CASE REPORT

Triplet to Singleton-A Successful Outcome

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Abstract:

We are presenting a case report of triplet pregnancy in a 25 years old lady, in whom single fetal reduction was done at 10 weeks. At 29 weeks, ultrasonography showed fetal demise of second twin. Conservative management was done, after evaluating the status of second twin. Maternal and fetal monitoring was done with PT INR, Ultrasound Doppler weekly till 33 weeks when an emergency cesarean was done due to preterm labour pains. A healthy baby of 1.8 kg was born along with a macerated IUD of 500 gms. Mother and baby are healthy on follow up till date. Hence conservative management should be followed in single fetus demise in twin pregnancy with proper monitoring.

Keywords: Fetal Demise, Multiple, Pregnancy, Twin.

Introduction:

The incidence of multiple pregnancies is increasing due to a trend towards delayed child bearing and widespread use of assisted reproduction. Twin and triplet rates are 14 fold and 54 fold higher respectively after assisted reproductive technique compared to general population. Single fetal demise in multiple pregnancy is not rare. Reported incidence varies from 0.5-6.5 % [1]. It is associated with maternal and fetal complications. Prognosis of surviving twin depends on gestation at demise and type of twin pregnancy. Multidisciplinary approach is usually preferred which includes psychological counseling, maternal and fetal monitoring and appropriate time for termination of pregnancy.

Case Report:

A 25 years old lady, married for 3 years, attended down town fertility clinic and in vitro fertilization centre for primary infertility for the same duration. She conceived following ovulation induction and intra uterine insemination. She was diagnosed to be having triplet pregnancy in her 1st trimester. Ultrasonography at 8 weeks showed triamniotic trichorionic triplet with all three active fetuses. Taking into account of complications associated with multiple pregnancy, she has opted for embryo reduction. Single embryo reduction was done successfully at 10 weeks of gestation with KCl. Post reduction, other two fetuses were healthy and normally growing. She had regular antenatal checkups. Routine blood and urine investigations were within normal limit. Anomaly scan at 19 weeks showed both live active fetuses. Her antenatal period was going uneventful until at 29 weeks, when a routine ultrasound suggested demise of one of the twins. Placenta was dichorionic and diamniotic and fused. There was no gross anomaly detected in any of the fetus. Doppler parameters of living baby were normal with no evidence of vascular anastomosis. After explaining all maternal and fetal risks, pregnancy was continued. Patient was kept under strict monitoring. Steroid cover with bethamethasone was given. Weekly maternal coagulation profile was done. Fetal well being was assessed by ultrasonography and doppler weekly. At 33 weeks she developed preterm labour pains with breech presentation. Emergency LSCS was done. A healthy female baby of 1.87 kg was delivered with a macerated male baby of 500 gms. No gross congenital anomaly was noted in any of the baby. Placenta was dichorionic and diamniotic, no gross placental abnormality was seen. Post operative period was uneventful. Detailed screening of baby

was done, which was within normal limit. Neuroscan of baby was within normal limit. Healthy mother and baby were discharged. Baby is under follow up. Till date she has achieved normal milestones.

Fig. 1: Normal and Macerated Baby

Discussion

Multifetal pregnancy reduction to twin pregnancy is usually advisable when number of foetus is three or more than three to avoid complications [2].

Antepartum death of one fetus complicates upto 2.6 % of twin pregnancies and up to 4.3 % of triplet pregnancy [3]. The causes being twin to twin transfusion, cord complication in 30%, congenital anomaly in 25 %, birth weight discordancy in 11-12 % cases [4], Demise of one fetus in utero in second or third trimester significantly increases the risk of adverse outcome in the surviving co-twin, particularly in case of monochorionic twins, with 25 % risk of death and 25% risk of neurological handicap and multi-organ injury. Whereas the risk is relatively lower in dichorionic twins [5]. There is theoretical risk of maternal consumptive coagulopathy due to retention of dead fetus. Management of single fetal demise in multiple gestation depends on the gestational age, chorionicity and condition of the surviving fetus. The goal should be to optimise the outcome of the survivor by avoiding prematurity and preventing potential adverse sequelae. Woo *et al* reviewed seven cases in their case series and concluded that single fetal demise in twin pregnancy should be managed conservatively in tertiary referral center, where intensive foetal surveillance and adequate neonatal support are available [6].

In our case, we have opted for conservative management, as pregnancy was at 29 weeks, placenta was diamniotic and surviving baby was healthy. By this approach we have continued the pregnancy by 4 weeks till baby was more mature, and hence our goal of giving a healthy baby has been achieved.

Conclusion:

Single fetal demise in twin pregnancy should be managed on individualized basis. It depends on gestation and chronicity. Conservative approach with fetal and maternal monitoring in a tertiary center may be preferred.

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