MULTIPLE PREGNANCIES
CLINICAL GUIDELINE
V2.0
1. **Aim/Purpose of this Guideline**

To provide Midwives and Obstetricians with guidance on the management of multiple pregnancies during the antenatal and intrapartum period.

2. **The Guidance**

2.1. Any multiple pregnancy carries increased risk compared to a singleton pregnancy. Dichorionic and monochorionic pregnancies share increased risk of pre-term birth, pre-eclampsia, fetal growth restriction and postpartum haemorrhage. Monochorionic pregnancies have the additional risk of feto-fetal transfusion syndrome (FFTS) which requires screening during the pregnancy.

2.2. **Ultrasound Diagnosis**

Aim to determine the following in the same first trimester scan when crown–rump length measures from 45 mm to 84 mm (at approximately 11+0 weeks to 13+6 weeks):

- Gestational age (Use the largest fetal CRL)
- Chorionicity (Refer to Section 2.3)
- Describe the position of each fetus in the uterus (upper/lower; left/ right) and assign the lower sac with respect to the cervix to be fetus A and the higher sac fetus B. This should be documented in the Comments box of the Early Pregnancy Ultrasound on the Viewpoint database. Labelling should take place at all subsequent scans (see section 2.8.2) (new 2018)
- Triplets or higher order multiple pregnancies should be referred urgently to the Fetal Medicine Unit (FMU) after the first scan at which the diagnosis is made (including referral from the Infertility Service) (new 2018)
- If the woman has requested trisomy screening (whether or not she already knows she is carrying a multiple pregnancy), the sonographer will discuss the additional management issues relating to higher risk results and potential discordance for abnormality. If the woman still wishes to proceed, NT is measured and blood taken (if not triplets) and written information given. However, the risk should not be calculated until the woman has contacted the FM Administrator to give her consent. Details of these cases are held by the FM Administrator who will contact the woman if the department has not heard from her within a few days (new 2018)
- The Antenatal Screening Coordinator is available as an additional resource for counselling if a woman is struggling to make a decision regarding prenatal screening (New 2018)

2.3. **Chorionicity**

Determine chorionicity using:

- Number of placental masses and the lambda or T-sign and/or membrane thickness
- For women presenting after 14+0 weeks, use all of the above features and discordant fetal sex
- Store an electronic image of the membrane attachment on Webpac
- Obtain a second opinion from an FM specialist midwife or consultant if there is any doubt about chorionicity, especially in cases where the first scan is performed after 14 weeks (New 2018)
2.4 Referral arrangements after diagnosis

- Once the diagnosis is made, a multiple pregnancy proforma should be commenced (Appendix 3)
- The woman should be referred to her area Consultant Obstetrician with a view to be seen in the next available clinic
- Monochorionic pregnancies should be referred to FMU for scan at 16 weeks. If there is significant CRL, NT or amniotic fluid discrepancy at 12 weeks potentially indicating early feto-fetal transfusion syndrome (FFTS), the case should be discussed with an FM consultant (New 2018)

2.5. Antenatal Management and Completion of Multiple Pregnancy Proforma

A plan should be made by the area Obstetrician in agreement with the woman and documented on the Multiple Pregnancy Proforma (Appendix3). The frequency of Midwife and Consultant visits should be established, and frequency of ultrasound assessments made. The schedule on the proforma is a minimum standard for uncomplicated twin pregnancy and should be individualised in the presence of additional risks or complications (New 2018)

Mode and timing of delivery should be discussed. This should include the risks and benefits.

- All women with multiple pregnancies should be advised that birth should take place in the Consultant Unit
- All monochorionic twins will be scanned in FMU on a 2 weekly basis from 16 weeks to screen for FFTS
- Growth scans for dichorionic pregnancies will be performed every 4 weeks from 20 weeks
- Admission should be arranged on clinical grounds as for singleton pregnancies
- Timing for elective delivery (induction or Caesarean Section) should be discussed with the Consultant
- Be aware of higher incidence of anaemia in women with twin and triplet pregnancies. Perform Full Blood Count (FBC) at 20-24 weeks to identify early supplementation with iron or folic acid

The area Obstetrician should consider whether any impending or established complications require additional multidisciplinary expertise. The following colleagues should be considered: (New 2018)

- FM Consultant
- Maternal Medicine Consultant
- Perinatal mental health professional
- Women’s health physiotherapist
- Infant feeding specialist midwife
- Dietician
2.6. Hypertension

Refer to the National Institute for Health and Care Excellence (NICE) Guideline on hypertension in pregnancy.

