



WOMEN'S CHOICE OF MANAGEMENT IN CASES OF 1ST TRIMESTER PREGNANCY LOSS: A STUDY IN TERTIARY CARE TEACHING HOSPITAL AT BIHAR

Obstetrics & Gynaecology

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ABSTRACT

NICE guidelines published on 17th April 2019 recommended expectant management as 1st line advice in patients of 1st trimester miscarriage. So, this study was done at department of obstetrics and Gynaecology, PMCH, Patna from June 2019 to May 2020 to see the uptake of expectant, medical and surgical management in the patients and study the outcome of choices they made.

150 patients recruited after taking informed consent and allocated to three group according to their choice of management. Out of these 20 patients in expectant group 9 patients turned up to surgical intervention. Out of 80 patients managed medically, 10 needed surgical intervention after 14 days. In surgical managed group 1 required repeat check curettage. Expectant management was found to be more successful in patients with incomplete abortion who were already in process of expulsion. Medical management was first choice in women with early pregnancy loss less than 7 week, especially primigravidas, who had apprehension about future fertility. Surgical intervention was opted mostly by patients with ≥ 9 weeks pregnancies and were most acceptive to recommendations for future pregnancies and also about contraception.

Satisfaction rate was highest in medical method group. Medical method was most popular among women and is a safe and effective choice. Women were apprehensive about surgery and anaesthesia.

Expectant management is not opted by most women of Bihar.

No method is found superior above one to another in terms of outcome. Therefore, choice of women should be taken into consideration.

KEYWORDS

Miscarriage, Misoprostol, Missed abortion.

INTRODUCTION

Spontaneous abortion in the first trimester is common, affecting at least 15–20% of the clinically recognized pregnancies. Approximately 80% of all cases of pregnancy loss occur within the first three months of pregnancy (first trimester).¹

Broadly we have 3 options for management of 1st trimester miscarriages- expectant management, medical management to expedite the process or a short surgical procedure under general or local anaesthesia for quick evacuation.

According to NICE guidelines published on 17th April 2019 expectant management for 7-14 days was recommended as 1st line strategy for women with a confirmed diagnosis of miscarriage. Other management options to be explored if the woman is at increased risk of haemorrhage (for example, she is in the late first trimester) or she has previous adverse and/or traumatic experience associated with pregnancy (for example, stillbirth, miscarriage or antepartum haemorrhage) or she is at increased risk from the effects of haemorrhage (for example, if she has coagulopathies or is unable to have a blood transfusion) or there is evidence of infection.^{2,3}

In women without medical complications or symptoms requiring urgent surgical evacuation, treatment plans can safely accommodate patient treatment preferences. Some may wait for spontaneous expulsion, others will wish to have an expedited process but want to avoid surgery, and therefore medical management could be the right option. Conversely, some women will want to manage their miscarriage as quickly as possible and would prefer surgery.⁴ The patient should be fully informed about the risks of surgery and general anaesthesia. In various studies medical management with misoprostol has comparable success rates to surgery but evidence is limited on outcomes such as women's preferences, satisfaction, and subsequent fertility.⁵

So, the aim of study was to see the uptake of expectant, medical and surgical management in the patients and study the outcome of choices they made.

CASE STUDY

This is a prospective study done at department of obstetrics and Gynaecology, PMCH, Patna in a period of one year from June 2019 to May 2020.

INCLUSION CRITERIA:

Women with 1st trimester spontaneous abortion (missed abortion, blighted ovum, and incomplete abortion) confirmed by USG up to 13 weeks were included.

Following USG criteria was used for diagnosis of miscarriage or pregnancy loss.⁶

CRL of 7mm or greater and no heartbeat.

Mean sac diameter 25mm or greater and no embryo.

Absence of embryo with heartbeat 2 weeks or more after a scan that showed a gestational sac without a yolk sac without a yolk sac.

Absence of embryo with heartbeat 11 days or more after a scan that showed a gestational sac with a yolk sac.

EXCLUSION CRITERIA

- Spontaneous abortion more than 13 weeks
- Patients using MMA,
- patients having extrauterine pregnancies or molar pregnancy, patients having any associated medical conditions.
- Patients in need of blood transfusion or immediate surgical intervention also excluded.

General characteristics of the patients noted. Based on inclusion and exclusion criteria 150 patients recruited. After taking informed consent for participation in study and also that their data can be shared, they were further divided in 3 groups according to choices they made

Grp A: Expectant Management 20

Grp B: Medical management 80

Group C: Surgical management 50

In group B symptomatic patients were treated by 800 microgram misoprostol vaginally or orally. Asymptomatic patients were given mifepristone 200 mg orally followed by misoprostol 800 micro gram vaginal or oral depending on women's choice after 24 hours.⁶

Group C patients managed with suction evacuation under short general anaesthesia.

