FACTORS AFFECTING PERINATAL MORTALITY IN MULTIPLE/TWIN PREGNANCY

by

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Introduction

Multiple pregnancy is high risk pregnancy deserving institutional delivery. Undue enlargement of the abdomen arouses suspicion of multiple pregnancy and diagnosis must be confirmed before patient goes in labour. But at times diagnosis is made very late when the patient is admitted in labour. Very rarely it is made after the delivery of the first baby or at the time of caesarean section.

Complications of pregnancy and labour in multiple pregnancy affect the perinatal foetal loss.

Material and Methods

To find out the role of various factors leading to perinatal loss a study of 67 cases of labour in multiple pregnancy was made at the B. J. Medical College and Sassoon General Hospital, Pune during the year 1-1-79 to 31-12-79.

During this period 5235 cases were admitted for delivery. Out of these, 65 had twins and 2 had triplets; giving an incidence of 1 in 78 for twins and 1 in 2618 for triplets. Mitra and Sikdar (1980) have quoted an incidence of 1 in 60 to 1 in 80 for twins. The occurrence of triplets as seen in literature is very infrequent viz. 1 in 89[2].

Two patients out of these 67 had twin pregnancy previously and during the same period 2 patients with previous twins delivered single babies. One patient had previous caesarean section and delivered both the babies vaginally.

Twenty-eight cases out of 67 were booked and the remaining 39 were admitted as emergency in labour.

As seen from Table I the incidence of multiple pregnancy does not vary with parity or age.

Both babies were presenting as vertex

TABLE I

Paritywise and Agewise Distribution

Parity	Total No. delivered	No. of cases witr multiple pregnancy	Percentage	Below 25 yrs.	Yrs. 26-30	Yrs. 31 & more
I	1667	19	1.19	18	1	—
II	1352	20	1.24	19	1	—
III	1122	14	1.00	10	3	1
IV & above	1114	14	1.2	—	7	7
Total	5255	67		47	12	8

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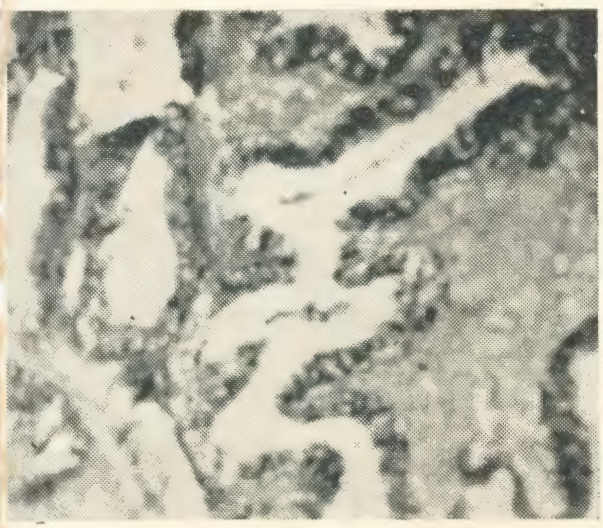

Fig. 1
Glycogen content 2 plus. Diastase digested.

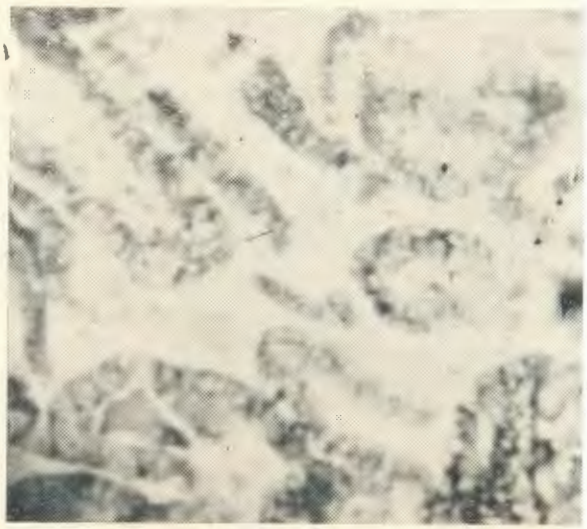

Fig. 2
Glycogen 4 plus. Complete clearing of PAS positive material after diastase treatment.

