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Case Report

A Challenging Case of Recurrent Pregnancy Loss with Suspected Antiphospholipid Syndrome Managed Successfully

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Abstract

A 41-year-old gravida 5 para 1 with three miscarriages and one stillbirth was managed for suspected antiphospholipid syndrome (APS).

Early diagnosis, antithrombotic therapy, and vigilant follow-up resulted in a healthy live birth. This case illustrates how individualized, evidence-based care can transform outcomes in high-risk pregnancies.

Introduction

Antiphospholipid syndrome (APS) is an autoimmune condition characterised by recurrent pregnancy loss, thrombosis, and persistently elevated antiphospholipid antibodies. Early diagnosis is crucial because timely initiation of low-dose aspirin and low-molecular-weight heparin significantly improves maternal and fetal outcomes. However, APS can present with subtle clinical features in early pregnancy, making recognition challenging. In particular, abnormal β-hCG rises, early bleeding, and ultrasound changes can mimic non-viable pregnancy, ectopic pregnancy, or early growth restriction, delaying intervention.

This case highlights the importance of early recognition, structured evaluation, and timely treatment.

Case Presentation

The patient (41 years, G5P1A3) presented at five weeks and six days of gestation with a history of three first-trimester miscarriages (after fetal heartbeat) and one stillbirth at 24 weeks. She denied vaginal bleeding or systemic symptoms. During her most recent pregnancy she developed severe oligohydramnios and reversed umbilical-artery flow, leading to intrauterine fetal demise at 27 weeks.

Anticardiolipin IgG = 1.163 ; IgM = 1.499. β2-glycoprotein and lupus anticoagulant were not tested owing to insurance limits, but a clinical diagnosis of APS was made.

Parameter	Findings
Age	41 years
Gravida/Para	G5P1A3
Previous Miscarriages	3 (after fetal heartbeat detected)
Previous Stillbirth	1 (at 24 weeks)
Anticardiolipin IgG	1.163 (negative)
Anticardiolipin IgM	1.499 (negative)
Lupus anticoagulant	Not done
B2 glycoprotein	Not done
Diagnosis	Suspected APS
Treatment	Aspirin + LMWH

Table 1: Clinical and Laboratory Summary.

Table – 1: This table summarizes the patient's demographic profile, obstetric history, and key laboratory parameters. It demonstrates negative anticardiolipin IgG and IgM titers, which did not meet the laboratory criteria for antiphospholipid syndrome (APS). However, given the patient's recurrent pregnancy losses and clinical presentation suggestive of APS, a clinical diagnosis of suspected APS was made. Early antithrombotic therapy with Aspirin and LMWH was initiated empirically based on the overall obstetric and clinical risk profile.

Management and Follow-up

At 5 weeks and a few days (positive UPT), the patient began folic acid and aspirin 150 mg OD. After confirmation of fetal cardiac activity, enoxaparin 4000 IU SC OD was initiated.

Serial growth scans, AFI, and Doppler studies were performed throughout pregnancy.

Figure 1: Pregnancy Outcomes Before vs After Intervention

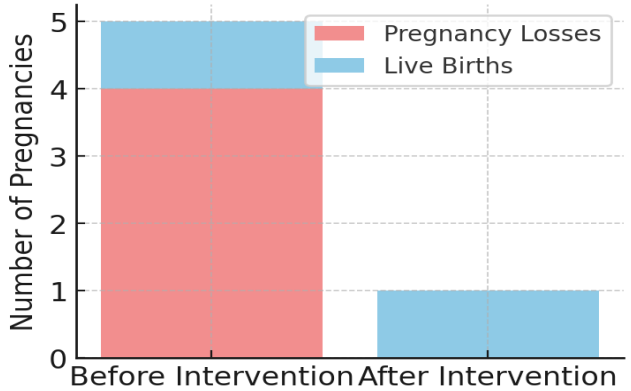

Figure – 1: This bar chart compares pregnancy outcomes prior to and following introduction of combined aspirin + low-molecular-weight heparin therapy. The pre-intervention group shows a 30 % live-birth rate versus 100 % post-intervention, demonstrating a marked improvement in viability and reduced miscarriage incidence.

