Recurrent abruptio placenta in three consecutive pregnancies: successful outcome with intensive fetomaternal monitoring.

Deepika Deka
Department of Obstetrics and Gynaecology, All India Institute of Medical Sciences, New Delhi 110029.

In abruptio placenta, there is bleeding following premature separation of a normally situated placenta. The fetus is dead in most of the cases, and the condition is also associated with significant maternal morbidity and mortality. The cause is frequently not understood, but pregnancy induced hypertension and chronic hypertension are predisposing factors. Prevention of abruptio placenta is still an obstetric dilemma. Early diagnosis and urgent appropriate management can result in better obstetric outcome.

A 30 year old, G4 PO was booked at 11 weeks of pregnancy. In her first pregnancy, she had severe pregnancy induced hypertension and fetal death occured as a result of abruptio placenta. In the second pregnancy, she was normotensive throughout, but had accidental haemorrhage and fresh stillbirth in the 8th month, again due to sudden, severe, pregnancy induced hypertension. The baby did not have any congenital malformations. Her blood pressure was controlled with antihypertensive drugs (alphamethyldopa). In 1993, during her third pregnancy she had acute pain in abdomen and bleeding per vagina in the sixth month, and a macerated stillborn fetus aborted. There was a large retroplacental clot. She was on alphamethyldopa during this pregnancy. In the fourth pregnancy, she was referred at 11 weeks of pregnancy with chronic hypertension. Her blood pressure was 140/90 mm Hg, and she was not on any drugs. She was monitored very carefully for blood pressure control and fetal growth. She was admitted to the hospital at 28 weeks for intensive feto-maternal surveillance. The antihypertensive dossage drug was increased to 500 mg three times daily as the B.P rose to 160/100 mmHg. Non-stress test was done twice weekly and biophysical profile weekly. Liquor volume was detected to be decreasing, (amniotic fluid index ranged from 5-6). There was mild fetal growth restriction. From 33 weeks onwards she complained of cramp-like sensation over the uterus. The uterine tone was slightly raised. Corticosteroid therapy for fetal lung maturation was given.

Labour was induced at 34 weeks with prostaglandin intracervical gel, with a plan for a short trial of labour under continuous electronic fetal monitoring. She was taken up for Ceasarean section due to incoordinate uterine action. A healthy male baby, weighing 1.56 kg was delivered. Mother and baby were discharged in good condition.