Multiple Pregnancy and Birth

Classification:	Guideline
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Guideline to be followed by (target staff): Reference and guidance in the clinical management of multiple pregnancies for all women during the antenatal and intrapartum period.

To be read in conjunction with the following documents:
MKHFT Antenatal Corticosteroids to reduce neonatal morbidity and mortality (MIDG/GL/53)
MKHFT Caesarean Section (MIDG/GL/36)
MKHFT Fetal Monitoring (MIDG/GL/48)

Are there any eCARE implications? No

CQC Fundamental standards:
Regulation 9 – person centered care
Regulation 10 – dignity and respect
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 13 – Safeguarding service users from abuse and improper treatment
Regulation 14 – Meeting nutritional and hydration needs
Regulation 15 – Premises and equipment
Regulation 16 – Receiving and acting on complaints
Regulation 17 – Good governance
Regulation 18 – Staffing
Regulation 19 – Fit and proper

Disclaimer

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.

The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Guideline Statement

To provide care which minimises the risk of complications and promotes the health and wellbeing of the woman and her babies in multiple childbearing.

To ensure that the correct procedures and effective communication has been adopted by staff who are dealing with multiple births.

Executive Summary

- Multiple pregnancies should have Consultant-led care.
- All multiple pregnancies should be started on aspirin from 12 weeks if they have one or more risk factors for hypertension.
- Upon identification at the dating scan, mono chorionic twin pregnancies should be referred to the Fetal Medicine Consultant where an individualised care plan can be agreed to include more frequent ultrasound monitoring for fetal well-being and earlier delivery than dichorionic twins.
- Multiple pregnancies with severe twin to twin transfusion should be referred to a Regional Fetal Medicine centre
- Multiple pregnancies are associated with an increased incidence of obstetric complications therefore experienced midwives and Obstetric Consultant should be involved in labour management plans.

1.0 Roles and Responsibilities:

Doctors – decision making, discussion, planning and delivering care.

Midwives – decision making, antepartum, intrapartum and post-delivery care.

The role of Midwives and other healthcare specialists is integral to the management of multiple pregnancies. Additional support to women is available from Twin and Multiple Birth Association (TAMBA) and the Multiple Births Foundation.

2.0 Scope of document

Reference and guidance in the clinical management of multiple pregnancies for all women during the antenatal and intrapartum period.

3.0 Implementation and dissemination of document

This guideline is available on the Trust intranet and has followed the full guideline review process prior to publication.

4.0 Processes and procedures

4.1 General Care (see also appendix 1)

- Multiple pregnancies should have a named consultant; they should have **shared care** with community midwives but with increased input from a consultant**. Higher multiple pregnancies should have the same shared care but will have further individualised care plans.**
- Women/birthing people with multiple pregnancies require the same advice on diet, lifestyle and nutritional supplements as singleton pregnancies.
- There is a higher risk of iron deficiency anaemia and therefore an additional full blood count should be sent at 20-24 weeks as well as the routine at 28 weeks. Twin pregnancies should have their ferritin levels monitored and be kept above 30.
- Advise the woman/birthing person that multiple pregnancy is a risk factor for pre-eclampsia. If the Woman/birthing person has 1 additional risk factor or more, as listed below, they should commence 75 -150mg of aspirin daily from 12 weeks until the birth.
  Risk factors for pre-eclampsia:
  - first pregnancy
  - age 40 years or older
  - pregnancy interval of more than 10 years
  - BMI of 35 kg/m2 or more at first visit
  - family history of pre-eclampsia

  Community midwives should refer to the GPs to prescribe aspirin to women with multiple pregnancies and the above risk factors to commence between 12 -16 weeks.

