Sir,

Heteropagus twin is a type of conjoined twin where an incomplete twin – the parasite, is attached to apparently fully formed twin – the autosite.\(^1\) Epigastric heteropagus twinning is a rare variety of asymmetric conjoined twins.\(^2\) Bhansali \textit{et al.} in review of literature found 25 reported cases epigastric heteropagus twinning from 1964 to 2005.\(^3\) Such cases have been reported from Pakistan as well that survived after removal of parasite,\(^4\) but this did not happen in the case reported below.

A male baby (autosite) was brought to emergency room of National Institute of Child Health, Karachi, in a critical condition 6 hours after traumatic attempt at vaginal delivery, with a parasite partially attached to the epigastrium and bowel loops protruding out of surgical incision (to facilitate delivery) made at primary facility. The gauze pieces were wrapped around the surgical wound in an attempt to secure haemostatis (Figure 1). The completely formed baby was lethargic and cyanosed, with upper torso dusky in appearance due to obstructed labour, parasite being the cause. In a desperate attempt the doctors at the primary facility had tried to chop off the parasite but failed. Parasite appeared dead pale on arrival (Figure 2). The combined weight of the heteropagus conjoined twins was 3 kg. Autosite was resuscitated with oxygen inhalation, intravenous fluids and measures taken to prevent hypothermia. They were then transferred to operation theatre and parasite was separated under general anaesthesia. Parasite had 4 limbs connected to each other with skin bridge. Head and upper torso were not formed. The two lower limbs had part of lower abdomen which housed bowel loops with multiple atresias. The genitalia of the parasite was that of male with bilateral undescended testis and imperforate anus. The joints of lower and upper limbs were fused. An omphalocoele was present caudal to the attachment of the parasite in autosite. No communication was found between viscera of parasite and autosite although aberrant blood vessels were ligated and divided that were running towards parasite. After separation of the incomplete twin the residual defect was closed. It was not possible to achieve fascial closure because of widely divergent recti at epigastrium.

Postoperative course remained stormy and baby was unable to maintain oxygenation. Patient was therefore placed on ventilatory support. Echocardiography revealed complex cardiac anomaly including transposition of great arteries, atrial septal defect - secundum type and patent ductus arteriosus while the ultrasound abdominal was reported as normal. In spite of all efforts baby died within 36 hours of admission.

Many shortcomings were identified in the management of this case. The mother was a booked case and had antenatal ultrasound. Family was not informed about status of the foetus and attempt at vaginal delivery was taken without anticipating problems at delivery. Once delivery had taken place no measures were taken to prevent the baby from further trauma. The chain of events led to more harm to the autosite. Ideally the conjoined twins must have been picked up on antenatal ultrasound and timely opinion sought from a paediatric surgeon. A team approach is warranted in dealing with complex foetal anomalies. A safe mode delivery is to be planned where facilities to take care of newborns are available.
including surgical intervention must be available. All such facilities are present in this city but lack of proper antenatal and labour care led to the demise of the baby.

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Clinically Justified Application of Obstetric Ultrasound

Sir,

I read with interest the editorial by Dr. Saba Sohail that appeared in the May 2010 issue of JCPSP. I appreciate her effort to contribute on this important radiology related service issue. I totally agree with author’s opinion regarding rational use of imaging services with appropriate indication by considering risk versus benefits. Furthermore, I would like to highlight another area of safety concern, misuse of obstetric ultrasound and Doppler especially in first trimester of pregnancy to cater the overwhelming requests by referring physicians or patients themselves due to possible lack of awareness related to ultrasound biosafety issues. Moreover, with the advent of 3D and 4D sonographic equipment, people are using it for “keep picture” rather than diagnostic or screening purpose. Ultrasound can produce bioeffects by cavitation and heating mechanisms leading to fetal anomalies. Therefore, obstetric ultrasound should be restricted to clinically justified request and it is operator’s responsibility to keep the acoustic technique as low as possible (ALARA) when necessary. There is a national need to assess the knowledge of operators, referring physicians and patients regarding the biosafety issues of ultrasound during pregnancy, so proper intervention can be implemented.

REFERENCES

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