

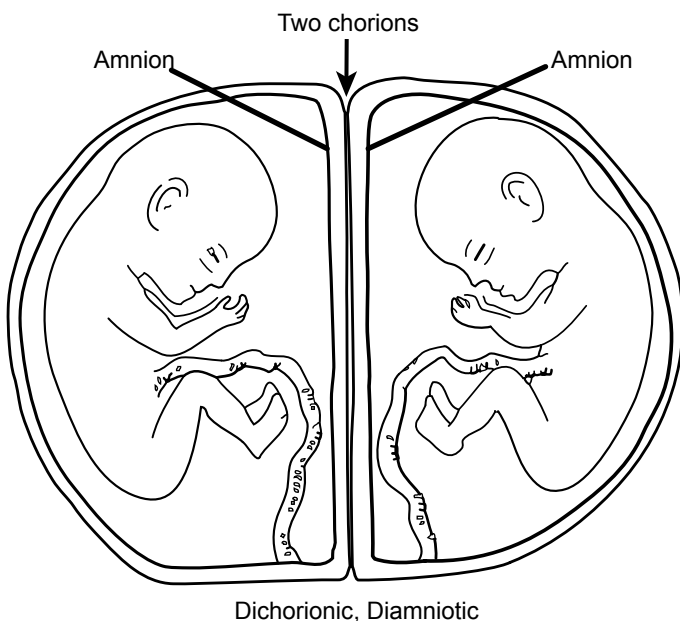
Dichorionic Twin Pregnancy

Congratulations!

You are expecting twins. About 1 in 80 pregnancies conceived are twin. Your twins are 'dichorionic'. About two thirds of twin pregnancies are dichorionic.

This means there are two separate pregnancy sacs containing their own separate placenta (afterbirth) and amniotic fluid. Most of the time this occurs when two different sperm fertilize two different eggs and the babies are therefore non-identical. However in one out of ten cases it can happen when one sperm fertilizes one egg and the babies will be identical.

The babies have their own afterbirth (placenta).



What does this mean to me?

Most women with twin pregnancies progress normally but there is an increased risk of having problems than if this was a single pregnancy.

You might experience an increased risk of:

- Symptoms of pregnancy

- Developing pre-eclampsia or blood pressure problems
- Anaemia
- Smaller babies and/or excessive fluid around the babies (polyhydramnios)
- Premature labour
- Your baby being admitted to our Neonatal Unit

Do I need aspirin?

Aspirin is safe in pregnancy and has been shown to reduce the risk of developing pre-eclampsia. Therefore if you have any one of the following whilst carrying twins/ triplets you are advised to take aspirin (150mg daily) for the duration of your pregnancy.

- High blood pressure, before or during pregnancy.
- Chronic kidney disease.
- Any auto-immune disease, such as antiphospholipid syndrome.
- Diabetes.
- This being your first pregnancy.
- Being over 40.
- Having a body mass index (BMI) of more than 35 (ie being obese).
- Having a family history of pre-eclampsia.

How will I be cared for?

You will be cared for by members of the multiple pregnancy multi-disciplinary team, including a Consultant obstetrician and a specialist midwife, as well as your community midwife.

See the **schedule** on the back of this leaflet with the anticipated pathway for your pregnancy.

Delivery of babies

Vaginal deliveries are possible if the first baby is head down (cephalic) and there is no significant difference in the babies' sizes.

Delivering twins has risks and therefore monitoring the babies closely during labour is essential to detect any problems as soon as possible.

Vaginal delivery would not be recommended if the first twin was bottom first (breech) or in a transverse position.

Timing of delivery

60% of twins will deliver spontaneously before 37 weeks. A minority of twin pregnancies will go on to term. If so, early induction of labour is recommended to lessen the chance of complications. Deciding to deliver dichorionic twins at 37 weeks has not shown to increase serious adverse outcomes. However, not delivering twins by 38 weeks is associated with increased risk to the babies.

How am I cared for in labour?

Your obstetrician will recommend that you deliver your babies in hospital. In hospital medical staff are available to assist you and your babies should the need arise.

You will be scanned on admission to determine the position of the babies.

In order to assess your babies' wellbeing whilst in labour it will also be recommended to monitor their heart rates continuously once you are in active labour. This is generally with a small electrode attached to the head of the first twin, and an abdominal transducer on your abdomen to record the heart rate of the second twin. Listening intermittently to the heart beats alone is not enough because it is not possible to easily distinguish between the two babies. It is only possible to tell the difference between the two with electronic monitoring that shows the different pattern of heart rates.

