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Pregnancy with Large Intra-Abdominal Tumor – Case Report

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Abstract: *The aim of this case report, is to make a Clinical presentation of a rare case of pregnancy, followed by large intra-abdominal intestinal tumor, which compromised the pregnancy and it was the reason for premature delivery. This tumor was diagnosed in 32 estational week of the pregnancy, when patient started with the symptoms of sudden and extreme vomiting and collapsing. She was hospitalized at the Department of Pathologic Pregnancies at Gynecology and Obstetrics Clinic in Skopje, after she was sent from a Clinical Hospital- Shtip, were she was first hospitalized. During the hospitalization at our Department, she undergo several Obstetrics and abdominal ultrasound examinations, hematological examinations, serological and infective examinations, tumor markers, gastroscopy and MRI which shown large abdominal intra peritoneal tumor located under the liver and gaster, dislocated the bowels toward the lower and the frontal part of the abdomen. The patient was submitted to a rehydration and symptomatic therapy, double antibiotic, anti anemic and t*hromboprophylactic therapy *to relieve the symptoms of vomiting and exhaustion. A fetal maturation with Flosteron 14mg was provided for two days, in 2 doses, within a period of 18 days. The premature delivery was planned with a surgeon. The patient gave birth 21 days after her hospitalization in the 35-th week of the pregnancy, with a Cesarean section and a medial infra umbilical incision. She gave birth to a living 2200 g male, 44 cm long with APGAR score 7/8.*

The Cesarean section was followed by opening of the upper abdomen with para- and supra umbilical incision and after the large abdominal tumor was removed by abdominal surgeon, it was sent to Pathohysthological examination. The pathohystologic diagnosis was: Adenocarcinoma intestini crassi Stage II b. In rare cases, pregnancy can be compromised by large intra-abdominal tumors which can put the health of both, the mother and the fetus in danger. The entire pregnancy period should be carefully observed, too, since the symptoms can sometimes lead to interdisciplinary examinations and consultations with other specialists.

Key Words: *Pregnancy, Intra-abdominal tumor, Prematurity, Ultrasound, MRI*

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I. Introduction

In some cases, pregnancy can occur with large tumor mases in the abdomen. This compromises the pregnancy and asks for premature delivery or abortion, depending on when the tumor mass is diagnosed. The abdominal tumors which occur during pregnancy may be of gynecologic origin, other abdominal tumors, lymphomas or other undiagnosed abdominal masses. These masses need to be operated as soon as the pregnancy ends. It's often difficult to diagnose them unless there are symptoms like pressure on the bowels, ileus, vomiting, weight loss and circulation problems.

II. Case Presentation

Pregnancy with large abdominal tumor, diagnosed in 32 g.w. in patient with symptoms including collapsing, and sudden and extreme vomiting.

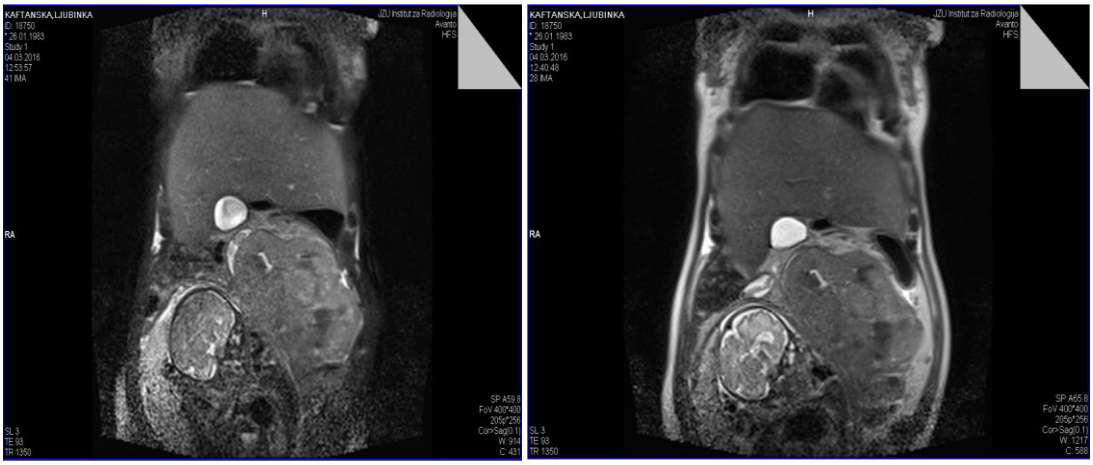
A 32-year old patient from a small town in Macedonia was hospitalized first at the Clinical Hospital in Shtip, after collapsing, abdominal pain and extreme vomiting. She was in 32 g.w. of 3rd pregnancy (2 unsuccessful pregnancies in the past). After submission, the anemic patient (she'd already received 2 units of erythrocytes at this Clinical hospital), a large intra-abdominal tumor mass was diagnosed and she was admitted at University Clinic of Obstetrics and Gynecology in Skopje were she was hospitalized, at the Department of Pathologic Pregnancies. During the first Obstetrics examination at our Clinic an eutrophic fetus with normal amniotic fluid, placenta on the front wall of the uterus and normal Doppler flow were confirmed. US show: a large intra-abdominal tumor mass – 165 X 105 mm - above the uterus and below the gaster was diagnosed, with hyper-echogenic tracks inside and splenomegalia.

