

Subtotal Hysterectomy Following Failed Second Trimester Medical Termination of Pregnancy

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Introduction
<ul style="list-style-type: none">Termination of pregnancy (TOP) has been legal in the UK since the passing of the 1967 Abortion Act.The most recent published statistics showed that 209,917 terminations were performed in England and Wales in 2020, the highest since records began , with approximately 1in4 pregnancies ending in termination (2).Approximately 6% of terminations occur in the second trimester, with 85% of all TOPs being medically induced.

Patient Background
<ul style="list-style-type: none">33 year old G4P3—all normal vaginal deliveries.Patient had an endometrial ablation performed in 2018 as a treatment for heavy menstrual bleeding (HMB).Patient was not aware she would be able to conceive following endometrial ablation, and therefore was not on contraception.Patient presented at 16+6 weeks gestation requesting Termination of Pregnancy.Patient had been amenorrhoeic following her endometrial ablation, and therefore pregnancy was diagnosed late in the first trimester.Initially presented to British Pregnancy Advisory Service, however they referred to Sheffield Teaching Hospitals due to history of previous endometrial ablation.

Initial Management
<ul style="list-style-type: none">Medical termination of pregnancy initiated with mifepristone 200mg, and then misoprostol, for which she received a full 2nd trimester regime (800mcg followed by 4x doses 400mcg misoprostol every 3 hours).No cervical response to first round of treatment, and therefore a second course of misoprostol was given. Again, no response, and a second dose of mifepristone was given followed by Cervagem pessaries x5.As there was still no cervical change, she was rested for 24 hours, then went on to have a spontaneous rupture of membranes 6 days following initiation of treatment, therefore antibiotics were commenced.MRI performed to ensure there was no evidence of morbidly adherent placenta given her history of endometrial ablation, this was normal.She went on to have a balloon catheter inserted. Again, no cervical change 24 hours following insertion.Commenced on IV Syntocinon, following 4 hours of Syntocinon, there was no uterine activity and no cervical change.

Surgical Management
<ul style="list-style-type: none">Options were discussed with the patient, surgical evacuation of uterus, hysterotomy vs subtotal hysterectomy.Patient preference for subtotal hysterectomy if dilatation and evacuation not possible.On examination in theatre, internal os remained closed and therefore proceeded to laparotomy and subtotal hysterectomy.Procedure was uncomplicated, although the uterus was noted to be very vascular. EBL 300ml. Patient recovered well postoperatively.

Key Points
<ul style="list-style-type: none">Importance of counselling at the time of endometrial ablation regarding need for ongoing contraception.Consider morbidly adherent placenta in pregnancy following endometrial ablation.In difficult cases it is vital to involve the MDT in discussions to ensure optimal management.

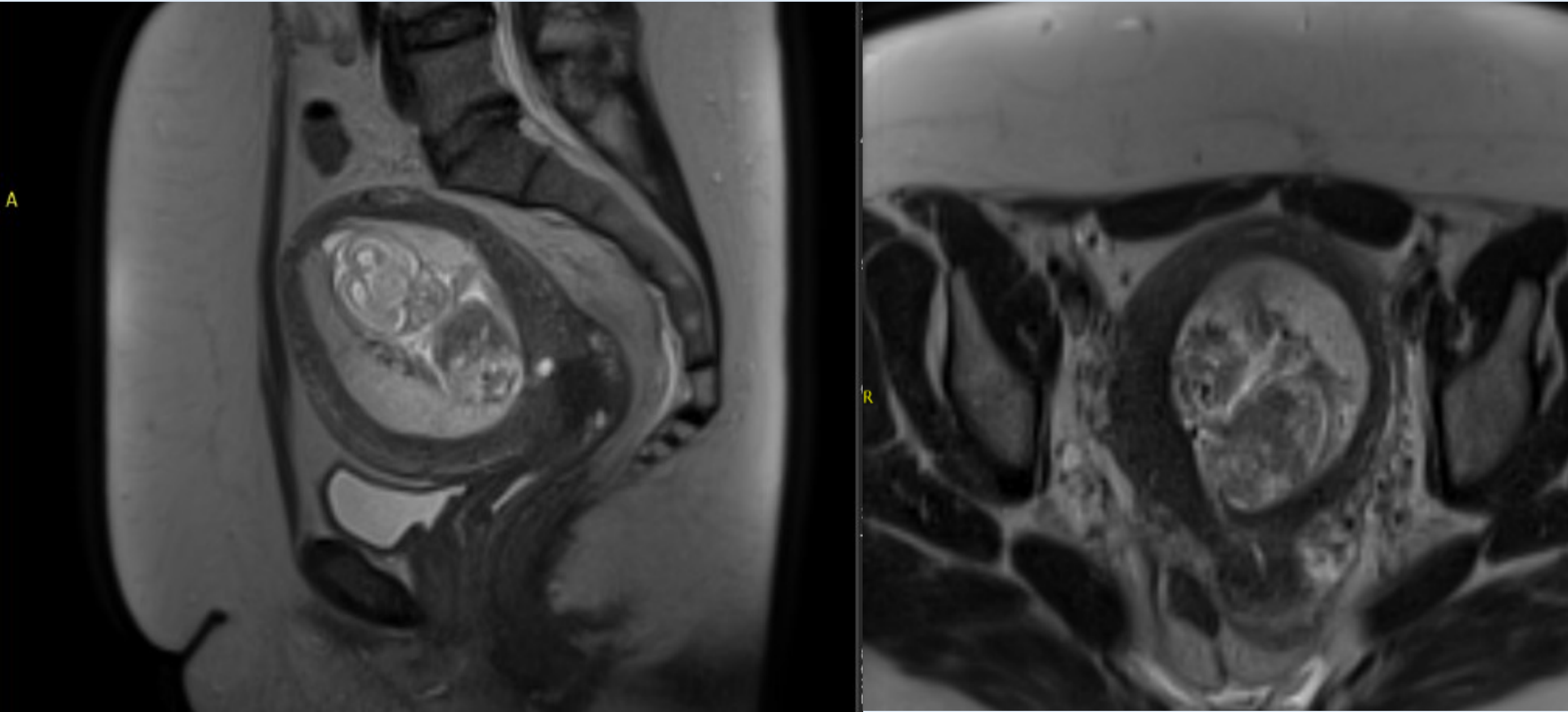


Figure 1. MRI scan showing a placenta which is clear of the internal os, with no features to suggest placenta accreta spectrum. Oligohydramnios can also be seen.

Discussion
<ul style="list-style-type: none">There are few case reports of patients undergoing a hysterectomy as part of a TOP, usually during an emergency, for example in the case of massive haemorrhage.Pregnancy following endometrial ablation is uncommon, with an estimated incidence of 0.24-0.68% (3). Kohn et al found that 85% of these pregnancies ended in either termination of pregnancy, miscarriage or ectopic pregnancy.In those pregnancies that continued, there was a high rate of morbidly adherent placenta, and therefore need for caesarean hysterectomy.For a woman that had completed her family, subtotal hysterectomy was deemed to be lower risk than hysterotomy, both in terms of post-operative morbidity, and potential for future surgical complications.This case emphasizes the importance of counselling patients regarding need for contraception following endometrial ablation at the time of procedure.It also highlights the risks associated with performing a TOP, in a patient who has had previous endometrial ablation.

References
1— The Impact of The Abortion Act 1967 in Great Britain, P Addison, Canadian medical association, June 1969, 2—National Statistics; Abortion statistics, England and Wales: 2020; Jan 2022, 3- Pregnancy after endometrial ablation: a systematic review, Kohn et al, BJOG Sept2017.