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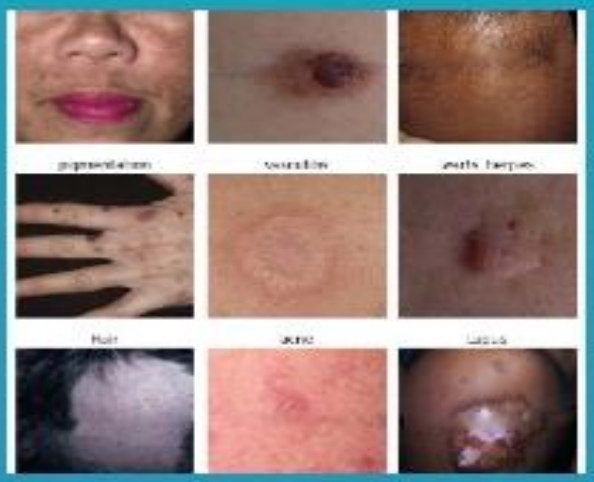
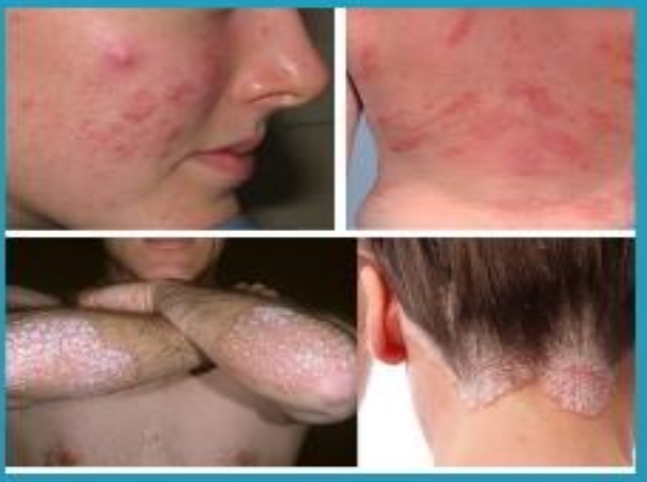
Advancing Cases





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A CASE REPORT

G4P2L2A1 Case at 21+5 Weeks with Multiple Comorbidities Undergoing LSCS and Hysterectomy for Fetal Anomalies

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Abstract

We report a case of a 32-year-old admitted in Acharya vinoba bhave rural hospital, sawangi, meghe, wardha, india, multigravida woman (G4P2L2A1) at 21+5 weeks of gestation with a complex medical history, including previous two LSCS, epilepsy, insulin-dependent diabetes mellitus, hypothyroidism, and left transverse ligament internal jugular vein thrombosis. Routine antenatal care and anomaly scan revealed multiple severe congenital anomalies incompatible with life. After multidisciplinary consultation and counseling, pregnancy termination was performed via LSCS followed by hysterectomy due to a thin uterine scar and significant adhesion risks. A male fetus weighing 480 grams was delivered at 12:20 PM, classified as abortus with no signs of life. This case highlights the importance of a comprehensive, multidisciplinary approach in managing high-risk pregnancies complicated by maternal comorbidities and congenital anomalies, emphasizing the need for individualized patient care and thorough prenatal counseling.

Keywords: Congenital anomaly, Epilepsy, Diabetes mellitus, LSCS with hysterectomy, Abortus delivery, High-risk pregnancy

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Introduction

The patient was under routine antenatal care for her fourth pregnancy at 21 weeks and 5 days of gestation admitted in Acharya vinoba bhave rural hospital, sawangi, meghe, wardha, india. A detailed fetal anomaly scan conducted during her second-trimester screening revealed multiple congenital anomalies, which were deemed severe and incompatible with life [1]. The anomalies included significant structural abnormalities affecting the major organ systems (specific anomalies can be described if known, such as cardiac, neural tube defects, or others). Based on the prognosis and multidisciplinary consultation involving obstetricians, pediatricians, and maternal-fetal medicine specialists, it was concluded that the pregnancy had a poor outcome with no reasonable chance of neonatal survival or long-term quality of life [2].

