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Successful Management of Mid Trimester Foetal Death with Major Placenta Previa by Expectant Management Followed by Induction of Labour

Cindy HN*

Department of Obstetrics and Gynaecology, University of Medicine, Myanmar

***Corresponding author:** Htoo Naw Cindy, Department of Obstetrics and Gynaecology, University of Medicine, Yangon, Myanmar, Tel: 7624381039; Email: nawcindyhtoo@gmail.com

Case Report

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Abstract

37 year, G2P1+0 woman with previous one LSCS scar was referred for reduced liquor index with placenta previa at 25 week gestations. Her first child was delivered by emergency LSCS due to failure of progress. USG was performed and revealed that IUFD baby with breech presentation with anterior low lying placenta covering os. There was no clear guideline for management of mid trimester foetal death with placenta previa and most of the management are based on the experience on the case report. To avoid repeat LSCS, expectant management was offered and Induction of labour with vaginal misoprostol was performed. Baby and placenta were successfully delivered by vaginal delivery. Blood loss was about 400 ml and there was no PPH. The present case suggests that expectant management followed by induction of labour may be an option for patients with placenta previa who desire vaginal delivery after intrauterine foetal death (IUFD) in a second-trimester pregnancy.

Keywords: Mid Trimester Foetal Death; Major Placenta Previa; Expectant Management; Induction of Labour

Abbreviations

IUFD: Intrauterine Foetal Death; DIC: Disseminated Intravascular Coagulation.

Case Report

37 year, G2P1+0 woman with previous one LSCS scar was referred to Consultant antenatal clinic from community for reduced liquor index with placenta previa at 25 week gestations.

Her first child was delivered by emergency LSCS due to failure of progress 3 year ago. There was no intraoperative and post-operative complication. She used injection depo provera for contraception since then. She conceived while taking depo injection and did not know her LMP.

She has no medical disease before. There was no complication in her early pregnancy. She did not have any loss per vagina, febrile illness, abdominal injury and bleeding per vagina in this pregnancy. However, she did not notice any significant foetal movement till first antenatal visit. Her blood pressure was normal throughout pregnancy. She took her first antenatal visit with Midwife in community. Because of the USG finding, she was referred to hospital antenatal clinic.

At hospital antenatal clinic, USG was repeated and found out that IUFD baby with breech presentation with anterior low lying placenta covering os at 25 week gestation. Thus she was admitted to the hospital for further management. Her random blood sugar was normal and full blood count and PT (INR) were within normal limit. Colour Doppler USG was performed as she had major placenta previa with previous LSCS and it revealed that there was increased blood flow to the placenta but no signs of accreta.

After thorough counselling, expectant management was provided and weekly full blood count and coagulation profile were offered. During monitoring, she was feeling well and there was no bleeding per vagina. But her Hb level was 8g% thus whole blood 1 unit was given. Other investigations were normal. After 18 days of expectant management, USG colour Doppler was rechecked and there was reduced blood flow to the placenta. And placenta size was also reduced slightly. She did not go into spontaneous labour. Thus after counselling, labour was induced by per vaginal misoprostol 100 microgram 8 hourly.

The patient went into labour after second dose of misoprostol and then her labour progress was satisfactory and the placenta passed first and the foetus delivered spontaneously. Blood loss was about 400 ml and there was no PPH. The foetus was macerated and 0.7 kg and post-mortem examination was not done because the patient did not give the consent. Oral antibiotics was given. Lactation was suppressed by oral cabergolin. Her postpartum period was uneventful. She was discharged from the hospital after day 4 delivery. She came back to follow up clinic after 2 week and there was no special complaint. She was advised for contraception and family planning.

Day	Event/Procedure	Findings/Decision
Day 0	Initial presentation (referred from community)	Admission
Day 0	Initial scan	Fetal Demise at 25 weeks with Major Placenta Previa
Day 1	Detailed scan with Color Doppler	Rule out Placenta Accreta
Day 1	Counselling and management planning	Offered Expectant Management
Day1-18	Expectant Management Correction of Anaemia	Patient monitored and stabilized
Day 18	Repeat Follow up scan	Reduced placenta size and reduced Placental Blood Flow
Day 18	Re-counselling management plan	Offered and accepted Induction of Labour
Day 19	Baby and placenta delivered	Blood loss 400ml, no postpartum haemorrhage

Table 1: Diagnostic and Management Timeline of Present Case Report.

Discussion

Foetal death after 20 weeks of gestation in combination with major placenta previa is rarely seen. Although infrequent, it is a very difficult problem because no consensus has been reached on the appropriate delivery strategy and management.

