"Whispers of a Lost Wombmate"

DR. TASNIM ISRAT JAHAN
DGO TRAINEE, BATCH 04
AD-DIN WOMEN'S MEDICAL COLLEGE & HOSPITAL

Case History

Mrs Tithi Rani Das, 23 years old, primi, housewife of low socio-economic family hailing from Chandpur got herself admitted in this hospital on 24-Oct-25 with the complaints of:

- **Pregnant for 32 weeks 2 days**
- **Known case of twin pregnancy (Dichorionic – Diamniotic) with single fetal demise**
- **Known case of GDM (Controlled on insulin)**

Continued……

According to patient's statement, she was a regularly menstruating women with average flow & duration. She was trying for spontaneous conception for only 2 months but failed to conceive & took ovulation inducing oral drug for one cycle following which she became pregnant. Her LMP was on 10-Mar-25. So accordingly her EDD will be on 17-Dec-25.

Continued……

She was on regular Antenatal check-up in Chandpur. She had exaggerated symptoms of pg in earlier weeks. She did her first USG at 13 weeks when twin pregnancy (Dichorionic-Diamniotic variety) was diagnosed.

Continued……

She was duly immunized against tetanus toxoid. Her pg was uneventful till 16 weeks following then she was diagnosed as GDM after doing OGTT (FBS 8.11 mmol/L, 2HABF 11.28 mmol/L). At first she was advised for medical nutritional therapy but due to unsatisfactory improvement, she was switched to insulin.

Continued……

Then on her 30 weeks of pg, she suddenly complaints of less fetal movement & due to this she did a USG in which one single fetal demise was found. Then she was referred to a tertiary level hospital and got herself admitted to our hospital for further management.

Regarding her Obstetrical History

Married for 1 year

Para:

0 + 0

Gravida:

Primi

Regarding her Menstrual History

- Age of menarche : 13 years
- Menstrual cycle was regular and flow was average.
- LMP : 10 March, 2025
- EDD : 17 December, 2025
- Couple used no contraceptive method

Continued……..

She was normotensive & gave no history of any other medical or surgical disorder.

Family History

She has family history of DM (her father was diabetic) but no family history of twin pg.

Continued……..

With due consent & by maintaining adequate privacy we examined the pt at 27.10.25 & found her-

Anxious but Co operative

Anemia	Not Found
Jaundice	
BMI	26
Edema	Mild

Continued……..

Vitals

BP : 110/80 mmHg

Pulse : 80 b/min

Temperature: Normal

Resp. Rate: 16 breath /min

Continued……..

Breast: Normal pregnancy change

Heart: Normal

Lung: Normal

Thyroid gland: Not enlarged

Per Abdominal Examination

Inspection

Abdomen was enlarged with
linea nigra & stria-graviderum

Height of uterus is 32 cm

Continued……..

Palpation

There are more fetal poles

Too many fetal parts are palpable

Liquor was normal

Her symphysio Fundal Height is 32 cm

Continued……..

Auscultation

One fetal Heart sound was present.
Fetal heart rate was 144 b/min which was at regular rate & rhythm.

Per vaginal examination

Not Done

Diagnosis

So, from history & clinical examination my diagnosis was –

Primi gravida 32 weeks 5 days of twin pregnancy (D/D variety) following OID with single fetal demise with GDM (on insulin)

Investigations

CBC

Test	Result
Hb	11.4gm/dL
TC WBC	11.23 x 10^3/UL
Neutrophil	71.5%
Lymphocyte	20.9%
Monocyte	5.6%
Eosinophil	1.9%
Basophil	0.1%
RBC	3.31M/UL
HCT	43.1%
ESR	79 mm in 1st hour
Platelet	350 x 10^3/UL
CRP	4.7mg/L

Others

Blood grouping & Rh typing	B Positive
HBsAg	Negative
VDRL	Negative
FBS	8.11 mmol/L
2HABF	11.28 mmol/L
HbA_1C	6.3%

