

MEDICAL MANAGEMENT OF 1ST TRIMESTER MISCARRIAGE IN THE BACKGROUND OF ANTICOAGULATION

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CASE REPORT

A 33-year-old woman who is diagnosed patient with rheumatic valvular heart disease with mechanical valve replacement 16 years back and was on warfarin since, presented with unexpected pregnancy. While on warfarin she has had 3 1st trimester miscarriages.

An initial USS showed a single live fetus. After MDT discussion, decided to continue the pregnancy under LMWH and warfarin was omitted. The Target INR value was 2.5-3.5. At POA of 16 weeks, the patient was readmitted for bridging therapy of LMWH to warfarin. Target INR was achieved with warfarin 8mg daily dose but at the discharge unfortunately USS showed evidence of missed miscarriage (CRL-11+5). The patient was asymptomatic and no bleeding manifestations were noted.

Decided to proceed with medical management. LMWH started at the therapeutic dose and warfarin was omitted. After achieving an INR of 1.5, unfractionated heparin (UFH) infusion was started in 18 units/kg per hour dose. The target was to maintain APTT more than twice the normal value. Per vaginal misoprostol 800µg inserted and the patient was kept under strict observation. With early evidence of expulsion of products of conception, UFH infusion was stopped and products of conception passed after 4 hours. TVS showed a bulky uterus with an empty cavity (ET- 6mm). Subsequently, LMWH was restarted at the therapeutic dose. Following bridging therapy patient was discharged with warfarin 9.5mg daily dose. A levonorgestrel-releasing implant was inserted for contraception. Planned for preconception counseling prior to the next pregnancy.

Rheumatic heart disease is a huge burden to countries with emerging economies and the age-standardized prevalence is high in women of childbearing age. With the advancement of cardiac surgeries and anticoagulation, the rate of pregnancies among women who undergo valve replacement has increased.

Because of the teratogenic nature of warfarin the risk of early pregnancy loss is high. Also in such a situation maintaining an adequate INR level for a metal cardiac valve while achieving hemostasis following miscarriage management is challenging. In such situations, UFH is a good alternative because of the easy reversal of action and monitoring by using APTT.

Pre-conception counseling and changing into LMWH from warfarin in women with fertility wishes is essential and if planning for contraception Levonorgestrel-releasing implant is a preferred option. With a background history of bleeding tendency, medical evacuation is reasonable.