PIPADOR REVISION

MRCOG Part 1 Revision Notes

Multiple Pregnancy

CLINICAL MANAGEMENT • LECTURE 471

VISUAL EXAMINATION REVISION NOTES

2026 Edition

471

MRCOG PART 1 REVISION NOTES | CLINICAL MANAGEMENT

Multiple Pregnancy

Chorionicity, antenatal care, complications, timing and mode of birth in twins and triplets (NICE NG137)

11–14 wk	MCDA	DCDA	TTTS
Determine chorionicity	Scans every 2 weeks from 16	Birth 37+0	≈ 10–15% of MCDA

■ KEY FACTS: Learning objectives

- Define zygosity, chorionicity and amnionicity.
- Describe antenatal care, screening and monitoring of twins and triplets (NICE NG137).
- Describe complications (including TTTS), timing and mode of birth.

471.1 Key definitions

Term	Definition
Zygosity	Number of fertilised eggs: dizygotic (two eggs — always dichorionic) vs monozygotic (one egg splits)
Chorionicity	Number of placentas (chorions): dichorionic (DC) or monochorionic (MC) — determines risk
Amnionicity	Number of amniotic sacs: diamniotic (DA) or monoamniotic (MA)
Lambda (twin-peak) sign	Tissue between membranes at placental origin — dichorionic
T-sign	Thin membrane meeting placenta at right angle — monochorionic diamniotic
TTTS	Twin-to-twin transfusion syndrome — unbalanced vascular anastomoses in a shared placenta
Growth discordance	(Larger EFW − smaller EFW) ÷ larger EFW; ≥ 25% significant

■ IN PLAIN ENGLISH: Multiple pregnancy

What matters most is **how many placentas** the babies share. Babies sharing one placenta (monochorionic) can pass blood between each other, so they need **scans every 2 weeks from 16 weeks** and earlier birth.

471.2 Antenatal care

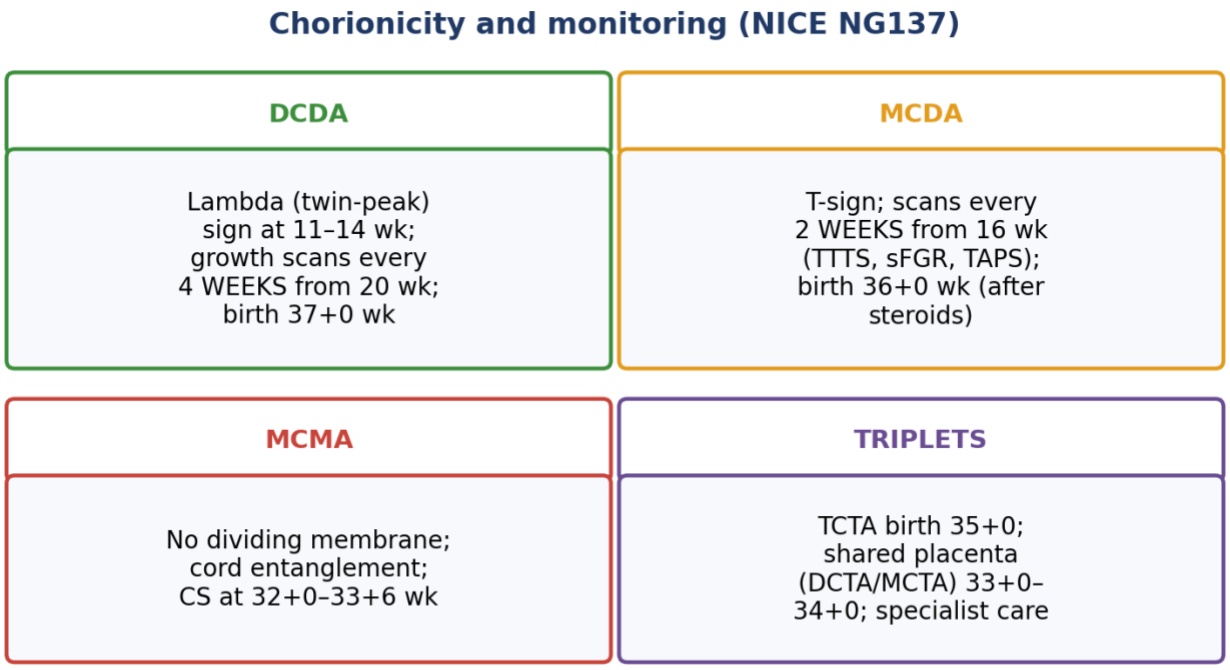


Figure 471.1 — Chorionicity and monitoring

Topic	NICE NG137
Dating & chorionicity	• CRL of larger twin at 11+2–14+1 wk • Chorionicity and amnionicity by USS • Label twins
Screening	• Combined test (twins) • NIPT possible (lower accuracy) • Second-trimester quadruple test
Care	• Specialist multidisciplinary multiple pregnancy team • More antenatal appointments
Supplements/prevention	• Aspirin if other PE risk factors (multiple pregnancy is a moderate risk factor) • Iron (FBC at 20–24 wk) • No routine progesterone/cerclage/tocolysis to prevent preterm birth
Growth	• Discordance ≥ 25% → refer to fetal medicine • DC: every 4 wk from 20 wk • MC: every 2 wk from 16 wk (TTTS, TAPS, sFGR)
Preterm birth	Higher risk — steroids, $MgSO_4$ as for singletons

