Portal hypertension management during pregnancy

Key words: Portal hypertension. Upper gastrointestinal bleeding. Pregnancy.

Dear Editor,

There are few publications on portal hypertension (PH) and pregnancy and there are no specific clinical guidelines, so the management of this complex situation is controversial. We review the literature and report the first case of upper gastrointestinal bleeding in pregnant patient with PH requiring emergency cesarean section during the same endoscopy procedure.

Case report

A 34-year-old woman at 30 weeks gestation, with portal vein cavernomatosis since age 7. Three episodes of upper gastrointestinal bleeding secondary to esophageal varices (EV) were reported during her adolescence. Patient was anticoagulated due to acute mesenteric vein thrombosis. In the first trimester of pregnancy, beta-blockers and oral anticoagulants were removed and changed to low weight heparin. In a gastroscopy performed six days before the event to review the EV, a grade I and II EV without red signs were observed.

She went to the emergency room for melenas and hypotension. Tests showed hemoglobin 7.1 g/dl. Urgent gastroscopy was performed in which EV grade II with red signs and active bleeding were observed, so we performed endoscopic variceal ligation. After that, we decided to perform emergency cesarean section for fetal extraction due to patient hypovolemic shock and then, we began treatment with somatostatin and revised endoscopically, aiming control of bleeding. The newborn required incubator care and both were discharged after a few days since admission.

Discussion

The PH worsens during pregnancy due to the increased blood volume and its major complication is bleeding by EV, which occurs in 25-75 % of cases (1,2). The greatest risk occurs in the second-third trimester and during the labour (1,3).

There is controversy about the management of the EV during pregnancy (3,4). A screening endoscopy should be done in pregnant women with cirrhosis or PH either before pregnancy or in the second trimester (1,3). When there are EV at high risk of bleeding may be used non-selective beta-blockers, but this implies to monitor neonate due to hypoglycemia and bradycardia risk; an endoscopic ligation (EL) could also be performed (2,3,5). Regarding the acute bleeding episode, EL is the method of choice (3,5). Octreotide, somatostatin and terlipressin are contraindicated because they may produce reduced placental perfusion (5). TIPS is only indicated as rescue therapy for radiation risk to the fetus (1,3). The choice of method of delivery is also controversial (2,3,6), some people prefer elective caesarean as the fetus is viable, others defend forceps vaginal delivery (3,6). Gastroenterologists and obstetricians should be involved in the management.

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