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Delivering your baby when you have diabetes in pregnancy

Issued by the maternity department

When you have diabetes in pregnancy it is important that you and the medical team looking after you and your baby consider the issues surrounding how you may deliver your baby. This is so that you can arrive at a shared decision that everyone is satisfied with.

When a mother has diabetes in pregnancy there is a chance that her baby may be slightly bigger, due to the effect of the diabetes on baby's growth. Even with modern ultrasound techniques it can be hard to exactly identify which babies are bigger; however, **we know that the majority of babies and mums will undergo a vaginal delivery with no problems.**

During your pregnancy your medical team will recommend an individualised management plan for you and your baby.

This leaflet has been produced to assist you and give you more information regarding these issues, however should there be anything you wish to ask the medical team further then please don't hesitate.

Induction of labour

The majority of women at this unit with diabetes in pregnancy will be offered an induction of labour. This is often offered between your due date and 3 weeks prior to it, to minimise any late pregnancy risks of stillbirth. The timing of your induction of labour will depend on the type of diabetes you have, the size of your baby, the medication you are on and your blood sugar control.

The induction of labour may include vaginal tablets (pessaries), breaking your waters or a hormone drip to start labour. Our policy of induction of labour is in line with local, regional and national guidelines (NICE, Royal College of Obstetrics and Gynaecology) and is considered a safe way to deliver your baby.

It potentially avoids the surgical risks associated with a caesarean section and if vaginal delivery is achieved, allows for quicker recovery, high levels of patient satisfaction and minimal risk of complications affecting future pregnancies. In this unit, there is a 70 % vaginal delivery rate for women with diabetes undergoing induction, based on deliveries in 2018.

Shoulder dystocia

This is a delivery problem that occurs when the baby's shoulders don't immediately deliver after the baby's head has delivered, sometimes people refer to it as the "baby's shoulders getting stuck". This can occur in any labour and is thought to happen in roughly 1 in 200 of all labours. It is very hard to accurately predict whether or not it will occur before the delivery. Sometimes it can occur without the mother or family knowing as it can resolve very quickly, other times it requires a midwife or a specialist doctor (obstetrician) to help deliver the baby. When a mother has diabetes in pregnancy the risk of a shoulder dystocia occurring during her labour is increased.

The likely risk of shoulder dystocia in women with diabetes is as follows:

Risk of shoulder dystocia by birth weight in pregnancies maternal diabetes	
Birthweight	**Shoulder dystocia**
Less than 4 kg *(8.5lbs)*	1 in 100
4-4.49kg *(8.5-9.5 lbs)*	1 in 20 babies
More than 4.5 kg (more than 9.5 lbs)	1 in 2 babies

If a shoulder dystocia occurs then it is considered a medical emergency; however, the midwives and specialist doctors are prepared and undergo at least yearly training to manage this situation without any complications. The majority of shoulder dystocia (90%) can be managed with simple manoeuvres; this includes pushing mothers' knees up to her chest to broaden the pelvis (McRobert's manoeuvre) or putting simple pressure on baby's shoulder.

In other situations, an experienced doctor or midwife may need to perform specialist manoeuvres such as easing out baby's lower arm, or rotating a baby's shoulders. In more serious cases there can be maternal problems such as bleeding after delivery (1 in 10), 3rd or 4th degree perineal tears (1 in 25). Uncommonly there can be problems relating to the baby including damage to the nerves in the arm (brachial plexus injury 1:2500), but more significant problems such as cerebral palsy are considered to be rare in this situation. In the majority of times even when a shoulder dystocia occurs there is no immediate or lasting harm to mother or baby.

Caesarean section

In line with local, regional and national guidelines we do not routinely offer caesarean section as the first line for delivering babies for mothers with diabetes in pregnancy. A caesarean section carries:

- frequent risks including:
  - maternal infection (1 in 10)
  - bleeding after delivery (1 in 20)
  - cut to baby's skin (1in 100)
- rare but serious risks:
  - maternal hysterectomy (8 in 1000)
  - bowel or bladder damage (1 in 1000)
  - blood clots (1 in 1000).

It is well recognised that the recovery time from caesarean section is longer and more difficult when compared to vaginal delivery.

In order to prevent one baby having a nerve injury following shoulder dystocia we would need to carry out 500 caesarean sections (in those mothers who have diabetes and a baby weighing more than 4.5kg).

It is important to note that, although a caesarean section will avoid the majority of cases of shoulder dystocia, up to 12% of cases of damage to the nerves in the arm (brachial plexus injury) have been seen to occur at caesarean section. If your medical team is aware of other issues or complications regarding your pregnancy and think that a caesarean section is the safest option for you, then this will be recommended as part of an individualised management plan for your pregnancy.

Notes

Notes

Alternative Formats

If you would like a copy of this information in large print, another language, audio tape or other format please call the Contact Centre on **03 44 811 8118**

Other sources of information

NHS 111

NHS Choices
www.nhs.uk/pages/homepage.aspx

NICE (National Institute for Health and Clinical Excellence)
www.nice.org.uk

Patient Advice and Liaison Service (PALS)
Freephone: **0800 032 0202**
Text: 07815 500015
Email: northoftynepals@nhct.nhs.uk

Northumbria Healthcare NHS Foundation Trust
General Enquiries **03 44 811 8111**
www.northumbria.nhs.uk

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