

***Northern Survey of Twin and Multiple Pregnancy (NorSTAMP)***

***Standards of Care for Multiple Pregnancies***

*Final Version – July 2009*

**1. Organisation of care at unit level**

1. Each maternity unit should have a dedicated multi-disciplinary team for multiple pregnancies.
2. The team should include 1-2 named consultant obstetricians, midwives and ultrasonographers with an interest in the care of multiple pregnancies.
3. Antenatal care for women with multiple pregnancies should be provided, wherever possible, in clinics led by the multidisciplinary team
4. The multiple pregnancy team should lead the development of local care pathways within each unit.

**2. Pregnancy care**

**2.1 Education and support**

5. Parents should be offered dedicated antenatal classes/education with twins-specific antenatal information, advice and support, including discussion of delivery and postnatal wellbeing, including breastfeeding. The content, and where possible the delivery of this advice and support should be the responsibility of members of the multiple pregnancy team.
6. Information about the additional support available from TAMBA and the Multiple Births Foundation should be given to parents with multiple pregnancies, and this should be documented.

**2.2 Ultrasound scanning and antenatal screening**

7. All women with a multiple pregnancy should be offered an ultrasound examination at 10–13 weeks of gestation to assess viability, chorionicity, and major malformation.
8. If chorionicity is not ascertained at 10-13 weeks, a further scan should be arranged within 2 weeks. If it remains impossible to diagnose chorionicity, refer for a specialist opinion.
9. An attempt should always be made to diagnose chorionicity at the first scan in women presenting > 13 weeks, and at all repeat scans when not diagnosed at first presentation.
10. Screening for Down's syndrome with measurement of nuchal translucency should be offered to all women. The National Screening Committee leaflet 'Screening for

Down's Syndrome in multiple pregnancy' should be made available to support informed decision making.

11. Where single fetal loss in a multiple pregnancy is diagnosed following visualisation of a fetal pole, women should be given appropriate information and this should be documented in the notes. Consent should be sought for inclusion in NorSTAMP. (see also standard 22)
12. Monochorionic twins require increased ultrasound surveillance from 16 weeks of gestation onwards to detect twin-to-twin transfusion syndrome and growth discordance. This should be offered at an interval of 2 weeks.
13. The 18-20 week anomaly scan should include examination of the four chamber view of the fetal heart and outflow tracts for monochorionic twins.
14. Women with dichorionic twins should be offered routine ultrasound scans at 12 wks, 20 wks and every 4 wks until delivery
15. Blood pressure monitoring and urinalysis should be performed at 20, 24, 28 and then two-weekly

### **2.3 Complicated pregnancies**

16. The management of complicated multiple pregnancies, requiring specialist advice and/or referral, should be guided by regionally agreed care pathways. This includes:
  - higher order ( $\geq 3$ ) multiple pregnancies
  - MC pregnancies complicated by twin-twin transfusion syndrome
  - pregnancies discordant for fetal anomaly
  - single fetal demise in the second or third trimester
  - growth discordance in DC pregnancies.
17. Parents of high order multiple pregnancies ( $\geq 3$ ) at 10-16 weeks should be counselled and offered multifetal pregnancy reduction (MFPR) to twins in the regional centre.
18. Monochorionic twins that are discordant for fetal anomaly should be offered referral at the earliest opportunity for assessment and counselling in the regional fetal medicine centre.
19. Twin-to-twin transfusion syndrome should be managed in conjunction with the regional fetal medicine centre.
20. Fetoscopic laser ablation should be recommended for severe twin-to-twin transfusion syndrome presenting prior to 26 weeks of gestation.
21. Second or third trimester single-twin demise in a monochorionic twin pregnancy should be managed in conjunction with the regional fetal medicine centre.
22. The survivor after second or third trimester single-twin demise in monochorionic twins should be offered follow-up ultrasound and, if normal, an MRI examination of the fetal brain 2–3 weeks after the co-twin death. Counselling should include the long-term morbidity in this condition.