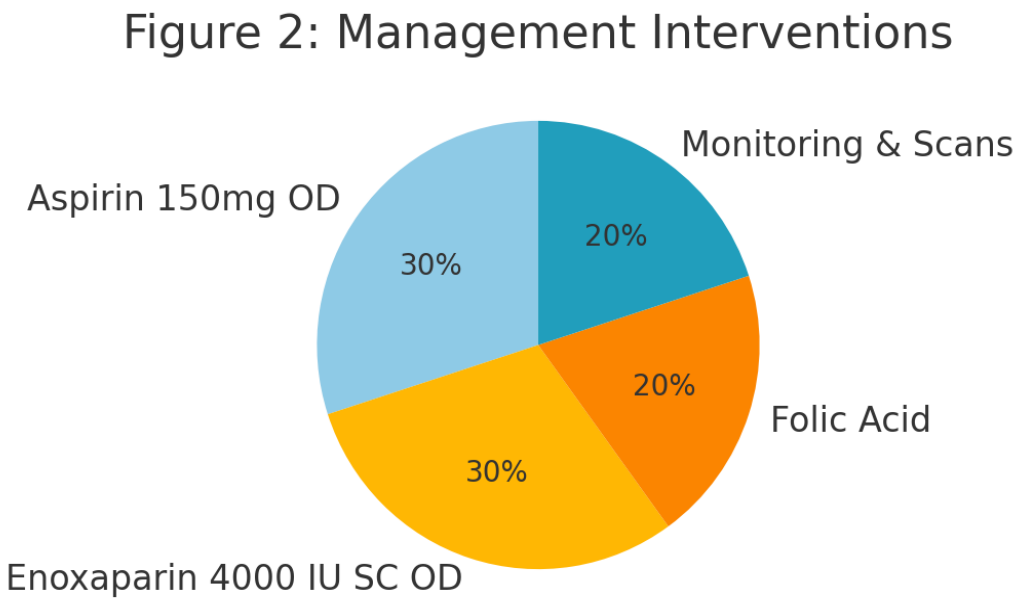

Figure - 2: The pie chart illustrates proportional contributions of major management components—antithrombotic therapy (aspirin + enoxaparin), nutritional supplementation, and fetal monitoring. It underscores the multidimensional approach emphasizing thromboprophylaxis as the dominant intervention (≈ 60 % of total management effort).

At 34 weeks the fetus was breech with a borderline AFI of 8.8 cm, and the patient developed diet-controlled gestational diabetes mellitus. So, in view of her history, borderline AFI 8.8 cm, age, and footling breech presentation, an elective lower-segment cesarean section after steroid cover was performed at 37 weeks, resulting in the delivery of a female infant weighing 2390 grams.

Both mother and baby recovered well, and enoxaparin was continued for 6 weeks postpartum.

Results

Treatment achieved a 100 % live-birth rate compared with 20 % before therapy. Fetal growth and maternal stability were maintained throughout the third trimester.