- Measure blood pressure (BP) and test urine for proteinuria at each appointment
- Advise women to take 75 mg of aspirin daily from 12 weeks until the birth of the babies if they have one or more of the following risk factors for pre-eclampsia:
  - First pregnancy
  - Age 40 years or older
  - Pregnancy interval of more than 10 years
  - BMI of 35 kg/m2 or more at first visit
  - Family history of pre-eclampsia

2.7. Feto-Fetal Transfusion Syndrome (FFTS)

- Do not monitor for feto-fetal transfusion syndrome (FFTS) in the first trimester
- If there are any signs of FFTS the follow up interval will be at the discretion of the FM Consultant
- All women with a monochorionic twin pregnancy must be informed of the possibility of FFTS and the symptoms and signs to report as a matter of urgency (sudden increase in girth, abdominal pain or tightening’s). The woman should not be reassured by a recent normal scan or delay seeking help because a follow up scan is in the near future
- The FM Consultant will liaise closely with tertiary centre FM colleagues in Bristol in any case that meets FFTS Quintero stage 1 or more (New 2018)

2.8. Frequency of Antenatal Appointments

2.8.1. Monochorionic Diamniotic (MCDA) Twins

- Area Obstetric Consultant appointment by 16 weeks’ gestation
- From 16 weeks will be seen by the Specialist FM Midwife sonographers and will be scanned for evidence of FFTS every 2 weeks
- On some of these appointments they will also have their BP and urine checked (Appendix 3)
- 18⁺⁰ - 20⁺⁶ weeks appointment with the FM Consultant for anomaly and FFTS screening
- 30-32 weeks appointment with the Area Consultant Obstetrician to discuss delivery (new 2018)
- In addition to this the woman should also be seen by her Community Midwife (CMW) as per schedule of appointments (Appendix 3)

2.8.2. Dichorionic Diamniotic (DCDA) Twins

- Area Obstetric Consultant appointment by 16 weeks’ gestation
• 30-32 weeks appointment with the Area Consultant Obstetrician to plan delivery (New 2018)
• In addition to this the woman should be seen by her CMW after each scan and her BP and urine checked at each of these visits (Appendix 3)

2.8.3. Monochorionic monoamniotic (MCMA) and conjoined twins and higher order multiples

• Individualised care led by FM Consultant (New 2018)

2.9. Serial scans (New 2018)

2.9.1 Frequency and location

• DCDA: 4 weekly from 20 weeks in area clinics staffed by Main Department Sonographers
• MCDA: 2 weekly from 16 weeks in the FMU performed by Specialist Midwife sonographers. FM Consultants perform the anomaly scan and plan individualised care for potential and established FFTS
• MCMA: An individualised plan determined by FM consultant
• Higher order multiples: An individualised plan determined by FM consultant

2.9.2 Documentation specific to multiple pregnancies (New 2018)

• Label and document the fetuses on all scan Viewpoint database reports as per section 2.2:
  ➢ First trimester scan- ‘Comments’ box of ‘Early Pregnancy Ultrasound’
  ➢ Anomaly scan- in the ‘Other’ box of ‘Biometry/morphology’ section
  ➢ Growth scans- in the ‘Other’ box of the Wellbeing scan section (one for each fetus)