Biochemistry: Hb - 95 g/l; Hct - 0,28%; Le 17 x 10-9L; Er 3,78 x 10-12L; Tr 464 x 10-9L; CRP-112.

III. Results And Discusion:

Realized examinations and results:

1. Serologic and infective disease examinations – negative.
2. Hematological examination – Anemia, leukocytosis with granulocytosis and thrombocytosis, and secondary fibrinolysis (D-Dimer 1997 ng/ml), CRP 112- very high.
3. Tumor markers: CEA, Ca125 and Ca 19-9 in normal range. Increased Ca 72-4 = 231,4 U/ml.
4. MRI of abdomen and pelvis were indicated:



A large polycystic tumor mass was detected in the central and left part of the abdomen. This mass (165x135x105mm), located under the liver and gaster, dislocated the bowels toward the lower and the frontal part of the abdomen. Doppler with mixed internal and pathologic signals and with polycystic mesenchymal tumor mass. Liver, spleen and pancreas without macroscopic changes. Suprarenal glands, kidneys and left ureter were normal. Hypotonic right ureter occurrence as a result of the uterus being pushed to the right side of the abdomen. Dg:Tumor hemiabdominis intraperitonealis lat.sin. (tumor abdominis magnum intraperitonealis) – mesenchymal tumor.

5.Gastroscopy examination - Reflux oesophagitis gr.B. Gaster and duodenum with normal findings.

6. Enteroscopy not possible.

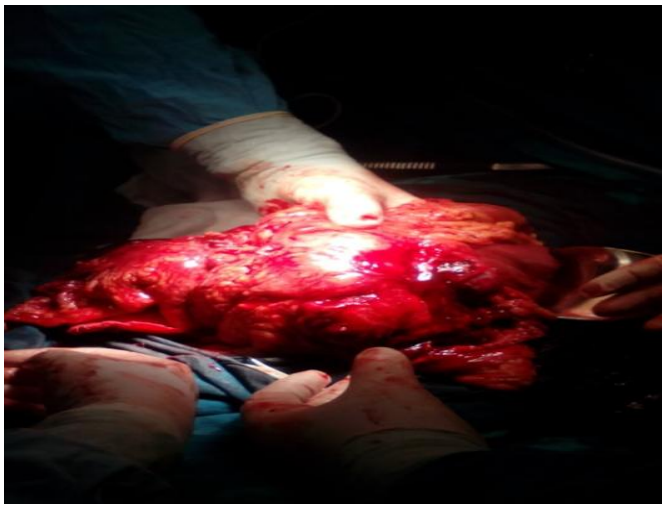
Pre operative treatment:

The patient was submitted to a rehydration and symptomatic therapy, double antibiotic, anti anemic and thromboprophylactic therapy to relieve the symptoms of vomiting and exhaustion. A fetal maturation with Flosteron 14mg was provided for two days, in 2 doses, within a period of 18 days. The premature delivery was planned with a surgeon.

Operative treatment:

The patient gave birth 21 days after her hospitalization with a Cesarean section and a medial infra umbilical incision. She gave birth to a living 2200 g male, 44 cm long with APGAR score 7/8.

The Cesarean section was followed by opening of the upper abdomen with para- and supra umbilical incision as a result of the discovery of a large tumor formation in collision with "curvatura major of the gaster" and infiltration of intestines. After the tumor was removed- resection of colon transersum with T-T-anastomosis and resection of the intestines with T-T anastomosis was conducted and the tumor mass was sent to Pathohystological examination.



Post operative treatment:

After the surgical procedure, the patient was transferred to the Clinic of Abdominal Surgery and submitted to rehydration, symptomatic, substitutional (erythrocytes, plasma and albumins), antibiotic, uterotonic and thromboprophylactic therapy. The postoperative period and peristaltic movement were normal, while the patient was defecated on the seventh day. She was released on the 10th day. The pathohystologic diagnosis was: Adenocarcinoma intestini crassi Stage II b. One month after surgery patient was sent to Oncology Clinic in Skopje, for further oncologic treatment.

IV. Conclusion:

In rare cases, pregnancy can be compromised by large intra-abdominal tumors which can put the health of both the mother and the fetus in danger. It's suggested that future mothers are regularly examined, prior to pregnancy, so that they can keep track of their health and ability to reproduce. The entire pregnancy period should be carefully observed, too, since the symptoms can sometimes lead to interdisciplinary examinations and consultations with other specialists. This will ensure mothers are healthy and can give birth to healthy offspring. Up to her 32nd g.w. the patient in this case report was only examined by her local gynecologist and was not submitted to secondary or tertial obstetrics examination or any other clinical or laboratory examination, hence her condition couldn't be diagnosed sooner.

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