Caesarean delivery for a death foetus carries significant maternal risks of bleeding and adversely affects the next pregnancy without any benefit for the foetus. On the other hand, management of mid-trimester foetal death in the presence of placenta previa is dilemma for obstetricians because induction of labour could cause massive bleeding from abruption of placenta covering the internal cervical os.

There was no clear guideline for management of mid trimester foetal death with placenta previa and most of the management are based on the experience on the case report. Moreover, cause of IUFD should also be found out for next pregnancy management.

Regarding the management of IUFD, clinical assessment and laboratory tests should be recommended to assess maternal wellbeing (including coagulopathy) and to determine the cause of death, the chance of recurrence and possible means of avoiding further pregnancy complications. There is also moderate risk of maternal disseminated intravascular coagulation (DIC): 10% within 4 weeks after date of IUFD, rising to 30% thereafter. This can be tested for clotting study, platelet count and fibrinogen measurement. These tests should be repeated twice weekly in women who choose expectant management [1].

In this case, thorough history taking and physical examination was done for maternal risk assessment (preeclampsia, chorioamnionitis and placental abruption) on arrival and everyday ward round in this case. Maternal monitoring by regular full blood count and PT (INR) was done weekly in this case. According to guideline, blood test monitoring should be done twice weekly. Fibrinogen level monitoring should also be included.

Regarding to identify the cause of IUFD, random blood sugar was the only one investigation in this case. Other investigations (Kleihauer test for feto-maternal haemorrhage, bacteriology, serology, karyotyping of paternal blood, foetal and placental tissue and post-mortem examination) were not done. Identifying the cause of foetal death is very important in management of future pregnancy thus these investigations should be done in this case. The clinician should have awareness to do these investigations and Laboratory facilities should also be promoted for important investigation.

Post-mortem examination of the baby and placenta has the highest diagnostic yield of all investigations. When combined with other diagnostics test, it offered information relevant to recurrence risk in 40 % of cases and to management of next pregnancy in 51%. But about half of the cases, cause of IUFD cannot be found although thorough investigations are made [1].

Regarding mode and time of delivery, there is limited experience with these cases and management is controversial. According to the case report of Sayuri N, et al. [2], 33 year primiparous with foetal death with placenta previa at 25 weeks and 5 days of gestation, was offered expectant management anticipating placental atrophy after foetal death. After 22 days of IUFD, USG showed placental atrophy and labour began spontaneously. The blood loss was 383ml [2].

In the case reports of Joke M, et al. [3], 2 multipara pregnant women with previous normal vaginal delivery, was offered induction of labour after 1-2 week expectant management. The foetus was delivered vaginally without any complications. One pregnant woman with previous two LSCS scar with placenta previa with foetal death with transverse lie with moderate blood loss was managed by emergency caesarean section [3].

In this case, although the patient had one previous LSCS scar, she had no bleeding per vagina and there was no sign of placenta accreta on USG. Thus expectant management followed by induction of labour was offered and the outcome was good with moderate blood loss. Before deciding mode of delivery, thorough clinical review, colour Doppler USG to exclude placenta accreta, optimizing maternal condition was done in this case. During and after delivery, the patient was closely monitored and follow up was planned after 2 week and provided necessary advice regarding next pregnancy and family planning. However, investigation for IUFD was not completed and the woman did not get adequate information for her baby death and next pregnancy management. Therefore, thorough investigation should be done to find out the cause of IUFD. On the other hand, in spite of thorough investigation, the patient should be informed that cause of death is unknown in some cases.

In conclusion, management of foetal death with placenta previa in midtrimester is controversial and challenging and need to balance against risk and benefit of patients. Management of IUFD is also part of the management. Thus these cases should be managed by the experienced obstetricians with multidisciplinary team approach including anaesthetist, blood bank staff, haematologist, senior midwife with well-prepared situation. According to the case reports, they favoured expectant management about 2-4 weeks as a management strategy and if expectant management failed, pharmacological induction of labour is better choice than surgical treatment (D&C) to avoid excessive bleeding and maternal morbidity (Table 1 and 2).

Case Report	No: Of Patients	Gestational Week	Mean Days From Fetal Death To Delivery	Management	Blood Transfusion Requirement	Post-Partum Haemorrhage
Sillender M, et al. [4]	1	22	1	Mifepristone followed by misoprostol	nil	nil
van der Ploeg, et al. [3]	2	23 and 33	17	Spontaneous labour and oxytocin infusion	nil	nil
Taki M, et al. [5]	1	23	21	Laminaria and gemeprost	1 unit	nil
Kaku S, et al. [6]	1	24	2	Uterine artery embolization followed by Laminaria and gemeprost	nil	nil
Present case	1	25	19	IOL with misoprostol	1 unit (before delivery)	nil

Table 2: Comparison of the Management and Outcomes of Mid-Trimester IUFD with Major Placenta Previa.

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