

MANAGEMENT OF HIGH-RISK PREGNANCY IN A PATIENT WITH HEPATOCELLULAR ADENOMA (HCA)

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OBJECTIVE

- ❑ HCA is a rare benign tumour of the liver with an incidence of 1 per 1000000 in oral-contraceptive-pill (OCP) naïve women
- ❑ Pregnancy impacts survival due to the risk of steroids-induced growth and rupture with high rates of maternofetal mortality [1]
- ❑ It is imperative to reflect upon the care of pregnant patients with HCA, to build upon the current limited evidence and strengthen future clinical management and recommendations

CASE REPORT

3 years old female, Gravida 5 Para 4, with BMI 50, was awaiting endometrial ablation and sterilisation for dysfunctional uterine bleeding. Meanwhile, she underwent laparoscopic cholecystectomy, where a sub-capsular lump was noted and subsequent MRI and CT scans confirmed multiple hypervascular liver lesions under 5cm, with significant splenic, renal varices with portal hypertension. Laparoscopic biopsy confirmed HCA. While awaiting her gynaecological procedures, the patient conceived (booking BMI of 54). Her medical history included repairs of strangulated umbilical hernias and chronic iron-deficiency anaemia.

She was followed up in medical obstetrics clinic and received concurrent care from the upper gastrointestinal team. Serial MRI and ultrasound scans through the pregnancy confirmed little changes in the size of the HCAs. She developed gestational diabetes mellitus (GDM) requiring Metformin and induction of labour (IOL) was organised at 39 weeks of gestational age. She was treated with intravenous proton-pump inhibitors and active phase of second stage was limited to 30-minutes. She proceeded to a vaginal delivery complicated by a postpartum haemorrhage of 600ml. She was discharged with a plan for sterilisation.

DISCUSSION

- ❑ HCA can grow and rupture during the length of pregnancy with high rates of mortality
- ❑ Multidisciplinary management is paramount and lesions demonstrating significant growth must be promptly identified with serial imaging and managed with embolization or surgery
- ❑ Surgical management is extremely hazardous in pregnancy and women with high BMI
- ❑ Ultrasonography can be challenging, and MRI should be used if readily available
- ❑ Labour and delivery must be arranged in tertiary healthcare settings that can support unexpected complications with advanced life support and resuscitation capabilities

CONCLUSIONS

- ❑ Holistic management of pregnant women with HCA is crucial
- ❑ Pregnancy and associated hazards should be approached based on individual risk profiles
- ❑ Sterilisation services must be optimised in women of reproductive age with HCA

1. Cobey FC, Salem RR. A review of liver masses in pregnancy and a proposed algorithm for their diagnosis and management. Am J Surg. 2004 Feb;187(2):181-91.