

# OUTCOME OF TWIN PREGNANCY IN UNBOOKED CASES

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## ABSTRACT

A descriptive study was carried out to assess the outcome of twin pregnancy in unbooked cases. This study was conducted in Military Hospital, gynae department, Rawalpindi, over a period of 1 year from 1 July 2002 to 31 June 2003. Total of 60 patients with twin pregnancy was included. The inclusion criteria were all unbooked cases who had completed twenty-eight weeks of pregnancy with twin gestation. Evaluation was done by detailed history and data was collected. Antenatal, intrapartum and postnatal complications as well as perinatal mortality and morbidity were noted. All 60 cases were unbooked. Majority came from distant places and belonged to age group of 20-40 years. The rate of instrumental deliveries was 30% and frequency of caesarean section was 41.6%. obstructed labour occurred in 4 patients (6.6%), and postpartum haemorrhage occurred in 9 patients (15%) the perinatal mortality was high in twin pregnancy as compared to singleton pregnancy. Twin pregnancy is a high risk pregnancy. Diagnosis before delivery is important. The patient should be provided with sufficient information regarding advantages of regular antenatal visits.

**Keywords:** Twin pregnancy, complication, unbooked

## INTRODUCTION

Twin pregnancy represents high risk pregnancy. Seen in approximately 01% of all the pregnancies and contributes to 10% of all the total perinatal mortality rate and approximately one third of twins are growth retarded at birth [1]. Twins gestation is regarded as an obstetrical abnormality mainly because the second twin is exposed to special hazard even during the course of normal labour.

Twin usually result from fertilization of two separate ovas while about one third often arise from a single fertilized ovum that subsequently divides into two similar structures [2]. The undiagnosed twin pregnancy imposes unnecessary risk for the mother and fetuses. The antepartum diagnosis of multiple pregnancies is made in only about 75% of cases, as they often

presented late, which is regrettable because much could be done for the mother and the off spring if treatment was given earlier. The aim of this study was to assess the outcome of twin pregnancy in unbooked cases.

## PATIENTS AND METHODS

A descriptive study was carried on 60 consecutive patients with twin pregnancies between 1st July 2002 to 31st July 2003 in Gynae Department Military Hospital.

Pregnancy, delivery mode and fetal outcome in unbooked patients were analyzed. All patients with twin pregnancy who had completed twenty eight weeks of pregnancy were included. The intrapartum, antenatal and postpartum complications, were noted. Patient with twin pregnancy who came in first and second trimester were not included.

Evaluation was done by a detailed history of the patient and data was collected with reference to age, parity, previous

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obstetrical history of twin, any complication during antenatal period, socioeconomic history and education status was assessed.

The frequency of intrapartum complication, malpresentation, rate of instrumental deliveries and caesarean section was noted. Perinatal mortality, morbidity and maternal morbidity were also noted.

## STATISTICAL ANALYSIS

Data were entered in SPSS version 10.0 and percentages were calculated to describe the data.

## RESULTS

The frequency of twin pregnancy is 16 for every 1000 singleton pregnancy. About 60 women with twin pregnancy of gestation more than 28 weeks were included in this study the age ranged from 20-40 years. Only 15% of these (unbooked) patients were educated, while most of these cases came from far off areas and they were ignorant about antenatal booking and regular check up. The patient with anaemia and haemoglobin level of 7gm% or less was found to be 10 out of 60 patients (16.6%). The mean haemoglobin was found to be 9.6g/dl (1.5 SD). The other antenatal complications with which these patient presented are shown in table-1.

Table-2 shows the intrapartum complications in unbooked twin.

Eighteen patients went through instrumental deliveries that are 30% and caesarean section was performed in 25 patients who come to (41.6%), which is quite high the indications for caesarean section were obstructed labour, neglected transverse lie, cord prolapse and retained second twin.

One patient had caesarean hysterectomy because of postpartum haemorrhage (1.6%). Out of these 60 patients number of the patients presented with ruptured uterus or chorioamionitis the perinatal mortality was

(15.3%) and morbidity was 26.93% the main causes of which were neonatal jaundice, prematurity, neonatal sepsis, respiratory distress syndrome and intracranial haemorrhage.

