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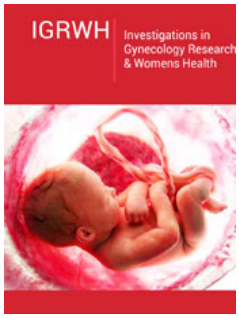
Case Report

Enigma of Multiple Pregnancies and DELAYED INTERVAL DELIVERY (DID)

Suresh Kishanrao*

Family Physician & Public Health Consultant, India

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***Corresponding author:** Suresh Kishanrao, Family Physician & Public Health Consultant, Bengaluru, Karnataka, India

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Abstract

The Globally multiple pregnancies occur in roughly 2% to 4% of all recorded births, while India's estimated rate ranges between 0.9% to 1.6%. Delayed-Interval Delivery is a rare medical strategy that intentionally delays the birth of remaining fetuses after the premature delivery of the first infant in a multiple pregnancy to improve survival outcomes for the retained babies. Indian obstetric case reports have demonstrated successful pregnancy extensions ranging from a few days up to several weeks or months, but mostly among twins. Early delivery of the first infant usually happens during the peri-viable period of 22 to 24 weeks, where the uterus may not stop contracting, & efforts to stop or delaying contractions can fail, leading to infant death or severe disability. Case Report of quadruplet's delayed delivery over more than a day is a very rare phenomenon reported. This case report is first of such DIDs in quadruplet delivery. The first baby was delivered on May 9, 2026, but active uterine contractions subsided and the remaining three fetuses remained stable in separate amniotic sacs. Doctors successfully managed a delayed-interval delivery, allowing the remaining three triplets to be delivered on May 14, 2026. The firstborn infant did not survive, while the subsequent three premature infants were stabilized and cared for in the Neonatal Intensive Care Unit (NICU) and are four months old now. The birth of one of the multiple twins is followed by days or weeks of waiting before the next baby is born, is very rare. To keep the remaining fetuses inside the womb longer so that their lungs and organs can grow stronger is a very rare choice, happening in a tiny fraction of multiple births. The biggest danger in such process is severe uterine infection, known as intraamniotic infection, which threatens lives of both the mother and the remaining babies.

However, obstetricians use Delayed-interval delivery strategy to try to pause labor safely

i. Tocolysis: Medication used to stop uterine contractions.

ii. Antibiotic Therapy to prevent or treat serious infections.

iii. Corticosteroids injections Shots to help speed up fetal lung development.

iv. Cervical Cerclage- a surgical stitch placed in the cervix to keep it closed.

The time between the first and subsequent births ranges widely from 29 hours to several weeks, with a common average of 7 to 36 days. The second and subsequent babies often have a higher chance of survival if the pregnancy is successfully prolonged, though infection risks rise the longer the delay continues.

Materials and methods: This article is a review of DID literature based on a very rare case of Multiple pregnancies with DID 4 babies born over 5 days in Uttar Pradesh, India in May 2026. Other 2 cases of multiple pregnancies in Karnataka in 2022 & 2023 and 2 twin pregnancies the author witnesse

Outcomes: All newborns of multiple pregnancies are of low birth weight due to sharing the placenta through which nutrition comes first-born baby in all deliveries was VLBW with bleak survival chances.

Keywords: Twins; Multiple pregnancies; Delayed-interval delivery; Quadruplets &DID

Introduction

Globally multiple pregnancies occur in roughly 2% to 4% of all recorded births, while India's estimated rate ranges between 0.9% to 1.6%. Multiple pregnancies delivered on consecutive days or even weeks apart is a rare possibility! Delayed-interval delivery is a rare

medical strategy that intentionally delays the birth of remaining fetuses after the premature delivery of the first infant in a multiple pregnancy to improve survival outcomes for the retained babies. The first fetus does not fail to survive because it is inherently weaker, but rather because it bears the full brunt of the early labor onset, while its sibling benefits from the medical delay that allows for vital extra time [1]. This phenomenon typically happens in one or two ways:

a) Asynchronous Birth meaning Delayed-Interval Delivery is a much rarer and medically complex situation where the babies are intentionally delivered days, weeks, or occasionally months apart. If a mother goes into extreme preterm labor (between 14 to 24 weeks), the first baby may be delivered because the cervix opens or the amniotic sac ruptures. If labor naturally stops after the first birth or doctors successfully halt it using medications (tocolytics) the remaining baby or babies are left inside the womb. The umbilical cord of the first baby is clamped and cut high up, and the cervix may be stitched closed (cervical cerclage) [1,2]. The incidence of such higher order multiple pregnancies ranges from 0.01% to 0.07% of all the pregnancies. However, the frequency of multiple gestations has been in a rising trend due to evolution of assisted reproductive techniques which defies the Hellin's Law, that is, quadruplets occurring 1:80 which translates to 1 in 512,000 live births.

b) Higher order multiple pregnancies could be monozygotic, multi-zygotic or a combination of the two [3].

