when the baby's umbilical cord falls into the birth canal ahead of the baby); high blood pressure that does not respond to medical treatment; slow progress in labour; and when assisted delivery (forceps or ventouse assistance) does not work. In relatively rare situations (5% or less of all twin births), you may deliver the first twin vaginally but the second twin may get into distress and need to be delivered by caesarean.



"I was in hospital for 4 weeks - 4cms dilated with my twins. It was a planned emergency C-section because the plan was as soon as I went into labour I would have a C-Section. When my waters finally broke, I was given my C-section within about 2 hours".

WHAT HAPPENS IN AN ELECTIVE/PLANNED CAESAREAN?

Hospital procedure for elective/planned caesarean sections varies, but typically involves:

- Standard preparation for operation includes avoiding food and drink for several hours, in case a general anaesthetic is required as the anaesthesia can sometimes cause vomiting. You may also be given a tablet or liquid to neutralise stomach acid.
- Your birth partner should be able

to accompany you into the operating theatre, but will have to wear theatre clothes. However, if you have a general anaesthetic, they will be unable to go into theatre with you.

- You will need to sign a consent form before the operation.
- Elective/planned caesareans are usually performed using an epidural or spinal analgesia, which allows you to remain awake, but provides pain relief. Although you should not feel any pain, you may still feel touch and pressure. Some women describe it as a gentle rummaging or tugging sensation.
- An intravenous (IV) drip is also inserted into your arm in case you need extra fluid or medicines. It is usually removed within 12 hours of the operation.
- After the anaesthetist has administered the appropriate pain relief, a catheter tube will be inserted to keep the bladder drained of urine. If you have an epidural or spinal, there is a risk you may be unable to feel your bladder filling up, so the catheter will enable you

to pass urine when the bladder is full. It is usually pain free and will remain in place for approximately 24 hours after the birth.

- In theatre, a screen will be raised across your chest so you will not be able to see the operation. Your partner can choose to watch or stay on the other side of the drapes.

IF THE BABIES ARE WELL, THEY CAN BE HANDED STRAIGHT TO THEIR MOTHER FOR A CUDDLE

- The obstetrician will clean your abdominal skin, before making a neat incision across your bikini line. The babies are taken out in the order in which they are nearest to the obstetrician; this may be baby 1 or baby 2 (or 3, 4 if triplets/quads). If the babies are well, they can be handed straight to their mother for a cuddle.
- The babies will be lifted gently from the uterus and the cords will be clamped and cut. The cords will dry up, turn black and fall off between 5 to 15 days after birth; in the meantime, keep the cords clean and dry to avoid infection.

- After the babies have been delivered, the obstetrician will deliver the babies' placentas, check your uterus and stitch up the layers and skin incision. This



process takes up to 30 minutes and may involve tiny metal staples or conventional sutures.

- Once the operation is over you will be taken to the recovery room, and once stable to the postnatal ward where you may stay for 3-7 days depending on your recovery, the babies' condition, and hospital procedure.

"I remember going into theatre and having the needle in my spine and then relaxing. There were 13 staff in the room with us, so you know you are being looked after."

WHAT HAPPENS IN AN EMERGENCY CAESAREAN?

In an emergency caesarean, the decision to operate is often taken quickly. If you have already had an epidural, it may be 'topped up' by giving another dose of the drug into the fine tube which lies in your back. The procedure is similar to the one



"THERE WERE 13 STAFF IN THE ROOM WITH US, SO YOU KNOW YOU ARE BEING LOOKED AFTER"

described above. However, you may need a general anaesthetic, in which case you will not be conscious during the delivery of your babies. During a general anaesthetic, it may not be possible for your partner to stay with you, but he should be able to hold the babies immediately after they are born if they are well enough. You should become conscious within an hour of the caesarean, but may feel weak and need to be supported in your care of the babies for the first 24-48 hours.

HOW LONG WILL IT TAKE ME TO RECOVER?

Recovery after a caesarean is typically slower than for a vaginal birth and the incision may be painful for several days. Your hospital will be able to advise you on when it is safe to resume normal activities, but it is best to take it easy for at least the first month. You should try to walk around a little to reduce the risk of blood clotting, but avoid heavy lifting, bending and stretching. It should take about 6-8 weeks for your body to fully recover. Your stitches will be removed after five days, if they are not self-absorbing.

"ONCE UPON AN ELECTIVE C-SECTION"

My two darling girls, Roxanne and Sadie, were delivered by elective C-section at Edinburgh Royal infirmary in January 2011.

