

# When things don't go as planned

## Introduction

Most women have a normal healthy pregnancy. However, some pregnancies will be affected by health problems that existed before the pregnancy, were caused by the pregnancy or developed throughout the pregnancy. Most of these problems mean women need more intensive care with an obstetrician and other specialist(s) during pregnancy. The following information is not exhaustive. It provides a very brief overview on some of the complications of pregnancy for which high level evidence or a body of expert opinion exists.

## Anaemia

Anaemia in pregnancy is most commonly caused by iron deficiency. Eating iron rich foods is important in the prevention of iron deficiency anaemia during pregnancy. Medical treatment of anaemia in pregnancy involves taking iron supplements.<sup>1</sup>

## Bleeding in the second half of pregnancy

If you have any bleeding in the second half of pregnancy, contact your doctor/midwife/hospital immediately so that appropriate investigation and treatment can be commenced. The most common reasons for bleeding in the second half of pregnancy are placental abruption and placenta praevia.

Placental abruption is the most common cause of bleeding during the second half of pregnancy and is often associated with abdominal pain/tenderness. Placental abruption occurs when part or all of the placenta separates from the wall of the uterus before the birth of your baby. The amount of bleeding varies, as does the impact on your baby. The cause of the bleeding is not always known. Treatment may involve monitoring you and your baby, bed rest and/or, in more serious cases, birth of your baby.<sup>2</sup>

Placenta praevia occurs where the placenta is either wholly or in part inserted into the lower part of the uterus and covering the cervix. One of the signs of placenta praevia is bleeding after 28 weeks gestation. Diagnosis is by ultrasound. The baby is usually born by caesarean section.<sup>3</sup>

## Breech presentation

A breech presentation or a 'breech baby' is one with its bottom coming first and its head up towards the top of the uterus. Your baby may be breech when you are six or seven months pregnant, but in most cases will turn in the last couple of months. Your breech baby may be born vaginally, however a caesarean section is more common, particularly in a first pregnancy.<sup>4</sup> It is best to discuss the birth alternatives with your doctor/midwife.

If your baby does not spontaneously turn in the last few weeks of pregnancy, it is common practice for these babies to be born by caesarean section. External cephalic version (ECV) has been shown to successfully turn the baby from a breech to a head presentation in 50% of cases. ECV involves a doctor trained in the technique gently turning the baby using hands on the outside of your abdomen.<sup>5</sup>

## High blood pressure

High blood pressure (hypertension) in pregnancy is diagnosed when either or both the systolic (upper reading) and diastolic (lower reading) blood pressure is equal to or exceeds 140/90, or when your blood pressure is significantly higher than your normal reading.<sup>6</sup> Hypertension in pregnancy may develop because of the pregnancy or you may already have high blood pressure. It can occur anytime, be a one off event or part of a more complex condition such as pre-eclampsia.

Treatment for hypertension includes rest, monitoring of your blood pressure, monitoring of your baby and your wellbeing, and may require medication.

## Pre-eclampsia

Pre-eclampsia is one of the more common complications of pregnancy, and can occur at any time during the second half of pregnancy and the first few days after birth. The signs of pre-eclampsia are high blood pressure and protein in your urine. Pre-eclampsia is a serious complication of pregnancy. It may be anywhere between mild and severe, and treatment varies accordingly.<sup>6</sup>

Women with pre-eclampsia are closely monitored and have access to extra care. In the case of severe pre-eclampsia, more intensive monitoring of the mother and baby may be required. Your doctor may also consider premature delivery of your baby.

## Premature labour

Premature labour is when labour begins before 37 weeks' gestation. The reason for labour starting prematurely is often not clear. Causes include multiple pregnancy, a weak cervix, fibroids, an abnormally shaped uterus, urinary tract or other infection in the mother, smoking and drug use. If you have had a premature baby before, your chances of having another premature baby are higher.