Given the patient's obstetric history of two prior LSCS and associated medical comorbidities—including epilepsy, insulin-dependent diabetes mellitus, hypothyroidism, and a history of thrombosis—the risks of continuing the pregnancy were carefully weighed against the potential complications of early delivery [3]. Termination of pregnancy was recommended as the most appropriate course of action to prevent further maternal morbidity or mortality [3]. A comprehensive counseling session was held with the patient and her family to discuss the nature of the congenital anomalies, procedural risks, future reproductive options, and the implications of her medical conditions on long-term health [4].

Under a well-coordinated multidisciplinary approach, the pregnancy was terminated by lower segment cesarean section (LSCS) [6]. Due to significant uterine adhesions from previous surgeries and the high risk of uterine rupture in future pregnancies, a concurrent hysterectomy was performed to ensure maternal safety [7]. The procedure was successfully completed without intraoperative complications, and the patient delivered a male fetus weighing 480 grams at 12:20 PM. The baby was classified as an abortus and was non-viable at the time of delivery, with no signs of life observed [8].

Patient Identification

The patient is a 32-year-old woman admitted to Acharya Vinoba Bhave Rural Hospital, Sawangi, Meghe, Wardha, India, with gravida 4, para 2, two living children, and one prior abortion. She was referred for termination of pregnancy after a detailed anomaly scan at 21+5 weeks revealed severe congenital abnormalities. She had been on regular antenatal follow-up and was under a multidisciplinary team's care for her high-risk pregnancy due to underlying medical conditions, including epilepsy diagnosed 8 years ago, currently managed with levetiracetam with no recent seizure episodes; diabetes mellitus diagnosed 2 years ago, treated with insulin therapy with fair glycemic control; hypothyroidism diagnosed 4 years ago, treated with levothyroxine with routine monitoring of TSH levels; and left transverse ligament internal jugular vein thrombosis diagnosed 1 year ago, managed with anticoagulants. There is no significant family history of congenital anomalies or chronic medical conditions.

A recent ultrasound revealed severe congenital anomalies, including structural organ defects, with a poor prognosis incompatible with life. After extensive counseling and discussion with a multidisciplinary team, termination by LSCS followed by hysterectomy was recommended to ensure maternal safety. Her obstetric history includes a term pregnancy (G1) delivered by LSCS for cephalopelvic disproportion, a second term pregnancy (G2) delivered by repeat LSCS for failed trial of labor, and a first-trimester miscarriage (G3).

Clinical Findings

The patient, at 21+5 weeks gestation, was diagnosed with multiple congenital anomalies on

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ultrasound, with a poor fetal prognosis. On admission, her vitals were stable, with a blood pressure of 130/80 mmHg and a pulse of 84 bpm. Abdominal examination revealed a uterine size consistent with gestational age, with no tenderness or contractions. Systemic examination showed no acute neurological or cardiovascular abnormalities.

The etiology of the congenital anomalies is likely multifactorial, possibly influenced by maternal diabetes, epilepsy, and associated medication use. Physical examination postoperatively indicated stable vitals, a clean, dry, and intact surgical wound, and no signs of active seizure activity.

Diagnostic assessments included an ultrasound confirming a single live fetus with multiple congenital anomalies. Blood investigations showed a fasting glucose level of 110 mg/dL, HbA1c of 6.8%, and TSH of 2.1 µIU/mL. The coagulation profile was within normal limits, with an INR of 1.2. A peripheral smear revealed normal red cell morphology with no evidence of thrombocytopenia.

Management

A multidisciplinary approach was employed in the patient's management, involving specialists from obstetrics, neurology, endocrinology, and hematology. Preoperative preparation included withholding low molecular weight heparin (LMWH) prior to surgery and resuming it postoperatively for anticoagulation management, continuation of levetiracetam with seizure precautions, insulin therapy adjustments for optimal perioperative glycemic control, and maintenance of levothyroxine for thyroid hormone replacement.

