INCOMPLETE ABORTION TREATMENT IN 15TH WEEKS GESTATION: A CASE REPORT

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ABSTRACT

Introduction: An incomplete abortion is a subtype of spontaneous abortion along with inevitable and missed abortion. Globally, 303,000 maternal deaths occurred in 2015, with 11% of maternal deaths and a large number of morbidities attributable to consequences of unsafe abortion. Complications from unsafe abortions continue to be a major contributor to the global maternal mortality ratio. This article will focus on incomplete abortion and the way it is treated, which is described as partial loss of products of conception before 20 weeks of pregnancy. Patients will present with vaginal bleeding with lower abdominal and/or pain and cramping.

Case Illustration: Patient Mrs. RO, 34 years old, 15 weeks gestation (G4P2A1) came to the referral hospital on October 4, 2020 with complaints of blackish red blood, clots, clots like chicken hearts from the birth canal since 2 hours before hospitalized.

Conclusion: Incomplete abortion can cause hypovolemic shock due to active bleeding. So, it should be considered for general conditions and to treat hemodynamic disorders. In women with heavy bleeding, good decision on the treatment prepare immediately evacuate with curettage, uterine contractions can go well and bleeding can stop.

Keyword: Curettage, Incomplete abortion, pregnancy.

I. INTRODUCTION

An incomplete abortion is a subtype of spontaneous abortion along with inevitable and missed abortion. Globally, 303,000 maternal deaths occurred in 2015, with 11% of maternal deaths and a large number of morbidities attributable to consequences of unsafe abortion. Complications from unsafe abortions continue to be a major contributor to the global maternal mortality ratio. The majority of abortion related deaths occur in low income-countries with restrictive abortion laws and low contraceptive prevalence (Atuhairwe S. et al, 2019; Cleeve A. et al, 2016).

Young and rural women, and women with low socio-economic status, are especially vulnerable to unintended pregnancies and unsafe abortions, demonstrating the inequity in safe abortion care access across the globe. Post abortion complications are exacerbated by lack of resources, delayed care-seeking and harmful abortion practices. Misoprostol is proven safe and effective for treatment of incomplete abortion in the first trimester and highly suitable in low resource settings as it is cost-effective, resource saving and heat stable (Makenzius M. et al, 2017; Upadhyay U. et al, 2016).

Observations in clinical practice show that the number of incomplete abortions in the second trimester are at least as high as in the first trimester. Evidence is compelling that the prostaglandin E1 analogue misoprostol is effective medication for first trimester incomplete abortions. This article will focus on incomplete abortion and the way it is treated, which is described as partial loss of products of conception within the first 20 weeks of pregnancy. Patients will present with vaginal bleeding with lower abdominal and/or pain and cramping (Gebretsadik A, 2018).
II. CASE ILLUSTRATION

Patient Mrs. RO, 34 years old, 15 weeks pregnant (G4P2A1) came to the referral hospital on October 4, 2020 with complaints of blackish red blood, clots, clots like chicken hearts from the birth canal since 2 hours before hospitalized. The patient also experienced complaints of pain and cramps in the lower abdomen that were felt since 5 hours before the complaint came out of the genitals.

The patient has a history of abortion in the first pregnancy. The patient does not have a history of other diseases in himself or in his family.

On general physical condition, the patient seems to feel moderate pain, compost mental awareness, blood pressure 130/70 mmHg, pulse 82x/minute, respiratory rate 22x /minute, and body temperature 37,2°C.

In obstetric examination with speculum examination we found that visible in the presence open external orifice of the uterus, active vaginal bleeding depending on the remaining tissue.

![Figure 1](image_url). Speculum Examination, visible in the presence open external orifice of the uterus, active vaginal bleeding depending on the remaining tissue.

EXAMINATION SUPPORT

At the laboratory examination on October 4, 2020, the results obtained hemoglobin 10.2 g /dL (N: 12.1-15.1), leukocytes 18,500/mm3 (N: 4,500-10,000), platelets 253,000 / mm3 (N : 140,000-450,000), 3.8 million erythrocytes (N: 3.9-5.1), MCV 82 fL (N: 80-100), MCH 27 pg (N: 26-33), MCHC 32% (N : 32-36), HbsAg Rapid: Non Reactive; Normal Value: Non Reactive.

