In the second one, in spite of severe anemia, parents opted for expectant management. In the following days, the PSV in MCA normalized and the ascites disappeared. In week 22.6 IVH grade 3 was observed. In both cases pathological examination of the placenta showed a marginal cord insertion in the occluded fetus, a complete obliteration of the umbilical cord with absence of residual circulation.

**Background:** Umbilical cord occlusion (UCO) may be indicated when fetal selective termination in a MC pregnancy is decided. Main indications include discordant malformation and prevention of neurological damage associated with the death of one fetus. The mechanism leading to neurological injury in the surviving fetus is thought to be acute fetal anemia and hypotension because of the fetal blood loss through vascular anastomoses to the dying twin.

**Two case reports:** We describe two MC pregnancies with sudden severe anemia in the surviving twin after UCO. The first one was a case of discordant malformation (anencephalia) and the second one was a case of early sIUGR type II in a DCTA triplet pregnancy. In both cases, the cord of the occluded fetus had a marginal insertion in the placenta. Both of them presented hydrops two days after the procedure, with PSV in MCA > 1.5 MoM. In the first one IUT was performed. At week 30, an extensive area of destruction of brain tissue at the right parietal-temporal-occipital level was diagnosed.

We hypothesize that the surviving fetus after the occlusion can become bloodless and hypovolemic when its blood is poured into the placental and umbilical circulation of the occluded twin through the vascular anastomoses. Marginal cord insertion may facilitate this complication. It should not be assumed that UCO remove the risk of transfusional brain injury in surviving co-twins.