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DIFFICULT LABOUR DUE TO CONGENITAL CAVERNOUS HAEMANGIOMA - AN UNUSUAL CASE PRESENTATION

Gynaecology

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ABSTRACT

Giant congenital cavernous haemangiomas are rare. I am presenting this case here because the haemangioma presented as a tumour of the back and led to unexpected obstruction and difficult labour. It remained antenatally undiagnosed, and caused sudden arrest of an otherwise uncomplicated vaginal delivery because of the tumour mass. This posed as a challenge. In this era of widespread antenatal care, this type of complication is very rare.

KEYWORDS

Congenital, Cavernous Haemangioma

Introduction

Cavernous Haemangioma is a wild jumbled growth of blood vessels fed by numerous tributary arteries. These tumours are benign by cell type, but can have serious consequences. About 30% haemangiomas are present at birth, the rest appear in the first several months of life. The haemangioma may be in the top layers of the skin called capillary haemangioma, it may be deeper in the skin called cavernous haemangioma or it may be located in the internal organs also.

This case is being reported here because of the giant size of the haemangioma leading to a difficult labour.

Case Report :

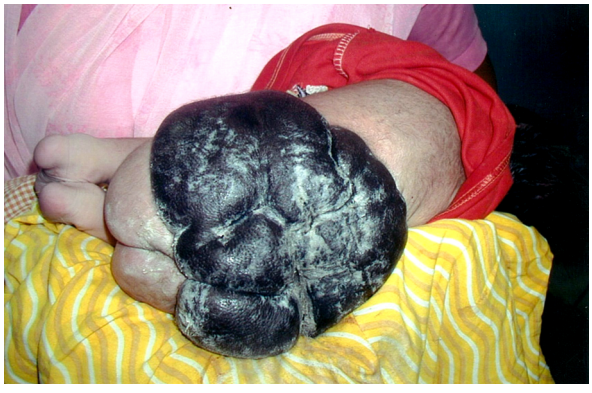
A 23 year old unbooked pregnant woman, Gravida 2, para 1 with amenorrhea of 9 months was admitted on 17/8/05 in our hospital. She had regular antenatal check up at a private hospital in the periphery.

She had taken iron, calcium and two doses of tetanus toxoid. There was no history of any other medication, fever, jaundice, or past history of any chronic illness during pregnancy. Her routine investigations were within normal limits which dated one month back. Two ultra sound examinations had been done. One at twenty four weeks, and the other at thirty two weeks of gestation. In both the reports, no congenital anomaly had been reported. Ultrasound showed that liquor was normal, placenta was fundal & the presentation was cephalic. Her obstetric history showed that she had a full term normal male child two years back.

On admission, on 17/8/05 at 8.00 am, the patient was having contractions every ten minutes. Foetal heart sound was 140/min. Her per vaginal examination showed that the cervix was two centimetre dilated, partly effaced, membranes were present, vertex was at -3 station and the pelvis was adequate. After about six hours, the cervix was fully dilated. She delivered spontaneously till the head and inferior angle of scapula, after which the trunk got stuck. The baby was half delivered and hanging from the introitus. The baby was mature with good vigour and crying well. On deep insinuation of the hand through the vagina along the back on the baby, a tense rubbery swelling was felt arising from the back. A provisional diagnosis of a tumour like growth on the lumbar region of the spine was made. Emergency approach in the form of caesarean delivery was thought, but continuous efforts for vaginal delivery were continued. As the tumour was soft & rubbery, with manoeuvring, pressing and twisting of back of the child and half rotating the baby from left to right and right to left and with continuous traction, we were able to deliver the child vaginally without any injury to the child. The APGAR of the baby was 8/10. There was no extensive injury to the birth canal. It was a female child weighing 3.5 kg.

On examination, there was a huge black coloured lobulated swelling on the back of the child. The baby was sent to the paediatric surgery unit of SMS Medical College where the following investigations were done. Ultra sound abdomen & ultra sound brain were normal. Doppler ultra sound of the mass showed soft tissue Hypertrophy with few dilated vascular spaces not showing flow on Doppler. MRI LS spine showed large soft tissue mass in subcutaneous tissues of posterolateral abdominal walls with no evidence of intra spinal or intra abdominal extension of the mass. So a diagnosis of haemangioma was made.

On 20/2/06 i.e. after six months, the child underwent excision and skin grafting. Residual lesion was present, for which she was readmitted on 8/11/06. Excision and closure was done. The girl is now thirteen years old and is healthy.



Giant congenital cavernous haemangioma of the back

Discussion :

By history and physical examination 96% of childhood vascular lesions can be classified as haemangiomas or malformations. Haemangiomas are often not present at birth (40%), but make their appearance during the 1st month of life. A proliferative phase, lasting an average of three months, is followed by a slow, but eventually complete involution.1 Hamartomas include several combined vascular and melanocyte proliferations grouped as phacomatosis, pigmentovascularis and the so called eccrine glands and blood vessels.2 In a study by Boon et al, only 3 of 23 congenital haemangiomas were diagnosed in utero by ultrasonography. The three most common morphologic forms were raised violaceous tumour with ectatic veins, raised greyish tumour with multiple tiny telangiectasis, surrounded by a pale halo, and flat infiltrative tumour with violaceous overlying skin. Two congenital haemangiomas had associated thrombocytopenic coagulopathy (Kasabach Merritt phenomenon). All the untreated congenital haemangiomas regressed by the time the infants were 14 months of age, leaving either atrophic skin or extra skin. Seven congenital haemangiomas required therapy for complication: three tumours responded to systemic corticosteroid administration and four were resected.[3]

Obstructed labour due to foetal anomalies, foetal ascites, conjoint twins, hydrocephalous are common.4 Sacrococcygeal tumours causing obstructed labour leading to retrograde extraction of the baby by emergency caesarean have been reported.[5]

Our case is rare. Also, on routine ultrasound, surprisingly, such a huge mass remained undetected, which led to a difficult labour.

Conclusion:

With the advent of widespread antenatal care and anomaly scan, labour dystocia (hindrance of almost complete vaginal delivery) of this type by an undiagnosed foetal tumour is rare. However, obstetricians in developing countries, where pregnancies often remain under supervised, may face this type of obstetrical challenge. Awareness of their potential occurrence and subsequent judicious management approach may avert maternal and neonatal jeopardy to some extent.

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