GUIDELINE: Twin/Multiple Pregnancy

SCOPE: All midwives and obstetricians working in maternity

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PURPOSE: To guide practitioners in the best management for optimal outcomes for mother and babies when a multiple pregnancy has been diagnosed. This will enable the woman to access appropriate care in the antenatal and intrapartum periods to facilitate a safe birth.

DEFINITIONS: Multiple pregnancy is where more than one fetus develops simultaneously in the uterus.

GUIDELINE: Twins and triplets naturally occur in approximately 1 in 80 and 1 in 8000 pregnancies. Multiple pregnancies comprise an increasing proportion of the total pregnancies in the developed world due to older maternal age at childbirth and the expanded use of fertility treatments. Malpresentation, fetal compromise, cord prolapse, delay in the birth of the second twin, premature expulsion of the placenta following the birth of the first twin are more common in multiple pregnancy. It is recommended that multiple pregnancies will give birth in a birthing facility with provision for operative birth, epidural care and neonatal resuscitation facilities.

1. At the initial confirmation of a multiple pregnancy an early antenatal referral to an obstetrician will be made by the LMC including an ultrasound for diagnosis of chorionicity prior to 14 weeks gestation. All triplets and higher order multiples, conjoined and mono-amniotic twins will be referred to Maternal Fetal Medicine (MFM) for consultation and likely global management. It is anticipated that the vast majority of women with higher order multiple pregnancies, though relatively rare, will be delivered at a tertiary facility. Dichorionic/diamniotic and monochorionic/diamniotic twins can be co-managed at Gisborne Hospital by the woman's Lead Maternal Carer (LMC) and obstetrician.

2. Please note that the referral guidelines recommend transfer of clinical responsibility for care of all women with multiple pregnancies to obstetrician-led care. However, the LMC may continue to provide midwifery care.

3. The decision regarding ongoing clinical roles/responsibilities will be agreed following a 3 way conversation between the obstetrician, the LMC & the woman and clearly recorded in the woman's records with an individualised care plan.

4. In terms of timing of delivery, it is recommended that monochorionic diamniotic twins should be delivered by 36+0/40 – 37+6/40 weeks gestation, though delivery for monochorionic diamniotic twins is typically individualized and MFM input may be suggested. In general, it is recommended that dichorionic/diamniotic twins be delivered by approximately 38 weeks gestation. It should be understood that preterm
labour, preterm delivery, and the complications associated with these are the major etiologies of fetal and neonatal morbidity, i.e., that many twin pregnancies will not last until this relatively late gestational age.

5. All women carrying twins should be counseled by an obstetrician regarding possible routes of delivery, no later than the beginning of the third trimester. They will also be counseled that although the first baby may deliver vaginally, it is possible that the second twin may be delivered via caesarean section, even if the presentation of the babies is vertex/vertex.

In general, route of delivery is determined by presentation. For those women presenting with twins in the vertex/vertex presentation, vaginal delivery is generally recommended. For those women where the presenting twin is non-vertex, delivery by caesarean section is highly recommended. Those twins where the presenting twin is vertex but the second twin in non-vertex, where both twins are greater than 2000g at ultrasound within three weeks of delivery, and where the second twin is not greater than 500g larger than the first twin, may be offered vaginal delivery after a full discussion of the risks and benefits of both routes of delivery.

If the woman chooses to have a vaginal delivery, she should be fully counseled that it is highly recommended that vertex/non-vertex vaginal deliveries take place in theatre, with two obstetricians in attendance when possible, with necessary theatre and anaesthetic staff available and a paediatrician present. All the required surgical/operative equipment will be available for an immediate caesarean section, in order to assure maximum safety for the woman and her babies. Regional anaesthesia is recommended for women with twins as this facilitates operative vaginal delivery, external or internal cephalic version, and breech extraction.

