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Conjoined Twins and Abortion Restrictions: Navigating ‘Ban State’ Challenges, a Case Report

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This case report highlights an unusual scenario of a conjoined twin pregnancy resulting from intrauterine insemination in a state with restrictive abortion laws. Despite a diagnosis deemed not compatible with life, the patient faced legal barriers preventing termination within their home state. Forced to seek care out-of-state, the patient underwent a successful termination at ten weeks and three days after lengthy and expensive travel. This case illustrates the profound challenges posed by restrictive abortion laws, which impose undue financial, social, emotional, and medical burdens. It underscores the intersections between medical care, ethics, legal constraints, and patient outcomes in managing complex pregnancies post-Dobbs v. Jackson Women’s Health Organization.

Introduction

Conjoined twins are exceedingly rare, with parapagus dicephalic twins — a subtype in which two heads share a single torso — occurring in approximately 1 in 1,000,000 births (Banjarnahor et al., 2022). A global collaborative study reported an overall prevalence of 1.47 per 100,000 births, with higher frequencies observed in Asia and Africa, reflecting geographic and cultural differences in reporting and pregnancy management (Mutchinick et al., 2011). Embryologically, conjoined twins result from incomplete division of the embryonic disc between 13–15 days post-fertilization, with several competing theories on pathogenesis, including fission and secondary fusion models (Kaufman, 2004; Spencer, 2000).

Conjoined twin pregnancies present significant medical and ethical complexities, often requiring cesarean delivery and carrying high risks of stillbirth or neonatal death (Mian et al., 2017; Brizot et al., 2011). These realities underscore the necessity of comprehensive counseling and, frequently, the medical indication for pregnancy termination.

The Dobbs decision has enabled states to impose severe abortion restrictions, many banning abortion at all stages of pregnancy (e.g., Texas SB8, Tennessee’s Human Life Protection Act). While some laws include exceptions for medical futility or emergencies, these provisions are vague and inconsistently applied. The Centers for Disease Control and Prevention (CDC) reports that severe maternal morbidity and mortality remain higher in U.S. states with more restrictive abortion laws (CDC, 2023). Similarly, research published in JAMA demonstrates increased travel distances and delays for patients seeking abortion care post-Dobbs (Riley et al., 2024).

While this case focuses on a rare presentation, abortion is often necessary in more common scenarios, such as ectopic pregnancies, preterm premature rupture of membranes, or severe maternal illness. This case underscores a broader knowledge gap: the impact of abortion bans on patients with medically futile pregnancies, where continuation of gestation is incompatible with neonatal survival yet still restricted by law.

For the purposes of this case report, the term *medically futile pregnancy* refers to a gestation in which continuation is not expected to result in sustained neonatal survival based on established clinical evidence. This designation reflects prognostic assessment rather than moral valuation and is distinct from statutory definitions of “medical emergency,” which typically focus on risks to the pregnant patient’s life or major bodily function. In this context, medical futility refers primarily to fetal conditions incompatible with sustained postnatal survival rather than maternal instability.

Patient Information

A 29-year-old nulligravida sought medical assistance after 18 months of infertility. Gynecological history included dysmenorrhea (2007), bacterial vaginosis (2014), and irregular menses (2022). Initial evaluations showed normal thyroid stimulating hormone (TSH), follicle-stimulating hormone (FSH), estradiol, prolactin, and testosterone (T) levels. Hysterosalpingogram (HSG) demonstrated bilateral tubal patency. Three cycles of ovarian stimulation with letrozole (Femara) were unsuccessful.

The patient had no significant past medical, family, or surgical history. Social history revealed rare alcohol use, no tobacco or illicit drug use, and no prescription medications. Her spouse's semen analysis and ultrasound were normal.

