



Triplet Pregnancy With Rh Negative-Management of Pre Term Labor

KEYWORDS

Duvadilan, Betnesol, Proluton

Dr Kumari Anamika

Final Year MS Obs & Gyn, Dr. D. Y. Patil Hospital & Research Institute, Kolhapur

Dr Shashikant Kulkarni

Head of Department, Obstetrics & Gynaecology, Dr. D. Y. Patil Hospital & Research Institute, Kolhapur, Maharashtra

ABSTRACT We report a case of Triplet with Rh Negative pregnancy in a 24 years old Primigravida. The patient presented with pain abdomen since 1 hr at 29 wk of her gestation. USG revealed a Triplet pregnancy with Trichorionic and Triamniotic placenta..

INTRODUCTION

Triplet pregnancy incidence is 1:7000 births. The perinatal mortality in triplets is 10 times higher than in singletons. Increase use of ovulation induction and advancement in Assisted Reproductive Technology has increased the incidence of multiple pregnancies which is associated with various complications. Triplet pregnancies are at increased risk of pregnancy complication and have higher perinatal morbidity. Selective fetal reduction is a procedure that has been widely employed over the last 15 years to reduce the risk of complications and improve pregnancy outcome. Obstetricians are increasingly challenged in managing triplet pregnancies because of its limited information and higher rate of complication

Patient aged 24 year primigravida with 29.4 wk of gestations with Triplet pregnancy with Rh negative pregnancy referred from Nipani in view of pre term labour. Patient was having pain abdomen since 1 hr which was intermittent, moderate in degree, non radiating to back or inner of thighs. She was given inj duvadilan 10mg stat, tab calgiguard 10 mg stat and Inj Betnesol 24mg IM outside. She was perceiving fetal movements well. History of infertility treatment for 1 year-ovulation induction was given. Cervical encirclage was done at 5th month, Inj Proluton 500mg IM on 6th month of pregnancy, Tab Duvadilan 10mg bd for 1wk on 7th months was also given. There was no H/O any multiple pregnancy in family.

On examination her vitals were stable. On P/A- Uterus was term size, multiple fetal parts were felt, lower pole was empty, multiple fetal heart sound were heard. She was getting 1-2 contractions/15-20 sec/10 min .On P/S - cervical stitch was in situ. Then under AAP cervical stitch was removed. On P/V -Cervix was 3 cm dilated, 2 cm long, membrane(+)

We sent her routine investigations-Cbc, Blood group and Rh typing (O-), Rbs, HIV, HbsAg ,ICT(Indirect Coombs Test)=Negative ,Husband blood group and Rh typing = A+ , USG -Obs with Doppler. Written n informed valid High risk consent was taken. Blood and blood products were reserved, Inj Duvadilan 10mg was started in IV drip stat & repeated 6 hrly IM, Inj Proluton 500mg IM was given stat. Strict maternal n fetal monitoring was done and Anti -D Prophylaxis 300 micro g was given. Patient was already given Inj Betnesol 24 mg IM outside.

After this management contractions came down and uter-

us was relaxed. Then we continued our management with Tab Duvadilan 10 mg TDS, Inj Betnesol 24 mg IM was repeated at 32 wk, Inj Proluton 500 mg IM was given every week. Strict maternal n fetal monitoring was done. USG -Obs with Doppler was repeated- Triplet live intrauterine pregnancy with 32/29.4/31wk, Fa-cephalic, 1.8kg/Fb-transverse, 1.3kg/Fc-breech, 1.6kg..with 3 separate placenta anterior..n AFI adequate..slight fetal growth restriction noted in fetus B..DOPPLER Normal.

At her 34 wk gestational age she went into labor. The Em LSCS was done under general anesthesia at 34wk. She delivered a male-2 kg, vertex, 2nd male- 1.6kg-breech and 3rd a female- 1.3 kg-vertex, Intra op -Trichorionic Triamniotic , 2 placenta fused n 1 placenta seperate .Post delivery all 3 babies were under observation in NICU. Both male babies were A Rh negative and female baby was A Rh positive. DCT(Direct Coomb's Test) was negative . Mother was given Inj Anti-D 300 micro gram.Piti el outlined that crumb rubber responses were found to denote greater flexibility and Toughness with larger deflection at peak load, longer post-peak load responses and higher fracture energy.Waste Tyres are a tremendous problem throughout the world. It is hardly surprising that in many countries it has been deduced that the best option is to simply burn them in cement kilns. At least in this way, the reasoning goes, some of the energy invested in the Tyre is reclaimed.





DISCUSSION:

Early diagnosis of multiple pregnancy is important both for maternal and fetal welfare. As far as the mother is concerned, it is psychologically beneficial to know the diagnosis as early as possible. From the fetal stand point, early diagnosis is important for the improvement of antenatal care and fetal salvage since it enables measures to be taken to prevent preterm labor. At 26 wk, morbidity became the primary risk factor for premature infants. Prophylactic cervical cerclage can be employed in good time. The main objective in managing multiple pregnancy is to enable the pregnancy to be carried on as far as possible, preferably to term¹.

