INTRAUTERINE FETAL DEMISE IN MULTIPLE PREGNANCY

A GRAVE CONCERN BUT STILL A FAVOURABLE OUTCOME

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Mrs Maya Netake ,26 years, primigravida resident of Thergaon, Pune a home maker referred from PAWAR hospital with ultrasonography suggestive of triplet pregnancy with fetus A, B- IUD spalding sign present ,marked fetal scalp and body edema present and fetus C alive.

Patient had history of 8 months of amenorrhea with complaints of pain abdomen since 2 days and white discharge since 2 days and decrease fetal movements since 2 days.

No complaints of pv bleeding, pv leak, nausea ,vomiting, headache,fever, cough and cold.

LMP 23/6/2020

EDD 30/3/21

BD 30.5WK

Past menstrual history- (10-15 days)/(20-30 days)/irregular cycles/no passage of clots/dysmenorrhea present

Patient took treatment to regularise the cycle.

OBSTETRICS HISTORY-

Married life- 3 years

History of follicular studies

History of Injection Letrozole taken.

Primigravida - present pregnancy, spontaneous conception

History of presenting pregnancy-

First Trimester-spontaneous conception , confirmed prenancy by urine pregnancy test at home after missed period. Took ANC treatment from Pawar Hospital. Took ANC visits 6 .

Dating scan was done at 8.2week and it shows three live intrauterine gestation

Started folic acid in first trimester.

No history of excessive nausea and vomiting.

No history of fever with rash/radiation exposure / UTI/ drug intake /bleeding PV

NT scan was done on 11.1 week. It shows 3 intrauterine gestation in 2 sacs

Fetus 1 NT-1.4mm, placenta anterior

Fetus 2 , NT- 1.5mm, placenta posterior

Fetus 3, cranial vault not developed.

Another scan was done on 12.1 week.

It shows DICHORIONIC TRIAMNIOTIC TRIPLETS

Twin peak sign present. Fetus 1 shows placenta anterior,liquor normal.

Fetus 2 shows placenta posterior , liquor normal. Fetus 3 shows placenta posterior liquor normal

Fetus 2+3 MCDA pair .FETUS 2 IS smaller and 16% discordancy.

2nd TRIMESTER:

Quickening felt at 5 MOA. Tablet iron and calcium taken regularly, 2 doses of Tetanus toxoid given 1 month apart, in second trimester.

Anomaly scan was done.

Fetus1 21.4 week, breech, placenta anterior, AFI adequate.

Fetus 2 20.4week, cephalic, placenta posterior, AFI adequate.

Fetus 22.3 week , cephalic, placenta posterior, AFI adequate.

Normal anomaly scan

5th month of gestation cervical encerclage was done.

3rd TRIMESTER

At 30 weeks patient got referred from Pawar hospital with complaints of pain abdomen and decrease fetal movements since 2 days and ultrasonography suggestive of triplet pregnancy with fetus A, B- IUD spalding sign present ,marked fetal scalp and body edema present and fetus C alive.

Ultrasonography done on 24/1/21 shows fetus 1 and 2 IUD with spalding sign

FETUS 1 25.5 wk

Fetus 2 23.2 wk

Fetus 3 31.1 wk live intrauterine gestation vertex liquor adequate EFW 1.4kg

Last scan was suggestive of dichorionic triamniotic gestation .

Fetus A and B INTRAUTERINE FETAL DEMISE.

FETUS C : 34.3wk gestation

with placenta anterior ,vertex ,AFI 16-17cm, EFW 2.2kg.

PAST HISTORY:

History of cervical stitch in situ since 5 month of gestation.

Patient is on T.Ecospirin 150mg OD since 4 month of gestation.

No history of HTN/DM/TB/Jaundice/thyroid/prolonged illness/bleeding disorder/blood transfusion/heart disease or surgery.

Family history;

No history of DM/ HTN

- Personal H/o- Patient has good appetite, is taking mixed diet, taking about 2400 kcal per day.
  No bowel and bladder complaints. No addictions , husband is a non smoker. No known drug allergies.