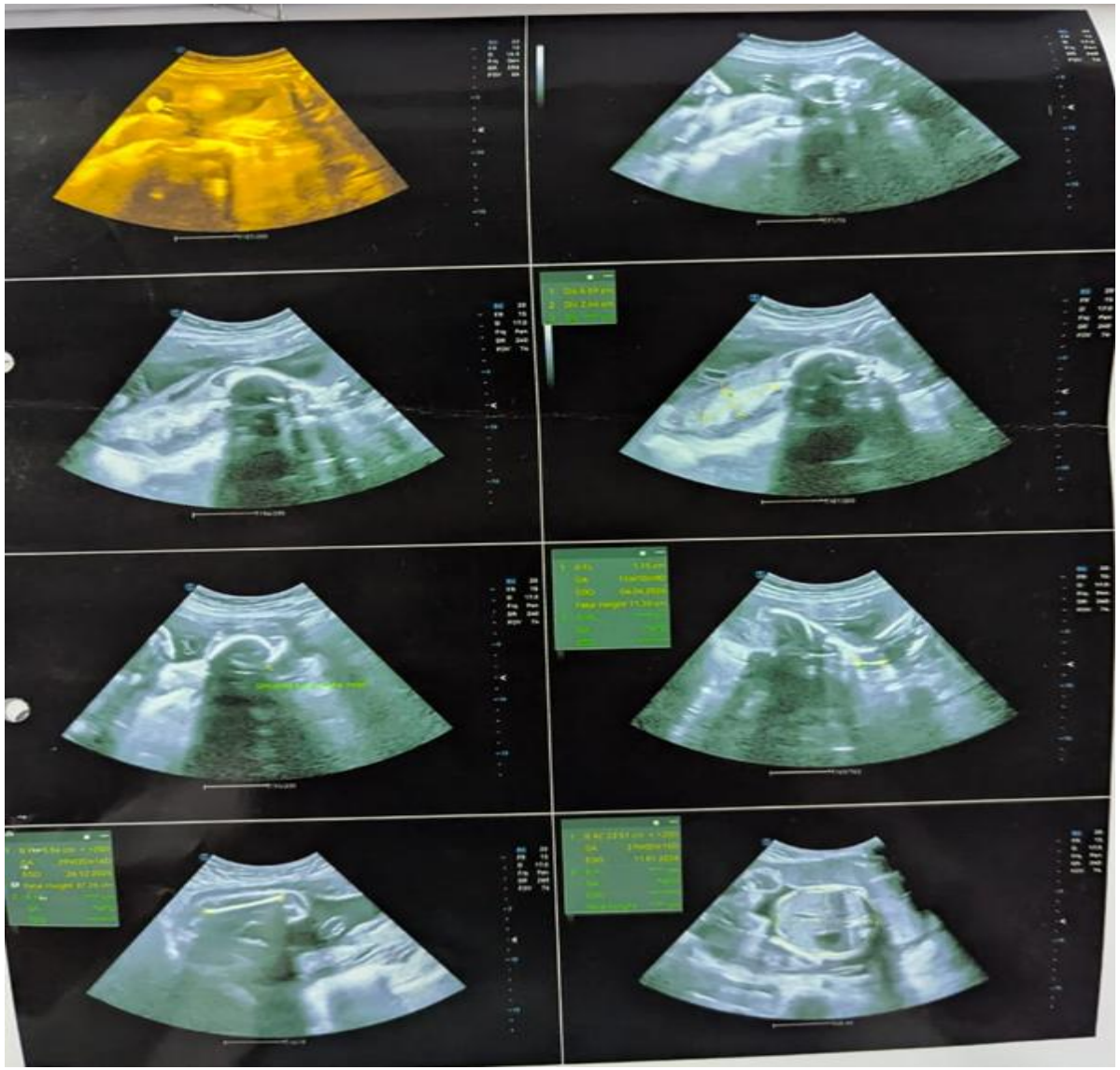
Others

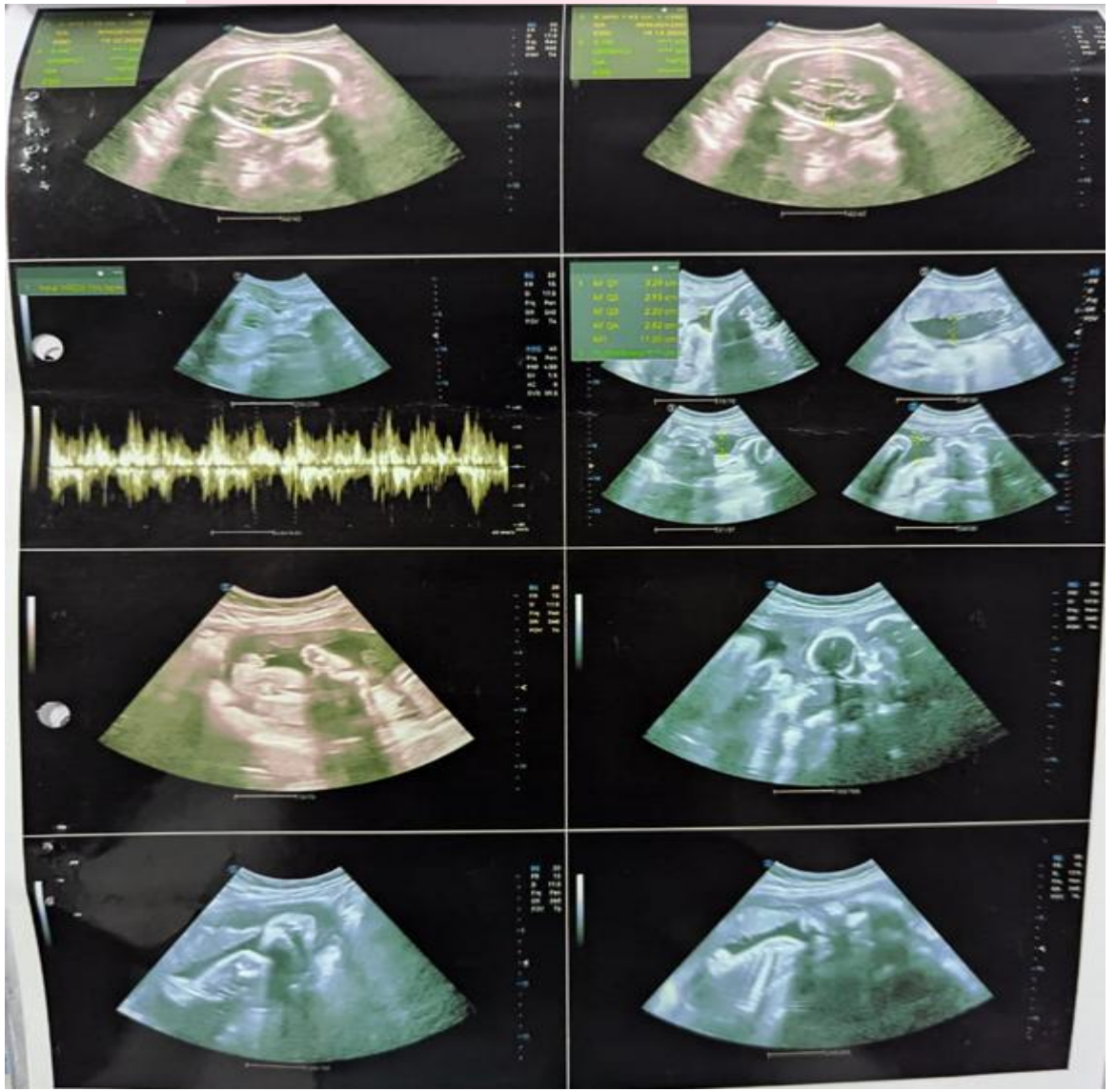
S. Creatinine	0.5 mg/dl
S. TSH	1.73 miu/ ml
FT4	14.91 pg/ ml
Urine R/E	
Pus Cell	4-6/ HPF
Epithelial Cell	8-10/ HPF

