

# Delivery Considerations for the Parturient with Conjoined Twins and Postnatal Palliative Care

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## Background

- Conjoined twins: true incidence of approximately 1 in 200,000 live births.
- Extent of organ sharing determines possibility and prognosis of a separation procedure, sharing of heart or brain virtually excludes separation (1).
  - **We outline a case of a parturient presenting for a cesarean delivery for conjoined twins without planned separation.**

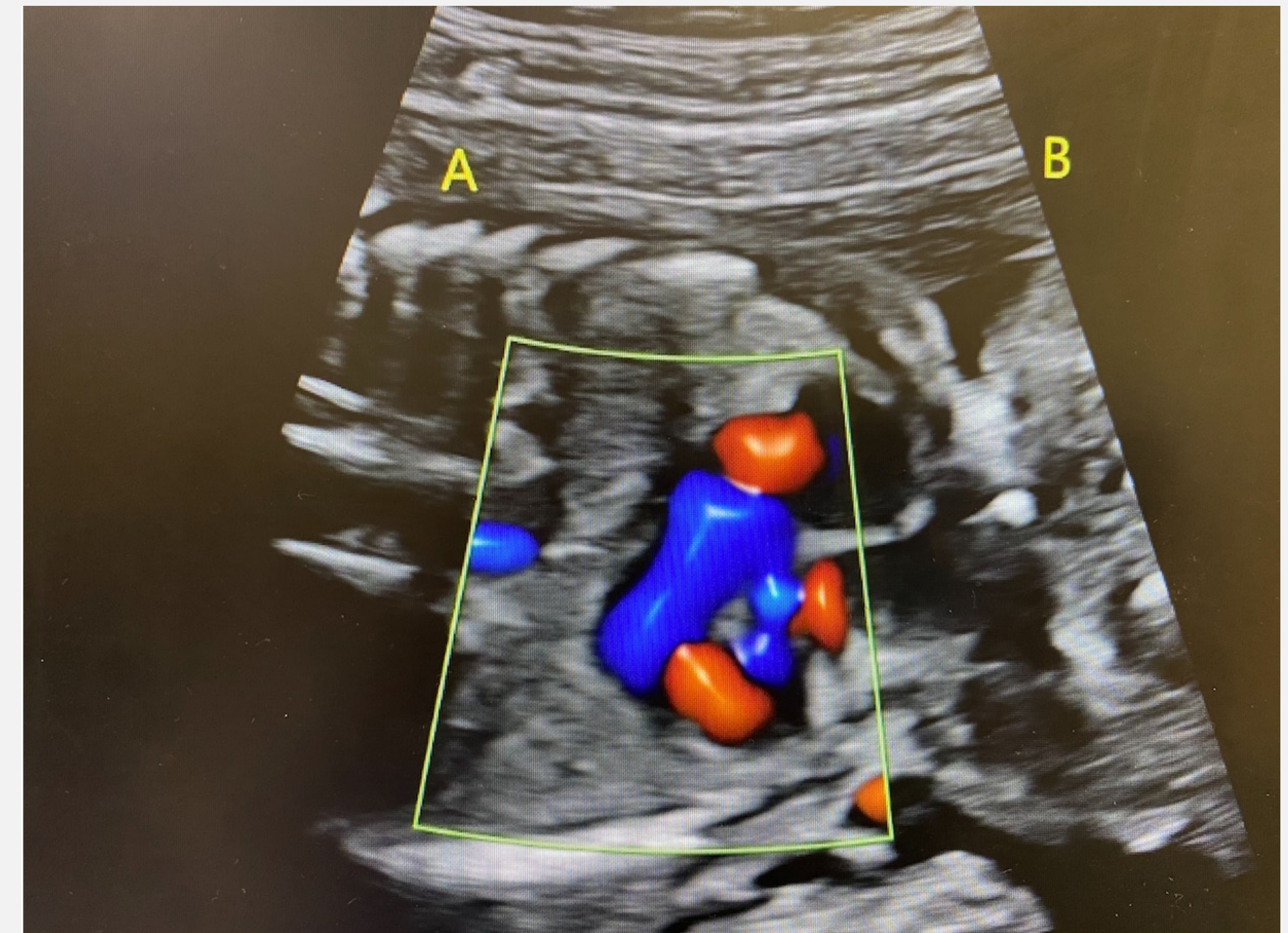


Fig 1. Dicephalic thoraco-omphalopagus conjoined twins

# Clinical Course and Treatment

## Antepartum

- 25F G2P1001 at 32w4d presented for scheduled cesarean delivery of dicephalic thoraco-omphalopagus conjoined twins.
- Dx at 17-week US, shared a single liver and 4 ventricle heart.
- Family and neonatology team planned for comfort measures and to prioritize bonding time between the parents and twins.

## Delivery

- Uncomplicated cesarean delivery was performed under spinal anesthesia.
- APGAR scores were 2 and 6 for Twin A and 6 and 8 for Twin B. Twin A started on PPV from 1.5 to 3 minutes of life. At 3 minutes, both babies on vapotherm 5LMP at 1.0 FiO2.
- Infants were brought to family for immediate bonding. The patient and infants were brought directly to the NICU after the c-section.

## Postpartum

- Post-op, patient required high dose vasopressor support, which was weaned by the OB anesthesia team in the NICU.
- NICU team delivered buccal morphine to both twins when they began to show signs of distress.
- Ultimately, the infants passed away simultaneously at 12 hours of life from cardiac failure.

# Conclusion

- Perinatal management of **conjoined twins** is complex and often **requires multidisciplinary care**.
- Goals for the anticipated neonatal demise include ensuring the family has time and space to spend with family, make memories, and process their loss.
- **Neonatal resuscitation** can play a big role in achieving these goals. Alterations to airway management, placement of monitors, location of venous access and dosing of medications should be **discussed before delivery** as these can vary based on the fetal anatomy.
- The **obstetric anesthesiologist** should be aware of fetal resuscitation limitations and be an **active member in helping the patient through this difficult time**.

- **Recognizing and addressing the family's values and goals as well as their concerns can help improve overall experience.**

## References

1. PMID: 28195364
2. PMID: 26382256
3. PMID: 30201416