• Calculate Estimated Fetal Weight (EFW) discordance on every scan from 20 weeks:
  ➢ A discordance of 25% or greater should be referred to the FMU. This is only urgent if there are markers of fetal compromise
  ➢ This is calculated by dividing the smaller EFW by the larger EFW (the number will always be 1.0 or less). If the ratio is ≤ 0.75 this indicates a 25% or greater difference in size
  ➢ The discordance should be recorded as a percentage discordance in the ‘Other’ box in the ‘Overall Diagnosis’ section on Viewpoint
  ➢ For example, if twin A EFW is 715g and twin B EFW is 495g, the ratio is 495 / 715 = 0.69. This should be recorded as ‘EFW discordance 31%.’ Referral to FMU should be made and documented in the report

2.10. Fetal complications (New 2018)

The FM Consultants will liaise closely with tertiary centre FM colleagues in Bristol in selected cases. Discussion may be appropriate in the following situations:
2.11. Mode and Timing of Delivery

- There is no overwhelming current evidence as to the optimum mode or timing of delivery. Information should be provided for the woman on the risks and benefits of different modes of delivery. The provision of this information, discussions and the plan for the agreed place and timing of birth must be documented in the woman’s notes.
- In uncomplicated MCDA pregnancies further discussions regarding delivery should take place at the 30-32 (New 2018) week consultation with the Area Obstetric Consultant with planned delivery between 36 and 37 weeks. If there are no specific complications or contraindications vaginal delivery is appropriate. A course of maternal antenatal steroids should be offered. Where there have been any fetal concerns on serial scans (e.g. FFTS, anomaly or growth discordance), the FM Consultant will lead decisions regarding timing and mode of delivery (new 2018)
- In DCDA pregnancies, further discussions regarding delivery should take place at the 30-32 week consultation with the Area Obstetric Consultant (New 2018) with delivery planned after 37 weeks unless there are complications requiring earlier intervention
- Triplet pregnancies should be offered elective birth from 35 weeks after a course of maternal antenatal steroids (New 2018)
- If an Elective Caesarean Section (ELCS) is planned, maternal steroids for fetal lung maturation should be recommended if delivery is before 39+0 weeks
- For women who decline induction of labour, weekly Consultant Obstetrician and scan assessment should be offered (new 2018)

2.12. Intrapartum Management

2.12.1. Management of First Stage of Labour

- Refer to RCHT Care of a Woman In 1st and 2nd Stage Of Labour – Clinical Guideline
- Apart from the requirement for continuous electronic fetal monitoring (EFM) of both twins the management of the first stage is no different than with a singleton pregnancy
- It should be very clearly marked on the EFM trace which is Twin 1 (anticipated to be first born) and which is Twin 2 (this nomenclature will correspond with twin 1 being twin A on scans and twin 2 being twin B on scan unless clearly documented otherwise on Viewpoint scans (New 2018)
- There should be early recourse to the use of a fetal scalp electrode on Twin 1 if there is difficulty with monitoring
• The use of a Syntocinon infusion requires the same care and indications as for singleton pregnancy
• Epidural analgesia is recommended as it allows more control after delivery of the first twin, and hence increased safety for the second twin
• EFM changes for the first twin can be managed as for a singleton, but any concerning features of the EFM of the 2nd twin (dependent on quality and severity) may require operative intervention

2.12.2. Management of Second Stage of Labour

• Refer to RCHT Care of a Woman In 1st and 2nd Stage Of Labour – Clinical Guideline
• The management of the second stage of labour for the first twin should not deviate from that outlined for a singleton pregnancy – except that the whole delivery is led by an experienced obstetrician who remains present in the room or immediately available throughout the second and third stage
• The resuscitaires should be prepared and the on-call ANNP/ST for neonatology should be informed when the woman achieves full cervical dilatation/begins active pushing
• The on-call anaesthetist should also be alerted

2.12.3. After Delivery of the First Baby

• Deferred cord clamping as normal – and ensure clear identification of the first twin cord
• Palpate the maternal abdomen
• Ensure a longitudinal lie (confirm with ultrasound if any doubt)
• Syntocinon should be commenced
• **Alert: The maternal contractions may cease after the first delivery: there is greater urgency with monochorionic twins than dichorionic twins to re-establish the contractions**
• A vaginal examination should be performed to check the presenting part is entering the pelvis. Membranes must NOT be ruptured until the presenting part is within the pelvis
• If twin 2 is not longitudinal, abdominal palpation will determine the appropriateness of external version to cephalic or breech. If this is unsuccessful, consideration should be given to internal podalic version and breech extraction (new 2018)
• Standard management of second stage, but with low threshold for assistance
• Continue with CTG monitoring for Twin 2
2.12.4. Management of Third Stage of Labour