I'm sharing my experience with you because, despite being gutted when I learnt we'd have to go down that road, the whole experience for me was very positive and I hope I can help ease your worries, if you have any. My first daughter had been delivered vaginally so I was really hoping we could do the same with the twins. All three of us had kept happy and healthy throughout pregnancy and my hopes were high. Sadie had been in and out of breech position for much of my pregnancy but I had been assured that since Roxanne, the presenting twin, was head first we would have no problems with vaginal delivery. Once the first one pops out there's usually plenty of room to flip the second baby around!

Then, at a routine scan at 36 weeks, disaster struck. To my horror, I was told that Roxanne had somehow managed to somersault into the breech position and there wasn't a whole lot of room left in there for manoeuvre. Both babies were breech. I was terrified. Now, can I just be clear about this? Deep down, I wasn't really worried for

the health or the safety of the babies (or myself) as I know it's a common and routine procedure. No, I'm ashamed to admit, my worries were twofold: a) would I ever be able to wear a bikini again and b) would I be judged as inferior or a failure in the eyes of all the more wholesome, more able mummies that I'd no doubt encounter at playgroup? With hindsight both of these worries have proven completely unfounded. My scar is small, discreet and very low down. And absolutely everyone (yes, everyone) I meet just thinks I'm a super-mum by virtue of having twins regardless of how they arrived in the world.

So, anyway, back to my story. When we discovered both babies were breech I was immediately scheduled

"ABSOLUTELY EVERYONE (YES, EVERYONE) I MEET JUST THINKS I'M A SUPER-MUM BY VIRTUE OF HAVING TWINS REGARDLESS OF HOW THEY ARRIVED IN THE WORLD"

for an elective C-section but since we were already very close to D day, the earliest date I could get was at nearly 39 weeks. Of course at this stage my predominant worry then became the more serious issue of "what if I go into labour naturally before then?" Everyone had told me I'd go early. I tried to rest

as much as I could and repeated the mantra over and over "I will not go early, I will not go early"! I have no idea if it worked or not, I suspect my girls were just happy to stay snuggled inside where they were nice and warm. This was all happening during the "big freeze" when most of Scotland ground to a halt and even major motorways were closed for days due to ice. On days when I was unable to drive or hobble to the clinic, the midwives, amazingly, always managed to get to

“AND FINALLY... WE MADE IT TO D DAY! IT'S ACTUALLY KIND OF NICE KNOWING WHEN YOUR BABIES WILL BE BORN”

me. I have to point out that the whole team of midwives at my practise were awesome. When I worried (which was often!) they always managed to squeeze in extra appointments for me. They were always very understanding of my concerns and I had very regular monitoring to ensure I wasn't getting close to labour.

And finally... we made it to D day! It's actually kind of nice knowing when your babies will be born. You can have their entire astrological futures mapped out before they're born, you completely avoid annoying texts along the lines of "we haven't seen you on Facebook for a while.... any news???" and on

a more practical note you can ensure you have reliable plans in place for the care of your older children and/or pets while you're away. We had to check in to the hospital at 7 o'clock on the Friday morning, but had no specific appointment for the actual procedure. It's just a case of come along, sit and wait and we'll do you when we can. On arrival I had a scan and was told that if, somehow, Roxanne had righted herself then I'd be free to go home and wait for natural labour. If I'm honest, by this stage, there was no way I was going home... I was simply too excited at the thought of finally meeting my babies! But then the almighty wait began. The morning lasted an eternity. I was exhausted, emotional, hormonal, aching all over and very, very hungry. Then lunchtime came and my husband ate a sausage roll. It was the final straw. The floodgates opened and I cried most of the afternoon. Looking back it seems completely absurd but I think your brain just kind of goes a bit crazy! The hospital have to make way for any emergency sections first (obviously) and by 4pm I was told there was a good chance I'd have to go home and sit out the weekend. The theatre was free but there was a shortage of space in the



ward to receive me afterwards. I can't find the words to describe how utterly devastated I was. I lost all self-respect, and begged! And somehow it worked. By 4.30 we were wheeling along en route to the theatre and 22 minutes later I had two more daughters!

Once we got the go-ahead everything seemed to happen very quickly and my memory of specific details is a bit blurred. But I can remember several things about the actual operation that I'd like to share. The first is that there was a large screen supposedly blocking out my view of my innards. A word of advice though, if you are at all squeamish, check out what's above you before they begin.... I had a large metal light unit which doubled up as a very effective mirror. My second memory - and this is very clear - is that I honestly didn't feel even an iota of pain. Nothing. It felt like someone was rustling around with my clothes rather than my actual flesh. It was a strange and rather unsettling feeling but the excitement of being only minutes away from holding my babies completely overwhelmed it. The final, and most exciting, thing I want to share with

you is that you may get to choose some music. Maybe I'm naive, but I completely hadn't expected this! In an operating theatre! The doctor said to my husband "Now you have a very important job here..." and directed him over to the CD player to choose the soundtrack to the birth of our children. He chose "I am the resurrection" by The Stone Roses which had been the last dance at our wedding.

