HEALTH HOLDING
HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Obstetrics and Gynecology (Ambulatory Care)		
Document:	Departmental Policy and Procedure		
Title:	Antenatal Management of Multiple Pregnancy		
Applies To:	All Obstetrics and Gynecology Staff		
Preparation Date:	January 08, 2025	**Index No:**	L&D-DPP-055
Approval Date:	January 22, 2025	**Version :**	2
Effective Date:	February 22, 2025	**Replacement No.:**	L&D-DPP-055(1)
Review Date:	February 22, 2028	**No. of Pages:**	3

1. PURPOSE:

1.1 To ensure that all patients with multiple pregnancy are identified, diagnosed and treated according to accurate evidence - based practice.

2. DEFINITIONS:

2.1 **Multiple Pregnancy**- occurs when more than one fetus simultaneously develops in the uterus.

3. POLICY:

3.1 All women with a twin pregnancy should be offered an ultrasound examination at 10 – 13 weeks of gestation to assess viability, chorionicity, major congenital malformation and nuchal translucency.
- 3.1.1 If there is doubt in the diagnosis of chorionicity, the woman should be referred to a specialist without delay, as chorionicity is best determined before 14 weeks.
- 3.1.2 All monochorionic twins should have a detailed ultrasound scan which includes extended views of the fetal heart.
- 3.1.3 A fetal echocardiographic assessment should be considered in the assessment of severe TTTS.

3.2 All healthcare professionals in contact with women who are diagnosed with diabetes of child-bearing age should be aware of the importance of pre-pregnancy, pregnancy care and local arrangements for its delivery, and should share this information with the woman.

3.3 Women with gestational diabetes should be instructed in self- monitoring of blood glucose. Targets for blood glucose control should be determined in the same way as for women with pre-existing diabetes.

3.4 Pre-conception care for women with diabetes should be given in a supportive environment and the woman's partner or other family member should be encouraged to attend.

3.5 Effort to establish combined antenatal/ diabetic clinics with day care and home glucose monitoring should be made. Daily self-blood glucose monitoring with fasting and pre-meal blood sugars for the remainder of the pregnancy.

3.6 Once women diagnosed will be with diabetes, she should be seen every other week until 36 weeks then weekly.

4. PROCEDURE:

4.1 Chorionicity is better assessed by ultrasound before 14 weeks later than after 14 weeks.
- 4.1.1 If there is doubt in the diagnosis of chorionicity, the woman should be referred to a specialist without delay, as chorionicity is best determined before 14 weeks.
- 4.1.2 All monochorionic twins should have a detailed ultrasound scan which includes extended views of the fetal heart.
- 4.1.3 A fetal echocardiographic assessment should be considered in the assessment of severe twin to twin transfusion (TTTS).

4.2 Diagnosis of twin-twin transfusion syndrome. The diagnosis of TTTS is based on ultrasound criteria:

4.2.1 The presence of a single placental mass.
4.2.2 Concordant gender.
4.2.3 Oligohydramnios with maximum vertical pocket [MVP] less than 2cm in one sac and polyhydramnios in other sac (MVP ≥ 8cm) (some would say ≥ 8cm at ≤20 weeks and ≥10cm over 20 weeks).
4.2.4 Discordant bladder appearances- severe TTTs.
4.2.5 Hemodynamic and cardiac compromise- severe TTTS

4.3 Fetal ultrasound assessment should take place every 2-3 weeks in uncomplicated monochorionic pregnancies from 16 weeks.

4.4 Women with monochorionic twin pregnancies should be asked to report sudden increases in abdominal size or breathlessness, as this may be a manifestation of TTTS.

4.5 If twin to twin transfusion syndrome suspected, case should be managed in conjunction with regional fetal medicine centers with recourse to specialist expertise.

4.6 Severe twin-twin transfusion syndrome presenting before 26 weeks of gestation should be treated by laser ablation rather than by amnioreduction or septostomy at a tertiary center.

4.7 Timing and mode of delivery for otherwise uncomplicated MCDC (with diamniotic) pregnancies without fetal growth restriction and TTTS.

4.7.1 It is appropriate to aim for vaginal birth of monochorionic twins unless there are accepted, specific clinical indications to deliver earlier.
4.7.2 Delivery should be planned for between 38 weeks and 40 weeks of gestation, unless there is an indication to deliver earlier.
4.7.3 Assessment of fetal lung maturity should be performed if elective delivery is considered prior to 38 weeks.
4.7.4 In the presence of complications associated with increased perinatal mortality, such as oligohydramnios, abnormal fetal growth, or maternal hypertension, delivery prior to 38 weeks without confirmation of lung maturity is reasonable.

4.8 Most monochorionic, monoamniotic twins have cord entanglement and are best delivered at 32 weeks by caesarean section, after corticosteroids.

5. MATERIALS AND EQUIPMENT:

5.1 CTG

6. RESPONSIBILITIES:

6.1 Physician
6.2 Nurses
6.3 Midwives

7. APPENDICES:

N/A

8. REFERENCES:

8.1 Guidelines for Obstetrics & Gynecology, Ministry of Health, 2013.
8.2 RCOG GUIDELINE NO. 51. The Management of Monochorionic Twin Pregnancy, December, 2008.
8.3 Cruiks Hank, DP. Intrapartum Management of Twin Gestations, Obstet-Gynecol, 2007; 109; 1167.
8.4 https://www.slideshare.net/fahadzaq1/multiple-pregnancy-48053673.

9. APPROVALS:

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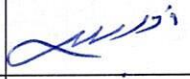
Prepared by:	Ms. Afrah Saud Al Sweilem	Head Nurse of OBS-OPD		January 08, 2025
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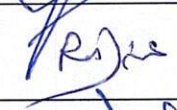
Reviewed by:	Mr. Sabah Turayhib Al - Harbi	Director of Nursing		January 13, 2025
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