AIMS For a better birth...

Are twins always high risk?

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Joanne Whistler asks whether they are really a variation on normal

After a wonderful home birth with my firstborn, Oliver, in 2006 I felt confident in my body's ability to labour and give birth. Even when I discovered that I was pregnant with twins late last year I had the attitude that it was just a variation on normal.

It was only when I started reading up about multiple pregnancy and birth that my belief that I would have another good experience began to falter. Everything I read said that multiple pregnancies were higher risk, that I should expect a more medicalised experience of pregnancy and birth than a mother of a singleton, and implied that for my babies' sake I should give up any thought of what I considered to be a normal birth. Of course I wanted my babies to be safe, but I also wanted their entry into the world to be gentle and unmedicated – I was very aware of the risks and side effects of pharmacological pain relief and interventions such as induction.

In the end I had a fabulous home water birth attended by two independent midwives. My husband and a trusted friend were also there. My midwife monitored the babies intermittently and removed the caul from twin two's face but otherwise my labour and birth were completely intervention-free. In this article I will discuss the evidence base for management of multiple pregnancies and explore some aspects of planning the birth of twins or more.

A dearth of evidence

With my scientific background and working as I do in health policy, I naturally tried to read up on the evidence to help inform my choices for this pregnancy. What soon became clear was that research in many areas was sparse and often of poor quality. Multiple births are often excluded from mainstream studies, or are lumped together with singleton births. Twin-specific studies may not separate out pregnancies where the twins have separate sacs and placentas, those with one placenta and two sacs, and where the babies share both sac and placenta, despite the different risk profiles of each type of twin pregnancy. The biggest problem with the published research, however, was that in most cases it did not evaluate the options I was considering. One consultant obstetrician I saw said that from research currently underway we would soon know 'whether planned csection or vaginal birth is safer fortwin births.' No. We will know whether c-section or typical hospital management of vaginal twin birth is safer, but physiological twin birth in a place the woman feels safe with a trusted and highly skilled birth attendant will remain unevaluated. Research into other 'high risk' situations has been similarly flawed –

the Hannah term breech birth trial[1] is a case in point.

Even when there is good-quality evidence, women need to be able to consider the research in the light of their own specific circumstances. For example, having twins put me at greater risk of pre-eclampsia than a secondtime mum with a singleton pregnancy. However, my uncomplicated previous pregnancy meant I was less likely to develop pre-eclampsia than a first-time mum expecting a single baby.

With the patchy evidence base for management of multiple births, the process of making informed choices can be particularly difficult for an expectant mother of multiples. The rest of this article explores some ideas for thinking through the issues.

Avoiding complications of multiple pregnancy and birth

It can be empowering for the expectant mother to realise that she can reduce the likelihood of some of the commonly-cited complications of multiple pregnancy and birth. For example, pregnancy-related stress is associated with pre-term labour.[2] so after panicking in my first trimester I made a conscious decision to stay away from upsetting birth stories and articles. I also ensured I ate well, as insufficient weight gain in twin pregnancy is associated with pre-term birth and low birth weight.[3] Before accepting an intervention, especially one with unproven benefits, mothers should consider potential iatrogenic complications. For example, artificially rupturing membranes (ARM) for twin two once the first twin has been born is a very common procedure, but the rush of fluid could bring the cord with it. Given that the presenting part may not yet be engaged in the pelvis, cord prolapse could result.

Understanding the risks, their likelihood and impact

The articles and books I read in early pregnancy that frightened me with their shroud-waving were frustratingly short on detail. They often simply said that multiple pregnancies were 'high risk' without specifying what those risks were, and used the 'high risk' label to justify why mothers of multiples should submit to interventions such as frequent ultrasounds and electronic fetal monitoring (EFM) without explaining how these interventions would reduce the risks. Those that gave more detail often mentioned complications such as premature birth and pre-eclampsia, but even then it was not at all clear how the interventions would help reduce risk. Discussion of the risks of the interventions themselves was almost nonexistent. I really struggled to find information on the additional risks of a twin birth where the pregnancy was uncomplicated and term, which was information I needed in order to plan my babies' place of birth in the event of everything going smoothly. It is not acceptable for care providers to justify increased routine intervention by simply using the 'high risk' label. Women should ask what specific complications the clinician is concerned about, and how the proposed intervention will alter the likelihood or effect of these risks.

Many of the additional risks of multiple birth relate to things that can be dealt with reactively if they occur, rather than trying to pre-empt them. Attempting to do so may be counterproductive, such as repeated ultrasound scans to detect reduced growth.[4] In addition most potential problems would be

extremely unlikely to lead to death or serious injury to the mother or babies. For example, postpartum haemorrhage is more of a risk in multiple pregnancies because of the larger placental site. However, should there be excessive blood loss in a physiological third stage, the opportunity has not been lost to administer drugs to contract the uterus and control the bleeding. Should this initial intervention not be sufficiently effective, further treatment might be necessary, but life-threatening blood loss in a healthy well-nourished woman is extremely unlikely.

