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Pregnancy Complications

Common pregnancy symptoms. You may experience a number of symptoms during pregnancy. Most of these are normal and will not harm you or your baby, but if they are severe or you are worried about them, speak to your midwife or doctor. You may feel some tiredness, sickness, headaches or other mild aches and pains, or have heartburn, constipation or haemorrhoids. There may also be some swelling of your face, hands or ankles or you may develop varicose veins. Changes in mood and sex drive are also common. Sex is safe unless you are advised otherwise by your care provider.

Problems in pregnancy require additional visits for tests and surveillance of you and your baby's well-being. Many conditions will only improve after delivery of the baby, therefore it may be necessary to induce your labour or undertake a planned (elective) caesarean section. Please discuss any worries with your midwife or doctor.

Body Mass Index. Is a test to see if you are a healthy weight for your height and is calculated by dividing your weight in kilograms by your height in metres squared. During pregnancy there are increased risks of certain complications if your BMI is less than 18 or more than 35.

High blood pressure. You need to tell your doctor or midwife immediately if you get headaches or spots before your eyes, as these can be signs that your blood pressure has risen sharply. If there is also protein in the urine, you may have **pre-eclampsia** which in its severe form can cause blood clotting problems and fits. It is also often linked to restricted growth and other problems for the baby.

Diabetes may be present before pregnancy, or may only happen during pregnancy (gestational diabetes). It can show as sugar in the urine, when blood sugar levels become high due to a lack of insulin. High sugar levels cross the placenta and can cause the baby to grow large (macrosomic). The baby gets used to these high sugar levels and sometimes can have difficulty getting used to managing without them – causing it to have *low* blood sugar (hypoglycaemia) after birth. If you have or develop diabetes you will be looked after by a specialist team who will check you and your baby closely throughout the pregnancy. Gestational diabetes usually settles after pregnancy but can happen again in future pregnancies.

Itching. Severe itching, especially on the hands and feet, can be caused by a liver condition known as **Obstetric Cholestasis**. Cholestasis can affect the baby and may result in stillbirth if not treated. Blood tests can check to see if you have the condition. If you do, you may require tablets and the baby will require careful monitoring. The timing of delivery should be discussed with you by your doctor according to your individual needs.

Thrombosis (clotting in the blood). Your body has naturally more clotting factors during pregnancy to stop the bleeding as quickly as possible once the 'afterbirth' is delivered. However this also means that all pregnant women are at a slightly increased risk of developing blood clots during pregnancy and in the first weeks thereafter. The risk is higher if you are over 35, overweight, smoke cigarettes, or have a family history of thrombosis. You are advised to see your doctor **immediately** if you have pain or swelling in your leg, or pain in your chest, or cough up blood.

Vaginal bleeding. Bleeding may come from anywhere in the birth canal, including the placenta (afterbirth). Occasionally, there can be an 'abruption', where a part of the placenta separates from the uterus, which puts the baby at great risk. If the placenta is lying low in the uterus, tightenings or contractions may also cause bleeding. Any vaginal blood loss should be reported **immediately** to your midwife or labour ward staff. You will be asked to go into hospital for tests, and advised to stay until after the bleeding has stopped or until the baby is born. If you are Rh -ve, you will require an Anti D injection (see page 6).

If the waters break. Spontaneous rupture of the membranes (SROM) is followed by a gush, leak or trickle of amniotic fluid. You are advised to contact your midwife or nearest maternity unit to check whether you are in labour, and to make sure that the baby's cord has not slipped down. If you are not in labour, swabs will be taken to check for infection. Labour often starts within a day of SROM.

Prematurity. Labour may start prematurely (before 37 weeks), for a variety of reasons. Before about 34 weeks, most maternity units have a policy of trying to stop labour for at least a day or two, whilst giving steroid drug injections (e.g. betamethasone) to help the baby's lungs to mature. However once labour is well established, it is difficult to stop.

Breech. If the baby's presentation (see page 12) is not head first (cephalic), there is an increased chance that labour will not be straightforward. If your baby is presenting bottom first (breech) it is now usually recommended to try to turn the baby before labour commences (ECV = external cephalic version). However, the procedure is not always successful. Your midwife and obstetrician will discuss with you the options on how best to deliver a baby that stays in the breech position: delivery by a planned (elective) caesarean section is now often recommended, but the alternative may be to allow labour to start naturally, to watch and see how things go and to intervene only as necessary; as always, the decision is yours.

Multiple pregnancy. Twins, triplets or other multiple pregnancies need close monitoring, and more frequent tests and scans are recommended. Further details about the special needs of multiple pregnancies can be found on www.preg.info



