

## High-risk multiple pregnancy and twin complications



### Why multiple pregnancy carries higher risk

In a multiple pregnancy, the uterus, placenta, and maternal cardiovascular system must support more than one fetus at the same time. That extra demand explains why complications are more common than in singleton pregnancy, and why the risk generally rises with fetal number. Twin pregnancy is already higher risk; triplet and higher-order gestations carry even greater concern.

The single most important downstream problem is prematurity. Babies born too early account for much of the neonatal morbidity and mortality seen in multifetal gestations. Preterm birth can occur spontaneously, or delivery may be recommended earlier if maternal or fetal health begins to deteriorate. Low birthweight is also common, partly because many babies in multiple pregnancies are born early and partly because growth may be more limited.

For this reason, clinicians often treat multiple pregnancy as a situation requiring closer surveillance rather than as an automatic emergency. The goal is not to alarm you, but to catch changes early enough to improve outcomes.

### Maternal complications to watch for

Several maternal complications are more common in twin and higher-order pregnancies. Preeclampsia is a key concern because blood pressure disorders occur more often when there is more than one fetus. The review literature also shows an increased risk of stillbirth in multifetal gestation, which is one reason fetal monitoring is taken seriously throughout pregnancy.

Anemia, especially iron deficiency anemia, is another frequent issue. The body needs to build more blood volume and support more fetal growth, so iron requirements are higher. Fatigue, shortness of breath, and reduced exercise tolerance may be more noticeable, although these symptoms are not specific and should be interpreted by a clinician.

Delivery itself carries additional maternal risk. Postpartum hemorrhage is more common after multiple pregnancy because the uterus has been stretched more than usual and may not contract as firmly after birth. There is also a higher chance of operative delivery, particularly when one or both babies are not in a head-down position.

Other problems can include abnormal amniotic fluid volumes and, in some pregnancies, a vanishing twin early on. Not every multiple pregnancy will develop these issues, but they are part of the standard risk discussion.

### **Fetal and neonatal complications in twins and triplets**

For babies, the major concern is being born before the lungs, brain, and feeding coordination are fully mature. Even a few weeks early can matter in a multiple pregnancy because preterm birth is so common. This is why neonatal outcomes depend heavily on gestational age at delivery and on whether the babies need intensive support after birth.

Low birthweight is common and may reflect both earlier birth and less available growth space. Some babies may also present in malpresentation, meaning they are not positioned head-down. Breech or transverse lie can complicate the delivery plan and influence whether a vaginal birth is appropriate.

The possibility of congenital abnormalities is also part of standard counseling, although most twins are born healthy. Ultrasound surveillance aims to identify structural concerns, growth issues, and fluid abnormalities that

could change management. If one baby appears smaller or if fluid levels look abnormal, the obstetric team may increase surveillance or discuss altered timing of birth.

Parents are often relieved to hear that many complications are predictable enough to be watched for. The fact that a pregnancy is high risk does not mean a poor outcome is inevitable; it means the margin for early detection is smaller.

### **How antenatal care is usually intensified**

Multiple pregnancy usually requires more frequent contact with the maternity team than a singleton pregnancy. Blood pressure checks, urine assessment when indicated, and blood tests for anemia are common parts of follow-up. Ultrasound surveillance is often used to track fetal growth, amniotic fluid, and overall well-being.

Risk assessment also looks at the pregnant person's history. A prior preterm birth or a short cervix increases concern for earlier delivery, so those factors are taken seriously in planning. In practice, the obstetric team may discuss the likelihood of prematurity early and may arrange care in a setting with neonatal expertise.

One preventive strategy mentioned in the medical literature is low-dose aspirin prophylaxis for patients whose obstetric team feels it is appropriate to reduce preeclampsia risk. This is not a universal instruction and should only be used under clinician guidance, because the decision depends on individual risk factors and local practice.

This stage of care is often easiest when it follows a High-risk pregnancy monitoring plan that sets out which tests will be done, how often visits will occur, and which symptoms should trigger urgent review. That structure can make the pregnancy feel more manageable for families.

### **Planning delivery and the postpartum period**

Delivery planning in a twin or higher-order pregnancy depends on maternal health, fetal growth, presentation, gestational age, and the overall course of

the pregnancy. Because malpresentation is more common, the route and timing of birth are often reviewed repeatedly rather than fixed very early. In some cases, planning the birth in a hospital with an obstetric anesthesia team and neonatal support is prudent.

Good care is usually multidisciplinary high-risk pregnancy care. Obstetricians, maternal-fetal medicine specialists, sonographers, midwives, anesthesiology, and neonatology may all have a role. That team approach is especially useful when there are signs of preeclampsia and eclampsia risk, preterm labor, or fetal growth concerns, because decisions may need to balance maternal safety and neonatal maturity.

After delivery, postpartum follow-up matters. Families may be focused on feeding, sleep deprivation, and the needs of more than one newborn, but the birthing parent also needs surveillance for hemorrhage, blood pressure problems, anemia, mood symptoms, and recovery after cesarean or complicated vaginal birth. When care is coordinated well, the postpartum period becomes safer and less overwhelming.

### **When to seek urgent medical advice**

Some symptoms in multiple pregnancy should never be watched at home for long. Urgent assessment is appropriate for vaginal bleeding, leaking fluid, painful regular contractions before term, severe abdominal pain, or a noticeable reduction in fetal movement. Headache with visual symptoms, sudden swelling, chest pain, or shortness of breath also deserves prompt medical review because these can signal a maternal complication.

If you have already been told that your cervix is short, that you have a history of preterm birth, or that one baby is growing differently from the other, stay especially close to your antenatal team. These findings do not automatically mean something is wrong, but they do justify faster evaluation when symptoms change.

It can be emotionally draining to balance hope with vigilance. Many parents find it helpful to keep the care plan written down, know exactly which unit to call, and ask what symptoms would prompt same-day review versus emergency assessment.

