Reference Number: UHBOBS089 **Version Number: 4a**	**Date of Next Review: 01/01/2021** **Previous Trust/LHB Reference Number:**

Multiple Pregnancy

Introduction and Aim

Twin pregnancy has an increased risk of both fetal and maternal complications.
Fetal complications include miscarriage, fetal anomaly, fetal growth restriction (FGR), preterm birth, intra-uterine demise and stillbirth.

Objectives

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Scope

Equality Health Impact Assessment	*An Equality Health Impact Assessment (EHIA) has not been completed.*
Documents to read alongside this Procedure	
Approved by	*Maternity Professional Forum*

Accountable Executive or Clinical Board Director	*Ruth Walker, Executive Nurse Director*
Author(s)	*Claire Francis, Consultant Obstetrician*

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	Jul 2011	*Jul 2011*	A Rees
2	Jul 2014	Aug 2014	Reviewed and Updated by C Francis
3	Mar 2018	Mar 2018	Reviewed and Updated by C Francis
4	11/5/18	14/5/18	Twin Pathway added as Appendix
4a	MPF 01/10/2018	14/01/2019	USS regime amended to align with GAP Guideline
4b		25/09/2020	No change to content. Twin pathway for Screening for Down's, Patau's and Edward's integrated into Multiple Pregnancy Guideline

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2 ANTENATAL CARE

Twin pregnancy has an increased risk of both fetal and maternal complications.
Fetal complications include miscarriage, fetal anomaly, fetal growth restriction (FGR), preterm birth, intra-uterine demise and stillbirth.

Chorionicity determines fetal risk
If there is any doubt over chorionicity then manage as monochorionic twins

Monochorionic twins have a higher rate of fetal complications than dichorionic twins.
Fetal growth discordancy in EFW should be calculated at each visit from 20 weeks onwards and if this exceeds 20% prompt referral should be made to the specialist twin clinic (OBST38) at UHW or to the Fetal Medicine Unit.

$$\text{Fetal Growth Discordancy \%} = \frac{\text{large twin EFW} - \text{small twin EFW}}{\text{Large twin EFW}} \times 100$$

Aneuploidy screening is currently not available for twin pregnancy within the NHS in Wales.

Start ferrous sulphate 200mg daily as prophylaxis for iron-deficiency anaemia.
Defer until after 20 weeks if nausea and vomiting are problematic.

Assess for low dose aspirin
Start low-dose Aspirin 75mg daily if one of the following risk factors are present;
BMI >= 35
1st pregnancy
Pregnancy interval >10 years
Age >= 40 years
Family history of PET

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2.1 DCDA twins

- USS at 10-13 weeks to determine viability and chorionicity
- Structural anomaly scan at 20-22 weeks
- Serial fetal growth scans from 26 weeks at 3 weekly intervals (GAP) or more often if any evidence of FGR

- BP and urinalysis at every visit
- 34-36 weeks discuss mode of delivery
- Plan delivery at 38 weeks gestation

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2.2 MCDA twins

- USS at 10-13 weeks to determine viability and chorionicity
- USS for TTTS and discordant growth from 16 weeks every 2 weeks Calculate growth discordancy and refer if >20%
- Structural scan at 20-22 weeks (consider fetal cardiac scan)
- Middle cerebral artery Doppler from 20 weeks every 2 weeks
- BP and urinalysis at every visit
- 32-34 weeks discuss mode of delivery
- Elective delivery at 36-37 weeks (if uncomplicated)

