

MID-TRIMESTER ABORTION POST ENDOMETRIAL ABLATION COMPLICATED BY RETAINED PLACENTA REQUIRING LAPAROSCOPIC EXPLORATION

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OBJECTIVE

- ❑ Pregnancy post endometrial ablation (EA) is a rare entity
- ❑ There is increasing use of EA to manage menorrhagia and majority of patients opting for termination of pregnancy (TOP) post EA [1]
- ❑ It is prudent to explore and reflect on the care and complications of TOPs post EA

CASE REPORT

39 years old female, Gravida 8 Para 3 (vaginal deliveries), was transferred to the facility with retained placenta following medical TOP at 17 weeks gestational age (GA). Her gynaecological history included second generation endometrial ablation 5 years ago to manage menorrhagia and LLETZ. Her complex obstetric history included surgical evacuations of a molar pregnancy and a first-trimester missed-miscarriage post EA and two previous first trimester surgical TOPs. Her medical history included class 2 obesity, anaemia (Hb 113), depression, asthma and congenital hip dysplasia. A pre-TOP ultrasound confirmed a live intrauterine foetus at 17 weeks GA and did not characterise the placenta despite the history of endometrial ablation.

Intraoperatively, an almost complete piecemeal removal of the morbidly adherent placenta, clinically with focal areas of accreta and poorly-defined planes, was achieved with a 500ml haemorrhage. Laparoscopic exploration excluded uterine perforation and bruising over right-lateral pelvic-side-wall abutting utero-vesical fold prompted methylene-blue dye-test and post-operative CT Urogram (both negative). Patient recovered uneventfully and was discharged on contraception and antibiotics, with a plan for pregnancy test in 28-days.

DISCUSSION

- ❑ Management of TOPs post EA requires a collaborative multi-disciplinary approach with readily available skilled practitioners (gynaecologists, anaesthetists, radiologists and intensivists) in settings that support emergency hysterectomy with advanced life support and resuscitation facilities
- ❑ Placental characterisation by skilled sonographers +/- advanced imaging (e.g. MRI) can identify high-risk patients who may require hysterotomy or hysterectomy
- ❑ In view of high rates of complications with increased morbidity and mortality, threshold to recourse to laparoscopy +/- laparotomy should be low
- ❑ Special care should be observed while treating patients who seek services from multiple healthcare facilities as history of EA could be omitted

CONCLUSIONS

- ❑ TOPs post EA is a rare, clinically-challenging and potentially morbid scenario
- ❑ Tertiary-level placental imaging and routine use of ultrasound guidance should be considered
- ❑ Risk mitigation by standardising care, in multi-disciplinary settings, with skilled practitioners, will optimise patient safety and care
- ❑ The importance of permanent contraception post EA cannot be overstated [1]

1. Khafizova L et al. Induction of abortion following radiofrequency ablation of the endometrium. Eur J Contracept Reprod Health Care. 2014 Feb;19(1):66-70.