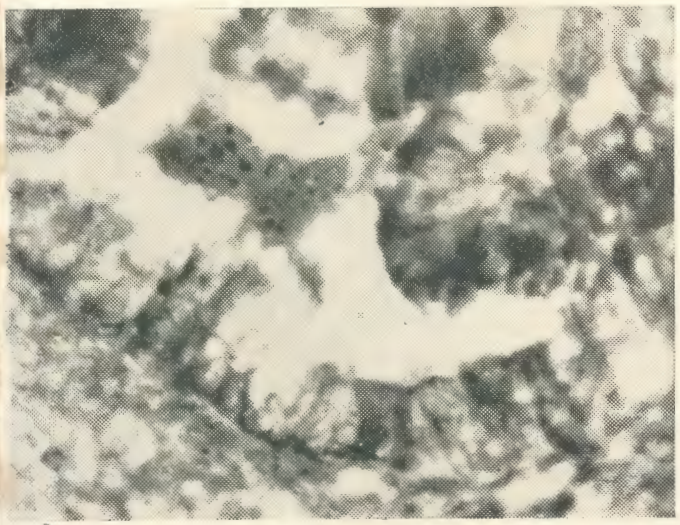

Fig. 3
Glycogen content—Nil. No digestion of PAS positive material after diastase treatment.

Functioning Ovarian Tumours in the Adolesc
—Hinduja et al. pp. 935-938

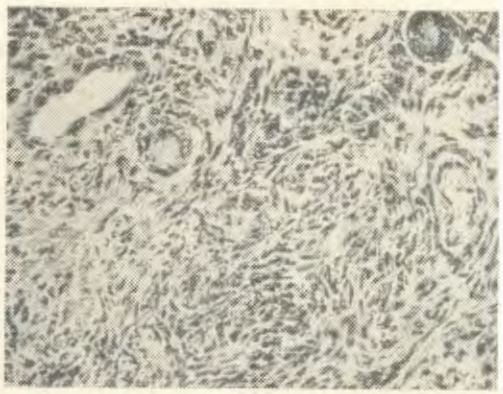

Fig. 1
Histopathological section of sertoli leydig c
tumour. (H.E. x 100).

Antepartum Fetal Heart Rate Monitoring Non Stress Test—Abbott pp. 961-965

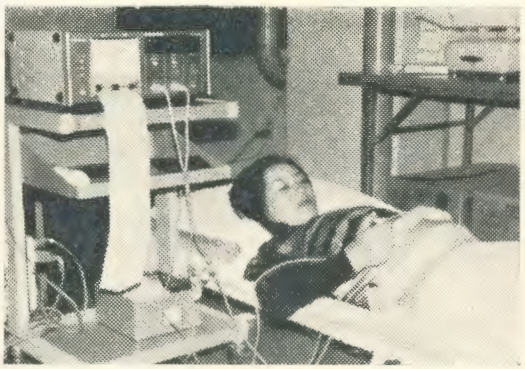

Fig. 1
Antepartum fetal heart rate monitoring.

Foreign Body in the Urinary Bladder—Goswami & Sharma p. 1104

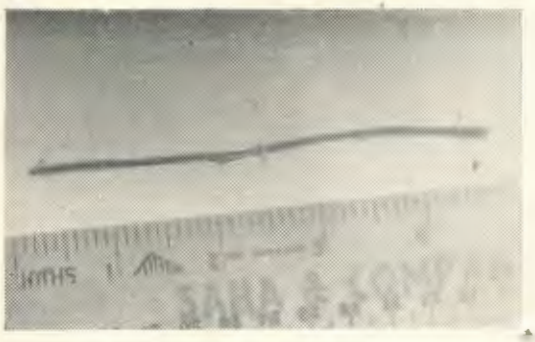

Fig. 1
Showing the herbal root removed from the urinary bladder

Desidual Change in the Serosa of Appendix—Rao & Bhaskaran pp. 1102-1103

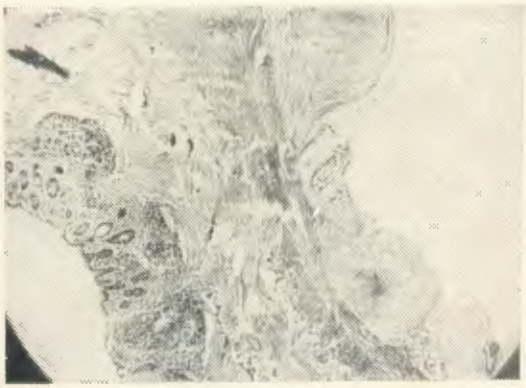

Fig. 1
Photomicrograph showing nodular serosa of the appendix H & E x 80.

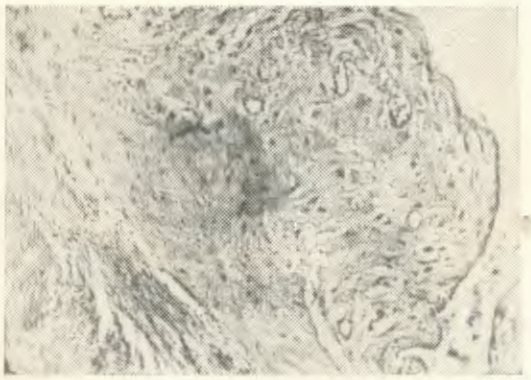

Fig. 2
Photomicrograph showing large, pale decidual cells with fibrinoid necrosis H x E x 320.