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DICHORIONIC TWINS

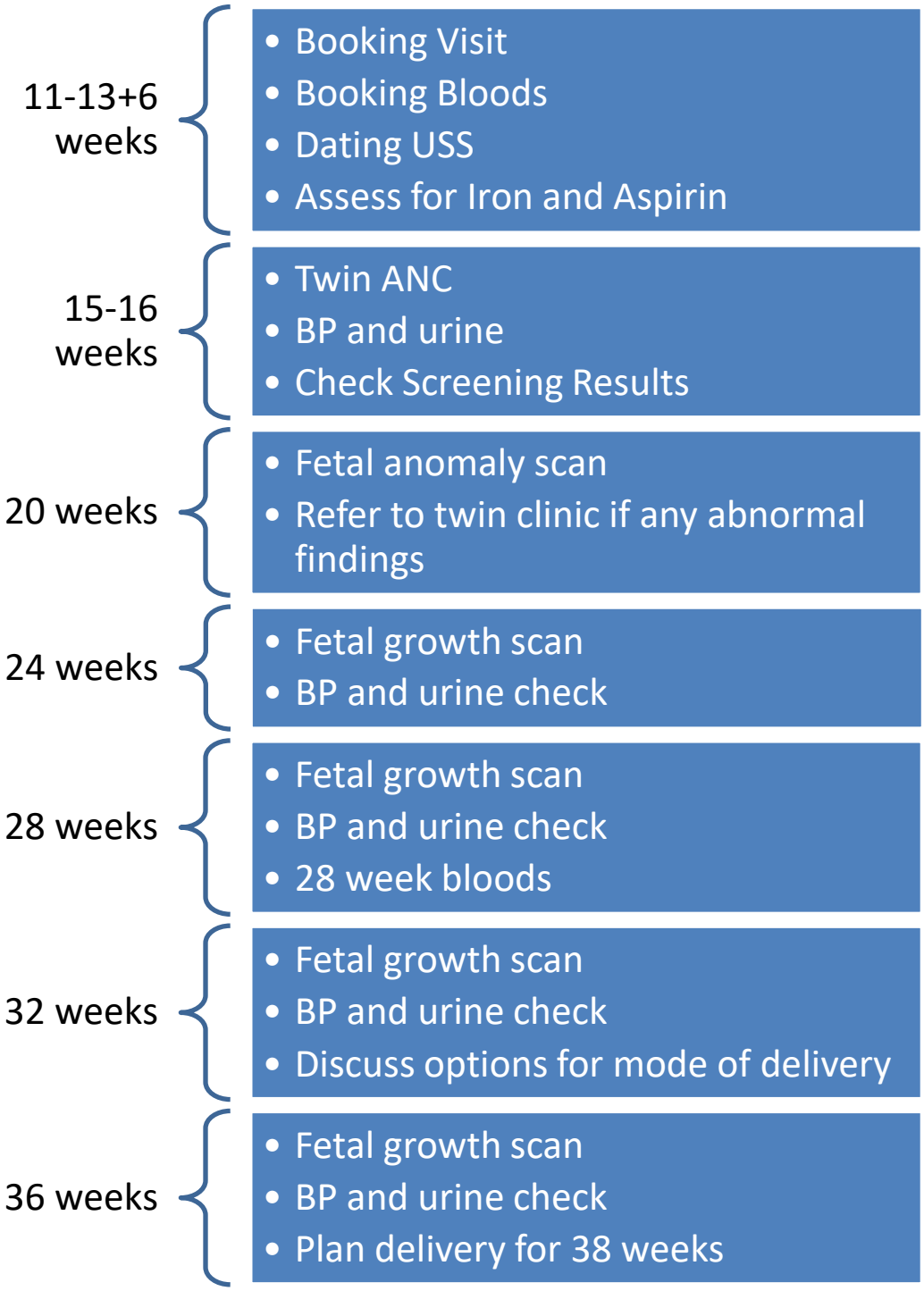

Figure 1 Antenatal Care for dichorionic twins

MONOCHORIONC TWINS

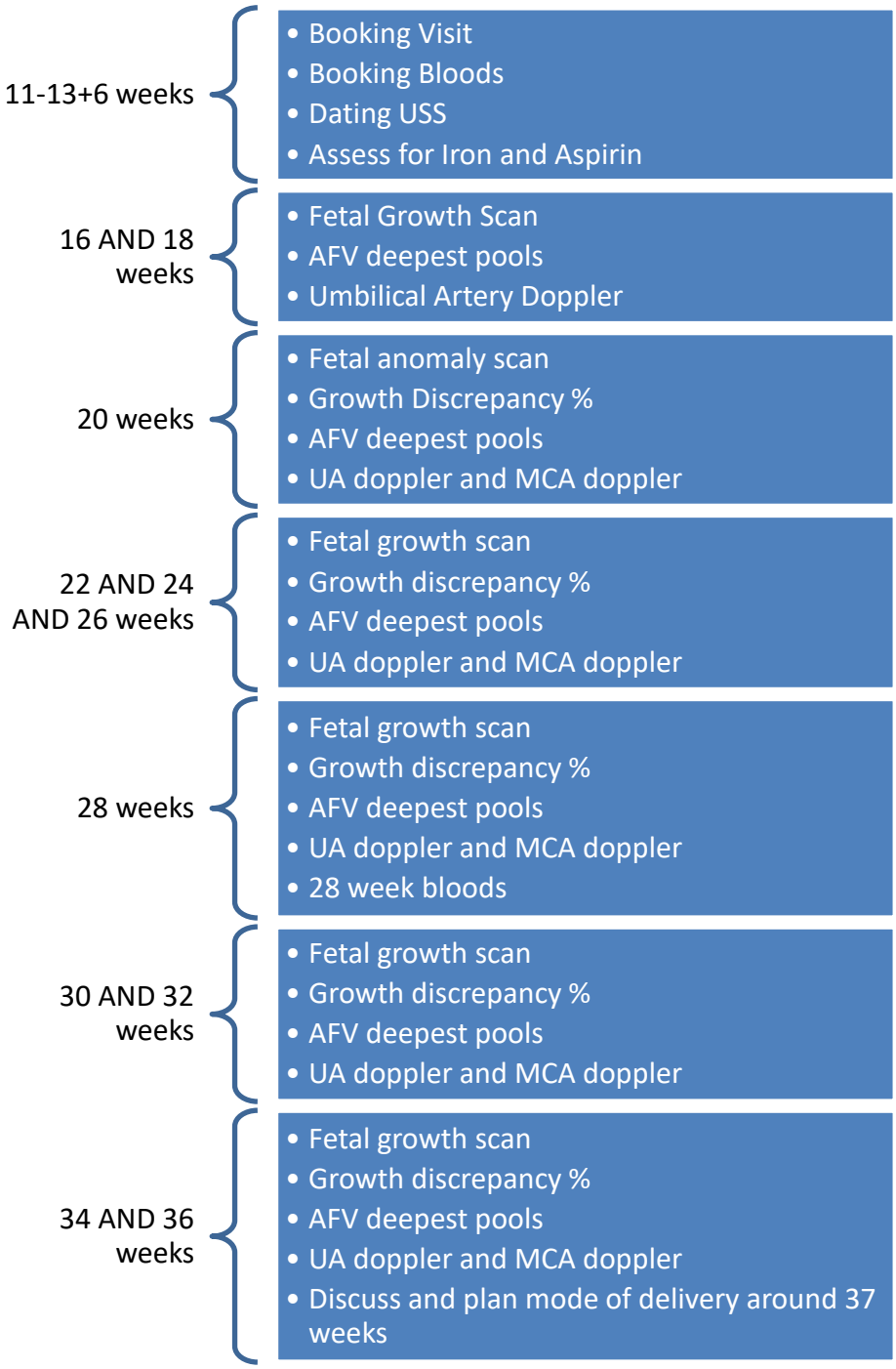

Figure 2 Antenatal Care for Monochorionic twins

3 CONDITIONS FOR VAGINAL DELIVERY

- T1 cephalic
- No overt evidence of IUGR
- 2nd twin not considerably bigger then T1
- Not extremely preterm/low birth weight >1500g
- Adequate fetal monitoring of both twins
- Mother accepts risk of emergency LSCS
- Appropriate staffing
- Appropriate place of delivery
- Advise epidural analgesia

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4 INTRAPARTUM CARE

1. Inform medical staff when a woman with multiple pregnancy admitted in labour.
2. Determine the lie and presentation of the 1st and 2nd twin by ultrasound and/or vaginal examination.
3. Where the 1st twin is cephalic allow labour to continue if patient wishes.
4. All vertex/non-vertex twins should be delivered by a senior obstetrician with the appropriate skill level . Discuss case with Obstetrician on call on admission to determine plan including supervision and place of delivery.
5. Send sample to laboratory for group and save and FBC: Site venflon: Consider epidural.
6. Monitor both twins with continuous CTG monitoring.

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4.1 VERTEX/VERTEX PRESENTATION

Second stage must be attended by senior midwife and the most experienced obstetrician on site. A paediatrician should be in attendance for delivery on delivery suite. The anaesthetist should be informed.

- Deliver T1 as per singleton and assistant to stabilise lie of T2 as longitudinal over pelvic brim
- Managed delivery of T2
- Ensure adequate fetal monitoring

- Start syntocinon if no contractions by 10 mins
- ARM when head entering pelvis – early ARM increases risk of cord prolapse
- Consider instrumental delivery if 2nd stage becomes protracted or any signs of fetal compromise
- Ideally no more than 30 minutes should elapse between delivery of twin 1 and twin 2 although up to 60 minutes is permissible provided the fetal heart is carefully monitored and is normal
- Watch for PPH – syntocinon 40iu infusion

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4.2 VERTEX/NON-VERTEX PRESENTATION

All vertex/non-vertex twins should be delivered by a senior obstetrician with the appropriate skill level. Discuss case with Obstetrician on call on admission to determine plan including supervision and place of delivery.

A paediatrician should be in attendance for delivery on delivery suite. The anaesthetist should be informed.

