

**CASE REPORT**

# A Rare Case of Syncephalus Thoracopagus Monster

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**Abstract**

Conjoined twins are rare with an incidence of 1 in 1,00,000 to 2,00,000 births. They are always monozygotic and are more common in females (3:1). About 40 to 60 % are stillborn and another 35 % die within 24 hours after the delivery. We hereby Report a rare case Syncephalus Thoracopagus Monster.

**Key Words**

Conjoined, Thoracopagus, Monozygotic

**Introduction**

Conjoined twins are commonly referred to as Siamese twins after Chang and Eng Bunker of Siam who were thoracopagus and lived for 63 years. Conjoined twins are rare with an incidence of 1 in 1,00,000 to 2,00,000 births (1). They are always monozygotic and are more common in females (3:1). About 40 to 60 % are stillborn and another 35 % die within 24 hours after the delivery. Theoretically they occur due to incomplete division of a monozygotic embryo at 13-15 days post ovulation i.e. after the embryonic disc and the rudimentary amnionic sac has formed. These twins can be conjoined at any number of physical points and classified accordingly - thoracopagus, omphalopagus, pyopagus, craniopagus, ischiopagus. The majority are thoracopagus. The incomplete division may begin at either or both poles of embryonic disc producing two heads; two, three or four arms; two, three or four legs; or some combination thereof.

**Case Report**

Mrs. Xyz, a 21 years old primigravida, originally resident of Chattisgarh, presented to our labour room on 19th Jan. 2010 with 8 months amenorrhoea with preterm labour and leaking for 6 to 8 hours.

Her LMP was not known, past menstrual history was 3-4/30, regular. No ante-natal record was available. It was a spontaneous conception and no h/o intake of any ovulation induction drugs nor any assisted reproductive technique. There was no exposure to any teratogen in first trimester. No h/o contraceptive used. There was no family history of multiple pregnancy or congenital malformation.

On examination, there was mild pallor, no oedema, pulse 90/min, BP 110/76 mm of Hg, Chest and CVS - NAD. P/A - uterus was corresponding to 34 weeks with multiple fetal parts being felt. Head was deeply engaged.

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**Fig 1. Showing Conjoined Twins**

FHS was not localized. She was getting good contractions. On P/V cervix was fully dilated with head visible at perineum.

As that patient was in advanced labour, she was shifted to delivery suite, an IV line established. With few maternal pushes and without oxytocin, head was born and it was clear that it was a syncephalus monster with 3 ears, 2 occiputs, 1 face with 2 eyes, single nose and single mouth. Surprisingly, rest of the monster was delivered easily and it was found to be a very rare case of syncephalus thoracopagus monster. External genitalia were female, weight 2.5 kgs and it showed no signs of life. Lower parts of bodies were separate with a pair of lower limbs each, but there were three arms and single umbilical cord. Single placenta was delivered. Photographs were taken and we tried to obtain consent for autopsy but attendants were reluctant and they went away with monster. Mother was observed for one day and discharged on request the next day.

### Discussion

We looked for similar cases in literature and found a very similar case described by Gough (2) in 1934 with two complete lower bodies, one face, two occiputs and four ears (Syncephalus Thoracopagus, subgroup Disprospus Diophthalmus). Ghaisas (3) has reported a case of conjoined twins in 2001 and in the same year

Dave *et al* (4) described case of conjoined twins in a triplet pregnancy. Manchanda (5) *et al* also reported a case of conjoined twins in 2002. All these reported cases were thoracopagus bicephalus.

The tragic death of Laden and Laleh in an operation theatre in Singapore highlights the daunting challenge of separating conjoined twins. The diagnosis of conjoined twins can frequently be made at mid pregnancy using sonography which allows the parents to decide whether or not to continue the pregnancy. 3-D USG is more useful. Amniography, foetography, CT scan and MRI are other useful modalities in the diagnosis of this condition. A thorough examination of point of connection and the organs involved is essential before counseling is provided. The surgical separation is successful when organs essential for life are not shared. Consultation with the pediatric surgeon often facilitates parental decision making. Twinning is a teratogenic event and conjoint twins may have discordant structural anomalies that further complicate decisions about whether or not continue the pregnancy. The surgical separation of conjoined twins is a delicate and risky procedure, although success rate has improved over the years. To determine the feasibility of separation, one must carefully access how the twins share organ function.

Vaginal delivery of conjoint twins for pregnancy termination is possible because union is mostly pliable although dystocia is common. If the fetuses are mature vaginal delivery may be traumatic.

### References

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