

Delayed interval delivery in a twin pregnancy with monochorionic placenta

To the Editors: We read with interest the article of Minakami et al. (Minakami H, Honma Y, Izumi A, Sayama M, Sato I. Emergency cervical cerclage after the first delivery in a twin pregnancy with dichorionic placenta. *Am J Obstet Gynecol* 1995;171:345-6) about the delayed delivery in two twin pregnancies with emergency cervical cerclage after the first delivery. The authors stated that this procedure may not be justified in pregnancies with monochorionic placentas because of hemodynamic complexities and recommended it only in pregnancies with dichorionic placentas.

Lately we succeeded in prolonging the gestation in a monochorionic, diamniotic pregnancy for 10 weeks after the delivery of the first sibling. A 30-year-old nulliparous woman with a spontaneous twin pregnancy had premature rupture of the membranes at 23 weeks' gestation. On ultrasonography only one placenta was seen. At 24 weeks 4 days a 730 gm female infant was delivered. Emergency cervical cerclage after ligation of the umbilical cord close to the internal os was performed. Prophylactic tocolytic therapy with fenoterol and short-term antibiotic therapy with piperacillin were administered. Ten weeks later, at 34 weeks 5 days, the second female infant, with a birth weight of 2260 gm, was delivered vaginally. Both fetuses survived without major sequelae. The pathologic examination confirmed the presence of a diamniotic, monochorionic placenta.

Delayed deliveries in multifetal pregnancies are rare events and the decision to attempt a prolongation of pregnancy after the first fetus is born should be based on gestational age and the absence of intrauterine infection and abruptio placentae. There are no generally accepted guidelines in the proper selection of pregnancies suited for a delayed delivery in literature, but in our experience, also in a monochorionic multifetal pregnancy, a delayed delivery can be attempted with success.

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Reply

To the Editors: Because we imagined a situation in which one twin is found to be dead in the vagina while the sibling is alive in utero, we stated that a policy to prolong the gestation of a second twin after the delivery of its sibling may not be justified in monochorionic twins. Actually, in case 1 the first twin was found to be dead in the vagina at arrival at our hospital, and there was a dichorionic placenta.

The shared placental circulation of monochorionic twins predisposes a surviving twin to devastating neurologic injury in the event of cotwin death.¹ Hypotensive

ischemia of the brain from hemorrhage, from the surviving twin to the dead twin, through placental anastomoses has been suggested as a cause of neurologic injury.² The comparative rarity of this disorder and the absence of any large study make it difficult to advise patients on the outlook; the optimum management of such patients is not fully established. It is not known whether early or delayed delivery of the second twin is better in such cases.

In the case presented by Beinder and Lang the first twin was liveborn. In such a case a policy to prolong the gestation of the remaining twin is justified if the first twin is born long before term. Cord ligation of the living twin may not be harmful for the cotwin even in monochorionic twins.³

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Long-term implications of cesarean section

To the Editors: We read the article by Hemminki and Meriläinen (Hemminki E, Meriläinen J. Long-term effects of cesarean sections: ectopic pregnancies and placental problems. *Am J Obstet Gynecol* 1996;174:1569-74) with interest and share their view that there is a dearth of studies on the long-term implications of cesarean section on the subsequent pregnancy.

We recently reviewed 65,488 deliveries that occurred during the 10 years from 1982 to 1991 in our hospital¹ and found an association between a history of cesarean section and emergency peripartum hysterectomy, which is probably the ultimate disaster as far as reproductive health is concerned. We reported 11 cases of hysterectomy done as a life-saving procedure. Five operations were performed for uterine rupture and six for uncontrollable bleeding. Of the 11 cases, 7 were associated with a previous cesarean section. There was no case of hysterectomy in nearly 22,000 nulliparous women, and a history of cesarean section increased the risk of hysterectomy 18-fold in parous patients.

The association between a previous scar and uterine rupture is well known. Of the six patients who required hysterectomy for life-threatening hemorrhage, three had an adherent placenta implanted over a lower uterine