



Fig.

twins where Twin to Twin transfusion is usually present. An antepartum death of a fetus in multiple gestation is an uncommon event.

Melnick (1977) reported 0.37 percent of antepartum deaths of fetuses in 188 sets of twins based on data of a perinatal project of the U. S. A. Enbom (1985) reviewed the published literature since 1954 and calculated the incidence to vary from 0.5 to 6.8 of all twin pregnancies but did not specify timing in gestation. Landy and Weingold (1989) identified 94 cases reported in 21 articles published in pediatric and obstetric literature and added to that five cases from their experience.

The main complication feared in association with prolonged retention of a dead fetus is maternal disseminated intravascular coagulopathy (DIC). Similarly the surviving co-twin can be affected when a fetal death occurs in a multiple gestation, especially if the twins are monozygotic and share circulation via placental anastomoses.

Hypofibrinogenemia usually occurs with prolonged retention of dead fetus (3-12 weeks) Pritchard (1959) reported that rarely haemostatic failure occurs when dead fetus is retained for less than 4 weeks but can occur in approximately 25% of cases if retention is longer in

singleton IUD (Pritchard, 1959). One of our patients had retention of fetus for more than 8 weeks and showed hypofibrinogenemia at term but recovered spontaneously following delivery. Spontaneous correction of the coagulation defect has been reported in association with retention of a dead fetus, but occurs very slowly (Cunningham are pregnancies complicated by retention of a dead fetus in a multiple gestation, Landy and Weingold (1989) observed that only three patients developed DIC in antepartum period and were successfully managed. It is important to diagnose this condition early and proper management would avert any fatality.

The second important complication is to the surviving co-twin. In 1961 Benirschke (1961) first implicated the death of a fetus in utero as being the factor responsible for problems in the monozygous surviving co-twin. Significant Central Nervous System abnormalities, some resulting in cerebral palsy have been reported. From his analysis of the national perinatal project, Melnick (1977) has estimated the risk of DIC/brain damage in a monozygotic twin pair to be 0.5 percent. Benirschke and Driscoll (1974) in examining 60 diamniotic-mono chorionic placentas of consecutive monozygotic twins demonstrated 85 percent with vascular connections which can aid transport of thromboplastic material from the dead co-twin. Antenatal evaluation of chorion type using sonography will aid in assessing the potential risk and serial sonograms will also help in evaluation of fetal growth and detect anomalies. Discordancy in Biparietal diameters may be due to the fetal demise of a smaller twin and should warn the obstetrician to this potential complication.

#### CONCLUSION

Twin pregnancy with an intrauterine fetal demise is a rare occurrence. When it occurs it raises concern about the surviving twin and the mother. Serial assessment of the surviving

Table

Case No.	Clinical data Gestational age at diagnosis	Delivery	Surviving new born	Placenta
1	G <sub>4</sub> P <sub>2</sub> 30 years diagnosed at term when patient presented with macerated cord at the introitus.	Delivered within 6 hours. Fetus papyraceous. Wt. 200 gms. Had mild Atonic PPH Coagulation profile was normal.	Live female baby Wt. 2.7 Kg.	Wt. 300 gms. Diamniotic, Monochorionic and Velamentine insertion of the cord of the dead fetus.
2	Primigravida, 20 years diagnosed at term as breech presentation with inadequate pelvis. X-Ray showed one fetus in extended breech and a second crumpled fetus in transverse lie.	Caesarean section was done. Macerated fetus weighing 1.2 Kgs. No Postpartum complication. Coagulation Profile normal.	Live male baby Wt. 2.5 Kg. Microcephaly +	Wt. 350 gms. Diamniotic and monochorionic with infarcts and calcifications near the cord of dead fetus.
3	32 years, sixth gravida, Para 5 with one living child. Had four still births, admitted with 8 months amenorrhoea for safe confinement. Ut. 32 weeks Cephalic presentation. Fetal heart good. Ultrasound revealed Twin pregnancy 1st Fetus BPD 8 cm. with cardiac activity 2nd fetus BPD 3 cm. with no cardiac activity. Diagnosis of Twins with Fetus papyraceous was made and patient was carefully followed up. Repeat sonar done after one month showed BPD of 1st fetus to be 9 cm. and the 2nd fetus to be 2.5 cm. Head was crumpled. Serial hematological monitoring was done to rule out coagulation disorder. Patient showed mild coagulation defects (Thrombocytes 1.5 lakhs/cmm. and Hypofibrinogenemia) which got corrected spontaneously.	Elective Cesarean section was done. 1st baby was live, normal. 2nd fetus was well formed 10 x 5 cm. Wt. 300 gms. There were no postpartum complications Coagulation was normal.	Live female baby normal. Wt. 2.6 Kg.	Wt. 300 gms. Diamniotic and monochorionic. Placental segment supplying the fetus papyraceous was white and avascular. Infarctions were present.

twin using sonography and biophysical profiles is mandatory. Coagulation status of mother also has to be assessed frequently and serially. Evidence of DIC should be properly corrected and is not an indication for termination of pregnancy. Delivery should be instituted for standard obstetric reason and the delivery should take place in a tertiary care institution where good mother/neonatal support care is available.

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