# Natural Reduction of Quadruplets to Twin Gestation with Intensive Role of Obstetrician - A Case Report

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Mrs 'X', aged 26 yrs, P0+0. (married 4 yrs. back) conceived after ovulation induction with clomiphene citrate 100 mg from 2nd – 6th day of menstrual cycle resulting in quadruplet gestation. The patient reported to us at 26 weeks of gestation when she was very uncomfortable and distressed because of her severe abdominal distension for termination of pregnancy. Clinical examination revealed – GC uncomfortable, vitals maintaned, CVS/Rep – clear, pedal oedema ++, Per abdominal examination – abdomen distended, FH – 36 wks, multiple foetal parts palpable, FHS difficult to auscultate, liquor excess. Ultrasonography done at the same time showed – quadruamniotic quadruchorionic quadruplet pregnancy with two live foetuses and two dead foetuses corresponding to 24 – 26 wks. of gestation; four placentae could be distinguished separately. Sacs containing dead foetuses had polyhydramnios. With great care, we could manage to do gradual ultrasound guided amniocentesis of about 50ml – 40 ml of liquor from each sac of dead foetuses. This was followed by rest, tocolytic drugs and tranquilizers and risk of premature labour was clearly explained. After a weeks time, patient was discharged with adequate advice for prevention of preterm labour and was asked to come after 4 weeks. Simultaneously the patient was also investigated for bleeding disorders besides routine blood tests as two foetuses were dead and chances of patient going into DIC were high. Four weeks later clinical examination along with USG was done and repeat USG guided amniocentesis was done removing 60ml and 40 ml of liquor from sac of both the dead foetuses. Patient felt much better after this procedure and distension was also relieved. The patient continued the pregnancy till term with absolute bed rest and careful clinical and haemotological monitoring. Elective LSCS was performed at 38 wks. of gestation and two live foetuses with good apgar score and two dead foetuses were delivered attached with 4 placentae separately (Fig. 1). It was perhaps difficult to perform amniocentesis through a very small area anteriorly and on left side between 2 placentae as almost whole uterine wall was occupied by 4 placentae. This natural reduction of quadruplet pregnancy to twin pregnancy and with careful obstetric monitoring foetal and maternal outcome in this high risk precious pregnancy was greatly improved.

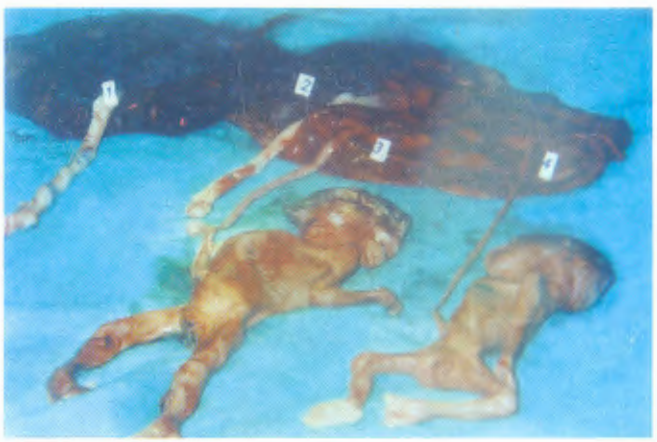

Figure 1 – 4 separate placentae attached with two dead foetuses