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Diccephalus Dipus – Triradious A Rare Conjoined Twin Delivered By Caesarean Section At Term – A Case Report

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ABSTRACT

Conjoined twins are monozygotic twins fused at any portion of body as a result of incomplete division of the embryonic disc. There are various types of conjoined twins classified by the point at which their bodies are joined. We reported a rare form of conjoined twin Diccephalus Dipus Tribachius where infant has two heads, two legs, three arms and one external genitalia with fusion of thoracic, abdominal and pelvic regions. It was an undiagnosed case delivered by caesarean section.

Keywords: *Obstructed labour, caesarean section, conjoined twins.*

INTRODUCTION

Conjoined twins are rare with an incidence ranging from 1 in 50,000 to 1 in 200000 of live births^{1,2,3}. The frequency is independent of maternal age or parity and it occurs sporadically conjoined twins are monozygotic twins when the embryo does not split until the second week of gestation⁴. Etiology is unclear but two theories have been proposed^{2,5,6}. Fission theory which is incomplete division of the embryonic disc from a single fertilized ovum between the 15 and 17th day of gestation and fusion, theory where secondary fusion of two originally separate monovular embryonic disc occurs. They are classified according to the location of the tissue that links the twins as craniopagus (joined at cranium),

thoracopagus (joined at thorax), omphalopagus (joined at the anterior abdominal wall), pyrophagus (joined at buttocks and lower spine and lying back to back) Ischiopagus (joined at sacrum and coccyx and lying side to side). Recurrence risk is negligible and females are more commonly affected with a male to female ratio of 3:1⁷. Perinatal diagnosis is important and can be diagnosed by an expert sonologist with few sonographic criteria.

Bifid appearance of the first trimester pole V of Y shaped twin pregnancy.

Continuous skin contours at the same anatomic level.

Absence of an intra-amniotic membrane between the twins.

Inability to separate fetal bodies.

Abnormal number of vessels (more than three) in the umbilical cord.

Two heads and bodies of both twins are seen at the same level.

Unusual extension of the spines.

Unusual proximities of the extremities.

Permanent position of the foetal relation to one another even after external stimuli.

Single heart

Bibreach or rarely bicephalic presentation.

Presence of foetal anomaly especially anencephaly, polyhydramnios, Fallots tetralogy.

Diagnosis is important for proper and timely management to decrease perinatal and maternal morbidity and mortality.

CASE REPORT

A 30 year old female, gravida two para one live one (G2P1L1) presented in the emergency of District Hospital Kulgam (a rural district of Jammu and Kashmir) at 8:30am on 9.11.2013 with complaints of amenorrhea 9 months with labour pains with history of handling by daia at home. She had no antenatal records available; her previous delivery was a full term vaginal delivery with no significant event. On general examination patient was exhausted, dehydrated, her pulse was 108 bpm, blood pressure was 120/70mmHg, tongue dry on per abdominal examination. Abdomen was over distended, bladder was full, uterus was acting and relaxing and presentation was breach. Fetal heart rate was all right. On per vaginal examination os was fully dilated. Presenting part at -3 station, membranes were absent and patient had drained all liquor. Investigation was done which revealed hemoglobin of 9gm, platelet count 1.2 lacks and blood sugar (random) 80mg/dl, KFT, LFT within normal limits. She was taken up for caesarean section. Intraoperative findings were distended and papery thin lower segment about to rupture. LSCS was done conjoined twins with two heads, three arms, one trunk, and one female external genitalia and two legs were delivered with great

difficulty with A/S of 6/10 with multiple tears in the uterus. Twins were examined by the pediatrician and shifted them to a tertiary care hospital where they died in the evening at 6pm.



CONCLUSION

Conjoined twins because of their complexities are a challenge in developing countries because early diagnosis is not often possible due to irregular, prenatal consultations, coupled with inadequate antenatal care and lack of ultrasound equipment in most health facilities and also lack of specialized teams. Equipment and more advanced imaging techniques possess a major therapeutic challenge. Undiagnosed cases till delivering may lead to obstructed labour which may lead to rupture of uterus with high maternal and foetal morbidity and mortality.

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