Every single day a premature baby can stay inside the uterus significantly increases their chance of survival and healthy development. Doctors will keep the remaining baby in utero as long as it is safe for both the mother and the child. Delayed-interval delivery is highly selective and cannot be performed in every multiple pregnancy. It is strictly inappropriate under the following circumstances:

Monochorionic twins

If the babies share a placenta, delaying the birth of one is impossible and dangerous. It is generally only attempted with dichorionic twins (separate placentas). If there are signs of intrauterine infection (chorioamnionitis), placental abruption, or severe preeclampsia, all babies must be delivered immediately to save the mother and children [4,5]. This article is a review of DID based on a very rare case of Multiple pregnancies with DID 4 babies born over 5 days in Uttar Pradesh, India in May 2026. Other 2 cases of multiple pregnancies in Karnataka in 2022 & 2023 and 2 twin pregnancies the author witnessed and followed in 2026.

Case Report



Figure 1: Quadruplet pregnancy.

In May 2026, a 31-year-old woman named Amina from Uttar Pradesh's Sambhal district gave birth to quadruplets (two boys and two girls) over a span of five days through a rare delayed normal delivery at Teerthanker Mahaveer University (TMU) Hospital in Moradabad. Amina, who married Muhammad Alim around two years ago, this was her first pregnancy. Amina and her husband run a grocery store. For Ms. Amina, the labour began on May 8, into early labor and delivered her first baby boy (weighing around 710g) on May 9, 2026. Doctors stabilized her and delayed the remaining births to reduce risks, and she delivered the other three babies on May 14, 2026. All four children were born naturally through vaginal route without a Caesarean section. This process is noted as an extraordinary medical occurrence for a high-risk multiple pregnancy. Amina was diagnosed with four fetuses early in her pregnancy, making it a high-risk and medically complex case. Throughout the pregnancy, she remained under close monitoring,

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underwent check-ups every 15 to 20 days. She also suffered from hypertension and liver-related complications, requiring multiple hospitalizations. The woman had been under treatment since the third month of her pregnancy after ultrasound reports confirmed four fetuses. "A specialized team closely monitored Amina throughout her pregnancy." Doctors had initially advised reducing the number of fetuses due to the risks involved, but the family decided to go ahead with the pregnancy. The newborns were placed on ventilator support as a precautionary measure (Figure 1). The first fetus was typically expelled because of a sudden, unstoppable complication of the Premature Rupture of Membranes (PPROM). The remaining three newborns received special medical care and observation alongside their recovering mother, though for extra 2-5 days.

A quadruplet pregnancy in Mangaluru

A rare case of a quadruplet pregnancy (4 fetus) was successfully managed and delivered at Father Muller Medical College Hospital in Mangaluru, Karnataka. Mrs. Banoth Durga, a resident of Telangana living in Mangaluru, gave birth at Father Muller Medical College Hospital. The diagnosis of quadruplets was done during a routine ultrasound. Antenatal care was led by consultant Obstetrician and Gynecologist, ensuring the couple felt supported at each stage. The couple was initially overwhelmed but made the courageous decision not to opt for fetal reduction. Despite the risks, they chose to go ahead with the pregnancy, fueled by hope and supported by a compassionate medical team. At 30 weeks of gestation, the couple underwent a challenging elective cesarean section on November 9th, 2023, due to the mother's history of a previous cesarean. Banoth delivered two beautiful girls and two boys. With the risk of premature birth and the possibility of requiring resuscitation for the newborns, extensive arrangements were made for neonatal resuscitation and the careful coordination between the obstetric and pediatric teams. The birth yielded four healthy newborns-two boys and two girls-born during the mother's seventh month of gestation. The newborns' weights were on the lower side (1.1kg, 1.2kg, 800g, and 900g), making neonatal care essential for their survival. Their immediate and effective care in the NICU was critical.

