## Stages of labor with twins and multiple pregnancy

## Why labor with twins and multiple pregnancy is managed differently

The basic physiology is still the same: the uterus contracts, the cervix effaces and dilates, a baby descends and is born, and the placenta follows. What changes in twin and multiple pregnancy is the margin for uncertainty. More than one fetus means more than one fetal heart rate to interpret, more than one position to assess, and more opportunities for presentation to shift as labor progresses.

This is why care is often concentrated in a hospital birth unit rather than a lower-acuity setting. The team may include an obstetrician, midwife, anesthetic support, neonatology staff, and, if needed, operating room personnel. The aim is not to make the experience feel medicalized for its own sake; it is to be ready if labor becomes faster than expected, if one baby shows distress, or if the second baby needs a different route of birth.

The overall plan depends on factors such as gestational age, chorionicity, fetal growth, the position of the first baby, previous uterine surgery, and whether there are maternal complications such as preeclampsia or bleeding. For some people, the plan is a straightforward planned vaginal birth. For others, especially with triplets or higher-order multiples, cesarean delivery is more

likely to be recommended.

**First stage: contractions, cervical change, and close monitoring**

The first stage of labor still begins with regular contractions and ends at full cervical dilation. In twin and multiple pregnancy, clinicians usually pay close attention to the early and active phases because the pattern can change quickly. The latent phase may last some time, but once labor is established, the focus turns to confirming that both babies are tolerating labor well and that the cervix is progressing.

NICE recommends continuous cardiotocography in established labor after 26 weeks in twin and triplet pregnancy. In practical terms, that means continuous fetal heart rate and contraction monitoring, which helps the team track each baby's response to uterine activity. Depending on the situation, ultrasound may be used to confirm presentation, especially if there is any doubt about whether the first baby is still head-down or whether the second baby has changed position.

Pain relief is individualized. Some people choose an epidural because it may make it easier to respond quickly if a procedure or cesarean becomes necessary, while others prefer other forms of analgesia. The key point is that the first stage can still look like labor in any other pregnancy, but the threshold for reassessment is usually lower because the team is managing multiple fetal considerations at once.

**Second stage: birth of the first baby and the interval before the next**

Once the cervix reaches full cervical dilation, the second stage begins. In a twin pregnancy, this stage is often the most psychologically intense because one baby may be delivered vaginally while the other still remains in the uterus. If the first twin is in a favorable position, a vaginal birth of Twin A may be possible, with the team prepared to support the next steps immediately afterward.

After the first baby is born, there is usually a brief pause while the uterus repositions and the team reassesses the second baby. This interval is not wasted time; it is when the clinicians check the second twin's heartbeat,

confirm presentation, and decide whether the next birth can proceed vaginally. The second twin may already be cephalic, may turn during labor, or may present breech or transverse. That assessment determines whether the birth can continue in the labor room or whether an urgent change in plan is needed.

In some cases, the second stage includes a short period of passive descent during labor before active pushing resumes. The exact sequence is individual, and it may not resemble a textbook single-baby birth. Still, the main goal remains the same: safe delivery of both babies with the least necessary intervention. When the labor is progressing well, the team may continue with assisted vaginal techniques or standard pushing, depending on fetal position and maternal condition.

**Third stage: placentas, bleeding risk, and postpartum observation**

The third stage of labor begins after the babies are born and ends with delivery of the placenta. In multiple pregnancy, this stage deserves special attention because the uterus has been stretched more than usual, which increases the chance of uterine atony, a common mechanism of postpartum hemorrhage. In plain terms, the uterine muscle can be less effective at contracting down after birth, and a relaxed uterus bleeds more easily.

For that reason, the team usually observes uterine tone, bleeding volume, vital signs, and the completeness of placental delivery very closely. Uterotonic medication may be used according to the birth unit protocol to help the uterus contract. This is one reason multiple births are so often planned in a setting with immediate access to blood products and emergency care if needed.

The placentas themselves may be examined after birth to ensure they are complete and consistent with the prenatal diagnosis of twin or multiple pregnancy. The days immediately after delivery matter as well, because bleeding can continue or increase after the third stage if the uterus becomes boggy. That does not mean a complication will occur, but it does explain why the third stage is treated as an active part of labor rather than as a quick footnote once the babies are born.

**When the plan becomes vaginal birth or cesarean**

One of the most important decisions in multiple pregnancy is whether labor is an appropriate route of birth at all. Evidence reviews and maternity guidelines support planned vaginal birth in selected twin pregnancies, especially when Twin A is cephalic and there are no other major contraindications. By contrast, cesarean delivery is more likely when the first baby is not head-down, when there are significant growth or placental concerns, or when there are triplets or higher-order multiples.

This decision is usually made before labor begins, but it can change if circumstances change in real time. For example, if fetal monitoring suggests distress, if the second twin is not in a safe position after the first birth, or if labor stalls in a way that makes vaginal delivery less advisable, the team may recommend a cesarean after labor begins. That can feel disappointing if you had hoped for a vaginal birth, yet it is often the safest adaptation to the situation.

It is helpful to view the birth plan as a set of options rather than a rigid script. The most successful plans for twins are usually those that already include a clear discussion of vaginal birth criteria, possible operative delivery for the second baby, and the circumstances under which the team would switch to cesarean. Knowing those decision points in advance can make labor feel less surprising, even when it remains unpredictable.

**Preparing emotionally and practically for a twin or multiple labor**

Preparation for multiple birth is both medical and emotional. On the practical side, people often benefit from knowing where they will give birth, who will be present, whether the neonatal team is expected to attend, and how quickly the team can move to an operating room if needed. It can also help to ask how fetal monitoring will be done, whether an epidural is recommended or simply offered, and what happens if the first baby is born vaginally but the second baby needs a different approach.

Emotionally, it is normal to hold several possibilities at once. You may hope for an uncomplicated labor, worry about interventions, and still want reassurance that your preferences will be respected. A good maternity team will usually acknowledge that tension and explain the reasoning behind each step. That includes discussing timing of delivery before labor starts, because some

twin pregnancies are delivered earlier than singleton pregnancies even when everything looks stable.

If you are preparing for this birth, the most useful mindset is flexible readiness. Learn the likely sequence, understand the main decision points, and ask how your team handles the unexpected. That preparation does not guarantee a predictable labor, but it often makes the experience feel more understandable and more contained.