Journal of Case Reports and Scientific Images

E-ISSN: 2708-0064
P-ISSN: 2708-0056
IJCRS 2023; 5(1): 05-08
www.allcasereports.com
Received: 06-10-2022
Accepted: 13-11-2022

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A case report of adolescent pregnancy denial in which an unsuspected labour in a hotel room resulted in a near miss

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DOI: https://doi.org/10.22271/27080056.2023.v5.i1a.56

Abstract
Denial of pregnancy or cryptic pregnancy is a common and underdiagnosed medical condition which could be a big challenge in adolescent pregnancy. This is a case report of cryptic pregnancy in an in-school adolescent in which unsuspected labour in a hotel room resulted in a near miss.
As denial of pregnancy is highly unpredictable and underdiagnosed, it has become imperative to have a high index of suspicion to be able to capture more people, especially the highly vulnerable adolescents that have the condition. At the primary level of prevention, sexual and reproductive health information, education and care, central to which is adolescent contraception, is Hobson's choice in secondary school educational curriculum.

Keywords: Denial of pregnancy, cryptic pregnancy, adolescent, near miss, Nigeria

Introduction
Pregnancy denial, otherwise known as cryptic pregnancy, is a refusal to accept that one is pregnant, It is a common but underdiagnosed medical condition that is of great reproductive health challenge [1, 2]. It cuts across all the subsets of reproductive age group, with no particular age preponderance or clear cut demographic characteristic [3]. It could be a big challenge in teenage pregnancy in which, if not recognized and handled appropriately, it could result in serious maternal and perinatal morbidity and mortality [2, 4]. Incidences ranging from 1 in 400 to 1 in 516 at 20 weeks gestation; and 1 in 245 to 1 in 2,500 at term have been quoted in different studies [3].
In pregnancy, a woman is expected to undergo some physical and emotional development which brings about adaptation to maternal roles of physiologically accepting the pregnancy, emotionally attaching to the unborn child and birth preparedness [3]. However, in denial of pregnancy, these mechanisms are inhibited and the woman temporarily or totally denies her pregnant state during the gestational period [3]. A study linked the mechanisms of this inhibition to life stress and psychological conflicts [5].
Pregnancy denial is of two variants [3], psychotic and non-psychotic; with the non-psychotic variant being commoner. The sub-variants of pregnancy denial include; pervasive denial in which emotional attachment and existence of pregnancy are denied; affective, in which the woman is aware of being pregnant but refuses to get prepared for labour and delivery; and persistent sub-variant, in which the woman only recognizes the pregnancy in the third trimester and makes no move to prepare for delivery. Pervasive, affective and persistence denials have incidences of 36%, 52% and 11% respectively [6].
Complications of pregnancy denial include depression, substance abuse, lack of antenatal care, unassisted labour with its attendant life threatening complications, precipitous delivery occurring in odd environments, child neglect and neonaticide [3, 7]. Management of pregnancy denial can be as challenging as the clinician is faced with ethical and legal dilemmas especially in the areas of determining maternal capacity in taking decision and knowing the best interest of the mother/baby [6]. Challenges and complications of pregnancy denial in teenagers could, most times, be more enormous in adolescents because of their relative physical, emotional and psychological immaturity [6, 8].
This case report is that of an eighteen-year-old university undergraduate managed as a case

of pregnancy denial in which unsuspected labour in a hotel room culminated in a near miss. This report will give an overview of this interesting and important underreported obstetric challenge; especially in the adolescent age bracket in which the situation can be more disastrous. Interestingly, there is paucity of data on cryptic or denial of pregnancy in adolescents; therefore, this report will be one of the few cases of cryptic pregnancies in adolescents described in sub-Saharan Africa [9]. The study would contribute appreciably to the existing body of knowledge on the holistic picture and management of pregnancy denial in adolescents.

Patient and Management

It was an eighteen-year-old unbooked primigravida, now primipara, of Yoruba ethnicity, Christian and university undergraduate who was rushed into the emergency obstetric unit of Ekiti State University Teaching Hospital, Ado-Ekiti, Nigeria in an unconscious state by her boyfriend (residing in Lagos, who came to pay her a visit in Ado- Ekiti) in the late hours of the day of presentation. Informants were initially her boyfriend, later her mother and patient herself when she regained consciousness. Her boyfriend brought her from one of the hotels in the neighbourhood (where they were both lodging) and gave a history of 2 episodes of tonic-clonic convulsion and loss of consciousness within 30 minutes before presentation.

