Twins and Their Complications During Labour *

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A clinical impression of a high proportion of difficulties in twin labours led to a review of the case records of the Blantyre Mission Hospital for the years 1949-55. Of 5,206 pregnancies terminating in hospital, or up to 28 days before the patients with their babies were admitted to hospital, there were 167 sets of twins and four sets of triplets, giving an incidence of 1 in 31 pregnancies for twins and 1 in 1,301 for triplets for patients coming to hospital.

Foetal and Maternal Loss

There were two maternal deaths among the women with twin pregnancies, one after a caesarean section (a three-day labour) and one after haemorrhage and internal version. This is a loss of 11.7 per 1,000 for multiple pregnancies. During that time there were 75 maternal deaths among the 5,035 single pregnancies, or 14.9 per 1,000.

Three hundred and twenty (6.3 per cent.) of the 5,035 single pregnancies ended in abortion. Of the 171 multiple pregnancies, there were eight abortions of twins and one of triplets (5.3 per cent.).

Of the 4,715 viable single babies, 566 were stillborn or died in the neonatal period—a loss of 12 per cent. (Admissions included 177 premature babies, 613 abnormal labours and 318 sick infants under four weeks old, which helps to explain the large number of deaths.)

Before the mothers were discharged, six of the triplet babies had died and the remaining three were all premature and had only a slight chance of survival, but the mothers insisted on going. Of the 159 sets of viable twins, 195

* Based on a talk given to the Nyasaland Branch of the British Medical Association, 1956.

babies were alive when the mothers were discharged. 123 had been stillborn or died, being a loss of 38.7 per cent.

Presentations

The presentations are known in only 87 of the patients. These are set out below, with the corresponding figures given by De Lee (*Principles and Practice of Obstetrics*, ninth edition). It is unlikely that there were any transverse lies in the unrecorded cases, as they were all spontaneous deliveries in hospital or village.

Table I

Presentations in 87 Patients

Present Series		De Lee
Vertex-vertex . . .	32 cases (36.8%)	38.7%
Vertex-breech . . .	33 „ (37.9%)	40.0%
Breech-breech . . .	11 „ (12.6%)	9.0%
Vertex-transverse .	8 „ (9.2%)	6.1%
Breech-transverse .	3 „ (3.4%)	5.8%
Both transverse . .		0.3%
	87	

Complications

Of the 4,715 confinements of single babies, 613 (13 per cent.) were abnormal (excluding spontaneous delivery in premature labours). Forty (25 per cent.) of the 159 women with twin confinements required assistance. In all three women the triplets were spontaneous deliveries. Of all these twin confinements, only four women had a post-partum haemorrhage. The incidence of placenta praevia among the multiple pregnancies was 4 in 162, or 1 in 40, but during the years 1951-55 the general incidence of placenta praevia was 26 cases in 3,844 pregnancies, or 1 in 148. De Lee (*op. cit.*) gives the Chicago figures as 1 in 140 for all confinements.

The following were the different conditions and measures adopted:

	Cases
1. Internal version—	
For transverse lie	11
For extraction of child	2
2. Breech extraction	4
3. Compound presentation, requiring replacement of limb	5
4. Prolapse of cord replaced	1
5. Acute hydramnios	2
6. Ante-partum haemorrhage	1
7. Retained placenta	1
8. Willett's forceps to scalp	1
9. Forceps delivery	1
10. Locked twins	1
11. Ruptured uterus	1
12. Caesarean section	9

Some Case Histories

1. *Internal Versions*

(a) A multipara whose first child was delivered spontaneously at a village maternity centre had a haemorrhage and was sent next day to hospital. The patient was anaemic on admission and a second large child was lying transversely. An internal version was done and the placenta removed manually because of a post-partum haemorrhage. The usual treatment was carried out, but the patient died soon after delivery. The internal version was done quickly, as it was feared the uterus might rupture, but it might have been better to delay until the effects of the first haemorrhage had been longer treated. On the other hand, the patient would probably not have survived a ruptured uterus.

(b) The first child was lying transversely, and after decapitation the body was removed; the second child was delivered alive as a breech presentation and the head of the first then removed.

(c) The first child had been delivered spontaneously at a maternity centre. The mother later collapsed and was sent to hospital. On admission, no foetal heart was audible and the placenta was felt at the edge of the dilated cervix. General treatment for shock was given, the membranes ruptured and a binder applied. Once the patient had recovered from the shock an internal version was done and the child extracted as a breech.

(d) The first child was lying transversely; when the cervix was three fingers dilated an internal version was done and a foot brought down and labour allowed to proceed. Later two live children were delivered as breech presentations.

2. *Breech Extraction*

The first child was a vertex and delivered normally. After a delay of two days the second was extracted as a breech presentation. This patient had a slight post-partum haemorrhage.

3. *Compound Presentation*

The membranes of child (a) having ruptured early in labour, its hand presented at the vulva, but the head of child (b) whose membranes were intact was at the brim of the pelvis. The hand was replaced in the uterus; the membranes of child (b) were ruptured to encourage its head to descend into the pelvis. The cervix was not then fully dilated. Labour then proceeded without difficulty, and later two live children were born spontaneously as vertex presentations.