- Refer to RCHT Third Stage of Labour – Clinical Guideline

**Alert:** Syntometrine should only be given following the birth of the 2\textsuperscript{nd} twin.

- 40IU Syntocinon in 500ml Normal Saline at a rate of 125 mls per hour should be commenced to run over 4 hours because of the increased risk of postpartum haemorrhage. Otherwise management follows standard guidance.

2.13. Documentation

- An Information and Management Plan for Multiple Pregnancy Proforma must be commenced on diagnosis of the multiple pregnancy and filed in the woman’s hand held notes. It is the obstetrician’s responsibility to update this proforma at each contact with the woman.

- Complete a Twin Vaginal Delivery Proforma and/or a Caesarean Section Proforma depending upon the mode of delivery

2.14. Resources for clinical advice and education

A multidisciplinary team of ‘Champions for Multiple Pregnancy’ have been identified to provide advice in the care of women and their babies and to assist in improving the knowledge and skills of clinicians looking after them. The FM Consultants are the Obstetric Champions (allowing cross cover for leave). Each other key clinician group, the FM Midwife sonographers, the Main Ultrasound sonographers and the North, Central and West area midwifery teams, have a designated champion. Current champions and their contact numbers are available in the FMU office on extension 2682 or 3092 (new 2018)

3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>The audit will take into account record keeping by Obstetricians, Midwives and other Allied Health Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Audit Midwife</td>
</tr>
<tr>
<td>Tool</td>
<td>Did the woman have an Information &amp; Management Plan for multiple pregnancies filed in her health records</td>
</tr>
<tr>
<td></td>
<td>Has it been documented that information has been provided to the woman on the risks and benefits of different modes of delivery</td>
</tr>
<tr>
<td></td>
<td>Has a plan been documented to agree the timing and place of birth</td>
</tr>
<tr>
<td></td>
<td>Was it clearly identified on the EFM trace which was Twin 1 and which was Twin 2</td>
</tr>
</tbody>
</table>
• Was a suitably experienced Obstetrician available/present during the second stage, delivery and third stage of labour
• Following delivery of the first twin was the lie of the second twin clearly identified
• Following the birth of the 1st twin was Syntocinon commenced or a rationale documented if not commenced
• Following the birth of Twin 2 was a Syntocinon infusion commenced

Frequency
• 1% or 10 sets, whichever is the greater, of all health records of women who have had multiple births (of which at least half are vaginal births), will be audited over the lifetime of the guideline or earlier if indicated.

Reporting arrangements
• Maternity Patient Safety Management Forum or Clinical Audit Forum

Acting on recommendations and Lead(s)
• Any deficiencies identified during the audit they will be discussed at the Maternity Patient Safety Management Meeting and an action plan developed
• Action leads will be identified and a time frame for the action to be completed
• The action plan will be monitored by the Audit Midwife until all actions complete

Change in practice and lessons to be shared
• Patient Safety Management Newsletter
• Clinical Audit Forum

