



SIAMESE TWINS - A CASE REPORT VAISHNAVI G S

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Abstract : Conjoined twins is a rare occurrence in obstetric practice. It is one of the complications of monochorionic monoamniotic twins. In the present case study, we are reporting a case of omphalopagus twins. A 28 year old women unbooked gravida 2 para 1 living 1 reported to antenatal outpatient department for routine antenatal checkup. Obstetric scan was done which revealed twin pregnancy, monochorionic monoamniotic conjoined twin of 30 weeks 5 days. The separation of conjoined twins is associated with increased chance of perinatal mortality. Therefore, making an early diagnosis with ultrasonographic examination provides the parents a chance to opt for pregnancy termination.

Keyword : Conjoined twins, Omphalopagus, Monochorionic monoamniotic

INTRODUCTION

Conjoined twins are a rare clinical condition, the incidence being one in 50,000–60,000 births [1]. So far 15 cases of conjoined twins have been reported worldwide in the 20th century and 21 cases in the 21st century. Of this, only 5 cases are omphalopagus twins. Moreover only one case has been reported in India (from Telangana), which is a case of craniopagus twins. Conjoined twins result if twinning is initiated after the embryonic disc and amniotic sac have formed and if the division of the embryonic disc is incomplete [2]. Approximately 40-60% of conjoined twins arrive stillborn, and about 35% survive only one day. The overall survival rate of conjoined twins is somewhere between 5 and 25%. This report is about a rare case of conjoined twins at 30 weeks gestation.

CASE REPORT

A 28 year old women unbooked gravida 2 para 1 living 1 who had previous full term normal vaginal delivery reported to antenatal outpatient department for routine checkup. Her LMP was 26.08.2012 and her period of gestation was 30 weeks 5 days. She was able to perceive fetal movements well. There was no history of twinning in the family.

Obstetric history

First child was a full term normal delivery, female baby born at government hospital which was 5 years old, alive and healthy.

On examination, she was moderately built and nourished. Her general physical and systemic examination was normal.

Obstetrical examination

Fundal height was 34 weeks, multiple fetal parts were palpable and exact presentation could not be made out. clinically liquor was excess.

Investigations

Hb 10.8g%, blood group A+ve, urine examination was normal. Obstetric scan was done which revealed two fetuses with 4 arms, 4 legs, and 2 heads (Fig. 1). There was a relative immobility of the fetuses with respect to each other and two fetal heads was seen in the same plane. There was sharing of liver and stomach. There was a single umbilical cord. The placenta was localized anteriorly, and one artery and one vein in the umbilical cord. Presentation was breech, placenta fundal, AFI of 16-17cm, fetal heart of both twins present and there was fusion of chest and abdomen of both fetuses.



The patient and her relatives were counseled about the incompatibility of babies' life. After arranging blood, she was induced with 50µg of misoprostol vaginally. Being a second gravida, initially she responded well to induction. There was adequate cervical dilatation and descent of the presenting part. So misoprostol was repeated after 6 hours. But there was arrest of descent for more than 1 hour with the breech at '0' station after 3 hours of second dose. So emergency caesarean section was done. The lower segment was thinned out. The second twin was delivered first as breech followed by the first twin. There was extension of the uterine angle on the left side and the same was sutured meticulously. There was atonic postpartum haemorrhage. Injection oxytocin 20 units were added to the IV infusion, in addition to the 10 units given intramuscularly.

Injection carboprost 0.25mg was given intramuscularly. The uterus was now well contracted. Both the babies were alive, fused at thorax and abdomen. They weighed 2.45 kg together. The placenta was single. Post operative period was uneventful. The twins survived for 7-8 hours and eventually died.

DISCUSSION

The precise etiology of conjoined twinning is unknown, but the most widely accepted theory is that incomplete division of a monozygotic embryo occurs at approximately 13-15 days post ovulation. Conjoined twins may be of two varieties, equal or unequal, depending on the duplication of structures. Unequal forms include the parasitic variety. The most common location is the chest (thoracopagus), followed by the anterior abdominal wall from the xiphoid to the umbilicus (xiphopagus), the buttocks (pygopagus), the ischium (ischiopagus), and the head (craniopagus) [3]. Major congenital anomalies of one or both twins are not uncommon. Polyhydramnios is said to be present in almost one half of the reported cases of conjoined twins [4]. Diagnosis is possible by ultrasonography which shows bifid appearance of the fetal pole, four vessels in the umbilical cord, heads at the same level, no change in fetal position relative to each other and extended position of spines [5]. Caesarean delivery near term is the preferred method of delivery to minimize maternal and fetal injury. If the twins are thought to have a poor chance of surviving and are small enough to pass through the birth canal without damaging the mother, vaginal delivery might be considered. Surgical separation of nearly completely joined twins may be successful if essential organs are not shared. Consultation with a pediatric surgeon often assists parental decision making. Conjoined twins may have discordant structural anomalies that further complicate decisions about whether to continue the pregnancy [6].

CONCLUSION

The separation of conjoined twins is associated with increased chance of perinatal mortality. Therefore, making an early diagnosis with ultrasonographic examination provides the parents a chance to opt for pregnancy termination.

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