4. *Prolapsed Cord*

A pack was inserted to try to keep the cord back after replacement, but later two premature children were delivered—both were stillborn.

5. *Acute Hydramnios*

Two patients each with a pregnancy of seven months were seen. Both had histories of sudden enlargement of the uterus within one day, causing much maternal distress. Both had extremely large, tense uteri. In one case we ruptured the membranes to relieve the mother, and very premature twins were delivered, both stillborn. The other woman went into labour spontaneously, and in her case, too, premature stillborn twins were delivered. In retrospect, one wonders whether a paracentesis uteri might have decreased the size of the uterus sufficiently to relieve the distress and prevent premature labour in both cases, but it is not without danger and may of itself cause the onset of labour.

6. *Antepartum Haemorrhage*

The membranes were ruptured artificially and the babies born spontaneously later. The patient then had a post-partum haemorrhage after delivery of the placenta, which had apparently been a low implantation, though it had not been palpable per vaginam.

7. *Willett's Forceps*

The patient was a para 11 whose first child was born on 15th January. By the evening of the 16th there was no progress with the second, so its membranes were ruptured. On the 17th, as there was still no progress, Willett's forceps were applied to the scalp and a 2 lb. weight attached. The baby was born alive a few hours later.

8. *Forceps Delivery*

The first child was born in the village, after which the mother walked to hospital! The second child required forceps delivery and the patient had a post-partum haemorrhage.

9. *Locked Twins*

A small primigravida presented with a large uterus, having been some time in labour. On examination (per vaginam), the leg and cord of one child and the head of the other were all found in the vagina. Both bags of membranes had already ruptured. The leg was replaced in the uterus and forceps applied to the head of the second child, which was delivered and, to our surprise, was alive. The second was then extracted as a breech. It had been dead some time, presumably from pressure on the cord. The cervix was sloughing, but there was no post-partum haemorrhage and the patient did well.

10. *Ruptured Uterus*

The patient was a para 1 whose first labour had been normal. She delivered the first of the twins in the village. It was stillborn. On admission to hospital the cervix was very oedematous. She rested for a day, then the second child's head began to come down into the vagina, and as contractions began again she pushed well, but without much progress. Her condition became poor and a ruptured uterus was found. Operation was done at once and the patient made good progress. No cause for the failure of delivery was found. One wonders how much Native medicine she had had in the village; the oedematous cervix indicated pushing in the first stage, and rupture of the uterus is not common in a second pregnancy.

11. *Caesarean Sections*

De Lee gives 18 reasons for doing a section, but twins is not one of them. The reason for the non-descent into the pelvis is often not obvious, but the twins apparently interfere with one another's position and the head does not engage.

(1) Three sections were done because of placenta praevia: one a central implantation in which both children were alive, and two partial placenta praevia in primigravida where all the babies were premature and stillborn.

(2) A primigravida who had had a three-day labour without progress was sectioned, but died shortly after the operation.

(3) A small, thin primigravida had a slow labour of three days, and finally at full dilatation of the cervix the head remained very high. On section, the presenting child was found to be an occipito posterior and the second was a breech—both alive.

(4) A para 1 whose first child had been a stillbirth after a three-day labour presented in this labour after

one day. On examination, two bags of membranes were found in the vagina and one head was high at the pelvic brim. No descent took place. At operation, both babies were vertex presentations, both alive.

(5) In a very similar case to the above the presenting vertex did not descend into the pelvis. Again there were two vertex presentations.

(6) In a primigravida the first child was a breech presentation which did not descend. This child was alive on section, but the other was a macerated foetus for some unknown cause.

(7) This was an unusual case, in that the section was done for the second child. The first child had been a breech with a prolapsed cord and was delivered spontaneously after a one-day labour. The patient was then tired and no uterine contractions were felt. She was given Pethidine and rested well, and in the evening the cervix began to dilate again and contractions began strongly, but in spite of these the head made no attempt to engage. The lower uterine segment began to distend, and therefore, to forestall rupture of the uterus, section was done and a live child delivered. Its head showed no signs at all of moulding, though why this should be, and why there had been no descent, was not obvious.

Conclusion

It would seem from these figures, and from other reports of multiple births, that if there are more than two babies the deliveries are usually spontaneous, but that twin births require interference twice as often as single ones. The maternal mortality is not increased if there is hospital treatment, but many of the women whose histories are given above would have died in the village. The rare occurrence of post-partum haemorrhage in African women is further exemplified in this series of twins in which only four women are reported to have had excessive loss. The foetal mortality is high, and by the end of the neonatal period would probably be higher, as many of the twin babies were small.

I have unfortunately no figures about the familial incidence of twins, nor of the relative frequency of binovular and monovular twins.

There does not seem to be any prejudice against twins in southern Nyasaland, where the tribes are matrilineal. The mothers do their best for the babies, but we have the impression that if one baby is much weaker than the other there is not much effort made to save it. This may be a false impression and the loss due purely to ignorance of how to care for a small weak baby. There is rarely any difficulty for the mother in breast-feeding both babies and there is always available a young member of the extended family—a sister, cousin or niece—to carry the second baby and help care for it.