

## CASE REPORT

# Chronic Abruptio Oligohydramnios Sequence at 16 Weeks Pregnancy with Compensated Severe Anemia

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## ABSTRACT

**Background:** Placental abruption usually presents as an acute event needing emergent measures, but may even present with diverse clinical features.

**Aim:** We report a case of chronic abruptio oligohydramnios sequence, a rare entity in itself.

**Case report:** We report an atypical case of a 20-year-old primigravida at 16 weeks of gestation who had complaints of mild pain in the lower abdomen for 1 month and minimal bleeding per vaginum for a day. Her vitals were stable but she was severely pale.

On per abdominal examination, uterus was felt corresponding to 20 to 22 weeks gestation and basal tone of uterus was raised. Ultrasound findings revealed a dead fetus of 16 weeks gestation and a large retroplacental clot of 12.5 × 7 cm. The patient was given three units of packed cell volume after which she started having uterine contractions and delivered uneventfully 23 hours after admission.

**Conclusion:** In our case, favorable maternal outcome was because of early diagnosis and treatment of chronic abruptio as discussed.

**Clinical significance:** Chronic abruptio should be an important differential diagnosis in patients presenting with pain in the abdomen in early pregnancy.

**Keywords:** Chronic abruptio, Chronic abruptio oligohydramnios sequence, Oligohydramnios, Second trimester, Severe anemia.

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## BACKGROUND

Premature separation of placenta is seen in 0.5 to 1.5% of all pregnancies.<sup>1</sup> Symptoms like minimal vaginal bleeding and lower abdominal pain sometimes leading to premature onset of labor are seen with a minor degree of placental separation. More extensive placental separation leads to fetal distress and even fetal demise. In worse scenarios, it may lead to maternal decompensation in the form of hypotensive shock, postpartum hemorrhage, leading to anemia, blood transfusions, disseminated intravascular coagulation, acute respiratory distress syndrome, renal failure, and sometimes even maternal mortality.

Abruptio placentae is common around 24th to 26th weeks of period of gestation. Its presentation prior to 20 weeks of pregnancy is a rare entity in itself.<sup>2</sup> Similarly, abruptio as the end result of chronic inflammatory process starting early in pregnancy is in itself a rare entity.

Here, we describe a fairly uncommon case of chronic abruptio at 16 weeks of pregnancy with severe anemia.

## CASE REPORT

The patient was a 20-year-old primigravida who came to us at 16 weeks of gestation and complaint of dull aching pain in the lower abdomen for 1 month and minimal bleeding per vaginum for a day. There was history of progressively increasing exertional dyspnea and easy fatigability for 1 month.

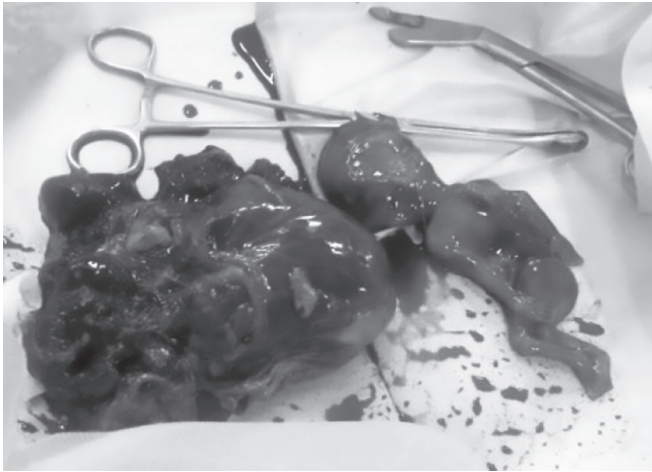
There was no history of leaking per vaginum or abdominal trauma. There was no significant past, personal, or family history. On examination, the patient had severe pallor. Her pulse was 114 beats per minute (regular and good in volume), blood pressure was 100/60 mm Hg, respiratory rate was 20 per minute, saturation was 100% on room air, and jugular venous pressure was not raised. Chest was bilaterally clear with no added sounds.

