



Debates Surrounding the Management of Inevitable Abortion: Two Case Reports

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Citation: Tesfai B, et al. Debates Surrounding the Management of Inevitable Abortion: Two Case Reports. *J Women Health Res.* 2026;1(1):1-4.

<https://doi.org/10.46889/JWHR.2026.1102>

Received Date: 07-05-2026

Accepted Date: 25-05-2026

Published Date: 02-06-2026



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Abstract

Two multiparous mothers presented with fluid leakage at 23 weeks. The diagnosis of inevitable abortion was made. The fetuses did not expel. The mothers were counseled for termination due to concerns about chorioamnionitis. Both patients declined termination. With conservative management involving antibiotics, dexamethasone, MgSO₄ and strict inpatient monitoring, both women reached near-term pregnancy and delivered active neonates. This raises the question: Should all inevitable abortions with fluid leakage at the pre-viable level be terminated if there are no signs of chorioamnionitis?

Keywords: Inevitable Abortion; Chorioamnionitis; Conservative Management

Introduction

The limit of viability is the stage at which a fetus has a reasonable chance of survival outside the uterus. Defining this threshold is important to avoid unnecessary interventions, but it remains challenging due to uncertainty in predicting outcomes for extremely preterm infants [1]. Survival rates vary across institutions, partly due to differences in clinical management. Care at this stage is individualized, with decisions guided by maternal preferences and clinical factors. Neonatal resuscitation is generally not offered before 22 weeks but may be considered between 22 and 24 weeks depending on prognosis and parental wishes [2].

Guidelines from the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recommend considering antenatal corticosteroids from around 22 weeks, with repeat dosing if needed [2]. Antibiotics may prolong latency and improve outcomes, although evidence for their use in previable PROM is limited. Magnesium sulfate is used for neuro-protection when delivery is imminent [3]. Other interventions, such as tissue sealants, lack sufficient evidence for routine use, as noted by the Cochrane Collaboration [4].

Outcomes in PROM before 28 weeks depend mainly on prematurity, infection and oligohydramnios. Infection, especially chorioamnionitis, is common, while prolonged oligohydramnios can lead to serious complications. Although survival improves with increasing gestational age, significant morbidity remains frequent [5]. Historical and recent studies show that expectant management may prolong pregnancy but is associated with variable survival and high rates of neurological impairment [6].

Due to ongoing uncertainty, the American College of Obstetricians and Gynecologists does not provide firm recommendations on immediate delivery versus expectant management [6]. Management is largely determined by gestational age, with expectant care generally recommended before 34 weeks in the absence of complications and individualized decision-making thereafter. Practices may vary by institution, as seen in Parkland Hospital, where earlier delivery is often preferred due to resource considerations [6].

Case Report

The first case was a 28-year gravida 3 parity two mother who presented with rupture of membranes at 23 weeks gestation associated with mild lower abdominal pain of 4 hours duration. She had a history of vaginal discharge, but denies vaginal bleeding, urinary complaints or fever. On physical examination, she was stable with vital signs of blood pressure 120/70 mmHg, pulse rate 76 beats/minute and temperature of 36.7°C. The abdomen was gravid with gestational age corresponding to 24 weeks, non-tender and moved with respiration. On sterile speculum exam, leakage of amniotic fluid was detected from the posterior fornix and cervical os was closed. Trans-abdominal ultrasound revealed a single viable fetus with adequate amniotic fluid and CBC was within the normal limit.

With the assessment of inevitable abortion, she was started on antibiotics and conservative management was decided to expect labor expedites in the first 24 hours. The management option of termination of the pregnancy was discussed with the patient and she didn't agree and decided on continuation of the pregnancy. On subsequent assessment, the fluid leakage decreased, she had no labor pain and she was covered with antibiotics and monitored for the signs and symptoms of chorioamnionitis. Unfortunately, she had none of the signs and symptoms of these complications and the leakage stopped. She was discharged with weekly follow-up for fetal and maternal evaluation.

After about ten days, she returned with the complaint of fluid leakage per-vagina, but it was negative on speculum examination. Even though she was admitted to the ward and monitored for any complications, she had no reported neonatal and maternal complications except the frequent fluid leakage. After one week of hospital admission, all investigative modalities were within the normal limits and she was followed as an outpatient on a weekly basis and to come early if she had any signs of complications.

Subsequently, after about two weeks, she again reported recurrent fluid leakage and was admitted to MCH2 for further management. She reached 30 weeks and started on dexamethasone 6 mg IM BID for 2 days, MgSO₄ for neuro-protection and antibiotics for prevention of chorioamnionitis. The fluid leakage decreased and she was monitored for about seven weeks in the ward. When she reached near term (36 weeks and 5 days), she was delivered by cesarean section for severe oligohydramnios and abnormal Doppler flow on ultrasound. The outcome was a 2.2 kg active neonate with Apgar scores of 7 and 9 in the first and fifth minutes on 24/05/25. Postoperatively, she was covered with antibiotics and discharged without sequel with her neonate.

The second case was 22-year-old gravida 2 parity 1 mother with previous cesarean section for primi breech, presented with leakage of fluid and back pain of one day duration. She didn't know her LMP, but she claims amenorrhea of six months. She had no vaginal bleeding, vaginal discharge or abdominal pain. She had no similar problem in her previous pregnancy and she denied fever and urinary complaints. On physical examination, she was stable and all vital signs were within the normal range. Abdomen was soft which corresponds to 22 weeks with positive fetal heartbeat. Sterile speculum exam was done and fluid leakage wasn't detected and cervical os was closed. Ultrasound revealed adequate amniotic fluid with a single viable fetus of GA 23 weeks. CBC revealed mild leukocytosis.

