

Case Report

A Case Report of Dicephalus Parapagus Conjoint Twins: Declined Caesarean Section for Obstructed Labour; Fetal Death in Utero and Successful Vaginal Delivery

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Conjoint Twins

Conjoint twins result from monozygotic twins incompletely separated and born physically connected, and this occurs when an early embryo only partially separate to form two developing foetuses.

The Types of conjoint twin depends on when and where non-separation occurred. They are called Thoracopagus if non-separation occurred at the chest; Omphalopagus if it occurred in the abdomen, Pyopagus if it occurred at the base of the spine: Rachipagus if it occurred at the whole length of the spine; Ischiopagus if it occurred at the pelvis; Parapagus if it occurred at the spine and Craniopagus if it occurred at the head [1]. Conjoint twins are rare, occurring in 1: 50,000-60,000 births and approximately 70 percent are females and mostly born stillbirths.

Case Report

We present a case of Dicephalus parapagus; conjoint twins with two separate heads. PA, is a 27 years old gravida 3, para 1+1 admitted in labour at a village health center after several hours of labour in a traditional birth attendant's home. She is a housewife, moslem, educated to first school leaving certificate and she registered late for ante natal care with an unknown LMP as she couldn't remember her last menstrual period nor could she afford a booking ultra-sound scan, so her gestational age was unknown.

On examination, her fundal height was term size; multiple fetal parts were felt and the babies were in cephalic presentation but no fetal heart activity was heard. Vaginal examination revealed a fully dilated cervix and the presenting part of the baby was at the pelvic spines without moulding but the obstruction was at the level of the pelvic brim, due to the second fetal head.

She was resuscitated with intravenous fluid. Blood investigations were arranged including group and save serum and she was prepared

for an emergency caesarean section. She declined the operation of emergency caesarean section in spite of detailed explanation and persuasion involving the elderly relatives invited to speak with her including counselling from ourselves. She was weepy and said she will not have an 'operation' for a baby no longer alive.

It was concluded by the staffs to assist her as much as possible in her decision. A telephone consultation was made with an experienced Obstetrician who was able to guide the staffs to achieve a vaginal delivery without traumatic injury to her genital tract.

The Manouvre to Deliver the Dicephalus Parapagus Conjoint Twins

She was placed in the lithotomy position and the bladder was emptied. The Pelvic examination was repeated. The presenting head was in occipito-anterior position in a roomy pelvis. There was no caput or moulding and as the parturient was contracting about 3: 10 with involuntary pushing, the fetal head was becoming visible but disappears after every uterine contraction and bearing down. It was also observed that the second twin head descended simultaneously with the head of twin one, so conjoint twins or interlocking twins were suspected.

At the following contractions, she was asked to bear down with uterine activity. When the presenting head was in +2 position, an assistant was requested to put pressure on the second head in a downward and forward direction.

On the third attempt, the second head slipped into the pelvic cavity and the head of twin 1 crowned and it was delivered from a meconium-stained liquor after a medio-lateral episiotomy. The diagnosis of a conjoint twin was confirmed. It was a fresh stillbirth. The cord was clamped and the placenta delivered by controlled cord traction.



Figure 1: Vernix Caseosa.

The blood loss was minimal with prompt suturing of the episiotomy. The lower genital tract was examined and found to be intact. The urine was clear of blood.

The twin had two heads joined at the neck, one trunk, two upper limbs one on either side and two lower limbs with meconium staining of the vernix caseosa covering her skin Figure 1.

Discussions

Dicephalus parapagus is a rare form of conjoint twins with two separate heads and accounts for about 11% of all conjoint twins which was some time ago referred to as Siamese twins named after conjoint twin that survived to adulthood in Siam in Thailand with two heads and one body.

This parturient has no twinning family history or use of medications with teratogenic side effects in early pregnancy. The gestational age at presentation was unknown because the LMP was unknown and no early scan was done.

Her first pregnancy was uneventful and she had a spontaneous vaginal delivery of a normal male child. The following pregnancy was a miscarriage at about 13 week's gestation with no known cause.

On presentation there was no fetal heart activity detected using the Pinnard's stethoscope so it was possible to deliver the baby as it was done so this method is not recommended for a viable baby.

The bladder was continuously emptied to prevent injury to it and to increase the pelvic capacity as a full bladder will be obstructive.

The size of the babies contributed to the successful outcome of the delivery as clinically the babies were preterm at about 32-34 weeks gestational size. Most conjoint twins are delivered by caesarean section except they are miscarriage as reported in literature of a 20 years old who delivered a conjoint triplet spontaneously in early pregnancy [2,3]. The normal vaginal delivery without surgical insult to the integrity of the uterus will prevent the risk of rupture of the uterus in subsequent pregnancy if she declines hospital delivery.

Conjoint twins warrant doing basic investigation like ultrasound scan in utero, total body x-ray or preferably a magnetic resonance imaging scan to determine the nature of the bony spine. These investigations were not done in this case as this happened in a rural setting.

References

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