CAESAREAN SECTION FOR TWINS WITH SPECIAL REFERENCE TO THE SECOND ONE

By

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SUMMARY

Twins have not been a frequent indication for caesarean section, although the rate of caesarean section has increased over the last few years all over the world. The incidence of caesarean section in twins at Eden Hospital has increased from 6.5% to 18.5% between January 1984 and September 1986. Caesarean section to salvage the second twin after the vaginal delivery of the first is a rare and recent entity. At Eden Hospital caesarean section was performed for the second twin only thrice during this period of time.

Introduction

Attitude towards caesarean section for twin gestation has surely become more liberal in recent times, all over the world, including Eden Hospital.

Analysis of the statistics of twin births at Eden Hospital from January, 1984 to September, 1986 showed incidence of twins in 68 (Table I).

Rate of caesarean section in twins has increased from 6.5% to 18% (Table II). Perinatal mortality in Twins has shown no improvement by increasing caesarean section for twins (Table III). The second twin is bigger than the first one but has a high perinatal mortality (Table IV).

TABLE I

Total Births (January 84 to September 1986)	22,195
No. of Twins	323
Incidence	1 IN 68

TABLE III

	1st Twin	2nd Twin
Low Birth Weight (1000-2500 gm)	72%	69%
PNM (>1000 gm)	12.38%	13.6%

TABLE II

	1984	1985	1986 (upto September)
Total No. of Caesarean Section	1350	1291	908
Caesarean Section in Twins	9 (6.5% of Twins)	20 (18.5% of Twins)	13 (17% of Twins)

From: Eden Hospital, Medical College, Calcutta.

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TABLE IV

Caesarean section for second twin—3 cases

	1984	1985	1986
Perinatal Mortality in Twins	12%	14%	16.5%

First Case:

On 25th March, 1985 Mrs. S.B., 27 years, PO+O delivered the first twin normally at Eden Hospital, presenting by the vertex. The baby weighing 2 kgs cried at birth. Just after the delivery of the first baby the membranes ruptured spontaneously resulting in the prolapse of a hand in a big baby. Emergency caesarean section was done to deliver a 3.05 kg living female baby. Baby cried at birth with an Apgar score of 8.

Second Case:

Mrs. A.D., 32 years PO+O was admitted in Eden Hospital at 1 p.m. on 27th February, 1986 with true labour pains. First baby presented by the breech and the second vertex. Till 11 p.m. no appreciable progress was observed and 5 units syntocinon was started in drip in order to accelerate labour. First twin weighing 1.8 kg was delivered at 4.30 a.m. on 28-2-86. Oxytocin was continued. As there was no progress membranes were ruptured after half an hour. Instead of progress of labour the cervix became thick. 10 units oxytocin was used tto augment labour. Till 6 p.m. 13½ hours after delivery of the first baby, gency section was performed and a living male thc second twin remained undelivered. Emer- baby weighing 2 kg was delivered. The baby cried at birth, with an Apgar score of 7.

Third Case:

Mrs. R. K., 22 years PO+O delivered the first twin, a living baby, at home at 3 a.m. on 27th June, 1986. She was admitted to Eden Hospital at 8 p.m. on 27-6-86, i.e., 17 hours after the delivery of first baby with the second twin undelivered. Examination revealed cord prolapse with compound presentation. Emergency caesarean section was performed and a living male baby weighing 2, 1 kg was delivered. The baby cried at birth with an Apgar Score of 8.

In all the 3 cases living babies were delivered and the babies thrived well. In the first and third nases there was no delay in doing the caesarean section, while in the second case caesarean section was delayed. As the outcome has been satisfactory without any maternal or foetal morbidity, it can be said in retrospect that caesarean section should have been done at an earlier period in the senond case.

Discussion

Statistically, increasing the number of caesarean section has not reduced perinatal mortality. But further scrutiny indicated as shown below, that mortality of babies delivered by caesarean section was much less than those delivered vaginally.

During the relevant period we had a total of 42 caesarean sections for twin

TABLE V

		Vaginal Delivery		Caesarean Section	
	Weight (Kg.)	Deaths	P N.M. %	Deaths	P N.M %
First Twin	1-2	11/88	12.5	2/25	8
Breech	2-4	2/194	1.0	2/142	1.4
Second Twin	1-2	41/249	16.5	3/32	9.4
Breech	2-4	1/590	0.2	2/222	0.9

pregnancies. Of these 10 sections were done for prolonged labour with fetal distress, 10 for PET, 9 for post caesarean for the second twin and the rest for early cases, 5 for antepartum haemorrhage, 3 rupture of membranes and bad obstetric history. Only 5 perinatal mortality occurred among the 81 babies delivered by caesarean section of 42 twin gestations. Of these two twin pairs were delivered by caesarean section for antepartum haemorrhage of which one pair weighed less than 1000 gm. This shows that perinatal mortality amongst babies delivered by caesarean section in twin gestations was lower than delivered vaginally—35 per thousand in cases of caesarean section in comparison with 155 per thousand delivered vaginally.

An analysis of breech twin deliveries show that in both first and second twins the fetal mortality is higher in vaginal delivery in babies weighing between 1 to 2 kgs as shown in Table V. In a recent publication Narvekar *et al* (1986) reported four cases of caesarean section in 53 twin pregnancies of which three were for the second twin.

According to Acker *et al* of Boston City Hospital although the method and route of delivery of second twin in a non-vertex presentation is controversial, recent obstetrics and neonatal reviews have concluded that the best results for such features are obtained from caesarean birth.

Conclusion

To conclude, it seems the trend for more caesarean section in twins may not be able to reduce overall perinatal mortality babies as the major loss is in the grossly low birth weight group. On the other hand one should not be hesitate to do caesarean section for the second twin after vaginal delivery of the first, if the size of the baby is good and abnormal presentation increases the risk of vaginal delivery. It is not uncommon to loose the bigger second twin in the process of internal version and breech extraction.

If this trend continues justified with improved perinatal mortality rate for the second twin, internal version with breech extraction as an obstetric maneouver will be an entity of the past.

References

1. Acker, D., Lieberman, M., Holbrook, H R., James, O., Phillippe, M. and Edelin, K. C.: Obstet, Gynec. 59: 710, 1982.
2. Narvekar, N. M., and Thakkur, S. S.: Obstet. Gynec. India, August 1986: 581.