PREGNANCY AFTER SHUNT SURGERY FOR PORTAL HYPERTENSION

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Introduction

There are isolated case reports in literature of pregnancy following shunt surgery for portal hypertension. Most cases are reported from Western World. Verka et al (1977) reviewed pregnancies in patients with cirrhosis as well as non-cirrhotic portal hypertension. Pregnancy outcome is better following shunt surgery in patients with Non-Cirrhotic Portal Fibrosis (NCPF) as compared to patients with Chronic Active Hepatitis (CAN) or cirrhosis.

We are reporting a case who had lieno-renal shunt surgery done during pregnancy and another successful pregnancy following that.

Case Report

Mrs. M.B., 24 year old para 3+0, married in 1979, had her first pregnancy in 1980. Antenatal course was uneventful. She was delivered by forceps at term because of fetal distress. Male baby weighing 2.6 kg. was delivered. The baby died after 21 days. He was suspected to have congenital heart disease.

Second pregnancy occurred in 1981. Patient developed features of portal hypertension and splenomegaly was noted during the third month of pregnancy. Since there was no feature of cirrhosis, portal hypertension was suspected to be due to NCPF. Patient was getting repeated bouts of haemetemesis and was managed conservatively. Surgery was postponed due to pregnancy. At 22 weeks of gestation she had a massive bout of haemetemesis and was brought to emergency in a state of shock. After resusitation lieno renal shunt surgery and splenectomy was done. The diagnosis of NCPF was confirmed. Patient stood the operation well and pregnancy course was uneventful following this. She started labour patients at 39 weeks and was delivered by lower segment caesarean section because of fetal distress during first stage. Male baby weighing 2.72 kg was delivered. Post operative period was normal.

During her third pregnancy in 1983, patient reported to antenatal clinic at 12 weeks of gestation. She had no symptoms as regards liver disease and liver function tests were within normal limits. Pregnancy and liver functions were monitored throughut. Patient had an uneventful course except for breech presentation. She started leaking at 36 weeks. The liquor was meconium stained. In view of previ-

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ous caesarean with breech presentation LSCS was done under general anaesthesia. A male baby weighing 2.56 kg was delivered. Post operatively patient had stitch sepsis and slight prolongation of prothrombin time. Rest of the liver functions were normal. Liver was also normal on ultrasound. Patient was discharged from hospital on 7/1/1984 in a fit condition. In subsequent 4 years she has had no further problem. Ligation was done alongwith second caesarean to prevent hazards from more pregnancies.

Discussion

Maternal mortality as high as 10% and fetal loss upto 40% has been reported in patients with hepatic cirrhosis (Welton and Sherlock, 1968). Nelson and Loughhead (1963) reported cases of pregnancy following porto caval shunt and found it to be less hazardous.

Verma et al (1977) reviewed literature on pregnancies in patients with cirrhosis and non-cirrhotic portal hypertension and reported a better outcome in patients with NCPF as liver functions are normal in these cases. A total of 58 pregnancies are reported with a pregnancy wastage of 33%. Inspite of shunt as many as 48% of their cases had gastro intestinal bleeds. Since renal haemodynamics is altered, fluid retention is commoner in these patients and a frequent antenatal check up is must to prevent metabolic encephalopathy, pulmonary oedema and convulsions etc.

Niven et al (1971) reported 10 pregnancies in 7 patients who were treated by shunt surgery upto 9 years previously. There were 8 live babies including on set of twins.

Cheng (1977) studied the effect of liver disease and/or portal hypertension on pregnancy and vise versa. According to him shunt surgery can be done safely during pregnancy and the prognosis is better following surgery. But these patients should preferably be delivered vaginally with a prophylactic forceps to avoid straining and blood should be kept ready. Caesarean is advocated for obstetric indications only.

Our patient was delivered by caesarean twice due to increased fetal risk of vaginal delivery and had two live babies following shunt surgery. Luckily she did not have any gastro intestinal bleeding during pregnancy or afterwards and but for slight stitch sepsis she did not develop any other complication.

References

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