



A CASE OF ABRUPTION TAKEN UNAWARE

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Abstract : Antiphospholipid antibodies which are nonspecific may be found in normal persons in 3-5 population. However these antibodies also have been associated with arterial and venous thromboses and adverse pregnancy outcomes. A Case of Gravida 2 Para 1 Live 0, who had placental abruption in the first pregnancy, was diagnosed as antiphospholipid antibody syndrome in the present pregnancy. She is being reported for the classical history, clinical presentation and complications. She had bad obstetric history, intra-uterine foetal death, early onset preeclampsia, and abruption in the first pregnancy. She had regular follow up at a peripheral level hospital. She was referred to our institution with bleeding per vaginum. Her ultrasonography revealed intrauterine fetal death with placental abruption. On admission her blood pressure was 160/100 mmHg. She was taken up for Emergency Lower Segment Caesarean section for Grade III placental abruption, as she was unresponsive to syntocin acceleration and delivered a dead macerated baby of

1.5kg and 750 grams clots was located retroplacentally. She required 2 units of blood transfusion and 2 units of fresh frozen plasma in the post operative period. She developed an episode of convulsion in the post operative period and Magnesium sulfate regimen started as anticonvulsant regimen. She was started on antihypertensives and the dosage tapered gradually. Computed Tomography of the Brain taken suspecting cortical venous thrombosis, but the finding was normal. She recovered well in the postoperative period. In the present pregnancy, she was investigated for bad obstetric outcome in the previous pregnancy and was found to be Antiphospholipid antibodies positive. She was started on Heparin 5000 IU subcutaneously and Low Dose Aspirin 75mg throughout the pregnancy. She had uneventful antenatal period with normal blood pressure and no Proteinuria during this pregnancy. She was delivered by an Elective Repeat Lower segment Caesarean Section under general anesthesia after discontinuing heparin 24 hours prior to the surgery and

Low dose Aspirin 1 week before surgery. She delivered an alive term girl baby of 2.8kg weight. She was restarted on subcutaneous heparin 12hours later and then switched to Oral warfarin 6mg for antithrombotic prophylaxis in the post partum period.s

Keyword :apla,boh,abruption,early onset preeclampsia

CASE REPORT: A 23 year old Gravida 2 Para 1 Live 0, married since 4 years, last child birth 2 years ago whose Expected Date of Delivery Falls on 09.10.11 has come for safe confinement on 27.09.11. She had bad obstetric history in the first pregnancy,. The first pregnancy was confirmed at a peripheral level hospital and she had regular antenatal follow up . She was referred to our institution at 32 weeks gestation with complaints of bleeding per vaginum. Her UltraSonography revealed Intra uterine fetal death with evidence of placental abruption. On admission her blood pressure was 160/100 mm Hg and she was treated as severe pre eclampsia with antihypertensives.

She was taken up for Emergency Lower Segment Caesaerean Section for Grade II Placental Abruption which was unresponsive to syntocin acceleration .She delivered a macerated dead baby of 1.5 kg and 750 gms of clots was located retro-placentally .In the post operative period, she required two units of Fresh Blood transfusion and 2 units of Fresh Frozen Plasma as supportive measure. She was haemodynamically stable in the post operative period. She developed an episode of Generalized Tonic Clonic Convulsion in the IIIrd post operative day and was started on Magnesium Sulphate regimen as anticonvulsant regimen for post partum eclampsia and was under observation. She settled down with antihypertensives and the dosage was tapered gradually,Computed Tomography of the Brain was done suspecting Cortical Venous Thrombosis but the finding was normal. Her post operative period was uneventful and she was discharged on the 14th post operative