Clinical Findings and Diagnostic Assessment

Following intrauterine insemination (IUI) in October 2023, ultrasound at seven weeks revealed a viable intrauterine pregnancy (IUP) with positive fetal cardiac activity (FCA). By nine weeks, ultrasound demonstrated two fetal heads, confirming parapagus dicephalic conjoined twins. Early identification at nine weeks was facilitated by close ultrasound surveillance following intrauterine insemination. In pregnancies without assisted reproductive monitoring, structural anomalies may not be detected until later in the first trimester or during the mid-trimester anatomy scan, potentially further narrowing legal options in jurisdictions with gestational limits. Fetal heart tones (FHTs) were present in the 170s. Counseling with maternal-fetal medicine specialists confirmed a uniformly poor prognosis, consistent with published experiences in which most conjoined twin pregnancies are not compatible with long-term survival (Brizot et al., 2011).

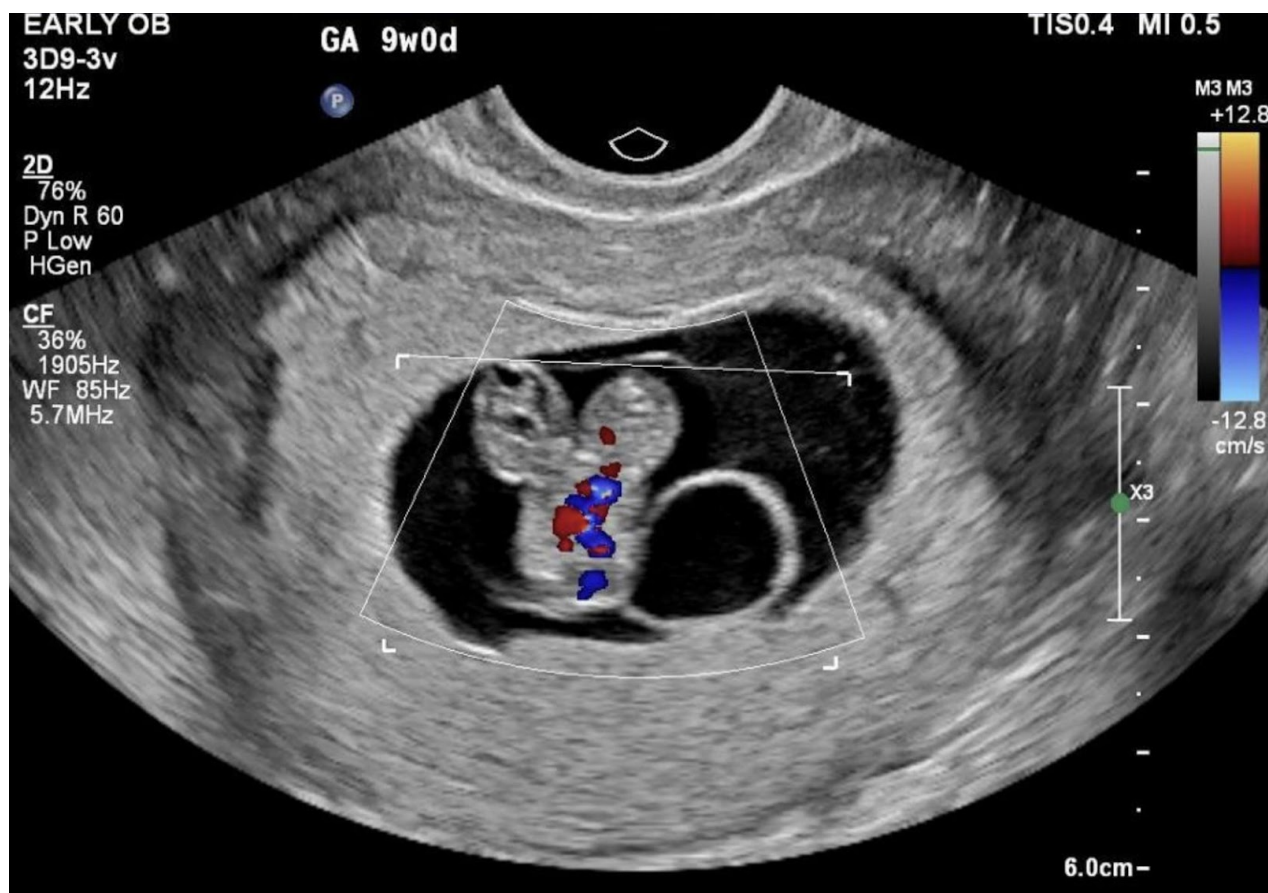


Figure 1: Diagnosis of conjoined twin pregnancy via ultrasound at 9 weeks and 0 days. Two heads and a single cardiac structure

