Offer women with twin pregnancies a first trimester ultrasound scan between 11 weeks 0 days and 13 weeks 6 days to estimate gestational age, determine chorionicity and screen for fetal trisomies (ideally, these should all be performed at the same scan).

Assign nomenclature to babies in twin pregnancy and document this clearly in the woman’s notes to ensure consistency throughout pregnancy.

Use the larger baby to estimate gestational age to avoid the risk of estimating it from a baby with early growth pathology.

Determine chorionicity at the time of detecting the twin pregnancy by ultrasound using the number of placental masses, the lambda or T-sign and membrane thickness.

If a woman presents after 14 weeks 0 days, determine chorionicity at the earliest opportunity by ultrasound using all of the following: the number of placental masses, the lambda or T-sign, membrane thickness and discordant fetal sex.

If transabdominal ultrasound scan views are poor because of a retroverted uterus or a high body mass index, use a transvaginal ultrasound scan to determine chorionicity.

If it is not possible to determine chorionicity by ultrasound at the time of detecting the twin pregnancy, seek a second opinion from a senior ultrasonographer or offer the woman referral to a healthcare professional who is competent in determining chorionicity by ultrasound scan as soon as possible. If chorionicity cannot be determined even after referral, manage as monochorionic pregnancy until proved otherwise.

Give the same advice about nutritional supplements, diet and lifestyle as in routine antenatal care.

Be aware of the higher incidence of anaemia in women with twin pregnancies compared with single pregnancies.

The core team should offer information and support specific to twin pregnancies at the first contact with the woman and provide ongoing opportunities for further discussion and advice covering:

- antenatal and postnatal mental health and wellbeing
- antenatal nutrition
- the risks, symptoms and signs of preterm labour and the potential need for corticosteroids for fetal lung maturation
- likely timing and possible modes of delivery
- breastfeeding
- parenting
- the different options for screening (as in routine antenatal care)
- the risks associated with twin pregnancies for women and babies:
  - hypertensive disorders
  - feto-fetal transfusion syndrome in monochorionic twin pregnancies
  - fetal abnormalities
  - chromosomal abnormalities (fetal trisomies)
  - the higher false positive rate of screening tests in twin pregnancies
  - the increased likelihood of being offered invasive testing in twin pregnancies
  - the risk of spontaneous preterm birth
- the physical risks and psychological implications related to selective fetal reduction.

A healthcare professional with experience of caring for women with twin pregnancies should offer information and counselling before and after every screening test.

Explain sensitively the aims and possible outcomes of all screening and diagnostic tests to minimise anxiety.

Discuss with women with twin pregnancies the timing of birth and possible modes of delivery early in the third trimester.
**Dichorionic twin pregnancies**

**Screening and management**
Inform women about the complexity of decisions they may need to make depending on the outcomes of screening, including different options according to the chorionicity of the pregnancy.

**Identify chromosomal abnormalities**
Healthcare professionals who screen for fetal trisomies should:
- map the fetal positions
- use the combined screening test for fetal trisomies between 11 weeks 0 days and 13 weeks 6 days
- calculate the risk of fetal trisomies in each fetus.

Do not use second trimester serum screening for fetal trisomies.

Offer women with twin pregnancies who have a high risk of trisomy 21 (Down’s syndrome) (use a threshold of 1:150 as defined by FASP) referral to a fetal medicine specialist in a tertiary level fetal medicine centre.

**Identify structural abnormalities**
Offer screening for structural abnormalities (such as cardiac abnormalities) as in routine antenatal care.

Consider scheduling ultrasound scans in twin pregnancies at a slightly later gestational age than in single pregnancies and be aware that the scans will take longer to perform.

Allow 45 minutes for the anomaly scan (as recommended by FASP).

Allow 30 minutes for growth scans.

Seek a consultant opinion from a tertiary level fetal medicine centre for:
- discordant fetal growth
- fetal anomaly
- discordant fetal death.

**Screening for intrauterine growth restriction**
Do not use abdominal palpation or symphys-fundal height measurements to predict intrauterine growth restriction.