On per abdominal examination, uterus was 20 to 22 weeks and basal tone of uterus was raised. Per speculum examination revealed no active bleeding. Ultrasound was done and it revealed a dead fetus of 16 weeks of gestation, with reduced liquor associated and a large retroplacental hematoma of 12.7 × 7 cm. Her initial laboratory parameters were hemoglobin 2.2 gm%, platelet count 1.54 lakh/μL, and total leukocyte count 20,500/μL.

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**Fig. 1:** Dead fetus and placenta with retroplacental clot

Her prothrombin time was 11.8, partial prothrombin time was 22.3, international normalized ratio was 1.07, blood urea and serum creatinine were 40 and 0.7, respectively, and liver function tests were normal. So, a diagnosis of primigravida with 16 weeks of pregnancy and intrauterine fetal demise with chronic abruption oligohydramnios sequence with compensated severe anemia was made based on clinical and ultrasound findings.

She was transfused with three units of packed cell volume and her condition was monitored with watch on her vitals. The patient went into spontaneous labor and delivered a male dead fetus weighing 100 gm with a retroplacental blood clot of 500 gm (Fig. 1) after 23 hours of admission. Placenta was sent for histopathology and revealed hemorrhage near the maternal surface with a zone of infarction.

Postdelivery, her hemoglobin rose to 8.7 gm%, platelet count was 1.09 lakh/ $\mu$ L, and total leukocyte count was 35,500/ $\mu$ L. The patient was started on triple antibiotics and oral iron and multivitamins postdelivery and was discharged in a stable condition after giving necessary preconception advice for the subsequent pregnancy.

## DISCUSSION

Abruptio placentae is one of the serious issues of pregnancy, as it is associated with adverse maternal and fetal outcome. The diagnosis is mainly clinical; however, laboratory tests and ultrasound can be used to support the clinical diagnosis. The maternal vessels in the decidua basalis interacting with anchoring villi in the placenta ruptures, leading to placental detachment. The etiology of bleeding in the decidua basalis remains speculative in most cases except in a small percentage of cases, where it is related to sudden mechanical events like sudden uterine decompression or blunt trauma. However, most causes appear to be correlated with chronic placental disease.<sup>3,4</sup> Usually, the cases of abruption present beyond 20 weeks

of gestation with symptoms of vaginal bleeding ranging from mild to massive abdominal pain and sometimes features of maternal shock due to massive hemorrhage, leading to disseminated intravascular coagulopathy, acute renal failure, and even maternal mortality.

It is rare for abruption to occur prior to 20 weeks of gestation. However, the knowledge that this can occur even in early second trimester will help clinicians to make a timely diagnosis and manage the condition accordingly. In a case report by Walker et al,<sup>5</sup> a 30-year-old woman presented at 30 weeks of pregnancy with asymptomatic preeclampsia and her routine ultrasound revealed a large retroplacental sonolucent area of  $4.7 \times 1.6$  cm.

She was admitted, kept on continuous monitoring, steroids were given, and cesarean section was done in view of increasing size of retroplacental clot of  $6.3 \times 2.2$  cm. Placental pathology revealed chronic abruption. It was suggested that timely diagnosis and intervention led to favorable maternal and fetal outcome. Elliott et al<sup>6</sup> did a retrospective study including all patients with diagnosis of placental abruption with ruptured membranes, leading to idiopathic oligohydramnios defined as chronic abruption oligohydramnios sequence. Twenty-four cases with chronic abruption oligohydramnios sequence were identified.

Out of these, 14 had evidence of abruption at less than 20 weeks. The mean gestational age at first bleeding was  $19.4 \pm 5.5$  standard deviation with mean gestational age at delivery being  $28.1 \pm 4.5$  weeks. Preterm rupture occurred in 15 of 24 cases.

## CONCLUSION

It is crucial to distinguish placental abruption as one of the causes of bleeding and pain in the abdomen during the early phase of the second trimester, so that timely diagnosis and intervention can help in optimal patient management and decrease in maternal morbidity.

Hence, our report demonstrates the significance of the clinical examination associated with obstetric ultrasonography in diagnosis and aggressive management for improving maternal outcome.

## CLINICAL SIGNIFICANCE

Chronic abruption may present with vague clinical features, especially in early pregnancy, but a high index of speculation should be in mind for timely recognition and management.

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