Patients were fully informed about possible consequences and were asked to immediately report to hospital if any complication occurs. Antiemetic and medicine for pain were given to patients of group A and B. Follow up at 7 to 14 days was done.

Completion of abortion process was diagnosed clinically and with USG showing empty uterine cavity in a woman who was diagnosed previously with intrauterine product of conception.⁷

Anti D prophylaxis was given to rh negative women.⁷ All patients were given antibiotic prophylaxis with doxycycline 100 mg oral twice daily for 7 days, starting on the day of abortion, plus metronidazole 800 mg oral at time of abortion (ICMR guidelines 2019).

Outcome was measured in form of completion of procedure, complications in different treatment group, and satisfaction rate of patients. Complications like incomplete abortion heavy bleeding, fever, sepsis, need of blood transfusion and change of treatment modality from one group to another were noted. Satisfaction rate was noted in terms of percentage of women in a group who would try the same method in future if ever circumstances repeat or recommend to others.

Statistical calculations done at Microsoft excel 2019 and data presented in mean, standard deviation and percentage as deemed appropriate.

RESULTS

After understanding the procedures and possible consequences 20 women opted for expectant management 80 for medical and 50 women opted for surgical management. Most women wanted something to expedite the procedure but didn't want anaesthesia and surgical procedure however short.

Mean age of the patients in group A, B, and C were 25.5±2.16 years, 23.5±6.15 years and 28.3±6.45 years respectively. Most primigravida women (45/58, 77.58%) choose medical management while 10 went for suction curettage. Gestational age was a major deciding factor among women as 36 out of 40 patients (90%) between 9-13 weeks of pregnancy opted for surgical intervention. Expectant and medical management was taken mostly by those women who had easy access to hospital after understanding the procedural consequences. Asymptomatic women mostly went for medical (87.5%) and surgical (67%, 20/30). Women with H/O previous caesarean section went for surgical (7/10) and medical (3/10) management.

Complete evacuation was highest in surgical group (49/50, 98%) followed by medical group (66/80, 82.5%). Eleven women in expectant group had complete expulsion, and 9 needed suction evacuation. Blood transfusion was needed for 2 women in medical group. Fever was reported in one woman in surgical and one in medical group which was investigated and managed with antipyretics. Sepsis was found in none.

Satisfaction rate in terms of trying or recommending same method in similar circumstances if ever, was highest in medical method group (70%).

DISCUSSION

Studies have demonstrated that expectant, medical, and surgical management of early pregnancy loss all result in complete evacuation of pregnancy tissue in most patients, and serious complications are rare. Moderate to high quality evidence shows that expectant management has a higher risk of incomplete miscarriage at 2 weeks and 6-8 weeks, with a higher need for unplanned surgical evacuation, more bleeding, and higher blood transfusion rates compared with surgery, as per a Cochrane review (seven randomised controlled trials, 1521 women). Limited data suggest that expectant management may be more effective in symptomatic women (those who report tissue passage or have ultrasound findings consistent with incomplete expulsion) than in asymptomatic women.^{8,9} Furthermore, studies that included women with incomplete early pregnancy loss tend to report higher success rates than those that included only women with missed or anembryonic pregnancy loss.¹⁰ In my study all women in expectant management group were already symptomatic and the success rate was 55%.

As a primary approach, surgical evacuation results in faster and more predictable complete evacuation.¹⁰ The success of surgical uterine evacuation of early pregnancy loss approaches 99%.¹¹ In my study success of surgical method was 98%.

The largest U.S. trial reported that success rates after medical management of anembryonic gestations (81%) was lower than with embryonic or foetal death (88%) or incomplete or inevitable early pregnancy loss (93%).¹¹ In my study success rate in medical group was 82.5%. Therefore, medical management is a reasonable option for any type of pregnancy failure.¹²

Overall, serious complications after treatment of early pregnancy loss are rare and are comparable across treatment types. Remote

complications like intrauterine adhesions or information about future fertility could not be followed up.

Studies have consistently shown that surgical management in an operating room is more costly than expectant or medical management, however, cost was not an issue in our hospital.

the overall rates of infection were low in all methods.

CONCLUSIONS

Because neither approach is clearly superior, the patient preference should guide choice of intervention.¹³

Expectant management is not opted by most women of Bihar if other methods are available to them. Medical method was most popular among women and it was found to be a safe and effective choice. Women are apprehensive of surgery and anaesthesia and operation theatre despite quick and successful outcome and free treatment.

Women who desire contraception may initiate hormonal contraception or intrauterine device after complete evacuation.

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