



ROYAL HOSPITAL FOR WOMEN

LOCAL OPERATING PROCEDURE

CLINICAL POLICIES, PROCEDURES & GUIDELINES

Approved by Quality & Patient Safety Committee

18/4/13

TWIN PREGNANCY – INTRAPARTUM VAGINAL BIRTH GUIDELINE

- **OPTIMAL OUTCOMES**

- Appropriate intrapartum management of a woman with a twin pregnancy
- Woman has been appropriately informed about benefits and risks of vaginal birth versus caesarean birth of twins

- **PATIENT**

- Woman with a twin pregnancy in labour

- **STAFF**

- Medical staff
- Registered midwives
- Neonatal nurse
- Student midwives
- Medical students

4. EQUIPMENT

- 16 gauge intravenous (IV) cannula
- Cardiotocograph (CTG) machine
- Portable ultrasound machine
- 5 cord clamps
- Amnihook
- Instruments for instrumental birth
- Episiotomy scissors
- 10 units Syntocinon infusion (for augmentation)
- 10 unit Syntocinon for Intramuscular injection (for third stage)
- 40 unit Syntocinon infusion (for postpartum haemorrhage prevention)
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5. CLINICAL PRACTICE

- Discuss on admission to Delivery Suite the woman's expectations for birth and her need for information regarding intrapartum care
- Notify Newborn Care of twin admission
- Examine the antenatal record for any documentation of birth plan from previous consultations
- Confirm fetal lie and presentation with palpation and ultrasound
- Recommend:
 - IV access and request full blood count and group and hold
 - Continuous electronic fetal monitoring for both twins
 - Epidural block in first stage to facilitate timely assisted delivery of the second twin
 - Oxytocin augmentation 10 units Syntocinon in 1 litre of 500mls sodium Chloride should be available in case of uterine inertia after the birth of the first twin
- Call senior obstetric staff and neonatal team to attend for the delivery of both twins
- Inform anaesthetist a twin delivery is occurring
- Assess epidural effectiveness for second stage of labour
- Following the birth of the first twin clamp and cut cord but do not deliver the placenta
- Assess fetal lie of second twin and ask for assistance to stabilise as required
- Assess fetal heart rate pattern, contractions and need for oxytocin augmentation

**TWIN PREGNANCY – INTRAPARTUM VAGINAL BIRTH GUIDELINE cont'd**

- Attempt internal podalic version or other manoeuvres as appropriate
- Perform amniotomy with a contraction for twin 2 when presenting part is engaged
- Double clamp the cord of twin 2 for postpartum identification
- Recommend active management of the third stage and administer prophylactic 40 unit Syntocinon infusion postpartum
- Deliver placentas
- Collect arterial and venous cord gases from each twin
- Send placentas for histological examination with cords clearly labelled as to the twin of origin

6. HAZARDS/SUB-OPTIMAL OUTCOMES

- Failure to inform woman of the benefits and risks of vaginal and caesarean birth of twins

7. DOCUMENTATION

- Antenatal yellow card
- Integrated clinical notes
- ObstetriX

8. EDUCATIONAL NOTES

- There is insufficient evidence to assess the best mode of delivery for twins. There are no trials examining the best mode of delivery for twins presenting vertex/vertex (40% of twins). In general, a trial of labour for uncomplicated DCDA twins with a vertex first twin should be offered as long as an experienced obstetrician is present and an anaesthetist and emergency operating facilities are immediately available.
- Complications associated with the delivery of the second twin include: malpresentation leading to trauma during delivery, cord prolapse, and premature separation of the placenta.
- The second twin must be monitored continuously and accurately during the interval between the first and second twin deliveries. Setting a specific time limit for the interval between the birth of twin 1 and twin 2 requires balancing the risks of early intervention by operative delivery and later intervention with increasing risks of fetal acidosis. Retrospective studies of intertwin birth intervals have documented increasing rates of fetal acidosis and pathological CTG tracings with increasing intertwin birth interval, particularly when > 30 minutes⁷. The presence of the consultant obstetrician is preferable for this stage of intrapartum management.
- Compared with trial of labour, elective caesarean section for non-cephalic second twin (about 35% twins) has shown no benefit in one small trial⁴. A Cochrane review⁵, concluded that: "Caesarean section for the birth of a second twin not presenting cephalically is associated with increased maternal febrile morbidity with, as yet, no identified improvement in neonatal outcome. This policy should not be adopted except within the context of further controlled trials."
- Previous Caesarean section is not an absolute contraindication to labour with twins.
- Caesarean section is usually recommended when the first twin is not cephalic.
- Women giving birth to twins are at increased risk of postpartum haemorrhage due to uterine atony and should have active management of the third stage and a prophylactic Syntocinon infusion.



TWIN PREGNANCY – INTRAPARTUM VAGINAL BIRTH GUIDELINE cont'd

9. RELATED POLICIES/ PROCEDURES/CLINICAL GUIDELINES

- Syntocinon induction or augmentation of labour
- Twin pregnancy – antenatal care
- Diabetes in pregnancy
- Third stage labour
- Anaemia in pregnancy
- Obesity in pregnancy, labour and postpartum
- Intrapartum fetal heart rate monitoring
- Placental examination
- Instrumental vaginal birth
- Higher order multiples
- Skin to skin contact for Newborns
- PPH – prevention and management
- Breech vaginal birth
- Conditions and procedures requiring specialist obstetrician attendance

10. REFERENCES

1. Maternal-Fetal Evidence Based Guidelines. Berghella, V (Ed.). UK Informa Healthcare, 2007.
2. RCOG Multiple Pregnancy 50th study group statement 2005
3. Dodd JM and Crowther CA. Evidence-based care of woman with a multiple pregnancy. Best Practice & Research Clinical Obstetrics and Gynaecology. 2005. 19(1): 131-153.
4. Rabinovici J et al. Randomized management of the second twin: Vaginal delivery or caesarean section. American Journal of Obstetrics and Gynecology 1987; 156:52-6
5. Crowther CA. Caesarean delivery for the second twin. Cochrane Database of Systematic Reviews 1996, Issue 1. Art. No.: CD 000047. DOI:10.1002/14651858.CD000047.
6. Conde-Aguldelo A, Belizan JM, Lindmark G. Maternal morbidity and mortality associated with multiple gestations. Obstet Gynecol 2000; 95: 899-904 (this is for the PPH references)
7. Leung TK et al. Effect of twin-to-twin delivery interval on umbilical cord blood gas in the second twins. BJOG 2002, 109: 63-67

REVISION & APPROVAL HISTORY

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