

Ideal Anesthetic Technique Of Choice In Patients Undergoing Emergency Caesarean Section For Delivery Of Second Twin Following Normal Vaginal Delivery Of The First Twin- Our Experience.

Vinod Krishnagopal¹, Sharanya Krishnakumar², Raj Murugan³, Sudhakaran. R⁴

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Dear Sir,

Trial of labor (TOL) in twin pregnancies is becoming a common practice and the success of vaginal delivery depends on the parity of the mother and the presentation of the twins¹. Caesarean section (CS) is indicated in twin gestation with non-cephalic presentation and nulliparous women. When TOL is attempted in twin gestation there is a possibility of normal vaginal delivery of the first twin and need for CS to deliver the second twin (Combined delivery- CD). This may be due to non-cephalic presentation, failure of progression and fetal distress of the second twin.

When the patient presents with CD the main challenge for the anesthetist is to decide the plan of anesthesia (General anesthesia versus spinal anesthesia). It is ideal to restrict the time interval between the delivery of the twins to less than 30 min¹. We faced this difficulty in two of our patients where the first twin was delivered vaginally and the second twin developed a deep transverse arrest. Labor epidural was not administered due to the fear of the uterus developing inertia due to over distention. The patient was not administered any utero-tonic agents following the delivery of the first twin. We shifted the patient to the operation theatre and started an

additional intravenous line. The patient's hemodynamic parameters were (Patient 1-PR-92/min, BP-100/60mm of Hg and Patient-2 PR-89/min, BP102/57mmHg) noted and they were placed in the right lateral position. Under strict aseptic precaution Rapid sequence spinal (RSS) block was performed with 1.8ml of bupivacaine and 0.2ml of buprenorphine². The main problem that we faced during the intra-operative period was the atonicity of the uterus following delivery. In addition to pharmacological agents, modified Blynch suturing of the uterus was done to arrest the bleeding. At the end of the procedure both the patients were placed in the lithotomy position to suture the episiotomy incision.

The major advantages of GA are reduction in procedural time, administration in the supine position and stable hemodynamics. The major concerns with the GA are risk of aspiration, difficulty in securing the airway and interference with uterine contraction.³ Additionally studies in the past have shown that the second twin in CD had a lower 5min APGAR and acidosis which could be worsened by GA^{1,4}. Though RSS can reduce the procedural time, it has the disadvantage of patient positioning and hemodynamic instability⁵. Both these factors could play a major role in these patients as they would be suffering severe perineal pain due to episiotomy wound and would have experienced blood loss following the vaginal delivery of the first twin. But however, spinal anesthesia has the advantage of avoiding airway manipulation in a full stomach patient and does not reduce the uterine tonicity. As our patients were cooperative enough to be positio-

^{1,3,4} Department of Anesthesiology, SreeBalaji medical college and hospital,

²Department of Microbiology, SreeBalaji medical college and hospital.

Correspondence: Dr Vinod Krishnagopal
Department of Anesthesiology, SreeBalaji
medical college and hospital

Email: vinodkrishnagopal@gmail.com

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ntied in the lateral position and as the hemodynamics were stable, we were able to perform spinal anesthesia safely. Considering these advantages, we feel that RSS would definitely be more safer than GA in cooperative and hemodynamically stable patients who undergo CD.

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