

A Case Report on 29-Year-Old Female Intrauterine Pregnancy 11 Weeks Gestational Age with No Fetal Cardiac Pulsations

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ABSTRACT

Background: Early first-trimester pregnancy loss affects 10-20% of clinically recognized pregnancies. Missed abortion, a type of embryonic pregnancy loss, requires timely diagnosis, appropriate management, and psychological support to reduce its emotional impact. **Case Presentation:** A 29-year-old woman confirmed pregnancy with a home β -hCG test. Serial β -hCG levels increased from 124.50 to 257.80 mIU/mL over 48 hr. Initial ultrasonography at 5-6 weeks showed a gestational sac (mean sac diameter 1.06 cm) with a yolk sac but no fetal pole. A repeat scan two weeks later demonstrated a fetal pole (crown-rump length 0.84 cm, corresponding to 6 weeks 5 days) without fetal cardiac activity, confirming a missed abortion. **Management and Outcome:** Although medical termination was advised, the couple opted for expectant management. Five days later, mild vaginal bleeding prompted repeat ultrasonography, which confirmed persistent nonviability and a subchorionic haemorrhage. The patient received 200 μ g misoprostol but developed severe abdominal pain and heavy vaginal bleeding within 2 hr, requiring emergency hospitalization. Surgical evacuation by Dilation and Curettage (D&C) was successfully performed. **Conclusion:** This case highlights the unpredictable course of medical management in missed abortion and the potential need for emergency surgical intervention. It also emphasizes the importance of individualized management, close follow-up, and comprehensive psychological counselling to support patients and their partners following early pregnancy loss.

Keywords: Early pregnancy loss, Ultrasound scan, Fetal cardiac pulsations, Obstetrician and gynecologist.

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INTRODUCTION

Early pregnancy loss, commonly known as miscarriage or first-trimester loss, is characterized as an intrauterine pregnancy that is not viable, which can either present as an empty gestational sac or one that contains an embryo or fetus but shows no fetal heart activity during the initial 12 weeks of gestation. This is a widespread occurrence that impacts 10-20% of all pregnancies.

The majority of early pregnancy losses happen before 10 weeks of gestation (two-thirds happen during the pre-implantation phase), and they become less common if a viable embryo with fetal cardiac activity is seen. Chromosomal abnormalities account

for 65-70% of cases, making them the most common cause of early pregnancy loss (9%). Other less common reasons include immunological conditions like antiphospholipid syndrome, uterine malformations, including submucosal fibrosis or 9% uterine septum, and toxic substances like alcohol, tobacco, or narcotics. Advanced maternal age (>40 years old) and a history of early pregnancy loss are the most commonly found risk factors among women who have experienced early pregnancy loss.¹

It affects over 30% of pregnancies after assisted reproduction and 10% of pregnancies conceived naturally, making it the most prevalent early pregnancy complication. An early miscarriage is readily missed, and the discrepancy can be explained by a later diagnosis of spontaneous pregnancy as opposed to assisted reproduction pregnancy. In actuality, delayed menses might be mistaken for vaginal bleeding, a typical indicator of early pregnancy loss, leaving the loss undetected. More than 50% of pregnancy losses in the first trimester are caused by embryonic genetic abnormalities, the most prevalent of which is aneuploidy.²



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CASE REPORT

A 29-year-old woman who planned to conceive after four years of marriage discovered she was pregnant. After three days of missed periods, she conducted a home pregnancy test, which revealed a faint positive result. She sought medical attention from a practitioner who recommended a beta-hCG test. The initial test result was 124.50 mIU/mL, and after two days, a repeat test indicated that the beta-hCG level had risen to 257.80 mIU/mL. The obstetrician and gynecologist prescribed Tablet Folic acid and scheduled an ultrasound scan to take place in two weeks Tables 1-3.

The obstetrician and gynecologist prescribed one dose of Mifepristone-200 µg and four doses of Misoprostol-200 µg. After taking the first dose of Mifepristone-200 µg the patient experienced severe abdominal pain and mild bleeding within 2 hr, leading to her admission to the hospital. After the examination

