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Manju Puri

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2 Approach to a Pregnant Woman Presenting with Bad Obstetric History

Monika Bhatia

INTRODUCTION

The term "*Bad Obstetric History* or BOH" is applied to mothers in whom a previous "poor" pregnancy outcome is likely to have a bearing on the prognosis of her present pregnancy. The previous pregnancy loss should be obstetrically related. Pregnancy loss is a devastating experience for the mother. Perinatal mortality remains a challenge in the care of pregnant women worldwide, particularly for those who had history of adverse outcomes in previous pregnancies. The obstetric disaster may be in the form of miscarriage, preterm birth, antepartum or intrapartum stillbirth, difficult delivery, birth asphyxia or early neonatal death consequent to intrapartum events. Depending on the nature of previous obstetric disasters, there can be various risk factors associated with it. A comprehensive work up of these women is indicated in the interval period to identify these risk factors and plan risk modification in the preconception period and during pregnancy. A detailed history and examination are followed by investigations in these women with the aim to identify the risk factors and initiate interventions to improve the outcome in index pregnancy.

DIFFERENTIAL DIAGNOSIS

Many obstetric disasters may have multiple causes. The differential diagnosis as regards the etiology of various obstetric disasters is as given in Box 1.

Box 1: Differential diagnosis of causes of bad obstetric history based on nature of previous obstetric disaster.

Recurrent abortions:
- *Anatomical*: Müllerian fusion abnormalities like septate uterus, cervical incompetence, intrauterine synechia, submucous fibroid
- *Immunological*: Antiphospholipid antibody syndrome, other immune disorders such as systemic lupus erythematosus (SLE)
- *Chromosomal*: Parental chromosomal abnormality like balanced translocations
- *Endocrinological*: Uncontrolled endocrine problems like diabetes and thyroid dysfunction
- *Others*: Thrombophilia

Previous intrauterine death:
- Chromosomal abnormalities
- Hypertensive disorders of pregnancy
- Uncontrolled endocrine problems such as diabetes mellitus, thyroid disorders
- Severe maternal systemic illness, renal disease, heart disease, SLE
- Maternal infections such as toxoplasmosis, *Cytomegalovirus* (CMV), syphilis, malaria
- Antiphospholipid antibody syndrome
- Thrombophilia
- Cholestasis of pregnancy
- Smoking
- Antepartum hemorrhage: Abruption

Previous hydrops:
- *Immune*: Rh incompatibility
- *Nonimmune infections*: Human parvovirus (HPV) B19, chromosomal abnormalities, cardiac causes, thoracic causes, hematologic causes—α-thalassemia, red cell enzyme defect, fetomaternal hemorrhage, metabolic disorders

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HISTORY

To find the likely cause of mishap, it is important to take a detailed obstetric history of previous pregnancies. It includes the exact nature of disaster whether it was a miscarriage, intrauterine death, preterm delivery or difficult delivery.

In case of miscarriage, it is important to find out the gestation at which it happened, was the pregnancy confirmed by ultrasound or urine pregnancy test, was there any documentation of presence of fetal node and cardiac activity, was the pregnancy terminated by medical or surgical method, and whether the post abortion period was uneventful or did she have any problems such as fever, foul-smelling discharge per vaginam or bleeding per vaginam.

For late pregnancy mishaps, the duration of pregnancy and any significant antepartum or intrapartum events are recorded.

A descending pattern of adverse pregnancy outcomes such as a serial improvement with an increase in pregnancy order points toward syphilis which may be confirmed by Venereal Disease Research Laboratory (VDRL) and fluorescent treponemal antibody absorption (FTA-ABS). This is due to an increase in maternal antibodies. In women with uterine anomalies like unicornuate uterus the capacity of uterus increase with each pregnancy, hence a similar pattern.

An ascending pattern of adverse pregnancy outcome that is worsening of obstetric performance is suggestive of Rh isoimmunization, where the initial pregnancy outcome is good but it worsens with increase in pregnancy order due to Rh isoimmunization.

Antenatal Period

The details of antenatal period include whether previous pregnancy was booked or unbooked, whether there was any history of high blood pressure, swelling feet suggestive of pre-eclampsia, any bleeding per vaginam or abdominal pain suggestive of placental abruption, any itching especially on palms and soles suggestive of obstetric cholestasis. Any leaking per vaginam suggestive of some cord accident associated with ruptured membranes. Any fever with rash suggestive of infections like toxoplasmosis, varicella-zoster, parvovirus B19, rubella, Cytomegalovirus, or any lesions on the genitalia of parents suggestive of sexually transmitted infections (STIs). Any history suggestive of Rh isoimmunization such as receiving anti-D injection or repeated ultrasound examinations and intrauterine transfusions is asked. Any history suggestive of oligohydramnios or hydramnios is elicited.