With the 'high risk' label comes an additional reliance on care providers for information and guidance. The content and emotional tenor of this advice will be heavily influenced by the clinicians' background and experience. I saw two consultant obstetricians at two different Trusts and they were each concerned about entirely different aspects of my twin pregnancy! Nevertheless, the experience of talking to them was positive and I felt that they respected my right to make 'unusual choices'. I know this is not the experience many women have of maternity services. If the consultant is exerting inappropriate pressure on a woman to conform to hospital guidelines, some of the following suggestions may help:

- taking another clinician, such as a senior midwife, to any meetings with the consultant
- approaching the midwife consultant in normality at the Trust for support (if there is one)
- considering changing to a different consultant or even a different Trust

Creating favourable conditions for physiological birth

In all labours, the conditions that facilitate physiological birth are privacy, warmth, low light levels, upright and forward-leaning positions and avoiding activating the labouring woman's neocortex by, for example, asking her questions. These conditions are even more important for multiple births, but are less likely to occur. I asked a consultant obstetrician how many mothers of multiples laboured and gave birth in her hospital in predominantly upright positions. The answer : 'almost none', due to a combination of EFM and epidural use. There are often more people around during a multiple birth, and clinicians' belief that multiple births are high risk can create an atmosphere of fear. Michel Odent says of twin births:

'In general those who know about privacy as a basic need in labour are not scared by this sort of birth. It is the art of doing nothing. First you wait for the first baby. Then you wait for the second baby and finally you wait for the placenta. The point is to make sure that there is not too much excitation around after the birth of the first twin, so that the mother is not distracted and has nothing else to do than look at her baby in a sacred atmosphere. The same after the second one, while waiting for the placenta […]. Those who don't know about the importance of privacy are so scared of twin births that they create a cascade of interventions… if they have not chosen the easy way, that is to say a caesarean section. Today many practitioners are right to prefer a caesarean section. Giving birth without any privacy among scared people can be dangerous.'

Unless the woman knows who will attend her in labour and trusts that the midwife will create and support the conditions that facilitate normal birth, having a doula or other birth supporter to protect those conditions is likely to be very helpful. The woman's partner may find it difficult to support her through labour whilst at the same time protecting her birth space.

I was privileged to have had a highly-skilled team of independent midwives looking after me during my twin pregnancy and birth. My first midwife has extensive experience of breech birth (my twins were both vertex, but over half of term twin pregnancies involve at least one twin in the breech position), water birth and physiological third stage, and also experience of twin home birth. I had complete confidence in her skills, but also knew she would only intervene if truly necessary. Can women under NHS care say the same things? Unfortunately not. Because of the very small number of women choosing (for example) vaginal breech birth and even physiological third stage, clinicians rarely get the opportunity to develop their skills and confidence in these areas. It is difficult for expectant mothers of multiples to choose physiological options if they cannot trust that the midwives and doctors are skilled in these areas. For example, inappropriate pulling on a baby during a physiological breech birth can be dangerous.

Minimising the negative impact of necessary interventions

Even when everything is in place to optimise a woman's chances of a normal, uncomplicated birth, it is important to recognise that complications can still occur and appropriate interventions can improve outcomes. Being prepared for the most common complications and interventions and planning for those eventualities can help a woman be and feel more in control if things do not go entirely to plan. For example, I was clear that if one or both of my babies were breech, I wanted to try for a hands-off vaginal breech birth. Should progress stall, however, I wanted a caesarean section rather than an attempted vaginal breech extraction, which I felt would be traumatic for both me and the babies. If I had ended up with a caesarean section in such circumstances I would have been disappointed, rather than traumatised as could have been the case if I had been bounced into a breech extraction.

Seek support

Being classified as 'high risk' can be a frightening and lonely experience. Women going through this in their pregnancy need support, but must take care where they seek it. It is very common to encounter the 'just do what the doctors tell you, what matters is a healthy mother and babies' attitude, even though it is not as simple as more medicalised = safer. The internet is particularly potent. I benefited from being able to talk to women who had experienced twin pregnancy and birth, and was very grateful to friends who sent me links to inspiring twin birth stories and film clips. On the other hand I was scared to the point of tears by some of the 'information' I found on the internet and found venturing onto the TAMBA (Twins and Multiple Births Association) message board an extremely negative experience.

The future

The biggest stumbling block to 'high risk' women wanting low-intervention, physiological births is the deskilling of clinicians that results from the vast majority of 'high risk' births being very medically managed. Independent midwives on the other hand have opportunities to develop their skills and confidence in a wider range of births. It is hoped that independent midwives will be able to contract in to the NHS in future through the arrangements IMUK is seeking to put in place. It would be a huge step forward if women wanting a low-intervention approach to the birth of twins could be offered the services of an independent midwife on the NHS.

References

Hannah ME et al (2000) Planned caesarean section versus planned vaginal birth for breech presentation at term: a randomised multicentre trial. The Lancet, Volume 356, Issue 9239, Pages 1375 - 1383.

- Hannah ME et al (2000) Planned caesarean section versus planned vaginal birth for breech presentation at term: a randomised multicentre trial. The Lancet, Volume 356, Issue 9239, Pages 1375 - 1383.
- Dole N et al (2003) Maternal Stress and Pre-term Birth. Am. J. Epidemiol. 157 (1): 14-24.
- Fox NS et al (2010) Weight Gain in Twin Pregnancies and Adverse Outcomes: Examining the 2009 Institute of Medicine Guidelines. Obstetrics & Gynecology. Volume 116 - Issue 1 - pp 100-106
- Beech BL (1999) Ultrasound – Weighing the Propaganda against the Facts. Midwifery Today. Autumn 1999