And then the wait was over. Roxanne with her gorgeous head of flaming red hair appeared, screaming healthily and wriggling in her father's arms. Tiny, pink and perfect in every way. Ha! Now it was his turn for waterworks! Two minutes later we had Sadie, with her head full of dark brown locks just like my late father. Both babies were exactly what I'd been waiting for all my life. After a brief cuddle they were whisked away to be weighed and washed and my husband and I had a brief minute to hug before I was stitched back up and presented with my little bundles. There were no beds in the ward to receive us so Roxanne and Sadie had their first feed in a recess off the corridor just outside the theatre. I have no idea how long we stayed there but we had a midwife right beside us the whole time and both babies fed hungrily. I can just remember being engulfed with such intense happiness that it sounds almost cheesy, but makes me well up even now writing about it. And then, finally, after some time, we were taken to the ward and settled down for the night. And thus ends the longest day, the worst day, and the best day, of my life!"

GILLIAN PERRIS

SECTION NINE AFTER YOUR BABIES' BIRTH

HOW DO I KNOW IF MY BABIES ARE IDENTICAL OR NON-IDENTICAL?

When you are first pregnant you may not think it is particularly important to know whether your babies are identical - but you will be asked about it again and again and for most parents and the children it will become important to know.

Generally about one-third of multiples are identical, and two-thirds are non-identical, as illustrated in the diagram.

A boy is not identical to a girl, for the obvious reason that they are of different sexes. So if you have multiples of different sexes, then they are fraternal (non-identical).

"There are some questions everyone asks you. The top one is 'Are they twins?' but a very close second is 'Are they identical?'. It makes me want to scream. Of course they're not identical - one's a girl and one's a boy, and they have different hair, different faces, different everything. I don't know why people ask me that all the time."

But what if the babies are of the same sex?

- In older children, you can examine them closely for physical differences such as the colour of their hair, eyes or skin, or the shape of their ears, shape of their feet and toes and palm creases. If there are obvious differences, they are non-identical. Bear in mind, however,



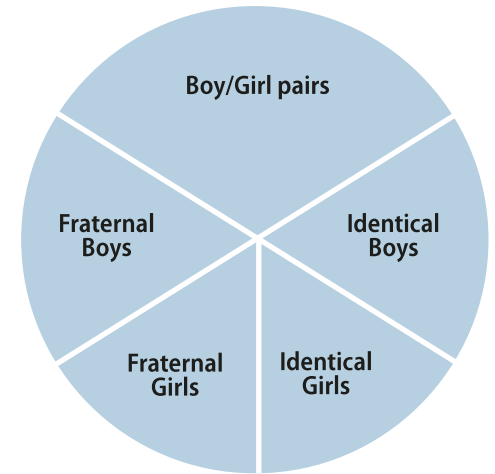
that premature babies change a lot as they grow, and that all babies' hair and eye colour may change.

- During scans in early pregnancy or at the birth, ask the hospital to check the number of placentas and membranes. If there is only one placenta then the babies are probably identical. However, the presence of two or more placentas does not necessarily mean the babies are fraternal - it is possible for identical twins to have separate placentas, depending on the stage at which the fertilised egg split. To further complicate matters, a single placenta is easily confused with two separate placentas, which have fused together.

- Close examination of your placenta after birth may reveal if your twins are identical or not and you can also ask for the placenta to be sent away to determine chorionicity. However, due to increasing pressure on pathology departments, this is not usually done

unless there is a medical reason. It is typically more of a concern for the parents than the hospital, although it can be good to know if either child becomes ill and you need to know if they are identical or not.

- The most accurate (but most expensive) test is DNA testing. By analysing the DNA a map is developed for each baby. If the DNA maps are identical, then the babies are identical. Contact Tamba to find out more about the availability of zygosity testing – some companies offer Tamba members a



MIDWIVES ARE ON HAND TO HELP YOU LEARN HOW TO CARE FOR YOUR NEW BABIES

discount to have these tests carried out which is done by means of a simple cheek swab. Further information about zygosity testing is also available from the Multiple Births Foundation.

HOW LONG WILL I STAY IN HOSPITAL?

If all goes well during, and after labour, you and your babies can go home a few hours later. The length of stay on the postnatal ward varies for each mother from 6 hours to 48 hours following a normal birth and up to 3 or 4 days following a complicated delivery or Caesarean section. Length of stay is reviewed on a daily basis and depends on the progress of both mother and

babies. Mothers with their baby or babies on the neonatal unit are often offered additional stay.

