HEALTH HOLDING
HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

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| **Department:** | Obstetrics and Gynecology | | |
| **Document:** | Multidisciplinary Policy and Procedure | | |
| **Title:** | Management of Multiple Births | | |
| **Applies To:** | All Obstetrics and Gynecology Staff | | |
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## 1. PURPOSE:

1.1 To standardize the clinical practice guidelines for management of multiple pregnancy in labor.

## 2. DEFINITIONS:

2.1 **Multiple birth**– is the culmination of one multiple pregnancy, wherein the mother delivers two or more offspring. A term most applicable to placental species, multiple births occur in most kinds of mammals, with varying frequencies.

## 3. POLICY:

3.1 For monochorionic and monoamniotic twin, caesarean section must be the mode of delivery.
3.2 For dichorionic and monochorionic twin (diamniotic), vaginal delivery is usual when the first twin is vertex. All other presentations should be discussed with consultant for plan of delivery unless specific instructions in notes.
3.3 Consider regional anesthesia for C/S if twin 1 is any other presentation than cephalic if available.
3.4 Continuous CTG of both twins (especially twin 2 during delivery of twin 1). It is often easier to distinguish the FHs by monitoring twin 1 with the FSE and twin 2 with an external transducer.
3.5 If patient is booked an antenatal plan for labor and/or delivery should be reviewed. If the woman is unbooked, the plan of delivery should be discussed with consultant on call.

## 4. PROCEDURE:

4.1 On admission: women should be assisted by resident and to inform registrar call to review the case in detail.
- 4.1.1 An ultrasound scan should be undertaken by physician in delivery room to document fetal lie, liquor volume, presentation and check both fetal hearts present, estimated fetal weight(if it has not measured during previous 2-3 weeks).
- 4.1.2 Inform pediatrician on duty assigned in delivery room (especially if ≤34/52).

4.2 Labor :
- 4.2.1 Call senior registrar if progress is unsatisfactory, CTG is abnormal/difficult to interpret.
- 4.2.2 The senior registrar should be informed when the woman is fully dilated and be present for the delivery. Spontaneous vertex delivery should be conducted by the resident.
- 4.2.3 The senior registrar is required as twin 2 may need stabilization of lie, external podalic version, breech extraction (which should be done in operation room) or immediate caesarean section.

4.3 Preparation of delivery:
- 4.3.1 Check and prepare two (2) resuscitaries.
- 4.3.2 Oxytocin infusion prepared (10 IU in 500ml normal saline) and connected to infusion pump.
- 4.3.3 Have ergometrine (methergine) ready (in case of PPH) and prepare another infusion of 40 IU oxytocin in 500ml normal saline (for use after delivery of both twins).
- 4.3.4 Extra cord clamps, ventouse and forceps pack, ultrasound available.

4.3.5 If the woman has an epidural and is at full dilatation, anesthetist to ensure adequate top up for second stage in case manipulation or caesarean section required.

4.4 Delivery:

4.4.1 Call Obstetrics and Gynecology registrar.

4.4.2 Call Pediatricians.

4.5 Delivery of twin 2:

4.5.1 After delivery of twin 1 the lie of twin 2 should be stabilized to longitudinal and descent waited. Methargin must not be used until after delivery of twin 2.

4.5.2 If the lie is transverse, use external version to convert to longitudinal with scan guidance by senior physician.

4.5.3 Cephalic or breech presentation are acceptable for vaginal delivery and should be conducted by resident or registrar.

4.5.4 Breech extraction for the second twin should be performed in OR by experienced person after discussion with registrar.

4.5.5 Oxytocin infusion to be commenced following the delivery of twin 1. Descent of the presenting part should be awaited prior to amniotomy. Do not rush to twin2 if there is no cord prolapses, bleeding or if the fetal heart rate is normal. The interval between delivery of twin 1 and twin 2 should generally be less than 30 minutes but may be prolonged if fetal hear is normal and informing senior registrar.

4.6 Third stage:

4.6.1 There is a risk of postpartum hemorrhage (PPH). Give Methergen 1ml, IM after delivery of twin2 for active management of 3rd stage. Oxytocin 10 units IM should be given for women with major cardiac disease and pre-eclampsia.

4.6.2 Give infusion of high dose oxytocin (40 IU in 500ml of normal saline) over 4–6 hours. Do not wait for PPH to occur before instituting this.

4.7 Undiagnosed twins:

4.7.1 If a newborn is delivered and 2nd twin discovered call pediatric resident on call.

4.7.2 Inform obstetrics registrar on call to assess the women and plan further action.

4.8 Absolute indication for caesarean section:

4.8.1 Monoamniotic twins.

4.8.2 Conjoined twins.

4.8.3 Abnormal placenta site ie. Previa.

4.9 Relative indication for caesarean section:

4.9.1 Twin 1 breech.

4.9.2 Non cephalic presentation for twin 2.

4.10 Triplets:

4.10.1 Any women with a triplet pregnancy admitted in established labor or threatened preterm labor should be discussed immediately with the senior registrar or obstetric registrar on call. In the absence of any evidence regarding the best mode of delivery in triplets, care will be individualized. In most cases in established labor, delivery by caesarean section is recommended.

4.10.2 Prophylactic steroids are indicated as in a singleton pregnancy if these have not previously been administered in the pregnancy. Tocolysis in the first 24 hours after steroids can be considered but should be discussed with the on call registrar.

## 5. MATERIAL AND EQUIPMENT:

5.1 N/A

## 6. RESPONSIBILITIES:

6.1 Physician

6.2 Midwife

6.3 Pediatrician

6.4 Nurse

## 7. APPENDICES:

N/A

## 8. REFERENCES:


8.1 MOH, Clinical Policies and Procedures, Guidelines for Obstetrics and Gynecology.
8.2 RCOG Guideline no:51, The Management of Monochorionic Twin Pregnancy, December 2008.
8.3 CBAHI Standard 3rd Edition 2016.


## 9. APPROVALS:

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