Case report
A Case of pregnancy with portal hypertension with splenectomy with oesophageal varices

Anand Manpreet, Lal M, Srivastav A
PG resident obs & gynaec (3rd year) himalayan institute of medical sciences swami ram nagar doiwala dehradun UTTARANCHAL, INDIA

ARTICLE INFO

Keywords:
Portal hypertension pregnancy

ABSTRACT

Pregnancy with portal hypertension with splenectomy is an uncommon condition. It is seen that maternal mortality is 2-18%, hematemesis is seen in 20-30% and perinatal mortality is 11-18% [1]. A number of patients with Extra hepatic portal venous obstruction (EHPVO) and non cirrhotic portal fibrosis (NCPF) are surviving to adult life. In patients with cirrhosis as long as liver function is relatively preserved pregnancy is possible.

Introduction

Portal hypertension is caused most often by cirrhosis (in developed countries), schistosomiasis (in endemic areas), or hepatic vascular abnormalities. Consequences include esophageal varices and portosystemic encephalopathy. Diagnosis is based on clinical criteria, often in conjunction with imaging tests and endoscopy. Prognosis of portal hypertension during pregnancy depends upon the underlying cause and the extent of derangement of liver function. Maternal prognosis is better with EHPVO and NCPF and poor with cirrhosis of the liver [2]. Maternal mortality ranges between 2% and 18%; being maximum with cirrhosis.

The causes of death are generally hematemesis, hepatic coma or postpartum hemorrhage. Perinatal mortality ranges between 11% and 18%, mainly due to preterm delivery or intrauterine growth restriction (IUGR).

Case report

A 33 yr old elderly primigravida , k/c/o chronic liver disease with portal hypertension and oesophageal varices came to gynaec opd at 8 weeks of gestation for regular antenatal checkup. There was no h/o fever, jaundice, hematemesis, bleeding tendencies. Sonographic examination confirmed pregnancy and was advised regular follow up. Repeat USG level II scan was done at 20 weeks as fundal height came as more than the period of ammenorrhoea. She came for regular follow up and all antenatal investigations done. The pregnancy proceeded uneventfully. Patient was on tab dytor (cat B), Tab inderal (cat C).

The patient was taken up for emergency LSCS at 34 weeks duration as NST was nonreactive and n alive female baby weighing 2.27kg was delivered. Post operative period went uneventful and patient was discharged under satisfactory conditions.

Discussion

Prognosis of portal hypertension during pregnancy depends upon the underlying cause and the extent of derangement of liver function. Of the women with cirrhosis, 20-30% will have hematemesis during pregnancy with the mortality ranging between 50-60%. The incidence of hematemesis in patients with EHPVO and NCPF is around 7%. The timing and severity of hematemesis, however are unpredictable. Hematemesis is more common in pregnancy complicated by varices [3]. Hematemesis during pregnancy is contributed to by increased portal pressure during pregnancy, reflux esophagitis and obstruction to the inferior vena cava by the gravid uterus.

Management of portal hypertension in pregnant women is similar to that in non pregnant patients. Beta blockers are given to reduce portal venous pressures. There is a danger of variceal rupture and hematemesis when the patient strains during labour [4]. Patients with EHPVO and NCPF generally tolerate labor well and cesarean section is not mandatory. They must not be allowed to bear down and the second stage should be cut short.

Pregnancy is not contraindicated in patients with portal hypertension due to NCPF, EPVOC and compensated cirrhosis. Termination of pregnancy needs to be considered only in patients with decompensated cirrhosis, recurrent hematemesis and deranged liver function, especially abnormal coagulation profiles. The management of pregnancy with portal hypertension should only be done at tertiary care centres by a multidisciplinary team with backup facilities for intensive care and blood transfusion.

* Corresponding Author : Dr Manpreet Anand
PG resident obs & gynaec (3rd year) himalayan institute of medical sciences swami ram nagar doiwala dehradun
UTTARANCHAL, INDIA
sheena.2k2@gmail.com
BIBLIOGRAPHY:


All rights reserved.