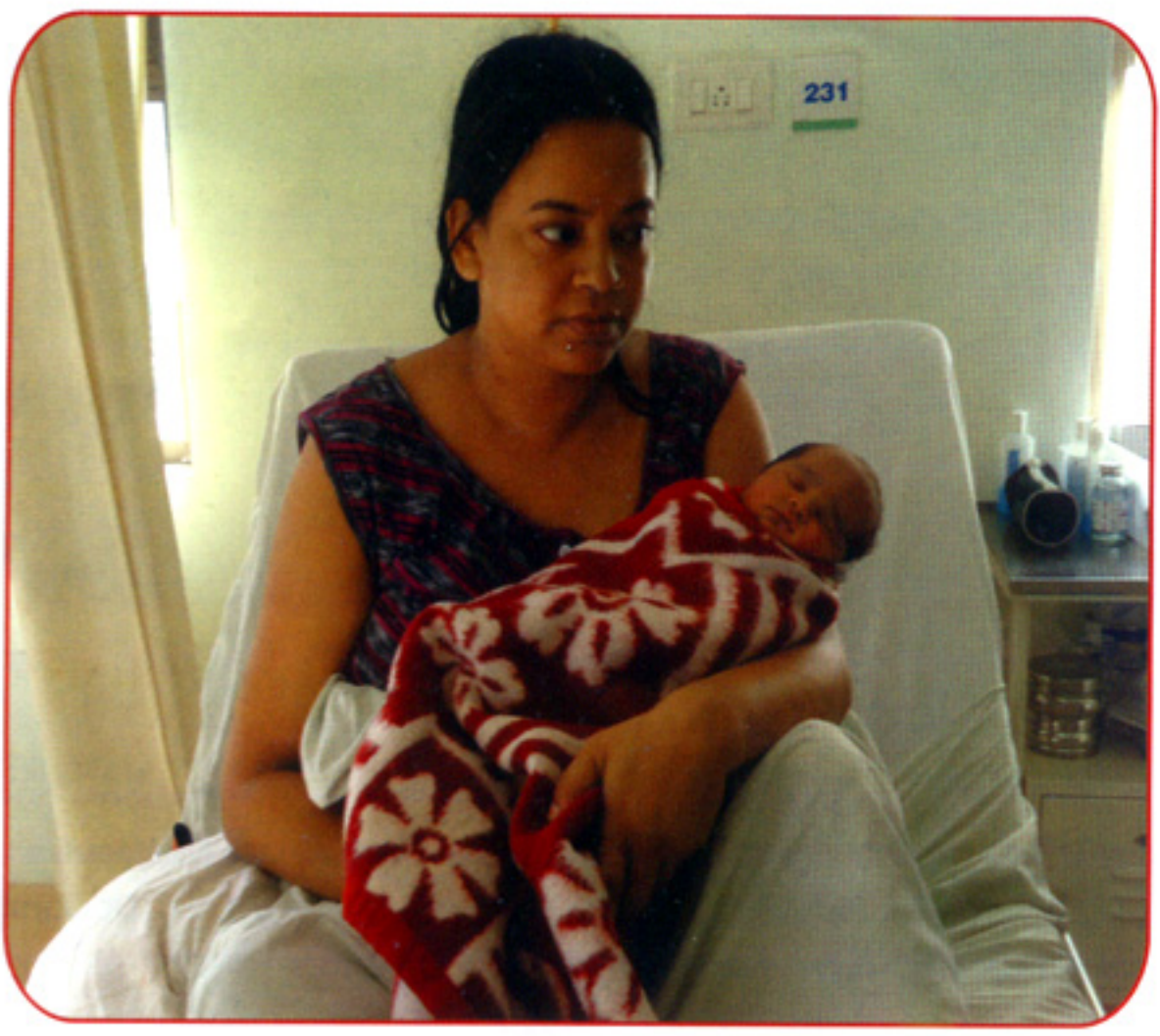
Mother combats multiple complications and delivers a healthy baby

Patient Name: Moumita Dey Age: 40 yrs

Medical team: Dr. Amit Dey (Critical Care Specialist), Dr. Sankar Das Mahapatra (Consultant-Gynae & Obs), Dr. Paromita Srimani (Registrar-Gynae & Obs), Dr. Sumita Saha (Consultant-Paediatrics & Neonatology)

A 40 yr old female, came to our emergency in March, 2012, with respiratory distress due to left ventricular failure (LVF) and hypertension, along with 18 weeks of pregnancy. She had a known case of Rheumatic heart disease (RHD) with systemic hypertension. She was treated in ICU by our medical team and thorough investigations were done. She was also referred to our endocrinologist



for stabilizing her thyroid level. Her complete hemogram, LFT & renal function parameters were quite normal. After bringing her respiratory distress under control she was discharged in stable condition after a week. Thereafter, she was referred to our High risk pregnancy clinic.

Her first pregnancy was uneventful, delivered by Caesarean Section, 11 yrs back. The first trimester of her second pregnancy was also normal until she developed LVF during 18th week of pregnancy. She was very compliant and regularly visited our clinic for proper monitoring of her RHD and pregnancy. Serial ultrasound scans were performed to determine adequate foetal growth and it was found that her left adnexal mass was gradually increasing in size. Her last scan during 30th week indicated size of left adnexal mass as 7.2cm x 4.7cm with low level internal echoes and calcification suggestive of dermoid.

Her antenatal progress was satisfactory even with mild Pulmonary Artery Hypertension (PAH) until at 36th week she developed acute LVF and was admitted in our ICU with severe respiratory distress. On admission she had pallor with generalized edema and very high BP. CTG monitoring confirmed foetal bradycardia (slow heart rate). She was not in labour but we immediately decided to perform the emergency caesarean Section after initial resuscitation of the mother. A live female baby of 3 kg was delivered with one episode of apnoea after birth so it was immediately transferred to NICU for proper resuscitation. Our Neonatal team took care of the baby till the mother fully recuperated. Along with caesarean section, left sided ovarian cystectomy and b/l tubal ligation were performed. The specimen of left ovarian mass was sent for histopathological examination. Post surgery the mother was kept on elective ventilation. Her vitals were meticulously monitored by our intensive care team. Gradually the ventilator support was removed and she was shifted to the ward. The baby and mother were finally discharged after a week in a stable condition.