Please refer to the Hypertensive Disorders in Pregnancy guideline:

Hypertensive Disorders of Pregnancy(including Pre-eclampsia and Eclampsia) .pdf (adobe.com)

4.2 Dating (First trimester) scan

- Offer women/birthing people with a multiple pregnancy a first trimester ultrasound scan to estimate the gestational age and determine chorionicity and amnionicity.
- Estimate gestational age should calculated from the largest baby
- Determine chorionicity and amnionicity at the time of detecting a twin or triplet pregnancy by ultrasound using:
  - the number of placental masses
  - the presence of amniotic membrane(s) and membrane thickness
  - the lambda or T-sign.
- Nomenclature for each twin assigned and documented clearly to ensure consistency throughout pregnancy. Twin in maternal right side is called twin 1.
- If woman/birthing person presents after 14+0 weeks, determine chorionicity and amnionicity at the earliest opportunity by ultrasound using all of the following:
  - the number of placental masses
  - the presence of amniotic membrane(s) and membrane thickness
  - the lambda or T-sign
  - discordant fetal sex.

- If it is not possible to determine chorionicity or amnionicity, refer the woman to Fetal Medicine consultant. If it is still not possible, plan the care for the pregnancy as a monochorionic pregnancy until proved otherwise.
- Nuchal translucency: This should be offered as the preferred method of chromosomal abnormality screening
- Upon identification of a twin pregnancy please inform Antenatal Newborn (ANNB) Screening to attend the department. A further discussion regarding informed consent for Trisomy screening is necessary prior to obtaining the blood sample. It is important the woman/birthing person understands the implications of receiving a separate result for each fetus.

  Please refer to the Fetal Anomalies guideline:

  Fetal Anomalies Guideline .pdf (adobe.com)

4.3 Antenatal Care

- Offer screening for structural abnormalities in twin and higher order pregnancies as in routine antenatal care. Consider a slightly later gestational age than in singleton pregnancies.
- Inform women/birthing person that 60% twin pregnancies will result in spontaneous delivery before 37 weeks. This increases to 75% in triplet pregnancies delivering before 35 weeks.
- Increased risk of admission into neonatal unit.

Dichorionic Diamniotic Twin Pregnancy

- Offer women/birthing people with an uncomplicated dichorionic diamniotic twin pregnancy antenatal clinic appointment with an Obstetrician along with a scan at 24, 28, 32 and 36 weeks.
- Women/birthing people will continue to have routine antenatal appointments with their community midwife.

Monochorionic Twin Pregnancy

- Offer women/birthing people with an uncomplicated monochorionic twin pregnancy antenatal clinic appointment with an Obstetrician along with a scan at 16, 18, 20, 22, 24, 28, 32 and 34. Some of these scans, especially the 16 weeks scan should be undertaken in the Fetal Medicine Clinic.
- Women/birthing people will continue to have routine antenatal appointments with their community midwife.

Higher Order Pregnancy

- Higher order multiple pregnancies are rare and for these individualised management plans should be developed by the Fetal Medicine Consultant. A referral should be made to a tertiary centre if appropriate.

4.4 Fetal Complications

Twin to Twin Transfusion Syndrome (TTTS)

- Women/birthing people with monochorionic twins should be asked to report a sudden increase in abdominal size or breathlessness as these may be manifestations of TTTS.
- Ultrasound evidence of TTTS includes:
  - difference between deep vertical pool (DVP) depth of 4 cm or more
  - One baby has a DVP depth of less than 2 cm, **and** another baby has a DVP depth of:
    - over 8 cm before 20+0 weeks of pregnancy **or**
    - over 10 cm from 20+0 weeks
  - One baby has normal DVP depth, **and** another baby has a DVP depth of:
    - Less than 2 cm **or**
    - More than 8 cm
- If twin to twin transfusion is present at any ultrasound scan, referral should be made to a Fetal Medicine Consultant Obstetrician.
- In the presence of moderate to severe twin to twin transfusion referral should be made to a Regional Fetal Medicine Centre. Ongoing care may be managed by the regional centre or may be returned to the local Fetal Medicine Consultant Obstetrician for ongoing management. These cases may be discussed at the monthly fetal medicine forum.
- Baby alert forms will be completed.