Many mothers of multiples prefer to stay in at least overnight to recover from the birth. Midwives are on hand to help you learn how to care for your new babies, for example how to change nappies, bathe your babies, care for their umbilical stumps. Breastfeeding mothers can also benefit from support and help establishing feeding.

For further advice on preparing for parenthood, birth and the babies' first six months, please see Tamba's 'Preparing for Parenthood - A guide for parents expecting twins, triplets or more'. It will help you to explore how you are feeling, how your pregnancy affects your relationships, how to take care of yourself, what support is available for you, how you get to know your babies and take care for them. It also includes some information on common illnesses that all babies can get and what to look out for.

FINAL WORD

Congratulations, your babies are finally here and your pregnancy journey is over. Now, let the real journey begin and let Tamba help you to enjoy the experience.

We are the only UK charity which is set up specifically to support you and your family. We provide support and information to over 20,000 families and 180 local clubs each year and our members enjoy a wide range of benefits, including:

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- Involvement in campaigns and research
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- Free access to a range of factsheets and information
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Not only does your membership help you to keep in touch, have fun and save money but our research shows that the peer group support provided by Tamba can help you to prepare for and cope better with multiple pregnancies and your children's early years.

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Valid From: Card Expires:

Switch Only Issue No.

.....

Please insert the 3 digit security code from the reverse

of your card:

Signature:

Date:

WHO TO CONTACT FOR MORE INFORMATION

● APEC

Action on Pre-eclampsia aims to educate, inform and advise the public and health professionals about pre-eclampsia.
www.apec.org.uk

● Antenatal Results and Choice (ARC)

– provides non-directive support and information to expectant and bereaved parents throughout and after the antenatal screening and testing process.
www.arc-uk.org

● Bereavement Support Group (BSG)

– Tamba's BSG supports all parents and carers who have lost from a multiple birth, whether it was during pregnancy, at birth or afterwards.
<http://www.tamba.org.uk/bsg>

● BLISS

the premature baby charity
Freephone: 0500 618140 and
www.bliss.org.uk

● Department for Work and Pensions (DWP)

for information about maternity leave and pay
www.dwp.gov.uk

● Diabetes UK (formerly the British Diabetic Association)

www.diabetes.org.uk

● Home-Start

the UK's leading family support charity which can place volunteers with multiple birth families
www.home-start.org.uk

● Multiple Births Foundation (MBF)

aims to improve the care and support of multiple birth families through the education of all relevant professionals.
www.multiplebirths.org.uk

● National Childbirth Trust (NCT)

Info about local antenatal classes (some areas run multiple-specific classes), meet other mothers-to-be and find out about local events and nearly new sales.
www.nct.org.uk

● NHS Choices

have an online pregnancy care planner, with sections on multiple pregnancies by looking under twins, triplets etc.
<http://www.nhs.uk/planners/pregnancyplanner/Pages/PregnancyHome.aspx>

● Obstetric Cholestasis Support Worldwide

provides support and information on Obstetric Cholestasis (OC), a liver disorder occurring during pregnancy
www.ocsupport.org.uk

● Tommy's

provides information on the causes and prevention of miscarriage, premature birth and stillbirth
www.tommys.org

● Twins and Multiple Births Association (TAMBA)

www.tamba.org.uk
Twinline: 0800 138 0509
(a confidential listening service for families of twins and more)

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FURTHER READING ON MULTIPLE BIRTH PREGNANCIES

THE FOLLOWING PUBLICATIONS
ARE AVAILABLE TO DOWNLOAD
FOR FREE FROM TAMBA'S WEBSITE:

- **Preparing for Parenthood**

A guide for parents expecting twins,
triplets or more

- **Twin-to-twin Transfusion Syndrome**

A guide for parents

- **Multiple Births – Parents' Guide to Neonatal Care**

- **Postnatal Depression**

A guide for mothers of multiples

- **Tamba Bereavement Support Group Booklet**

For parents who have lost one or more
babies from a multiple birth

Other recommended reading includes:

- **Twins & Multiple Births – The Essential Guide From Pregnancy to Adulthood** (pub. Vermilion)
Dr Carol Cooper

- **The Twins Handbook**
(pub. Robson Books)
Elizabeth Friedrich and Cherry Rowland

- **When You're Expecting Twins, Triplets or Quads**
(pub. HarperCollins)
Dr Barbara Luke and Tamara Eberlein

- **Double Trouble**
(pub. Thorsons)
Emma Mahony

- **NICE Guidelines for Multiple Pregnancy**
National Institute for Health and Clinical
Excellence (NICE)



For a detailed list of publications related to multiple births or to
obtain further copies of this booklet, please contact Tamba or go to

www.tamba.org.uk





Twins and Multiple Births Association (Tamba)

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