



ORIGINAL RESEARCH PAPER

Gynaecology

A RETROSPECTIVE STUDY OF MATERNAL AND PERINATAL OUTCOME IN WOMEN WITH BAD OBSTETRIC HISTORY

KEY WORDS:

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I.INTRODUCTION

The term BOH is applied to a pregnant mother where her present obstetric outcome is likely to be affected by the nature of previous obstetric disaster. It implies previous unfavorable fetal outcome in terms of repetitive spontaneous abortions, lethal congenital anomalies, IUGR, preterm labor, history of intra uterine fetal death and early neonatal deaths^[1].

The major causes of bad obstetric history include

1. Chromosomal abnormalities account for 50-60% pregnancy losses.
2. Immunological abnormalities - APLA syndrome is a significant immunological contributor to the pregnancy loss. Women with APLA syndrome are at higher risk for spontaneous miscarriage, pre-term labor, pre-eclampsia, intra uterine growth restriction, intra uterine fetal death at later gestational age^[2].
3. Endocrine disorders – gestational diabetes mellitus and hypothyroidism. Women with diabetes in pregnancy (GDM/PGDM) may have an adverse pregnancy outcome at any gestational age.
4. Structural abnormalities – uterine anomalies and cervical insufficiency.

II.AIMS AND OBJECTIVES

To study the maternal and perinatal outcome in women with bad obstetric history.

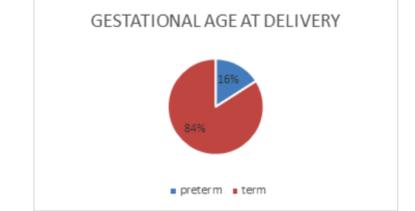
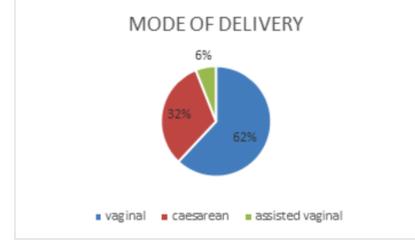
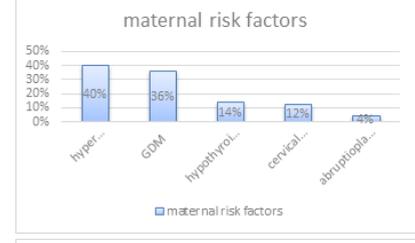
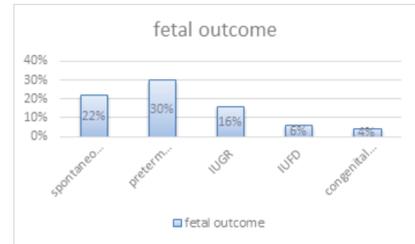
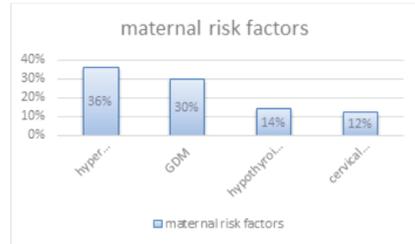
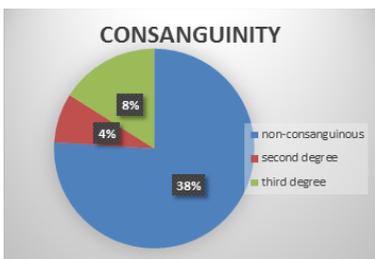
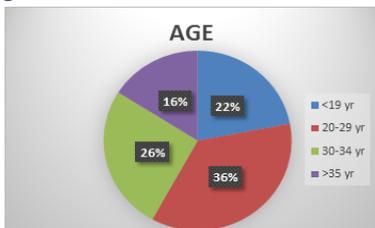
III.MATERIALS AND METHODS

Study design: a retrospective observational study.

Subjects: 50 antenatal women with bad obstetric history attending the antenatal OPD of Dr. PSIMS&RF from June 2016- June 2017.

Study sample included women with unexplained fetal loss, intra uterine deaths, recurrent miscarriages, gestational diabetes mellitus, hypertensive disorders of pregnancy, Hypothyroidism and cervical insufficiency

IV.RESULTS



V.COMPARISION OF STUDIES

	OUR STUDY	Lt Col G Singh et al. (2007)
Hypertension	44%	5.33%
GDM	36%	2.33%
Hypothyroidism	14%	5%
Cervical insufficiency	12%	0
Preterm labor	16%	6.33%
IUGR	8%	-
Abruptio placenta	4%	-
APLA	0	4%

VI.DISCUSSION

Overall incidence of BOH in literature is variable with large etiological heterogeneity.

