Streptococcus milleri and second trimester abortion

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SUMMARY Review of 214 fetal necropsies performed in the department of pathology, University of Aberdeen, showed 40 cases of chorioamnionitis or intrauterine pneumonia, five of which were associated with Streptococcus milleri. In two cases there was good evidence to implicate S milleri as the cause of infected abortion while in the other cases its pathogenic role was less clear.

Results

The table shows clinical and pathological findings of the patients studied. Three patients (cases 1, 3, and 4) had prolonged rupture of membranes (longer than 24 hours); one had an intrauterine contraceptive device (case 5). Case 3 had a cervical suture inserted in this pregnancy after a cone biopsy in 1975, and case 4 had had a previous septic abortion and two terminations. The maternal ages ranged between 20 and 38 years and abortion occurred between 18 and 23 weeks’ gestation. In all five cases there was no systemic evidence of infection in the mothers.

Histological sections (stained with haematoxylin and eosin) of all five cases exhibited chorioamnionitis and in three cases intrauterine pneumonia. Gram stains of placenta and lungs in case 1 showed intracellular Gram positive cocci in neutrophil polymorphonuclear leucocytes, and S milleri was also isolated from the maternal high vaginal swab taken the day before abortion. Similarly, in case 2 profuse S milleri was isolated from the maternal high vaginal swab the day before the abortion, but no organisms were seen on Gram staining of tissue sections.

Discussion

Ascending infection is only one of several ways in which the placenta and fetus may be infected; it is intimated histologically by chorioamnionitis or membranitis in early infection and vasculitis of the cord and suppurative chorioamnionitis in more advanced disease. It is known that the incidence of intrauterine infection and chorioamnionitis increases with prolonged rupture of membranes and is more common in premature delivery. Whether infection follows spontaneous rupture of membranes or whether heavy vaginal colonisation with a particular organism pre-
disposes to rupture and preterm labour is not known.

Many bacteria isolated from cases of chorioamnionitis are also commensals of the bowel and vagina—for example, *Streptococcus faecalis*, *Escherichia coli*, *Proteus*, *Klebsiella*, *Gardnerella vaginalis*, *Candida albicans*, *Bacteroides*, and *Peptostreptococcus* species. The latter two anaerobic bacteria are often found in mixed infection, as in case 3. S. milleri is a known vaginal commensal and is also found in the faeces of 5% of normal puerperal women. It has also been reported as a cause of septicemia and pneumonia in premature neonates. It has not, however, been associated with chorioamnionitis and intrauterine pneumonia in abortion.

There was good evidence to implicate *S. milleri* as a cause of septic abortion in cases 1 and 2. In each case a profuse growth of *S. milleri* was obtained from a maternal high vaginal swab collected prior to abortion and from a swab taken at necropsy from the fetal airways. There was also histological evidence of chorioamnionitis and intrauterine pneumonia with Gram positive cocci identified in the tissues of case 1.

The importance of the isolation of *S. milleri* in cases 3, 4, and 5 is doubtful as high vaginal swab culture was unhelpful and *S. milleri* was isolated with other organisms associated with chorioamnionitis. Nevertheless, these observations suggest that *S. milleri* can act as a pathogen in the female genital tract and cause infected abortion.

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