CASE REPORT

Not your average birth: considering the possibility of denied or concealed pregnancy

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SUMMARY

A 23-year-old woman presented to the emergency department (ED) with a 3-day history of lower back pain. She had seen her general practitioner 2 days previously who prescribed trimethoprim for a confirmed urinary tract infection. Routine admission observations showed she was tachycardic, tachypnoeic and slightly hypotensive but non-feverish with normal oxygen saturations. Her urine sample revealed that she was pregnant but was otherwise negative. The patient maintained that she was unaware she was pregnant. She was reviewed by an ED staff grade who was suspicious of a ruptured ectopic pregnancy. She was subsequently referred to the obstetrics and gynaecology registrar who on examination found she had a gravid uterus and vaginal examination revealed that her cervix was 8 cm dilated. The patient was very promptly admitted onto the labour ward for further assessment. She gave birth to a live male infant in the early hours of the next morning.

BACKGROUND

Denial of pregnancy is a woman's subjective lack of awareness of being pregnant or when a male partner contests or disputes the pregnancy.^{1 2} In clinical practice, pregnancy sometimes remains unrecognised until the end of the first trimester, especially in primiparous women who are unfamiliar with the symptoms.¹ However, in some cases, bodily symptoms of pregnancy (nausea, abdominal swelling and amenorrhoea) are absent and in many cases pregnancy is often not detected by relatives or by the partner where present.^{2 3} When pregnancy is denied throughout most of gestation, or even up to unexpected 'sudden' delivery, significant risks to mother and fetus may result from inadequate antenatal care, such as poor nutrition, fetal abuse, unattended or precipitous delivery.¹ There have been some published data on denied pregnancy, of which some have been case reports.^{1 4-7} The most recent figures suggest that the prevalence of denied pregnancy is 1/475 births, which is higher than previously thought.^{1 8 9} Furthermore, a significantly increased neonatal risk was confirmed for outcome parameters such as prematurity, low birth weight and small for gestational age.^{1 9} In contrast, concealed pregnancy is when a woman knows she is pregnant at a very early stage but deliberately does not tell anyone.¹ Various factors are thought to contribute to denied and concealed pregnancies, for example, a strict religious upbringing and taboo associated with premarital sex.^{1 4 5} The main health concerns accruing to concealed

pregnancy are the increased risk of stillbirths, neonatal death, neglect and other forms of harm to the baby and the likelihood of (usually undiagnosed) mental disorder in the mother.¹⁰

CASE PRESENTATION

A 23-year-old woman presented to the emergency department (ED) with lower back pain and nausea. She described a 3-day history of severe colicky lumbar back pain. She also reported dysuria, increased frequency and urgency of micturition for which her general practitioner (GP) had recently prescribed trimethoprim. She had presented to her GP several times over the preceding few months for generalised myalgia, malaise and recurrent urinary tract infections (UTIs), which she put down to being overworked and stressed. In the ED she did not have any abdominal pain or vaginal blood loss. She was sexually active but had been taking the combined oral contraceptive pill back-to-back for over 4 months and was adamant she had not missed any pills. The date of her last menstrual period was documented as 6 months ago, although the history was vague. The patient had a raised body mass index and full examination was delayed as the patient was very reluctant to lie flat due to the pain. Therefore, effective analgesia was sought before attempting a thorough examination. Her observations showed she was tachycardic and tachypnoeic with mild hypotension but was non-feverish with normal oxygen saturations.

The patient was initially managed in the ED with analgesia, intravenous fluid and an antiemetic. A cannula was inserted and immediate investigations included routine blood tests, urinalysis and a pregnancy test. The blood test results showed a deranged full blood count; her urine test was positive for β -human chorionic gonadotropin (β -hCG) but was otherwise negative. On disclosing the information to the patient in the ED, the patient and her partner seemed surprised and were unaware that she was pregnant. The obstetrics and gynaecology registrar was contacted on the grounds of haemodynamic instability associated with positive β -hCG in a patient with unknown dates. This picture was suggestive of early pregnancy with signs and symptoms indicative of a ruptured ectopic pregnancy. On examination the obstetrics and gynaecology registrar found that the patient had a gravid uterus up to the xiphisternum with a palpable head in the pelvis, obvious striae gravidarum and palpable abdominal contractions. Vaginal examination revealed her cervix was 8 cm dilated with a cephalic direct occipito posterior presentation.