She was observed to have started convulsing, following about 2hours' history of frontal headache and dizziness. She had earlier been having on and off abdominal pain for about 2 days, which she thought was her usual menstrual pain. The abdominal pain was associated with blood stained mucus per vaginam and passage of foul smelling watery vaginal discharge. She had earlier requested her boyfriend to help her get buscopan, ibuprofen and antibiotics to treat the menstrual pain and the foul smelling watery vaginal discharge. She could not remember her normal last menstrual period (LMP) as she had been having skipped periods (seeing menses 3 to 5 monthly) since she attained menarche. She had been having recurrent nausea with no vomiting, which she thought was part of her premenstrual symptoms; and the mother admitted that she had been gaining weight excessively in the preceding 3 months, which she thought was part of her usual fatness. No pregnancy test was done and the patient, as well as her informants, denied pregnancy initially until it was convincingly demonstrated to them that she was pregnant and that a baby was delivered to her.

She attained menarche at 15 years and her first sexual experience (coitarche) was about a year before presentation and had it with the boyfriend whom she claimed was her only sexual partner. She was aware of modern contraceptive methods but had not used any. She was not a known epileptic or psychiatric patient and there was no family history of such. She was the first child in a monogamous family of three children, father was a panel beater and mother, a hairdresser and they were staying together. Patient was well taken care of in school and there was no history of poor academic performance or any social challenges.

Significant findings at presentation included an unconscious young lady with a Glasgow coma scale of 5 (eye opening, 1; best verbal response, 1; best motor response, 3), obese with a body mass index (BMI) (measured after delivery when being conscious and ambulatory) of 38.9 kg/m^2 (weight = 105 kg, height =1.64 m), centrally cyanosed, severely dehydrated, not pale, febrile (39.8 °C), bilateral pitting pedal oedema extending up to mid leg. Blood Pressure was 180/120 mmHg. She had a respiratory rate of 50 breaths per minute; with fine bilateral basal crepitations on auscultation. Her abdomen was uniformly enlarged with symphysiofundal height (SFH) of 45 cm, fetus in longitudinal lie, cephalic presentation, 3 contractions palpated in 10 minutes each lasting an average of 45 -50 seconds, fetal heart sound not heard, oedematous vulva smeared with foul smelling brownish discharge, cervix fully dilated, fetal membranes not felt, severe caput up to station +2, moulding could not be assessed.

Complete blood count (CBC) showed moderate leucocytosis with left shift and toxic granulations, packed cell volume of 39%; normal platelet count; normal liver function test; bedside clotting time was normal; hepatitis B surface antigen and human immunodeficiency virus screening were negative, normal electrolyte, urea and creatinine, urinalysis showed 3+ proteinuria; bedside ultrasonography showed a macrosomic baby (4.2 kg) with no cardiac activity. The working diagnosis was denial of pregnancy in an 18-year-old un-booked obese primigravida with intrapartum eclampsia and acute pulmonary oedema, prolonged obstructed labour, chorioamnionitis with sepsis and intrauterine fetal death at term.

She was, in an appropriate position with oropharyngeal airway in-situ and continuous intranasal oxygen administration, stabilized with appropriate fluid management, antibiotics, anticonvulsant, antihypertensives, high dose furosemide and bladder catheterization. She had an emergency lower segment Caesarean section following taking consent from her mother. Intraoperative findings were: oedematous bladder, a dead and macerated male fetus in longitudinal lie, cephalic presentation (with an impacted head which was dislodged from below) weighing 4.4 kg. She was stable post-operatively, making adequate urine and seizure-free. She was nursed in the High Dependency Unit (HDU) of the hospital. She was briefed about her condition when she was fully conscious and stable, during which she accepted the reality of her being pregnant, in labour and having a dead baby along with the other complications. The mental health team was invited to evaluate her mental state when she was observed to be sad most times and keeping to herself. The team observed that she had been having insomnia; crying excessively; depressed mood; loss of interest in pleasurable activities and loss of energy along with other symptoms. A diagnosis of severe depression without psychosis was made and was promptly commenced on antidepressants and cognitive behaviour therapy was also done, with positive response. The medical and anaesthetic teams were also actively involved in her management.

