

A Case Study of Recurrent Miscarriage Due to Uterine Anomaly at Orotta Referral Hospital Asmara –Eritrea

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Abstract

Recurrent miscarriage is defined as 3 consecutive pregnancy losses prior to 20 weeks from the last menstrual period. Associated factors with recurrent second trimester miscarriage are congenital uterine abnormalities, adhesions, fibroids or polyps including unicornuate, bicornuate, septate or double uterus and endometriosis, intrauterine and cervical incompetence. In this case report, 35 year old patient with history of three consecutive miscarriages in early second trimester presented in outpatient clinic with complaints of 14.5 weeks of amenorrhea, severe lower abdominal pain and vaginal bleeding. Fixed enlarged mass like structure was felt along the right side of the cervix with no irregularities on bimanual pelvic assessment. This examination finding remained the same before and after evacuation and curettage procedure. Two months later, patient reported for reevaluation as advised and hystero-salpingo-graphy (HSG) was performed that revealed septate uterus. Surgical correction of the septum (resection) was done on her septate uterus. Patient was advised to have contraception for 18 months after surgery. Couple received preconception counselling. Pregnancy occurred two months following the cessation of family planning method. During her ante-natal period, counselling and psychological support was offered. She had uneventful normal pregnancy and live infant was delivered by cesarean section.

Keywords

Miscarriage, Septate uterus, Hysterosalpingography, Resection

I. Introduction

Spontaneous pregnancy loss is a common occurrence with 15% of all clinically recognized pregnancies. Many of these pregnancies fail prior to being clinically recognized. Recurrent miscarriage is defined as 3 consecutive pregnancy losses prior to 20 weeks from the last menstrual period; it affects approximately 1% to 2% of women [1]. The etiologies are uncontrolled diabetes, untreated hypothyroidism, certain uterine anatomic abnormalities and antiphospholipid antibody syndrome. Other possible etiologies include endocrine disorders acquired thrombophilias, immunologic abnormalities, infection and environmental factors [1]

Congenital uterine abnormalities (including unicornuate, bicornuate, septate or double uterus), adhesions, fibroids or polyps, endometriosis, intrauterine and cervical incompetence are associated with recurrent second trimester miscarriage.

The definitive cause and generally accepted etiology is anatomic defects which account for 10%-15% of cases of recurrent miscarriage by interrupting the vasculature of the endometrium, prompting abnormal and inadequate placentation [1]

Mullerian anomalies including unicornuate, didelphic and bicornuate uteri have been associated with smaller increases in the risk of recurrent pregnancy loss [1]. However, the

definitive cause may not be found in most women with recurrent miscarriage unless appropriate evaluation and follow up is done. There is limited data regarding this area of practice, clinically the risk of having a spontaneous miscarriage for the first time is doubled in women experiencing recurrent miscarriage.

Diagnosis of uterine anatomic abnormalities usually includes hysterosalpingography (HSG) or hysteroscopy. Surgical intervention to correct these abnormalities is undertaken when indicated or required.

II. Case Study

A 35 year old with history of three consecutive miscarriages in early second trimester presented in the out-patient clinic at Orotta Referral Hospital. Her main complaints were amenorrhea of fourteen and half weeks followed by severe lower abdominal pain, backache and vaginal bleeding since one day. Vaginal bleeding increased since six hours, accompanied with severe pain around the pubic area. **On assessment:-** Patient looked in pain but alert. Her pulse was 78/minute, blood pressure 110/70, respiration 14/per minute and temperature 36.8 degree centigrade. On abdominal palpation, non-tender mass was

found palpable just above the symphysis pubis.

On pelvic examination:- fresh clotted blood was noticed on her perineal pad, some conceptus tissues was observed coming out through the vagina, cervical os was 3-4 cm open and uterus was enlarged. Speculum examination was performed to view the cervix and vaginal canal. Conceptus tissues were removed with sponge forceps from the cervical os, curettage and evacuation was done. Ergometrine 0.05 mg as intramuscular injection was given, following which the bleeding minimized. On bimanual pelvic assessment, a fixed enlarged mass like structure was felt along the right side of the cervix felt. No irregularities palpated. Patient was admitted to the gynecology ward for bed rest and observation. She received Antibiotics for seven days.