Selective Fetal Growth Restriction

- Do not use abdominal palpation or symphysis–fundal height measurements.
- Use ultrasound scan from 24 weeks using two or more biometric parameters to estimate fetal weight (EFW).
- Calculate and document EFW discordance in monochorionic twins using the formula below:

  (EFW larger fetus − EFW smaller fetus) ÷ EFW larger fetus
- Increase ultrasound frequency to at least weekly, and include doppler assessment of the umbilical artery flow for each baby, if:
  - there is an EFW discordance of 20% or more and/or
  - the EFW of any of the babies is below the 10th centile for gestational age
- Refer woman to fetal medicine clinic if there is an EFW discordance of 25% or more **and** the EFW of any of the babies is below the 10th centile for gestational age because this is a clinically important indicator of selective fetal growth restriction.

Preterm Labour

- Women with multiple pregnancy are at higher risk of spontaneous preterm birth than women with a singleton pregnancy (up to 60% of twin pregnancies).
- This risk is further increased if they have other risk factors, such as a spontaneous preterm birth in a previous pregnancy.
- Do not use fetal fibronectin or cervical length alone to diagnose preterm labour.
- Do not offer the following interventions (alone or in combination) routinely to prevent spontaneous preterm birth in women with a multiple pregnancy:
  - Arabin pessary
  - cervical cerclage
  - oral tocolytics
  - Progesterone therapy

See Appendix 2: Indications for referral to a tertiary level fetal medicine centre

4.5 Planning Birth

Discussion

- Discuss the following with the woman/birthing person from 24 weeks:
  - place of birth and the possible need to transfer in case of preterm birth
  - timing and possible modes of birth
  - analgesia during labour (or for caesarean birth)
  - intrapartum fetal heart monitoring
  - management of the third stage of labour.

Timing of birth

- Uncomplicated DCDA pregnancy:
  - Explain to women/birthing person that elective birth from 37 weeks 0 days does not appear to be associated with an increased risk of serious adverse outcomes, and that continuing uncomplicated twin pregnancies beyond 38 weeks 0 days increases the risk of fetal death.
  - Offer delivery after 37 weeks 0 days if uncomplicated pregnancy.
- Uncomplicated MCDA pregnancy:
  - Explain to women/birthing person that elective birth from 36 weeks 0 days does not appear to be associated with an increased risk of serious adverse outcomes, and that continuing uncomplicated twin pregnancies beyond 38 weeks 0 days increases the risk of fetal death.
  - Offer delivery after 36 weeks 0 days following **corticosteroids**.
- Uncomplicated MCMA pregnancy:
  - Explain to women/birthing person that planned birth between 32+0 and 33+6 weeks **with corticosteroids** does not appear to be associated with an increased risk of serious neonatal adverse outcomes, and that continuing the pregnancy beyond 33+6 weeks increases the risk of fetal death.
  - Babies will usually need to be admitted to the neonatal unit and have an increased risk of respiratory problems.
- Higher order pregnancy or in complicated twin pregnancy the timing of birth will be decided and discussed with each woman/birthing person individually by Fetal Medicine Consultant Obstetrician.
- For women/birthing person who decline planned birth at the expected timing as above, offer weekly appointments with the specialist obstetrician. At each appointment, offer an ultrasound scan and perform assessments of amniotic fluid level and doppler of the umbilical artery flow for each baby in addition to fortnightly fetal growth scans.

Mode of Birth

- DCDA and MCDA pregnancy:
  - Explain to women/birthing person with uncomplicated pregnancy that planned vaginal birth and planned caesarean section are both safe choices for them and their babies.
  - Planned Induction of labour could be started on Ward 9.
  - Discuss caesarean section to women/birthing person if the first twin is not cephalic at the time of planned birth.
  - Discuss an individualised assessment of mode of birth to women/birthing people in suspected, diagnosed or established preterm labour before 26 weeks. Consider the risks of caesarean section and discuss these with the Woman/birthing person.
  - Explain to women/birthing person who plan for vaginal birth that a small number of women will need an emergency caesarean section to deliver the second twin after vaginal birth of the first twin.

