

Pregnancy Against all Odds – A Successful Pregnancy in a Case of Abdominal Koch's

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Abstract: *We report the case of a 32-year-old, known case of secondary infertility, diagnosed with abdominal Koch's. Investigations during the course of treatment revealed a viable uterine pregnancy. The pregnancy continued until term and she delivered a healthy male baby. Diagnostic and therapeutic challenges in the course of treatment are discussed.*

Keywords: Pregnancy, infertility, Tuberculosis, Obstetric dilemmas

1. Introduction

Tuberculosis one of the oldest diseases known to affect human, is still a major worldwide concern. It is estimated that 216 500 active tuberculosis cases existed in pregnant women globally in 2011^[1].

India recorded the highest number of cases among the pregnant women - 44 500 i.e. 21% of the global tuberculosis burden^[1]. The presence of tuberculosis infection during pregnancy, delivery, and postpartum, compounded by effects of poor nutrition and poverty, is known to cause unfavorable outcomes for mother and child^[2, 3].

The non-specific nature of clinical symptoms, the overlap with complaints commonly reported during pregnancy and the delay in utilizing investigative modalities such as radiology makes the management challenging^[1, 2, 3]. We present case of a 32 years lady, known case of secondary infertility, diagnosed to have abdominal Koch's and during the course of investigations was found to be pregnant. The relevant literature is briefly reviewed.

The objective of our work is to emphasize the importance among clinicians the importance of early diagnosis and active clinical management to prevent maternal and neonatal morbidity.

2. Case Report

We present here a 32-year-old woman, Para 1 Neonatal Death 1, case of secondary infertility since 13 years with the history of laparoscopic myomectomy done 5 years ago. She was married since 14 years – non consanguineous marriage, with the history of preterm vaginal delivery with neonatal death at day 1 of life attributed to respiratory distress. She came to our institute with abdominal pain - which increased in intensity in the last 2 days and with distention of the abdomen since one week. On clinical examination patient was afebrile, vitals were within normal range, abdomen was

distended and tender with diffused dullness on percussion without guarding, rigidity and palpable masses. Patient was admitted first in surgery department and referred to us in the view of irregular menses. Urine Pregnancy test done was negative. Laboratory investigation showed normal hemogram without leucocytosis. Chest X –ray was within normal limits. Abdominal ultrasound showed intra-abdominal fluid. CT Abdomen was done which showed moderate free fluid in abdomen and pelvis, loculated fluid collection in Morrison's pouch, bulky pancreas and peripancreatic fat stranding. Ascitic fluid tapping was done which showed hypocellular smear with occasional lymphocytes, raised ADA levels, normal GeneXpert study and CA 125 levels. Fluoroscopy guided pig tailing of the loculated cyst was done. Patient was started on category 1 antitubercular drugs according to RNTCP guidelines 7 days after admission. MRI abdomen – pelvis was done which showed bulky uterus with the possibility of intrauterine gestation. Urine pregnancy test was repeated 10 days after the first testing, which tested positive. Serial beta HCG titers were done, which showed doubling. An obstetric ultrasound was done, which showed intrauterine pregnancy. Continuation of pregnancy was a dilemma. Concerns about radiation exposure, recent medications and anti-tubercular drugs started in periconceptional period vs. history of infertility of 13 years and strong desire of the couple to have a child of their own were weighed. The couple was counseled, risk of teratogenicity and congenital anomalies were discussed. They opted for the continuation of pregnancy with due risk. Regular Antenatal visits, hematinics and calcium supplementation, detailed 2nd trimester anomaly scan and regular obstetric ultrasound were done. During pregnancy at 28 weeks, patient had developed pain in abdomen and was admitted and evaluated. While the obstetric ultrasound was within normal limits, ultrasound of abdomen – pelvis showed cholelithiasis, which was managed conservatively. AKT by DOTS regimen was continued for 6 months i.e. until 34 weeks of pregnancy. Pregnancy continued till term safely. At term elective cesarean section vs. vaginal delivery was discussed taking

into account the precious nature of pregnancy. Patient and husband were not willing for elective LSCS. Patient went into spontaneous labour at 38 weeks. Emergency LSCS was done in the view of fetal distress - meconium stained liquor in early labour at 3cm dilation of cervix. Intra-operatively flimsy adhesions were present on anterior wall of uterus, the procedure was otherwise uneventful. 2.607 kg Male baby was delivered, baby cried immediately after birth. Baby was evaluated for evidence of TB by Gastric lavage GeneXpert study and USG Abdomen. All were negative for Tuberculosis. Post-operative stay was uneventful. Baby was breastfed by the mother and both had an uneventful hospital stay of 7 days. Mother and baby were discharged in healthy condition.

3. Discussion

The challenges of diagnosing TB during pregnancy may lead to under-recognition of TB in pregnant women^[4, 5]. When dealing with at-risk groups, a high index of suspicion needs to be maintained. Non-obstetric causes such as infectious diseases including tuberculosis now account for 28% of maternal deaths^[6]. It is therefore important for clinicians to remain vigilant while managing pregnant women to minimize harm to the mother and the baby. Adverse outcomes correlate with late diagnosis, incomplete or irregular treatment.

The patient an elderly, with the history of preterm delivery 13 years ago that resulted in neonatal death at day 1 of life came with the history of irregular periods, diagnosed as abdominal tuberculosis. As gynecologists, we are often referred patients with tuberculosis from other departments for the termination of pregnancy. In the past the coexistence of tuberculosis and pregnancy was considered so disastrous that the pregnant women were invariably advised termination. The prognosis in tuberculosis has become vastly more favorable. The latest national guidelines specify except for patients with multi-drug resistant tuberculosis or patients on category 2 drugs, tuberculosis is not an indication for therapeutic termination of pregnancy. We need to be aware that tuberculosis is a cause of primary and secondary infertility. Despite radiation exposure and patient taking antitubercular drugs, in this case keeping in mind their strong desire for an offspring, after detailed and non-directive counseling, the choice to continue pregnancy was made by the couple. Reluctance to undergo elective LSCS probably due to previous history of vaginal birth, respecting the patient's decision we waited for spontaneous labor. However, the outcome was LSCS but resulting in good outcome for mother and child.

Antenatal care services provide a unique opportunity for tuberculosis screening and follow up, in the view of a pregnant woman's ongoing contact with the health system during antenatal care, delivery and afterwards. Provision of the treatment to pregnant women with active tuberculosis who are already integrated into the health system through maternal and child health services should optimize outcomes for both the mother and potentially reducing tuberculosis transmission to the neonate, ultimately reducing secondary cases in children, an important subpopulation with high burden of disease. Hence, in high HIV and TB-burden

antenatal clinics, the WHO recommends National TB Programmes (NTPs) to make a concerted effort to capture pregnancy-associated TB and to follow-up on perinatal outcomes. A multidisciplinary and improved care for pregnant women with tuberculosis will contribute significantly in achieving the Sustainable Development Goal target of ending tuberculosis by 2030.

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