DIFFERENTIAL DIAGNOSIS

The differential diagnosis of abnormal excessive uterine bleeding includes organic causes that may be subdivided into reproductive tract disease, iatrogenic causes, and systemic disease. Reproductive tract disease that may result in abnormal uterine bleeding comprises the complications of pregnancy (threatened, incomplete, or missed abortion, ectopic pregnancy, trophoblastic disease, placental polyp, and subinvolution of the placental site), malignant tumors (endometrial, cervical, vaginal, vulvar, and oviduct malignancies and granulosa theca cell ovarian tumors), infection (endometritis, salpingitis), and other benign pelvic disorders (traumatic lesions of the vagina, severe vaginal infections, foreign bodies, cervical polyps, cervical erosion, cervicitis, submucous uterine leiomyomas, adenomyosis, endometriosis, and endometrial polyps) (Brenner P, 2010).

III. TREATMENT

This patient is diagnosed with an incomplete abortion. So, it should be consider for general conditions and to treat hemodynamic disturbances. Dilatation and Curetage is the surgical method for abortion >12–14 weeks of pregnancy. Prior to the evacuation action, the patient was treated with diazepam IV 1 ampule, Ringer's lactate infusion of 20 drops per minute and ketorolac. During the curettage procedure, 100cc of blood and tissue were obtained. After curettage, the patient was given 3 tablets of misoprostol suppository, antibiotic cefadroxil 500 mg/12 hours orally, mefenamic acid 500 mg/8 hours orally.
The post-operative condition of the patient is stable with the results of the physical examination of the patient in good general condition, vital signs within normal limits. The patient was treated for 2 days, with continuous improvement every day. The patient went home on day 3 in good condition and pain free.

IV. DISCUSSION

Patient diagnoseis an incomplete abortion at 15 weeks' gestation.

Abortion is a threat or release of the product of conception before the fetus can live outside the womb. Based on the types of abortion, it consists of imminent abortion, incipient abortion, complete abortion, incomplete abortion, missed abortion, and habitual abortion (Prawirohardjo, 2016).

Incomplete abortion is the removal of part of the product of conception from the uterine cavity and some are left behind. As a limitation according to National Center for Health Statistics, the Centers for Disease Control and Prevention, and the World Health Organization gestational age less than 20 weeks or fetal weight less than 500 grams (Cunningham, et al. 2014; Prawirohardjo, 2016).

An average of 114 abortions occurred per hour. Most of the studies stated that abortion occurrences occur in 10% to 15% of pregnancies (Prawirohardjo, 2016; Jp, 2013) The incidence of abortion is close to 50%, this is due to the high number of chemical pregnancy losses that cannot be known 2-4 weeks after conception (Prawirohardjo, 2016).

The cause of abortion is generally unknown but most are likely to be due fetal factor (developmental abnormality of the zygote, embryo, fetus, or at times the placenta) (Cunningham., et al. 2014; Jurcovic & Bender-atik, 2013), several other factors that can increase the incidence of abortion is Maternal factor (infections, chronic debilitating disease, endocrine abnormalities like hypothyroids, diabetes mellitus, nutrition), drug use and environmental factors (tobacco, alcohol, caffeine, radiation, contraceptive, environmental toxins), Immunological factors, inherited thrombophilias, maternal surgery, trauma, uterine defects (acquired uterine defects, developmental uterine defects, incompetent cervix (Cunningham., et al. 2014).

The diagnosis of incomplete abortion can be confirmed at less than 20 weeks of gestation through history and physical examination. Patients with incomplete abortion will usually complain of abdominal pain and cramps, partial discharge of conception tissue, moderate to large amounts of active vaginal bleeding depending on the remaining tissue, and inspekulo results there was open cervical canal (Prawirohardjo, 2016; Kemenkes RI, 2013).

The ultrasound diagnosis of incomplete and no consensus exists regarding the best diagnostic criteria abortion is difficult (Jurcovic & Bender-atik, 2013). Ultrasound examination is only performed when in doubt about the clinical diagnosis. The uterus is smaller than the gestational age and the gestational sac is difficult to recognize. In the uterine cavity there is a hyperechoic mass which is irregular in shape (Prawirohardjo, 2016). A crown-rump length (CRL) of 5 mm without cardiac activity have been used diagnostic criteria to confirm early pregnancy loss (Prager&Dalton, 2018).