day. Her blood pressure was normal on discharge and she was advised follow up every fortnight. The patient came was seen in our institution in the present pregnancy at 10 weeks gestation for registration. She was investigated for early onset preeclampsia with the previous pregnancy. The investigations revealed the following results, Complete Hemogram revealed normal findings Platelet Count-Normal Urine - No Proteinuria Prothrombin time – 13.5 (within normal reference range) INR – 1.05 (within normal reference range) Serum Uric acid-4mg% Antiphospho Lipid Antibody IgG = 32 (reference more than 15 positive) IgM = 80.5 (reference more than 15 positive) Renal function test and Hepatic function test was normal. She was diagnosed as Antiphospho Lipid Antibody Syndrome and was started on Heparin 5000 IU and Low dose Aspirin 75 mg on a daily dosage basis. She had a regular follow up during this pregnancy. All the three trimesters were uneventful with normal growth parameters and ultra sonogram findings. She had no proteinuria and had normal blood pressure throughout this pregnancy. She was planned for Elective LSCS at 38 weeks gestation after stopping Heparin 2 days prior to the surgery and Low dose Aspirin 1 week before surgery. Caesarean section was performed under General anesthesia and she delivered an alive term girl baby of 2.8 kg with normal APGAR score. She was restarted on Subcutaneous Heparin 5000 IU 12 hours after surgery. She was then switched over to Oral Warfarin 6 mg for 6 weeks post partum as Anti

thrombotic prophylaxis and Physiotherapy was advised to prevent Deep Vein Thrombosis.

DISCUSSION :

Antiphospholipid antibody syndrome or APLA syndrome, now called as "PAPS", primary antiphospholipid syndrome¹ is a syndrome consisting of lupus anticoagulant and anticardiolipin antibodies in patient's serum. Other antibodies also associated with it, but rare are antibodies to phosphatidylserine, phosphatidylethanolamine.² These are antibodies directed against negatively charged phospholipids on the cell membrane. They may be of IgG, IgM or IgA classes, alone or in combination. Lupus anticoagulant is characterized by a prolonged partial thromboplastin time and paradoxically the so-called 'anticoagulant' is a powerful thrombotic agent in vivo.³ The prevalence of lupus anticoagulant in²

Low risk population is less than 1%

Bad obstetric history - 9.1%

Early pre eclampsia - 16%

Abruptio - 33%

Systemic lupus erythematosus - 34%

AC interferes with platelet function, causing platelet aggregation and thrombosis⁴ and also it interferes with endothelial function, causing procoagulant activation and thrombosis.^{5,6}

Primary antiphospholipid antibody syndrome can present in a classical manner as seen in our case or it can be present and be totally asymptomatic.⁷ The various clinical presentations associated with lupus anticoagulant antibody are⁸:

Recurrent pregnancy loss

Unexplained second or third trimester loss

Early onset severe preeclampsia

Arterial or venous thrombosis

Unexplained fetal growth restriction

Prolonged coagulation studies

Autoimmune diseases

Cardiac valvular diseases

Neurological disorders

Thrombocytopenia.

Our patient a case of APLA syndrome was given heparin and warfarin for prevention of stroke and later low dose aspirin and dexamethasone for chronic treatment of APLA syndrome^{9,10}. These patients require therapeutic anticoagulation during the pregnancy and puerperium in next pregnancy.

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The diagnosis of API A Syndrome follows the,	
Sapporo Criteria for Diagnosing APLA Syndrome	
Presence of 1 Clinical Event and A Repeatedly* Positive lab test	
Clinical Events	Lab Tests
Blood Clot = thrombosis	Lupus anticoagulant confirmed with clotting test that depend on phospholipids OR
Deep Vein thrombosis (DVT) =clot in leg or arm	Medium or high levels of anticardiolipin IgG or IgM antibodies
Pulmonary embolism (PE)= clot in lung	
Other (in eye = retina vein thrombosis ; around brain = sinus vein thrombosis; in abdomen = mesenteric, portal, or hepatic vein thrombosis; etc	
Arterial	
Stroke	
Heart attack	
Leg or arm arterial clot = (ischemia or gangrene)	
Other (in eye = retinal artery thrombosis; in abdomen=mesenteric artery thrombosis, etc	
Pregnancy loss, defined as one of the following**-	
Three or more losses before the 10 th week of pregnancy	
One or more losses at or after the 10 th week of pregnancy	
One or more premature deliveries at or before the 34 th week of pregnancy because of eclampsia, preeclampsia, or placental insufficiency	
*Tested at least 6 weeks apart	
**Other possible causes of pregnancy loss or premature delivery should be excluded , such as birth defects, chromosomal abnormalities, and abnormalities of the mother's uterine anatomy or hormone levels	

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