Others

	14.10.25	24.10.25	27.10.25	31.10.25
FDP	< 200 ng/ml	400 ng/ml	400 ng/ml	800 ng/ml
PT with INR		Normal	Normal	Normal
D dimer			7.42 mg/L	8.78 mg/L

USG (15 weeks – 26.06.25 || Dichorionic-Diamniotic Variety)





USG (15 weeks – 26.06.25 || Dichorionic-Diamniotic Variety)

Fetus 1

FHR: 162 bpm

BPD: 2.92 cm

EFW: 108 gm

Fetus 2

FHR: 159 bpm

BPD: 2.86 cm

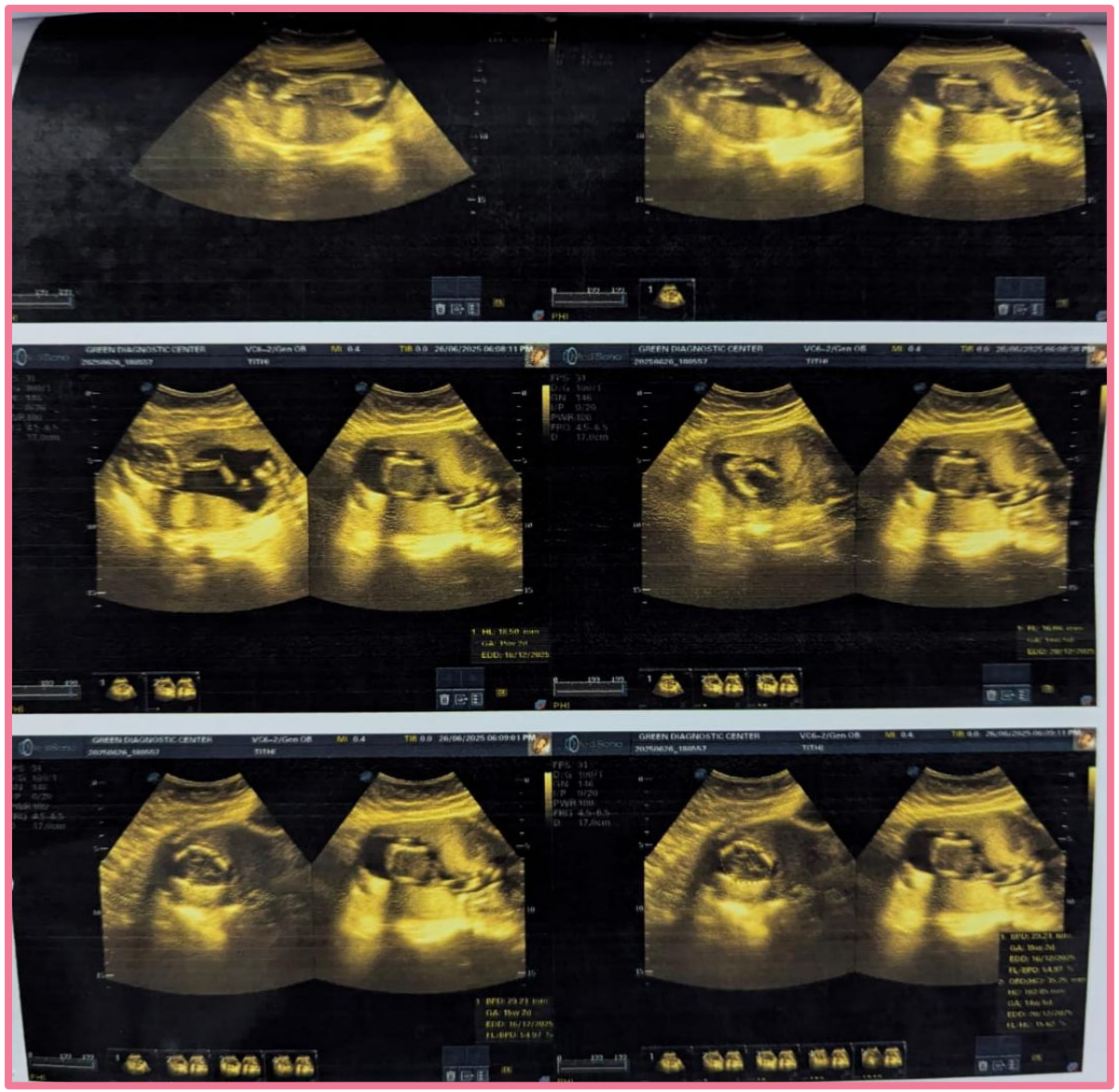
EFW: 109 gm

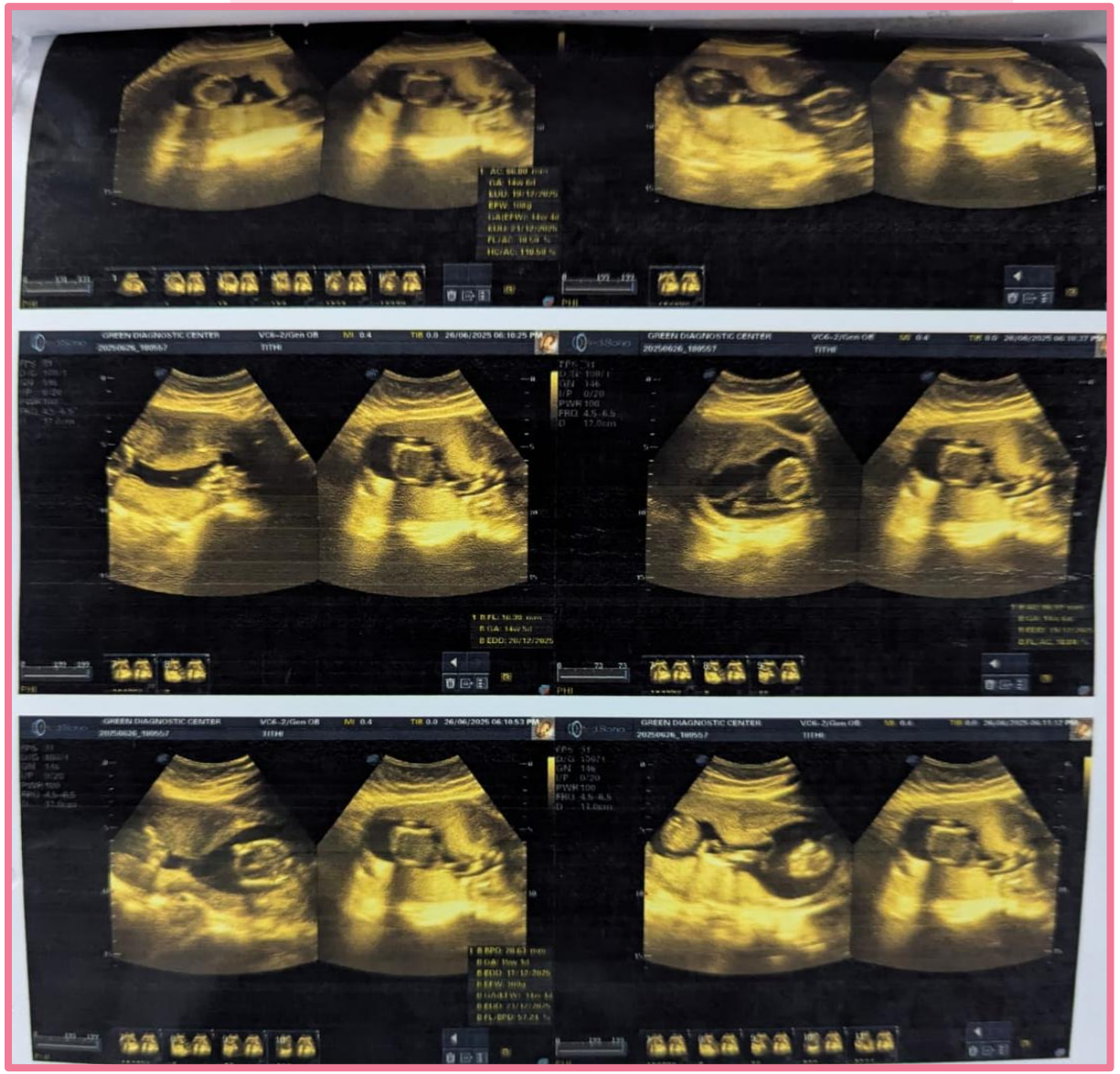
Both unstable lie

Placenta: Anterior, posterior away from OS

Amniotic fluid: Adequate

USG (30 weeks || 12.10.25)



