UNDIAGNOSED DICEPHALIC MONSTER

(A Case Report)

by

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Conjoined twins are usually monovular and can vary in degree of union and extent of sharing of vital organs. The commonest and clinically most important type belongs to the lateral symmetrical disomata group. Most of the cases reported in literature belong to its subdivision thoracopagus; very few cases of dicephalic double monsters have been recorded. In these the lower parts of each foetus are fused into one, forming a single trunk, surmounted by two heads of equal size. Such monsters may cause marked dystocia and maternal injury in labour. The following case describes the problem of managing an undiagnosed dicephalic monster late in labour, which was delivered vaginally.

CASE REPORT

A 20 year old Hindu primigravida was admitted on 22-5-1978 at L.T.M.M.C. and L.T.M.G. Hospital, Bombay, with 8 months' amenorrhoea and pain in the abdomen. She had attended antenatal clinic only once and that too about 6 weeks back, when it was diagnosed as single living foetus with vertex presentation. At the time of admission uterine size corresponded with duration of amenorrhoea, only single foetus was felt presenting as vertex and FH.S were present.

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On vaginal examination, cervix was fully dilated, and membranes were absent. Presenting part was confirmed as being vertex, biparietals were at the spines and pelvis seemed adequate clinically. A low forceps delivery under pudendal block was planned as there was no progress of labour for almost 1 hour. Suddenly patient started getting strong uterine contractions and only the vertex delivered. However, with great difficulty face could be delivered, which was cyanosed but rest of the foetal parts were absolutely jammed and it felt as if foetus was being strangulated. Attempt to deliver anterior shoulder also failed. Head was pulled forward and lifted up so as to hook down the posterior shoulder. This manoever resulted in prolapse of the posterior arm with two palms fused at the wrist joint and ten digits. This gave us the clue about presence of a monster. On vaginal examination a smooth hard mass was felt near the chest of the foetus, leading us to think in terms of conjoined twins or a monster. Since it was a premature foetus vaginal delivery was attempted. Gentle traction was exerted by pulling the head laterally towards right side of the mother along with little fundal pressure, so as to allow enough space for easy delivery of second head. By this manipulation head of the second foetus along with anterior shoulder delivered spontaneously. Now the delivery of rest of the foetus was very easy. Within 5 minutes normal placenta weighing 400 gms was delivered without any difficulty. Uterine cavity was explored to rule out rupture and other anomalies. Episiotomy was sutured after ruling out injury to cervix and bladder.

On examining foetuses it was found to be male dicephalus double monster weighing 2200 gms with 3 hands (Fig. 1). The third hand was present posteriorly at the site of fusion of both the foetuses. Both foetuses were equal in

length (38 cm). The chest circumference was 41 cms, while the abdominal girth was 23 cms. They were alive for about 5 minutes only. Post-mortem X-ray showed double spine formation (Fig. 2)

The puerperal course was uneventful The clinical history and investigations (retrospectively) could not give any clue about probable aetiological factor.

Discussion

There are only 4 cases described in the English literature over the past 30 years, where vaginal delivery was undertaken with heads presenting. In all of them the foetus weighed between 2000 gms to 3500 gms and in 2 of these cases severe trauma to the vagina occurred. In our case also which delivered vaginally without any trauma weight was 2200 gms. Thus suggesting that vaginal delivery with head presenting is extremely rare and is only possible if the pelvis is roomy and the foetuses are small. One head was born first, the other in the meantime occupied the space between the chin of the first twin and its chest. Then the second head was expelled with the help of traction on the first and then the two bodies came away simultaneously.

Conclusion

1. Clinical diagnosis of conjoined twins is difficult. Radiography and Sonar can help in early diagnosis and management.

2. The frequent occurrence of obstruction during labour makes antenatal diagnosis imperative, if maternal morbidity and foetal mortality is to be kept to a minimum.

3. Decision as to vaginal delivery verses caesarean section should be based on the possibility of survival of the infants, their sizes, type of conjoined twins and duration of gestation.

4. Caesarean section is the ideal choice of treatment in cases of obstructed labour.

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See Figs. on Art Paper I