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CASE REPORT ON PORTAL AND SPLENIC VEIN THROMBOSIS IN PREGNANCY

Obstetrics And Gynaecology

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ABSTRACT

Portal vein thrombosis is rare in pregnancy. The common causes are thrombophilias ,liver cirrhosis,myeloproliferative disorders,inflammatory disorders like pancreatitis .The hypercoagulable state of pregnancy itself can precipitate this condition.They can present as either acute or chronic ,Acute portal vein thrombus presents as abdominal pain ,fever and new onset ascitis,where as chronic one presents with hematemesis,splenomegaly and ascitis.The incidence of spontaneous abortion ,prematurity ,small for gestation age babies ,perinatal death are high .Pregnant women are at high risk of variceal bleeding which can lead to maternal morbidity and mortality.Timely recognition and management of complications is essential .In our present case report ,she is G4P2L2A1 with 39weeks of gestation with portal and splenic vein thrombosis with splenomegaly with thrombocytopenia with history of banding for oesophageal varices 2years back . There was successful maternal and neonatal outcome with multidisciplinary approach.

KEYWORDS

Thrombosis, portal vein, splenic vein, splenomegaly, pregnancy.

INTRODUCTION :

Portal and Splenic vein thrombosis with splenomegaly is a rare condition in pregnancy where there is development of collateral circulation, splenomegaly and thrombocytopenia .The aetiology is diverse and treatment is individualised. Pregnancy in these cases is considered high risk and management is multidisciplinary. Pregnancy is not contraindicated if underlying disorder is stabilised, the decision about mode of delivery is individualised depending on obstetric factors, and presence or absence of varices, thrombocytopenia.

CASE report:

A 24years G4P2L2A1 at 39weeks was referred to our hospital with massive splenomegaly (18cms) and chronic liver disease. She had history of oesophageal banding for varices done 2years back at private hospital and kept on Tab .Propanalol 2mg OD .she was asymptomatic since then and had an uneventful antenatal checkups this pregnancy .On examination she was anaemic, Vitals : pulse -90bpm . Bp: 110/70mm of hg, Temp: Afebrile, thyroid and breast –clinically normal Cardiovascular system: S1 S2 heard no murmurs Respiratory system: normal vesicular breath sounds heard. Per abdomen examination: massive splenomegaly felt, no lymphadenopathy .Obstetric examination: uterus term gestation, relaxed, FHR good 146bpm at regular rhythm.

Investigations: pre-operative investigations : Hb % : 8.3gm%.TC :4000/cu.mm, platelet count : 61000 /cu.mm, ESR -18mm, LFT and RFT –Normal , PT :16.3 APTT :34 INR :1.38

Post-operative investigations: HB: 9.3 gm. %, TC: 4700/cu.mm, Platelet count: 66000/cu mm.

Pheripheral smear: Normocytic normochromic anaemia with presence of few macrocytes with thrombocytopenia.

USG (whole abdomen) : Single live intrauterine foetus with 35weeks+1day with AFI :9.7CMS , FHR :154Bpm , weight -2683gms . Doppler –normal. Liver: echo texture coarsened with minimal surface irregularity Portal vein : small echogenic partial thrombus 1.6*0.8cms noted at distal part before bifurcation .Spleen : enlarged (19.5cms) thrombus of 3.6*1.6cms noted in splenic vein at Hilum .Pancreas ,kidney -normal.No free fluid noted .

MANAGEMENT:

Medical and Surgical Gastroenterology opinion was sought for and they advised conservative management. They advised against anticoagulant as she was well compensated Chronic Liver Disease with Portal vein thrombosis and also due to underlying thrombocytopenia. Haematologist Consultation taken in view of thrombocytopenia, advised prophylactic platelet transfusion preoperatively. 1 Unit packed red cells and 4 Units of Platelets transfused .She underwent Elective LSCS with Bilateral tubectomy at 39+3days under General anaesthesia, an active Female baby of 2.8kgs delivered. INTROPERATIVE findings : Grade3 meconium stained liquor, blood loss about 300ml , Haemostasis well secured .shifted to SICU for post operative monitoring for 48hours ,given injection vitamin k 1ml i.v. OD for 3days ,her post op scan showing : Gross Spleenomegaly with dilated 17mm portal vein ,partial thrombus in splenic with multiple collaterals .Patient was discharged on 7th postoperative day with Tab. Propanolol 2mg OD.

DISCUSSION:

The clinical management of portal vein thrombosis depends on variable factors ,its association with liver disease and hypercoagulable states[1]. In the present case , patient has no complaints when she presented to us , there are no symptoms suggestive of portal hypertension except she had history of oesophageal banding for Varices .It has been suggested that upper GI endoscopy for prophylactic treatment of varices before conception[2] or during 2nd trimester , reduces risk of bleeding to 8.6% . Either sclerotherapy or ligation considered safe procedure during pregnancy although later is preferred technique. The use of Beta Blockers ,Propranlol 2mg which is Nonselective Beta Blocker is recommended for prevention of Variceal bleeding despite its potential adverse foetal events[2].In order to to avoid variceal rupture or splenic rupture due to increase intrabdominal pressure during pushing efforts in labour some advocate caesarean section[3, 4].

Anticoagulant therapy was not given in the present case as she had history of oesophageal varices prepregnancy and thrombocytopenia in present pregnancy The associated thrombocytopenia and history of varices in these patient are limiting factors for anticoagulant therapy[1] .Neonatal outcome in these cases reported till now are good ,including the present case .

CONCLUSION:

Portal and Spleenic vein thrombosis is a rare complication in pregnancy.Preconception counselling should be done regarding aggravation of portal hypertension during pregnancy in women with this complication. A Multidisciplinary approach including obstetrician, gastroenterologist, anaesthetist, paediatrician is essential for good maternal and neonatal outcome.

Abbreviations:

1. USG- Ultrasonography
2. FHR -Foetal Heart Rate
3. AFI -amniotic fluid volume
4. SICU –surgical Intensive care unit.

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