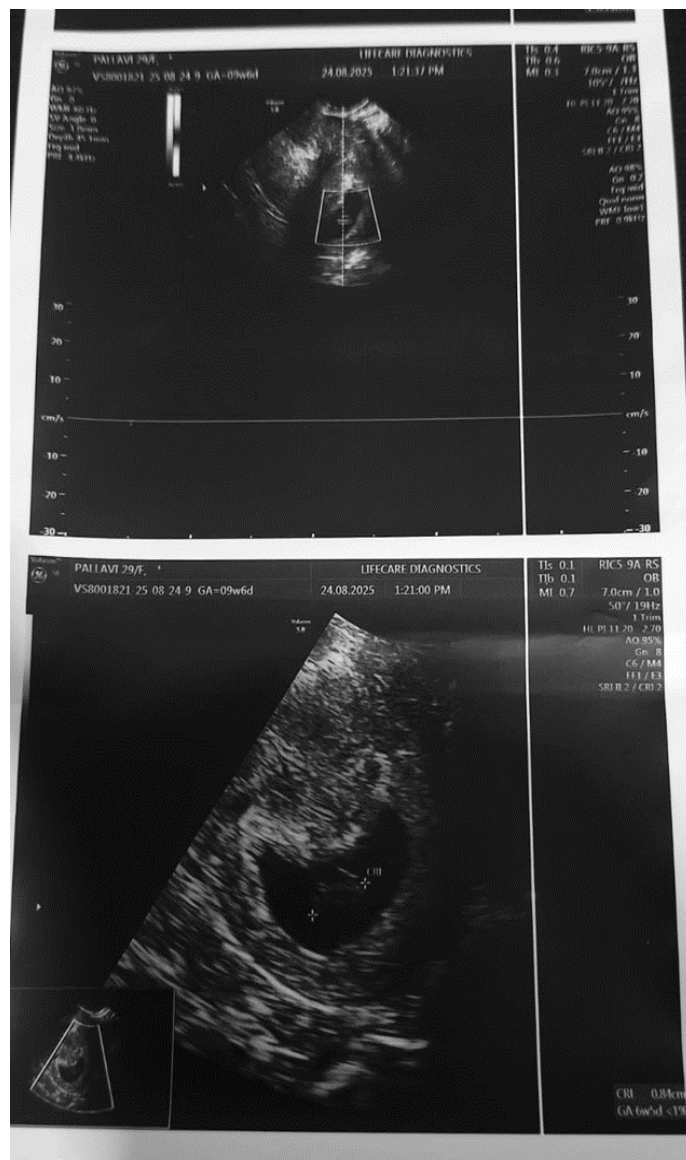
of the pregnant women, the medical practitioner suggested for the D&C procedure. Under short GA, Patient put in position, parts painted and draped. Cervix held with sponge holding force OS open; products of conception removed with ovum forceps. Evaluation done with karmans cannula no.06 procedure uneventful, patient with stood procedure well. After one day of observation the women were discharge. According to NICE guidelines misoprostol cervical priming for first trimester surgical abortion reduces the force required to dilate the cervix and the risk of incomplete abortion. This evidence, in combination with clinical expertise, supports the use of routine cervical priming prior to first trimester surgical abortion with 400 µg misoprostol.³

DISCUSSION

Mothers need not be overly concerned if an ultrasound at 6-7 weeks shows no fetal heartbeat, as this could be due to late fertilization or irregularity in menstrual cycles, which can lead



First ultrasound scan. The obstetrician and gynecologist recommended a follow - up scan in two weeks to confirm the viability of the fetus.



Second ultrasound scan.

to miscalculations in gestational age. At this stage, the ultrasound might not pick up the fetal heartbeat since the fetus may only be advancing in development to the 4th-5th week of pregnancy. In some situations, the embryo may progress more slowly than usual, which means the heartbeat might only be identifiable between the 8th and 10th week. The doctor will carry out assessments to check for any abnormalities and evaluate the state of the fetus. Generally, if no issues are found, a follow-up appointment and ultrasound will be arranged in 1-2 weeks. According to ACOG Practice Bulletin 162, the objective is to present up-to-date information on available screening tests for fetal chromosomal abnormalities, as well as to evaluate their benefits, performance characteristics, and limitations.⁴

Table 1: Ultrasound scan report of first diagnostic findings of pregnancy.

Sl. No.	Parameter	GA/LMP: 5 Weeks 6 Days
1.	Gestational sac	Single intrauterine gestational sac present
2.	Mean sac diameter	1.06 cm (corresponding to 5-6 weeks)
3.	Yolk sac	Visualized
4.	Fetal pole	Not visualized yet
5.	Fetal cardiac activity	Not seen
6.	Subchorionic hemorrhage	No evidence seen
7.	Cervical length	3.3 cm; cervical OS closed
8.	Ovaries	Both ovaries normal; no corpus luteum cyst