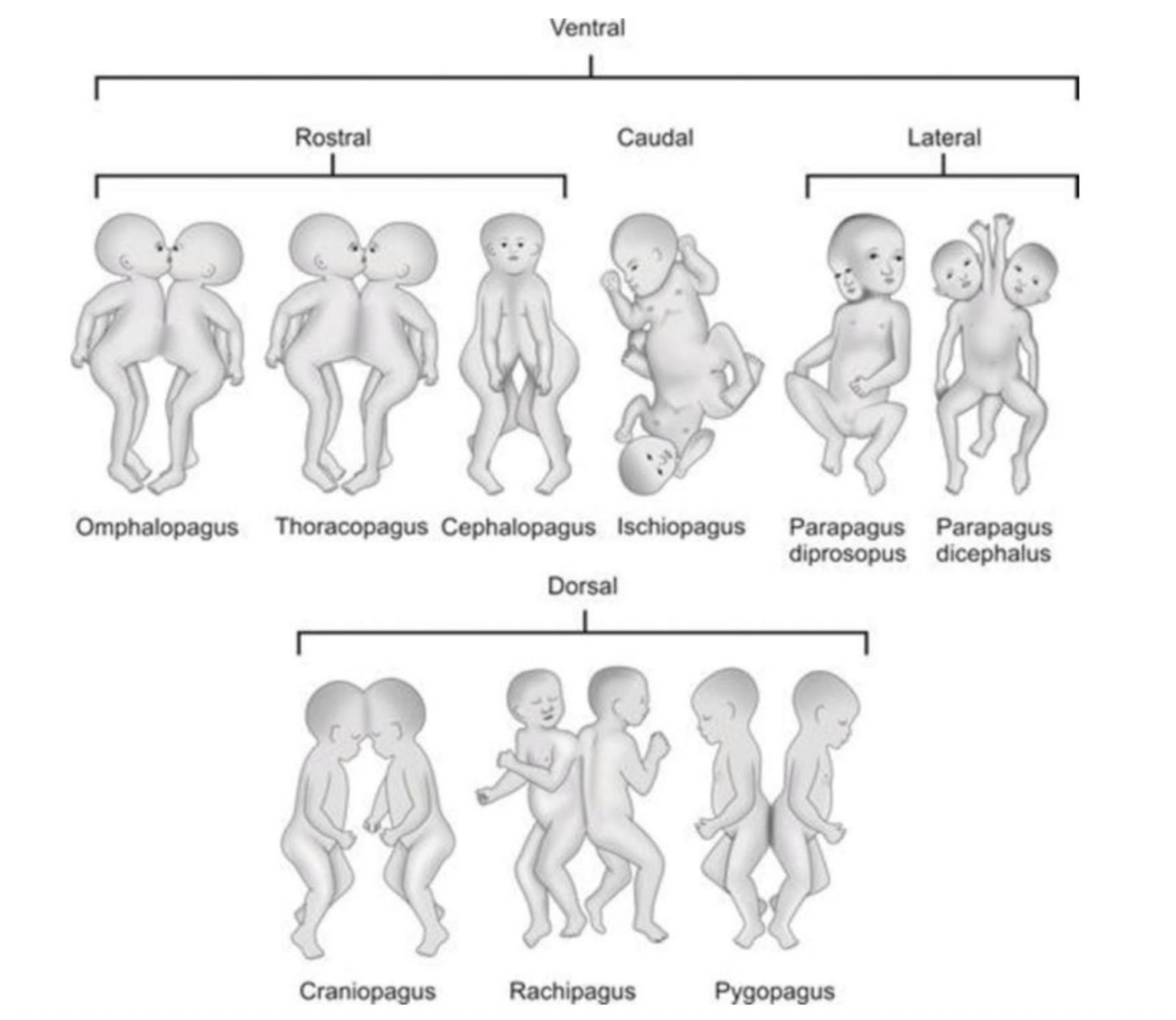


Figure 2: Classification of conjoined twins suggested by Agarwal S and Kore S.5

Timeline of Care

1. **Initial Consultation and Infertility Evaluation** – Laboratory and imaging evaluation; ovarian stimulation ×3 cycles; HSG confirming tubal patency.
2. **IUI and Pregnancy Confirmation** – IUI performed; viable singleton IUP noted at 7 weeks.
3. **Diagnosis of Conjoined Twins** – 9-week ultrasound showed parapagus dicephalic twins; poor prognosis confirmed.
4. **Legal and Medical Barriers** – State law prohibited termination after 6 weeks except under an affirmative defense permitting abortion to prevent the death of the pregnant patient or serious risk of substantial and irreversible impairment of a major bodily function. The statute does not explicitly define lethal fetal anomaly or medical futility, creating interpretive uncertainty for clinicians managing pregnancies incompatible with neonatal survival.
5. **Seeking Out-of-State Care** – Patient traveled 12 hours to access termination at 10 weeks +3 days.
6. **Procedure and Outcome** – Aspiration abortion performed without complications; pathology confirmed conjoined twins. Patient discharged home, reporting confidence in decision.

Therapeutic Intervention

Termination via aspiration abortion was performed at 10 weeks + 3 days in a neighboring state. The procedure was uneventful, with estimated blood loss <25 mL. Products of conception revealed two calvaria, one heart, and six extremities. The patient experienced moderate cramping for one hour post-procedure and was discharged the same day.

Discussion

This case exemplifies how restrictive abortion laws endanger patients by delaying necessary medical care, even in circumstances of medical futility. The patient faced financial strain, emotional distress, and increased medical risk due to prolonged gestation and mandatory travel.

Although the prognosis was uniformly poor, local providers expressed concern regarding the absence of explicit statutory language addressing lethal fetal conditions. Because the law operates as an affirmative defense requiring retrospective justification of clinical judgment, uncertainty regarding legal exposure influenced the recommendation to seek care in a neighboring state. Commentaries in *JAMA* and the *Columbia Law Review* have described similar “chilling effects” in restrictive jurisdictions, in which ambiguity alters clinical decision-making even absent explicit prohibition (Cutler et al., 2025; Cohen, Donley & Rebouché, 2023).