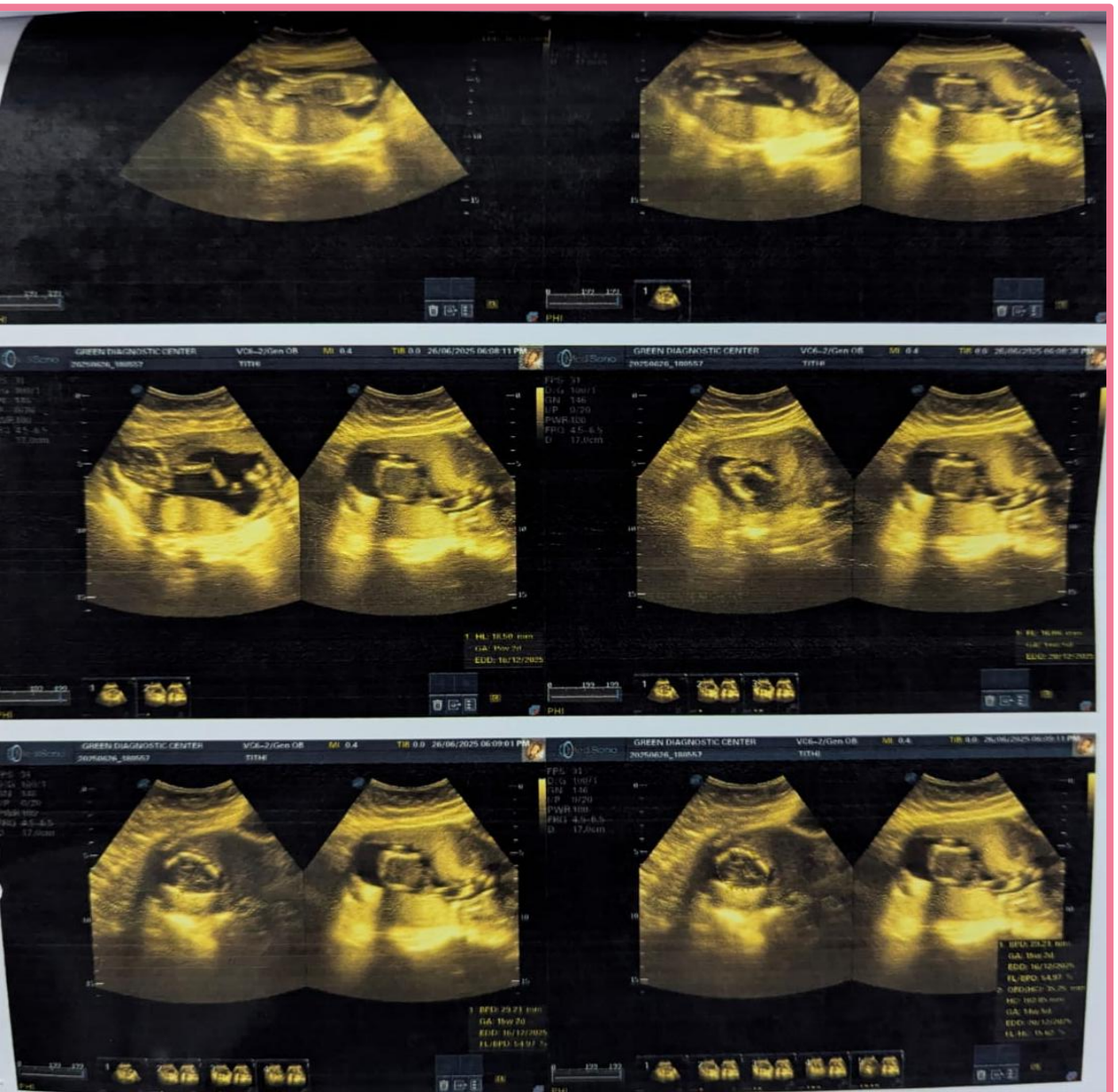


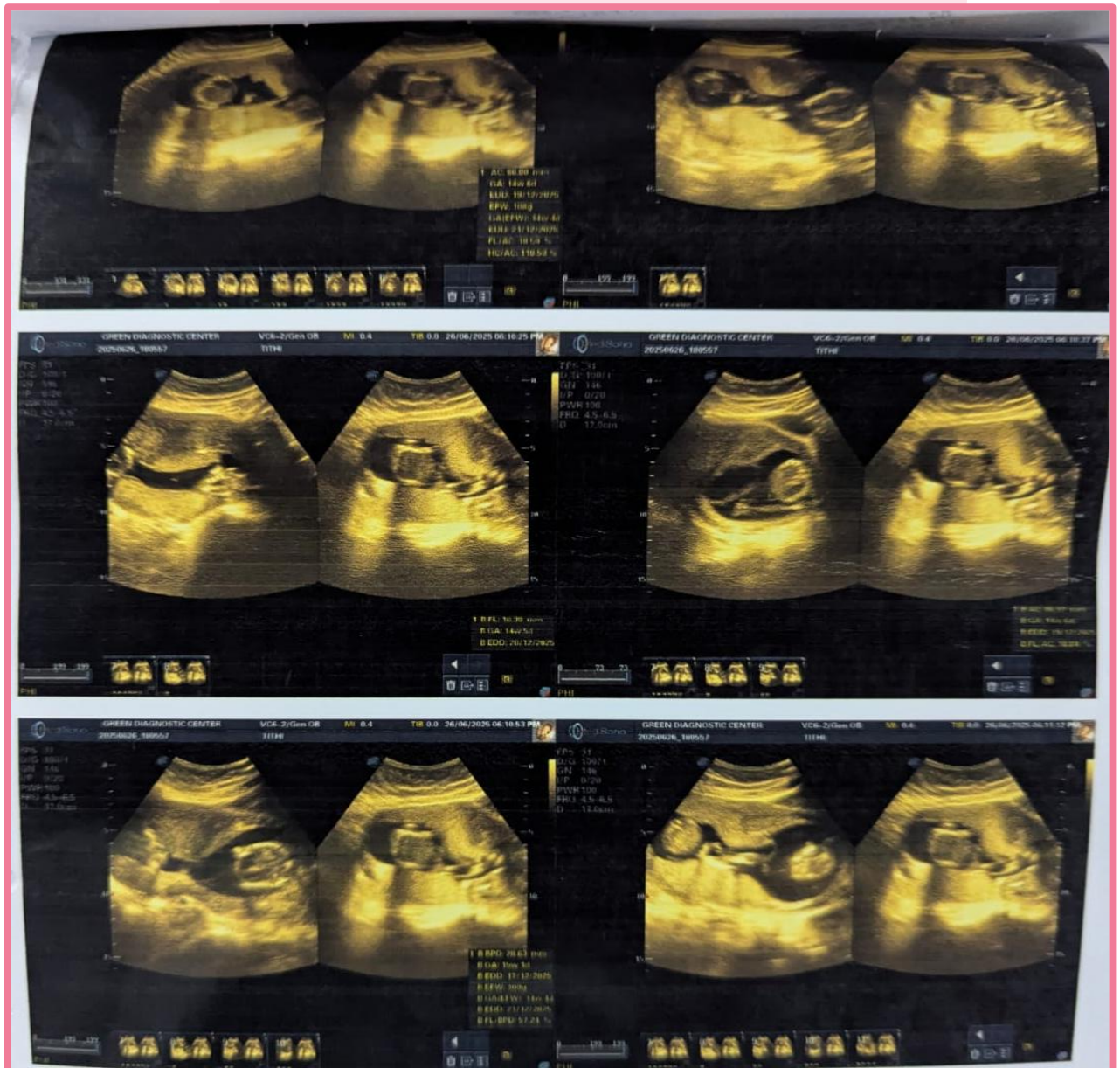
USG (30 weeks || 12.10.25)