The procedure involved termination of pregnancy via lower segment cesarean section (LSCS), delivering a male fetus weighing 480 g at 12:20 PM. A hysterectomy was performed due to a thin uterine scar and significant adhesions, preventing the risk of future uterine rupture.

Postoperatively, LMWH was restarted 12 hours after surgery, with continuous monitoring of vitals, blood sugar levels, and wound status. Pain management was ensured through appropriate analgesia.

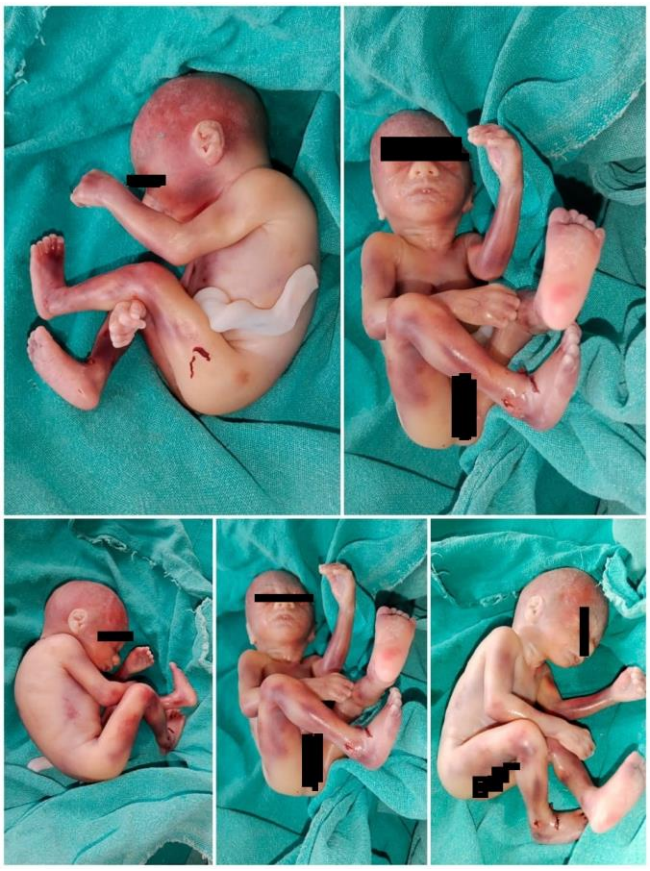

Figure 1: Congenital Anomaly Case - G4P2L2A1, 21+5 Weeks Gestation, Hysterectomy and LSCS Pregnancy Termination

Therapeutic Intervention and Outcomes

Termination of pregnancy was performed via lower segment cesarean section (LSCS), followed by hysterectomy due to a significantly thin uterine scar and adhesions from previous surgeries, posing a high risk of uterine rupture in future pregnancies. A male fetus weighing 480 g was delivered at 12:20 PM with no signs of life.

Postoperatively, the patient had an uneventful recovery. There were no intraoperative or

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immediate postoperative complications. Wound healing was satisfactory, and the patient was mobilized on postoperative day 2. Blood glucose levels were effectively managed, remaining within the target range throughout the perioperative period.

Discussion

This case illustrates the management challenges in a high-risk pregnancy complicated by significant medical comorbidities. the decision to perform a hysterectomy was guided by the risks posed by previous lscs and the likelihood of uterine rupture in future pregnancies. early identification of fetal anomalies allowed timely intervention and comprehensive counseling [9].

proper anticoagulation management, seizure prophylaxis, and blood sugar control were critical elements in ensuring a favorable maternal outcome. a multidisciplinary approach was instrumental in addressing the complexities of this case [10].

Conclusion

This case emphasizes the importance of individualized care and multidisciplinary management for high-risk pregnancies. Early anomaly detection and proactive maternal risk mitigation strategies significantly improve maternal outcomes.

Patient Perspective

The parents expressed gratitude for the comprehensive care provided, noting visible improvements in the child's general health and activity levels post-surgery.

Informed Consent

The patients inform consent was taken and singed by the patient before writing a case report.

Conflict of Interest

Nil

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