Unexplained Ten Consecutive Early Third Trimester Intrauterine Fetal Deaths: A Diagnostic Dilemma

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INTRODUCTION

Recurrent early third trimester fetal deaths may result from variety of causes like chronic maternal illness, Rh-immunization, syphilis, uterine anomalies and chromosomal abnormality. Several reports also have indicated an association between recurrent fetal death with antiphospholipid antibodies, congenital protein C or protein S deficiency, activated protein C resistance, lupus anticoagulant, prothrombotic mutations, and disorders of maternal-placental interface, such as feto-maternal hemorrhage, as well as maternal floor infarction. In some cases primary placental pathology viz chorio-angiomas, primary avascularity of placenta, and chronic villitis of unknown origin has been implicated. However, universal acceptance of the later two associations are still lacking. We here report a case of ten consecutive early third trimester (27-31 weeks) fetal losses with very low maternal serum alpha feto protein (<0.15 MOM MSAFP), turbid liquor amni and extensive placental pathology viz., fibrosis, hyalinization, infarction, narrowing as well as poor vascularization of chorionic vessels.

CASE REPORT

A macerated stillborn female fetus was referred for fetal autopsy. The fetus was delivered at 31 weeks of gestation to para ten, hindu, brahmin, middle class mother who had noticed decreased fetal movements three weeks prior to delivery and loss of fetal movement 4-5 days before the delivery. The mother was 32 years and father 38 years old at the time of birth of the child. There was no history of consanguinity. The present pregnancy had remained uncomplicated until decreased fetal movements were noticed around 27th week of pregnancy. At the onset of decrease in fetal movement an obstetric ultrasound was carried out privately that showed ill-sustained fetal breathing (at 27 weeks) and turbid liquor amni. All other fetal parameters were normal. Follow up ultrasound at the time of loss of fetal movement revealed fetal death at 30 weeks of gestation. Labour was induced by oxytocin infusion and a female fetus weighing 1.535 Kg was delivered vaginally. Autopsy findings revealed no intrauterine growth retardation (good subcutaneous fat and normal weight), no internal or external malformation & no umbilical cord pathology. However, thymus & placenta were hypoplastic and placenta was firm (nonspongy). Placental histopathology examination showed extensive placental fibrosis, hyalinization, infarction, narrowing as well as poorly vascularization of chorionic vessels (Fig.1 & 2).
Figure 1
Figure 1: (X50 magnification) and Figure 2: (X125 magnification). Section of placenta showing fibrosis, hyalinisation, poor vascularisation and narrowing of vessel lumen.

Figure 2

Similar autopsy findings were reported in previous pregnancy. Almost similar obstetrics history had followed in previous pregnancies. The mother was under care of private obstetricians throughout most pregnancies and fetal death was unstoppable even after antiplatelet therapy in last pregnancy. All the fetuses were normal externally; seven were male and three were female. There were no signs of growth retardation in any of fetuses. The couple was investigated in detail in 10th pregnancy and also in the interval period between 9th & 10th pregnancy. The findings are summarised in Table 1. The mother was not known to have any chronic disease, however, she had two episodes of right sided hemiparesis at the age of 8 years and 14 years from which she had recovered fully.

Family history revealed no similar fetal losses. However, multiple sets of twin pregnancies were reported in first degree relatives of the couple (both sides).