Fetus 1

- Mixed echogenic coiled structure in one corner of uterus (5.8 * 2.5 cm)
- Dead coiled fetus
- Spalding sign positive
- Roberts sign positive
- Placenta: Posterior
- Scanty amniotic fluid

USG (30 weeks || 12.10.25)



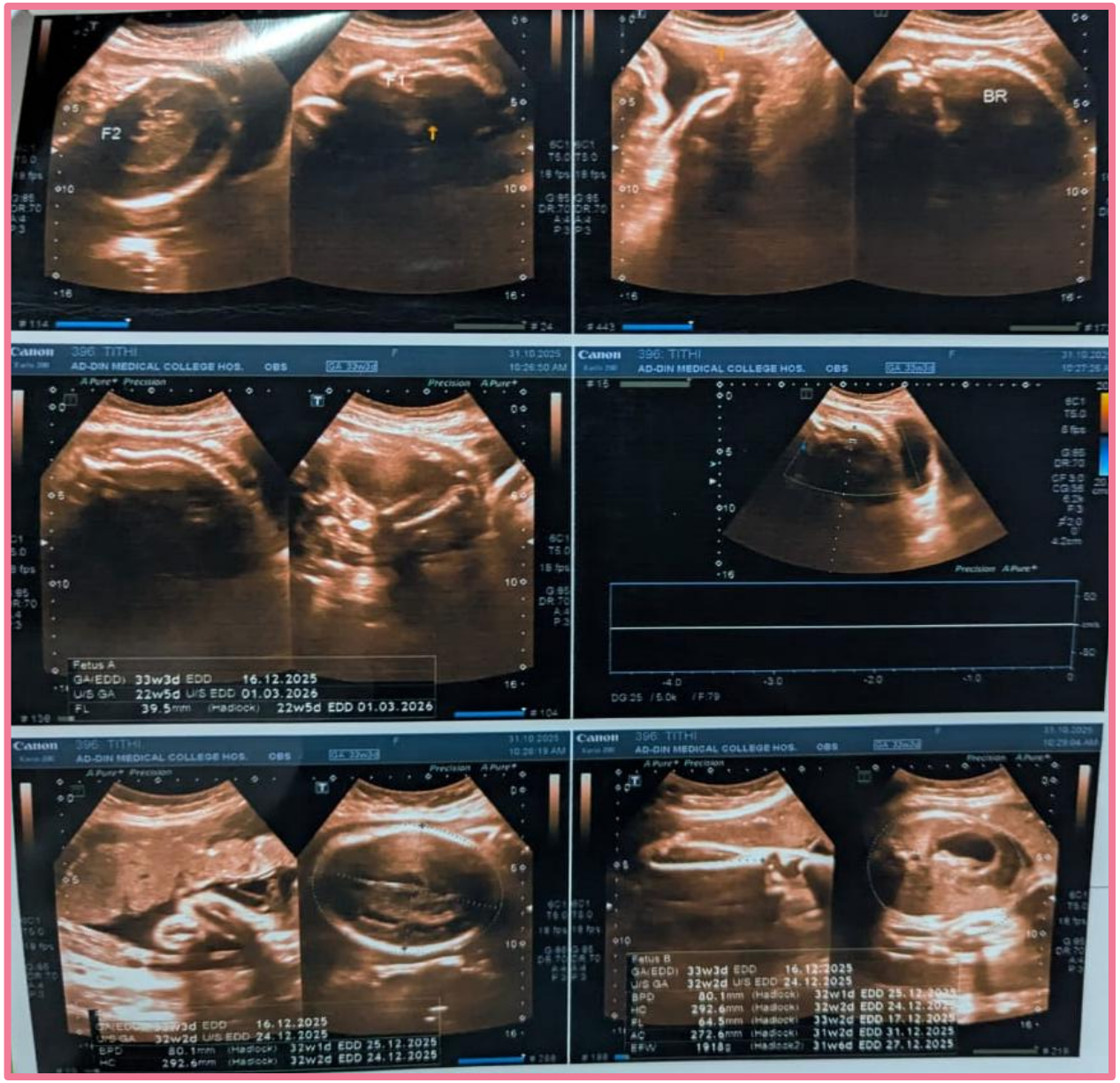


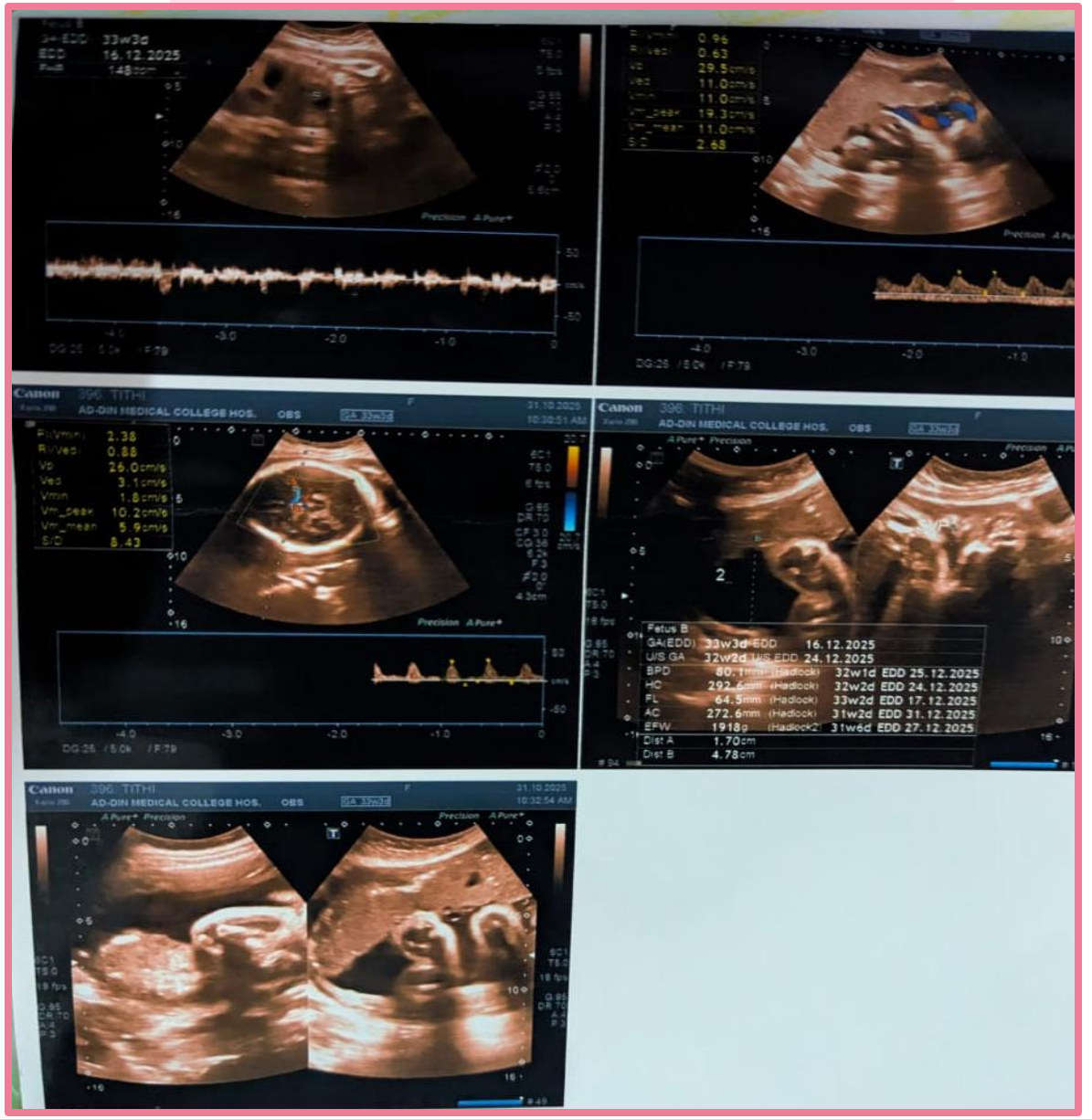
USG (30 weeks || 12.10.25)

Fetus 2

FHR: 154 bpm
BPD: 7.50 cm
EFW: 1203 gm
Placenta: Anterior away from OS
AFI: 11.2 cm
Presentation: Cephalic

USG (33 weeks || 31.10.25)





USG (33 weeks || 31.10.25)

Fetus 1

Presentation: Breech
AFI: Single Vertical Pocket – 1.7 cm
Spalding Sign: Positive
Placenta: Posterior

Fetus 2

FHR: 148 bpm
BPD: 8.00 cm
EFW: 1918 gm
Placenta: Anterior away from OS
AFI: Single vertical pocket 4.7 cm
Presentation: Cephalic

Management

Management

General Mx

- **Diet:** Diabetic
- **Inj Diasulin R, Inj Diasulin N** was given with proper dose.
- **Tab Carva, Tab Microgest** etc. were given to continue the remaining pg.

Continued……

Obstetric Mx

We keep the pt on follow up with coagulation profile and when FDP & D-dimer started to rise , due to risk of coagulopathy decision of emergency LUCS was taken at 1.11.2025.

