The High Risk Pregnancy Dilemma: Navigating Recurrent Adverse Pregnancy Outcomes

Executive Summary · Country Focus: Kenya

PART 1 · EXECUTIVE SUMMARY

Overview

Recurrent adverse pregnancy outcomes, including miscarriage, stillbirth, pre-eclampsia, fetal growth restriction, preterm birth and neonatal death, are among the most distressing and complex problems in obstetric practice. When they recur across several pregnancies, they rarely reflect chance alone. More often they point to an underlying maternal, placental, fetal or genetic cause that can be identified, modified and, in many cases, treated before the next pregnancy.

In many African settings, the care of these women is fragmented. Records are scattered across facilities, each pregnancy is managed as an isolated event, preconception care is rarely offered, and the psychological toll of repeated loss is seldom addressed. Women may move from one emergency to the next without anyone reconstructing the full story or asking why the same complications keep returning.

This WATOG Africa case series session, with Kenya as the country focus, presented a woman with fifteen pregnancies over nineteen years and only three surviving children, whose most recent pregnancy followed tubal ligation and ended in a live birth at 33 weeks. The discussion moved from the dilemmas of her care to a practical framework built on four actions: reconstruct the history, recognise recurring patterns, investigate and intervene, and maintain continuity of care. Expert commentary then distilled management into three objectives: understand the cause, modify the risk and improve the outcome.

Case at a Glance

Patient	38-year-old woman with a 19 year history of poor pregnancy outcomes (2007 to 2026)
Obstetric history	15 pregnancies: 3 living children, 2 miscarriages, 4 stillbirths and 6 neonatal deaths
Key complications	Recurrent pre-eclampsia, reported eclampsia, multiple preterm births and five previous caesarean scars
Index pregnancy	Unexpected pregnancy in 2026 after bilateral tubal ligation in 2024
First admission	30 weeks: abdominal pain; steroids, magnesium sulphate and specialist review; normal growth and Doppler indices
Second admission	32 to 33 weeks: severe headache and vomiting with normal blood pressure and laboratory results
Delivery	Caesarean section at 33 weeks; recanalised right fallopian tube found at surgery
Outcome	Live male infant of about 2.05 kg; respiratory distress resolved within two days; mother discharged on day three

Evidence Snapshot

Question	What the evidence shows
Can low dose aspirin prevent pre-eclampsia?	In women at high risk, aspirin started before 16 weeks markedly reduces preterm pre-eclampsia; the ASPRE trial showed a reduction of about 62% with 150 mg nightly
What about calcium?	WHO recommends calcium supplementation in pregnancy where dietary intake is low, to reduce the risk of pre-eclampsia

Question	What the evidence shows
When should antiphospholipid syndrome be considered?	After recurrent early losses, unexplained fetal death, or preterm birth before 34 weeks from severe pre-eclampsia or placental insufficiency
Does treatment help in antiphospholipid syndrome?	Low dose aspirin with prophylactic heparin is standard care and improves live birth rates in obstetric antiphospholipid syndrome
Can tubal ligation fail?	Yes; long term follow up has shown cumulative failure of about 1 to 2% over ten years, with a higher risk of ectopic pregnancy
Are there long term risks after pre-eclampsia?	Women have higher lifelong risks of chronic hypertension, heart disease and stroke, so postpartum follow up matters

Key Messages

- Treat recurrent adverse outcomes as a pattern to be explained, not a series of unrelated emergencies.
- Reconstruct the full obstetric history, including gestation, complications, placental findings and neonatal outcomes for every pregnancy.
- Match investigations to the pattern, and consider antiphospholipid syndrome early when losses, stillbirths and hypertensive disease coexist.
- Offer preconception care, early booking and first trimester risk assessment, with aspirin and calcium where indicated.
- Balance historical risk against current findings, using fetal surveillance to avoid unnecessary prematurity.
- Keep one consolidated record and a written, individualised care plan shared across facilities.
- Care for the whole woman: screen for depression, anxiety and trauma, and respect her reproductive autonomy.
- Continue care beyond delivery, including contraception, recurrence counselling and long term cardiovascular follow up.

PART 2 · DETAILED SUMMARY

1. Session Context

The WATOG Africa bimonthly clinical case series promotes collaborative, African led clinical learning, strengthens networking between trainees and specialists across the continent, encourages evidence based practice and provides mentorship through shared clinical experience. This session focused on a woman with a long history of recurrent adverse pregnancy outcomes, a scenario familiar to many clinicians but rarely approached in a structured way.

2. The Case

A 38-year-old woman presented with a history of extremely poor pregnancy outcomes spanning nineteen years. Her obstetric history is summarised below.