Quadruplets (Hubballi/Karnataka, 2022)

On Tuesday 24 May 2022, a 22-year-old woman gave birth to quadruplets at the Sarji Hospital here in the city. The babies-two boys and two girls-were hale and hearty and were born to Almaz Banu and her spouse Arif; both hail from Bhadravathi taluk. Case was managed by obstetrician Dr. Chetana N. in a private hospital. Natural conceptions resulting in quadruplets occur in roughly 1 in 600,000 pregnancies, making this an exceedingly rare event for the region (Figure 2). In a 2025 report a hospital had total 2 cases of delayed delivery of twins. First case was of Mrs. M, admitted at 27+6 weeks with PPROM, expelled twin 1 after 12 hrs. of admission. Due to labour inertia, DID planned, delivered twin 2, after 3 days latency period. Twin 1 had neonatal death, twin 2 was delivered with weight of 1.1kg, with 60 days of NICU and discharged with weight of 2.2kg. In second case, Mrs. A, admitted with PPROM at 26+5 weeks, delivered twin 1 after 6hrs. of admission. DID planned, placenta of twin 1 left in situ. Steroids and tocolysis, prophylactic antibiotics given. Emergency LSCS done and delivered twin 2 in view of breech in labour, after 29 days of twin 1 delivery. In this case also Twin 1 had NND. 2 Twin was delivered with weight of 1.1kg, with 45 days of NICU (Because of more exposure to intra uterine environment) and discharged with weight of 2.4kg. DID of the second twin may prolong pregnancy and lead to a viable term of birth.



Figure 2: Gave birth to quadruplets at the Sarji Hospital.

Discussion

The incidence of high-order multiple pregnancies (triplets, quadruplets, and above) varies significantly between naturally occurring conceptions and those assisted by medical interventions. While natural quadruplets are exceptionally rare at roughly 1 in 600,000 births, though naturally occurring triplet births happen in

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about 1 in 7,000 to 10,000 births. Because of fertility treatments, the global incidence spiked drastically from the 1970s through the late 1990s. Today, about 30% to 40% of all triplet pregnancies and 5-10% of quadruplets worldwide are a result of ovarian stimulation or IVF [3,6]. India reflects a dual trend. In rural areas or cases of natural conception, Hellin's Law still holds relatively true (quadruplets at ~1 in 60,000+). However, the country's average overall multiple pregnancy rate is quite high, sitting at 30.5 per 1,000 deliveries in modern clinical settings. In urban medical centers, the rise of unregulated or aggressive ovulation induction and multi-embryo IVF transfers has made quadruplet and triplets much less "rare" than they used to be. In Indian healthcare settings, high-order multiples are increasingly classified under critical high-risk obstetrics due to a 12.7-fold increase in cerebral palsy risks for triplets and above compared to singletons, alongside high rates of prematurity (65.7%) [6]. Delayed-Interval Delivery (DID) is a rare obstetric procedure where the delivery of the first baby in a multiple pregnancy (such as twins or triplets) is not followed immediately by the birth of the remaining sibling(s), allowing the remaining fetus(es) to stay in the uterus (in utero) to gain valuable gestational age [4].

In a higher-order multiple pregnancy (such as quadruplets or quintuplets) as was in our reported case, can feature a combination of homozygous (identical/monozygotic) and heterozygous (fraternal /dizygotic or polyzygotic) fetuses. Higher-order pregnancies can result from a combination of multiple eggs being fertilized (polyzygotic/heterozygous) combined with one or more of those fertilized eggs subsequently splitting into identical twins or triplets (monozygotic/homozygous). In a quadruplet pregnancy, a woman might release two separate eggs that are fertilized by two separate sperm (creating two distinct, heterozygous/fraternal zygotes). If one of those zygotes then splits into a pair of identical twins, the total set of four fetuses will consist of one pair of homozygous (identical) twins and two other separate, heterozygous siblings [5,7].