Then at 8.30 pm, 1.11.25, 2 baby was delivered at her 33 weeks 3 days of pg (F1 by breech extraction, F2 by vertex presentation)

Neonatal Outcome

- 1st Baby: Dead macerated
- 2nd Baby:
  - Sex - Female
  - Weight - 1.6 kg
  - Apgar score – At 1st minute: 6/10
    At 5 minutes: 6/10

Emergency newborn care was given & after that baby was sent to NICU due to prematurity and IUGR. No apparent congenital anomaly was seen.

Maternal outcome

- After delivery, patient shifted to post natal ward.
- All the vitals were normal
- Uterus well contracted
- Blood sugar profile was maintained & it was under control without insulin
- Per vaginal examination- Bleeding was average

Discharge

Mother was discharged on 4th November, 2025 with advice to take post natal care in our postnatal clinic but baby was in NICU.The baby was also discharged at a healthy state from NICU at 10th November, 2025.

Single Fetal Demise in Multiple Pregnancy

When more than one fetus simultaneously develops in the uterus, it is called multiple pregnancy.

And single fetal demise refers to the death of one fetus in a multiple pregnancy which is relatively rare but a serious complication.

Single fetal loss of a twin pg during the first trimester is not an uncommon event and seems not to impair the further development of the survival one. The situation is described as the **“Vanishing twin syndrome”**

In contrast, the death of a twin in the late second or third trimester of pg is a rare obstetric complication associated with increased maternal and fetal mortality & morbidity.

Apart from important psychological stress to both parents & attending obstetrician, this condition is highly associated with preterm labour, pre-eclampsia, IUGR, neurological complications or even the death of the surviving twin, as well as maternal DIC.

In case of pregnancy continuation, the dead fetus will progressively transform into "**Fetus papyraceous**" due to the absorption of the soft tissues, placental & amniotic fluids. The dead fetus will be found compressed between the amniotic sac of the survival twin & the uterine wall.

In contrast, if the single fetal death occurs at 32 weeks of gestation or above, the other twin will have better chances of survival.

Causes

May be spontaneous or iatrogenic

1. **Twin-twin transfusion syndrome**
2. **Placental insufficiency**
3. **Placental abruption**
4. **IUGR related to PE**
5. **Discordant growth**
6. **Congenital abnormalities**

7. **Vilamentous insertion of cord**

8. **Cord stricture or true knot, cord around the neck**

9. **Blunt abdominal injury**

10. **Twin reversed arterial perfusion**

11. **Intra uterine infection**

12. **Chorioamnionitis**

Incidence

	Monochorionic	Dichorionic
Intrauterine Single Fetal Demise	50% – 70%	20% – 30%
Mortality & Morbidity of Surviving Twin	3 – 4 Times Greater	Less
Co-twin Death	12%	4%

Risks

The severity of complication following death of a twin is dependent on the chronicity, gestational age & length of time from death to delivery of surviving twin.

Risk to Mother

- Preterm labour
- Pre eclampsia
- Polyhydramnios
- DIC

Most important among them is **DIC**. In rare cases, the release of fibrin & tissue thromboplastin from the dead fetus in the maternal circulation will activate the extrinsic coagulation pathway & subsequently induce DIC.

It occurs in about 3-5 weeks following fetal demise. Therefore, an initial maternal clotting profile with reassessment in 2-3 weeks is recommended.

Risk to Fetus

A wide range of structural abnormalities in the surviving twin such as:

1. **Neural tube defects**
2. **Optic nerve hypoplasia**
3. **Hypoxic ischemic lesions of white matter (multicyclic encephalomalacia)**
4. **Microcephaly**

Risk to Fetus

5. **Hydranencephaly**
6. **Procencephaly**
7. **Hemorrhagic lesions of white matter**
8. **Post Hemorrhagic hydrocephalus**
9. **Bilateral renal cortical necrosis**

Management

Management

After diagnosing single fetal death in multiple pg, it should be referred & assessed in a fetal medicine center with multi disciplinary expertise to manage this cases. In this team, there should be:

- Obstetricians
- Neonatologist
- Hematologist
- Psychologist

Management

Then fetal MRI of brain may be performed 4 weeks after co-twin's demise to detect neurological morbidities.

Frequent antenatal visits & intensive fetal monitoring is mandatory as it is a high risk pregnancy & includes

- Frequent non stress testing
- Biophysical profiling
- Serial USG scan & UA doppler velocimetry

Management

- Coagulation profile or other maternal medical conditions should be carefully evaluated
- Fibrinogen & FDP
- Steroid administration for lung maturation

Management

In most cases → labour will develop spontaneously within the next weeks

90% cases → deliver within 3 weeks after fetal death

Management

Despite the fact that single fetal death in twin pg alone is not an indication for LUCS.

There are a lot of additional factors that need to be considered in order to recommend the safest way of delivery for both the mother at surviving fetus.

Management

Thus, gestational age, presentation, biological condition of surviving twin, location of dead fetus in the uterine cavity that can obstruct the birth canal.

Other obstetrical conditions such as placenta previa, abruptio placenta, coagulation profile, pelvic adequacy, cervical ripening or other maternal medical conditions should be carefully evaluated.

Management

If the live twin is leading & is in cephalic presentation, vaginal delivery may be considered.

If the live twin is mal presenting or is growth restricted or if the dead twin is leading, LUCS is preferred.

Post Partum Care

- Following delivery, the placenta should be sent for histopathology.
- The dead fetus should be sent for postmortem.
- The newborn has to be followed through its neonatal period.

Questions…?

THANK YOU!