Second trimester termination due to fetal anomaly complicated by placenta previa and antepatrum haemorrhage

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BACKGROUND

The concern in a viable pregnancy for placenta praevia is maternal and/or fetal haemorrhage resulting in fetal demise. However, in the context of medical termination, fetal viability is not a consideration. This case discusses the management of known placental praevia in a medical termination that resulted in an antepartum haemorrhage.

CASE

A 30-year-old female G1P0 was diagnosed at the morphology scan with a fetal anomy of Potter sequence that is not viable with life and was noted to have complete placenta praevia. She was referred to MFM and counselled for management. The risk of vaginal delivery with haemorrhage in context of placenta praevia vs hysterotomy at early gestation was discussed. The patient opted for medical termination of pregnancy (MTOP). At 21+4 weeks she was admitted for MTOP. Mifepristone and misoprostol were administered. Profuse bleeding occurred as dilatation progressed. Bedside US showed fetus engaged past the placenta. The observations remained stable throughout. The haemoglobin dropped from 102 to 86. A total of 1.8L blood loss occurred. She required 2x PRBC and tranexamic acid to be administered. Medical termination was continued as delivery was anticipated in a short period of time from when the bleeding started and a spontaneous expulsion occurred of the fetus and placenta.

DISCUSSION

The risk of a haemorrhage to the fetus with placenta previa is a consideration in an MTOP. The optimal method for termination of pregnancy in cases of low-lying placenta is complicated due to the concern of maternal haemorrhage in a MTOP compared to a dilatation and evacuation with limited research. A D&E requires an experienced clinician as the risk of complications are higher including perforation and bleeding, especially in the context of placenta praevia likely resulting in significant bleeding from the beginning of the procedure. She was offered both options and in the context of a para 0 in a young female wanting to avoid surgery and/or hysterotomy fall pregnant again soon, she opted for an MTOP and the haemorrhage was managed. The APH was significant and was closely monitored throughout with a low threshold for theatre however was not required.

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