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Case Report

Continuation of pregnancy after abortion / delivery of first twin

Kamra Sangeeta Baweja [1], Panigrahi Parmanand [2],

[1] Specialist, [2] Joint Director and Head

Department of Obstetrics and Gynaecology, JLN Hospital and Research Centre, Bhilai (Chhattisgarh)

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Introduction

The complications of twin pregnancy and their contribution to early pregnancy loss and perinatal mortality are well known. Continuation of pregnancy after one twin is delivered or aborted is rare. The occurrence rate of asynchronous delivery is 0.14 per 1000 births[1]. We report three cases where conservative management was adopted after the early spontaneous rupture of membranes of the first sac and subsequent expulsion or delivery of the presenting fetus.

Case report 1

A 30 year old unbooked woman attended the labor ward as emergency case in August 2001 with history of four months amenorrhea (last menstrual period 29th April, 2001) and complaint of watery vaginal discharge since one hour and something descending down in her lower genital tract since the past few minutes. She gave history of carrying twin fetuses after being treated for infertility for five years. She was pleading to save at least one of her fetuses, as this pregnancy was precious for her. On examination she was in the process of expulsion and a male fetus was aborted. In view of her earlier sonography (USG) report showing a diamniotic twin (Figure 1), a decision for conservative management of the 2nd twin was taken. Cord of the 1st twin was cut short as near the external os as possible. Informed consent was taken after counseling about the possibility of ascending infection and disseminated intravascular coagulation (DIC) due to retained placenta. High vaginal swab was taken for a culture and sensitivity. Tocolytic (isoxsuprine 10mg intramuscularly 8 hourly for four days followed by 10mg orally 8 hourly for 14 days) and antibiotics covering both aerobic and anaerobic flora for five days were started. Biweekly total and differential count and coagulation profile was done to rule out any sign of intrauterine infection or DIC developing. USG after one week showed a live fetus with adequate liquor. After 2 weeks of hospitalization, she was discharged with advice for regular follow up. She did not turn up for check up as she was from a remote area. On 9th December, 2001 at 32 weeks gestation she came with a history of labor pain and watery vaginal discharge. Cervix was fully dilated and she delivered as breech a preterm live female baby weighing 1.4 kg with apgar score of 7 and 8 at 1 and 5 minutes respectively. Third stage was uneventful except that membranes adherent to the uterine wall at places were removed digitally. After a neonatal stay of 4 weeks she was discharged with a healthy baby. The girl is four years old now and neurodevelopmentally normal.

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Correspondence :
Dr. Kamra Sangeeta Baweja
9/B, South Park Avenue, Sector - 9
Bhilai (Chhattisgarh) 490 006
Tel 0788 2346144 Email : sabakamra@rediff.com

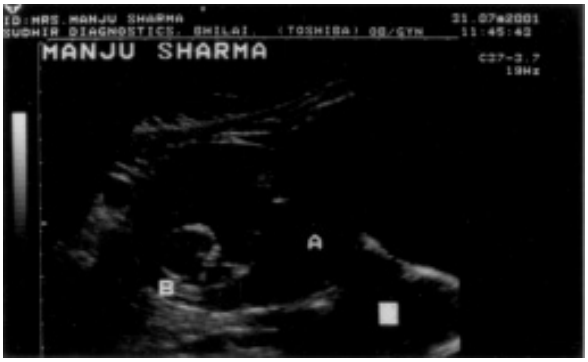

Figure 1. First trimester sonography of case 1 showing diamniotic twin.

Case report 2

A 28 year old $G_4P_2A_1L_1$ presented in her fourth pregnancy complaining of vaginal bleeding with 3 months amenorrhea. Her last menstrual period was on 22nd July, 2004 and USG showed two sacs with 12.3 weeks fetuses one live and one dead. Her first pregnancy was with twins, hydramnios and ended at 30 weeks with intrauterine deaths of both the fetuses. The second pregnancy was a 10 week abortion. The third pregnancy ended 2 years back is a normal delivery of a male baby at term. After admission she was given progesterone support but brownish discharge continued she aborted an autolysed dead fetus on 26th October 2004. Cord was friable and was cut short at the level of external os. Same conservative management as in the previous case was followed. Repeat USG 2 weeks later showed two sacs, one with 14 weeks live fetus and the other empty and deformed. She was discharged on 1st November, 2004 and was regularly followed up. On 4th March, 2005 she presented again with vaginal spotting, was admitted and USG showed 31.1 weeks fetus with sub chronic hemorrhage and venous lakes. Her routine investigations were within normal limits. She was given antibiotics orally and advised bed rest. She wad discharged on 6th March, 2005. She was again admitted on 27th April 2005. USG 34.2 weeks live fetus with 5x7 cm retroplacental clot.