Estimate fetal weight discordance using two or more biometric parameters at each ultrasound scan from 20 weeks. Aim to undertake scans at intervals of less than 28 days. Consider a 25% or greater difference in size between twins as a clinically important indicator of intrauterine growth restriction and offer referral to a tertiary level fetal medicine centre.

Do not use umbilical artery Doppler ultrasound to screen for intrauterine growth restriction or birthweight differences.

**Pregnancy complications**
Measure blood pressure and test urine for proteinuria to screen for hypertensive disorders at each antenatal appointment in twin pregnancies as in routine antenatal care.

Advise women that they should take 75 mg of aspirin daily from 12 weeks until the birth of the babies if they have risk factors for hypertension.

Perform a full blood count at 20-24 weeks to identify women who need early supplementation with iron or folate acid, and repeat at 28 weeks as in routine antenatal care.

**Timing of birth**
Inform women that spontaneous preterm birth and elective preterm birth are associated with an increased risk of admission to a special care baby unit.

Inform women with uncomplicated pregnancies that elective birth from 37 weeks 0 days does not appear to be associated with an increased risk of serious adverse outcomes, and that continuing uncomplicated twin pregnancies beyond 38 weeks 0 days increases the risk of fetal death.

Offer women with uncomplicated pregnancies elective birth from 37 weeks 0 days.

For women who decline elective birth, offer weekly appointments with the specialist obstetrician. At each appointment offer an ultrasound scan, and perform weekly biophysical profile assessments and fortnightly fetal growth scans.

**Risks of spontaneous preterm delivery**
Inform women with twin pregnancies that about 60% of twin pregnancies result in spontaneous birth before 37 weeks 0 days.

Be aware that women with twin pregnancies have a higher risk of spontaneous preterm birth if they have had a spontaneous preterm birth in a previous single pregnancy.

Inform women of their increased risk of preterm birth and about the benefits of targeted corticosteroids. Also inform them that there is no benefit in using untargeted (routine) corticosteroids.

Do not use fetal fibronectin testing alone to predict the risk of spontaneous preterm birth.

Do not use home uterine activity monitoring to predict the risk of spontaneous preterm birth.

Do not use cervical length (with or without fetal fibronectin) routinely to predict the risk of spontaneous preterm birth.

Do not use the following interventions (alone or in combination) routinely to prevent spontaneous preterm birth:
- bed rest at home or in hospital
- intramuscular or vaginal progesterone
- cervical cerclage
- oral tocolytics.

Do not use single or multiple untargeted (routine) courses of corticosteroids.
Identify feto-fetal transfusion syndrome (FFTS)
Do not screen for FFTS in the first trimester.
Start diagnostic monitoring with ultrasound for FFTS (including to identify membrane folding) from 16 weeks. Repeat monitoring fortnightly until 24 weeks.
Carry out weekly monitoring of twin pregnancies with membrane folding or other possible early signs of feto-fetal transfusion syndrome (specifically, pregnancies with intertwin membrane infolding and amniotic fluid discordance) to allow time to intervene if needed.

Identify structural abnormalities
Offer screening for structural abnormalities (such as cardiac abnormalities) as in routine antenatal care.
Consider scheduling ultrasound scans in twin pregnancies at a slightly later gestational age than in single pregnancies and be aware that the scans will take longer to perform.
Allow 45 minutes for the anomaly scan (as recommended by FASP).
Allow 30 minutes for growth scans.

Pregnancy complications
Measure blood pressure and test urine for proteinuria to screen for hypertensive disorders at each antenatal appointment in twin pregnancies as in routine antenatal care.
Advise women that they should take 75 mg of aspirin daily from 12 weeks until the birth of the babies if they have risk factors for hypertension.
Perform a full blood count at 20-24 weeks to identify women who need early supplementation with iron or folic acid, and repeat at 28 weeks as in routine antenatal care.

Screening and management
Inform women about the complexity of decisions they may need to make depending on the outcomes of screening, including different options according to the chorionicity of the pregnancy.

Monochorionic twin pregnancies

Monochorionic diamniotic twin pregnancies
Offer women with uncomplicated pregnancies appointments with a healthcare professional from the core team as indicated in Box 1.