Intrapartum Period

The details of the intrapartum period include the duration of labor whether spontaneous or induced, prolonged or precipitate, any rupture of membranes, cord prolapse, any bleeding per vaginam, presentation of the baby whether cephalic or breech; if breech, any difficulty or delay in delivery of the head of the baby, any instrumentation, any passage of meconium, any tight cord loops around the neck of the baby, weight of the baby whether it was very small suggestive of growth restriction or large as in diabetes mellitus. In case of a stillborn, it is important to know if it was a fresh stillborn as with abruptio placentae or macerated as with syphilis or swollen and hydropic as with Rh isoimmunization and parvovirus infection. It is important to find out if the baby had any gross congenital abnormality.

All these details are recorded systematically for each pregnancy.

The old records of the woman are reviewed to verify the facts furnished by the

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woman and review any investigations she has done for the fetal loss. Depending on the nature of the fetal loss according to obstetric history, certain points are elicited in the present and past medical and surgical history of the woman to identify the likely cause of the mishap (Table 1). Personal history is important in all women with bad obstetric outcome as smoking and drug abuse adversely affect the pregnancy outcome.

EXAMINATION

A detailed general and systemic examination may further help to shortlist the likely cause of BOH. These are then followed by a

Table 1: Detailed questions regarding specific etiologies to be elicited.

Relevant history	*Disease*
Previous history of genital ulceration, generalized rash or lymphadenopathy, gradually improving obstetric performance like late abortions, macerated stillbirth, fresh stillbirth, baby with congenital syphilis followed by birth of a healthy baby	Syphilis
Polyuria, polydipsia, polyphagia, polyhydramnios, large for date baby or fresh stillborn baby in previous pregnancy	Diabetes
Weight gain, lethargy, tiredness, dry skin, constipation, fluid retention, goiter, cold intolerance; untreated women may have increased risk of miscarriage, pre-eclampsia, abruption, low birth weight, stillbirth, impaired neurological development, and decreased intelligence quotient of offspring	Hypothyroidism
Weight loss, heat intolerance, palpitations, vomiting, emotional lability, recurrent fetal growth restriction with congenital goiter	Hyperthyroidism
Fever, fatigue, myalgia, lymphadenopathy, erythema over cheeks, photosensitivity, oral ulcers, small joint pain and swelling, seizures, headaches Increased risk of miscarriages, fetal growth restriction, fetal death and prematurity if active, disease is present at conception	Systemic lupus erythematosus
Venous or arterial thrombosis or pregnancy wastage in the form of three or more recurrent miscarriages before 10 weeks, one fetal death after 10 weeks, or one or more preterm births before 34 weeks due to placental insufficiency or pre-eclampsia	Antiphospholipid antibody syndrome
Breathlessness on exertion, chest pain, palpitations, syncope	Heart disease
Weakness, swelling over face or body, vomiting, decreased urine output	Renal disease
Painless cervical dilatation and rupture of membranes followed by expulsion of a live fetus in mid pregnancy Any history of trauma, cervical surgery like deep unrepaired cervical tear, conization, cervical amputation, etc.	Cervical incompetence
Recurrent preterm births and increasing mean gestational age at birth	Uterine anomalies
Worsening fetal outcome classically in the form of one or two uneventful births followed by neonatal death due to severe jaundice followed by stillborn hydropic baby	Rh-sensitized pregnancy
Recurrent abortions, early onset pre-eclampsia, fetal growth restriction and abruption	Thrombophilias: Inherited or acquired

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Table 2: Physical examination and diagnosis.

General physical examination	*Diagnosis*
Generalized maculopapular rash involving palms and soles	Syphilis
Obesity, acanthosis nigricans	Diabetes
Bradycardia, delayed relaxation of deep tendon reflexes, goiter, carpal tunnel syndrome	Hypothyroidism
Tachycardia, goiter, palmar erythema, tremors, lid lag, lid retraction	Hyperthyroidism
Malar rash sparing nasolabial folds, discoid rash, arthritis	Systemic lupus erythematosus
Leg ulcers, hypertension, livedo reticularis	Antiphospholipid antibody syndrome
Cyanosis, clubbing	Heart disease
Pallor, facial puffiness, hypertension	Renal disease

per speculum and per vaginam examination if required.

The general physical examination is carried out as in any antenatal woman. The body mass index (BMI) of the woman is important as obesity is associated with poor obstetric outcome. Undernutrition and malnutrition also affect the pregnancy adversely. The findings on general physical examination suggestive of various diseases are as given in Table 2.

Systemic Examination

On respiratory system, look for any evidence of pleuritis or pericarditis, which are suggestive of systemic lupus erythematosus (SLE). In cardiovascular system, presence of any significant murmur that is any diastolic or loud systolic murmur grade 2 or more is suggestive of heart disease.

