CASE REPORT

Recurrent vomiting in a woman due to miscarriage: think out of the box

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SUMMARY

A 25-year-old gravida 2 para 1 with 12-week amenorrhoea presented a second time for recurrent vomiting in pregnancy. She was diagnosed to have a missed miscarriage following absent fetal heart seen in an early scan. She opted for conservative management. However, on the third presentation, her vomiting continued. Repeated transvaginal ultrasound scan showed a fetus with a crown rump length of 19 mm, which is equivalent to 8 weeks and 4 days, with absence of fetal heart pulsation. Thyroid function tests and β human chorionic gonadotropin were then requested. Results showed that the patient's serum β human chorionic gonadotropin level was markedly raised to 147 000. A molar pregnancy was suspected. Her thyroid function tests came back normal. Suction curettage was performed and histopathology confirmed a partial molar pregnancy. On follow-up, the β human chorionic gonadotropin level was normal by 7 weeks after the curettage.

BACKGROUND

The diagnosis of miscarriage was made based on the finding of a normal appearing fetus with crown rump length (CRL) of more than 7 mm, with absent fetal heart pulsation. There were no other findings to suggest a molar pregnancy, such as a snow storm appearance. However, the clinical presentation of recurrent vomiting did not correspond to a missed miscarriage. One should consider other differential diagnoses such as a molar pregnancy, as the management is crucial and different.

CASE PRESENTATION

A 26-year-old gravida 2 para 1 at 12 weeks of amenorrhoea presented with a 2-day history of vomiting. She continued vomiting for 7 days and was not able to tolerate an oral diet. This was her third presentation with similar symptom.

She had earlier been treated for hyperemesis gravidarum. It was noted that she had a missed miscarriage based on ultrasound findings. At that time, management options of miscarriage were discussed with the patient. These included conservative, medical or surgical management and she opted for conservative management.

Owing to persistent vomiting, she had further blood tests including β human chorionic gonadotropin (hCG) and thyroid function tests. Repeat transvaginal ultrasound scan showed findings similar to her first scan.

Otherwise, she had undergone a vacuum delivery in her first pregnancy, which was uneventful.

She was not known to have any medical or surgical illness. She was not on any medications and not known to have a drug allergy.

INVESTIGATIONS

Transvaginal ultrasound showed CRL of 19 mm and absent fetal heart pulsation (figure 1). She had a normal thyroid function test. Her β hCG level was 147 055 IU prior to suction curettage. One week postsuction, the β hCG dropped to 2743 IU and β hCG returned to a normal level of <5 IU 7 weeks after suction curettage. Baseline chest X-ray was normal. The histopathology report of product of conception confirmed the diagnosis of a partial hydatidiform mole.

DIFFERENTIAL DIAGNOSIS

Hyperthyroidism complicating pregnancy.

TREATMENT

Suction and curettage was carried out for histopathological diagnosis of product of conception. Intraoperatively, the product of conception resembled vesicles, which was consistent with a molar pregnancy. Weekly β hCG level monitoring was performed with the aim of normalisation of β hCG level within 7 weeks of suction and curettage.

OUTCOME AND FOLLOW-UP

The patient was advised to use a barrier method of contraception until normalisation of hCG prior to hormonal contraception. Subsequently, her monthly β hCG levels reached a normal value. After 7 weeks of follow-up it was noted that her β hCG level had returned to normal. She was advised to wait at least 6 months after normalisation of her β hCG before attempting to conceive again. She was also counselled to monitor her β hCG level 6 weeks after each episode of pregnancy regardless of the outcome of the pregnancy, in order to ensure no disease recurrence.

DISCUSSION

Miscarriage affects one out of four pregnancies. Common symptoms of pregnancy, including nausea and vomiting, usually occur in early pregnancy due to raised β hCG levels. The symptoms usually subside by the second trimester. In the case of a miscarriage, symptoms of early pregnancy such as nausea and vomiting will usually subside as the level of β hCG decreases. It is very uncommon for a patient to present multiple times due to nausea and vomiting because of a miscarriage.

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Figure 1 Transvaginal ultrasound features.

In this case, the diagnosis of miscarriage was made solely based on absent fetal heart pulsation on ultrasound scan. When in doubt, transvaginal ultrasound scan is the method of choice in assessing the viability for early pregnancy. The National Institute for Health and Care Excellence advocates repeat ultrasound scanning in 7 days if CRL is noted to be more than 7 mm with absent fetal heart pulsation prior to diagnosis of miscarriage.¹ In this patient, a repeat transvaginal ultrasound, performed 7 days later, had similar findings. Hence the diagnosis of missed miscarriage was made. There were no findings to suggest a molar pregnancy.

Nevertheless, the patient's symptoms persisted during the third presentation. The challenge presented to the medical doctor who attended her the third time was the need to re-evaluate the whole history, physical examination findings and investigation results in the presence of a diagnosis that had already been made. One could easily mistakenly diagnose her as having a missed miscarriage.

A blood test for β hCG was not part of the initial investigations for a missed miscarriage. It was only requested during her third presentation. Hence a revised diagnosis of molar pregnancy could be made. If the initial diagnosis was not revised, the patient could be wrongly managed for a missed miscarriage, hence leaving her with the risk of undiagnosed gestational trophoblastic disease. While the treatment option for missed miscarriage can be conservative, medical or surgical, the treatment option for a partial mole is via suction and curettage.

Although the outcome of the disease after treatment is usually good, gestational trophoblastic neoplasia can occur after gestational trophoblastic disease at any later time. This brings us to the importance of long-term follow-up of the patient. In some countries, patients who have a gestational trophoblastic disease will need to be registered at a specialised centre. This centre will then follow-up the patient to ensure normalisation of the β hCG level. The length of follow-up will depend on the time taken for the β hCG to normalise in relation to the time of suction curettage. The patient is advised to use a barrier method for contraception until the β hCG level has normalised. Once normalised, combined contraceptive methods as well as intra-uterine contraceptive devices can be used. β hCG levels need to be taken 6–8 weeks after the end of each future pregnancy in order to rule out persistent disease. There is a 0.5% risk of women with a partial mole needing chemotherapy due to persistent molar pregnancy.²

Learning points

- ▶ When making a diagnosis, take into account the history, physical examination and investigation results.
- ▶ Solving the mystery is akin to making up a picture by correctly joining the pieces of a jigsaw puzzle. If a piece does not fit, reconsider your diagnosis.
- ▶ In a patient who presents repeatedly with similar symptoms, one should reconsider the diagnosis in order to ensure that the right diagnosis and treatment is given to the patient.

Competing interests None declared.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

REFERENCES

- 1 Ectopic pregnancy and miscarriage: diagnosis and initial management in early pregnancy of ectopic pregnancy and miscarriage. National Institute of Clinical Excellence guidelines [CG154] Published date: December 2012.
- 2 The management of trophoblastic disease. Green-top guideline no. 38. Royal College of Obstetricians and Gynaecologists. February 2010.

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