From: "ROOT" <root@sctimst.ac.in>
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Date: 06/08/2024 07:55 AM
Subject: Invitation for CGR

Greetings from AIIMS, Rishikesh !!

The CGR will be held on the **Aug 6, 2024** in **CPD Hall**, AIIMS Rishikesh from **8:00 AM to 9:00 AM**. You can join online through the following link:

Meeting link:

https://aiimsrishikesh.webex.com/aiimsrishikesh/j.php?MTID=me30f4135d780c59c32d6f20a4510deae

Tuesday, Aug 6, 2024, 8:00 AM | (UTC+05:30) Chennai, Kolkata, Mumbai, New Delhi

Meeting number: 2519 974 5448

Meeting password: 060824

The Clinical handout of the case to be discussed is attached herewith.

Thanks & Regards

Regional Resource Centre
Dept of Telemedicine
AIIMS Rishikesh

Fetal Reduction and Beyond

Clinical Grand Round on Invasive Procedures in Fetal Medicine

Dept. of Obstetrics and Gynecology

PRESENTER

DR SUREKHA THAKUR

FELLOW, MATERNAL & FETAL MEDICINE

DEPT. OF OBSTETRICS AND GYNECOLOGY

AIIMS RISHIKESH

MODERATOR

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ADDITIONAL PROFESSOR,

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FETAL REDUCTION IS A PROCEDURE USED TO REDUCE THE NUMBER OF FETUSES IN A MULTIFETAL PREGNANCY. THIS IS DONE WITH THE INTENTION TO IMPROVE CHANCES OF A HEALTHY PREGNANCY & REDUCE MATERNAL & FETAL RISKS ASSOCIATED WITH MULTIPLE BIRTHS. MULTIFETAL REDUCTION IS CARRIED OUT IN TRIPLET OR HIGHER ORDER GESTATIONS. SELECTIVE FETAL REDUCTION IS CARRIED OUT IN TWINS WHERE ONE OF THE FETUS HAS A GENETIC DEFECT, STRUCTURAL MALFORMATION OR UNIQUE COMPLICATIONS OF MONO CHORIONIC TWIN PREGNANCIES [EXAMPLE TWIN TO TWIN TRANSFUSION SYNDROME (TTTS), TWIN REVERSE ARTERIAL PERFUSION SEQUENCE (TRAP), SELECTIVE FETAL GROWTH RESTRICTION (SFGR) AND TWIN ANEMIA POLYCYTHEMIA SYNDROME (TAPS).

WE PRESENT FOLLOWING FOUR CASES OF MULTIFETAL GESTATION WHERE FETAL REDUCTION WAS PERFORMED FOR DIFFERENT INDICATIONS.

Case 1:

A 35 year G3P2L2 with di-amniotic di-chorionic twin (DADC) pregnancy at 22 weeks period of gestation was referred in view of Non Invasive Prenatal Testing (NIPT) showing increased risk of Down Syndrome (T21) in one of the twin fetus. Detailed Anomaly Scan - No structural malformation in both twins. After detailed genetic counselling and explaining the procedure and the risks associated with it, amniocentesis was done from both the gestational sacs - Samples sent for QFPCR & Karyotype. Proper identification of the twins & labelling of the amniotic fluid samples ensured. Qualitative Fluorescent Polymerase Chain Reaction (QF PCR) report revealed trisomy 21 in one of the twins. Management: Selective Fetal Reduction of twin with aneuploidy was done with Intra- cardiac instillation of Potassium Chloride (KCl). Pregnancy continued to term and patient had a normal vaginal delivery of a healthy baby at 37 weeks.

Case 2:

A 28 year G3 P1L1 at 13 weeks period of gestation pregnancy, conceived following In Vitro Fertilisation (IVF) was referred with an ultrasound report showing a tri-amniotic tri-chorionic triplet pregnancy (TATC). Ultrasound (Nuchal Scan): Three separate foetuses with three separate placenta - lambda sign seen

I- CRL 69mm =13+2 weeks POG, NT 1.1mm No obvious anomaly

II - CRL 68 mm = 13+1 weeks POG, NT1.2 mmNo obvious anomaly

III - CRL 69 mm = 13+2 weeks POG, NT 1.2mm No obvious anomaly

Cervical length 3.7 cm

Management: Multifetal pregnancy reduction was done using intra-cardiac KCL resulting in a twin pregnancy. Pregnancy is currently ongoing at 17 weeks period of gestations with twins.

Case 3:

A 26 year female, G2P1L1 at 21+4 weeks period of gestation was referred in view of di -amniotic mono-chorionic twin pregnancy with Twin Reversed Arterial Perfusion Sequence [TRAP]. Ultrasound showed a twin gestation with a single placenta with thin intervening membrane [Di-amniotic monochorionic]. Twin A: Bi-parietal Diameter 20+3 weeks POG, No obvious congenital anomaly. Twin B was an amorphous mass (18 weeks) with generalised subcutaneous oedema & bilateral pleural effusion, hypo plastic heart [TRAP]. Amniocentesis of Twin A + Selective Fetal reduction of TRAP twin was done using Radio Frequency Ablation (RFA). Outcome: Pregnancy continued as a singleton pregnancy and patient had a normal vaginal delivery of 2.9 Kg baby at 36 weeks.

Case 4:

A 27 year old Primigravida at 22 weeks 4 day period of gestation was referred with a diagnosis of di-amniotic mono-chorionic twin (DAMC) pregnancy with polyhydramnios in one twin. A diagnosis of Twin to Twin Transfusion Syndrome [Quintero Stage I] was made. Ultrasound: Twin gestation with a single placenta with thin intervening membrane [Di-amniotic Mono-chorionic]. Fetus A: Stuck/Donor Twin - severe oligo-hydramnios, bladder seen, BPD 18 weeks , fetus stuck near the fundus, no obvious gross congenital anomaly. Fetus B: Recipient Twin - Polyhydramnios, bladder seen BPD 22weeks, no obvious gross congenital anomaly. Cervical 2.9 cm Management: Patient underwent selective fetal reduction by cord occlusion of stuck/donor twin with Interstitial Laser Ablation (ILA). Patient underwent selective fetal reduction by cord occlusion of stuck/donor twin with Interstitial Laser Ablation (ILA). Outcome: Patient went in to spontaneous preterm labour at 29 weeks 2 days. She delivered a 1.2 kg baby which was managed in the neonatal intensive care unit . Baby developed feed intolerance . An exploratory laparotomy was performed by pediatric surgery team on day 47 of life. Baby was found to have ileal atresia: resection & anastomosis was done. Baby was discharged on 67th day of life. Is currently stable at 11 months of age.

Attachments:

File: CGR summary 6_8_2024_OBG.docx	Size: 11k	Content Type: application/vnd.openxmlformats-officedocument.wordprocessingml.document