Cause Oriented Treatment in Recurrent Pregnancy Loss- Case Report

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ABSTRACT

Here is one challenging case who had a devastating experience of recurrent pregnancy loss and was successfully treated at our centre. A case of a 36 yrs female patient Gravida 5 Medical Termination of Pregnancy1,Abortion 3, with 36 weeks gestation with autoimmune thyroiditis with history of recurrent pregnancy losses with uterine septal resection done 1 year back with mild PIH. A healthy baby of 3.2 kg was delivered by a planned caesarean section. Skill full screening and cause oriented treatment helps many couples have a successful pregnancy outcome.

Key Words: Miscarriages, Pregnancy induced Hypertension

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INTRODUCTION

The loss of pregnancy at any stage of gestation can be a devastating experience. The stories that end badly are sad, sadder still are the ones that never begin. It carries a heavy social stigma and a negative psychological impact on the patient. The miscarriages don't just occur in the uterus but in the women and the entire family. Here is one challenging case who had such an experience and was successfully treated at our centre.

CASE REPORT

A case of a 36 yrs female patient, Gravida 5 Medical Termination of Pregnancy1Abortion 3 with 36 weeks gestation with autoimmune thyroiditis with history of recurrent pregnancy losses with uterine septal resection done 1 year back were admitted for safe confinement in view of mild PIH in September 2014.

In March 2011, her pregnancy had to be medically terminated after detection of anencephaly in the fetus. She had 2 spontaneous abortions at 2 months gestation in July 2011 and March 2012. On both occasions check curettage was done. While she was following up at other hospital for routine checkup, her thyroid function tests (TFTs) were found to be abnormal (raised TSH) in May 2012 and was started on tablet thyroxine 50 mcg once a day. Thereafter her thyroid levels were normal. In September 2012 she

visited another government hospital. She was advised thyroid function tests and TORCH titre. IgG rubella and IgG cytomegalovirus titre were positive and she was treated with acyclovir.

In January 2013 she had a missed abortion at 2.5 months gestation and visited our hospital. Suction evacuation was done. We investigated her further. TFTs were normal, but anti mitochondrial antibody (AMA45) was positive. APLA was negative and ANA was found to be positive. Anti thyroid drugs were continued.

In March 2013 we did a diagnostic hysteroscopy .The uterine cavity was regular, a uterine septum was present, and endometrium was flaky. We did a hysteroscopicseptal resection in July 2013and advised her contraceptives for 6 months

In January 2014 she conceived and was following up with us regularly. Apart from minor complaints the course of pregnancy was uneventful. At 36 weeks gestation she had pedal edema and her blood pressure was found to be 140/90mmHg. Toxemia charting was kept and with bed rest, dietary advise and sedation at bed time, her blood pressure was under control. She delivered a 3.2 kg female child by caesarean section at 38 weeks gestation. Both mother and baby were discharged in a healthy condition.

DISCUSSION

Pregnancy loss is a common entity occurring in almost 12 to 15 % of pregnancies.These are clinical pregnancy losses. Many more pregnancies are lost before becoming clinically apparent so called chemical pregnancy losses. Majority of sporadic cases before 10 weeks of gestation are as a result of chromosomal anomalies. Recurrent pregnancy loss (RPL) is defined as two or more failed clinical pregnancies. Less than 5% of women experience two consecutive miscarriages whereas 1% experience three or more. Differentiating between sporadic miscarriages from RPL is challenging and so documentation with the help of investigations is very important. RPL has a very wide spectrum of etiology ranging from genetic causes, medical causes, autoimmune disorders, infections, endocrinological disorders, uterine anomalies, sperm quality, lifestyle related factors to unexplained causes. So arriving at a particular causative factor is difficult, expensive and takes time. Also after tentatively making a diagnosis, treatment of RPL successfully in terms of fertility, positive uneventful antenatal to postpartum course is difficult.

Overt hypothyroidism is estimated to occur in 0.3-0.5% of pregnancies. Autoimmune thyroiditis is the most common cause of hypothyroidism. Maternal complications of untreated hypothyroidism include microcytic anemia, preeclampsia, placental abruption, postpartum hemorrhage, cardiac dysfunction, and miscarriage. Fetal or neonatal complications include prematurity, low birth weight, congenital anomalies, stillbirth, and poor neuropsychological development. Abalovich et al showed about 60% risk of fetal loss with inadequate treatment or detection of hypothyroidism. Leung et al noted a 22% risk of gestational hypertension in pregnancy associated with hypothyroidism, compared to controls.[1]

In about 15% of patients with recurrent pregnancy loss anatomical deformities are thought to be cause with the septate uterus as the most common finding.[2] According to the classical study by Buttram there is a 60% risk of a spontaneous abortion, this being more common in the second than in the first trimester.[3] Hysteroscopic removal of a uterine septum is generally the preferred method, as the intervention is relatively minor and safe in experienced hands. In a case of recurrent pregnancy wastagesseptum if present must be excised.

Autoimmune diseases are suspected of causing recurrent pregnancy wastage. Many autoantibodies have been associated with impaired fertility and it is still not completely clear which antibody panel should be assessed in the management of pregnancy complications. In the absence of specific antibodies that are pathognomic of pregnancy failure, it may be that a group of combined antibodies is more significant than any one antibody, and it may be more appropriate to assess a panel of antibodies rather than one antibody. Cubillos *et al.* [4] found that the incidence of ANAs was 31.8% in patients with a history of miscarriages (110 patients), but only 5.7% in 35 healthy patients with proven fertility and no history of pregnancy loss or autoimmune disease.

They are a group of viral, bacterial, and protozoan infections that gain access to the fetal Blood stream transplacentally via the chorionic villi. Primary infections caused by TORCH—Toxoplasma gondii, Rubella virus, cytomegalovirus (CMV), and herpes simplex virus (HSV)—are the major causes of BOH. These infections usually occur before the woman realizes that she is

pregnant or seeks medical attention. The primary infection is likely to have a more important effect on fetus than recurrent infection and may cause congenital anomalies, spontaneous abortion, intrauterine fetal death, intrauterine growth retardation, prematurity, stillbirth, and live born infants with the evidence of disease.

CONCLUSSION

There are multiple causes of repeated pregnancy wastages. If you identify the cause you are half way there. Sometimeswhat we forget is that there can be multiple causes present in the same patient simultaneously. In this case the patient had multiple problems which could have been the culprit. But to identify, pin point, that particular cause is difficult and lack of details of previous pregnancies make it even more difficult. Appropriate documentation is very crucial and should be reliable in such cases. Proceeding management midway of the patient after failed attempts at other centres is challenging. Managing cases like this should be individualized. Detailed history taking is required for targeted risk factors. We must use the correct weapon to shoot the correct target. Sometimes tears roll down your cheeks when you lose something you cannot replace. But don`t quit. One has to be patient and there is always light at the end of the tunnel. Skillfull screening and cause oriented treatment helps many couples have a successful pregnancy outcome.

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