Lower survival rate of the first expelled fetus

In a multiple pregnancy, the lower survival rate of the first expelled fetus is heavily tied to a medical intervention known as Delayed-Interval Delivery (DID). This scenario occurs during extreme preterm labor, where the first baby is born at a pre-viable stage, but doctors manage to stop the labor process to allow the remaining fetus(es) to stay in the womb. The primary reasons the first expelled fetus struggles to survive compared to the remaining siblings include:

Extreme immaturity and gestational age: The first fetus is typically expelled because of a sudden, unstoppable complication such as cervical insufficiency (a weak cervix) or the Premature Rupture of Membranes (PPROM). Because this occurs very early in the pregnancy, often between 14 and 24 weeks, the first fetus is born at a point where the lungs, brain, and other vital organs are not developed enough to sustain life outside the womb.

Time gained by the remaining fetuses: When the first fetus is born, the goal of a delayed-interval delivery is to use tocolytics to stop contractions, progesterone, and antibiotics and sometimes a physical stitch (cervical cerclage) to seal the cervix back up. This gives the remaining fetus(es) days, weeks, or even months of extra time in the uterus. Every extra day inside the womb vastly improves the remaining babies' birth weight, lung maturity, and overall chance of survival.

Statistical disparity in survival: Clinical data highlights a stark contrast in survival outcomes between the first and subsequent fetuses in these rare scenarios:

i. **First born:** In a multicenter study tracking early multiple births, only about 7% to 14.3% of the first-born fetuses survived because they were born too early.

ii. **Second born:** In contrast, 54% to 79% of the second twins survived because the medical delay successfully pushed their birth to a safer, more viable gestational age [1].

The first twin or triplet or multiple is delivered usually in the second trimester due to extreme preterm labor or Premature Rupture of Membranes (PPROM) while the umbilical cord of the remaining baby is tied and safely returned into the womb. The delay between the birth of the first baby and the next can range anywhere from a few days to several weeks or even months. In our case report there was gap of 5-9 days. To prolong the pregnancy for the remaining fetus, as every additional day or week gained inside the womb significantly lowers the risks of severe prematurity complications like chronic lung disease, brain bleeding, or death.

Delayed-interval delivery is highly selective and cannot be performed in every multiple pregnancy. It is strictly inappropriate under the circumstances of

i. Monochorionic twins, where the babies share a placenta, and delaying the birth of one is impossible & dangerous. It is generally only attempted with

a) Dichorionic twins (separate placentas)

b) If there are signs of intrauterine infection (chorioamnionitis)

c) Placental abruption, or

d) Severe preeclampsia, all babies must be delivered immediately to save the mother & children [5,8]

Clinical management: DID is considered only if the first delivery happens before viability (less than 23 to 26 weeks), with no sign of severe maternal infection (chorioamnionitis), and the placenta for the remaining fetus is separate (usually dichorionic twin pregnancies). Medicines called tocolytics are used to stop contractions, antibiotics to prevent infection, and corticosteroids to help mature the remaining baby's lungs. A stitch in the cervix (cerclage) is sometimes placed to keep the womb closed. The biggest danger to the mother is severe intrauterine infection or bleeding, which requires immediate delivery of the remaining baby if signs of sepsis or placental abruption appear.

In a standard singleton pregnancy, 710 grams aligns closely with 24 to 25 weeks of gestation. However, fetuses in multiple

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pregnancies (such as twins or triplets or quadruplets) like our reported case, face uterine space limitations and shared nutrition, which causes their growth to slow down slightly compared to singletons after 28–30 weeks, and sometimes earlier if there is selective fetal growth restriction. Consequently, a baby from a multiple pregnancy weighing 710 grams might be slightly further along to 26 weeks—or experiencing growth restriction. A baby born at this weight and gestational age is classified as a micro-preemie and requires immediate, specialized care in a Tertiary Level 3 Neonatal Intensive Care Unit (NICU). Multiples can have discordant growth, meaning one baby may weigh significantly less than their sibling(s) despite being born at the exact same gestational age as was in our case report [7].

Epidemiology and association with perinatal outcomes in multiple pregnancy: According to the Modern Diagnostic & Research Centre Fetal Growth Chart Week by Week, the average weight of a single fetus at 26 weeks of pregnancy is 913 grams. All infants in a quadruplet pregnancy delivered around this gestational age will present with low birth weight. Multiple pregnancy can be two or more separate eggs fertilized by separate sperm, or a single fertilized egg, split into two or more embryos. In fertility treatments, if the maternal age is higher, more than one embryo is transferred to increase the chances of pregnancy. This increases the possibilities of multiple pregnancies. Multiple pregnancy can happen through natural conception, too (Figure 3).

