



LATE ONSET OHSS AND PREGNANCY OUTCOME: A CASE REPORT

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ABSTRACT

Ovulation induction has been an important mode of treatment of infertility. Ovarian stimulation may result in a supraphysiologic response leading to an iatrogenic complication known as the ovarian hyperstimulation syndrome (OHSS). This syndrome is a potentially lethal condition, the pathophysiologic hallmark of which is the accumulation of massive extravascular exudate combined with profound intravascular volume depletion and hemoconcentration. We report a case of severe OHSS with very large ovaries in a 38yr old case of G2A1 with 4weeks 5days GA, ICSI conception with TCTA triplets presented to the emergency department with abdominal pain, ascites and respiratory distress. The patient was managed symptomatically with no complications. Although ovarian hyperstimulation is a rare entity, it is important that the physician recognizes this condition. Prompt diagnosis and successful management is likely to avoid serious and rapid development of complications.

KEYWORDS : Ovarian stimulation, Ovarian hyperstimulation syndrom, ovulation induction, Assisted reproduction.

INTRODUCTION:

Ovarian hyperstimulation syndrome (OHSS) involves an increase in vascular permeability resulting in a fluid shift from intravascular to third space compartments such as the peritoneal and thoracic cavities. First described in 1943, the first fatal cases were documented in 1951. This syndrome occurs almost exclusively during assisted reproductive technology (ART) cycles, although OHSS might also occur during ovarian stimulation using gonadotropin and clomiphene citrate.

CASE REPORT:

A 38 year old G2A1 at 4weeks +5days, ICSI conception, Trichorionic triamniotic triplets, Rh negative pregnancy, hypothyroid on supplements, pre gestational diabetes, polycystic ovarian syndrome- referred to KIMS with complaints of abdominal pain, abdominal distension and breathing difficulty since 10days. (4 Paracentesis & 4 PC transfusion done outside). On examination she was conscious, coherent, oriented and vitals stable. Respiratory system auscultation: crepitations present, decreased breath sounds noted on the left side. On local examination abdominal distension and shifting dullness present. Lab findings: Hb 11.8, TC 17200, potassium 5.6, Total protein 4.8, Beta HCG - 1195.7 USG: at admission Bilateral enlarged ovaries, ascites and minimal pleural effusion with live TCTA triplets. Dating scan at 6weeks 6days -live TCTA triplets.

NT scan at 12weeks -cardiac activity had disappeared for triplet 3. Target scan at 21weeks -Twin gestation with fetus B -IUGR, Sacral dysgenesis, left renal agenesis, single umbilical artery.

COURSE OF PREGNANCY: Patient was treated conservatively and paracentesis done once at 7weeks as patient developed severe pain abdomen. Reduction was planned (at request) after NT scan but cardiac activity disappeared for triplet 3 by 12weeks. Prophylactic encercilage done at 14weeks and 1day.

Serial growth monitoring and supportive treatment offered throughout pregnancy. At 34weeks patient had PPROM. Fetus A non cephalic presentation, Fetus B cephalic presentation

Emergency lower segment caesarean section was done.

Post operative period uneventful.

Baby details: Twin A - Girl 7/10, 8/10, 1.775 kg. Twin B - Girl 7/10, 8/10, 1.695 kgs. Twin B had Bicuspid thumb, single umbilical artery.

DISCUSSION:

OHSS is a serious complication of controlled ovarian hyperstimulation, almost always presents either after HCG administration or during early pregnancy.

Direct action of excessive gonadotrophins on ovarian tissue accounts for the ovarian enlargement.

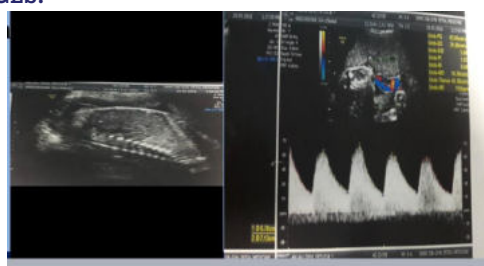
HCG induces the release of a mediator by gonadotropins hyper-stimulated ovaries, causing endothelial activation resulting in increased capillary permeability.

DIAGNOSIS:

It is diagnosed on the basis of history, symptoms, examination findings, blood and ultrasound findings showing bilateral enlarged ovaries and minimal pleural effusion with live TCTA triplets at the time of admission.

CONCLUSION:

This is to emphasize that severe OHSS can be managed conservatively. Following resolution of the OHSS, pregnancies should be regarded as any pregnancy resulting from IVF treatment, with special attention to prevent preterm labor.

IMAGES:

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