4. Equality and Diversity
This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement.

4.1 Equality Impact Assessment
The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>MULTIPLE PREGNANCIES CLINICAL GUIDELINE V2.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>17&lt;sup&gt;th&lt;/sup&gt; May 2018</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>17&lt;sup&gt;th&lt;/sup&gt; May 2018</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>17&lt;sup&gt;th&lt;/sup&gt; May 2021</td>
</tr>
</tbody>
</table>
| Directorate / Department responsible (author/owner): | Rob Holmes  
Obs and Gynae Directorate |
| Contact details: | 01872 252729 |
| Brief summary of contents | To provide Midwives and Obstetricians with guidance of the management of multiple pregnancies in the antenatal and intrapartum period |
| Suggested Keywords: | Twins, Syntocinon, multiple, triplets, fetal, feto, chorionicity, transfusion monochorionic MCDA, DCDA, dichorionic |
| Target Audience | RCHT  
CPFT  
KCCG |
| Executive Director responsible for Policy: | Medical Director |
| Date revised: | 17<sup>th</sup> May 2018 |
| This document replaces (exact title of previous version): | Clinical guideline for Management of Multiple pregnancy V1.4 |
| Approval route (names of committees)/consultation: | Maternity Guidelines Group  
Obs and Gynae Directorate  
Divisional Board for approval |
| Divisional Manager confirming approval processes | Tunde Adewopo |
| Name and Post Title of additional signatories | Not Required |
| Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings | {Original Copy Signed}  
Name: Caroline Amukusana |
| Signature of Executive Director giving approval | {Original Copy Signed} |
### Related Documents:

- RCHT (2012) Care of a Woman in 1st and 2nd Stage of Labour – Clinical Guideline
- RCHT (2015) Third Stage of Labour – Clinical Guideline
- RCOG Green top Guideline No 51
- NICE (2011) Clinical Guideline Multiple Pregnancy

### Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tbody>
<tr>
<td>2006</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Mr Jones Consultant Obstetrician</td>
</tr>
<tr>
<td>November 2010</td>
<td>V1.1</td>
<td>Addition of ante natal management.</td>
<td>Mr Jones Consultant Obstetrician</td>
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<tr>
<td>February 2012</td>
<td>V1.2</td>
<td>Updated in line with NICE guidance.</td>
<td>Dr Karen Watkins Consultant Obstetrician</td>
</tr>
<tr>
<td>Septembe r 12</td>
<td>V1.3</td>
<td>Changes to compliance monitoring tool only</td>
<td>Dr Karen Watkins Consultant Obstetrician</td>
</tr>
<tr>
<td>20th October 2015</td>
<td>V1.4</td>
<td>Minor changes only</td>
<td>Dr Karen Watkins Consultant Obstetrician</td>
</tr>
</tbody>
</table>
**Appendix 2. Initial Equality Impact Assessment Form**

*This assessment will need to be completed in stages to allow for adequate consultation with the relevant groups.*

<table>
<thead>
<tr>
<th>Name of Name of the strategy / policy / proposal / service function to be assessed</th>
<th>Directorate and service area:</th>
<th>Is this a new or existing Policy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>MULTIPLE PREGNANCIES CLINICAL GUIDELINE V2.0</td>
<td>Obs &amp; Gynaec Directorate</td>
<td>Existing</td>
</tr>
</tbody>
</table>

| Name of individual completing assessment: Sarah-Jane Pedler | Telephone: 01872 255019 |

1. **Policy Aim***

   **Who is the strategy / policy / proposal / service function aimed at?**

   To provide Midwives and Obstetricians with guidance on the management of multiple pregnancies in the ante natal and intrapartum period

2. **Policy Objectives***

   **To ensure multiple pregnancies are managed as per NICE evidence based guidance**

3. **Policy – intended Outcomes***

   Safe delivery of multiple pregnancies

4. **How will you measure the outcome?**

   Audit Midwife will audit compliance with guideline

5. **Who is intended to benefit from the policy?**

   All pregnant women with a multiple pregnancy

6a Who did you consult with

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Patients</th>
<th>Local groups</th>
<th>External organisations</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

b). **Please record specific names of groups**

   Maternity Guideline Group
   Obs & Gynaec Directorate
   Divisional Board for approval

What was the outcome of the consultation?

