Complications During Pregnancy

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Complications During Pregnancy

Bleeding during pregnancy

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- Vaginal bleeding it deviation from the normal that may occur at any point during pregnancy
- It never normal
- It must always be carefully investigated
- It can impair both mother and fetus

Spontaneous Miscarriage

Spontaneous Miscarriage

- Abortion – is a medical term for any interruption of a pregnancy before a fetus is viable (able to survive outside)
- When the interruption occurs spontaneously – miscarriage
- Spontaneous Miscarriage occurs in 15% – 30% of all pregnancies and occurs from the natural causes
- Early Miscarriage before 16 weeks, late – 16-24 weeks (after 24 it s abortion)

Causes of the Spontaneous Miscarriage

- Abnormal fetal formations (teratogenic factors, chromosomal aberrations)
- 50 % - 80% of fetuses which aborted had some structures abnormalities
- Immunologic factor (immune response)
- Abnormal implantations
- Corpus luteum stopped to produced enough progesterone
- TORCH infections
- Teratogenic drugs
-

Threatened Miscarriage

It is manifested by vaginal bleeding

Recommendations:

- Bed rest for 2 days
- Do not lift heavy things 48 hours
- Forbidden coitus during 2 weeks

50 % of thretened miscarriage change for imminent or inevitable miscarriage

Imminent (inevitable) miscarriage

- As usually coming with uterus contractions
- We should ask the woman to save all fragments of the blood
- The woman who reports cramps as usually asked come to the hospital
- If no fetal heart sounds are detected and sonogram reveals the empty uterus vacuum extractions can be performed

Complete Miscarriage

The entire products of conception (fetus, membranes and placenta) are expelled spontaneously without any assistance

Incomplete Miscarriage

Part of the conceptus (usually fetus) is expelled, but membrane or placenta is retained in the uterus. Incomplete Miscarriage is danger about maternal hemorrhage. As usually the physician proposing suction or normal curettage

Missed Miscarriage (early pregnancy failure)

- The fetus dies in uterus but is not expelled
- Finding when the fundal height is measured but no increase in size
- This kind of women may need support from the medical care staff

Recurrent Pregnancy Loss

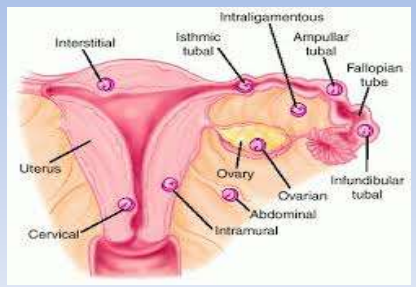
If the woman has a three spontaneous miscarriage at the same gestation age it calls Recurrent Pregnancy Loss

- occurs around 1% of women
- can be defect of spermatozoa or some autoimmune reactions or infections

Complications of Miscarriage

- Hemorrhage
- Infection
- Isoimmunization (the production of antibodies against Rh positive blood by immunologic system)

Ectopic Pregnancy – implantation occurs outside of the uterine cavity



Second Trimester Bleeding

- Gestation trophoblastic disease
- Premature cervical dilatation

Gestational Trophoblastic Disease (Hydratidiform Mole)

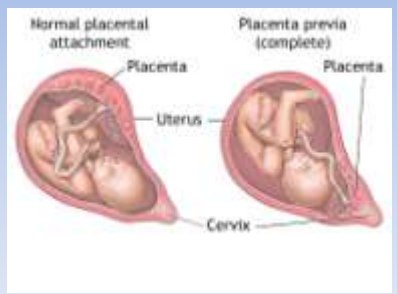
- Gestational Trophoblastic Disease is abnormal proliferation and degeneration of the trophoblastic villi
- it s approximately 1:1500 women
- Complete mole and partial mole

Premature Cervical Dilatation

Premature Cervical Dilatation (incomplete cervix) – cervix became extra delatated and cannot hold the fetus until the date of delivery

- occur 1% of the woman
- surgical treatment – cervical cerclage

Conditions associated with third-trimester bleeding



Conditions associated with third-trimester bleeding

- Slight spotting late in pregnancy can be caused by trauma from a pelvic examination or coitus
- Bleeding during late pregnancy usually occurs, however , form placenta previa, premature separation of the placenta or preterm labor

Placenta Previa

Placenta Previa

- Because the ultrasonography occurs so often nowadays, the placenta previa diagnosed before it giving symptoms.
- Bleeding with placenta previa occurs when the lower uterine segment begins to differentiate from the upper segment. The cervix begin to dilatate
- The bleeding is usually painless, bright red
- It can stop suddenly like it s began

Placenta Previa

- It s an emergency situation
- Woman immediately placed to the bed rest in a side lying position
- Blood supply to the woman
- Note duration of pregnancy and time of bleeding
- Woman s estimation of the amount of blood
- Was it painful
- Was it episodes of the bleeding before
- Inspect the perineum for bleeding

Placenta Previa

NEVER attempt a pelvic or rectal examination, coz the placenta may initiate massive hemorrhage

- Measuring the blood pressure every 5-15 minutes
- Begin intravenous fluid therapy
- Attach the external fetal monitoring
- Hemoglobin and Hematocrit should be controlled

Placenta Previa

Partial placenta previa has a percentages of covering the cervix :

- 100%
- 75 %
- 30 %

If it s 30 % and less the fetus can be birth true the normal way, if it more – cesarean will be more safetty

Premature Separation Of the Placenta (Abruptio Placentae)

The placenta appears to have been implanted correctly. It s occurs in about 10 % of pregnancy and most frequently causes of perinatal death. It can occurs in a first or second stage of labor

