Twin Pregnancy

Management

- **Establish chorionicity at initial ultrasound**
- **Dichorionic twin gestations:**
  - Routine prenatal care visits every 3-4 weeks starting at 16 weeks gestation.
  - Ultrasound for growth every 4-6 weeks beginning at 18-20 weeks gestation.
  - Initiate antenatal testing for all twins by 32 weeks or earlier for discordant growth or other conditions (IUGR).
  - Delivery at 38 weeks (no later than 39 weeks) in uncomplicated pregnancies. Individualize delivery plans for complicated pregnancies.
- **Monochorionic twin gestations:**
  - Routine prenatal care every 2 weeks.
  - Ultrasound for growth every 2 weeks beginning at 16 weeks.
  - Watch for signs of twin-twin transfusion syndrome.
  - Refer for targeted ultrasound.
  - Initiate antenatal testing for all twins by 32 weeks or earlier for discordant growth or other conditions (IUGR).
  - Delivery at 36-37 weeks for uncomplicated pregnancies. Individualize delivery plans for complicated pregnancies.

Prenatal Diagnosis

- Markers for aneuploidy screening are approximately twice as high in twin pregnancies as in singleton pregnancies.
- Maternal serum AFP levels > 4.0 MoM should be referred for targeted scan.
- Refer all monochorionic twin gestations for targeted scan.

Recommendations

- Provide nutritional education for 3000 Kcal/day.
- Supplement diet with 60-100 mg/day elemental iron (ferrous sulfate 325 mg/day) and 1 mg/day folic acid.
- Women at risk for delivery between 24 and 34 weeks of gestation should receive one course of antenatal corticosteroids unless a contraindication exists.
- A single repeat course of antenatal corticosteroids should be considered in women with a GA <34 weeks, at risk for PTB within the next 7 days, and whose prior course of antenatal corticosteroids was administered >14 days previously.
- The incidence of preeclampsia is 2.6 times higher in twins than in singletons, thus screen for signs and symptoms each visit and if preeclampsia develops before term, consider transfer to tertiary care center.
- Magnesium sulfate reduces the severity and risk of cerebral palsy in surviving infants if administered when birth is anticipated before 32 weeks of gestation, regardless of fetal number.
- Route of delivery depends on gestational age, EFW, fetal presentation, and obstetric provider's skill in breech deliveries.
- Progesterone is **not** effective in preventing preterm birth twin pregnancies and should not be used.
- Interventions, such as prophylactic cerclage, prophylactic pessary, routine hospitalization, and bedrest have not been proven to decrease neonatal morbidity or mortality and should not be used in women with multifetal gestations.
- There is no role for the prophylactic use of any tocolytic agent in women with multifetal gestations, including the prolonged use of betamimetics for this indication. In the setting of acute preterm labor, a brief course of tocolysis may be considered for up to 48 hours to allow for corticosteroids and transport to a tertiary care facility.

Quality Indicators/Benchmarks
- Delivery at appropriate facility
- ANCS if labor @ <34 weeks

This document should not be construed as dictating an exclusive course of treatment or procedure to be followed.