

The most serious complication of IMPs is preterm birth of very and extremely low birth weight infants. The expecting mothers of twins and triplets have a 10% chance of delivering at least one infant who weighs <1500 and <1000 g, respectively. Preterm delivery and very and extremely low birth weight correlate with neonatal mortality and with short- and long-term morbidity. For example, it is currently estimated that IMPs alone increase the cerebral palsy rate by 8%. In addition, although most IMPs are polyzygotic, it has been established that ART is associated with a 3- to 10-fold increased incidence of zygotic splitting. The consequences of monozygosity are higher frequencies of malformations, twin-twin transfusion, and complications of monoamnicity. The expecting mother is at 4 to 6 times increased risk to develop serious hypertensive disorders, to experience preterm contractions, to be anemic, to sustain hemorrhage, and to undergo operative interventions.

Because there are no practical methods to significantly reduce these complications, the only potential solution is to control the frequency of IMPs by either avoiding OI or by transferring only a single high-quality embryo in each IVF cycle.

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MANAGEMENT OF MULTIPLE PREGNANCY: APPLICATION TO DEVELOPING COUNTRIES

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Multiple pregnancies (MP) are at high risk for adverse perinatal outcome. The following objectives seem to be important in the management of MP and are applicable for developing countries. Keeping in mind these objectives may reduce perinatal and maternal morbidity and mortality.

1. Early diagnosis of MP is essential for a successful follow up. This can be done by clinical and sonographic means.
2. Physicians who are specialized in obstetric care should do pregnancy follow up.
3. Diagnosis of chorionicity by simple sonographic means is of central importance.
4. Care for the mother having a MP should include liberal work leaves and reduced physical activity.
5. Complications occurring more frequently in MP (PET, anemia, PTD, etc.) should be looked for.
6. Frequent assessment of cervical status towards the end of the second trimester may help recognizing impending preterm birth.
7. Transport of high-risk patients to secondary or tertiary centers should be available.
8. Delivery of multiples should be carried out in a tertiary center or where cesarean delivery and blood transfusion are at hand.

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CONTRIBUTION OF MULTIPLE PREGNANCIES TO PERINATAL MORTALITY AND MORBIDITY

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The twinning rate has increased from 10 per 1000 pregnancies in the 1970s to 13 per 1000 pregnancies, as a result of infertility treatment. But for every twin pair born, at least 10 singletons are conceived as one of a twin pair (the vanishing twin syndrome). The dizygotic to monozygotic ratio is up to 2.0 in some countries. Monozygotic twinning rate is constant worldwide at 3-5 per 1000 pregnancies. Dizygotic twinning is highest in Africa and lowest in the Far East, with Caucasians and Indians in between (increasing with maternal age and parity). Australian data showed that multiple births account for 10% of perinatal deaths (7% of fetal deaths and 13% of neonatal deaths). Perinatal mortality rate in twins is 4.1 times higher than singletons (stillbirth rate 3.1 times higher and neonatal mortality rate 5.6 times higher). Data from the United Kingdom showed that the infant mortality rate in twins is 6.2 times higher than singletons. Furthermore, the cerebral palsy rate among survivors is 5.5 times higher in twins compared to singletons (difference greatest among term infants). The risk for both mortality and morbidity is increased in monozygotic twins due to (1) the cell division process leading to chromosomal or other ano-

malous lethal aberration in one fetus, (2) twin-twin transfusion syndrome (TTTS), and (3) adverse consequences on the surviving fetus after the fetal death of its co-twin. The incidence of TTTS is 15-30% in monochorionic monozygotic twins. Obstetric risks, survival and neurological outcome associated with interventions for treating TTTS (serial amnioreduction, fetoscopic laser ablation of placental vascular anastomoses, amniotic septostomy, and selective feticide) have been reported, and several randomised controlled trials are in progress.

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MULTIFETAL PREGNANCY REDUCTION

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This study was undertaken to evaluate the pregnancy outcome in women who underwent multifetal pregnancy reduction

The data reported here reflect the multifetal pregnancy reduction experience of Hacettepe University Hospital Dept of Ob/Gyn, Division of Perinatology from 1995 through 2002.

Pregnancy records were retrospectively reviewed.

In the absence of any abnormal findings, the fetuses most readily accessible were chosen for reduction, usually those most fundal in location. All multifetal pregnancy reduction procedures were performed between 9 and 14 weeks gestation via intrathoracic injection of potassium chloride under ultrasonographic guidance.

The fetus chosen for reduction was the one with suspicious ultrasonographic findings such as increased nuchal translucency thickness or delayed growth in comparison with others.

122 procedures were performed on 83 pregnancies. Of these pregnancies 53 (63,85%) were triplets, 20 (24,09%) were quadriplets, 6 (7,22%) were quintuplets and 4 (4,81%) were sextuplets.

Mean age of patients was 31,8±4,2, mean gestational age at MFPR was 11,2±1,2, mean starting number was 3,4±0,8 (3-6) and finishing number was 2.

Fetal loss rates according to starting number of fetuses are summarised in Table 1.

	Loss <20 weeks	Loss btw 20-28 weeks	Total loss
3-2 (53)	1 (1,88%)	2 (3,76%)	3 (5,66%)
4-2 (20)	1 (5%)	2 (10%)	3 (15%)
5-2 (6)	1 (16,6%)	2 (33,3%)	3 (50%)
6-2 (4)	1 (25%)	1 (25%)	2 (50%)
Total loss	4 (4,81%)	7 (8,43%)	11 (13,25%)

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WEIGHT GAIN IN PREGNANCY: DEFINITIONS AND CONSEQUENCES OF ABNORMAL PATTERNS

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The weight gain of the pregnant women is the end result of many, usually physiologic metabolic changes occurring during pregnancy and is prone to wide individual variation. Strict control of weight gain during pregnancy as practiced worldwide until mid seventies gave way to a more liberal approach following reports revealing a direct relationship with suboptimal weight gain and low birth weight and prematurity. Currently recommendations of weight gain during pregnancy are based on the prepregnancy body mass index. Roughly a gain of less than 10 kg is associated with an abrupt increase in the incidence of low birth weight infants whereas a gain of more than 16 kg is associated with an increase in macrosomia and cesarean section rate. Another late sequelae of excessive weight gain during pregnancy is the retention of the weight gain after delivery, which occurs more frequently among black race. Though the meta-analysis of mostly observational studies done so far suggests optimum maternal and