An Unusual case Report of Conjoined twin pregnancy

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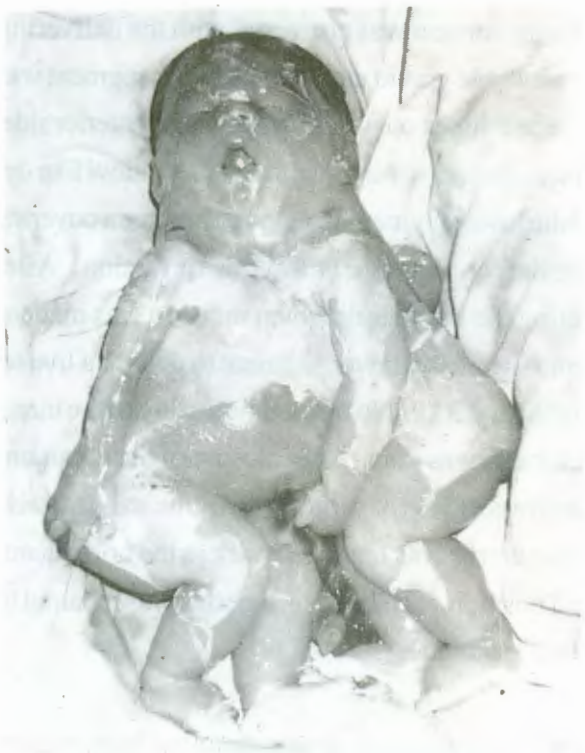
Mrs XY 24 years old female G2PILI with 7½ months amenorrhoea was admitted to ANC ward on 11/2/97 with PIH with severe bilateral lower extremity swelling.



LMP was on 13/07/96 and her EDD was on 24/04/97. Past Menstrual Cycles were regular. Obstetric history showed one FTND 2 years back, a female child. She had no history of pregnancy induced hypertension in last pregnancy. She had no other significant history.

On examination all parameters were normal except that she had a BP of 140/90 mm of Hg and edema feet with pitting on pressure. Per abdomen findings showed a uterus of 30 weeks gestation with a cephalic presentation. Uterus was relaxed. Liquor was increased, FHS were 130 / minute and regular.

Investigations showed a Hb of 8.6 gms% with microcytic hypochromic anaemia. Other investigations were within normal limits.

USG findings showed a single live fetus in cephalic presentation of 28 weeks gestation with fetal pleural effusion, ascites and scalp edema. Placental thickness was increased. Liquor was increased and AFI was 18. Findings were suggestive of fetal hydrops with sluggish limb movements. Induction of labour was done on 15/02/97 at 2 pm with cerviprime gel instillation. Patient delivered macerated conjoined twin female fetuses at 6 pm on 16/02/97.

Both fetuses were female and had craniophagus having one fetal head as well as thoracophagus. Each had 2 upper and 2 lower extremities and a single umbilical cord. Combined weight of both fetuses was 2.7 kgs. Placenta was monochorionic, monoamniotic. The insertion of the single umbilical cord was eccentric & umbilical vessels showed no abnormality. Placenta showed areas of calcification.

Postpartum period was uneventful and patient was discharged on third postpartum day on antibiotics, hematinics and drugs suppressing lactation.