General examination

- A pregnant lady well built and nourished. Patient was conscious and well oriented to time place and person.
- Height 150cm. Weight 58kg
- BMI 25.8kg/m2

- Patient afebrile, no pallor, no icterus, no clubbing, no cyanosis and no lymphadenopathy. No thyroid enlargement seen.
- Vitals 90 bpm regular and good volume.
- Blood pressure120/80mm Hg in sitting position in right hand.Spo2 99% on room air. RR-18 breaths/min

Systemic examination

- CVS- S1 S2 heard. No murmurs.
- RS- b/l air entry equal. b/l normal vesicular breath sounds heard in all lung fields.
- CNS – within normal limits.
- DTR normal.

PER ABDOMEN EXAMINATION

- Inspection: uterus is longitudinally enlarged, overdistended, umbilicus everted, linea nigra and striae gravidarium present. No scars sinuses or dilated veins seen.
- On palpation: Fundal height 34-36 weeks, Relaxed,
- Fundal grip – non ballotable, broad, irregular part suggestive of breech
- Lateral grip- smooth curved continuous structure on left lateral grip suggestive of backK and multiple irregular fetal parts felt on right lateral grip.
- First pelvic grip- smooth hard globular ballotable mass palpated in lower pole of uterus suggestive of head.

- Second pelvic grip s/o head not engaged.
- Auscultation: fetal heart sounds heard 154 bpm on maternal left.
- Local examination: External genitilia normal.
- Speculum examination: No leaking.
- Per vaginal examination: Cervix os closed. Uneffaced. No show.

DIAGNOSIS

PRIMIGRAVIDA WITH 35.6wkBD/ 35.2wk BU ADMITTED WITH ULTRASONOGRAPHY SUGGESTIVE OF TWO INTRAUTERINE FETAL DEMISE WITH SINGLE LIVE PREGNANCY IN TRIPLET GESTATION.

MANAGEMENT

Patient was admitted at 30weeks of gestation and conservative management was given till 35.6wks by

I<u>NTENSIVE FETOMATERNAL SURVEILLANCE.</u>

REGULAR FETAL FHR MONITORING

NST

DFMC

BIWEEKLY DOPPLER

WEEKLY COAGULATION PROFILE

PATIENT WAS TAKEN FOR EMERGENCY CEASEREAN SECTION AT 35.6wkBD/35.2wkBU OF GESTATION DERANGED COAGULATION PROFILE WITH NICU COUNSELLING AND HIGH RISK CONSENT

Patient delivered a 2.2kg male child.

Baby was shifted to NICU i view of respiratory distress.

Baby was on room air and wsf for 4 days.Baby was shifted to ward on POD4.

Patient was vitally stable post op and had no intraop and post op complications.

It was uneventful.

NOT ONLY SUCH HIGH RISK PREGNANCY MANAGED BY CAESEREAN SECTION BUT ALSO BY NORMAL VAGINAL DELIVERY WITH INTENSIVE FETOMATERNAL SURVEILLANCE.

CASE 2

Mrs Pratiksha Khanekar 22 yr old resident of khamshed pune a homemaker primigravida with 37wkBD/37wkBU came with complaints of PV leak since 30 minutes with pain abdomen since 1 hour.

No complaints of pv leak, headache, fever ,cough ,cold ,nausea ,vomiting.

LMP:13/2/22

EDD:20/11/22

BD:37weeks

Past menstrual history: regular cycles

3-4days/28-32days/2-3 pads/day/no passage of clots/no dysmenorrhea

OBSTETRICS HISTORY:

Married life 1.5years

Primigravida : Present pregnancy spontaneous conception

Present pregnancy

First trimester- spontaneous conception , confirmed pregnancy by urine pregnancy test at home after missed period

Dating scan was done at 6wk

It is suggestive of Dichorionic diamniotic twin live intrauterine gestation of twin A 6.2wk and twin Bis 6.3wk

Started folic acid in first trimester.

No history of nausea and vomiting/fever with rash/radiation exposure/UTI/drug intake/PV bleeding.

