Massive splenomegaly in pregnancy

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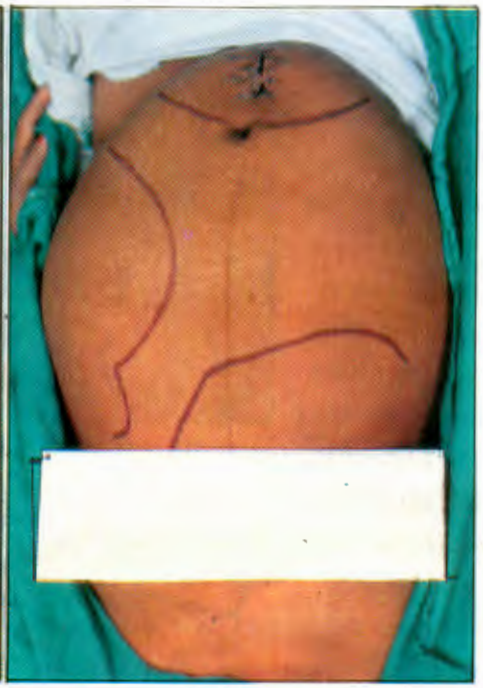
A 24 year old migrant from Bihar, G_2P_1 with no live issue was admitted through routine antenatal clinic of Guru Teg Bahadur Hospital & University College of Medical Sciences, Delhi, on 10/9/96 at 32 weeks pregnancy, as a case of severe anemia. She gave a history of breathlessness and swelling of face and feet of 2 weeks duration. She had no episode of bleeding per vaginum or bleeding from any other site. There was no history of diarrhoea, urinary tract infection or hematuria. Her diet was nutritionally poor.

Constitutional Dwarf
Height 120 cm


Surface markings showing massive hepatosplenomegaly

Patient was married 5 years back. Her first pregnancy was unsupervised and resulted in a fresh stillbirth at home 4 years back.

Patient was admitted at LNJP hospital, Delhi in 1994 with a diagnosis of condyloma lata and splenomegaly. Her VDRL was strongly positive, HbF 2.5% and was Coomb's negative. The bone marrow aspirate showed an erythroid hyperplasia with reticulocytosis and mild dyserythropoiesis. There was no parasite seen. The splenic aspirate showed a lymphoid aggregate and was essentially normal. Leishman Donovan bodies were absent. Skeletal survey showed no evidence of achondroplasia. She was labelled a constitutional dwarf.

On examination she was very short, height being 120 cms (Fig 1) and weight 35Kg. She had marked pallor, minimal edema feet, no clubbing of fingers and no cyanosis. Her pulse rate was 100/min, BP 100/70, respiratory rate 25/min. Cardiovascular system examination detected a haemic murmur and tachycardia. JVP was raised. There were occasional rhonchi in both lungs and fine basal crepitations.

The abdomen was found to be overdistended. There was ascites and a massive splenomegaly 10cm below the costal margin (Fig.2). The liver was also enlarged 4 cm below the costal margin. Obstetric palpation showed the uterus to be 28 weeks size with a single live fetus in cephalic presentation.

Investigations

Hb%-5.2gm%, TLC 3500, RBC 1.38 million, MCV 123 fl, MCHC 30 g/dl, MCH 37 pg, Platelet count $63x10^9$, reticulocyte count 2.5% and Hematocrit 17%. Peripheral smear showed a moderate anemia with pancytopenia probably nutritional macrocytic type. Her serum proteins were 6.1gm% and A:G ratio 0.9:1. Liver function tests and kidney function tests were normal. Urine examination showed numerous pus cells but culture was sterile. Antimalarial antibodies were negative. Serial ultrasound showed a normally growing fetus.

She received 2 units of blood, parenteral iron & folic acid supplementation and was dewormed. She also received a high caloric and high protein diet.

4 weeks after admission her hemoglobin was 9.5gm% and fetal growth was appropriate. A surgical consultation was sought advised and a splenectomy was 3 months after delivery. Patient was discharged and was asked to attend the high risk clinic and return for an LSCS. LSCS was done on 9-11-96 and a fetus with no evidence of congenital syphilis was delivered. At surgery the spleen & liver were markedly enlarged as is evidenced by the surface markings shown in figure 2.