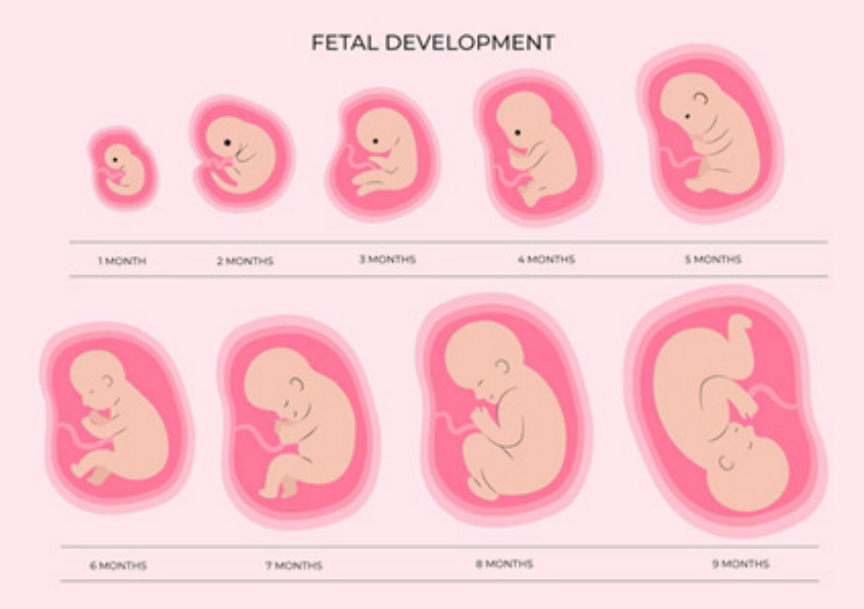


Figure 3: Fetal development.

A case of DID in a quadruplet pregnancy and review the relevant literature to summarize the management of DID in multiple pregnancies [1], reported a case presentation of a 22-year-old woman, 22 2/7 weeks' gestation, with quadruplets, was admitted to the hospital for a first cervical cerclage due to cervical dilation. Twenty-five days later, it was found that the cervix was dilated again, so after removing the cervical cerclage, the first quadruplet was delivered vaginally (25 6/7 weeks), and a second cervical cerclage was performed. Four days later, due to re-dilation of the cervix, after removal of the cervical cerclage, the second quadruplet was delivered vaginally (26 3/7 weeks), followed by a third cervical cerclage. Six days later, the pregnancy was terminated by cesarean section due to fetal distress, and the third and fourth quadruplets were delivered (27 2/7 weeks). The patient had no postoperative complications, and all four infants were treated in the neonatal intensive care unit and discharged successfully. Conclusion This case emphasizes that comprehensive management of delayed interval delivery can improve perinatal outcomes in multiple pregnancies [9].

A retrospective cohort study of infants born 22-28 weeks' gestation or weighing 401-1500g. DID was defined as a passage of >24h between the birth of firstborn and retained infants. Rates of mortality, morbidity, and developmental outcomes were compared within DID multiples, to other multiples not born by DID, all infants in the Generic Database & follow-up datasets. Results indicated that DID-born multiples were younger and smaller than other multiples. Retained infants had no significantly different rates of mortality & morbidities compared to their firstborn counterparts, apart from less bronchopulmonary dysplasia. It was inferred that DID shows no evidence of harm and a potential benefit of decreased bronchopulmonary dysplasia mediated by increased gestational age & birthweight [4].

Tracking of fetal weight by weeks of pregnancy: Tracking of Fetal weight, is important for

i) Identifying Intrauterine Growth Restriction (IUGR) or excessive growth that might signal health risks

ii) Helping doctors determine optimal delivery timing and necessary interventions

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iii) Parental assurance by providing peace of mind by comparing their baby's measurements to healthy averages

iv) Supporting evaluation of organ maturation and fat accumulation in later pregnancy stages and

v) Identifying potential complications before they become serious problems [10].

