SHORT COMMUNICATION

SUCCESSFUL MANAGEMENT OF SUPER TWINS

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INTRODUCTION

Mutliple gestation has generated more interest in obstetrics than any other topic[1]. Higher order multiple births, when a single pregnancy produces three or more offsprings is called super twins or by numerical designation as:

Triplets (3), quadruplets (4), quintuplets (5), sextuplets (6), septuplets (7), octuplets (8), nonuplets (9),decaplets (10).

In the UK, twins currently account for approximately 1.5 percent of all pregnancies. Higher multiples occur 1 in 2500 pregnancies[2].

Super twins are uncommon even in this era of Assisted Reproduction Techniques or ART. Twins and higher order multiple pregnancies are more often conceived than born[3]. Its tried that number of feti be kept to single or at best not more than two due to high probability of complications associated with multifetal pregnancy, during assisted reproduction. In case of early diagnosis of multi fetal pregnancy selective feticide is offered to avoid hazards of super twins though it is debatable in our setup. On the basis of higher complication rate such pregnancies are labeled as high risk. Almost every maternal and obstetric problem occurs more frequently in multiples[4]. Despite good antenatal care and safe delivery, it is difficult to take care of multiple babies unless there is excellent support system at home. It is observed generally that in lower social class, despite best medical support system, all three or four do not live to celebrate their first birthday even. Twins are five times more likely than singletons to die within a month of birth. Triplets are nearly 15 times more likely to die within a month of birth.

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Highest order of multiple births seen during the experience of 20 yrs was quadruplet.

Quadruplet pregnancy is rare even with ovulation-stimulating drugs. It is generally accepted as occurring once in about 600000 pregnancies and it carries a mortality for the fetuses of up to 50%.

We present two cases of super twins, successfully managed, delivered by varied routes and survived to see their first birthdays.

CASE NO.1

A 28 year-old woman pregnant for third time, presented at 10 weeks of gestation, for routine antenatal checkup. It was a spontaneous conception. Her previous two pregnancies were uneventful and had normal labours at term. The last child born was 2 years old.

On examination this was a young normotensive lady. Her ultrasound examination revealed 3 gestational sacs with viable foetal nodes. Patient was counseled about the diagnosis of triplet pregnancy and she was briefed about care with special emphasis on diet and rest, and possible antenatal and intrapartum complications such as anemia, pre-term labour, hypertensive disorders, gestational diabetes, mal-presentation and increased risk of Caesarian section. She was recommended tablet Folic Acid 5 mg 1 OD till 12 weeks and later antianaemics.

Routine investigations were carried out which were all normal. Anomaly scan at 20 weeks of gestation revealed normal triplet pregnancy.

Her pregnancy progressed uneventfully till 35 weeks when she reported with mild labour pains for last half hour. On vaginal examination she was 8 cm dilated and started bearing down with the next pain. During next 30 minutes all 3 babies were delivered.

First as cephalic, remaining both as breech with good apgar scores weighing 1.6 kgs, 1.5 kgs & 1.5 kgs respectively. Patient was managed actively and had minimal blood loss post-partum. One out of the three was male and two females. Neonates were transferred to nursery for care under supervision of the paediatrician, as they were preterm and low birth weight. One was discharged three weeks later and remaining two went home after 4 weeks.

Patient remained well. She had a detailed post-natal counselling session along with her husband and her mother regarding need for special care for management of triplets, exclusive breast-feeding, dietary requirements of the patient, need for psycho-social support, requirement of helper at home to optimize rest and avoidance of post-natal exhaustion. Her mother agreed, after long discussion and convincing arguments, to stay till babies would be 3 months old. On follow up all three survived to two years and had normal milestones.

CASE NO. 2

A 31 year old lady married for the last 2 years primigravid presented at 20 weeks gestation with a ultrasound report revealing 4 viable normal feti in separate sacs. She had conceived with first course of clomiphene citrate. Her pregnancy was progressing well. She was suggested antianemics and counselled regarding diet, need for rest and possible complications associated with quadruplet pregnancy. It was categorized as high-risk case. Regular and more frequent ante-natal visits were recommended. Routine investigations were carried out. They were all normal. Patient reached term un-eventfully. Elective Caesarian-section was performed under spinal anesthesia at 38 weeks. Four healthy baby boys were born weighing between 2.4 and 2.7 kgs. They were seen by the paediatrician and were handed over to mother after initial observation in nursery for 6 hours. Patient had an uneventful recovery. At the time of discharge on 2nd post-op day lactation was established. Patient and her relatives were counselled at length regarding need for special care for mother and babies. She was adviced to continue antianemics and to have good quality diet, rest and continue with exclusive breast feeding till 6 months, contraceptive advice was given in detail. Need for extra help at home was emphasized to the relatives for avoidance of complications. All four survived to see their 1st birthday.

