Conservative Management of Dizygotic Twin Pregnancy with Intra-Uterine Demise of One Foetus: A Case Report

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Case Report

Abstract: We are presenting a case of dizygotic twin pregnancy with intra uterine demise of one foetus at 30 weeks of gestation. After evaluation and administration of steroids, conservative management was done with bi-weekly NST, PT INR weekly and an ultrasound 2 weekly. The pregnancy was continued upto 34 weeks. The result was a healthy, mature baby of 2kg birth weight. We recommend conservative management in all cases of dizygotic twin pregnancies with intrauterine demise of one foetus.

Keywords: Dizygotic twin pregnancy, Intra uterine demise.

Introduction

Intra-uterine demise of one foetus complicates 1.1% of all dizygotic twin pregnancies. Demise of one twin can trigger coagulation defects in the mother, as well as cause demise or neurological abnormalities in the other twin. Once IUFD of one twin is diagnosed, there is always a dilemma regarding further management. Here we present a case of dizygotic twin pregnancy with demise of one twin at 30 weeks of gestation where conservative management was done till 34 weeks of gestation.

Case Report

A 25 yr old primigravida, at 30 weeks of gestation was referred from a private practitioner as a case of twin pregnancy with one foetus IUD. She had no complaints. She had insignificant past and family history with no history of drug intake or X-ray exposure in 1st trimester. Her early ultrasound examinations showed a di-amniotic, di-chorionic twin pregnancy with all normal readings. She had an ultrasound examination ten days ago which showed both foetuses to be alive, with foetus A showing EFW of 1200 grams and Foetus B showing EFW of 800 grams. Foetus A showed mild polyhydramnios while foetus B had normal liquor. After 10 days, a repeat ultrasound was performed which showed intra-uterine demise of Foetus B while Foetus A was normal and had normal colour Doppler parameters. The placenta of foetus A was showing type 2a placenta praevia and both the foetuses had adequate liquor. We admitted the patient and investigated her. Hb-9.4gm/dl, BT 2 min, CT 5 min, PT-INR 1.0, Urine normal, DIPSI screening of BSL 2hrs after 75 gm glucose – 80 mg/dl. Regular blood pressure measurements were done which were all in the normal range. The patient was given two doses of inj. Dexamethasone 12 mg i.m. 24 hrs apart. The patient was discharged two days later and was asked to follow up in the OPD after 3 days. Bi-weekly NST was done for the patient and PT-INR was done weekly. A follow up ultra-sound was done after two weeks which showed Foetus A to be healthy with EFW of 1800 grams and adequate liquor with normal movements while Foetus B had developed hydrops. The patient was re-admitted to the hospital after completing 34 weeks. She was again investigated and then posted for elective LSCS after an ultrasound examination. First baby was a living, male child weighing 2000 grams and cried immediately after birth. Liquor was adequate and there was type 2a placenta praevia. Second baby was a macerated, female child weighing 800 grams. The surviving twin was of 33-34 weeks maturity and was admitted in NICU. The mother had an uneventful post-operative period and was discharged on 7th post-operative day. The baby is currently living, healthy and breast-feeding well.

Discussion

In 1994, Rhydstorm reviewed foetal death in 15,066 twin pairs weighing 500 grams or more. Incidence of foetal demise was 1.1% in opposite sex twins. Risk of death increased with weight discordancy and discordant growth is the most common cause of demise of one twin in dizygotic foetuses. This is explained to be due to separate placentas which lead to one placenta having a sub-optimal implantation site. Utero crowding also leads to foetal growth restriction. Diagnosis of size discordancy is done by comparing the weight of smaller twin with that of the larger twin and is expressed in percentage. Percent discordancy greater than 20% is diagnostic of growth discordancy and weight discordancy of 25-30% greatly

suggests adverse perinatal outcome. Risk of foetal demise is about 18.9% with weight discordancy 40% or more. In our case, 10 days before demise, the discordancy was 1200-800/1200 *100 = 33.33%. Demise of one twin late in gestation can trigger coagulation defects in the mother, but only a few cases of maternal coagulopathy after a single foetal death in twin pregnancy have been reported. However, transient, spontaneously corrected consumptive coagulopathy is observed in many cases. The prognosis for the surviving twin depends on gestational age at the time of demise, chorionicity and the length of time between the demise and delivery of the surviving twin. Management, once there is demise of one foetus, largely depends on cause of death and risk to surviving foetus. If death is due to discordancy, its death should not affect its surviving twin. Most investigators conclude that in most cases, the benefit derived from continuation of a multi-foetal pregnancy after demise of one twin exceeds the risk. They recommended conservative management of the living foetus.

References

1. Rhydstrom H: discordant birthweight and late fetal death in like-sexed and unlike-sexed twin pairs: A population-based study. Br J Obst Gynaec 101:765, 1994
2. Mordel N, Benshushan A, Zajicek G et al: Discordancy in triplets. Am J Perinatol 10:224, 1993
3. Hollier LM, McIntire DD, Leveno KJ: Outcome of twin pregnancies according to intrapair birth weight differences. Obstet Gynaecol 94:1006, 1999
4. Landy HJ, Weingold AB: Management of a multiple gestation complicated by an antepartum fetal demise. Obstet Gynaecol Surv 44:171, 1989
5. Cheschier NC, Seeds JW: Spontaneous resolution of hypofibrinogenaemia associated with death of a twin in utero: A case report. Am J Obstet Gynaecol 159:1183, 1988
6. Santema JG, Swaak AM, Wallenburg HCS: Expectant management of twin pregnancy with single fetal death. Br J Obstet Gynaecol 102:26, 1995b

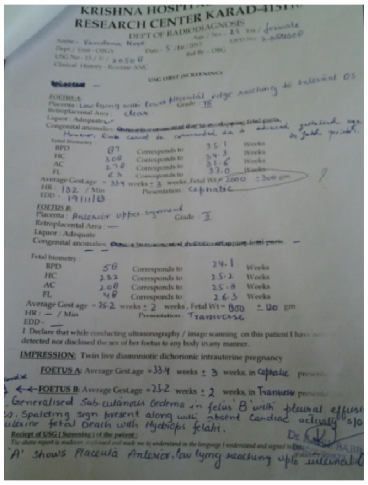

Figure 1: USG done on re-admission

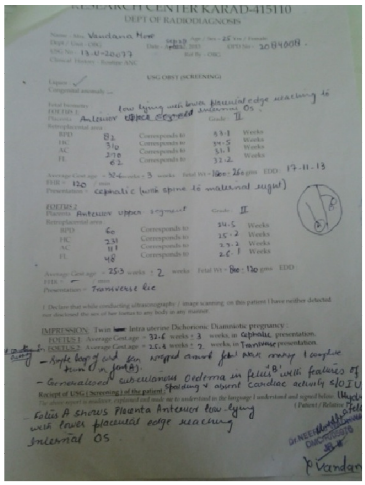

Figure 2: USG done 2 weeks after discharge

Figure 3: Both placentas and dead twin

Figure 4: Dead twin with surviving twin