NT scan was done at 14.2wk and 14wk

Fetus A is 14.2wk NT 1.68mm, nasal bone present,ductus flow normal, no TR,placenta posterior

Fetus B is 14wk NT 1.49mm, nasal bone seen, ductus flow normal , no TR,placenta posterior

2nd TRIMESTER

Quickening felt at 5th month. Tablet iron and calcium taken regularly. 2 doses of tetanus toxoid given 1 month apart in second trimester.

Anomaly scan was done

Dichorionic diamniotic twin live pregnancy in variable lie of average maturityof 21.1wk and 21.3wk

3rd TRIMESTER

On 10th september ultrasonography was done which was suggestive of twin pregnancy with foetus B showing intrauterine demise with spalding sign positive

Fetus A is cephalic presentation with 30.3wk maturity.

The doppler is essentially within normal limits.

On 19th september ultrasonography was repeated which was suggestive of twin intrauterine gestation

Fetus A on maternal right side of 31.1wk maturity.

No other obvious anomalies are seen except persistent right umbilical vein incidental finding.

Fetus B on maternal left side IUD/ intrauterine demise of fetus B.

Mild fetoplacental insufficiency.

Scan done on 28th october is suggestive of twin intrauterine gestation

Fetus A on maternal right side of 37.3wk maturity.

No other obvious structural anomalies are seen except persistent right umbilical vein.

Fetus B on maternal left side intrauterine demise

Cerebroplacental in ratio is 1.1 suggestive of fetoplacental insufficiency.

PAST HISTORY

History of cervical encerclage at 7th month of gestation.

Patient had a history of hypertension since 3rd month of gestation.

Patient was on T Labet 100mg TDS

History of DM since 1 month of gestation

Patient was on INJ ACTRAPID 8-8-6

GENERAL EXAMINATION

- A pregnant lady was obese and well nourished. Patient was conscious and well oriented to time place and person.
- Height 167 cms. Weight 86kgs
- BMI 30.8kg/m2

- Patient afebrile, no pallor, no icterus, no clubbing, no cyanosis and no lymphadenopathy. No thyroid enlargement seen.
- Vitals 90 bpm regular and good volume.
- Blood pressure150/90mm Hg in sitting position in right hand.Spo2 99% on room air. RR-18 breaths/min.
- URINE ALBUMIN +1 URINE KETONE TRACE.

SYSTEMIC EXAMINATION

- CVS- S1 S2 heard. No murmurs.
- RS- b/l air entry equal. b/l normal vesicular breath sounds heard in all lung fields.
- CNS – within normal limits.
- DTR normal.

PER ABDOMEN EXAMINATION

- Inspection: uterus is longitudinally enlarged, overdistended, umbilicus everted, linea nigra and striae gravidarium present. No scars sinuses or dilated veins seen.
- On palpation: Fundal height full term, irritable,
- Fundal grip – non ballotable, broad.
- Lateral grip- smooth curved continuous structure on right lateral grip suggestive of back.
- First pelvic grip- smooth hard globular ballotable mass palpated in lower pole of uterus suggestive of head.

- Second pelvic grip s/o head engaged.
- Auscultation: fetal heart sounds heard 154 bpm on maternal right.
- Local examination: External genitilia normal.
- Speculum examination: frank leak present.
- Per vaginal examination: Cervix os 2-2.5cm dilated

Cervix 20-30% effaced

Station -2

Membranes absent

Pelvis adequate

DIAGNOSIS

PRIMIGRAVIDA WITH 37WK BD/37WK BU WITH PRE ECLAMPSIA WITH GDM WITH PROM WITH TWIN INTRAUTERINE GESTATION WITH ONE INTRAUTERINE FETAL DEMISE AND ONE LIVE PREGNANCY.

MANAGEMENT

Patient was admitted at 37 weeks of gestation and

I<u>NTENSIVE FETOMATERNAL SURVEILLANCE was done on OPD basis.</u>

REGULAR FETAL FHR MONITORING

NST

DFMC

BIWEEKLY DOPPLER

WEEKLY COAGULATION PROFILE

PATIENT DELIVERED BY FULL TERM NORMAL VAGINAL DELIVERY WITH EPISIOTOMY AT 37WK BD/ 37WK BU OF GESTATION.

Patient delivered male child 3.1kg.baby mother side.

Patient was vitally stable post delivery.


Thank you