While opponents of abortion argue that exceptions for medical emergencies or futility are sufficient, clinical experience demonstrates that these exceptions are vague, inconsistently applied, and create chilling effects among providers concerned about legal repercussions (JAMA, 2022; ACOG, 2022). Policymakers may justify restrictions as protecting fetal life, but in cases like parapagus dicephalic twins, survival is not possible (Mian et al., 2017). In circumstances where neonatal survival is not medically achievable, restrictive statutes may prolong gestation without altering outcome while increasing patient burden.

Conjoined twin pregnancies present a uniquely illustrative challenge within restrictive legal frameworks. Fetal cardiac activity may be present despite structural anatomy incompatible with sustained independent survival. Unlike conditions that immediately threaten maternal life, prognosis may be incompatible with neonatal survival without triggering statutory “medical

emergency” language. This disconnect between physiologic markers and survivability complicates legal frameworks grounded primarily in gestational age or detection of cardiac activity.

Limitations: This is a single case report and cannot be generalized to all patients. However, it highlights recurring systemic issues reported nationwide (Guttmacher Institute, 2023; NEJM, 2023).

Future Directions: Further research should document how abortion bans affect clinical decision-making, maternal morbidity, and healthcare disparities. Legal scholarship should explore strategies to clarify or challenge ambiguous statutory language. Clinically, there is a need for standardized guidelines to navigate medically futile pregnancies in restrictive states.

Conclusion

Conjoined twin pregnancies are rare and medically complex, but abortion restrictions amplify patient harm by obstructing timely and compassionate care. Abortion is essential medical care, whether in rare cases of conjoined twins or in more common emergencies. Legal frameworks must unequivocally protect patient autonomy and access to comprehensive reproductive healthcare.

