

Rare Surgically Correctable Anomalies of the Fetus- An Obstetrician Dilemma

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Abstract

By Universal adoption of first and second trimester screening, the rate of detection of congenital anomalies has been improved with sensitivities ranging up to 85-90%, but their detection at an advanced gestational age becomes a dilemma for the patient as well as the obstetrician. With this article we share our experience, dilemma and doubts about some of these rare surgically correctable anomalies managed at our institute.

Keywords: Rare surgically correctable anomalies, Ultrasound, role of Obstetrician.

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INTRODUCTION

Obstetric challenges are full diagnostic dilemmas. One such situation arises when rare surgically correctable anomaly is detected at an advanced gestational age. The biggest task is to break the news of these rare anomalies to the parents. For the obstetrician point of view, deciding the mode of delivery becomes most challenging. Cases which were encountered at our Center were -Dandy Walker Malformation, gastroschisis, congenital megacolon, myelomeningocele and Trachea-esophageal fistula over duration of one year with delivery rate of 1000 per year. Most of these anomalies can be corrected post natally hence the delivery of such fetus at tertiary care centers where the expertise in areas of genetic, neurosurgery, gastro-surgery, urology, neonatology, pediatric surgery and peri-neonatology is available is the most important pre-requisite [1].

CASE SCENARIOS

Case-1

A 26-year-old G2A1 presented late at 38 weeks gestation with USG (24 weeks) suggestive of Dandy -Walker Malformation. No other antenatal markers had been done. LSCS was done on maternal request and delivered a male, 2.6 kg. No other associated anomalies were detected. Diagnosis was confirmed by MRI brain and ventriculo-peritoneal shunt was performed post-natally. Long term prognosis

is still awaited. The baby is being followed up to determine long term prognosis.

Case-2

A 23-year-old G1P0L0 presented late in labor at 35 weeks gestation with USG (28 weeks) suggesting gastroschisis. She gave birth to 1.8 kg male boy baby. No associated anomalies were detected. Baby referred to another center for further management due to lack of surgical expertise at our institution.

Case-3

A 22-year-old G1P0L at 36 weeks came in labor with thick meconium at 6 cm cervical dilation and non -reassuring CTG. Her USG (30 weeks) reported congenital megacolon. Patient underwent LSCS and give birth to a male baby of 2 kg. No associated anomalies were detected. Baby referred to another center due to lack of surgical expertise available at our institution.

Case-4

A 26-year-old came at 40 weeks for induction of labor. Previous scans were normal. Due to meconium stained liquor at 4 cm and pathological CTG, Emergency caesarean section was done. Post-natally, lumbar myelomeningocele was detected which was not detected in her antenatal ultrasounds. No other associated anomalies were detected. Successful myelomeningocele repair was done with no residual defects.

Case-5

A 25-year-old G1P0L0 presented at 40 weeks in labor with antenatal diagnosis of Tracheo-esophageal fistula at 26 weeks for further management. Due to meconium stained liquor and pathological CTG, Emergency caesarean section was performed. Post-natally multiple anomalies such as undescended testis, anal atresia also detected and baby developed severe respiratory distress. Baby put on artificial ventilation but eventually succumbed.

DISCUSSION

With the advancement of ultrasound technology, the detection of these rare surgically correctable anomalies has increased but they can be missed if done by unexperienced personal and when detected at a later gestational age causes a chaotic condition in the mind of both the obstetrician and the parents. Many a times such anomalies are associated with chromosomal anomalies; posing a dilemma regarding mode of delivery thus the need for the antenatal screening of all patients needs to be emphasized. The goal is to offer non-invasive training (trisomy 13, 18 and 21) to all pregnant women and to offer invasive testing who screen positive [2]. Earlier detection can help in making better informed choices. Antenatal diagnosis has the advantage of planning delivery at centers which are equipped in handling these surgically correctable anomalies and counselling regarding post-natal prognosis [3]. At our institute the incidence of such anomalies is 6 to 8 per 1000 deliveries and all such cases were unbooked and were referred from other hospitals. The counselling of parents of malformed newborns is very critical and may involve several meetings to make them understand and accept such situations [4]. The decision to terminate can also be made if such anomalies are detected earlier. There can be mixed reactions, some might fail to accept, some will develop parental love for such malformed babies [5]. There is immense psychological impact of these conditions and repeated consultations has shown to have lower anxiety levels in parents [6]. With the advancement of pediatric surgery these rare anomalies can be corrected but carry with them the morbidities such as residual sequela, prolonged NICU stay, failure to thrive and the heavy expenses which could be incurred for these corrective surgeries. The scarcity of skilled surgeons in managing these conditions is one of the main limiting factors [7]. The most difficult decision for the obstetrician is deciding the mode of deliveries when they present at a later gestational age. Delivering such anomalous babies by caesarean section also raises the question of long-term survival of such babies. Appropriate and intensive counselling, understanding the limitations of the institution, lack of surgical expertise, all put together a pose a great challenge to the managing obstetrician.

CONCLUSION

Surgically correctable anomalies of the fetus have now become a surgical reality. The need of prenatal diagnosis, appropriate counselling, planning deliveries at centers equipped with facilities to manage these anomalous babies can help the obstetrician in better dealing with these babies presenting at later gestational age.

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REFERENCES

1. Kumar, P., & Burton, B. (2008). Malformations, Evidences based evaluations and management. New York. Mc Graw Hill Medical.
2. Chitayat, D., Langlois, S., Wilson, R. D., Audibert, F., Blight, C., Brock, J. A.,... & Johnson, J. A. (2011). Prenatal screening for fetal aneuploidy in singleton pregnancies. *Journal of obstetrics and gynaecology Canada*, 33(7), 736-750.
3. Kurjak, A., Gogolja, D., Kogler, A., Latin, V., & Rajhvajn, B. (1984). Ultrasound diagnosis and perinatal management of surgically correctable fetal malformations. *Ultrasound in medicine & biology*, 10(4), 443-455.
4. Provoost, V., Cools, F., Deconinck, P., Ramet, J., Deschepper, R., Bilsen, J., ... & Deliens, L. (2006). Consultation of parents in actual end-of-life decision-making in neonates and infants. *European journal of pediatrics*, 165(12), 859-866.
5. Stanojevic, M. (2010). Medical management of newborn with severe malformations—ethical aspects. *Schenker GJ. Ethical dilemmas in perinatal medicine. Jaypee Brothers Medical Publishers, St. Louis, Panama City, Delhi*, 197-204.
6. Aite, L., Trucchi, A., Nahom, A., Zaccara, A., La Sala, E., & Bagolan, P. (2003). Antenatal diagnosis of surgically correctable anomalies: effects of repeated consultations on parental anxiety. *Journal of perinatology*, 23(8), 652-654.
7. Farmer, P., Sikin, N., & Lofberg, K. (2015). Surgical intervention for congenital anomalies. *Esse Surgery*. Chapter 8.