STAMFORD HEALTH

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When Patience Leads: A Collaborative Approach to Preterm Breech Vaginal Delivery

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Background

• There has been a steady rise in the rate of twin cesarean sections that is multifactorial
  - Provider discomfort with twin vaginal deliveries
  - Fetal malpresentation, specifically of the non-presenting twin
  - Inadequate resources
  - No standardized risk assessment or prediction model tools to assist with decision making
  - Concern for adverse outcomes

Case Presentation

25 y.o. G4P3003 at 32w5d with di-di twins who presented to L&D with vaginal spotting and abdominal cramping.

- Vaginal spotting: negative speculum exam
- Preterm contractions vs preterm labor: contracting q1-2min on TOCO
- Di-di twins: Presenting Twin Vertex, **Non-presenting Twin Breech**

Pregnancy course: FGR twin B, inaccurate dating due to late prenatal care, unknown GDM status, asthma, anxiety, hx lap chole (2016), migraines, hx full-term SVD x3.

Initial evaluation:
- SSE 1/10/floating
- Ctx q1-2min on TOCO
- Cervical funneling and dilation of 1.2cm on TVUS

Hospital Course

Final diagnosis: Preterm Labor, Malpresentation
  - SSE: 1/10/-5 (1535) > 6/80/-3 (1730)
  - Presentation: Presenting Twin Vertex, **Non-presenting Twin Breech**

Counseling: by MFM attending and Laborists
  - Betamethasone, MgSO4, nifedipine, ampicillin, and alternatives to vaginal delivery of both twins

Hospital course
  - Betamethasone complete 11/1
  - S/p nifedipine 10mg x1 for tocolysis
  - MgSO4 x6hrs
  - Quickly progressed to full dilation on HD#3 at 0741

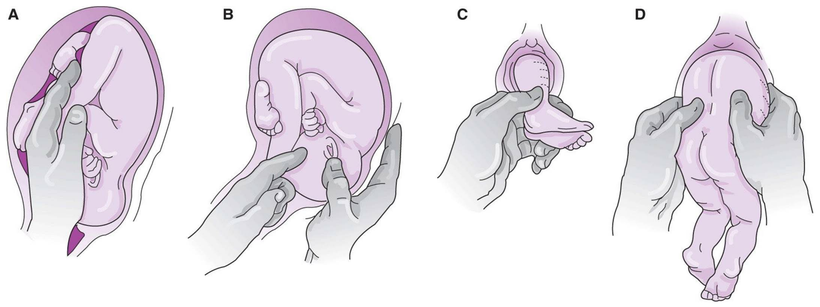
•Delivery
  - Presenting twin delivered cephalic
  - Second twin now oblique to mat right, rotated to breech position, and delivered via breech extraction

•Outcomes

•Newborn outcomes: Twin A + B: s/p NIPPV for RDS, weaned to CPAP and then to RA on DOL #1, LOS: 19 days. **Twin B** referred to hip USN to screen for Congenital Hip Dysplasia.

•Maternal outcomes: discharged on PPD#1

Images



Images

Internal Podalic Version
1. Place one had opposite to fetal back
2. Opposite hand on maternal abdomen
3. Elevate fetal head into the cavity then reach for fetal foot
4. Elevate vertex, pull feet caudad to complete breech
5. Proceed with breech extraction

Conclusion

- Twin breech vaginal deliveries is dependent on several factors
  - Research has shown that there is no excessive morbidity or mortality associated with planned vaginal delivery of a non-vertex second twin
- Fetal presentation and clinician comfortability with extraction must be considered
  - Simulation trainings for twin vaginal deliveries should be incorporated into residency training
- Active patient participation in shared-decision making process can significantly improve patient satisfaction in their birthing experience

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