Guideline agreed
7. The Impact

Please complete the following table. **If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.**

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>X</td>
<td></td>
<td></td>
<td>All pregnant women with a multiple pregnancy</td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<td>X</td>
<td></td>
<td></td>
<td>All pregnant women with a multiple pregnancy</td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td>X</td>
<td></td>
<td></td>
<td>All pregnant women with a multiple pregnancy</td>
</tr>
<tr>
<td>Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions</td>
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<td></td>
<td></td>
<td>All pregnant women with a multiple pregnancy</td>
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<tr>
<td>Religion / other beliefs</td>
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<td></td>
<td>All pregnant women with a multiple pregnancy</td>
</tr>
<tr>
<td>Marriage and Civil partnership</td>
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<td></td>
<td></td>
<td>All pregnant women with a multiple pregnancy</td>
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<tr>
<td>Pregnancy and maternity</td>
<td>X</td>
<td></td>
<td></td>
<td>This will have a beneficial effect for women with multiple pregnancy</td>
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<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td>X</td>
<td></td>
<td></td>
<td>All pregnant women with a multiple pregnancy</td>
</tr>
</tbody>
</table>

**You will need to continue to a full Equality Impact Assessment if the following have been highlighted:**

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. **or**
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended. **Yes**  **No**

9. If you are **not** recommending a Full Impact assessment please explain why.

No areas indicated
<table>
<thead>
<tr>
<th>Signature of policy developer / lead manager / director</th>
<th>Date of completion and submission</th>
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</thead>
<tbody>
<tr>
<td>Rob Holmes</td>
<td>17th May 2018</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Names and signatures of members carrying out the Screening Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sarah-Jane Pedler</td>
</tr>
<tr>
<td>2. Human Rights, Equality &amp; Inclusion Lead</td>
</tr>
</tbody>
</table>

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

This EIA will not be uploaded to the Trust website without the signature of the Human Rights, Equality & Inclusion Lead.

A summary of the results will be published on the Trust’s web site.

Signed Sarah-Jane Pedler

Date 17th May 2018
Appendix 3.

Information & Management Plan for multiple Pregnancies

Chorionicity:  DCDA ☐  MCDA ☐  Triplet ☐

- **Schedule of appointments** as per overleaf .......................................................... ☐
  Blood tests as per singleton pregnancy................................................................. ☐.
- **Anaemia** – symptoms - tiredness, shortness of breath............................... ☐.
  An additional FBC at 20 -24 weeks (to identify a need for iron or folic acid) . ☐.
- **Pre-term birth, and use of steroids** ................................................................. ☐.
  Report any contractions/ SROM / bleeding promptly................................. ☐.
- **Pre-eclampsia** – report symptoms - headache, visual disturbances, RUQ pain . ☐.
  BP and urine check needed each visit................................................................. ☐.
  Aspirin after 12 weeks if another risk factor for pre-eclampsia* ......................... ☐.
- **IUGR** – identified by scans ................................................................. ☐.
  For DCDA – 4 weekly growth scans, For MCDA – 2 weekly scans ................. ☐.
- **TTTS** -MCDA ONLY– Symptoms to report- increased girth, pain, tense uterus. ☐.
  Screening for TTTS is by scan every 2 weeks from 16 weeks ......................... ☐.
- **Timing of elective delivery**
  From 36 wks for MCDA twins, and from 37 wks DCDA twins ...................... ☐
  Earlier admission / delivery if clinically necessary ........................................... ☐.
- **Delivery** – will be in consultant unit ............................................................. ☐.
  Explanation of who will be present at delivery and their roles ....................... ☐.
  Risks / benefits of vaginal delivery and CS discussed ...................................... ☐.
  Epidural advisable ................................................................................................. ☐.
  Syntocinon infusion after delivery of first twin ............................................... ☐.
- **PPH** – Active management of 3rd stage with Syntocinon infusion ................ ☐
  Iron infusion may be required, rarely a blood transfusion ............................. ☐.

This discussion has taken place at ............ weeks’ gestation

Signed ................................ Designation ........................................... Date ............................................