471.3 Complications

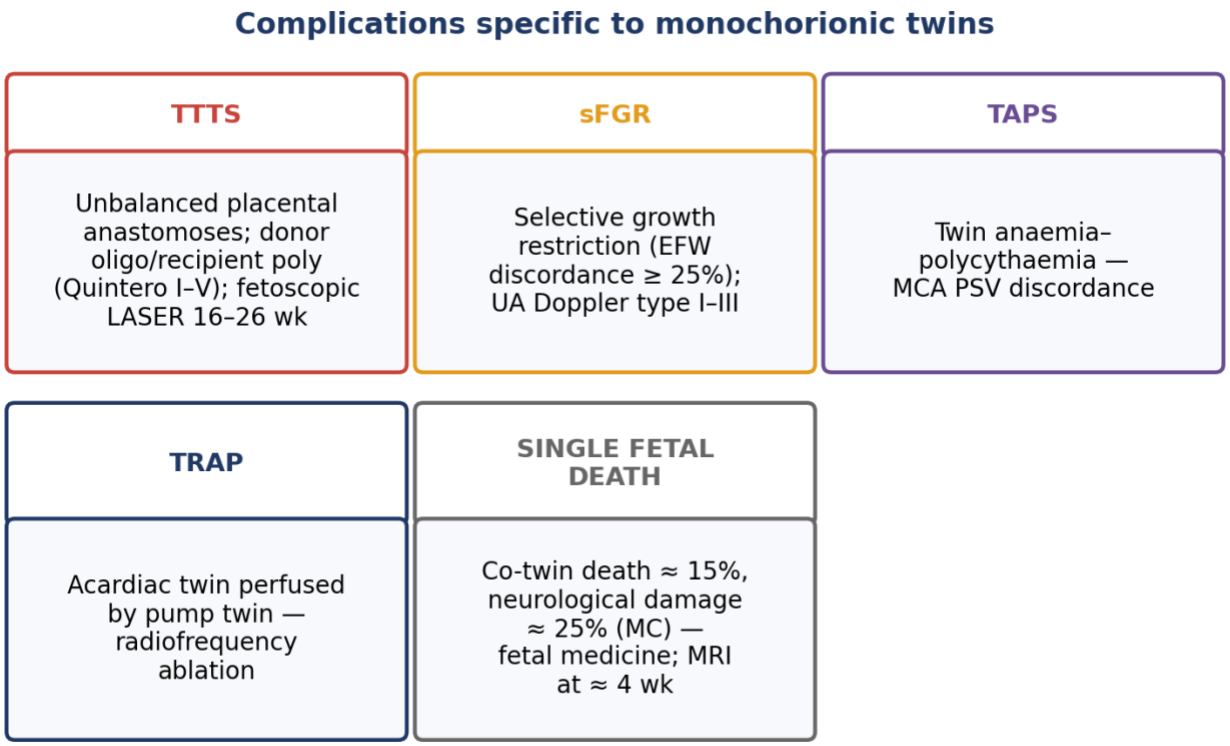


Figure 471.2 — Monochorionic complications

- Maternal: hyperemesis, anaemia, pre-eclampsia (≈ 3×), GDM, APH/PPH, VTE, CS, mental health.
- Fetal: preterm birth (≈ 60% of twins < 37 wk), FGR, congenital anomalies, stillbirth (higher in MC), cord entanglement (MCMA).

471.4 Timing and mode of birth

Type	Timing (NICE NG137)	Mode
DCDA twins	37+0 weeks	Vaginal birth possible if twin 1 cephalic; CS if twin 1 non-cephalic
MCDA twins	36+0 weeks (after steroids)	As for DCDA if uncomplicated
MCMA twins	32+0–33+6 weeks	Caesarean section
Trichorionic triplets	35+0 weeks	Usually CS
Shared-placenta triplets	33+0–34+0 weeks	CS

- Intrapartum: continuous CTG for both twins, IV access, group and save
  - Oxytocin ready for second twin (active 3rd stage — PPH risk)
  - Anaesthetist and neonatal team
  - Aim twin-to-twin interval < 30 min
  - Internal podalic version/breech extraction or CS for second twin if needed.

■ COMMON PITFALLS

Not determining chorionicity in the first trimester.

Scanning MC twins only every 4 weeks (TTTS missed).

Underestimating PPH risk after twin birth.

471.5 Must-know summary

■ EXAM TIP

- Chorionicity at 11–14 wk (lambda = DC, T-sign = MC); risk depends on chorionicity.
- DC scans 4-weekly from 20 wk; MC 2-weekly from 16 wk; discordance ≥ 25% → fetal medicine.
- TTTS (laser 16–26 wk), sFGR, TAPS, TRAP; single MC death — co-twin death ≈ 15%, neuro damage ≈ 25%.
- Birth: DCDA 37+0, MCDA 36+0, MCMA 32+0–33+6 (CS), triplets 35+0 (TC).

■ MNEMONIC / MEMORY AID

Twin timing — 'DC 37, MC 36, MCMA 32–33'.