Carrying Twins Brings Risk - An Argument For Birth At 37 Weeks

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Increasing numbers of mothers are now pregnant with twins, mainly due to the use of assisted reproductive techniques such as IVF. These pregnancies can either be monochorionic, where the twins share the same placenta, or dichorionic, where each twin has its own and which is more common.

Twin pregnancies are often complicated by problems related to the placenta, maternal age, obstetric complications, and concerns about the growth of the twins. Complications can often happen in pregnancies near term that have otherwise gone well, with no single cause identified for why this happens.

Twin pregnancies are at high risk of stillbirths compared to mothers carrying just one baby. This risk increases 13-fold if twins share the placenta, and five-fold when they have their own placenta.

Stillbirth risk also increases as the pregnancy advances so mothers are often delivered before their due date. But early delivery poses additional risks to the baby including neonatal death and other complications, often arising from being born prematurely. The optimal time for delivery believed to minimise risk to newborns varies and current national and international guidelines recommend delivery at different time points, with some including the UK and France advising delivery as early as 34 weeks if the twins share the placenta – six weeks before the expected date of delivery.
In a new paper published in the BMJ, we identified the optimal time to deliver mothers with twin pregnancies to reduce the risks of both stillbirth and neonatal death. The work involved a team of international research collaborators from the Global Obstetric Network. We systematically reviewed all published and unpublished evidence on delivery times for twins, which compared the weekly risks of stillbirth when a pregnancy was continued to the following week, to the risks of neonatal death when delivered at that gestational week.

We identified 32 studies that provided data on about 35,000 twin pregnancies (29,685 dichorionic and 5,486 monochorionic). We found that in twin pregnancies where each has its own placenta, the risks of neonatal death from delivery was more or equal to the risk of stillbirth from continuing the pregnancy. However, when pregnancy was continued from 37 to 38 weeks, the risks of stillbirth appeared to be greater than neonatal death, resulting in 8.8 additional infant deaths per 1,000 pregnancies.

In twin pregnancies that shared the placenta, this risk of stillbirth appeared to be greater than neonatal death when pregnancy was continued from 36 weeks to 37 weeks, resulting in 2.5 additional deaths per 1,000 pregnancies. But this increase was not statistically significant.

We also provided estimates of other complications in twin babies such as respiratory distress syndrome, septicaemia, neonatal seizures, and admission to the neonatal intensive care unit for a complication.

Based on our findings, we recommend that delivery should be offered to mothers with twin
pregnancies that have their own placentas (dichorionic) at 37 weeks of pregnancy. We did not find clear evidence to deliver twins with a shared placenta (monochorionic) before 36 weeks of pregnancy – two weeks after some guidelines – and so suggest that delivery should be considered at 36 weeks in these pregnancies.

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