

REPEATED ABORTION

Essay
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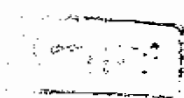
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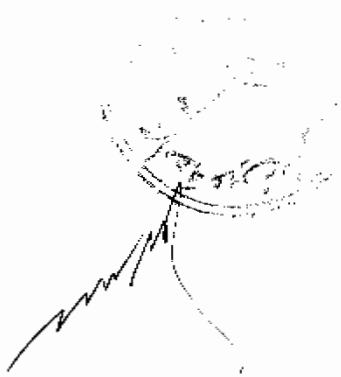
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THANKS GOD



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INTRODUCTION

One of the most distressing problems in obstetrics is recurrent abortion , particularly in those who have no successful pregnancies.

There is no precise definition of recurrent abortion, but most authorities would accept three consecutive abortion as evidence of recurrent abortion (Howie 1986)

The more recent definition of repeated abortion by ultra sound. For the first time during pregnancy we can diagnose patulous internal os. if mucosal to mucosal. diameter at the level of internal os exceeds 6 mm during the frist trimester and more than 8 mm during the second trimester of pregnancy (Mahran M 1980)

recurrent pregnancy loss is a distressing problem for both the patient and physcian becouse of its serious complicitons , These complications include, Psychological disturbances , absolute & relative sterility , and shock either hemorrhagic or septic , which is now the most common factor implicated in matenal mortality. The population incidence has been put at up to 1 % of the gravida 3 or more among female population (Alberman , 1988)

B

On a theoretical basis , Malpas (1938) calculated that after three consecutive abortion the risk of abortion in the next pregnancy was 37 % but the practical experience in published servies has indicated that the prognosis is much better than that.

WARBURTON AND FRASER (1964), reported that the chance of a further abortion in the next pregnancy after one abortion was 32.7 % which increased to 26.2 % after two abortions and to 23.2% found a rather higher percent of a 47% risk of abortion after three adortions.

For years , a cause of repeated pregnancy loss could be determined in only a minority of couples more recent studis have focused the light on the pathophysiological features of recurrent pregnancy loss, allowing for more rational methods of treatment.

Up till now, the well - established causes of recurrent pregnancy loss included genetic d sorders and morphologic abnormalities of the uterus (closs R.H. et al 1978)

other causes impilicated but not proven include recurrent uterine infection by Mycoplosma hominis or ureaplasma urealyticum

(story - pedersen B., 1978) thyroid dysfunction, corpus luteum insufficiency (closs R.H. et al , 1978) and collagen vascular disease (Fraga A et al 1974). Within the last few years, results of clinical and laboratory investigation have shown that here to fore unexplained recurrent pregnancy losses can be explained by immunogenetic factors Mc Intyre J.A., 1986

Aim of the Essay

The aim of the Essay is to review the pathogenesis of maternal fetal out comes and to offer a protocols for mangement (surgical and medical) a case of repeated abortion to improve fetal out come.

DEFINITION

Repeated Abortion

(I) Definition

Although the term spontaneous abortion is medically exact, many women are distressed by the term and therefore the word miscarriage is preferred. Miscarriage is broadly defined as the expulsion of the embryo or fetus before viability has been achieved. (Stirrat G.M. 1990).

Abortion is defined in British Law as termination of pregnancy before 28 weeks gestation with no evidence of life. An inherent deficiency in this definition is that many babies delivered before 28 weeks prove to be viable (Howie 1986, Trindal 1987).

In united states this definition is confined to the termination of the pregnancy before 20 weeks gestation based upon the date of the first day of the last normal menses. (cunningham et al 1989) In 1977 the "World Health Organisation" defined abortion as the expulsion or extraction from its mother of a fetus or an embryo weighting 500 grams or less. Such a definition which use an upper limit of fetal weight, overcomes the difficulty of defining an abortion when the gestational age is in doubt and 500 grams would usually correspond to a gestational age of 20-22 weeks. On other hand, a definition of abortion based on fetal wieght alone takes no account of the possibility of sever intrauterine growth failure when a very small

may have reached a gestational age of 28 weeks or more, (Howie 1986) so there is a difficulty in defining abortion is that the term is meant to imply the period during which the fetus was not viable, and viability is not constant. Recently in the USA an abortion of 480 gm, could maintain the life in the incubator.

Definition of recurrent abortion :

There is no precise definition of recurrent abortion but most authorities would accept three consecutive abortions as evidence of recurrent abortion (Howie 1986).

The definition of recurrent miscarriage should be three or more consecutive pregnancy losses. Data should be collected to 28 weeks or 500 grams fetal weight should also be possible.

Women meeting the definition can be subdivided into **Primary and Secondary groups (recurrent miscarriage)** respectively consisting of those who have lost all previous pregnancies and those who have had one successful pregnancy followed by consecutive losses. Stirrat G. M. 1990.

INCIDENCE OF MISCARRIAGE

Incidence of miscarriage :

The incidence of miscarriage should ideally cover a representative section of the community and not hospital patients only.

The reported early loss rate among clinically recognised pregnancies is between 12% and 15% (Warburton D. et al., 1964, Hertz - picciotto I, et al., 1988).

Table II - Risks of recognised pregnancy loss in CDHORT studies . (Hertz, PicciottoI, et al., 1988).

No of recognised pregnancies	No of losses		Risk of loss among recognised pregnancies	References
	Subclinical	Clinical		
102	50	14	13.7%	Miller J.R. et al., 1980.
41	67	6	14.6%	Edmonds D.K, et al., 1982
85	7	1	12.9%	Whittakar PG et al. 1983
154	43	18	11.7%	Wilox AJ. et al 1988.

Higher figures in some older studies are flowed by the inclusion of ectopic pregnancies, the lack of rigorous exclusion of induced abortions, and biased selection of patients.

Little 1988 suggest that about **15% of fertilised ova** are lost **before implantation** with an overall conception loss rate of 52%.

Edmonds et al., (1982) concluded from a controlled study that the postimplantation embryonic loss rate is probably **four times the clinically** recognised miscarriage rate. In Regan's(1988) prospective study of 456 non-pregnant women contemplating pregnancy in the near future, 226 women had had a contemplated pregnancy by the end of the study, the miscarriage rate was 10.3% and all occurred at or before 14 weeks' gestation.

Fontal and Shepard (1987) related pregnancy loss rates to gestational age - 52% at or before 8 weeks, 18% at 9-18 weeks and 15% at or after 19 weeks of gestation.

There are two studies which more or less fulfill these demands, but neither of them is very recent, in a careful field study on the Kawai-French and Bierman (1962) followed over 3000 pregnancies from as early as possible (half of them from before week 12) until the island end of pregnancy. (Shapiro et al., 1963) used data from a well defined part of the New York population. Both studies come up with much higher incidences than are usually accepted. This in part at least is due to the use of life table analysis which gives rates per pregnancy period, correcting for the loss of the women for follow up who aborted in a previous period. In the kauai study, an overall fetal loss between 4 and 20 weeks of 23.6% was reported, in the New York study, this percentage was 21.6 the losses per week are given in table III.