RECURRENT EARLY PREGNANCY LOSS
A Clinician's View from the front lines

THE GOAL
THE OBJECTIVES

• The attendee should be able to:
  • Define pregnancy recurrent loss
  • Identify “at risk” patients when providing procreative care
  • Listen and understand the timing of appropriate care as well as the various treatment options available

THE PROBLEM

• Out of date concepts
• Concept confusion
• Costs
  • Emotional and Financial
• Disconnection
• Discounting
THROMBOPHILIA

• Definition
  • A tendency to form blood clots

• Common

• Likely causes
  • Factor V Leiden
  • Prothrombin mutation
  • Antiphospholipid Syndromes
  • Autoimmune conditions
  • MTHFR

ABNORMAL PLACENTATION
ENDOTHELIAL DAMAGE

THE APPROACH

- History and Physical
- Lab work
- Planning
- Supportive Care
SUPPORTIVE CARE

CASE HISTORY #1

• 35 yo G7P3043
• No significant past medical history
  • Other than a personal history of Lipoprotein Level A
• Strong family history of cardiovascular disease
  • Father age 70 w/HTN who was subsequently encouraged to be tested and was
    ultimately diagnosed with Lipoprotein Level A based on the knowledge of her
    diagnosis.
• Treatment Regimen
  • (2) 81mg Aspirins QD
• Outcome
  • 3 full-term deliveries w/one miscarriage while not on the regimen
CASE HISTORY # 2

• 39 yo G6P1
• No significant medical history
  • Other than a personal history of MTHFR homozygous for C677T
• Family History
  • She has a brother, father and paternal grandfather with history of heart attack at ages 46-48.
• Treatment Regimen
  • Lovenox
  • BPP
• Outcome
  • Successful full-term normal delivery and she is currently pregnant on the same regimen with a spontaneous pregnancy

CASE HISTORY # 3

• 39 yo G12 P3092
• Medical history significant for recurrent pregnancy loss and PTSD
  • She has had pregnancy losses from 6 weeks to an IUD at 37 weeks
  • She had one elective 20 week termination for severe IUGR secondary to suspected, but not confirmed Dandy-Walker Syndrome
  • She was also found to be positive for MTHFR A1298C mutation
• Treatment
  • Aspirin, Lovenox + Progesterone
• Outcome
  • Pregnancy with normal growth however, that pregnancy did end in fetal demise at 10 weeks due to trisomy 15
PARTING THOUGHTS

• Do give supportive care
• Do team with specialist
• Do initiate early care
• Do entertain multiple causes and treatments
• Do educate

PARTING THOUGHTS CONTINUED

• Don’t gaslight
• Don’t refer to infertility specialist for RPL
• Don’t equate thrombophilia with disease
• Don’t ignore special circumstances
THE FUTURE

• “The pathophysiologic processes involved in complicated pregnancies echo those of CAD and stroke: inflammation, altered angiogenesis, vasculopathy, thrombosis, and insulin resistance.”
• “All of these data underscore the importance of identifying at-risk women based upon reproductive history.”
• “Pregnancy complications give us a glimpse of this awful disease trajectory at a time when women are completely asymptomatic and we could intervene and perhaps change outcomes with targeted therapy when it might be expected to work better.”

– Dr. Carole A. Warnes

THANK YOU
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- Figure 2
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- Figure 3
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