With the assessment of inevitable abortion, she was started on antibiotics and expectantly to expel the fetus. On subsequent assessment, the fluid leakage continued, but labor didn't progress and the fetus wasn't expelled. Even though she had no clinical signs of chorioamnionitis, she was counseled for possible pregnancy termination as the pregnancy was far from the previable limit. She disagreed with medical advice for termination and the pregnancy continued with strict hospital monitoring and antibiotics. The fluid leakage decreased and she had no clinical signs of chorioamnionitis. After two weeks of hospital admission, she was discharged with close follow-up and advice on a weekly basis.

On subsequent follow-ups, she had recurrent admissions for the same complaint and she was managed conservatively as she

was strongly against termination of pregnancy. All investigative modalities did not detect any abnormality. She had no clinical signs of chorioamnionitis and dexamethasone was given for lung maturity and $MgSO_4$ for neuro-protection. Surprisingly, she reached early term of 37 weeks and delivered a 2.5 kg active neonate by cesarean section for previous CS and oligohydramnios on 28/05/2025. She was discharged with her neonate after 04 days' hospital stay without complications.

Discussion

Management of preterm Premature Rupture of Membranes (PROM) at or before the limit of viability differs substantially from management at later gestational ages, as the balance between the risks of expectant management and immediate delivery is markedly different when pregnancy is far from term. In the present cases, membrane rupture occurred during the second trimester; however, spontaneous expulsion of the fetus did not occur. Given the extremely poor prognosis at this gestational age, termination of pregnancy was considered a reasonable option based on maternal indications. Both patients were initially admitted and received antibiotics along with maternal and fetal monitoring. During subsequent episodes of symptoms, they were managed in the hospital and later discharged once clinically stable, with strict follow-up arrangements. Consistent with this approach, previous studies recommend hospitalization for women with preterm PROM (PPROM), with the possibility of home management only after at least 48 hours of stable inpatient observation [7]. Therefore, continued hospital-based care is important to monitor for maternal and fetal complications until a definitive decision regarding delivery is made. Neither patient had identifiable risk factors for membrane rupture or a prior history of PPRM. Additionally, neither developed clinical chorioamnionitis or postpartum endometritis. Evidence suggests that in cases complicated by intrauterine infection, prompt intravenous antibiotic therapy combined with early delivery is recommended [7]. Both patients were counseled regarding pregnancy termination due to the high risk of chorioamnionitis and the previable gestational age. However, they declined termination and opted for conservative management. Literature indicates that, in previable pregnancies, careful discussion of the risks and benefits of expectant management versus termination is essential [1]. Furthermore, ongoing counseling and psychological support play a critical role in managing this complex obstetric condition [5]. Parents should also be informed that antenatal glucocorticoids may improve survival but may increase the likelihood of survival with severe impairment [8]. Thus, comprehensive counseling regarding the risks of preterm birth and infection is crucial for informed decision-making.

In these cases, management included antibiotics, dexamethasone, Magnesium Sulfate ($MgSO_4$) for fetal neuro-protection and close inpatient monitoring. Ultimately, both pregnancies progressed to term, resulting in the delivery of viable neonates. These outcomes raise an important clinical question regarding the optimal timing of such interventions whether they should be initiated early, even when delivery is not imminent or reserved until delivery is anticipated. Evidence from a case series with PROM before 23 weeks suggests that antibiotic therapy is associated with prolonged latency and improved neonatal outcomes [8]. Magnesium sulfate is typically administered when delivery appears imminent, while antenatal corticosteroids are recommended before 34 weeks' gestation, particularly if delivery before 32 weeks is expected [7]. Administration of corticosteroids as early as 22 weeks may be considered if delivery at 23 weeks is anticipated [8].

These cases also highlight the question of whether all cases classified as inevitable abortion with fluid leakage should undergo termination in the absence of infection. Studies suggest that, in cases of membrane rupture remote from term especially near the limit of viability clinical management can significantly influence both maternal and neonatal morbidity. Nevertheless, rupture before fetal viability remains associated with substantial risks regardless of management strategy [8]. Survivors often experience at least one major neonatal complication. Conservative management of PPRM before 21 weeks is associated with particularly poor outcomes and although survival improves after 22 weeks, significant neonatal morbidity remains common [9]. In the present cases, termination could have been justified when PPRM occurred before the limit of viability, particularly prior to 28 weeks' gestation. However, evidence indicates that beyond 22 weeks, management often involves expectant observation with close ultrasonography and microbiological surveillance [5]. After 25 weeks, management becomes more proactive, incorporating antibiotics, tocolytics and corticosteroids to prolong latency and improve neonatal outcomes [5]. It is important to note that management approaches may vary across settings, particularly in regions with advanced neonatal intensive care capabilities and higher survival rates for extremely preterm infants.

Conclusion

Rarely, in self-selected previable pregnancies, if chorioamnionitis does not develop, these cases progressed to viable near-term pregnancy under strict fetal and maternal monitoring with live delivery.

Conflict of Interest

The authors declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

Funding Statement

This research did not receive any specific grant from funding agencies in the public, commercial or non-profit sectors.

Acknowledgement

Authors acknowledge all staff and patients of the hospital for inpatient care and follow-up.

Data Availability Statement

The data supporting the findings of this study are available from the corresponding author upon reasonable request.

Ethical Statement

The project did not meet the definition of human subject research under the purview of the IRB according to federal regulations and therefore was exempt.

Informed Consent Statement

Written informed consent was obtained from the patient to use her data for educational purposes.

Authors' Contributions

All authors have contributed to writing the case report and all reviewed and approved the final version of the case report.

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