DISCUSSION

Super twins beyond triplets are very rare and usually a result of super-ovulation as part of assisted reproduction. Twins and triplets can be spontaneous as in our first case of triplet pregnancy.

Multi-foetal pregnancy becomes high risk as the number of feti increase. Now a days a trend of selective feticide is on a rise in UK and USA to avoid complications associated with higher order multiples. To minimize higher order pregnancy 2-3 fertilized ova are placed in-utero in ART.

Early scanning plays vital role in diagnosis of twins and higher order multiples and their chorionicity. Anomaly scan with a 3D or 4D scanner is recommended with a special eye to pick even minor abnormalities as multifoetal pregnancies are associated with higher incidence of congenital malformations.

Specialized care of a lady, pregnant with higher order multiples is required. Counselling of patient, her husband and relatives if living in joint family, plays an important role in the outcome of such pregnancy as without domestic support, risk of complications is observed to be higher. Need for prolonged bed rest, good quality diet containing proteins and calcium and vitamins and iron supplementations can not be over emphasized. Regular ante-natal visits as suggested by the managing obstetrician are very essential in prevention and early diagnosis of complications. Patient needs to be briefed about possible complications such as anemia, increased risk of miscarriage, pregnancy induced hypertension, gestational diabetes, intrauterine growth restriction, preterm labour, thromboembolic event due to prolonged rest, increased incidence of operative delivery and its associated complications. Laison with a neonatologist for management of possible pre-

term neonates is recommended. The still birth rate for triplets is four times that of singelton births and the perinatal mortality rate five times that of singelton pregnancy[5].

Delivery of multi-foetal pregnancy must be conducted in hospital setting with 24/7 OT and blood supply facilities, preferably under consultant supervision. Delivery is usually by Caesarian section due to higher risk of birth hypoxia in second and third twin, unless it is a precipitate labour as in our first case of triplet pregnancy. Risk of post-partum haemorrhage increases due to two factors: 1) increased surface area of placental implantation and 2) uterine atony. Prophylactic use of uterotonic agents and B-Lynch suture in case of C-section prevents loss of precious blood and conserves uterus.

MOST (mothers of super twins), a community of families, volunteers and professionals was founded in 1987. It is the leading non-profit provider of support, education and research on higher order multiple births. Following delivery, MOST also helps families address the unique challenges associated with parenting 3, 4, 5 or more infants, toddlers and school age children[6].

Post-natal management is also very important. Good post-natal advice and good support system at home are very important for initial sustainance. Neonates of higher order pregnancy have high infant mortality rate, especially in lower socio-economic strata. Mothers also have increased morbidity. Anaemia, malnourishment, hypocalcaemia, thromboembolism, post-partum psychosis and poor lactation are common problems. Prevention is both simple and economical compared to management of full blown problem. Good diet, iron. vitamin and calcium supplementation, rest and assistance in management of the babies go hand in hand in prevention of post-natal complications

CONCLUSION AND RECOMMENDATION

As multifoetal pregnancies are high risk therefore management under consultant supervision in a well equipped hospital is recommended. Risk categorization, endorsement in documents with capital red letters, of all pregnancies is a very good practice hence strongly recommended.

REFERENCE

1. Rana S. Multiple Pregnancy. In : Rana S editor. Obstetrics and perinatal care for developing countries. Islamabad: SAF publications; 1998 .p. 895-911.
2. Baker PN. Twins and higher multiple gestations. In : Baker PN editor. Obstetrics by ten teachers. 18ed.Newyork: Oxford university Press ; 2006 .p. 146-155.
3. Crowther CA. Multiple pregnancy. In: James DK, Steer PJ, Weiner CP, Gonik B editor(s). High risk pregnancy management options. 3rd ed. London: WB Saunders Company Limited; 1999.p.129-52.
4. Fisk NM. Multiple pregnancy. In : Edmonds DK. Dewhurst's textbook of obstetrics and gynaecology.7th ed. London: Blackwell publishing ; 2007.p.166-76.
5. Daw E. Triplet pregnancy. Br J Obstet Gynaecol 1978; 85(7):505-9.
6. Mothers of Supertwins[Homepage of the mothers of super twins][online][updated 2010 August 17, cited 2010 October 10]. Available from :URL: http://www.mostonline.org/about.htm