She had a wound breakdown with persistent long standing fever. Blood culture showed *Escherichia coli* which was sensitive to meropenem. She had a secondary wound closure twice. She also developed urinary incontinence (vesico vaginal fistula) (noticed about 8th day post operation); she, however, became continent after 4 weeks of continuous bladder catheterization. She had bladder training before discharge. She was counselled on her condition, family planning and how to prevent a repeat of such an occurrence. She was on admission for 7 weeks. She was discharged in a good physical and mental state and followed up.

Discussion

The case report gives an overview of the burden and

possible complications of denial of pregnancy in adolescent age bracket which is a highly vulnerable subset of the reproductive age group. In this undergraduate teen, denial of pregnancy culminated in severe preeclampsia with acute pulmonary oedema, fetal macrosomia, intrauterine fetal death, prolonged obstructed labour with obstetric fistula, chorioamnionitis with overwhelming sepsis and severe depressive episode, all of which were precipitated by lack of antenatal care and unassisted labour. Lack of antenatal care and unassisted labour are common and well documented risks associated with denial of pregnancy [1, 3, 9]. The type of pregnancy denial in the patient was non-psychotic and pervasive and it was difficult to actually pin down reasons for the denial; this essentially supports the assertion that pregnancy denier may not have a clear-cut typology [3]. However, her masking body build, menstrual irregularity and other concealed personality challenges could be contributory. In this case study, features supporting the diagnosis of denial of pregnancy include amenorrhoea, weight gain, recurrent nausea, clinical and radiological demonstration of pregnancy and unassisted labour; all of which are in line with findings and pregnancy denial criteria of related studies [1, 4, 5]. A similar case, which would probably be the first case of cryptic pregnancy reported in Nigeria, was also described in a 19-year-old overweight adolescent in south-eastern Nigeria; the severity of the case was, however, much less than what was reported in this study [9].

In the areas of ethical and legal issues, maternal capacity regarding decision making to accept or reject the recommended obstetric care was not a big challenge in this patient because the case was a near miss in which an unconscious patient admitted as obstetric emergency must be helped; in addition, the challenge of knowing the best interest of the mother/unborn child was minimal as the fetus-*in-utero* was already dead at presentation. Thus, the stress of brainstorming on the prevention of child neglect and neonaticide was non-existent. Furthermore, detention of the patient in hospital for continued care was not an option in her as the pregnancy denial variant was non-psychotic and her mental state was satisfactory on discharge.

Pregnancy denial in adolescents can result in high maternal and perinatal morbidity and mortality. There is, therefore, a pressing need to intensify efforts on sexual and reproductive health education, information and care especially in secondary schools; emphasis should be laid on the importance of adolescent family planning and emergency contraception [10, 11]. Embracing contraception could have saved this patient from all the pregnancy-related challenges! Adolescent reproductive health education should also cover reproductive system structure and functions and their relationship with weight disorders; especially childhood and adolescent obesity. Childhood and adolescent obesity has been described as a contemporary epidemic with great public health challenge [12, 13]. Excessive weight gain predisposes them to developing ovarian dysfunction, serious cardiovascular disorders like hypertension with its attendant pregnancy and non- pregnancy related complications; and menstrual irregularity which makes it difficult for them to observe, detect and treat pregnancy-related issues [14, 15]. There should be multidisciplinary-based advocacy on the prevention of childhood/adolescent obesity.

Conclusion

As denial of pregnancy is highly unpredictable and underdiagnosed, it has become imperative to have a high index of suspicion to be able to capture more people, especially the highly vulnerable adolescents that have the condition. At the primary level of prevention, sexual and reproductive health information, education and care, central to which is adolescent contraception, is Hobson's choice in secondary school educational curriculum.

Acknowledgement

Not available

Author's Contribution

Not available

Conflict of Interest

Not available

Financial Support

Not available

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How to Cite This Article
Dominic OO, Ajayi OB, Pius AOI, Peter AO, Nelson OB, Omoladun OT, *et al*. A case report of adolescent pregnancy denial in which an unsuspected labour in a hotel room resulted in a near miss. Journal of Case Reports and Scientific Images 2023; 5(1): 05-08.