### **3. Labour and delivery**

#### **3.1 Planning for delivery**

23. There should be on-going discussions with the parents about plans for delivery, including mode, timing and the professionals who may be present, and a delivery plan should be documented by 32-34 weeks. The discussion about mode of delivery should include reference to regional guidance, and a regional information sheet.
24. Vaginal delivery of twins should be performed in a setting with continuous intrapartum monitoring, immediate recourse to caesarean section, appropriate analgesia, including epidural analgesia, and an obstetrician experienced in twin delivery.
25. In otherwise uncomplicated pregnancies, elective delivery should be offered between 37 and 38 weeks of gestation for DC and 36-37 weeks for MC twins

#### **3.2 Management of labour and delivery**

26. The duty consultant should be informed about the onset of labour in women with multiple pregnancies.
27. Dedicated one to one care from a midwife with appropriate expertise should be provided throughout labour and delivery
28. Two midwives should be present at delivery.
29. At delivery, the duty consultant obstetrician (or an SpT with documented competencies in the management of multiple births) should be immediately available on the labour ward. In all cases, the duty consultant should be on site.
30. The duty anaesthetist and paediatrician should be informed as appropriate.
31. Syntometrine should be used as the drug of choice for the 3<sup>rd</sup> stage unless contra-indicated.
32. The routine administration of antenatal steroids is not recommended, but women at greater-than-usual risk of preterm delivery should be considered for an elective course of steroids.
33. The placenta (e) should be examined at delivery and placental histology to establish chorionicity obtained if it is a single placental mass.

### **4. Postnatal care**

34. Statutory registration of multiple pregnancies complicated by fetal or perinatal loss should be in accordance with RCOG guidance.
35. Where perinatal loss has occurred, consent for autopsy should be sought.
36. All mothers should be screened for signs of perinatal psychological disturbance, which is increased after multiple births, and to offer treatment and support.
37. Parents with multiple births require additional individualised postnatal advice and support, including appropriate breast feeding support and contraception advice.

## 5. Performance management and audit

38. Consent for inclusion in NorSTAMP should be sought from all women with multiple pregnancy, including where early fetal loss following visualisation of a fetal pole results in a single legally registrable birth. Where consent is declined, multiple pregnancy teams should retain information locally to ensure local audits are complete.
39. Maternity units should participate in regional audit of performance against these standards of care, and surveillance of key performance indicators as agreed by the regional group.

## References

Many of the standards are based on the recommendations in 'Consensus views arising from the 50<sup>th</sup> study group', Chapter 19 of *Multiple Pregnancy* (ed Kilby et al), RCOG 2006.

RCOG Good Practice Guide no 4. Jan 2005. Registration of stillbirths and certification for pregnancy loss before 24 weeks gestation.

Screening for Down's syndrome in Multiple Pregnancy. NHS Fetal Anomaly Screening Programme/UK National Screening Committee. July 2007  
(<http://nscfa.web.its.manchester.ac.uk/cms.php?folder=54>)

## Further information

These standards were developed in consultation with clinicians throughout the North East and North Cumbria, overseen by the NorSTAMP Steering Group. Further information about NorSTAMP and the RMSO can be obtained at [www.nepho.org.uk/rmso](http://www.nepho.org.uk/rmso) or via Danielle Crowder at the RMSO, tel: 0191 233 1658 or email: [danielle.crowder@ncl.ac.uk](mailto:danielle.crowder@ncl.ac.uk).

## **Appendix 1**

### **Audit indicators for baseline audit**

The following indicators can be derived from data currently collected within NorSTAMP. A retrospective baseline audit will be completed to provide benchmark data for the region. Data collection will be revised from 2010 to support provision of a wider range of audit indicators based on the regional standards.

#### **1. Participation in audit**

Proportion of ONS registered multiple births notified to NorSTAMP

Proportion of NorSTAMP notifications with complete data collection and consent recorded

#### **2. Process of care:**

Pregnancies with known chorionicity (postnatally)

Perinatal deaths with autopsy performed

Maternities delivered at optimum gestation (as defined in standard 25)

Maternities delivered by caesarean section/proportion of deliveries discordant for mode of delivery (CS/vaginal)

#### **3. Outcomes:**

Fetal loss rates 16-24 weeks

Perinatal mortality

Admission to SCBU

## Appendix 2

### Units participating in NorSTAMP

<b>Hospital</b>	<b>Unit lead</b>
James Cook	Karen Lincoln
Friarage	Kumar Kumarendran
RVI	Andrew Loughney
Darlington	Jerry Oghoetuoma
North Durham	Jane Milne
Gateshead	Helene Brandon
South Tyneside	Umo Esen
Sunderland	Helen Cameron
North Tees and Hartlepool	Iona Macleod
Wansbeck	Shonag Mackenzie
Cumberland Infirmary	Ruth Lawley
West Cumberland	Linda Bell