Pregnancy outcome	Number
Living children	3
Miscarriages	2
Stillbirths	4
Neonatal deaths	6
Total pregnancies	15

Her history also included recurrent pre-eclampsia, reported eclampsia in 2015, multiple preterm deliveries and five previous caesarean section scars. She underwent bilateral tubal ligation in 2024, followed by an unexpected pregnancy in 2026. Her previous records were scattered across several hospitals, so much of the history had to be reconstructed from her own recollection, a process that was emotionally distressing for her.

3. Management of the Index Pregnancy

First admission. She presented at about 30 weeks with lower abdominal pain radiating to the back, together with vaginal itching and discharge. Given her history, preterm labour was suspected. She was admitted for observation and received dexamethasone for fetal lung maturation and magnesium sulphate for fetal neuroprotection. Liver function, coagulation and urinalysis were normal, and a specialist ultrasound showed normal fetal growth and Doppler indices. She remained normotensive, and vaginal candidiasis and constipation were treated. After five days, the plan changed from anticipated delivery at 31 weeks to continued monitoring towards delivery at 37 weeks.

Second admission. Two weeks later she returned with lower abdominal pain, a severe headache of three days and one day of vomiting. Blood pressure and laboratory results remained normal, yet her history raised concern about evolving pre-eclampsia. Considering her symptoms, history and multiple uterine scars, a caesarean section was performed at 33 weeks.

Outcome. A live male infant of about 2.05 kg was delivered. He developed respiratory distress, was admitted to the newborn unit and recovered within two days. At surgery, the right fallopian tube appeared to have recanalised, explaining the pregnancy after sterilisation. The mother recovered well and was discharged on the third postoperative day.

4. Clinical Dilemmas

- **Underlying cause:** it was unclear whether the repeated outcomes reflected placental dysfunction, maternal disease, genetic factors or several mechanisms together.
- **Risk versus reassurance:** clinicians had to weigh a history of repeated loss against reassuring current maternal and fetal assessments.
- **Diagnostic uncertainty:** severe headache and vomiting raised suspicion of pre-eclampsia despite normal blood pressure and laboratory results.
- **Provider anxiety:** a history of repeated adverse outcomes can push clinicians towards early intervention even when investigations are reassuring.
- **Timing of delivery:** historical risk, current findings, prematurity and cumulative surgical risk had to be balanced.

- **Reproductive autonomy:** pregnancy after tubal ligation raised questions about consent, documentation, repeat sterilisation, affordability and respect for the woman's choices.

5. Missed Opportunities for Care

Stage	Identified gaps
Preconception	No consolidated obstetric history or systematic investigation of recurrent losses
Antenatal care	Fragmented records and no documented individualised high risk care plan
Investigations	Limited review of placental pathology, fetal examination and neonatal records
Tubal ligation	Inadequate documentation of the procedure, consent and histopathology
Psychological care	No structured assessment despite extensive pregnancy related trauma
Postpartum care	No structured follow up or long term cardiovascular risk assessment
Reproductive health	Cervical cancer screening about ten years overdue

These gaps were not attributed to any single provider. They reflected weaknesses in continuity and coordination across multiple facilities, which is the central system lesson of the case.

6. A Framework for Recurrent Adverse Outcomes

Step	Action
1. Reconstruct	Obtain a complete history: gestation at each complication, maternal conditions, fetal growth, placental findings, delivery indications and neonatal outcomes
2. Recognise	Identify the recurring pattern: miscarriage, stillbirth, pre-eclampsia, growth restriction, spontaneous preterm birth or neonatal death
3. Investigate and intervene	Target investigations to the pattern and provide individualised treatment
4. Maintain continuity	Coordinate preconception, antenatal, delivery, postpartum and long term care around one shared record

Investigations should follow the pattern identified, as summarised below.

Clinical pattern	Suggested investigations and interventions
Recurrent miscarriage	Antiphospholipid antibodies, thyroid function, uterine assessment and genetic studies where indicated
Second trimester loss	Cervical and uterine assessment, infection screening, and fetal and placental investigations
Recurrent stillbirth	Placental histopathology, fetal examination or autopsy, genetic evaluation and maternal investigations
Recurrent pre-eclampsia	Blood pressure, renal and liver function, urine protein, diabetes assessment and screening for antiphospholipid syndrome
Fetal growth restriction	Serial growth scans, Doppler studies, placental assessment and evaluation of maternal disease
Spontaneous preterm birth	Cervical assessment, infection screening and review of relevant maternal history
Recurrent neonatal death	Review of neonatal records; investigation for infection, congenital and genetic causes and maternal conditions

Treatment should address the cause identified, for example low dose aspirin with heparin in antiphospholipid syndrome, treatment of thyroid disease, cervical cerclage where indicated, and calcium supplementation where dietary intake is inadequate.

