Challenges in the Management of Second Trimester Miscarriage with Multiple Caesarean Sections

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Objectives

Management of second trimester miscarriage in patients with multiple repeat caesarean sections or other uterine incisions has been challenging due to the increased risk of uterine rupture and other complications. In this report, we present our experience in the management of a relevant case and review of international clinical guidelines in an attempt to help guide the safe management of such patients.

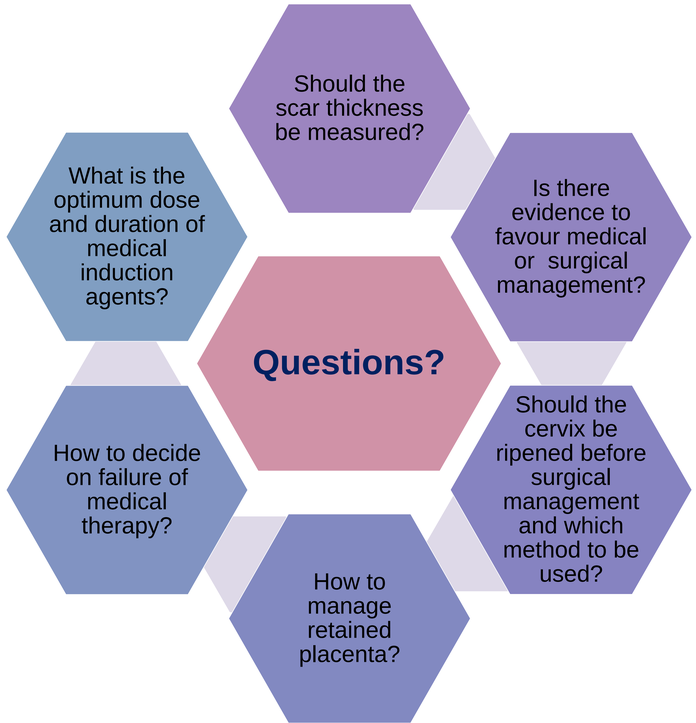

Table1: Variable Terminology and Gestational Age Range used by International Guidelines for Fetal Loss in the Second Trimester

WHO	Fetal demise between 13-19 weeks
RCOG	Missed miscarriage, Incomplete miscarriage
ACOG	Second-trimester abortion, Still birth between 20-28 weeks
FIGO	Fetal death 13-26 weeks
French	IUF demise as loss of viability after 14 weeks. Late miscarriage: spontaneous evacuation of fetus after 14 weeks and before 22 weeks (the age of viability is 22 weeks)
Irish	Second trimester miscarriage Early: 13-17 weeks Late: 18-24 weeks
SOGC	Induced abortion

Case

A multiparous woman with previous four caesarean sections was diagnosed with second trimester missed miscarriage at 14 weeks. Conservative management for two weeks was unsuccessful, therefore the patient was managed medically with 200 mcg misoprostol. The plan was to give another 200 mcg of misoprostol after 12 hours but the fetus was expelled after 10 hours of the first misoprostol dose. Surgical evacuation was eventually performed for the retained placenta. No complications occurred.

Acknowledgement

We thank the patient for her cooperation

Discussion and Conclusion

- There is limited available evidence on the management of patients with second trimester miscarriage and multiple previous uterine incisions.
- Search and appraisal of the available international clinical guidelines was performed, and relevant recommendations will be summarized (not shown in this poster).
- The significant variation in the definitions and terminologies used for second trimester miscarriage in the guidelines has added to the difficulty in identifying the applicable recommendations (Table1).
- Data related to choosing the initial intervention (medical or surgical), the type and dosage of medical induction agents, and the need for cervical preparation prior to surgical evacuation, are compared between the guidelines in this study.
- The assessment and the management of the placenta and the significance of assessing the scar thickness to predict the risk of uterine rupture are also discussed.
- Considering the progressive rise in the rate of caesarean sections, this report highlights deficient areas where evidence-based recommendations are highly required.