

POLYCYSTIC KIDNEY DISEASE ASSOCIATED WITH PREGNANCY

Pages with reference to book, From 167 To 167

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The Current view regarding renal disease complicating pregnancy suggests that there are no adverse effects on the kidney if kidney function is only moderately compromised in the absence of hypertension¹⁻⁵. Sustainance of a viable pregnancy depends mainly on the degree of functional impairment rather than on the underlying parenchymal disease. Polycystic kidney disease should be included in the differential diagnosis of abdominal masses associated with pregnancy. An unusual case of renal disease associated with pregnancy is presented.

CASE REPORT

A 25 year old primigravida was admitted with acute abdominal pain at 29 weeks unsure gestation. On examination she was clinically anaemic, uncomfortable but not in acute pain. She was normotensive and pulse was 100/minute, regular and good volume. Temperature was normal. On abdominal examination a huge cystic mass was filling the whole abdomen. Fluid thrill was present. Foetal parts were felt on the right side. Presenting part was cephalic and foetal heart rate was 140/mt regular. Pervaginam examination was inconclusive. Cervix was however closed. There was definite history of pain in the left renal region radiating to the back and dysuria since the first trimester of the pregnancy. Symptomatic treatment had been given by local general practitioners from time to time. An ultrasound examination done two days prior to admission revealed a huge, cystic, partially septate mass arising from the pelvis, extending to the left hypochondrium and epigastrium with a single active foetus of 29 weeks gestation. A presumptive diagnosis of ovarian cyst complicating pregnancy was made. At laparotomy, a 18 cm x 10 cm left retroperitoneal cyst was found pushing the transverse colon, splenic flexure and descending colon to the midline and the gravid uterus of 30 weeks gestation to the right. Right kidney was normal. Both ovaries were normal. A left-sided nephrectomy was done. Foetal cardiac activity remained normal throughout the uneventful postoperative period. Histopathological examination confirmed the diagnosis of polycystic kidney disease. Spontaneous labour commenced at 35 weeks gestation. Second stage of labour was expedited by elective outlet forceps with episiotomy. A live male infant weighing 2.2 kg was delivered. Apgar scores were 7 at 1 minute and 10 at 5 minutes. Unfortunately, on the 5th postnatal day the baby expired 2 hours after feeding (neonatal death). The same patient, however, booked for hospital confinement in her second pregnancy at 26 weeks gestation. All renal function tests remained normal throughout. A live female infant weighing 2.7 kg was delivered at 38 weeks gestation. She failed to attend the post natal clinic on both occasions.

COMMENTS

Renal disease is known to be associated with intrauterine growth retardation^{2,6}. Average birth weights are low since most deliveries are preterm. In child bearing age, usually the functional impairment is minimal and hypertension absent leading to favourable outcome in delivery⁷. This was so in the present case.

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