Biochemical markers are not routinely used in the diagnosis of abortion. Human chorionic gonadotrophin concentrations in maternal serum double over 1.4-1.6 days from the time of first detection to the 35th day of pregnancy and then double every 2.0-2.7 days from the 35th day to 42nd day. It has been well documented that slower doubling times are associated with miscarriage. However, absolute concentrations of the hormone cannot be used to discriminate between viable and nonviable pregnancies. In women with non-diagnostic ultrasound findings, declining chorionic gonadotrophin values can diagnose a complete abortion with a sensitivity of 93-97% (Jurcovic & Bender-atik, 2013).

Management of abortion can be given by the expectant, medical, and surgical treatment. Expectant management is often chosen by women because of a desire for a natural approach. Women are usually advised to wait for two weeks for abortion to complete, but it is safe to continue with expectant management for longer if there are no signs of infection. Medical treatment, or expectant care (no treatment) may also be effective, safe, and acceptable (Jurcovic & Bender-atik, 2013).
Medical management is chosen as the primary treatment option in 20-30% of women. The drug most commonly used is a prostaglandin analogue misoprostol, which can be given in single or divided doses. Can be given in oral, vaginally, sublingually, or rectally (Jurcovic, Overton & Bender-atiak, 2013). As Mifepristone was also used in those cases for termination of pregnancy. Mifepristone with misoprostol is more effective than misoprostol used alone, and is associated with fewer side-effects (WHO, 2014).

The treatment women with incomplete abortion (<12 weeks of gestation) in Kenya has been to perform surgery to remove any remaining placental tissue in the uterus (Jurcovic& Bender-atiak, 2013). As in the Sub-saharan Africa access to post-abortion care service especially of incomplete abortion has been the use of manual vacuum aspiration (MVA) for uterine evacuation size in consistent with or ≤12 weeks of gestation (Ibiyemi & Adesina, 2019).

Surgical curettage was the gold standard management for abortion for many years (Lemmers, et al, 2018). Dilatation and Curetage the surgical method for abortion >12–14 weeks of pregnancy (WHO, 2014). Curettage is more effective than expectant in women with suspect incomplete evacuation for the first trimester miscarriage (Lemmers, et al, 2018). In women with heavy bleeding, evacuate immediately so that the blocked tissue is immediately removed, uterine contractions can go well and bleeding can stop. And if there is fever antibiotics are given before evacuation incomplete abortion by curetage (Cunningham, et al. 2014; Prawirohardjo, 2016).

This patient has complain of abdominal pain and cramps. So, appropriate pain management before medical or surgical abortion. Pain management option for surgical abortion is Analgesia (non-steroidal anti-inflammatory drugs [NSAIDs], e.g. ibuprofen 400–800 mg). Anxiolytics/sedatives (e.g. diazepam 5–10 mg). Local anaesthetic (paracervical block using lidocaine (usually 10–20 mL of 0.5 to 1.0%), Conscious sedation or general anaesthesia in some cases, not routinely (WHO, 2014).

Post abortion, additional follow-up: assess the woman’s recovery and confirm completion of the abortion, ask about any symptoms she has experienced since the procedure; perform a focused physical examination in response to any complaints (WHO, 2014).

V. CONCLUSION

The cause of incomplete abortion is generally unknown, but most often it is due to abnormalities in fetal factors. The diagnosis of incomplete abortion can be confirmed at less than 20 weeks of gestation through history and physical examination. For clinical symptoms that often appear, abdominal pain and cramps, partial discharge of conception tissue, moderate to large amounts of active vaginal bleeding depending on the remaining tissue, and speculum examination there was open cervical canal. The USG is supporting examination only performed if there is doubt from the clinical assessment. A doctor must be aware that bleeding before 20 weeks of gestation is an abortion event and incomplete abortion can cause hypovolemic shock due to active bleeding. So, it should be consider for general conditions and to treat hemodynamic disorders. In women with heavy bleeding, good decision on the treatment prepare immediately evacuate with curetage, uterine contractions can go well and bleeding can stop.

REFERENCES