Factors: advanced maternal age, a short umbical chord, chronic hypertensive disease, direct trauma, vasoconstriction from cocaine or cigarette

Premature Separation Of the Placenta (Abruptio Placentae)

- It s an emergency situation
- Oxygen and fluid therapy
- Monitoring mother and fetal vital functions every 5-15 min
- Control of hemoglobin and hematocrit

Diabetes During Pregnancy

Diabetes affects 2% to 3% of all pregnancies. Of those, approximately 90% are cases of gestational diabetes, which is diabetes whose onset occurs during pregnancy

Effect of pregnancy on glucose metabolism

Maternal metabolism adjusts to provide nutrition for both the fetus and the mother:

- Increased insulin secretion occurs as a result of -cell hyperplasia from the increased levels of estrogen and progesterone.
- Insulin antagonism results from the increase in human somatomammotropin (produced by syncytiotrophoblasts).
- Increased insulin degradation by placental insulinase occurs

Effect of pregnancy on glucose metabolism

- A more than 40% decrease in insulin sensitivity normally occurs by late in pregnancy and maintenance of glucose homeostasis results from exaggeration in both the rate and amount of insulin release.
- Therefore, as pregnancy progresses, women with marginal pancreatic reserve may be unable to meet insulin demands, especially in late pregnancy, and those with preexisting diabetes will need more insulin.
- Fetal glucose levels are directly proportional to maternal glucose concentrations.

a. Insulin does not cross the placenta.

b. After delivery, insulin requirements for patients with underlying diabetes decrease because of the decrease in estrogen, progesterone, placental insulinase, and human somatomammotropin

Risk of complications from the diabetes in pregnancy women

- Preeclampsia and eclampsia
- Diabetic ketoacidosis
- Worsening preexisting nephropathy
- Worsening preexisting retinopathy
- Infection
- Polyhydramnios
- Cesarean delivery
- Postpartum hemorrhage
- Mortality
- Miscarriage of fetus
- Unexplained stillbirth

Management of patients with diabetes

- Provide folic acid supplementation.
- Provide nutrition counseling
- Obtain ultrasound between 6 and 8 weeks' gestation if possible for accurate dating
- Order hemoglobin A1C to assess glycemic control
- Multiple daily injections of insulin
- Maternal serum -fetoprotein (AFP) screening at 15 to 20 weeks to assess the risk for fetal
- neural tube abnormalities
- Ultrasound at 16 to 20 weeks to evaluate fetal anatomy
- Fetal echocardiography at 20 to 22 weeks to help screen for fetal cardiac abnormalities
- Surveillance of fetal well-being should begin at 28 weeks with maternal fetal activity assessment (kick counts) because the risk of unexplained stillbirth is increased. Nonstress testing or biophysical profi les should begin at 32 weeks or earlier if signifi cant maternal vascular disease exists or there is evidence of fetal growth restriction.
- Ultrasound every 4 to 6 weeks to assess fetal growth

Gestational diabetes

- Increased risk of macrosomia
- Increased risk of preeclampsia
- Increased rate of stillbirth if fasting glucose is elevated
- Fetal anomalies are not increased

- Provide nutritional counseling and dietary adjustment. If the disease can be controlled by diet alone, patients can be followed similarly to those without diabetes. No evidence supports early delivery.
- Monitor fasting and 2-hour postprandial glucose values.
- Give insulin if fasting glucose values are greater than 95 mg/dL and 2-hour postprandial values are greater than 120 mg/dL.
- Oral hypoglycemics such as glyburide can also be used. If Glyburide fails to control sugars, treat with insulin.
- Patients who require medications or are unable to maintain glycemic control should be followed similarly to patients with preexisting diabetes.
- Follow-up. After the postpartum visit, patients with gestational diabetes should be screened routinely for diabetes

PREECLAMPSIA

PREECLAMPSIA: EPIDEMIOLOGY

- Pregnancy history. Primigravidas constitute 65% of cases.
- Multiple gestation: 30% incidence
- Gestational trophoblastic disease: 70% incidence
- Maternal age. Preeclampsia occurs at extremes of maternal age. However, the association with young age is confounded by the association with primigravidity. However, maternal age of more than 40 years is an independent risk factor.
- Family history
- Obesity
- Chronic hypertension

PREECLAMPSIA: CLINICAL MANIFESTATIONS

- Hypertension is required for diagnosis
- Edema is related to sodium retention, and is not limited to dependent edema
- Hyperreflexia is common

PREECLAMPSIA: MANAGEMENT

- Delivery is the only known treatment. At term (37 weeks' gestation), delivery is recommended.
- Vaginal delivery is preferable to cesarean delivery, which should be reserved for the usual obstetric indications.
- Cesarean delivery may be preferred in cases of severe preeclampsia remote from term with an unfavorable cervix

Antepartum treatment (before 37 weeks)

- Bed rest
- Blood pressure and urinary protein monitoring
- Twice-weekly nonstress tests
- Laboratory surveillance

ECLAMPSIA

ECLAMPSIA

- Eclampsia is preeclampsia complicated by generalized tonic–clonic seizures
- May occur before, during, or after labor and delivery
- May cause maternal death
- Consider cerebral imaging, especially if the seizures occur more than 24 hours postpartum
- Treatment includes magnesium sulfate to control seizures; antihypertensive therapy with hydralazine, labetalol, or nifedipine; prevention of aspiration and hypoxia; and delivery when the mother is stabilized

THANK YOU
for your
ATTENTION!