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CASE REPORT OF RECURRENT PREGNANCY LOSS

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ABSTRACT

In this report we are presenting a challenging case of Bad Obstetric History, a 35 yrs old female, elderly grand multigravida G10P9L0/previous all stillbirths at 6th to 8th months of gestation, married since 17yrs, known case Hyperthyroid on treatment, delivered an alive preterm baby by elective Caesarean section at 36weeks and 4 days of gestation KEY WORDS -Bad obstetric history, heart disease complicating pregnancy, hyperthyroidism, heparin, aspirin.

Keywords: Recurrent Pregnancy Loss, Caesarean section, hyperthyroidism

INTRODUCTION

Recurrent spontaneous pregnancy loss (RPL), recurrent miscarriage, or habitual abortion is defined as loss of two or more pregnancies. It affects about 1% couples, a rate which is higher than would be expected to occur due to chance alone, which should be about 0.34%. Primary RPL is described as RPL without a previous viable pregnancy, whereas secondary RPL refers to women who have had one or more pregnancies that progressed beyond the period of viability (20-24 weeks) **[1, 2]**.

CASE REPORT

35years old female, grand multigravida, G10P9L0,previous history of 9 stillbirths at 6-8th months of gestation, married since 17yrs non-consanguinous marriage, with regular menstrual periods incidentally diagnosed as hyperthyroid during this

pregnancy, APLA screening negative treated prophylactically with inj. Heparin and T. Aspirin. She conceived spontaneously after 2years of marriage. Her past obstetric history was remarkable with previous 9 stillbirths, all normal vaginal deliveries of dead born fetuses, 7 of which at 8 months of gestation, 1 at 6th month and other at 7th month of gestation. There was no significant past medical history diagnosed to have complicating her prior pregnancies. She was diagnosed as hyperthyroid at 5 months of amenorrhoea and was started on T. Propranalol and T. Carbimazole. She was admitted for safe confinement at 32weeks of gestation. On admission she was asymptomatic with normal vital signs-PR-84bpm, BP-110/80mmHg, SpO2-100% in room air. Her laboratory analysis were unremarkable, APLA screening was negative.

Echocardiogram was normal. She was treated prophylactically with inj. Heparin 5000units Subcutaneous bd, T. aspirin 1/2 od, T.carbimazole. She was monitored with cardiotocogram and biweekly fetal Doppler and biophysical profile in USG and was found to be normal.

Following discussion with cardiologist, obstetricians, endocrinologist and anaesthetist team, she was taken up for elective Lower Segment Caesarean section with intracaesarean copper T insertion at 36weeks and 4days of gestation in view of elderly multigravida with Bad Obstetric History. She delivered an alive preterm Girl baby 1.935kg, cried immediately after birth, baby was admitted in NICU for preterm/LBW evaluation. Post-operative period was uneventful. She was discharged after the baby being discharged from NICU on 20th postoperative day. Follow-ups advised as per paediatric clinic protocol.

DISCUSSION

Bad Obstetric History is defined as previous two or more consecutive spontaneous abortions, stillbirths, intrauterine growth restriction, early neonatal death and/or congenitally malformed babies **[3]**.

Causes: Genetic, immunological, hormonal and maternal infections.

A complete history taking should be obtained. Previous obstetric history and outcomes should be dealt in detail. For recurrent intrauterine death for no apparent cause shortly before term should be evaluated for placental insufficiency, as in the above discussed case we monitored her with biweekly fetal Doppler and biophysical profile. Screening for TORCH infections can be done in suspected cases. Antiphospholipid syndrome is now recognized as an important cause in recurrent pregnancy loss, which present as early first trimester abortions, early onset severe pre-eclampsia, severe placental insufficiency resulting in premature

delivery or intrauterine death after 10weeks of pregnancy in a morphologically normal fetus **[4, 5]**.

In the above case APLA screening was negative. Still we put her on prophylactic aspirin and Heparin. Maternal medical disorders in previous pregnancy like diabetes, congenital heart disease, thyroid disorders, Rh isoimmunization are causes to be dealt with. In the above discussed case, patient was diagnosed to be hyperthyroid at 5 months of amenorrhea was treated with antithyroid drugs and she was euthyroid before surgery.

Clinical dilemma in the management of above case was the timing of delivery, to prolong pregnancy till 36weeks to deliver a salvageable baby and to cope with expected maternal complications due to hyperthyroidism during Caesarean section. A high risk informed consent about the foreseen complications were taken before surgery **[6]**.

CONCLUSION

We have discussed about a rare case of Bad obstetric history managed successfully to deliver a live baby by elective Caesarean section. A multidisciplinary team approach of obstetrician, rheumatologist, endo-crinologist and anesthetist was required to optimize maternal and fetal outcome.

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