- MCMA pregnancy:
  - Delivery by caesarean section should be discussed. Delivery should be planned for between 32+0 and 33+6 weeks as there is a higher risk of cord entanglement.
- Higher order pregnancy or in complicated twin pregnancy Delivery by caesarean section should be discussed. A management plan will have been formalised with the woman/birthing person antenatally.
- For elective caesarean sections before 37 weeks gestation, steroids should be given.

Please refer to Antenatal Corticosteroids to Reduce Neonatal Morbidity and Mortality guideline.

Antenatal Corticosteroids to reduce Neonatal Morbidity and Mortality .pdf (adobe.com)

4.6 Care in Labour

Analgesia

- Discuss options for analgesia and anaesthesia with the women/birthing person, whether they are planning a vaginal birth or caesarean section.
- Discuss an epidural with women/birthing people who choose to have a vaginal birth. Explain that this is likely to:
  - enable a quicker birth by emergency caesarean section if needed.
- Discuss regional anaesthesia to women with a twin or triplet pregnancy who are having a caesarean section.

Intrapartum Care

Once admitted in labour

- When a woman/birthing person with a multiple pregnancy is in labour the obstetric consultant on call and Specialist Registrar will be informed. The most senior obstetric team member will review the plan of care and birth preferences with the Woman/birthing person
- Labour care will be provided by a midwife
- The obstetric Anaesthetist and Neonatal team should be informed the Woman/birthing person is in labour
- If there is no clear plan of labour and documentation of the discussed mode of delivery in the maternal records, then the Obstetric Registrar will discuss the Womans/birth persons wishes and discuss the plan with the Consultant on-call, this will then be document in the maternal records.
- A large bore intravenous cannula (grey 16g venflon) should be inserted. Take full blood count and group & save serum.
- Commence Omeprazole orally 12 hourly
- Prepare the room for delivery and prepare resuscitation equipment for the babies
- For women between 23+0 and 25+6 weeks of pregnancy who are in established labour, involve a senior obstetrician in discussions with the woman/birthing person about how to monitor the fetal heart rates
- Perform a portable ultrasound scan when established labour starts, to confirm which twin is which, the presentation of each twin, and to locate the fetal hearts
- Continuous electronic fetal monitoring is indicated for all women/birthing people above 26 weeks gestation, with a twin pregnancy in labour. Please refer to Fetal Monitoring Guideline.
  Fetal Monitoring Guideline .pdf (adobe.com)
- Consider FSE monitoring for the presenting twin if abdominal monitoring difficult or a continuous CTG is not being obtained.
- If the registrar or lead midwife has any concerns about CTG monitoring including concerns that only one twin is being monitored, this must be escalated immediately to the Consultant on-Call.

On diagnosis of 2nd stage of Labour

- Inform Labour Ward shift lead
- Inform the obstetric consultant on call and specialist registrar. The obstetric consultant on call should be present on labour ward during the 2nd stage of labour
- The obstetric registrar, obstetric SHO, neonatologist, anaesthetist and ODP must be present on labour ward when presenting twin is imminent and stay until the 3rd stage of labour.
- The woman/birthing person and partner must be fully informed at all times.
- Consider birth in theatre if difficulties with birth are anticipated.
- The ultrasound scanner should be available outside the birthing room.
- Prepare Oxytocin 10 units in 500ml 0.9% Saline for possible use to augment contractions after first baby is delivered if required

Following birth of first baby

- One cord clamp is applied to mark the first cord
- Palpate abdomen to assess lie of second baby.
- If the lie of second baby is not longitudinal then stabilise the lie to longitudinal lie, if necessary, an external version could be performed by the obstetric registrar or consultant. Ultrasound should be used to confirm the lie and presentation.
- If no contractions are apparent within 5-10 minutes, the woman/birthing person should be reviewed by the obstetric registrar or consultant and to discuss commencing oxytocin infusion, 10 units in 500mls as per augmentation regime.
- Artificial rupture of membranes should NOT be performed until the presenting part is engaged to reduce the risk of cord prolapse. If it is not, to stabilise to a longitudinal lie by performing external version.
- External version to achieve longitudinal lie should be performed if needed. If unsuccessful, internal podalic version or Caesarean section needs to be considered depending on clinical judgement
- For second twin second stage of labour should be managed as per the intrapartum care guideline
  Intrapartum Care.pdf (adobe.com)
- If delivery of the second twin is not anticipated within 30mins of the first, the Consultant on Call is to be informed.
- The cardiotocograph should be interpreted based on the clinical picture and the delivery managed accordingly.
- Two cord clamps are applied to mark the cord of the second twin.

