

Introduction

Meningiomas account for approximately one third of intracranial tumors. They are the second most common brain tumor seen in adults after gliomas [1]. Meningiomas are 2 to 3 times more common in women, Pregnancy is a physiological state that gives any maternal pathology a specific character. The de novo diagnosis of a neurosurgical pathology in a pregnant woman is a rare circumstance that poses a neurological, obstetrical and anesthetic problem.

Methodology and research tools:

We report a case of a meningioma discovered in a pregnant woman, and we aim to discuss its management and prognosis.

Results

A 42 years old female patient with no previous pathological history, G3P3 bi-scarred uterus, with an imprecise last period and no previous prenatal care.

The patient reported frontal headaches that have been evolving since 2 months, yet neglected. The evolution was characterized by the development of vomiting associated with urinary and fecal incontinence.

Results

The patient was brought in by the civil protection for altered consciousness. The medical examination in the emergency room showed an afebrile patient with a stable hemodynamic state. A Glasgow coma scale of 11 with no localization sign. The rest of the clinical examination was unremarkable. Ultrasound: evolving monofetal pregnancy of 28SA. Given the suspicion of cerebral thrombophlebitis, a cerebral CT angiography was performed, showing a 66*65*72 frontal expansive process responsible for a deviation of the midline and a cerebral involvement[figure1]. The patient was immediately transferred to the neurosurgery department. The operation was performed the same day under general anesthesia. The surgical excision was macroscopically complete. The histological study revealed a WHO grade I transitional meningioma. The postoperative course was simple.

The recovery was satisfying and functional autonomy was regained within 10 days

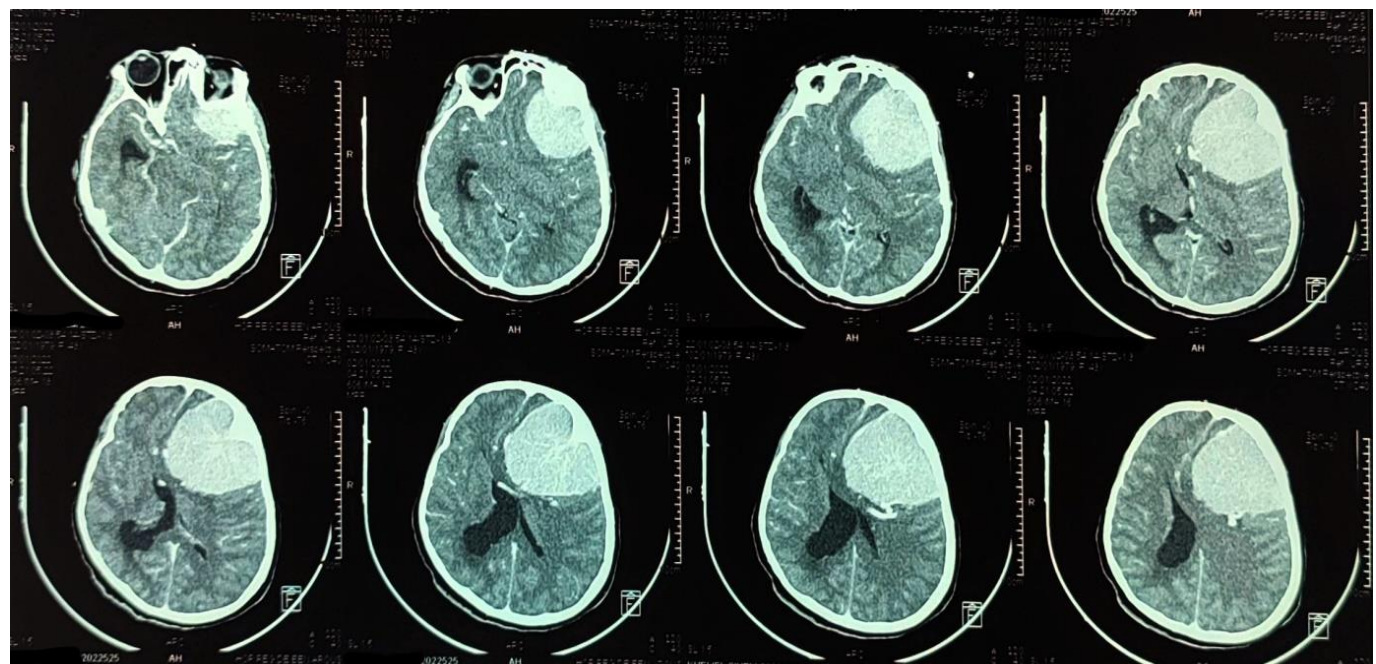


Figure 1: Left frontal extra axial intracranial expansive process responsible for midline deviation and diencephalic engagement

Discussion

Numerous studies have underlined the role of sexual hormones in the development of meningiomas.[2]

The aggravation of the symptoms during pregnancy would be due to the following factors: the presence of hormonal receptors on the tumoral cells, the vasogenic cerebral edema due to the retention of water and sodium, and the immunosuppression related to pregnancy[3,4].

MRI remains the most adequate exploration[5].

When cranial surgery is indicated during pregnancy, the first risks to avoid are hypotension, blood loss and hypoxia which can alter fetal perfusion. The positioning of the pregnant patient also poses a great challenge. Classically, a semi-sitting position is used for posterior fossa lesions, and during pregnancy Pre- and postoperative corticosteroid therapy is useful for cerebral edema, the administered dose is divided, and mannitol should only be administered in acute emergencies because it crosses the placenta and can be harmful to the fetus [6],

Conclusion

The diagnosis of a neurosurgical pathology during pregnancy is a rare situation leading to specific neurological, obstetrical and anesthetic difficulties. Therefore, It’s management should be multidisciplinary.

Références

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