Causes of LBW in general

a) Maternal nutrition: Adequate intake of calories, protein, iron, calcium, and essential vitamins is crucial for steady fetal growth. Poor nutrition or deficiencies can slow weight gain and affect overall development.

b) Genetic factors: A baby's growth potential is partly determined by parental height, body build, and family growth patterns. These genetic influences explain why some babies are smaller or larger than average.

c) Placental health: The placenta acts as the lifeline between mother and baby, supplying oxygen and nutrients. Placental insufficiency can limit foetal weight gain even when maternal health appears normal.

d) Maternal medical conditions: Conditions such as gestational diabetes, high blood pressure, or thyroid disorders, which may be evaluated using an FT4 test, can alter nutrient delivery and foetal metabolism.

e) Lifestyle factors: Smoking, alcohol use, and exposure to high altitudes reduce oxygen availability to the fetus & interfere with normal growth & lower the expected foetal weight.

f) Multiple pregnancies: In multiple pregnancies, all babies are more often LBW and one coming out first has very Low birth weight or prematurity, and has least chance of survival (Table 1) [11].

Table 1: Interpreting the fetal growth chart.

Gestational Age	Length (in cm) (Head to Bottom)	Weight (in grams) (Head to Bottom)
8 weeks	1.57cm	20 grams
9 weeks	2.30cm	27 grams
10 weeks	3.1cm	35 grams
11 weeks	4.1cm	45 grams
12 weeks	5.4cm	58 grams
13 weeks	6.7cm	73 grams
14 weeks	14.7cm	93 grams
15 weeks	16.7cm	117 grams
16 weeks	18.6cm	146 grams
17 weeks	20.4cm	181 grams
18 weeks	22.2cm	223 grams
19 weeks	24.0cm	273 grams
20 weeks	25.7cm	331 grams
21 weeks	27.4cm	399 grams
22 weeks	29.0cm	478 grams
23 weeks	30.6cm	568 grams
24 weeks	32.2cm	670 grams
25 weeks	33.7cm	785 grams
26 weeks	35.1cm	913 grams
27 weeks	36.6cm	1055 grams
28 weeks	37.6cm	1210 grams
29 weeks	39.3cm	1210 grams
30 weeks	40.5cm	1559 grams
31 weeks	41.8cm	1751 grams
32 weeks	43.0cm	1953 grams
33 weeks	44.1cm	2162 grams
34 weeks	45.3cm	2377 grams
35 weeks	46.3cm	2595 grams
36 weeks	47.3cm	2813 grams
37 weeks	48.3cm	3028 grams

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38 weeks	49.3cm	3236 grams
39 weeks	50.1cm	3435 grams
40 weeks	51.0cm	3619 grams
41 weeks	51.8cm	3787 grams

Causes of LBW in multiple pregnancies

i. Most multiple pregnancies end up in premature delivery (before 37 weeks of pregnancies). The earlier they are born as was in our case around 26-28 weeks, underweight as babies gain maximum weight in the last few weeks of pregnancy. Premature babies are often born with low birth weight because they miss the final weeks of growth in the womb.

ii. Limited space: Where one baby must grow, if four babies grow as in our case, the uterus expands with pregnancy, but it cannot stretch beyond a point. The lack of space limits the babies' growth and weight gain.

iii. Shared nutrients: Though an expecting mother eats more than usual, she cannot eat enough to meet the nutritional requirements for multiple babies. As a result, twins and triplets receive fewer nutrients than single babies, limiting their weight gain.

iv. Placental insufficiency is when the placenta is unable to meet the needs of the multiple fetuses to provide for, the placenta may not supply enough nutrients and oxygen required for healthy development. This, in turn, can restrict growth and weight gain.

v. Twin-to-twin transfusion syndrome: When identical twins share a placenta, the blood flow between them may become unbalanced. As a result, one baby may receive more blood and nutrients and grow larger, while the other may receive less and remain smaller.

vi. Preeclampsia: Preeclampsia is a serious pregnancy complication where the mother's blood pressure is too high. High blood pressure can restrict blood flow to the placenta, thereby affecting the growth and weight gain of babies.

vii. Mother's health: Maternal health plays a vital role in the development and weight gain of the babies. In the case of health issues, unhealthy lifestyle, poor diet, exposure to substances, etc., the risk of low birth weight is higher [2,12].