DISCUSSION
Recurrent early third trimester fetal death may remain unexplained inspite of indepth investigation. The case which is described in this report is preferably termed as inadequately explained despite indepth investigations. As all her ten pregnancies ended in the same fashion and almost at the same period, we presume a common underlying etiopathologic factor. Our prime suspects are antiphospholipid like syndrome/antiphospholipid like syndrome and inherited thrombophilias (protein S deficiency, activated protein C resistance, prothrombotic mutations, etc). Primary antiphospholipid syndrome (APS) is unlikely in the absence of negative investigations (lupus anticoagulant, platelet count, VDRL test, complements and anticardiolipin antibody). However, adverse pregnancy outcome has been reported in patients with APS with low positive autoantibody titre as in our case. In addition Branch et al earlier reported that some patients with this history may produce antiphosphatidylserine antibody. Similarly, Triplett et al reported that patient with APS may have positive reaction only against phosphatidylserine or phosphatidylinositol. Although testing for anticardiolipin antibody may provide some insight into patient with APS, testing for phosphatidylserine antibody identifies some rare patient who are non-reactive for anticardiolipin and lupus anticoagulant. Antiphospholipid like syndrome (in presence of absent autoantibodies) could be the possibility for the underlying cause and is supported by the history of recurrent transient ischemic attack (in the form of hemiparesis), pattern of recurrent fetal death after detection of fetal heart and placental histopathology viz. infarction, intravascular fibrin deposition and fibrosis, although placental changes could be partly due to post mortem changes. Placental fibrosis is commonly seen with macerated stillbirth (long standing intrauterine death). However, it is very unlikely that placental histologic changes are solely postmortem and is supported by the history of recurrent transient ischemic attack (in the form of hemiparesis, decrease fetal movement 2-3 week before fetal death and thymic hypoplasia) indicate its antenatal onset. Very low maternal alpha feto protein can be seen with chromosomal abnormality (trisomy 21, trisomy 18, 48,XXYY and triploidy), placental chorioangiomas or placental fibrosis. Very low MSAFP levels with later condition can be explained by lack of transfer of AFP from fetus to mother because of placental fibrosis and hypovascularity. The
reason for turbid liquor is not apparent. However, it was not due to oligohydramnios or amniotic infection or bleeding or meconium in amniotic fluid. Placental fibrosis and hypovascularity may probably the end result of chronic villitis of immunologic origin through antiphospholipid or antiphospholipid-like syndrome, activated protein C resistance, prothrombotic mutations, and anti-annexin V autoantibodies. Placental fibrosis may also be seen with methyl parathion exposure, hyperthermia, hypoxia, and transforming growth factor-beta overactivity. Chronic hypoxia is unlikely to be the underlying cause (commonly seen with pregnancy induced hypertension) as this results in minimal fibrosis of the villi, whereas a marked fibrosis with increase in stromal connective tissue and villous avascularity results from thrombosis in main stem and surface vessels as seen with prothrombotic mutations and antiphospholipid syndrome.

Possibilities like cogenital protein C deficiency, uterine anomalies, balanced chromosomal translocation in parents, etc were excluded by appropriate investigations (Table 1). Similarly, monogenic, polygenic, multifactorial, uniparental disomy and genomic imprinting as underlying cause is unlikely as none recur in 100% offsprings. Maternal floor infarction or fetomaternal hemorrhage as cause is also unlikely in the absence of high MSAFP.

In conclusion we feel that evaluation of recurrent unexplained fetal death is incomplete unless it directs investigation towards detailed immunologic (beyond anticardiolipin & lupus anticoagulant), inherited thrombophilias as well as placental pathology. Time has come to stress pathology of placenta as a factor in fetal demise and not only as part of epiphenomena.

Figure 3
Table 1: Summary of Investigations

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Results During Non-Pregnancy Interval</th>
<th>Results During 9th &amp; 10th Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECG group &amp; Type</td>
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<td>E + vs</td>
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<tr>
<td>NICHD</td>
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<td>Normal</td>
</tr>
<tr>
<td>Screening test</td>
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<td>Normal</td>
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<td>Email function test</td>
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<td>No Growth</td>
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<tr>
<td>a-Thalassemia Screening</td>
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<td>Negative</td>
</tr>
<tr>
<td>Thyroid Function Test</td>
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<td>Normal</td>
</tr>
<tr>
<td>Ultrasonography</td>
<td>Normal uterus &amp; adnexa</td>
<td>Turbid liquor after 24 weeks of pregnancy, 100% elevation of alphafetoprotein.</td>
</tr>
</tbody>
</table>

| Maternal Floor Infarction | Normal |
| Uterine Anomalies | Normal |
| Balanced Chromosomal Translocation | Normal |
| MSAFP | Normal |

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REFERENCES
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