Seven days after admission, pelvic examination was performed to assess the uterine size. Cervical os was closed, with normal vaginal discharge; Finding of enlarged mass, that was initially noticed, was the same. Patient was discharged and was counselled to come back for evaluation.

Two months later, patient came to the gynecology out patient service with history of regular menstrual cycle twice since her last admission. Her last menstrual cycle was five days ago. On gynecological examination: the enlarged mass like was palpated on bimanual examination, cervix normal and non-tender. Hystero-salpingo-graphy was arranged and performed the next day which revealed complete septate uterus with patent fallopian tubes. Laparotomy under general anesthesia and resection of the septum was performed. Intra-operatively both fallopian tubes and ovaries were inspected and found normal. Post-operative recovery was excellent. On discharge, patient was counselled to have contraceptive method for 18 months and the need for reassessment (pre-conception) prior to the cessation of contraceptive method was explained. Couple complied well. Pregnancy occurred 20 months following surgical intervention/correction. During the ante-natal period, continuous counselling and psychological support was offered. She had uneventful normal pregnancy followed by a delivery of live infant through cesarean section. She is a mother of two children at present.

III. DISCUSSION

Miscarriage is defined also as the spontaneous loss of pregnancy before the fetus reaches viability from time of conception until 24 weeks of gestation [2]. Recurrent miscarriage is defined as the loss of three or more consecutive pregnancies. Epidemiological factors for miscarriages include maternal and paternal age of equal to or above 35 and equal to or above 40 years of age respectively [2]. Other risk factors for recurrent miscarriage include; autoimmune (20%), genetic factors (2- 5%), infections (0.5-5%), endocrine factors (17-20%) and anatomic abnormalities (10-15%) [1].

Unexplained risk factors including Non-antiphospholipid antibody syndrome and thrombophilias account for 40-50% recurrent miscarriages [1]. Developmental defects include such as septate, bicornuate and unicornuate uterus as well as uterine didelphys [3].

Diagnostic evaluations for recurrent miscarriage are very many depending on the causes. According to the Royal College of Obstetricians and Gynecologists Guideline (2011) recommendation, all women with recurrent first trimester miscarriage and all women with one or more second trimester miscarriages should have a pelvic ultrasound to assess uterine anatomy and that suspected uterine anomalies may require further investigations to confirm the diagnosis using hysteroscopy, laparoscopy or three-dimensional pelvic ultrasound [2]. Uterine abnormalities could be anatomic, Mullerian

anomalies and leiomyomas and are usually confirmed by hysteroscopy and/or hysterosalpingography (HSG).

In this case report however, the availability of ultrasound and the required skill was not possible for various reasons. Thus, diagnosis was based on client's history, a thorough clinical (pelvic) examination and later was confirmed by hysterosalpingography (HSG) as septate uterus. Treatment is primarily surgical corrections such as resection of septa and adhesions, myomectomy for intramural and subserosal myomas etc. Literatures reviewed state that patients undergoing successful hysteroscopic treatment seem to enjoy near normal pregnancy outcomes with term delivery rates of approximately 75% and live birth rates of approximately 85% [4]. In this case report, the intervention was laparotomy under general anesthesia for resection of the septum as the hospital never owned a hysteroscopy. During her ante-natal period, continuous counselling and psychological support was provided to the couples by the midwifery/obstetric care providers that empowered the woman and her husband. As was stated by Lin PC (2004), ante-natal counseling and support have shown to have subsequent pregnancy success rates of 86% when compared with success rates of 33% in women provided with no additional care [5]. Though this was the first case of this kind that was diagnosed and managed in our hospital with limited resources, patient had an optimal outcome.

IV. References

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