Twin Vaginal Delivery Checklist

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Planned vaginal delivery of a twin gestation should include every effort to avoid delivering the first twin vaginally followed by urgent or emergent cesarean delivery of the second twin. This checklist should be used for all patients admitted to L&D for planned vaginal delivery of twins.

On admission to labor and delivery

Obstetrician

- ❑ Patient should be counseled on importance of epidural analgesia for delivery
- ❑ An obstetrician skilled in twin delivery, including possible breech extraction of 2nd twin, should be present or readily availability (within 30 minutes) throughout labor
- ❑ H&P should include the following documentation:
  - ✓ Ultrasound estimated fetal weight (EFW) of both twins, ideally within 2 weeks of admission
  - ✓ Ultrasound assessment of fetal presentation of both twins
  - ✓ Delivery plan that includes mode of delivery of 2nd twin if non-cephalic (breech extraction vs. cesarean birth) that takes into consideration weight discordance of twins

RN

- ❑ Patient should have large bore IV access placed
- ❑ RN should know covering and delivery provider's name(s) and contact information

Anesthesia

- ❑ Patient should be assessed for possible early epidural placement to ensure it is in place and working at complete dilation

At complete dilation

- ❑ Patient should be transferred to the operating room for delivery when she reaches complete dilation and/or no later than +3 station of the 1st twin
- ❑ Delivering provider should be at bedside to initiate transfer to operating room
- ❑ Primary RN should notify Charge RN and anesthesia of plan to move to operating room
- ❑ Patient should be transferred to operating room for delivery with preparation for double set up

Upon arrival to the Operating Room:

- ❑ Transfer via LDR Bed to OR suite and place in Allen stirrups on OR table.

- ❑ Confirm presence of the following in the OR:
  - ✓ Ultrasound is in room and powered on
  - ✓ Indicated anesthesia and neonatal personnel
  - ✓ All uterotonic agents
  - ✓ PPH cart (in hallway)
  - ✓ Vaginal delivery table
  - ✓ Cesarean delivery table
  - ✓ Amnihook for AROM of 2nd twin
  - ✓ Fetal scalp electrode and cables
  - ✓ Oxytocin pump
  - ✓ Forceps (type to be specified by delivering obstetrician)
  - ✓ Vacuum

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A time-out should be performed and the delivering obstetrician should announce the following:

- ❑ Positive patient identification (PPID)
- ❑ Planned mode of delivery of 1st twin (i.e., spontaneous, forceps, vacuum). If forceps or vacuum planned, they should be in OR
- ❑ Identification of ultrasound operator to assist with presentation of 2nd twin after delivery of 1st twin
- ❑ EFW, weight discordance, and current presentation of twins
- ❑ Contraindications to any uterotonic agents based on the patient's medical history
- ❑ Immediate or post-placental oxytocin after delivery of 2nd twin
- ❑ Plan after delivery of 1st twin:

If 2nd twin is cephalic, consider the following plan:

- ✓ Increase/start oxytocin PRN (increase by 2-4 mU/min or start at 4 mu/min) – **to be administered by RN**
- ✓ Continue patient expulsive forces, when appropriate
- ✓ Avoid AROM until head is engaged
- ✓ Confirm forceps or vacuum if planned are in OR

If 2nd twin is non-cephalic

- ✓ Will vaginal or cesarean delivery be performed?
- ✓ If vaginal delivery, consider the following plan:
  - Have Piper forceps available in the OR
  - Discontinue oxytocin and patient pushing
  - Have terbutaline and/or nitroglycerin in OR for uterine relaxation – **to be administered by Anesthesia**

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Reference

References

1. Schmitz T, Bernabe C, Azria E, Goffinet F. Intrapartum management of twin gestations. *Obstet Gynecol*. Sep 2007;110(3):712; author reply 712. doi:10.1097/01.AOG.0000280282.83266.15