On 28th April 2005 she went in to spontaneous labor and delivered a full term live female baby weighing 2.080 g with apgar 7 and 9 at 1 and 5 minutes respectively. The placenta was delivered uneventfully but the membranes were adherent needing blunt curettage for their removal. Puerperium was uneventful. The girl is 1 year and 8 months old now and neurodevelopmentally doing well.

Case report 3

A 25 year old primi, married for 4 years and treated for infertility presented on 2nd December, 2004 in active labor. She was a diagnosed case of twin pregnancy, with 12th January 2005 as expected date of delivery. Her latest USG showed twin fetuses in two different sacs. The first twin was presenting by vertex and had an estimated weight of 2.3 kg whereas the second of the twins was in transverse lie with estimated weight of 990g. She delivered a preterm live male baby weighing 2 kg with apgar 7 and 9 at 1 and 5 minutes respectively. The second of the twins was in transverse lie. The option was internal podalic version with breech extraction, but as estimated the weight of the baby was 990g and the membranes were intact, a decision for conservative management was taken. After written informed consent, cord of the first twin was doubly tied with vicryl no '0' and cut close to the cervix. Same conservative management as for the previous cases was followed. On day 6 her c-reactive protein (a marker for subclinical infection) was positive and she went into active labor. Her presentation changed to cephalic and she delivered a live female baby weighing 1.5 kg on 8th December 2004 with apgar of 7 and 8 at 1 and 5 minutes respectively. Placenta was delivered uneventfully. After a neonatal stay of 7 days both the babies were discharged. Now they are 1 year old and growing well.

Discussion

It is a rare but well documented occurrence to encounter a case where one fetus is expelled or born preterm, labor ceases and many days or months later labor spontaneously resumes and the second twin is born[2,3]. In our three cases the interval was 118 days, 108 days and 6 days. Retrospective literature review using Medline and Cochrane database yielded 111 cases of delayed interval delivery[5]. Management for the second twin can be only medical[3-5] or medical with surgical[6-7] (cerclage). In our series only conservative management was adopted after early spontaneous rupture of the membranes of the first sac and subsequent expulsion of the presenting fetus. In each case pregnancy continued and the second twin survived. In the third case, during the interval of 6 days, the lie and presentation changed from transverse to favorable vertical lie and cephalic presentation. The sonographic estimation of the baby's weight of 990g was obviously

erroneous but the sonography was not done at our clinic. Christinelli et al[5] also reported relatively good outcome even with a modest interval between the delivery of siblings of critical gestational age.

Conclusion

Though there is no consensus on its management of pregnancy after the abortion / delivery of the first twin, conservative management must be performed in the interest of the second twin.

Reference

1. Livingstone JC, Livingston LW, Ramsey R et al. Second trimester asynchronous multifetal delivery results in poor perinatal outcome. Obstet Gynecol 2004;103:77-81.
2. Drucker P, Finkel J, Savel LE. Sixty-five day interval between the births of twins. Am J Obstet Gynecol 1960;80:761-3.
3. Ghulmiyyah LM, Wehbe SA, Schwartz SA et al. Successful obstetrical management of 110 day intertwine delivery interval without cerclage: counseling and conservative management approach to extreme asynchronous twin birth. BMC Pregnancy Childbirth 2004;4:23.
4. Long MG, Gibb DM, Kempley S et al. Retention of the second twin: a viable option? Case reports. Br J Obstet Gynaecol 1991;98:1295-9.
5. Cristinelli, S, Fresson J, Andre M et al. Management of delayed – interval delivery in multiple gestations. Fetal Diagn Ther 2005;20:285-90.
6. Arias F. Delayed delivery of multifetal pregnancies with premature rupture of membranes in the second trimester. Am J Obstet Gynecol 1994;170:1233-7.
7. Kalchbrenner MA, Weisenborn EJ, Chyn JK et al. Delayed delivery of multiple gestations: maternal and neonatal outcomes. Am J Obstet Gynecol 1998;179:1145-9.