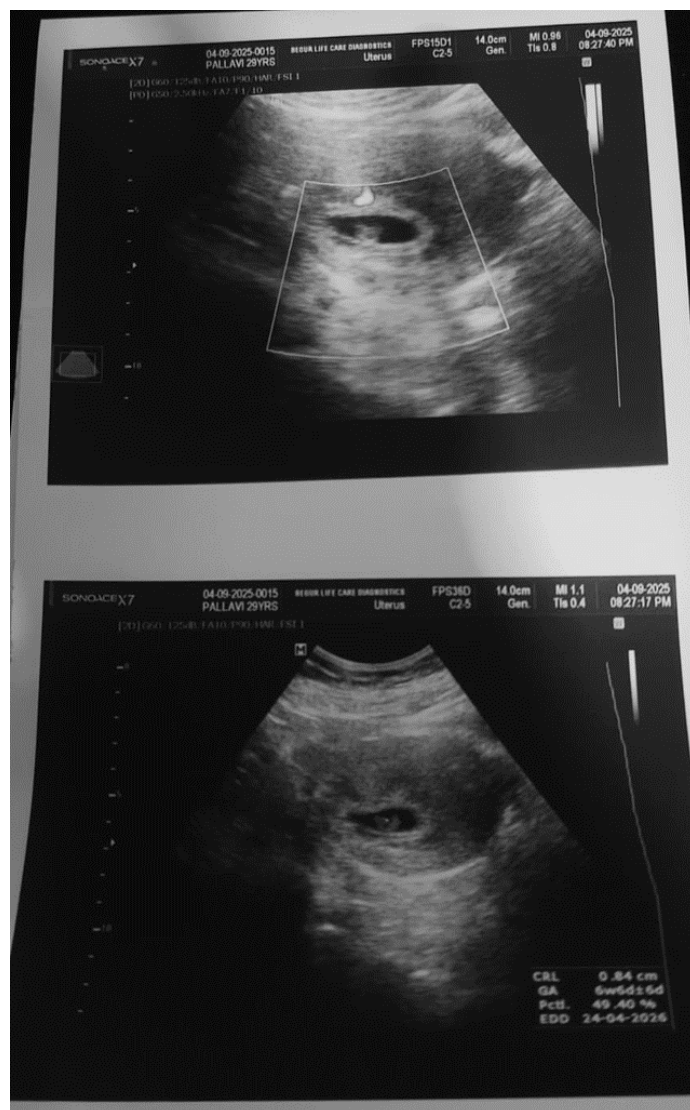
Table 2: Ultrasound scan report of Second diagnostic findings of pregnancy.

Sl. No.	Parameter	GA/LMP: 9 Weeks 6 Days
1.	Gestational sac	Single intrauterine gestational sac present with slightly irregular margins
2.	Mean sac diameter	(corresponding to 6 weeks 5 days)
3.	Yolk sac	Visualized
4.	Fetal pole	Present. Crown-Rump Length (CRL)=0.84 cm (corresponding to 6 weeks 5 days)
5.	Fetal cardiac activity	Not seen
6.	Subchorionic hemorrhage	No evidence observed
7.	Cervical length	2.9 cm; cervical OS closed
8.	Ovaries	Both Ovaries normal; no corpus luteum cyst

The mother's HCG levels should be measured to determine whether the fetus is still alive if a 7-week ultrasound reveals no heartbeat as a result of external influences, an inaccurate gestational age estimate, or delayed fetal development. If the mother's HCG levels are normal, she should wait a week before having another ultrasound to look for the existence of a fetal heartbeat. The mother shouldn't be overly concerned in order to prevent negative health effects.

Call your doctor right away to get the fetus checked out if a seven-week ultrasound reveals no fetal heartbeat or if the fetal heartbeat has stopped and the mother is experiencing unusual symptoms like severe lower abdominal pain, vaginal bleeding, or a loss of morning sickness.

All women who experience significant bleeding or pain should have their viability evaluated. Additionally, since the degree of bleeding or pain does not predict the outcome and uncertainty can be more stressful than unfavorable information, it should



Third ultrasound scan.

Table 3: Ultrasound scan report of third diagnostic Findings of pregnancy.

Sl. No.	Parameter	GA/LMP: 11 Weeks 3 Days
1.	Gestational sac	Single intrauterine gestational sac with slightly irregular margins
2.	Mean sac diameter	(corresponding to 6 weeks 6 days)
3.	Yolk sac	Visualized
4.	Fetal pole	Present; CRL corresponding to 6 weeks 6 days
5.	Fetal cardiac activity	Not seen
6.	Subchorionic hemorrhage	Present along posterior aspect of gestational sac measuring 1.4×0.3 cm
7.	Cervical length	2.9 cm; cervical OS closed
8.	Ovaries	Both ovaries normal in size and echo pattern

be offered to all women who experience persistent, recurrent, anxiety-inducing bleeding and who request it.⁵

CONCLUSION

If an ultrasound performed 11 weeks after the procedure continues to show no signs of a fetal heartbeat, an HCG test should be done right away to see if the pregnancy is viable or if there is a problem with the fetus. In the event of a miscarriage, medical professionals will use secure and effective procedures to remove the fetus, prioritizing the mother's safety. The mother should receive support and solace from family, friends, and relatives in the event of the worst-case scenario, such as a miscarriage resulting in the absence of a fetal heartbeat, since this is a major and distressing loss. The most crucial thing for the mother right now is to get over this immense pain and get back to being healthy. Give yourself time to rest and recover by waiting at least three months following a miscarriage before attempting to get pregnant again.⁶

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ABBREVIATIONS

ACOG: American College of Obstetricians and Gynecologists; **β-hCG:** Beta-Human Chorionic Gonadotropin; **CRL:** Crown-Rump Length; **D&C:** Dilation and Curettage; **GA:** Gestational Age; **LMP:** Last Menstrual Period; **mIU/mL:** Milli-international units per milliliter; **NICE:** National Institute for Health and Care Excellence; **OS:** Ostium (Cervical).

CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

ETHICAL APPROVAL AND CONSENT TO PARTICIPATE

The institutional ethical clearance was obtained with the approval number IEC/TOCP/25/2025-2026.

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