References

1. American College of Obstetricians and Gynecologists (ACOG). (2022). Abortion restrictions jeopardize patient safety [Practice Statement].
2. Banjarnahor, D. P. P., Wardhana, M. P., & Sulistyono, A. (2022). Case Report : Dicephalic parapagus conjoined twins. *International Journal of Health Sciences*, 6(S7), 2992–2997. <https://doi.org/10.53730/ijhs.v6nS7.12443>
3. Brizot, M. L., Liao, A. W., Lopes, L. M., et al. (2011). Conjoined twins pregnancies: Experience with 36 cases from a single center. *Prenatal Diagnosis*, 31(12), 1120–1125. <https://doi.org/10.1002/pd.2843>
4. Centers for Disease Control and Prevention. (2023). Maternal mortality and severe maternal morbidity. <https://www.cdc.gov>
5. Devi, L., & Prasad, G. (2021). A rare case of conjoined twins: Craniothoraco-omphalopagus. *International Journal of Reproduction, Contraception, Obstetrics and Gynecology*, 10, 2110–2114. <https://doi.org/10.18203/2320-1770.ijrcog20211557>
6. Guttmacher Institute. (2023, December). High toll of U.S. abortion bans: Nearly one in five patients now traveling out-of-state for abortion care. <https://www.guttmacher.org>
7. Cutler, A. S., Hale, C. M., Bennett, E., Jacques, L., & Higgins, J. (2025). Experiences of obstetrician-gynecologists providing pregnancy care after *Dobbs*. *JAMA Network Open*, 8(3), e252498. <https://doi.org/10.1001/jamanetworkopen.2025.2498>
8. Kaufman, M. H. (2004). The embryology of conjoined twins. *Child's Nervous System*, 20(8–9), 508–525. <https://doi.org/10.1007/s00381-004-0985-4>
9. Mian, A., Gabra, N. I., Sharma, T ., et al. (2017). Conjoined twins: From conception to separation, a review. *Clinical Anatomy*, 30(3), 385–396. <https://doi.org/10.1002/ca.22839>
10. Mutchinick, O. M., Luna-Muñoz, L., Amar, E., et al. (2011). Conjoined twins: A worldwide collaborative epidemiological study. *American Journal of Medical Genetics Part C: Seminars in Medical Genetics*, 157C(4), 274–287. <https://doi.org/10.1002/ajmg.c.30321>
11. Osmanağaoğlu, M. A., Aran, T., Güven, S., Kart, C., Ozdemir, O., & Bozkaya, H. (2011). Thoracopagus conjoined twins: a case report. *ISRN obstetrics and gynecology*, 2011, 238360. <https://doi.org/10.5402/2011/238360>
12. Spencer, R. (2000). Theoretical and analytical embryology of conjoined twins: Part I. *Clinical Anatomy*, 13(1), 36–53. [https://doi.org/10.1002/\(SICI\)1098-2353\(2000\)13:1<36::AID-CA5>3.0.CO;2-3](https://doi.org/10.1002/(SICI)1098-2353(2000)13:1<36::AID-CA5>3.0.CO;2-3)
13. Riley, T., Fiastro, A. E., Benson, L. S., Khattar, A., Prager, S., & Godfrey, E. M. (2024). Abortion provision and delays to care in a clinic network in Washington State after *Dobbs*. *JAMA Network Open*, 7(5), e2413847. <https://doi.org/10.1001/jamanetworkopen.2024.13847>
14. Cohen IG, Donley G, Rebouché R. *The new abortion battleground*. Columbia Law Review (online supplement January 2023). Available at:

https://columbialawreview.org/wp-content/uploads/2023/01/Cohen-Donley-Rebouche-THe_new_abortion_battleground.pdf

15. Watson, K., & Oberman, M. (2023). Abortion counseling, liability, and the First Amendment. *New England Journal of Medicine*, 389(7), 663–667. <https://doi.org/10.1056/NEJMms2306439>

16. American College of Obstetricians and Gynecologists. (2022). Abortion is essential health care. ACOG Practice Advisory.

17. American College of Obstetricians and Gynecologists. (2017, reaffirmed 2025). Periviable birth. ACOG Obstetric Care Consensus No. 6. *Obstetrics & Gynecology*, 130(4), e187–e199.