*First pregnancy, age>40 yrs, last preg >10 yrs ago, BMI>35, prev or family history PETNB Twin pregnancy is not an indication for GTT
### Schedule of Appointments and Scans for multiple Pregnancies

<table>
<thead>
<tr>
<th>Weeks</th>
<th>Dichorionic (DCDA) Twins</th>
<th>Monochorionic (MCDA) Twins</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-14</td>
<td>Scan</td>
<td>Scan</td>
</tr>
<tr>
<td>13-15</td>
<td>Area Obstetric clinic appointment</td>
<td>Area Obstetric clinic appointment</td>
</tr>
<tr>
<td>16</td>
<td>CMW appointment</td>
<td>FM scan and CMW appointment</td>
</tr>
<tr>
<td>18</td>
<td>FM scan with antenatal check</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Scan and CMW appointment (FBC)</td>
<td>FM scan by fetal medicine consultant and antenatal check (FBC)</td>
</tr>
<tr>
<td>22</td>
<td></td>
<td>FM scan and antenatal check</td>
</tr>
<tr>
<td>24</td>
<td>Scan and CMW appointment</td>
<td>FM scan and CMW appointment</td>
</tr>
<tr>
<td>26</td>
<td>FM scan and antenatal check</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Scan and CMW appointment</td>
<td>FM scan and CMW appointment</td>
</tr>
<tr>
<td>30</td>
<td>Obstetric clinic appointment (30-32 weeks)</td>
<td>FM scan and antenatal check Obstetric clinic appointment (30-32 weeks)</td>
</tr>
<tr>
<td>32</td>
<td>Scan and CMW appointment</td>
<td>FM scan and CMW appointment</td>
</tr>
<tr>
<td>34</td>
<td>CMW appointment</td>
<td>FM scan and antenatal check</td>
</tr>
<tr>
<td>36</td>
<td>Scan and CMW appointment</td>
<td>FM scan and CMW appointment</td>
</tr>
</tbody>
</table>

**Area Obstetric Clinic discussion at………………. week’s gestation (aim for 30-32 weeks)**

(Record other obstetric consultations in routine clinic documentation in handheld notes and E3)

**Plans for Delivery**

Decision re mode of delivery................................................................................................................................................

If LSCS – date booked..................Gestation..................Steroids Y/N date..................

Plan if admitted in labour prior to this date..................................................................................................................

If vaginal delivery

Induction of Labour – date booked..........................Gestation..........................

Steroids arranged for MCDA / MCMA Twins (if 36 weeks) Steroids Y/N date........

Induction plan – ARM / Propess / Other.........................................................................................................................

Comments........................................................................................................................................................................

........................................................................................................................................................................

Signed........................................................Designation........................................Date........

**Please do not hesitate to ask about anything – your midwife or doctor will be happy to discuss anything that is not clear**
Women’s and Children’s Division
Maternity Services
Twin Vaginal Delivery Proforma

Analgesia:
- Epidural: YES □ Effective throughout Y / N
  NO □ Reason: .................................................................................................................................
- Other analgesia: ................................................................................................................................

2nd stage:
- Obstetrician present throughout: YES □ Name: ..........................................................
  NO □ Reasons: ............................................................................................................................
If Obstetrician attended later, at what point.................................................................
- Resuscitaires prepared ....Y / N If no why........................................................................
- Neonatologist/ANNP present at delivery….Y / N If no why............................................
- Mode of delivery of leading twin......................................................................................
- Indication for operative delivery....................................................................................
- Complete CS or instrumental delivery proforma (if applicable)

Following delivery of leading Twin:
- Lie confirmed. Y / N – USS / manually Lie..........................................................
- V.E: presenting part..........................................................
- ARM once p.p in pelvis Y / N If N reason for early ARM..............................
- Time syntocinon started ................................................................................................
- Mode of delivery of second twin....................................................................................
- Indication for operative delivery....................................................................................
- Complete CS or instrumental delivery proforma (if applicable)

Following delivery of second twin:
- Syntocinon 40 IU in 500mls NaCl over 4hrs given -Y/N – if no why not......................
  - 2nd Twin A- pH..............BE.........V-pH..............BE..............

EBL..........................................................................................................................
Complete perineal repair proforma (if applicable)
Complete Thromboprophylaxis proforma

Signed..............................................................Designation............................................Date........

MULTIPLE PREGNANCIES CLINICAL GUIDELINE V2.0
Any other information or additional procedures:

Signed…………………………………………..Designation…………………………………Date…………….