

Signs something is wrong during labor



Why warning signs during labor matter

Labor places major physiologic demands on both the birthing person and the fetus. Uterine contractions temporarily reduce blood flow through the placenta, maternal oxygen and fluid balance can shift quickly, and cervical dilation or descent may not always progress as expected. Most labors remain safe with routine monitoring, but warning signs help clinicians identify when the situation may be moving outside the expected range.

A sign that something is wrong does not automatically mean a catastrophe is happening. It means the clinical team may need to assess maternal vital signs, fetal heart rate, contraction pattern, cervical change, amniotic fluid, pain characteristics, and bleeding. In a hospital or birth center this may involve continuous or intermittent fetal monitoring, a physical examination, laboratory tests, intravenous fluids, antibiotics, medication to adjust contractions, assisted birth, or cesarean birth if indicated.

At home, especially in early labor, it can be harder to judge what is normal. The safest approach is to take red flags seriously. A call to maternity triage is not an overreaction when symptoms are severe, sudden, persistent, or different from what you were told to expect.

Changes in the baby's movement or heart rate

One of the most important fetal warning signs is decreased fetal movement. Many babies move differently during labor, and movement may feel less spacious as contractions intensify, but reduced fetal movement in labor should still be reported promptly. A noticeable drop in the baby's usual activity, no movement when you would normally expect it, or a sense that something has changed can justify immediate assessment.

In a monitored labor, clinicians also watch the fetal heart rate. An abnormal baby heart rate may include persistent tachycardia, persistent bradycardia, recurrent decelerations, reduced variability, or other concerning patterns depending on the full tracing. These findings can be associated with fetal distress, cord compression, infection, placental problems, or the normal stress of labor becoming harder for the baby to tolerate.

If you are not already in a care setting and you notice decreased fetal movement, do not wait for the next contraction-timing milestone. Contact your maternity unit or go in as instructed. If you are already being monitored, ask the team to explain what they are seeing and what the next steps are. The goal is not to create fear, but to make sure the baby's oxygenation and wellbeing are being evaluated in real time.

Concerning amniotic fluid after the waters break

Rupture of membranes can happen before contractions, during labor, or close to birth. Clear or pale fluid is commonly expected, although small streaks of blood can occur. Certain fluid changes deserve immediate attention because they may signal infection, fetal stress, or another complication.

Green or brown amniotic fluid can suggest meconium, the baby's first stool, in the fluid. Meconium can occur for several reasons and does not always mean an emergency, but it changes the risk profile and usually warrants clinical assessment. Thick meconium, especially with an abnormal fetal heart rate, may indicate that the baby is under stress and needs closer monitoring.

Yellow fluid, foul-smelling fluid, or a foul-smelling vaginal discharge can

raise concern for infection. Maternal fever combined with fetal tachycardia, uterine tenderness, or malodorous fluid is particularly important to report. Infection during labor can affect both mother and baby and may require antibiotics and continuous observation.

Also report water breaking without contractions, especially if you are preterm, group B strep positive, unsure of your status, or the fluid continues leaking for many hours. The longer membranes are ruptured, the more carefully clinicians consider infection risk and timing of care.

Bleeding, severe pain, or symptoms that do not fit normal contractions

Some blood-tinged mucus, often called bloody show, can be a normal sign of cervical change. Heavy bleeding is different. Bleeding that soaks pads, contains large clots, runs down the legs, or is accompanied by dizziness, faintness, pallor, or rapid heartbeat needs urgent medical evaluation.

Severe abdominal pain that remains constant between contractions is another warning sign. Labor contractions usually build, peak, and ease. Pain that does not let up, pain associated with a rigid or very tender uterus, shoulder-tip pain, sudden weakness, or a sense of impending collapse can indicate a serious problem and should be treated as urgent.

People with a prior cesarean birth or uterine surgery are often monitored for symptoms that could suggest uterine scar complications, such as sudden tearing pain, abnormal fetal heart rate, loss of fetal station, unusual bleeding, or maternal instability. These signs require immediate professional assessment, not watchful waiting.

It is also important to report severe headache, visual disturbances, right upper abdominal pain, chest pain, shortness of breath, seizures, confusion, or sudden swelling of the face or hands. Some of these symptoms may overlap with hypertensive disorders, thromboembolism, neurologic events, or other serious conditions around birth.

Fever, exhaustion, dehydration, and infection signs

Labor is hard physical work, but extreme maternal symptoms should not be

dismissed as simply being tired. Fever during labor can be associated with intra-amniotic infection, epidural-related temperature elevation, dehydration, viral illness, or other causes. Because maternal fever can also affect the baby's heart rate and newborn management after birth, it should be reported and evaluated.

Warning signs that may accompany infection or physiologic stress include chills, foul-smelling discharge, uterine tenderness, a very fast maternal pulse, increasing fetal heart rate, confusion, or feeling acutely unwell. Increased fetal heart rate together with maternal fever is a combination clinicians take seriously.

Dehydration can worsen fatigue, dizziness, nausea, and contraction tolerance. In some labors, dehydration or prolonged vomiting may contribute to maternal tachycardia or ketones, and intravenous fluids may be considered by the care team. However, severe exhaustion, inability to stay awake, persistent fainting, or trouble breathing is not typical labor fatigue and needs urgent help.

If you are laboring at home, call your clinician if you develop a temperature according to the threshold you were given, if you feel feverish with chills, or if the baby's movement changes. If you are in a facility, tell the nurse or midwife right away rather than waiting for the next routine check.

Labor that is not progressing as expected

Labor that slows down is common, especially in first births, with an epidural, or when the baby's position makes descent more difficult. Still, labor that does not progress can become a complication when cervical dilation, effacement, fetal descent, or contraction effectiveness remains inadequate over time.

Clinicians evaluate progress in context: gestational age, parity, membrane status, contraction strength, fetal position, maternal pelvic anatomy, fetal wellbeing, and whether the birthing person and baby remain stable. Slow progress is not usually judged from one contraction or one cervical check alone. It becomes more concerning when there is a persistent lack of change, maternal exhaustion, infection signs, abnormal fetal monitoring, or prolonged rupture of membranes.

Possible responses may include rest, position changes, hydration, amniotomy if membranes are intact and appropriate, oxytocin augmentation, pain-management changes, or operative delivery. The right choice depends on clinical circumstances and patient preferences. If you feel pressured or confused, it is reasonable to ask: What is the concern right now? How urgent is it? What alternatives are available? What happens if we wait?

Preterm labor warning signs also deserve special attention. Regular contractions, pelvic pressure, backache, fluid leakage, or bleeding before term should be assessed quickly because management may differ when the baby is premature.

When to seek immediate help and what to say

During labor, it is better to make an early call than to stay silent because you fear being dramatic. Maternity teams are used to sorting urgent from non-urgent concerns, and your description helps them decide whether you should come in, call emergency services, or continue close observation.

Seek immediate help for chest pain, trouble breathing, seizures, loss of consciousness, heavy bleeding, severe persistent abdominal pain, a suspected prolapsed cord, or thoughts of harming yourself or your baby. A cord prolapse may be suspected if you feel or see cord-like tissue in the vagina after the waters break; this is an emergency.

When you call, state your gestational age, whether this is your first birth, contraction pattern, membrane status, fluid color and odor, bleeding amount, fetal movement, temperature, pain severity, medical conditions, medications, group B strep status if known, and distance from the birth facility. If something feels deeply wrong but you cannot describe it neatly, say that clearly. Clinical care should include both objective signs and your lived sense of change.