## DISCUSSION

Twin pregnancy still represents a high risk pregnancy condition. Twins are diagnosed by clinical and ultrasound examination.

Management of twin pregnancy is effective when the diagnosis has been made early in gestation. Undiagnosed twin presented additional risk to the mother and the second fetus as was noticed in these unbooked cases where the diagnosis was made after the delivery of the first twin. These patient delivered first twin at home and came with second retained twin. Early detection of multiple pregnancies is one of the proven benefits of routine early ultrasonography [3]. In the past X-ray diagnosis were used to confirm twin gestation. Modern ultrasound studies can outline the twin pregnancy, its placentation, the structure of the central membranes and fetal gender [4-6] ultrasonography also helps us to choose a suitable management during pregnancy and an optimal mode of delivery [7]. The sonographic determination of chorionicity and amnionity allows better estimation of pregnancy risk as there is up to 50% mortality in monochromic and mono-amniotic twins [8]. Similarly, in the second and third trimester, the opportunity to examine the cervix by trans vaginal ultrasound should not be missed to detect the risk of premature delivery [8]. Cervical assessment allows calculation of the cervical score. A cervical score of 2 or less at 34 weeks is reported to have a positive predictive value of 75% for preterm labour [9]. Finally ultrasound is needed for the detection of the position of twin and decision of the optimal route of delivery as was observed in those cases admitted to our unit in which there was difficulty in assessing the presentation and

position of the fetuses by abdominal palpation. History and physical examination are important in diagnosing the twins. Maternal serum alpha fetoproteins screening is of value in the detection of discordant neural tube defects in twin pregnancy. Similarly, doppler ultrasound gives examination of the umbilical arteries and detection of twin transfusion syndrome [10]. Preterm labour, pregnancy induced hypertension and hyperemesis are more common in twin pregnancy than in singleton pregnancy [7]. There is general consensus that vaginal delivery should be attempted in those circumstances in which both twins presented by vertex. Therefore, a greater percentage of the twins presented by vertex are delivered vaginally. Vaginal delivery is associated with fewer risks, requires less analgesia and has a low potential for postpartum morbidity [7].

According to Cochrane review, after a single randomized controlled trial comparing elective induction of labour at 37 weeks for women with twin pregnancy with expectant management, insufficient data was available to support a practice of elective induction at 37 week [11]. Six unbookd patient needed induction for pregnancy induced hypertension in this study. In another study 25 twin pregnancies out of 100 cases were diagnosed at delivery due to non-availability of ultrasound [12].

Instrumental delivery rate was 30%. These patients came with either prolonged second stage of labour or fetal distress. Most of the patient with vertex presentation and having no complication were given a chance for vaginal delivery and the success rate was 80%. When the first twin was cephalic and second was breech and of average size, vaginal birth was recommended and success rate was 90% as in other studies [13].

Internal version and breech extraction are considered safer than external cephalic version. The use of elective caesarean sections in this group of babies has not been subjected to randomized controlled studies of sufficient

**Table-1: Antenatal complication in unbooked twin pregnancies.**

Complication	Patient	Percentage
PIH	8	13.3
Anaemia	10	16.6
Diabetes	2	3.3
APH	6	10
IUGR	4	6.6
Pre term labour	7	11.6
Preterm rupture of membrane	4	6.6
No complication	9	15

*PIH: Pregnancy induced hypertension*

*APH: Antepartum haemorrhage*

*IUGR; Intra uterine growth retardation*

**Table-2: Intrapartum complication of unbooked twin pregnancies.**

Intrapartum	Patient	Percentage
Obstructed labour	4	6.6
PPH	9	15
Abruptio placenta	3	5
Retained second twin	2	3.3
Cord prolapse	4	6.6
Neglected transverse lie	5	8.3
No complication	23	31.3

power to determine the best method of delivery of second twin [14]. It is further suggested that malpositions, malpresentation and contracted cervix are indications for caesarean section for birth of second twin [15]. Some recommended elective caesarean section delivery [16]. Claiming reduced neonatal mortality and morbidity for the second twin, caesarean section of twin two is a more common clinical event than previously reported [17].

