Affix Patient Label here or record

NAME: . . . . . .

NHS NO:

HOSP NO:

D.O.B: D D M M Y Y Y Y MALE ☐ FEMALE ☐

Worcestershire NHS
Acute Hospitals NHS Trust

MANAGEMENT PLAN FOR UNCOMPLICATED MULTIPLE PREGNANCY - CHECKLIST

This checklist should be completed at first ANC visit following consultant review. If the consultant is not present at first ANC visit, the checklist should be countersigned by the consultant when they first review the patient in ANC to confirm provision of information regarding risks and management plan. Management plan may vary in presence of additional risks. Any change in the management plan should be clearly documented in patient and hospital held records. File this checklist next to the management plan page in antenatal records. Refer to the Management of Multiple Pregnancy Guidelines WAHT-OBS-016 for details.

Number of fetuses: Twins ☐ Triplets ☐ Other (number of fetuses) ☐

Chorionicity: ☐

Down syndrome screening: ☐

Provide information: (Verbal / written)

Antenatal support group ☐ Nutrition ☐ Mental health / support ☐

DISCUSS RISKS AND THEIR MANAGEMENT:

- Anaemia ☐

FBC should be checked routinely at booking, 20-24 weeks and 28 weeks red cell antibodies should also be checked at 28 weeks.

- IUGR/Growth discordancy ☐
- Pre-eclampsia ☐
- Preterm delivery (20%) ☐
- Twin to Twin Transfusion Syndrome in MC twins (15-20%) ☐ N/A ☐
- Postpartum Haemorrhage ☐
- Other risk factors and specific management

ANTENATAL AND SCAN SCHEDULE

- Booking scan ☐
- Combined screening ☐
- First consultant appointment by 16-18 weeks (unless late booker) ☐
- Mid trimester anomaly scan requested (write date if known) ☐
- DCDA growth scans from 24 weeks + ANC appointments with scans (3-4 weekly) ☐
- In MC twins/triplets monitor for TTTS/TAPS/growth by fortnightly scans and ANC from 16 weeks until delivery ☐
- CMW visit / review to be arranged for ☐

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FETAL MONITORING

Discuss and recommend continuous electronic fetal monitoring in labour

DISCUSS OPTIONS FOR MODE OF DELIVERY WITH PROS AND CONS

Vaginal delivery (approximately 2/3)	☐	N/A	☐
Caesarean section (CS)(approximately 1/3))	☐	N/A	☐
Trial of vaginal birth after CS	☐	N/A	☐

Inform risk of CS delivery for Twin 2 after vaginal delivery of twin 1 (approximately5%)

DISCUSS ANALGESIA

Consider epidural - risk of internal podalic version (IPV), episiotomy or CS for twin 2 (insert tick box here)

DISCUSS DELIVERY

Timing of elective delivery

• In uncomplicated DCDA twins aim for elective birth at 37 weeks	☐	N/A	☐
• In uncomplicated MCDA twins aim for elective birth at 36 weeks	☐	N/A	☐
• In uncomplicated MCMA twins and triplets aim for elective caesarean section at 32 weeks after giving antenatal steroids at 29-31 weeks.	☐	N/A	☐
• Recommend delivery suite as place of delivery	☐		☐
• Manage second stage of labour as per WAHT-OBS-16 Guidelines	☐	N/A	☐
• Recommend active management of third stage of labour	☐		☐

- Corticosteroids should be given to reduce the risk of respiratory morbidity in all babies delivered by elective caesarean section prior to 39+0 weeks of gestation.

ASPIRIN

Advise women to take 150mg of aspirin daily from 12-36 weeks or until birth if they have either:

One of these conditions; Essential hypertension or hypertensive disease during a previous pregnancy/ chronic kidney disease/ autoimmune disease/ IDDM or NIDDM/ placental disease during a previous pregnancy (including abruption)

One of the following risk factors in addition to multiple pregnancy First pregnancy/ aged 40 years or older/ pregnancy interval of more than 10 years/ booking BMI of >35/ family history of pre- eclampsia.

Information provided to the patient and checklist completed by:

Name of Consultant	Signature	Date of first consultant review

If different from above

Name of Doctor	Signature	Date of first ANC review