

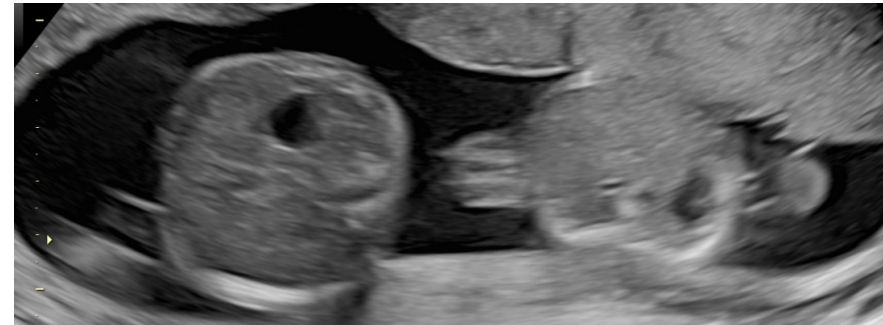
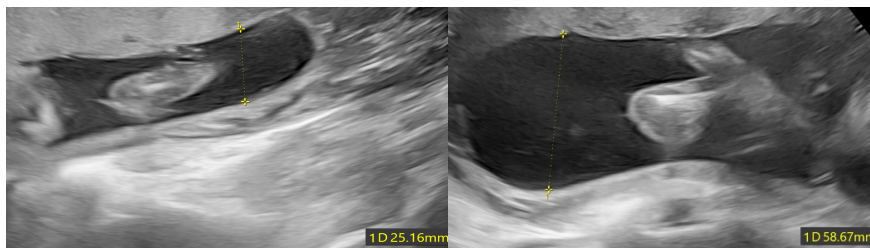
## MONOCHORIONIC PREGNANCY: SELECTIVE INTRAUTERINE GROWTH RESTRICTION

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**OBJECTIVE:** Selective fetal growth restriction (sFGR) is defined as the presence of growth retardation in one of the fetuses of a gestation. It is more in monochorionic monoamniotic gestations. Differential diagnosis should be made with other pathologies, especially with twin twin transfusion syndrome (TTT). In this poster we describe both, the diagnostic criteria for sFGR and the features that differentiate it from TTT.

**METHODS:** We present the case of a 25-year-old woman, primigravida, with no personal history of interest. Spontaneous biamniotic monochorionic twin pregnancy treated at Hospital Complex of Albacete. In week 18, after ruling out twin - twin transfusion syndrome, a diagnosis of selective fetal growth restriction was made.

**RESULTS:** According to guidelines, a monochorionic gestation should be checked by ultrasound every two weeks. During these controls, in our patient, an estimated foetal weight discordance of 18% was observed at week 21. The first twin was appropriate for its age, while the second twin has an estimated weight <10<sup>th</sup> centile and a CA <10<sup>th</sup> centile, no Doppler abnormalities. At this time, the second twins had enough contributory parameters for a diagnosis of sFGR according to the current literature: one solitary parameter (EFW of one twin <3<sup>rd</sup> centil) or 2 out of 4 (EFW of twin <10<sup>th</sup> centile; AC of one twin <10<sup>th</sup> centile; EFW discordance  $\geq 25\%$ , UA - PI of smaller twin > 95<sup>th</sup> centile). However, the diagnosis of sFGR is a diagnosis of exclusion, and TTT must have been previously ruled out. For this purpose, the bladders of both fetuses must be visualised and a measurement of the amniotic fluid must be taken. In this case, both bladders were visualised, with no discordance between them, and amniotic fluid measurement was normal in both foetuses. Therefore, the diagnosis of FGRs could be done.



There are three types of FGRs depending on the diastolic flow of the umbilical artery (UA). Our second twin was diagnosed of type I sFGR. Type I, with a fairly good outcome, may be treated with an expectant management. If it were to evolve to other types of FGR, management may not differ from type I monitoring until deterioration of the sFGR fetus is observed. Active management could be cord occlusion or laser coagulation. Both therapies seem to increase the chances of intact survival of the larger fetus, although cord occlusion has better survival rates and less fetal morbidity. Our patient had a great evolution during the pregnancy, being closely monitoring. An echocardiography and neurosonography had been done and weekly doppler and biometry was done every two weeks until delivery. Type I have lower overall rates of fetal demise, neonatal mortality, and cerebral injury compared with the other types. Delivery is recommended at 35 weeks of pregnancy. In this case, caesarean section was done at 35 weeks because of fetal presentation, being possible in other cases vaginal delivery.

**CONCLUSION:** Selective fetal growth restriction is a complication of monochorionic twins. For its diagnosis, other complications should be ruled out, especially TTTS. sFGR needs a closely monitoring and appropriate management according to the type to improve fetal outcomes