Pelvic Examination

Per speculum examination is important in pregnant women with history suggestive of incompetent os for any shortening of cervical length, any old healed cervical tears, ectropion, etc. In women with previous preterm birth, it is important to look for any vaginal discharge suggestive of bacterial vaginosis where the discharge is profuse homogenous and grayish white.

On per vaginum examination, any abnormality in the uterine contour, broad fundus or a marked deviation of uterus to one side may be suggestive of a uterine anomaly.

INVESTIGATIONS

Routine investigations are carried out for any antenatal woman as described in Chapter 1. Other investigations are based on the condition suspected on history and examination. But if no specific cause is suspected, then the woman has to be screened for all the likely causes. List of investigations depending upon the condition suspected to be the cause of loss is detailed in Table 3.

The clinical approach to a pregnant woman with a bad obstetric history is shown in Flowchart 1.

MANAGEMENT

Women with BOH are devastated and need reassurance and psychological support. Tender loving care should be given to all. The management is according to the cause identified. Table 4 lists the various treatment options according to the cause. However, the woman needs to be carefully monitored during her pregnancy.

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Table 3: Investigations for a pregnant woman with bad obstetric history.

Investigations	*Disease*
Venereal Disease Research Laboratory, fluorescent treponemal antibody absorption test	Syphilis
Glucose tolerance test, glycated hemoglobin (HbA1c)	Diabetes mellitus
Free triiodothyronine (FT_3), free thyroxine (FT_4), thyroid-stimulating hormone	Thyroid disorders
Antinuclear antibody, anti-double-stranded DNA (anti-dsDNA) antibodies	Systemic lupus erythematosus
Lupus anticoagulant, Antiphospholipid antibody immunoglobulin G (IgG)/IgM, anti-β2 glycoprotein antibodies (documented twice 12 weeks apart)	Antiphospholipid antibody syndrome
Electrocardiogram, echocardiography, chest X-ray	Heart disease
Serum creatinine, blood urea, 24-hour urine protein estimation, urine microalbumin, GFR, USG for kidneys	Renal disease
Serial cervical length from 14 to 24 weeks for any shortening, or change in shape of cervical canal that is any funneling on transvaginal ultrasound	Cervical incompetence
High resolution ultrasound, three-dimensional (3D)-ultrasound, hysterosalpingography or hysteroscopy, or magnetic resonance imaging	Uterine anomalies
Blood group and Rh typing, titer of anti-D antibodies, Indirect Coombs' test	Rh-sensitized pregnancy
Thrombophilia screen (protein C, protein S, antithrombin 3)	Genetic thrombophilia

KEY POINTS

- A variety of causes are associated with recurrent poor pregnancy outcomes.
- Identification of various causes of adverse pregnancy outcomes can facilitate preconception and antenatal interventions to improve the perinatal morbidity and mortality in the index pregnancy.
- Some of the diseases may be identified with a specific pattern of presentation, others may present with overlapping pattern of abortions, preterm births, poor growth, fetal death, high blood pressure or abruption.
- In women with recurrent first trimester miscarriage, antiphospholipid antibody (APLA) syndrome and anatomical uterine anomaly may be specifically suspected.
- In women with recurrent second trimester miscarriage and preterm births, causes like cervical incompetence and uterine anomalies like Müllerian fusion defects are more likely.
- A descending pattern of adverse pregnancy outcomes such as a serial improvement with an increase in pregnancy order points toward syphilis or uterine anomalies like unicornuate uterus.
- An ascending pattern of adverse pregnancy outcomes that is worsening of obstetric performance is suggestive of Rh isoimmunization.
- Recurrent fetal growth restriction along with features of systemic disease may point toward heart or renal disease in the mother.
- Recurrent high blood pressure or placental abruption may be indicative of an underlying immune-mediated illness like SLE or APLA syndrome.