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- Ensure adequate fetal monitoring
- Examine and repeat ultrasound scan after delivery to determine fetal lie of T2
- Encourage cephalic version at delivery of T1 and stabilise over pelvic brim

- If lie stabilises as breech then consider starting Syntocinon if no contractions by 10 mins. ARM once breech entering the pelvis – early ARM increases the risk of cord prolapsed.
- If still transverse ECV or IPV or LSCS depending on level of skill of operator.
- Transverse lie with ruptured membranes should be managed by immediate caesarean section
- Ideally no more than 30 minutes should elapse between delivery of twin 1 and twin 2 although up to 60 minutes is permissible provided the fetal heart is carefully monitored and is normal
- Watch for PPH – syntocinon 40iu infusion

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5 Screening for Down's, Patau's and Edward's in Twin Pregnancies

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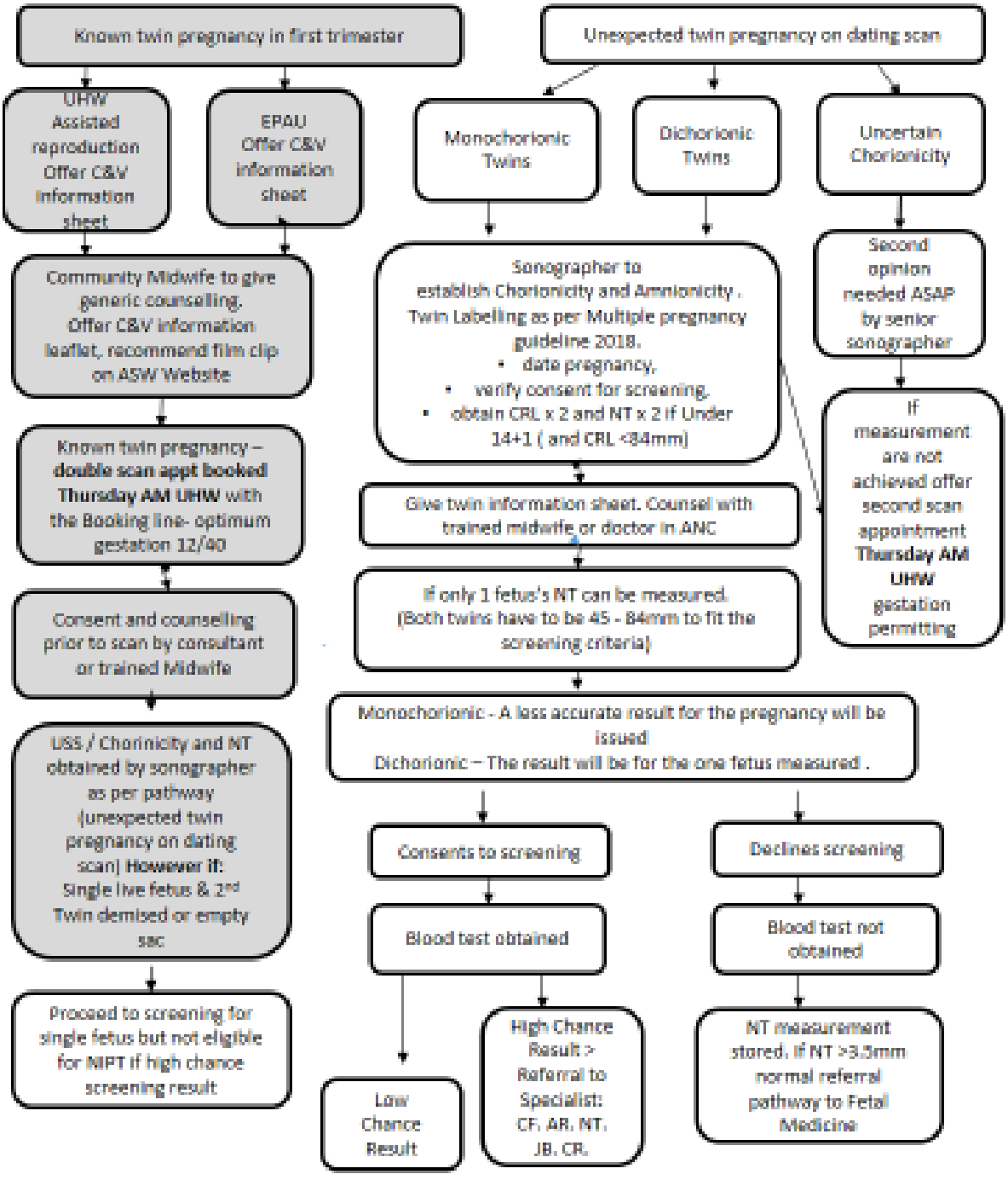
Pathway for Combined Screening for Twins from 30th April 2018



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Natasha Thomas / Dr Amy Robb
27.03.18