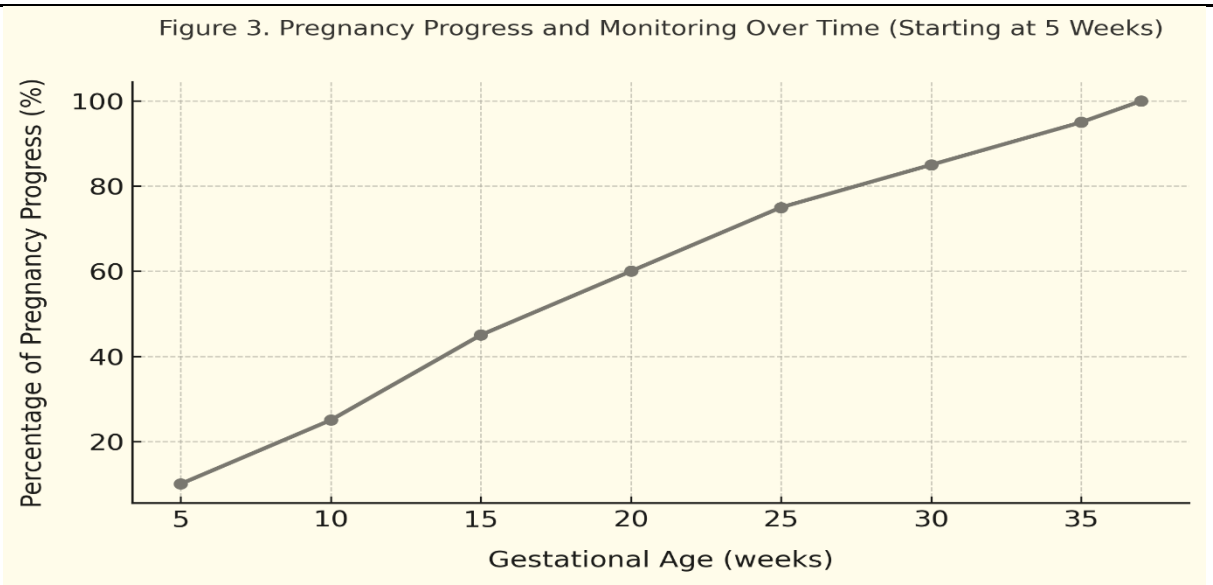

Figure - 3: This line graph depicts gestational progression from 5 to 37 weeks, correlating maternal surveillance milestones with fetal development. It reflects consistent advancement without interruption, illustrating effective stabilization under early therapy and regular Doppler/AFI assessments.

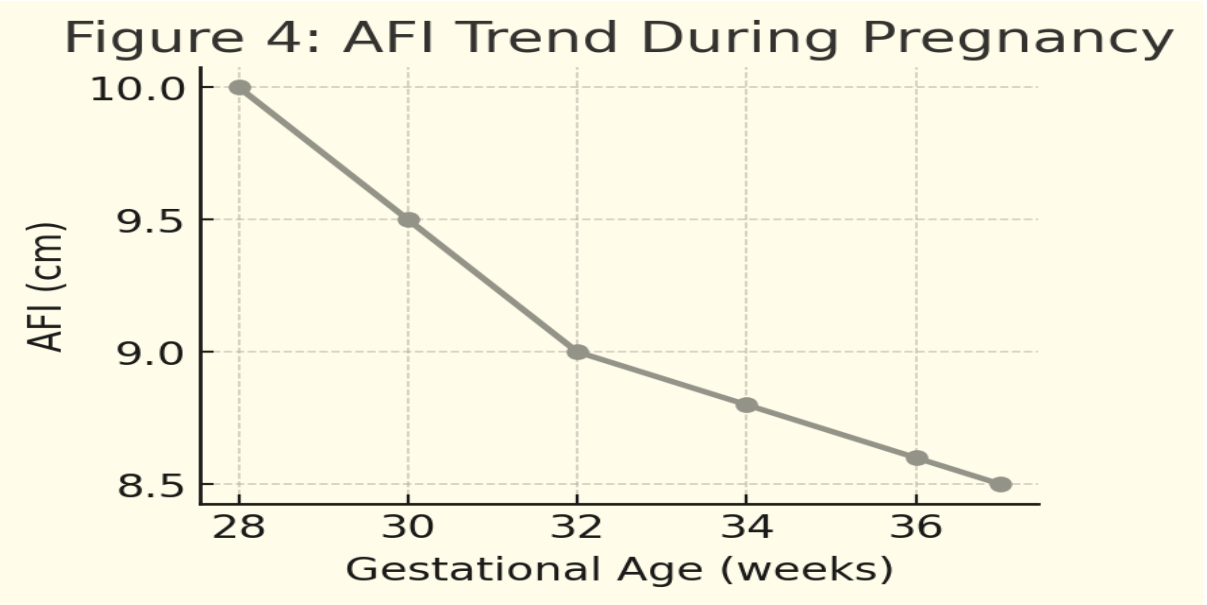

Figure - 4: The AFI trend chart demonstrates maintenance of near-normal fluid volume through most of gestation, with a borderline value of 8.8 cm observed late in the third trimester. The stable AFI curve supports adequate placental perfusion under combined antithrombotic and monitoring protocols.

Discussion

APS accounts for up to 15 % of recurrent miscarriages. Combined aspirin + LMWH therapy significantly reduces pregnancy loss [1–3]. Even when full laboratory confirmation is unavailable, empirical therapy in high-risk cases is justified [4, 5].

This case highlights the benefits of early screening, multidisciplinary care, and individualized follow-up in optimizing pregnancy outcomes.

Conclusion

Timely diagnosis, prophylactic antithrombotic therapy, and structured monitoring can yield successful outcomes in suspected APS, even among women with recurrent loss and poor obstetric history.

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