A case of intertwin delivery with the interval of 46 days with good outcome

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Objective

In the last decades, the occurrence of multiple pregnancies has increased as a result of the assisted reproductive technologies. Consequently, PPROM of the presenting fetus and subsequent preterm labour in the second trimester have also increased. The delivery of the presenting fetus is usually followed by the delivery of the second fetus or fetuses shortly thereafter. We report a case of an intertwin delivery with an interval of 46 days between the delivery of the first twin and the second one.

Methods

This is a case report.

Results

We present a 34 year old, G8P7, 6 living children, 3 of which had history of a genetic heart problem. This was an IVF DCDA pregnancy. She was diagnosed with GDM, which was diet controlled. She attended labour ward at 24+6/40, with history of a gush of fluid per vagina which was not associated with bleeding or contractions and had PPROM. The vital signs were normal, Hb 9.7 g, WBC 10.5, CRP 105, AB+ve, urine dip stick 3+ leukocytes, 3+ ketons, 2+ erythrocytes, urine culture and HVS were negative. Twin 1 was in breech presentation, the fetal biometry on 4th centile with EFW 490 g and had a left anterior high placenta.Twin 2 was in transverse lie, fetal biometry on 16th centile with EFW 560 g and had a right lateral/posterior low-lying placenta. The patient was started on erythromycin 500mg QID for 10days, along with 2 doses of betamethasone injection 12mg, 24 hours apart and insulin on sliding scale. On the following day the patient delivered vaginally the twin 1 (male, weight 420 g, Apgars of 0 at 1min, 5 at 5 min). The baby was intubated and admitted to NNU. The placenta remained in situ. The membranes of twin 2 remained intact with minimal vaginal bleeding and the contractions had subsided. The patient was counselled for and accepted the plan for a conservative management with all the risks of maternal and fetal infection and prolonged hospital stay being explained. The cord of twin 1 was emerging out of the vagina and thus it was cut (absorbable suture) which helped retracting it inside the uterus. The patient was put on SC insulin injection to control her blood sugar. The vital sign were checked every 6 hours. WBC, CRP were repeated twice a week and HVS weekly (Gardenella vaginalis was treated with metronidazole). USS was repeated regularly in FMU and showed progressive fetal growth with normal amniotic fluid and Doppler studies. The placenta of twin 1 was becoming thinner. After 3 weeks the patient was discharged home on insulin/metformin and haematinic with the instructions to report any fever, uterine contractions or vaginal bleeding/leaking and she continued to be followed up weekly in the outpatient clinic. After 16 days, at 30+, the patient presented with contractions with no signs of active bleeding. Labour progressed and she delivered vaginally a male infant, weight 1280 g with Apgars of 8, 9, 10. Both placentas were delivered spontaneously but exploration of the uterine cavity was carried out and placental tissue was removed and sent for histopathology. The patient had a smooth postnatal period and was discharged home in a good condition. Both twins received full resuscitation and immediate life-support intervention. Now the twins are 7 months old and both of them have a normal neurodevelopment so far.

Conclusion

Conservation of the pregnancy for the undelivered co-twin is beneficial with a carful observation of maternal morbidity. A delay of two or more days in the delivery of babies born before 30 weeks of gestation is associated with improved infant survival and higher infant birth weight.

Placenta of retained twin

Placenta of delivered twins with thrombosed vessels