Pregnancy at 65, risks and complications

INTRODUCTION

In the era of assisted reproduction, we have potential to achieve pregnancy for women at any age. Irrespective of menstrual functioning of the women, we can now have pregnancy even in the postmenopausal period. Our ability to make this possible with advent of donor embryo transfer have given us a sense of pride and potential to have near control on reproduction biology, but it raises the question of how ethically are we correct. Ignoring the unforeseen complications associated with conception at an elder age can lead to increased morbidity for the expectant mother. Such patients are at high risk for developing multiple complications during pregnancy, and we came across with one such case which needed a multidisciplinary approach in managing postmenopausal pregnancy.

CASE REPORT

A 65-year-old postmenopausal primigravida who conceived after donor embryo transfer was referred to our center at 29 weeks of pregnancy with antepartum hemorrhage. Her previous antenatal monitoring was at the private hospital where she had undergone in vitro fertilization (embryo donation). At the time of admission, her blood pressure was 160/108 mmHg for which she received intravenous labetalol. Other vitals were within the normal range. Cardiovascular system examination revealed a Grade 3 diastolic murmur, but there were no signs of congestive heart failure. Obstetric examination showed uterine height corresponding to the period of gestation with a transverse lie; uterus was relaxed and regular fetal heart rate. On local examination, there was no active bleeding.

Patient was hospitalized. For control of blood pressure, she was started on oral methyldopa 250 mg thrice a day and labetalol 100 mg thrice a day. She was kept on conservative management and was evaluated further for heart disease and diabetes. Echocardiography showed trace tricuspid regurgitation with moderate pulmonary artery hypertension with normal left ventricular function. No active intervention was advised by the cardiologist. She was also diagnosed as

ABSTRACT

A 65-year-old postmenopausal pregnant woman was referred with antepartum hemorrhage at 29 weeks of gestation. Postadmission diagnosed with chronic hypertension, gestational diabetes mellitus, valvular heart disease, and placenta previa. Her pregnancy was terminated by cesarean delivery at 32 weeks as she had a bout of bleeding per vaginum. Most of the placenta was adherent with no plane of cleavage; therefore, cesarean hysterectomy was performed. Baby birth weight was 1650 g and was shifted to nursery for observation and mother needed intensive care unit care postcesarean. On the 15th day, both healthy mother and baby were discharged. Although pregnancy is possible in postmenopausal women with hormone support but the incidence of complications remain very high. It raises a need for developing well-laid guidelines for performing in vitro fertilization in older age group women.

KEY WORDS: Cesarean hysterectomy, placenta previa, postmenopausal pregnancy
gestational diabetes mellitus controlled on diabetic diet and insulin therapy. Ultrasonography complete placenta previa. She also received steroid cover for fetal lung maturity. At 32 weeks period of gestation by date of embryo transfer, she had another bout of bleeding; therefore, emergency lower segment cesarean section was performed. A male child with birth weight 1650 g was born with an APGAR score of 9, 9, 9. Most of the placenta was adherent with no plane of cleavage and hence cesarean hysterectomy was performed. She received two units of packed cells blood intraoperatively. Postoperatively, the patient was monitored in the Intensive Care Unit (ICU) for 24 h. Baby was shifted to neonatal ICU for observation. In ICU, her systolic blood pressure ranged 190–220 mm Hg and diastolic blood pressure ranged 110–130 mmHg. Nitroglycerin drip was required for blood pressure control on postoperative day 1. On the 2nd postoperative day, she was started on tablet amlodipine 10 mg per orally once daily. Mother started lactating from the 3rd postpartum day. Both healthy mother and baby were discharged on the 15th postoperative day.

**DISCUSSION**

This case is one more example of maintenance of uterine receptivity to embryo implantation and development well beyond the natural menopause if adequate hormone replacement is given. Sauer et al. used a uniform preparatory cycle of hormone replacement and found no differences in the histologic, ultrasonographic, and tissue receptor response of women 50–60 years of age and younger recipients 25–40 years of age.\(^1\)

One of the largest series of delivered pregnancies in women over the age of 50 years showed outcomes were good although gestational hypertension was seen at a much higher incidence than expected and same was seen in our patient.\(^2\) It also concluded that though pregnancy rates and risk of multiple gestation after oocyte donation is similar as in younger population but higher obstetric surveillance and care is required due to more antenatal complications in patients over the 50 years.

Postmenopausal pregnancy (PMP) though helps the couple to fulfill their wish of having their own child, raises several issues such as like ethics, psychological, and health aspects.\(^3-5\) Oocyte donation has been used over a decade to establish pregnancies in functionally agonadal women.\(^6\) Landau et al. who examined the psychosocial, health, and ethical aspects of PMP concluded that it increases human suffering rather than decreasing it.\(^7\) Older women are more likely to suffer from comorbidities such as hypertension, diabetes, and heart disease and all these three were present in this case. In addition, they are at a risk of obstetric complications such as morbidly adherent placenta and intrauterine growth restriction. All these multiple problems coexisted in our patient.

Although pregnancy is possible in postmenopausal woman with hormone support, the incidence of complications remains very high.

It raises a need for developing well-laid guidelines for performing IVF in elder age group women. Furthermore, counseling the couple regarding pros and cons of PMP will help them weigh risks against benefits for the same.

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**Conflicts of interest**

There are no conflicts of interest.

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