Misoprostol toxicity in second trimester pregnancy: A case review

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ABSTRACT

Introduction: Misoprostol, a synthetic prostaglandin E1 analogue, is commonly used for various obstetric and gynaecological indications. While it has proven efficacy in these settings, there is a growing concern regarding the potential for misoprostol toxicity in second-trimester pregnancy. This case study review aims to summarize the current understanding of misoprostol toxicity and its implications in second-trimester pregnancy. **Case Description:** A 20-year-old primigravida presented to the emergency department with a history of recurrent seizures at home. Her partner reported that she took six tablets of misoprostol (200 mcg each) orally and one tablet per vaginally. Clinical examination showed a gravid uterus of 29 weeks gestation with no fetal heart activity. She was admitted to ICU for supportive therapy and subsequently recovered well. **Discussion:** Misoprostol administration during the second trimester carries potential risks, including uterine hyperstimulation, which can lead to fetal distress, uterine rupture, and maternal haemorrhage. Additionally, misoprostol exposure during this critical period of fetal development may be associated with adverse outcomes, such as congenital malformations, fetal demise, and maternal morbidity. In summary, misoprostol toxicity in second-trimester pregnancy poses significant challenges and potential risks for both mother and fetus. This review concludes with future directions for research and clinical practice. It emphasizes the need for further studies to better understand the risks and benefits of misoprostol administration in second-trimester pregnancy, as well as the development of standardized protocols for its use.

Placenta accreta spectrum in unscarred uterus.

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ABSTRACT

Introduction: Placenta accreta spectrum (PAS) is a term to describe abnormal trophoblast invasion into the myometrium and serosal layer. Diagnosis is via ultrasound and magnetic resonance imaging (MRI). The pathogenesis is thought to be placental implantation at an area of defective decidualization caused by pre-existing damage to the endometrial-myometrial interface. However, PAS in a non-scarred uterus and in a normally located placenta does occur but is exceedingly rare. **Case Description:** We report two cases that occurred on the same day. Both were multipara in their early thirties with no prior history of uterine surgery. Both presented with labour symptoms but their third stage of labour was complicated with retained placenta resulting in massive primary postpartum haemorrhage. One patient required cardiopulmonary resuscitation prior to a subtotal hysterectomy. Both received massive transfusions of blood products but recovered well subsequently. Diagnosis of placenta accreta spectrum was confirmed histologically in both cases. **Discussion:** Difficulty in delivering the placenta in the third stage of labour is a red flag for PAS in a normally-located placenta with an unscarred uterus. Rapid availability of blood products and early recourse to surgery is mandatory as the bleeding could be life-threatening. Antenatally, the presence of suspicious lacunae; multiple large, irregular intra-placental sonolucent spaces in between a lobule or cotyledon which give a 'moth-eaten' appearance, during ultrasound scan must raise suspicion. Thus, an ultrasound scan is a useful diagnostic modality in recognising the depth and topography of the placental invasion of PAS.