Insulin resistance is being seen in many pregnant women accounting to present life style and as such diabetes complicating pregnancy is also in growing trend. In our study 30% of women have GDM in their previous pregnancy. All these women had recurrence of GDM in index pregnancy in their second and third trimester. According to Lt Col G Singh et al. GDM is seen in 2.33% women with BOH. Incidence of GDM is higher in women with high BMI.

Hypertensive disorders of pregnancy can adversely affect both mother and fetus at any gestational age. They can result in complications like preterm labor, abruptio placenta, IUGR and neonatal deaths. In our study hypertensive disorders were noted in 40% of women. Out of these recurrences was observed in 60% women. According to Lt Col G Singh et al. hypertension was observed in 5.33% of women.

Cervical insufficiency was observed in 12% of women in index pregnancy who had cervical encirclage around 14 weeks of gestational age. They continued till term without any complications. All these women had cervical insufficiency in their previous pregnancy who ended up in spontaneous second trimester miscarriage, preterm labor and few continued till term. In the study Lt Col G Singh et al., none had cervical insufficiency.

Preterm labor was observed in 16% of women in our study. More than half are spontaneous and rest of them are induced due to complications like pre-eclampsia and GDM. According to Lt Col G Singh et al. Preterm labor was observed in 6.33% of women^[4].

Uncorrected hypothyroidism in pregnancy can lead to increased rate of miscarriage, preterm labor, fetal demise, placental abruption, increased perinatal and infant mortality rate^[5]. 14% of women in our study presented with hypothyroidism at the booking visit in our hospital. Most of them had their 1st antenatal visit in the 1st trimester. These women with proper supplementation of thyroxine continued their pregnancy till term and delivered without any maternal or perinatal complications. According to Lt Col G Singh et al. hypothyroidism is noted in 5% of women.

In our study 44% of women who had previous two or more spontaneous miscarriages, continued till term without any complications in this pregnancy.

APLA syndrome refers to a varied group of auto antibodies including lupus anticoagulants and anti-cardiolipin antibodies. These are frequently associated with a h/o repetitive fetal death. In our study none was affected with APLA. According to Lt Col G Singh et al. 4% of women with BOH had APLA^{[5][6]}.

Teenage pregnancies had higher incidence of preeclampsia, preterm births and spontaneous miscarriages.

VII.CONCLUSION

Pregnancy loss is a frustrating and challenging problem for couples and clinicians alike. Miscarriage is often associated with guilt, embarrassment and depressive states. The emotional issues surrounding the pregnancy loss become magnified when miscarriage occurs on a repetitive basis. Overall incidence of BOH is

variable with large etiological heterogeneity. Diabetes complicating pregnancy, hypertension, cervical insufficiency and preterm deliveries were found significantly more in BOH group. Recurrence rates of pre-eclampsia and GDM are higher in subsequent pregnancies. There should be appropriate inter pregnancy interval and follow up with optimal control of the previous complications. Next conception should be planned when all the medical disorders are under control. Preconceptional counseling should be given.

These women must be carefully evaluated at an earlier gestational age.

Pregnancy outcome was generally good in subsequent pregnancy with optimal antenatal care and advice. It certainly warrants a detailed consultation with multi-disciplinary approach and reassurance

REFERENCES

1. Smith GCS, Shah I, Pell JP, Crossley JA, Dobbie R. Maternal Obesity in Early Pregnancy and Risk of Spontaneous and Elective Preterm Delivery. A Retrospective Cohort Study. *Am J Public Health*. 2007;97:157-162.
2. Spegiorin LCJF, Godoy JMP, Orliani AH. Evaluation of prophylaxis using low doses of heparin associated with aspirin in pregnancy with multiple miscarriages and high antiphospholipid antibody levels - preliminary report. *Arch Med Sci*. 2007;3:43-45.
3. Aziz N, Reddy P, Fernandez E. Hypothyroidism in pregnancy: Is universal screening needed? *J Obstet Gynecol India*. 2006;56:495-498.
4. Surkan PJ, Stephansson O, Dickman PW, Cnattingius S. Previous Preterm and Small-for-Gestational-Age Births and the Subsequent Risk of Stillbirth. *N Engl J Med*. 2004;350:777-785.
5. Salim R, Regan L, Woelfer B, Backos M, Jurkovic D. A comparative study of the morphology of congenital uterine anomalies in women with and without a history of recurrent first trimester miscarriage. *Human Reproduction*. 2003;18:162-166.
6. Kruse C, Rosgaard A, Steffenson R, Varmint K, Jensen us JC, Christiansen OB. Low serum level of manna-binding lectin is a determinant for pregnancy outcome in women with recurrent spontaneous abortion. *Am J Obstetric Gynecol*. 2002;187:1313-1320.