Birth weight discordance (Weight differences of multiple fetuses at the same gestational period)

Birth weight discordance is the term used to describe when one or more babies experience profound growth restriction while their co-multiples grow normally. The underlying causes depend on how the babies are configured in the womb:

i. Placental issues: The most common cause is of the placenta, which is the life-support system providing oxygen and nutrients. In multiple pregnancies, uneven plumbing is the primary driver of weight discrepancies. In identical twins Sharing placenta: Twins who share a single placenta (monochorionic),

a) One baby may simply be allocated a much smaller piece of the "pie". This restricted surface area limits how much nutrition that specific baby can pull from the mother.

b) Selective Fetal Growth Restriction (sFGR) occurs when the placenta develops abnormally for just one fetus, leading to poor umbilical blood flow to that baby while the sibling's blood flow remains completely normal.

c) Abnormal cord insertion: If one baby's umbilical cord attaches to the very edge of the placenta (marginal insertion) or into the surrounding membranes (velamentous insertion), that baby will receive less blood flow and grow much slower.

ii. Twin-to-Twin Transfusion Syndrome (TTTS): In identical twins sharing a single placenta, abnormal blood vessel connections can form between their circulatory systems causing blood to flow unequally, with one twin "donating" blood to the other. The donor twin loses critical fluid and nutrients, resulting in severe growth restriction and VLBW, while the recipient twin grows much larger.

iii. Genetic or chromosomal differences: In fraternal multiples (who develop from separate eggs and sperm), each baby has an entirely unique genetic makeup. If one baby inherits a genetic abnormality, a chromosomal condition (like Down syndrome), or a structural birth defect, that specific baby's growth may be severely stunted in utero, even while the genetically typical sibling thrives.

iv. Localized intrauterine space constraints: As multiple pregnancy progresses, room in the uterus becomes highly limited. If one fetus is structurally positioned in a compressed or crowded corner of the womb, physical overcrowding can organically restrict its late-stage structural growth compared to a sibling who has more physical room to stretch and expand [2,13].

Handling low birth weight in multiple pregnancy: In the case of low birth weight in multiple births, parents and nurses must be aware of the need for following:

i. Close monitoring: Such babies will require close monitoring and specialized care in the NICU (Neonatal Intensive Care Unit) as was done in our reported case. The duration of their stay in the NICU will vary depending on complications, developmental progress, and their ability to cope with the new environment. The doctors and nurses must keep a close watch to ensure any danger signs or complications are addressed at the earliest.

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ii. Temperature control: Multiple LBW babies may struggle with temperature control. They must be kept in special temperature-controlled beds to ensure they are always warm.

iii. Kangaroo care: Skin-to-Skin contact supports overall development, thermal regulation, and help establish breastfeeding. Both parents and any adult can offer kangaroo care.

iv. Due to low birth weight, premature babies may be unable to suck properly, and may need to be fed through IV or a feeding (Ryle's) tube reaching their stomach.

v. The doctors and Nurses must evaluate the babies and check for complications, like low blood sugar, Cyanosis, or gastrointestinal issues as early as possible and treat the complications to prevent long-term consequences, through regular blood and other tests.

Summary

The incidence of high-order multiple pregnancies (triplets, quadruplets, and above) varies significantly between naturally occurring conceptions and those assisted by medical interventions. While natural quadruplets are exceptionally rare at roughly 1 in 600,000 births, naturally occurring triplet births happen in about 1 in 7,000 to 10,000 births. Delayed-Interval Delivery (DID) is a rare obstetric procedure where the delivery of the first baby in a multiple pregnancy is not allowed to follow immediately by the birth of the remaining sibling(s), giving an opportunity to the remaining fetus(es) to stay in the uterus to gain valuable gestational age and development of key organs [14]. Birth weight discordance- one or more babies experiencing profound growth restriction while their co-multiples grow normally is common in such pregnancies. The underlying causes depend on how the babies are configured in the womb. In the case of low birth weight in multiple births, parents and nurses must be aware of the need for

i. Close Monitoring and ensure any danger signs or complications are addressed at the earliest.

ii. Multiple LBW babies may struggle with temperature control and must be kept in special temperature-controlled beds to ensure they are always warm.

iii. Kangaroo care or skin-to-skin contact supports overall development, temperature regulation, and helping to establish breastfeeding. Mother, father or even any other adult can offer kangaroo care to the babies.

iv. Due to low birth weight, or prematurity they may be unable to suck properly, and may need to be fed through IV or a feeding (Ryle's) tube reaching their stomach.

v. The doctors and Nurses must evaluate the babies and check for complications, like hypoglycemia, respiratory or gastrointestinal issues to prevent long-term consequences.

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