THE CASE OF PREGNANCY WITH PORTAL HYPERTENSION :

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Abstract:

This is a case of a 26 yrs primigravida at 31 weeks gestation with known case of portal hypertension, admitted with c/o epigastric pain ,Nausea and belching. On examination there was pallor and lower limb edema with abdominal distention. Blood investigations showed microcytic anaemia with thrombocytopenia with hypoalbuminemia.USG showed shrunken liver with spleenomegaly with 1000 ml free fluid. Patient was taken for Emergency L.S.C.S under high risk and a live preterm baby delivered.post operative one episode of massive haematemesis,managed with emergency EVL.

Key words: portal hypertension with pregnancy,emergency L.S.C.S, Esophageal variceal ligation.

INTRODUCTION :

Pregnancy is a hyperdynamic circulatory state. Hemodynamic changes, although necessary for pregnancy, pose special problems in patients with pre existing portal hypertension. This condition needs specialised care to prevent potentially life threatening condition such as gastroenteric haemorrhage. Risk of variceal bleeding in pregnant patients with portal hypertension is 400 times more than in pregnant patients without portal hypertension. Variceal haemorrhage occurs in around 19-45 % of patients with portal hypertension who become pregnant. Almost 78% of patients who have detectable varices during pregnancy are likely to bleed during index gestation.

CASE PRESENTATION :

A 26 yrs,8 months pregnant female presented with upper abdominal pain since 1 day,lower abdominal pain since 1 week.

She was a known case of CHRONIC LIVER DISEASE. Patient was apparently well 12 months back ,then she had episodes of frank blood in vomitus & stools for which she was

investigated thoroughly

Presently patient presented with c/o upper abdominal pain,confined to epigastric region, burning type, non radiating,aggravated by food intake,relieved with medication. She also complained of Lower back pain which was dull aching,non radiating, relived on rest. She gave history of nausea and belching on and off. This was unplanned pregnancy,hence no preconceptional counseling taken.her first trimester was uneventful.she was admitted at 19wks, with c/o unilateral vulval & lower limb edema(right side) ,pt was investigated,& Managed conservatively with aldactone,frusamide,albumin infusion, B/l lower limb Doppler was normal, USG Abdomen and Pelvis showed mild to moderate ascitis

At 22 weeks ,she had one episode of haematemesis for which She underwent one session of EVL.steroid prophylaxis given at 30 weeks.

She was a k/c/o portal vein thrombosis, detected in March 2011(6months prior to pregnancy).she underwent 2 sessions of esophageal variceal ligation in march/April 2011, with interval of 15 days.she had taken blood products transfusion for moderate anemia & thrombocytopenia. There is history of similar complaints in younger brother,detected at end stage,he expired with in one month of diagnosis.on examination she was poorly built & poorly nourished.she was pale and had pedal edema.There was b/l vulval edema,more on right side.Abdomen was uniformly distended.

Investigations showed microcytic anaemia with thrombocytopenia with hypoalbuminemia. USG Abdomen showed Cirrhosis of liver.Spleenomegaly with peri spleenic collaterals.ascitic fluid of 800-1000 ml.SLIUG of 28 weeks ,estimated fetal weight -1.5 kg

Patient was admitted on 11 april ,relevant investigations were done.Gastroentrologist opinion sought,started on proton pump inhibitors.

On day 2 Pt developed abdominal discomfort &vulval swelling was increasing gradually,

Blood investigation done showed features of anemia,thrombocytopenia & hypoalbuminemia **USG-Abd/pelvis** showed shrunken liver,free fluid .Pt received Albumin infusion, loop diuretics,inj vit –K& Aldactone.

Knowing the pt condition i.e decompensated liver and worsening of symptoms& its effect on fetal out come ,case discussed with Gastroentrologist,anaesthetist,haematologist and patient was taken for CS under high risk.Pre operatively, Pt received 2SDPP & minirein nasal spray. Intra operatively ascitic fluid about 600-800ml drained,Yellow color amniotic fluid

drained .Alive preterm male of wt-1.4kg was delivered,She received 1 FFP and 1 Plt conc./ Albumin (20%),No PPH.In third post operative day, in view of anaemia and thrombocytopenia,packed cell volume transfused. Immediately following transfusion- PCV,patient vomited frank fresh blood (about 200-300ml). Gastroentrologist Called,Patient was stabalized & Emergency EVL done under GA,post op patient was shifted to ICU for further care.She received 3 FFP, 1PCV ,1 platelet concentrate &received other supportive measures. Pt Condition improved & was discharged in clinically stable condition.