Repeated Pregnancy Wastage

By F. J. SCHOENECK, M.D.

PRECONCEPTIONAL study, treatment, and other medical attention for women whose pregnancies repeatedly end in misfortune have been accepted as a hope of reducing pregnancy wastage.

I have previously reported that a relatively small group of childbearing women account for a disproportionately high percentage of such wastage (*1*). Schlesinger and Allaway (*2*) state that the expectation of perinatal loss among women with a history of previous child loss was 2.7 times greater than among multiparous women without such loss. They concluded: "This trend toward further narrowing of the problem of perinatal loss points to the need for increased concentration of research and public health services on the vulnerable group of women who present a history of previous child loss." Randall, and associates (*3*) state: "When all other factors were disregarded and the outcome of the present pregnancy was compared among women with good obstetrical history and those with poor obstetrical history, abortion was found to have occurred 20 times more frequently when the previous obstetrical history was 'poor'."

Other articles of the general nature of those quoted are appearing in medical literature. The Syracuse Department of Health is reporting here the pregnancy outcomes of a group of women selected specifically because of their poor obstetrical histories.

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Pregnancy Outcomes

Clinical histories of these women have been gathered in the past 2 years from sources in and around Syracuse, N. Y. These sources included private records, completed prenatal clinic records, and histories obtained by public health nurses in patient interviews in connection with the department's current survey of pregnancy outcomes. The histories were collected primarily as "matching controls" to compare with the histories of patients attending our local prepregnancy treatment clinic.

The material consists of the obstetrical histories of 135 patients who had completed 653 pregnancies (an average of 4.8 pregnancies per patient). There were 3 sets of twins among the 135 patients; 126 (93.3 percent) were white and 9 (6.6 percent) were Negro; 75 (55.5 percent) were private patients, and 60 (44.5 percent) were service cases. Four patients, (2.9 percent) had definite Rh problems.

Outcomes of 653 pregnancies, according to the histories of these 135 patients, were:

	Number	*Percent*
Living babies	201	30. 8
Term	141	21. 6
Premature	60	9. 2
Unsuccessful pregnancies	452	69. 2
Postnatal deaths:		
Term	8	1. 2
Premature	64	9. 8
Stillborn	49	7. 5
Abortions	324	49. 6
Ectopic pregnancy	7	1. 1

Of the total of 653 pregnancies, 12 babies (1.8 percent) had congential anomalies. Of 201 living children, 3 (1.4 percent) had retrolental fibroplasia.

Unfortunately, the information available is not sufficiently complete to allow epidemiological analysis. Such an approach to each patient might establish whether these women have more in common than their obstetrical history. Identification of such common factors is a step toward their elimination or control.

There is some question in our minds about the complete reliability of the retrospective observations of these women, but we are gathering data from our continuing study which we hope will provide clues for further preventive and remedial action.

Reduction in infant loss and salvage of babies from unusual pregnancies have certainly not kept pace with the reduction in maternal mortalities. Pregnancy salvage for the minority of unsuccessful patients is a challenge to the public health-obstetric-pediatric team.

Comments

We subscribe to the current methods of correction as exemplified by the present programs in New York City, Chicago, and New York State, outlined by Yankauer (*4*) and by various other professional groups and health agencies. In general these programs aim at improving care during the prenatal, labor, and delivery periods, and pediatric care.

Our previous studies in the field of unsuccessful pregnancies would seem to indicate that fetal salvage is essentially an obstetrical problem (*5*). Hughes (*6*) in speaking of fetal salvage states: "Although we believe that all these standards should be carried out carefully; that prenatal care should be improved; that pediatric care after birth should be made better, we are of the opinion that in order to reduce the infant death rate to a new low in this country, we must take a more specific approach to the problem."

One example of a specific approach is the preconceptional study and prophylactic treatment of women with a history of repeated unsuccessful pregnancies, as carried out by Hughes and his group in Syracuse. Many other types of study are necessary to cope with the obstetrical complications so often associated with abortion or fetal loss.

Public health activities can play important roles in such a program. As an example, in Syracuse we are trying to find women who have or probably will have unsuccessful obstetrical experiences so that they may be studied and perhaps helped to bear healthy babies.

Women with habitual pregnancy loss should be recognized as having specific problems worthy of consideration from all interested medical groups.

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