Complications of birth

Shoulder dystocia

Shoulder dystocia occurs unexpectedly during childbirth, when the baby's head has been born but the shoulders become stuck behind the mother's pelvic bone, preventing the birth of the baby's body. It can occur during a normal (spontaneous) birth or an instrumental (ventouse or forceps) birth, and is considered an emergency. The baby's shoulder needs to be released quickly so that the baby's body can be born and he or she can start breathing. Obstetricians and midwives are trained in certain manoeuvres that may help release the shoulders and in most cases the baby will be delivered promptly and safely.

It is estimated to affect about 1 in 150 (0.7%) births.

About 10% of women with shoulder dystocia are affected by heavy bleeding (postpartum haemorrhage) and vaginal tears can occur (see below).

About 10% of babies who have shoulder dystocia have a brachial plexus injury. This is where the nerves in the neck become damaged, which may cause loss of movement (paralysis) to the baby's arm. The most common type of brachial plexus injury is called Erb's palsy. In most cases it is temporary and movement returns within hours or days but a small number of babies (about 1%) will experience permanent damage.

Sometimes shoulder dystocia can cause other injuries including fractures of the baby's arm or shoulder. In the majority of cases, these heal extremely well. In some situations, even with receiving the best care, a baby can suffer brain damage if he or she did not get enough oxygen, however this is very rare.

Postpartum haemorrhage(PPH)

Postpartum haemorrhage is a complication where you bleed heavily from the vagina after the baby's birth.

There are two types of PPH, depending on when the bleeding takes place:

- primary or immediate – bleeding that occurs within 24 hours of the baby's birth

- secondary or delayed – bleeding that occurs after the first 24 hours and up to six weeks after the birth

It is normal to bleed after you have had a baby. The bleeding mainly comes from the area in your womb (uterus) where the placenta was attached, but it can also come from any cuts and tears caused during the birth. Bleeding is usually heaviest just after birth and gradually becomes less over the next few hours. The bleeding will continue to reduce over the next few days. This bleeding is called the lochia and should stop by the time your baby is four to six weeks old, but more often by two weeks.

A primary PPH is when you lose more than 500ml (a pint) of blood and affects about 5 in 100 women. Severe haemorrhage (more than two litres or four pints) is much rarer, affecting about 6 in 1000 women. If you lose a lot of blood, you are likely to feel dizzy, light-headed, faint or nauseous. You may be given oxygen and a drip for extra intravenous fluids. Drugs will be used to help stop bleeding and you may be given a blood transfusion and fluids to help your blood clot. With fluids and blood, you should start to feel much better. You will be very closely monitored and may need a longer stay in hospital.

A secondary PPH affects less than 2 in 100 women. It is usually associated with an infection and you may need antibiotics. You should contact your community midwife or GP if your bleeding is getting heavier after you have gone home, or the loss becomes offensive.

Tears

Most women, up to 9 out of 10 (90%), tear to some extent during childbirth, it is common and nothing to worry about. Most tears occur in the perineal area, the area between the vaginal opening and the anus (back passage).

They may be:

- first degree tears - small, skin-deep tears which usually heal naturally
- second degree tears – deeper tears affecting the muscle of the perineum as well as the skin. These sometimes require stitches.

Of those women that tear, 9 out of 100 (9%) have a more extensive one. This may be:

- a third degree tear – involves the vaginal wall, perineum and the anal sphincter (the muscle that controls the back passage)
- a fourth degree tear – also involves the lining of the back passage

Sometimes during the process of giving birth, a doctor or midwife may be required to make a cut in a woman's perineum to make more space for the baby. This is called an episiotomy. Although an episiotomy makes more space for the baby to be born it does not prevent a third or fourth degree tear.

If you have a severe tear you will be given an appointment in our specialist clinic where there is access to a consultant obstetrician and urogynaecologist, as well as a specialist midwife and specialist physiotherapist. Both third and fourth degree tears can lead to a decrease in bladder and/or bowel control and it is important to have an expert evaluation to identify or prevent problems.

Some women develop an infection in their stitches following a perineal tear. It is important that you know how to care for your tear. Your midwife will be able to advise you on this. You should also contact your midwife or GP if you have any of the following symptoms:

- increased pain
- redness or increased swelling around the perineal area
- an offensive smelling discharge
- feeling unwell or feverish

Please read our patient information leaflet for more information on third and fourth degree tears.

Retained placenta

Retained placenta at delivery

In the majority of women the placenta will separate and deliver within 30 minutes to 1 hour. In all small number of women (about 2%) this does not occur despite the use of drugs to encourage separation.

If your placenta does not deliver and you are not bleeding heavily we will try a few simple measures such as emptying your bladder and feeding your baby but if these do not work it may be best to go to the operating theatre. With appropriate pain relief the doctor will then deliver your placenta, carry out any necessary stitching and give antibiotics to prevent infection. This will have no longer term effects on you.

Retained placental tissue

Following the delivery of the placenta it is checked by the midwife to make sure it appears to be complete. Despite this it is possible for small pieces of placental tissue to be left in the womb. This can occur whether the placenta separates naturally or artificially. If we think the placenta is complete and you are not bleeding heavily it is not standard practise to perform

any further investigations to make sure the womb is empty.

In the majority of cases any small pieces of retained of placental tissue will either be passed spontaneously or be reabsorbed. However a small number of women may develop infection or continued bleeding. If after you go home you feel that your bleeding is becoming heavier or you experience any of the following; fever, shivering, abdominal pain and/or vaginal discharge that looks or smells unpleasant, you should contact your GP. They may prescribe antibiotics if they are concerned you have an infection.

If you have very heavy bleeding or you continue to have problems despite having had antibiotics you will need to be reviewed at the Rosie to decide whether you need any further investigations or treatment.