In the presence of uterine scars, placenta praevia, footling presentation, transverse lie and fetal distress with or without cord prolapse and obstructed labour, caesarean section is recommended.

As protracted interdelivery interval carries risk of placental separation and cervical contraction, prompt trial of version of the second twin, followed by vaginal breech extraction under anesthesia might improve perinatal outcome [18].

## CONCLUSION

Twin delivery should be conducted in a fully equipped hospital. Diagnosis before delivery is important. The mode of delivery

should be based upon the presentation, rather than the estimated birth weight. Good nutrition, adequate rest, early booking, and regular antenatal visits can reduce complication rate and improve perinatal outcome.

## REFERENCES

1. Blickstein I, Shoham Schwartz Z, Lancetm: Growth discordancy in appropriate for gestational age, term twins. **Obstet Gynecol** 1988; 72: 582.
2. O' Grady JP, Gimovsky M. Instrumental delivery: a list art. In stud j, eds. *Progressive in obstetric and gynaecology* vol 10. Edinburgh: **Churchill Livingstone** 1993; 183: 212.
3. Slawatynsk IA, leszezynska, Gorzelak B, Oleszezu k BJ, szymula D, Zycon I. Ultrasonic diagnosis in the first trimester of multiple pregnancy. **Ginekol Pol** 2000; 71: 1458-63.
4. Chamberlain G. *Turrbulls' ind ed. Philadelphia WB Sanders* 1995.
5. Baghdadi S, Geeh, whittle M, Khan K. Twin pregnancy outcome and chorionicity. **Acta Obstet Gynecol Scand** 2003; 82:18-21.
6. Bracero LA, Byme DW, ultrasound determination of chorionicity and perinatal outcome in twin pregnancies. Using dividing membrane thickness. **Gynecol Obstet Invest** 2003; 55: 50-7.
7. Centrulo CL. The controversy of mode of delivery in twin: the intrapartum management of twin gestation. **Semin Perinatol** 1986; 10: 39-40.
8. Harrison SD, Cyr DR, palten RM, mach LA. Twin growth problem; causes and sonographic analyses. **Semin Ultrasound LT MR** 1993; 14: 56-7.
9. Neilson JP, verkuyl DA, crow ther CA, Bannerman C. Preterm labour in labour pregnancies: prediction by cervical assessment. **Obstet Gynecol** 1988; 72: 719-23.
10. Arabin B, van Eyck J, the role of ultrasound in multiple pregnancy. **Twin Res** 2001; 4: 141-5.
11. Dodd JM, crowther CA, Elective delivery of a women with a twin pregnancy from 37 weeks gestation. **Cochrane Database Syst Rev** 2003; (1): CD003582.
12. Groof MC, Burchmann EJ. Where there is no ultrasound; delay and failure of antenatal diagnosis of twin pregnancy. **Trop Doct** 2003; 33: 5-7.
13. Hulton EK, Hannah ME, Barrette J. use of external cephalic version for breech pregnancy and twin pregnancy. **J Obstet Gynaecol Can** 2002; 24: 804-10.
14. Barrett JF, Ritchie WK. Twin delivery. **Best pract Res Clin Obstet Gynaecol** 2002; 16: 43-56.
15. Skubbicki S, szymanski W, Jagielskal I, Bernaciak K. the influence of delivery methods for twins on obstetric results. **Ginekol Pol** 2000; 71: 1451-7.
16. Sulliran CA, Hasikins D, Seago DP, Robert WE, Morrison JC. Caesarean section delivery for the second twin in the vertex presentation. Operative indication and predictability. **South Med J** 1998; 91: 155-8
17. Evrand JR, Gold EM. Caesarean section for delivery of second twin. **Obstet Gynaecol** 1981; 57: 581-3.
18. Roopnarine Sigh AJ. Abdominal delivery of the second twin. **J Obstet Gynaecol** 2002; 22: 379-80.