It is also recommended that a plastic cannula (venflon) is inserted into your vein. This gives instant intravenous access if it is required.

Once labour is established and you are 3cms or more dilated, an epidural is recommended.

What are my chances of a caesarean section if I go into labour?

Women who labour with twins have at least a 40% chance of needing an emergency caesarean section. Sometimes the first baby will be born vaginally, but a caesarean section is required for the second baby. The risk of a caesarean section is lower if both babies are presenting head down.

What will happen at delivery?

Generally delivery would be in a normal labour ward room. After delivery of the first baby the obstetrician will perform a scan to confirm the position of the second baby. If the second baby is in a favourable position, good contractions are then required. If there is delay of more than 30 minutes between the babies' deliveries the risk of complications and a need for an emergency caesarean section is increased.

If the second twin is not in a favourable position the obstetrician may attempt either external or internal movements to rotate the baby into a better position or may recommend a caesarean section. If contractions do not commence a hormonal drip is usually started once a favourable position is confirmed by ultrasound.

What about pain relief?

An epidural is recommended for a twin delivery for two reasons. Firstly that any additional movements needed for the second twin are more easily carried out if the woman is comfortable and secondly because it may be possible to use the epidural for an 'awake' caesarean section for which your birth partner can be present.

After delivery of the babies

There is a higher risk of bleeding after delivery of the placenta (post partum haemorrhage or PPH), due to the greater distension of the womb. Therefore after delivery a higher dose hormonal drip for four hours is advised. Waiting for spontaneous delivery of the placenta without intervention is not recommended because this is associated with a much higher risk of bleeding.

Support groups

- Twins Trust 01252 322334
- Exeter Twins and Multiples group

Useful websites

- www.twinstrust.org.uk
- www.multiplebirths.org.uk

Please detach the next 2 pages and attach to the patients' hand held notes.

The Trust cannot accept any responsibility for the accuracy of the information given if the leaflet is not used by RD&E staff undertaking procedures at the RD&E hospitals.

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Appendix 1. Information & Management Plan for DCDA Pregnancies

Discuss the following in ANC/ FMC at 20 weeks:

- **Schedule of appointments** as per Appendix 2
 - Blood tests as per singleton pregnancy
- **Anaemia** – symptoms - tiredness, shortness of breath.....
 - An additional FBC at 20 -24 weeks (to identify a need for iron or folic acid).....
- **Pre-term birth, and use of steroids**
 - Report any contractions/ SROM / bleeding promptly
- **Pre-eclampsia** – report symptoms - headache, visual disturbances, RUQ pain
 - BP and urine check needed each visit.....
 - Aspirin after 12 weeks if another risk factor for pre-eclampsia (see page 1).....
- **IUGR** – identified by scans
 - For DCDA – 4 weekly growth scans
- **Timing of elective delivery**
 - From 37 wks.....
 - Earlier admission / delivery if clinically necessary
- **Delivery – (see Appendix 3)** will be in consultant unit
 - Explanation of who will be present at delivery and their roles.....
 - Risks / benefits of vaginal delivery and CS discussed.....
 - Epidural advisable
 - Syntocinon infusion after delivery of first twin.....
- **PPH** – Active management of 3rd stage with Syntocinon infusion.....
 - Iron infusion may be required, rarely a blood transfusion

This discussion has taken place at.....weeks' gestation

Signed

Designation

Date

NB: Twin pregnancy is **not** an indication for GTT

Appendix 2. Schedule of Appointments and Scans for multiple Pregnancies

Weeks	Dichorionic (DCDA) Twins
12-14	First trimester screening clinic (hospital)
16	Community midwife (CMW) appointment
20	Scan and consultant appointment Full blood count (FBC)
24	Scan and consultant appointment to include appointment with FMAU midwife to discuss preparation for birth and the early postnatal period.
28	Scan and consultant appointment
30	CMW appointment
32	Scan and consultant ANC
34	CMW appointment
36	Scan and consultant ANC
37	CMW appointment
38	Deliver by 37-38 weeks

Appendix 3.

ANC discussion at..... week's gestation (aim for 30-32 weeks)

Plans for Delivery

Decision re mode of delivery

If LSCS -

Date Gestation Steroids Y/N date.....

Plan if admitted in labour prior to this date

If vaginal delivery

Induction of Labour – date booked Gestation

Induction plan –ARM / Propess / Other.....

Comments.....

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Signed

Designation

Date

Please do not hesitate to ask about anything – your midwife or doctor will be happy to discuss anything that is not clear

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