In some cases because of illness, your doctor may suggest that your baby is born early. The main reasons for this would be pre-eclampsia, infection, placenta praevia and placental abruption.

For more information and support about premature labour, having a premature baby and parenting a premature infant, see [Austprem](#).

## Blood clots and deep vein thrombosis (DVT)

Although rare, the risk of developing blood clots and/or deep vein thrombosis (DVT) begins in the first few weeks of pregnancy, and continues until the weeks after the birth of your baby.<sup>7</sup>

Some women have more risk of developing these conditions. They include women who:

- give birth by caesarean section
- have had a blood clot or DVT in the past
- have a family member who have had a blood clot or DVT
- have a medical condition which may increase chances of acquiring a blood clot or DVT.<sup>8</sup>

The symptoms and signs of DVT are leg pain or discomfort, swelling, tenderness, increased temperature and oedema, and/or lower abdominal pain. The signs of blood clots in the lung(s) include difficulty with breathing, chest pain, feeling faint, in addition to those signs and symptoms for DVT.<sup>7</sup>

Some of these symptoms and signs are found in normal pregnancy, so it is recommended that you contact your doctor/midwife/hospital to arrange special tests if you have any of these signs or symptoms. Treatment is anticoagulant/anticoagulation medication and the use of elastic support stockings.<sup>7</sup>

## Baby with an unexpected illness and/or impairment

When things do not go as planned, it can come as a great shock. Parents expecting a healthy baby who have a baby with an illness or impairment may grieve, and the grieving process may take months or years to complete. If you do experience a baby who is ill, or has impairment, you will be encouraged to have close contact with your baby, with the support of care providers. Arrangements to see senior doctors and midwives are usually made to discuss the reason for the unexpected illness or impairment, including obstetric and genetic information and/or counselling as appropriate. These meetings usually involve both parents. For genetic or inheritable conditions, [Genetic Health Services Victoria](#) can be accessed for expert clinical, diagnostic, and counselling services to families and individuals. These services are provided at metropolitan rural and regional hospitals. A doctor may refer you to Genetic

Health Services Victoria or you can make the contact yourself.

When you go home, ongoing professional support and care is provided by the local doctor, midwife and/or maternal and child health nurse. In addition, there are a number of community support groups that offer support and advocacy for families (e.g. PANDA, SANDS, SIDS).

## References

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<sup>1</sup> National Institute for Health and Clinical Excellence, (2008) Clinical Guideline: Antenatal care .routine care for the healthy pregnant woman (<http://www.nice.org.uk/Guidance/CG62>).

<sup>2</sup> Neilson JP. (2003) Interventions for treating placental abruption (Cochrane Review). In: The Cochrane Library, 2008. Oxford: Update Software.

<sup>3</sup> Royal College of Obstetricians and Gynaecologists (RCOG) (2005) Clinical Green Top Guidelines: Placenta Praevia and Placenta Praevia Accreta - Diagnosis and Management (27).

<sup>4</sup> Royal College of Obstetricians and Gynaecologists (RCOG) (2006) Clinical Green Top Guidelines: The management of breech presentation (20b)

<sup>5</sup> Royal College of Obstetricians and Gynaecologists (RCOG) (2006) Clinical Green Top Guidelines: External cephalic version and reducing the incidence of breech presentation (20a).

<sup>6</sup> Council of the Australasian Society for the Study of Hypertension in Pregnancy (2000) Consensus Statement: The detection, investigation and management of hypertension in pregnancy: executive summary.

<sup>7</sup> Royal College of Obstetricians and Gynaecologists (RCOG). (2007) Clinical Green Top Guidelines: Thromboembolic Disease in Pregnancy and the Puerperium: Acute Management (28).

<sup>8</sup> Gates S, Brocklehurst P, Davis LJ. (2002) Prophylaxis for venous thromboembolic disease in pregnancy and the early postnatal period (Cochrane Review). In: The Cochrane Library, Issue 3, 2003. Oxford: Update Software.