7. Continuity of Care

Stage	Priorities
Preconception	Review past outcomes, investigate and treat conditions, optimise health, discuss spacing and contraception; begin at least three months before a planned pregnancy
First trimester	Early booking, referral to a high risk clinic, early ultrasound, medication review, preventive measures and a written care plan
Second trimester	Fetal anatomy scan, cervical assessment where indicated, and monitoring of maternal conditions and fetal growth
Third trimester	Individualised maternal and fetal surveillance, and a delivery plan covering timing, mode and place
Postpartum	Blood pressure follow up, discussion of outcomes and recurrence risk, contraception, mental health screening and long term follow up

A single comprehensive obstetric record shared between facilities underpins every stage. In Kenya, the Mother and Child Health Handbook offers a practical, woman held vehicle for this continuity when it is completed consistently.

8. Whole Woman Care and Psychological Support

Women who experience repeated pregnancy loss may live with grief, anxiety, depression, relationship strain and community stigma. In this case, repeated loss had also affected marital and family relationships. The session recommended:

- A trauma informed approach to history taking that acknowledges both grief and hope.
- Avoiding unnecessary repetition of traumatic pregnancy histories by keeping a consolidated record.
- Screening for depression, anxiety and post traumatic stress disorder, with referral for psychological support.
- Assessing family circumstances and safety at home.
- Respecting reproductive autonomy and the woman's own preferences about future pregnancy.

9. Expert Perspective: Understand, Modify, Improve

The expert commentary distilled the management of recurrent adverse outcomes into three objectives: understand the underlying cause, modify the associated risks and improve pregnancy outcomes.

- **Preconception care:** remains underused in many African countries; conditions such as diabetes and thyroid disease should be identified and treated before conception.
- **First trimester screening:** assessment at 11 to 13 weeks, including nuchal translucency, structural review, ductus venosus and uterine artery Doppler, combined with maternal factors, helps identify pregnancies at risk of pre-eclampsia and growth restriction.
- **Prevention of pre-eclampsia:** early risk identification with low dose aspirin and calcium where indicated; first pregnancies should not be overlooked.
- **Avoiding unnecessary prematurity:** not every woman with pre-eclampsia needs immediate delivery; fetal biometry, growth velocity and umbilical, middle cerebral and uterine artery Doppler help time delivery safely.
- **Antiphospholipid syndrome:** the combination of recurrent loss, stillbirth and hypertensive disease in this case should have prompted earlier testing, allowing treatment with low dose aspirin and low molecular weight heparin.

10. Discussion Highlights

Participants asked whether a specialist ultrasound with cerebroplacental ratio and middle cerebral and umbilical artery indices had been performed before delivery at 33 weeks. A specialist scan had been reassuring during the first admission at 31 weeks, but only a standard obstetric scan was performed during the second admission, and the decision to deliver followed the next day. The discussion underlined the value of repeat Doppler assessment when the clinical picture changes. The moderator also encouraged the team to publish the case so that its lessons are preserved.

11. Challenges in African Settings

- Fragmented records across public, private and faith based facilities make it difficult to reconstruct obstetric histories.
- Preconception and interpregnancy care are rarely offered, so women enter each pregnancy with uninvestigated risk.
- Placental histopathology, perinatal autopsy, antiphospholipid testing and genetic studies are limited and often costly.
- Specialist ultrasound and Doppler services are concentrated in larger centres.
- Repeat caesarean sections accumulate surgical risk, including placenta accreta spectrum, in women with recurrent complications.
- Mental health support after pregnancy loss is scarce, and stigma may discourage women from seeking it.

12. Evidence Gaps

- African data on the causes of recurrent stillbirth and neonatal death remain limited.
- The best strategy for timing delivery when history and current surveillance disagree is not well defined.
- Access to and the cost effectiveness of first trimester screening programmes in African settings need evaluation.
- Models for shared, woman held or digital records across facilities require testing in routine care.

13. Session Notes

The session highlighted the WATOG Africa and European Menopause and Andropause Society global collaborative survey, launched on 18 October 2026 to assess knowledge, training and educational gaps in menopause medicine among obstetrics and gynaecology residents. At the time of the webinar it had received more than 1,390 responses, exceeding its initial target of 1,000, with a new target of 3,000, and participants were encouraged to complete and share it. The Qwiva Health clinical decision support platform was demonstrated, including its consult and study modes and referenced access to guidelines and research. The next case series session, hosted by Tunisia, will focus on cornual and interstitial ectopic pregnancy.

14. Key Takeaways

- **Reconstruct:** establish a complete obstetric and medical history rather than managing each pregnancy in isolation.
- **Recognise:** identify recurring patterns that point to maternal, placental, fetal or genetic causes.
- **Investigate:** undertake targeted investigations to establish the cause.
- **Intervene:** provide preventive and therapeutic interventions based on individual risk.
- **Plan:** document individualised pregnancy and delivery plans.
- **Support:** provide psychological, reproductive and social support alongside clinical care.
- **Follow up:** maintain continuity from preconception through pregnancy, delivery, postpartum and long term maternal health.