The prevention of prematurity poses a major challenge. A number of approaches have been evaluated. These included hospitalization, cervical cerclage, and the use of tocolysis. Intravenous infusion of Beta-mimetic drugs for actual threatened premature labor may be of benefit². With the increasing number of triplet pregnancies resulting from assisted reproduction technology, obstetricians are increasingly becoming confronted with the question of the optimal mode of delivery, namely elective cesarean section (CS) or vaginal birth. There appears to be a general tendency to favor CS in triplet pregnancies. The reported benefits of this procedure include the avoidance of the risks of intrapartum complications, such as malpresentation, cord accident, reduction in utero-placental blood flow and increase in the interval between delivering fetuses with its accompanying intrauterine asphyxia in those premature triplets³. The frequency of triplets and higher order multiples can be estimated by Hellin hypothesis. This formula predicts that if the incidence of twins is 'n', the incidence

of triplets will be the square of 'n', quadruplets the cube of 'n' and so on 4.

The major complicating factors are preterm labour, anemia and PIH. Preterm delivery is the most significant complication of triplet gestation, approximately 75-100% of triplets are born prematurely. It is the only complication that occurred significantly more often in the triplet than in twin gestation⁵. Pre-eclampsia complicates 20-46% of triplet gestations compared to 5% of singleton pregnancies. Pre-eclampsia occurs earlier and is more severe in multiple gestations and HELLP syndrome is more likely⁶.

The four most common presentations of triplet pregnancy are vertex-breech-breech, vertexvertex- breech, vertex-vertex-vertex and breech-breech-breech. In this study, vertexbreech- breech (22.2%) and breech-breech-vertex were the most common presentations⁷. Triplets had 5-fold increased risk of requiring neonatal intensive care compared with twins⁸. The main postpartum complication of triplet pregnancy is hemorrhage, whether the delivery is by vaginal or abdominal route due to uterine atony⁹. Multiple gestations have a significantly higher occurrence of emergent peripartum hysterectomy than singletons¹⁰. There is a worldwide tendency to favour caesarean section in triplet pregnancies, as it reduces birth intervals between the births and problems for second and third triplets. It also safeguards the mother against injuries from blind intrauterine manipulations¹¹.

CONCLUSIONS

Once the triplet pregnancy is diagnosed, patient should undergo regular antenatal visit and frequent ultrasonography and Doppler to detect and prevent the various complications associated with triplet pregnancy.

REFERENCES:

1. Weissman A, Yoffe Y, Jakobi P, Brandes JM, Paldi E, Blazer S. Management of triplet pregnancies in the 1980s - are we doing better? *Am J Perinatol* 1991; 8:333-337
2. Daw E. Triplet pregnancy. *Br J Obstet Gynecol* 1978; 85:505-509
3. Miller M, Leader CR. Vaginal delivery after caesarean section. *Aust NZ J Obstet Gynecol* 1992; 32:213-216.
4. Benirschke K, Kim CK. Multiple pregnancy. II. *N Engl J Med* 1973; 288:1329-36.
5. Adegbite AL, Castille S, Ward S, Bajoria R. Neuromorbidity in preterm twins in relation to chorionicity and discordant birth weight. *Am J Obstet Gynecol* 2004; 190:156-63.
6. American College of Obstetricians and Gynaecologists Committee on practice bulletins-obstetrics; Society for Maternalfetal Medicine; AGOG joint editorial committee. ACOG practice bulletin # 56: multiple gestation: complicated twin, triplet and higher order multifetal pregnancy. *Obstet Gynecol* 2004; 104: 869-83.
7. Jones DC. Triplet pregnancy: mid and late pregnancy complications and management. Up-to-date patient information [internet]. 2007 [cited 2008 Mar 19]. Available from: <http://patients.uptodate.com/topic.asp?file=pregcomp/9296>.
8. Sassoon DA, Castro LC, Davis JL, Hobel CJ. Perinatal outcome in triplet versus twin gestations. *Obstet Gynecol* 1990; 75:817
9. Dommergues M, Mahieu-Caputo D, Dumez Y. Is the route of delivery a meaningful issue in triplets and higher order multiples? *Clin Obstet Gynecol* 1998; 41:24-9.
10. Francois K, Ortiz J, Harris C, Foley MR, Elliot JP. Is peripartum hysterectomy more common in multiple gestations? *Obstet Gynecol* 2005; 105:1369-72
11. Wildschut HI, van Roosmalen JV, van Leeuwen EV, Keirse MJ. Planned abdominal compared with planned vaginal birth in triplet pregnancies. *Br J Obstet Gynaecol* 1995; 102:292-6.