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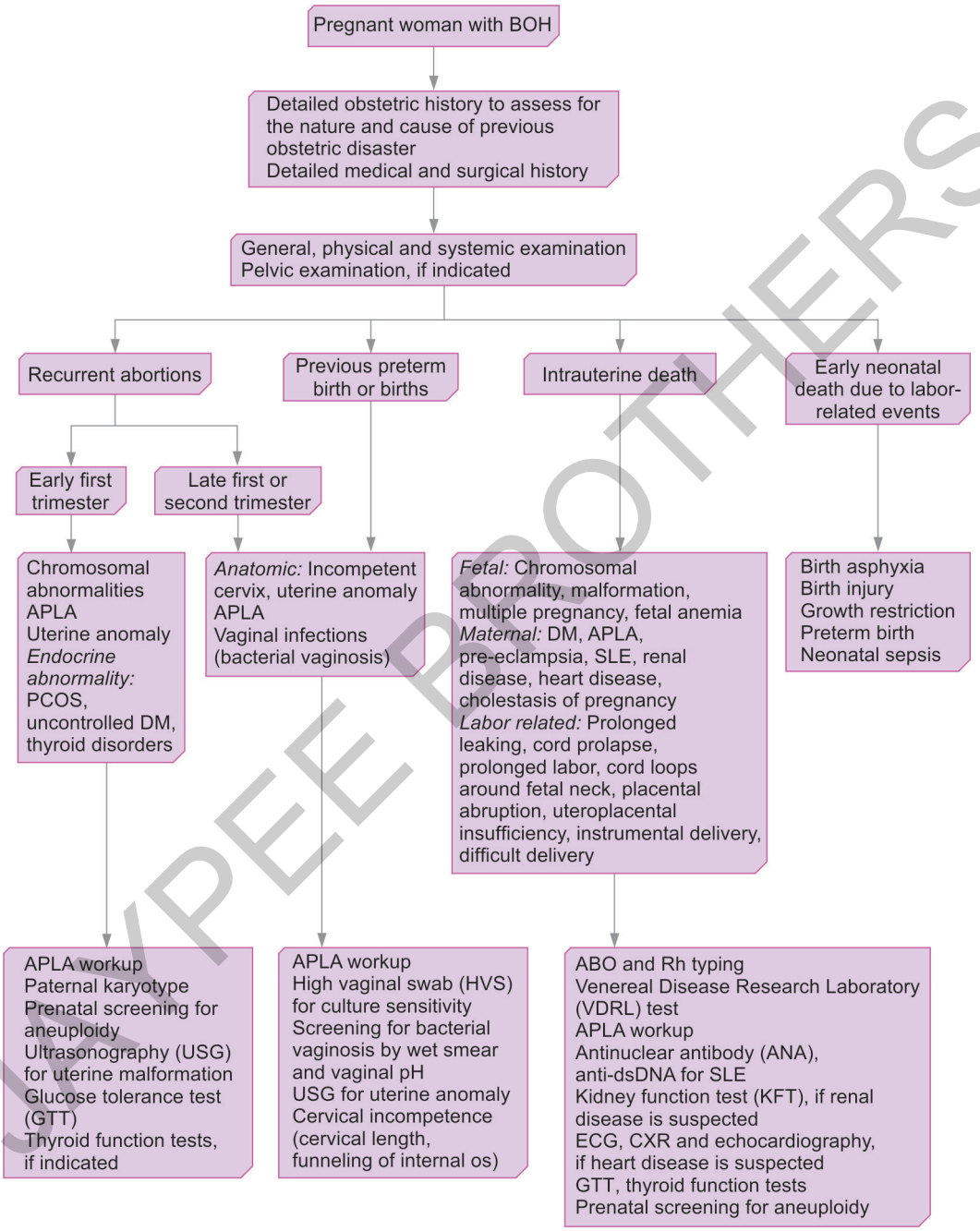
Flowchart 1: Algorithm for clinical approach to a pregnant woman with bad obstetric history.



(APLA: antiphospholipid antibody; BOH: bad obstetric history; CXR: chest X-ray; DM: diabetes mellitus; dsDNA: double-stranded DNA; ECG: electrocardiography; PCOS: polycystic ovary syndrome; SLE: systemic lupus erythematosus)

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Table 4: Interventions for women with bad obstetric history.

Condition	*Interventions*
Recurrent miscarriage: • Uterine septum • Cervical incompetence • Antiphospholipid syndrome • Parental karyotype abnormality • Uncontrolled DM/hypothyroidism	Tender loving care and lifestyle modification cessation of smoking, normalize BMI: • Hysteroscopic resection of uterine septum • Cervical cerclage • Aspirin + LMWH • Genetic counseling • Control with medications OHA/insulin, thyroxine
Preterm births	• Lifestyle modification cessation of smoking, normalize BMI • Treatment of asymptomatic bacteriuria • Avoid interpregnancy interval of <6 months preferably <12 months • Progesterone supplementation • Cervical cerclage in selected cases
Syphilis	• Benzathine penicillin 2.4 million units IM every week × 3 • Ceftriaxone 2 g IV every day × 10–14 days
Rh isoimmunization	• Assess fetal RhD genotype by fetal cf DNA after 10 weeks or from uncultured amniocytes by amniocentesis after 15 weeks • Follow maternal anti-D titers every month; if rising, then every 2 weeks till they reach critical value ≥10 IU/mL • Then follow with MCA-PSV • IUT if MCA-PSV ≥1.5 MOM Delivery 35–38 weeks
Recurrent anomalies	Genetic counseling

(LMWH: low-molecular-weight heparin; BMI: body mass index; DM: diabetes mellitus; OHA: hypoglycaemic agents; IUT: intrauterine transfusion; MOM: multiples of median; MCA-PSV: multiples of median middle cerebral artery peak)

SUGGESTED READING

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