Lymphoma in pregnancy – devastating decision of delivery and treatment

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ABSTRACT

Introduction: Non-Hodgkin's Lymphoma (NHL) in pregnancy is rare. B-cell lymphomas may be either indolent or aggressive type. Once NHL is diagnosed during pregnancy, it tends to be a fast-growing and high-grade type. **Case Description:** A 28-year-old, G2P1 was diagnosed with diffuse large B-cell lymphoma (DLBCL) stage IVB at 26 weeks POA. She presented with B symptoms, multiple cervical lymphadenopathies, and markedly elevation of lactate dehydrogenase. CT neck and Thorax showed the presence of a huge mediastinal mass with multiple bilateral cervical and upper abdomen lymphadenopathy. The diagnosis was confirmed by the cervical lymph node biopsy. She received tumour debulking therapy followed by combination chemotherapy which led to remission of the disease. She had undergone an elective caesarean section and bilateral tubal ligation after 2nd cycle of chemotherapy at 32 weeks, and a healthy girl was born without congenital abnormalities. She recovered well and resumed further chemotherapy treatment three weeks post-operative. She had repeated CT neck and thorax at mid-cycle chemotherapy, showing excellent response to treatment. She is planning for a PET scan after the completion of the chemotherapy. **Discussion:** DLBCL is a fast-growing and aggressive form of NHL; it leads to fatality if left untreated. With timely and appropriate treatment with combination chemotherapy of 21-day cycles even in pregnancy, the overall cure rates are approximately two-thirds in the general population. It should not delay in administration of chemotherapy in a pregnant lady. Decision timing and mode of delivery are crucial and require a multidisciplinary approach.

Not the usual abdominal pain – Case report on spontaneous intraabdominal bleeding in pregnancy

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ABSTRACT

Introduction: Spontaneous hemoperitoneum in pregnancy is defined as unprovoked intra-abdominal bleeding in pregnancy and up to 42 days postpartum. Common causes include spontaneous rupture of vessels or direct bleeding of endometriosis implants which can be associated with severe adverse pregnancy outcomes. **Case Description:** We report a case of spontaneous intraabdominal bleeding in a patient who presented with labour symptoms. A 36-year-old, gravida 4 para 3 presented at 39 weeks 2 days with strong contraction pain for one day. Upon assessment, the patient was restless and tachycardic with abdominal tenderness and guarding. Vaginal examination showed os 4 cm. She also had hyperglycemia with metabolic acidosis. Cardiotocography showed poor variability with contraction more than 5 in 10 minutes. She was sent to the labor room for amniotomy and delivery. However, shortly after amniotomy, there was fetal bradycardia and decision was made for an emergency lower segment caesarean section to rule out placenta abruptio. During the surgery, there was hemoperitoneum of 1.3 L and no other obvious bleeding or uterine rupture was identified besides oozing from the endometriosis spots over posterior fundus of the uterus. She then had uterine atony which was stopped with uterotonics and compression sutures with total estimated blood loss was 4 L. Baby was delivered with low Apgar 2,5. Patient and baby were then discharged in stable condition after an uneventful recovery. **Discussion:** Spontaneous hemoperitoneum in a pregnancy is a rare but life-threatening event. Prompt diagnosis and management are essential to prevent maternal and fetal mortality and morbidity.