

Quadruplet Pregnancy Following Spontaneous Conception: A Rare Case Report

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ABSTRACT

Quadruplets are a set of four offspring born at one birth which can be fraternal (multizygotic), identical (monozygotic) or a combination of both. Multizygotic quadruplets occur from fertilisation of four different sets of ovum and sperm. Monozygotic multiples are the result of a fertilized egg that splits into two or more embryos. Multizygotic quadruplets can be all male, all female, or a combination of both while monozygotic quadruplets will always be of the same gender. Here we present a case of 32-year-old G4P3L0 with previous history of three term intrauterine foetal death (IUFD) at 27 wk of gestation. After evaluation, she was found to carry three live fetuses with an IUFD. She was managed conservatively till 35 wk of gestation with regular monitoring of coagulation parameters. Elective caesarean section was done at 35 wk and three live female babies and one male still born were delivered. This case is unique due to the fact that our patient conceived a multizygotic quadruplet pregnancy spontaneously following a bad obstetric history (3 previous term intrauterine fetal deaths). One fetus died in utero and the pregnancy continued successfully resulting in 3 live born healthy babies.

Keywords: Multiple gestations, Quadriamniotic quadrichorionic placenta, intrauterine death

CASE REPORT

A 32-year-old G4P3L0 was admitted to our hospital at 27 wk gestation with chief complaint of shortness of breath and lower abdominal discomfort of one week duration. She had been married for six years with three previous term intrauterine fetal deaths (2 male & 1 female) expelled vaginally in hospital. The cause of the intrauterine deaths remained unknown as there were no anomalies or abnormal investigation reports on further evaluation. She was diagnosed as a case of quadruplet pregnancy by ultrasound in first trimester at 11 wk gestation in the present pregnancy. Folic acid tablets were taken in the first trimester. In view of previous three unexplained, term intra-uterine deaths, she was empirically put on heparin and aspirin in this pregnancy from 11 wk of gestation. There was no history of ovulation induction or use of assisted reproductive techniques. Her previous menstrual cycles were regular and her marriage was a non-consanguineous one. There was no other relevant past and family history.

On general examination, our patient was conscious, oriented and afebrile. She was pale with demonstrable pedal edema. Respiratory and cardiovascular system examinations were found to be normal. On per abdomen examination uterus was over-distended with multiple palpable fetal parts. Two fetal heart sounds were distinctly audible on auscultation. Vaginal examination revealed cervix long, soft posterior with os closed. On ultrasound examination at the time of admission, she was diagnosed to have one intrauterine death with three live fetuses. She was on hematinics, folic acid, calcium, heparin and aspirin. Patient and attendees were counseled regarding risks of continuation/termination of pregnancy, outcome of fetus with respect to short term and long term effects were considered. After obtaining their consent, she was managed conservatively till 35 wk gestation with regular monitoring of coagulation parameters. She received 2 doses of betamethasone at 30 wk gestation to improve fetal outcome. Elective caesarean section was done at 35 wk gestation and quadruplets were delivered, among which 3 were live female babies (were admitted to Neonatal Intensive Care Unit and discharged after 3 days) and one male dead fetus [Table/Fig-1,2]. The birth weight of the three female babies was 1800 gm, 1400 gm and 1350 gm respectively. The male still born weighed 800 gm. Placenta was found to be quadrichorionic quadriamniotic [Table/

Fig-3,4]. Intra operative and postoperative period were uneventful. Patient was discharged from hospital with three live babies on seventh postoperative day.



[Table/Fig-1]: Three live female babies of the quadruplet pregnancy



[Table/Fig-2]: Macerated male intrauterine fetal death of one of the quadruplets



[Table/Fig-3]: Maternal side of Quadrichorionic quadriamniotic placenta



[Table/Fig-4]: Fetal side of placenta

DISCUSSION

Higher order (triplet or more) multiple pregnancies occur when more than two fetuses are present in the uterus at the same time. The incidence of higher order multiple pregnancies range from 0.01% to 0.07% of all pregnancies [1]. Maternal mortality and morbidity are greater in quadruplet pregnancy than in singleton pregnancy. The perinatal mortality and morbidity are also relatively high and are mainly due to premature delivery which is seen in more than 90% of the cases [2]. Spontaneous quadruplet pregnancy is very uncommon with an incidence rate of 1 in 512000 to 1 in 677, 000 births [2,3]. Though ovulation induction and ART procedures contribute to the bulk of cases in the present arena, cases of quadruplet pregnancies have been reported following the cessation of Clomiphene citrate for ovulation induction, the so-called "sustained effect" [4]. Single fetal death in twin pregnancies, the reported incidence ranges from 0.5% to 6.8% [5] though exact data is not available for quadruplet gestations. In monochorionic pregnancies, death of one twin confers the risk of cerebral damage in co-twin of about 25% and of death in a further 25%. Disseminated Intravascular Coagulation is a major maternal complication especially if the time interval from intrauterine death to delivery exceeded 5 wk [6].

Nnadi D et al., [1] reported a case of spontaneous monochorionic tetra-amniotic quadruplet pregnancy by natural conception following a 12-year history of unexplained primary infertility. Elective caesarean section was done at 37 wk and a set of monochorionic tetra-amniotic quadruplets (all females) were delivered. Vikranth U et al., [7] reported a case of quadruplet pregnancy following ovulation induction with gonadotrophin and human chorionic gonadotrophin. Elective caesarean section was done at 35 wk of gestation and a set of quadruplets (3 females and 1 male) were delivered. All the three female babies had no obvious congenital anomalies whereas the male baby had features of asymmetric intrauterine growth restriction with vesico-rectal fistula. In a study by A L Adegbite et al., in TC

(trichorionic) quadruplets, only one pregnancy was complicated by fetofetal transfusion syndrome. The patient went into spontaneous labor soon after the diagnosis at 23 wk of gestation and all four infants died immediately after birth [8]. As regards the neonatal outcome, TC quadruplets had significantly higher risks of respiratory distress syndrome (RDS), anemia and IVH compared to QC (quadrichorionic) infants. Long-term outcome in terms of chronic lung disease was also higher in TC than those of QC infants [8]. A thorough neonatal evaluation is indicated for the surviving fetuses to detect CNS, renal, circulatory and cutaneous defects. Investigations may include high resolution ultrasonography of brain, CT, MRI and renal function tests. Long term follow up is mandatory [9].

A case series by HHN Woo et al., concluded that, single fetal death in multiple pregnancies should be managed in a tertiary referral centre, where intensive fetal surveillance and adequate neonatal support are available [10]. A multidisciplinary approach should be adopted. The preferred method of delivery of quadruplet pregnancies is elective Caesarean section. This is because of increased risk of fetal malpresentations and difficult intrapartum fetal monitoring associated with the condition.

CONCLUSION

Conservative management is preferred in case of single fetal demise in multiple gestations. However the risk of keeping surviving twin in a hostile intrauterine environment must be weighed against the risk of preterm delivery. Multifetal gestation comprises a high risk pregnancy and proper antenatal and intrapartum care results in a successful maternal and fetal outcome as seen in our case.

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