ASSISTED DELIVERY OF THORACOPAGUS TWINS

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Conjoined twins are rare and the diagnosis is seldom possible before labour. The problem is recognised when obstruction to delivery in the second stage is encountered. The case mentioned below is interesting in that minimum interference was necessary during delivery of thoracopagus twins. It is surprising how much nature tries to help in obstetric practice.

Ours is a small hospital and most of the patients come from surrounding villages. Ante-natal care is almost unknown in villages. Usual means of transport is by bullock carts. In only abnormal deliveries medical help is sought, and that too some times, hours and days after the labour is obstructed. Patients insist on being delivered vaginally and post-mortem examinations are rarely permitted. Most of the obstructed deliveries are completed by destructive operations on the foetus per vaginam.

Case History

A healthy farmer's wife, aged 25 years, was brought in a bullock cart from a distance of about 12 miles for admission to our hospital at 4 p.m. on 13th November, 1958. She was having labour pains since 10 A. M. 17th November, 1958. This was her second pregnancy, the first terminating in a spontaneous delivery of a normal male infant weighing 7 lbs 3 years ago.

The patient stated that she had completed nine months. The abdomen looked large and gave a suspicion of multiple pregnancy or hydramnios. The blood pressure was 120/80 and there was slight oedema of ankles. The urine did not contain albumen. She had no previous history of any serious illness.

Her girth at umbilicus was 40 inches. On palpation two foetal heads could be made out, one head in right iliac fossa and the other felt in the pelvis and confirmed by vaginal examination.

Foetal heart was audible, rate 130 per minute. Two separate foetal heart sounds could not be confirmed.

On vaginal examination on admission, the cervix was found to be taken up and three-fourths dilated. Bag of waters was intact and pelvis was roomy. Cephalic presentation of the first infant with occiput anterior was confirmed. The case was diagnosed as one of twins, both foetuses with cephalic presentation. X-ray facilities were not available. The patient was prepared for labour and events awaited.

The patient was getting strong and regular contractions since admission and at 6 P.M. on 18th November, 1958, the membranes ruptured spontaneouslly. The liquor was meconium-stained and foetal heart sounds suddenly disappeared.

At 6-10 P.M. the perineum started bulging and at 6-15 P.M. the head of the first child was born up to the neck in occipito-anterior position. The child made no at-

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tempt to breathe and foetal carotid pulse was absent. In spite of good contractions and moderate amount of traction on the head, there was no further descent.

At 6-25 P.M. it was decided to explore for a contraction ring or the very rare complication of locked twins. A general anaesthetic was administered and under full aseptic precautions an episiotomy was done and a vaginal examination was carried out. The forearms of the leading infant were found folded across its chest and were easily delivered. The infant could be then brought out up to its nipple line and the diagnosis of thoracopagus twins became obvious from the palpation of the broad thick thoraco-abdominal junction. While palpating the extent of the union, the two feet of the first infant came within reach and almost slipped out of the vagina following withdrawal of the examining hand. At 6-35 P.M. the leading foetus was born following slight traction on the feet. It lay transverse with its face against the right buttock of the mother with a sharp angulation of its spine because of its abdominal wall being still inside the vulva.

The head of the second foetus was now felt per abdomen on the right side of the pelvic brim, the delivery of the leading foetus making the foetus inside to lie transversely. We now decided that the only way to deliver the second foetus was by separating the two foetuses and extracting the second foetus by cephalic or podalic version. However, at 6-45 P.M. a clockwise rotation through 90° of the infant already born took place and a foot of the foetus still inside the uterus appeared at the introitus. By traction on this foot the anterior lower extremity of the second foetus was delivered. The second leg could be brought down easily and the delivery of the second foetus was completed very easily after bringing down the arms. The head was born with the occiput posterior. Ergometrine was given intravenously while the head was being born. Thoracopagus twins were completely born at 6-50 p.m.

The placenta was expelled spontaneously at 6-55 p.m. It was large, weighed one lb. and fourteen ounces, with insertion of a single umbilical cord near its centre. There was one amniotic sac.

Inspection of cervix and vagina showed no injury and the episiotomy wound was sutured with two silk sutures.

The stillborn foetuses were both females and together weighed eleven lbs. and two ounces. No post-mortem was allowed. As the photograph shows, they were full-term. The junctional tissue was broad and thick and felt cartilaginous in the area of the sternum.

The patient was given antibiotics for 3 days. She remained apyrexial throughout and went home in her bullock cart on the 8th day after delivery. She was seen actively working in her fields 3 weeks after delivery.

Discussion

With modern facilities for x-ray examination it may be possible to diagnose conjoined twins before labour. In the experience of the senior writer (D.V.C.), of 34 years, there have been rapid changes for the better in the type of treatment available for the average villager in India but still one comes across people who insist on a vaginal delivery only. On many occasions for want of x-ray facilities or assistance of a trained anaesthetist or assistant, one has to be extremely conservative and depend entirely on one's own clinical judgment. Watchful conservatism gives much better results under such circumstances especially when nature seems to be so wonderfully helpful, as was seen in this case. When abdominal delivery is refused or is out of the question due to unsatisfactory surroundings, the only way to treat an obstructed delivery is by destructive operation on the foetus by the vaginal route. With dexterity, gentleness and a pair of embryotomy scissors it is possible to save a woman with obstructed labour from almost certain death. Dwyer and Ripman

(1959) delivered a thoracopagus twin after intrauterine separation of the twins with an embryotomy scissors. Mahfouz (1949) warns against hasty methods of treatment and attempts at forceful extractions. With small infants and roomy pelvis it may be possible to deliver a thoracopagus twin as parallel breeches. Foster (1948) and Siegel (1950) carried out such procedures.

In the present case if the infants were separated as soon as the head and hands of the first foetus were born, a procedure which could not have been very difficult, delivery of the two separate infants would have been easier. But the diagnosis came as a surprise to us and before we finalised our plans for further treatment, nature almost dictated us the management.

Summary

A case of conjoined twins is reported. The diagnosis of thoracopagus twins was only made when progress ceased in the second stage. Except for assistance, as and when necessary, the delivery was almost spontaneous. The first infant was born as a vertex and the second as a breech presentation.

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