**Procedure**

1st Stage of Labour

1. Prior to or on admission refer to the agreed plan for labour and birth which should have been clearly documented in the woman’s records during the AN consultation with the O&G and LMC.
2. The Obstetrician is to be informed of the woman’s admission to Labour Ward.
3. Consider informing the NNU, paediatrician, anaesthetist & theatre once labour has been confirmed.
4. Examine lie/presentation of both twins, with aid of an ultrasound scan performed by the O&G. Labour care will be provided by the LMC with continuous electronic fetal monitoring (refer to Fetal heart rate assessment and monitoring – Antenatal and Intrapartum guideline). Consider FSE on the first twin if difficulty in picking up both fetal heart rates. Ensure a hovermat is placed on the delivery bed.
5. IV cannula inserted (preferably 18g) and blood sent to laboratory for Full Blood Count (FBC) and Group & hold.
6. Regular vaginal assessments will be performed at a minimum 3-4 hourly to assess labour progress; the obstetrician will be kept informed of progress. There is an increased incidence of dysfunctional labour in twin pregnancies. Augmentation of labour may be necessary (refer to Management of abnormal labour: protraction and arrest disorders guideline).

7. Have the Pre-Operative Checklist and the Anaesthetic Questionnaire completed to save valuable time in the event of an emergency LSCS being required.

8. Discuss and offer an epidural for analgesia during labour, or the possibility of placement of the epidural catheter, in anticipation of emergency interventions being required.

9. Prepare the birth room to receive two infants ie: delivery equipment, cots and resuscitaires.

10. Have forceps/ventouse and ultrasound scanner in the birthing room.

**2nd Stage of Labour**

1. Obstetrician is to be informed when the woman is fully dilated. Also update the NNU, paediatrician and theatre team with this information.

2. After the birth of the first child, carry out an abdominal palpation/ultrasound scan/vaginal examination to confirm the lie, presentation, descent and position of the second baby. The obstetrician may perform ECV to correct any malpresentation.

3. Continue cardiotocograph (CTG) monitoring of the second twin. As long as the trace is normal there is no reason to be worried about the clock, however CTG abnormalities are common when 30 minutes have elapsed.

4. Syntocinon augmentation may be necessary for second twin (refer to Syntocinon intravenous infusion for induction or augmentation of labour guideline).

5. Be prepared to arrange emergency LSCS for second twin, have paperwork ready.

6. If the births are to take place in theatre, two resuscitaires will be required; the second is to be obtained from the NNU. This will need to be attached to the oxygen and air gas pipes in theatre. The resuscitaire in theatre will run off the attached gas bottles. Check that these are full & opened on arrival in theatre. If both babies require transfer to the NNU after the birth, attach the portable oxygen cylinder from the caesarean cot to the NNU resuscitaire for use during the transfer.

7. Identify babies and umbilical cords in order of their births. Use one cord clamp for the first twin and two for the second.

**3rd Stage of Labour**

1. If the condition of the first twin is satisfactory and the situation allows, it may be put to the breast to stimulate uterine contractions.

2. Cord blood gases may be requested by O&G if any fetal compromise has occurred during the labour or birth.

3. Administer ecbolic after the birth of the second twin. Once the ecbolic has taken effect, controlled cord traction is applied to both cords simultaneously.
4. There is an increased risk of postpartum haemorrhage in multiple pregnancies. Risk-assess using the “PPH traffic light risk assessment tool” (refer to Prevention and management of primary postpartum haemorrhage guideline).

5. Ask the woman and whanau if they wish to keep their whenua (refer to Whenua/placenta management guideline).

ASSOCIATED DOCUMENTS:
Maternity: Management of abnormal labour: protraction and arrest disorders guideline
Maternity: Fetal heart rate assessment and monitoring – Antenatal and Intrapartum guideline
Maternity: Syntocinon intravenous infusion for induction or augmentation of labour guideline
Maternity: Prevention and management of primary postpartum haemorrhage guideline
Maternity: Perinatal Post-mortem and placenta/whenua histology guideline
Maternity: Whenua/placenta management (of disposal) guideline.

REFERENCES:
TDHB Labour manual: Multiple Pregnancy 2012


RANZCOG Clinical Guideline C-Obs 42. Management of Monochorionic Twin Pregnancy.


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