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Case Study

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VAGINAL DELIVERY OF THORACOPAGUS TWINS: CASE REPORT

Dr. Ankisha Sharma[1]* and Dr. Aabha Sharma[1]

[1]MS OBGY, Medical Officer, Dr. RPGMC Tanda, Himacgal Pradesh.

***Corresponding Author: Dr. Ankisha Sharma**

MS OBGY, Medical Officer, Dr. RPGMC Tanda, Himacgal Pradesh.

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ABSTRACT

Background: Developmental anomaly leading to malfusion of body parts in twins is called as conjoined twins. These rare cases are usually diagnosed in early pregnancy if patient is under good antenatal follow up. If patient is not under good surveillance then these cases may present as complications of labour. **Case report:** This case report is about 38 years gravid 5 with 4 live issues, an unbooked and unsupervised female referred from primary health centre to medical college in view of pre term labour with fetal heart not auscultable. It was an undiagnosed case of pre term conjoined twins presented with shoulder dystocia and delivered vaginally with challenging management of labour. **Conclusion:** Undiagnosed conjoined twins during labour can cause both maternal and fetal morbidity and mortality. So, timely detection with proper antenatal investigations and good plan of management is required on prior basis to avoid any untoward events.

INTRODUCTION

Conjoined twins have occurrence ranging from 1 in 50,000 to 1 in 100,000 live births. The etio-pathogenesis of incomplete division resulting in fused body parts is not completely known.[1] Thoracopagus is the most common conjoined twin type. There is female predominance in these twins up to 68%.[2] The vaginal delivery of conjoined twins is a rare case. Here we are reporting an undiagnosed thoracopagus twin pregnancy with complicated labour managed in a medical college.

CASE REPORT

38 years old 5th gravid with 4 live births with no history of twin pregnancy in past and no twinning in family reported in labour room with spontaneous onset of labour at 31 weeks 4 days of gestation. Patient was referred from a primary health centre for pre term labour with fetal heart not auscultable by stethoscope.

On examination the patient was in labour with height of uterus 34 weeks size with multiple fetal parts palpable with adequate uterine contractions of 4 in 10 minutes lasting for 40-50 seconds with adequate relaxation in between. Fetal heart was not auscultable. Patient was bearing down.

Per speculum examination was done and it showed fetal head. Meconium stained liquor was draining. No cord prolapse was seen.

Per vaginal examination showed fully dilated cervix with fetal head at +3 station coming upto +4 station on bearing down. Liquor was meconium stained. Intravenous fluids were started along with oxygen inhalation and in the mean time ultrasound was planned to confirm fetal heart status. Before the ultrasound was done patient delivered spontaneously head of one twin followed by spontaneous delivery of head of other twin indicating probability of conjoined twin pregnancy. The shoulders were not delivered spontaneously even after adequate contractions. The condition was diagnosed as shoulder dystocia and managed accordingly.

Diagnosis: 38 years, G5P4004 at POG 31 weeks 4 days with conjoined twin pregnancy with pre term labour with shoulder dystocia.

Management: The hydration of patient was maintained and bladder was emptied beforehand. The legs of the patient were hyper flexed with continuous suprapubic pressure (McRobert's maneuver). Successful delivery of shoulders of both twins followed by delivery of fused thorax and rest of the body was done. Both were dead females with combined weight of 2900 grams. Cervicovaginal examination showed grade 2 perineal tears at 3 o'clock and 7 o'clock position, stitched and complete haemostasis was achieved. Patient was discharged on day 3 after counselling.

Figure: 1.

DISCUSSION

The conjoined twins united at thorax are called thoracopagus twins. This is the commonest type of conjoined twins.[3] These share thoracic organs among themselves including cardiac fusion of different degrees, sterna fusion and fusion of lungs etc.[4] The risk of stillbirth is higher in monochorionic twin pregnancy than in dichorionic twin at all periods of gestation. This risk is highest before 28 weeks' gestation.[5]

About 28% of conjoined twins are stillborn and almost 54% land up in early neonatal mortality. Only 8% is the average count of conjoined twins that survive.[6]

An early diagnosis of this condition is necessary. Key methods of diagnosing the multifetal gestation are clinical evaluation and sonography. But in cases when patient is not under follow up during antenatal period these cases are diagnosed during labour and can land up into complications. 13 percent of unscanned women with multifetal gestations were diagnosed during their admission for delivery. The mode of delivery in viable conjoined twins should be caesarean section. For the purpose of pregnancy termination if vaginal delivery is planned then it can lead to dystocia and if the fetuses are mature, vaginal delivery may be traumatic to the uterus or cervix.[7]

CONCLUSION

The undiagnosed multifetal pregnancies can have poor maternal and fetal outcomes. The time and mode of delivery is pre decided in patients who are on regular checkups. The antenatal care in pregnancy should be strengthened so that the maternal mortality and morbidities are reduced and best fetal outcomes can be provided.

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CONFLICT OF INTEREST

The authors declare that they have no conflict of interest.

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