Monochorionic monoamniotic twin pregnancies
Seek a consultant opinion from a tertiary level fetal medicine centre for an individualised care plan.

Identify chromosomal abnormalities
Healthcare professionals who screen for fetal trisomies should:
- map the fetal positions
- use the combined screening test for fetal trisomies between 11 weeks 0 days and 13 weeks 6 days
- calculate the risk of fetal trisomies in each fetus.
Do not use second trimester serum screening for fetal trisomies.
Offer women with twin pregnancies who have a high risk of trisomy 21 (Down's syndrome) (use a threshold of 1:150 as defined by FASP) referral to a fetal medicine specialist in a tertiary level fetal medicine centre.

Risks of spontaneous preterm delivery
Inform women with twin pregnancies that about 60% of twin pregnancies result in spontaneous birth before 37 weeks 0 days.
Be aware that women with twin pregnancies have a higher risk of spontaneous preterm birth if they have had a spontaneous preterm birth in a previous single pregnancy.
Inform women of their increased risk of preterm birth and about the benefits of targeted corticosteroids. Also inform them that there is no benefit in using untargeted (routine) corticosteroids.
Do not use fetal fibronectin testing alone to predict the risk of spontaneous preterm birth.
Do not use home uterine activity monitoring to predict risk of spontaneous preterm birth.
Do not use cervical length (with or without fetal fibronectin) routinely to predict the risk of spontaneous preterm birth.
**Timing of birth**

Inform women that spontaneous preterm birth and elective preterm birth are associated with an increased risk of admission to a special care baby unit.

Inform women with uncomplicated pregnancies that elective birth from 37 weeks 0 days does not appear to be associated with an increased risk of serious adverse outcomes, and that continuing uncomplicated twin pregnancies beyond 38 weeks 0 days increases the risk of fetal death.

Offer women with uncomplicated pregnancies elective birth from 36 weeks 0 days, after a course of antenatal corticosteroids has been offered.

For women who decline elective birth, offer weekly appointments with the specialist obstetrician. At each appointment offer an ultrasound scan, and perform weekly biophysical profile assessments and fortnightly fetal growth scans.

**Screening for intrauterine growth restriction**

Do not use abdominal palpation or symphysis-fundal height measurements to predict intrauterine growth restriction.

Estimate fetal weight discordance using two or more biometric parameters at each ultrasound scan from 20 weeks. Aim to undertake scans at intervals of less than 28 days. Consider a 25% or greater difference in size between twins as a clinically important indicator of intrauterine growth restriction and offer referral to a tertiary level fetal medicine centre.

Do not use umbilical artery Doppler ultrasound to screen for intrauterine growth restriction or birthweight differences.

Seek a consultant opinion from a tertiary level fetal medicine centre for:
- discordant fetal growth
- fetal anomaly
- discordant fetal death
- FFTS.

**Do not use the following interventions (alone or in combination) routinely to prevent spontaneous preterm birth:**
- bed rest at home or in hospital
- intramuscular or vaginal progesterone
- cervical cerclage
- oral tocolytics.

Do not use single or multiple untargeted (routine) courses of corticosteroids.
<table>
<thead>
<tr>
<th>Type of twin pregnancy</th>
<th>Timing of antenatal appointments with a healthcare professional from the core team</th>
<th>Timing of ultrasound scans</th>
<th>Minimum number of contacts with a specialist obstetrician</th>
<th>Minimum total number of antenatal appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monochorionic diamniotic</td>
<td>11 weeks 0 days to 13 weeks 6 days, 16, 18, 20, 22, 24, 28, 32 and 34 weeks</td>
<td>At each antenatal appointment (see left)</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Dichorionic</td>
<td>11 weeks 0 days to 13 weeks 6 days, 16, 20, 24, 28, 32, 34 and 36 weeks</td>
<td>11 weeks 0 days to 13 weeks 6 days, 20, 24, 28, 32 and 36 weeks</td>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>

Women with pregnancies involving a shared amnion should be offered individualised care from healthcare professionals with expertise in this area.