The 3rd stage of labour

- Postpartum haemorrhage is more common after multiple delivery therefore active management of the third stage is advised.
- IM syntometrine (or IV Oxytocin if the woman is hypertensive) is administered following birth of the 2nd twin.
- 40 units of Oxytocin in 500mls of Normal Saline should be commenced at a rate of 125mls/hour (10iu/hr) after delivery of the placenta.

5.0 Statement of evidence/references

National Institute for Health and Clinical Excellence. (2019).
The management of twin and triplet pregnancies in the antenatal period.
London:NICE

Kilby M, Baker P, Critchley H, Field D, editors. *Multiple Pregnancy* Consensus views arising from the 50th Study Group: In: Multiple Pregnancy p. 283–6. London: RCOG Press; 2006.

Royal College of Obstetricians and Gynaecologists. (2016). *Management of Monochorionic Twin Pregnancy.* London: RCOG.

American Academy of Family Physicians (2001) Advanced Life Support in Obstetrics. Revised 4th edition.

Crowther, C.S. (1999) Multiple pregnancy. High Risk Pregnancy 2nd edition. London.

National Institute for Health and Clinical Excellence. (2008). *Antenatal care: Routine care for the healthy pregnant woman*. London: NICE.

National Institute for Health and Clinical Excellence. (2007). *Intrapartum care: Care of healthy women and their babies during childbirth*. London: NICE.

NICE Quality Standards. September 2013.

Twins and Multiple Births Association (TAMBA) (2006) A Midwive's Guide to Twins, Triplets and more. Surrey.

6.0 Governance

6.1 Document review history

Version number	Review date	Reviewed by	Changes made
5	January 2018	Mr Hanna	Reviewed and updated.
5.1	October 2018	Sharon Page	Page 5 continuation of 4.1 add a bullet point after Nuchal Translucency: This should be offered as the preferred method ..... • Upon identification of a twin pregnancy please inform ANNB Screening to attend the department. A further discussion regarding informed consent for Trisomy screening is necessary prior to obtaining the blood sample. It is important the woman understands the implications of receiving a separate result for each fetus.
6	January 2021	Mr Hanna/ Mr Nasr/ Katie Selby	Complete review and GAP

6.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Janice Styles	Consultant Midwife	25/01/2022		Changes to wording	Yes
Anita Males	Screening Lead	25/01/2022		Read guideline,	
Stuart Spencer	Obs and Gynea Registrar	29/01/2022		Minor changes to wording	
Maternity guideline review group	Maternity	25/02/2022			
Maternity CIG	Maternity	02/03/2022			

6.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
a) Women with a multiple pregnancy have the chorionicity and amnionicity of their pregnancy determined using ultrasound and recorded between 11 weeks 0 days and 13 weeks 6 days. b) Women with a multiple pregnancy have their fetuses labelled using ultrasound and recorded between 11 weeks 0 days and 13 weeks 6 days. c) Women with a multiple pregnancy are cared for by a multidisciplinary core team. d) Women with a multiple pregnancy have a care plan that specifies the timing of appointments with the multidisciplinary core team appropriate for the chorionicity and	Audit	Midwives and doctors as designated by audit leads	Quarterly	Audit Group Meeting

amnionicity of their pregnancy. e) Women with a multiple pregnancy are monitored for fetal complications according to the chorionicity and amnionicity of their pregnancy. f) Women with a higher-risk or complicated multiple pregnancy have a consultant from a tertiary level fetal medicine centre involved in their care. g) Women with a multiple pregnancy have a discussion by 24 weeks with one or more members of the multidisciplinary core team about the risks, signs and symptoms of preterm labour and possible outcomes of preterm birth. h) Women with a multiple pregnancy have a discussion by 32 weeks with one or more members of the multidisciplinary core team about the timing of birth and possible modes of delivery so that a birth plan can be agreed.				