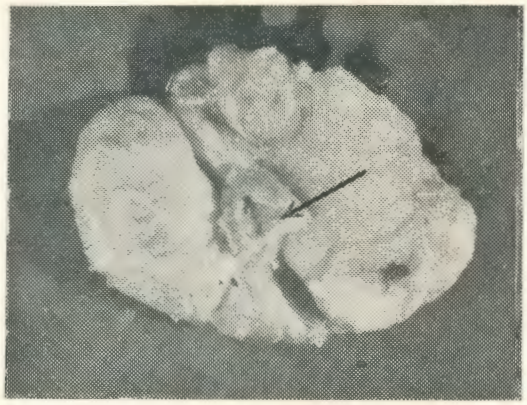

Fig. 1
Photograph of the specimen showing mucoid cystic as well as solid. The thyroid like tissue is present in the centre of the specimen as shown by an arrow.

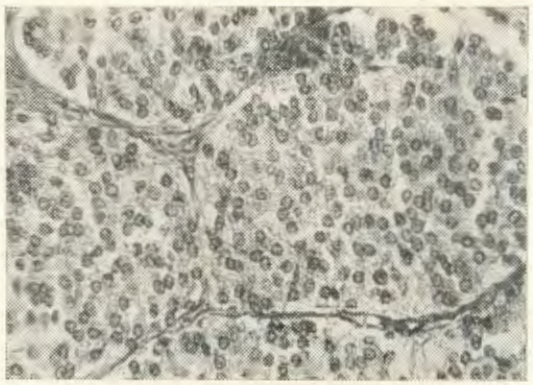

Fig. 2
Microphotograph showing solid clusters of compactly arranged cells of uniform appearance (H x E x 280).

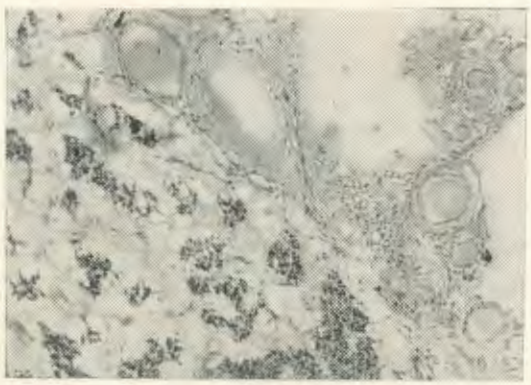

Fig. 3
Microphotograph showing follicles of variable sizes lined by cubicle to kattened epithelium and containing colloid material sheets of compactly arranged cells of uniform appearance. (H. & E x 70).

Appendiceal Perforation by Cupper-T I.U.D. —Sharma et al. p. 1106

Fig. 1
Photograph showing the appendix with the vertical limb of copper-T lying in the luemen of the appendix.

Sarcoma Bartryoids in a Female Child—Sahay & Singh p. 1108

Fig. 1
Vulva showing the grapre like mass.

Fig. 2
Specimen of the tumour mass with the uterus

Celvical Endometriosis—Vijayshree & Mishra p. 1109

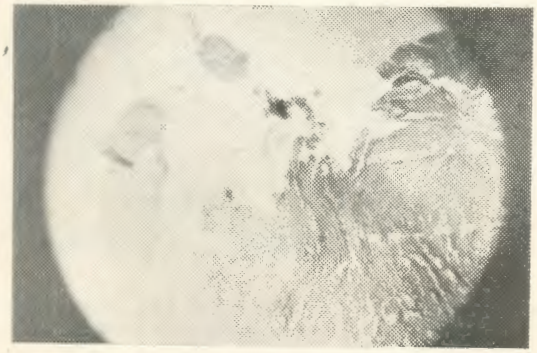

Fig. 1
Endometrial glands in cervical tissue. (3.5 x 5 H.E. stain).

Omental Hernia After Laparoscopic Sterilization —Vijayshree et al p. 1110

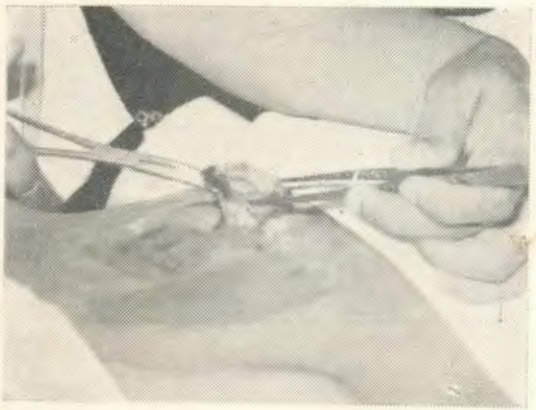

Fig. 1
Showing mental hernia.