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INVESTIGATIONS

Haematological results showed a raised white cell count $27.4 \times 10^9/L$ ($4\text{--}10 \times 10^9/L$), neutrophil count 25 ($1.8\text{--}7.5 \times 10^9/L$) and platelet levels 405 ($105\text{--}400 \times 10^9/L$). There was a decreased red blood cell count 2.97×10^{12} ($3.8\text{--}5.5 \times 10^{12}/L$) and haemoglobin 111 g/L ($120\text{--}150$ g/L). Biochemical results showed a positive β -hCG test at a value of 19750 iu/L ($0\text{--}5$ iu/L) and C reactive protein was raised at 44 mg/L ($0\text{--}5$ mg/L). The urinalysis results were 4+ for erythrocytes and 3+ for leucocytes.

OUTCOME AND FOLLOW-UP

The patient was transferred to the delivery suite and ultrasonography showed a fetus that was likely to be 35+5 weeks, bearing in mind that it is difficult to confirm an accurate due date when calculating gestational age based on a third-trimester ultrasound.¹¹ However, the baby looked to be well grown with normal dopplers and liquor. Over the course of the next few hours her labour progressed slowly and later her cardiotocography became pathological. She went on to have a category two caesarean section due to failure to progress, suspected fetal compromise and increasing maternal tachycardia. The patient requested to have a general anaesthetic for this procedure.

There were no maternal postnatal complications and the baby weighed 3040 g. Unfortunately, the baby's APGAR scores were initially poor scoring, 1 at 1 min, 2 at 5 mins but increased to 6 at 10 mins. There was concern that the baby had suffered hypoxic brain injury. After birth, the baby spent 2 weeks in the special care baby unit where he had some initial problems with breathing, feeding and had a few short-lasting seizures but was subsequently discharged home.

Owing to the circumstances in which the child was born and the potential neonatal risks associated with concealed and denied pregnancies, the healthcare professionals involved thought it was appropriate to complete a child protection referral form for safeguarding purposes.

DISCUSSION

In this particular case it was hard to truly establish whether this was a denial of pregnancy, a concealed pregnancy or a genuine surprise for the mother and her partner. Although the common symptoms of pregnancy include weight gain, abdominal striae and morning sickness, not all women can relate this collection of signs and symptoms to being pregnant. In this situation, clinicians should always consider the possibility of a concealed or denied pregnancy. Alternatively, there may be a number of other factors contributing to a woman's decision to tell others that she is pregnant; this may include the current family situation, religious reasons or financial implications. It may be necessary to assess women's mental capacity and also establish their sexual health and contraceptive knowledge, educating them if necessary. Men may also deny or dispute a pregnancy, although it is less widely reported due to the lack of studies focusing on denied paternity.² Previous research shows that men's doubts, denials or disputes of pregnancy are generally based on the credibility of the woman, questioning her moral or drinking behaviour, infidelity and spiteful intentions.²

This case reinforces the need for general and emergency practitioners to always be mindful of pregnancy, especially in a

woman who presents with recurrent UTIs, as was the case for this patient. Currently, there is very little literature pertaining to concealed and denied pregnancies and in particular, men's views about paternal responsibility. Therefore, there is a need for a larger retrospective study to be conducted. Are there other common factors in these women that we as clinicians are missing?

Learning points

- ▶ To maintain a high index of suspicion for pregnancy and its associated complications in women of childbearing years, regardless of their contraceptive history.
- ▶ A pregnancy test should be carried out in all women of a fertile age who present to primary care services with any symptom that could be attributed to pregnancy.
- ▶ To avoid delay of a thorough clinical examination even if the woman is in pain, as this may postpone necessary or lifesaving treatment.
- ▶ Concealment of pregnancy and denial of pregnancy are more common than previously thought. Healthcare professionals should safeguard the newborn and mother if denial of pregnancy or concealment of pregnancy is suspected.

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Competing interests None.

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