6.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division	Maternity	Department	Maternity
Person completing the EqIA	Erica Puri	Contact No.	Ex 87153
Others involved:	Yes	Date of assessment:	15/03/2022
Existing policy/service	Yes	New policy/service	No

Will patients, carers, the public or staff be affected by the policy/service?	Yes
If staff, how many/which groups will be affected?	*All staff*

Protected characteristic	Any impact?	Comments
Age	NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	NO	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?
face-to-face and meetings
How are the changes/amendments to the policies/services communicated?
Email, face to face and teams
What future actions need to be taken to overcome any barriers or discrimination?

What?	Who will lead this?	Date of completion	Resources needed
Review date of EqIA			

Appendix 1: Routine Antenatal Care Outline

Visit Number	Pregnancy Weeks	What to expect at your appointment
1	When pregnancy confirmed	You will see your Midwife or GP and a dating scan will be arranged, which you will have around your twelfth week of pregnancy.
2 Midwife	Booking at 8-12 weeks	Your medical and obstetric history will be taken and recorded. You will be given information on antenatal screening tests and blood may be taken. Information will be given on diet and lifestyle, options on place of birth and any additional care needed. **Your will receive your pregnancy record which you should carry with you at all times.** Various information leaflets will be provided for you to read at your leisure.
3 Hospital	10-13 weeks	Nuchal Translucency & dating scan – confirmation of multiple pregnancy. Consultant appointment arrangedwithin one or two weeks.
4 Hospital	13-14 weeks	Consultant appointment and discussion regarding the type of multiple pregnancy. Discuss screening options.

		Monochorionic Twins		Dichorionic twins
Hospital	16 weeks	scan for fetal well-being, antenatal review	20 weeks	20 week scan for fetal anomaly cardiac scan including outflow tracts and fetal well-being. Full blood count
Hospital	18 weeks	Scan for fetal well-being, antenatal review		
Hospital	20 weeks	Scan for fetal anomaly cardiac scan including outflow tracts and fetal well-being. Full blood count to be taken by MCA in ANC.	24 weeks	Scan for fetal well-being and antenatal review
Hospital	22 weeks	Scan for fetal well-being, antenatal review		
Hospital	24 weeks	Scan for fetal well-being and review by Consultant.	28 weeks	28 weeks scan for fetal wellbeing and review by consultant.
Hospital			31 weeks Midwife	Routine antenatal review
Hospital	28 weeks	Scan for fetal well-being and review by Consultant.	32 weeks	34 weeks scan for fetal well-being and review by Consultant. Discussion on mode, place and timing of delivery
Hospital	30 weeks	Scan for fetal well-being and review by Consultant.	36 weeks	34 weeks scan for fetal well-being and review by Consultant. Decision on mode, place and timing of delivery
Hospital	32 weeks	Scan for fetal well-being and review by Consultant. Discussion on mode, place and timing of delivery		Remainder of care as per plan for delivery
Hospital	34 weeks	Scan for fetal well-being and review by Consultant. Decision on mode, place and timing of delivery		

Appendix 2: Indications for referral to a tertiary level fetal medicine centre

Seek a consultant opinion from a tertiary level fetal medicine centre for:

- pregnancies with a shared amnion:
  - monochorionic monoamniotic twins
  - dichorionic diamniotic triplets
  - monochorionic diamniotic triplets
  - monochorionic monoamniotic triplets

- pregnancies complicated by any of the following:
  - fetal weight discordance (of 25% or more) and an EFW of any of the babies below the 10th centile for gestational age
  - fetal anomaly (structural or chromosomal)
  - discordant fetal death
  - feto-fetal transfusion syndrome
  - twin reverse arterial perfusion sequence (TRAP)
  - conjoined twins or triplets
  - suspected Twin Anaemia Polycythemia sequence (TAPS)