Case Report

Huge cystic hygroma a rare congenital malformation- A case report

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Abstract

Cystic hygroma [CH] is a rare congenital malformation, it is a fluid filled sac resulting from blockage in the lymphatic system. CH is usually presented in the posterior triangle of neck (B/L) but can be found in other body parts such as chest, legs, groin and buttocks. A literature review revealed that for CH 42% of infants are 45*0, 38% have a normal karyotype and 18% have trisomies. survival rate for fetal cystic hygroma is 10%,extensive usage of usg has increased the rate of detection of CH in pregnancy2. It can be detected on usg from the end of the 1st trimester. The prognosis depends on chromosome analysis, associated anomalies and the size of fetal cystic hygroma. Causes of CH is viral infection passed from mother to baby during pregnancy, exposure to drugs or alcohol during pregnancy. CH may be associated with nuchal lymphangioma or fetal hydrops.
Key Words: cystic hygroma.

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21 year old primigravida 32.2 wks b/d and 32.4 wks b/s(19.4 wks) unregistered patient referred from outside In view of congenital anomaly i.e. USG suggestive of large cystic hygroma. 2nd trimester USG (19.4wks) was done which was normal without any anomaly. At 32.1wks of gestation USG revealed multiple anomalies i.e large cystic mass lesion in the region of neck s/o cystic hygroma, Aplasia of the entire mandibular bone, echogenic bowel loop, subcutaneous fluid collection in the abdomen.MRI was done which s/o large multiloculate cystic lesion in the anterior part of neck extending upto abdomen, no other associated anomalies. There was no family history of any congenital anomaly. Serial of scan was done which revealed increase in the size of mass causing deflexed head. A planned lscs was done at 40wks in cooperation with neonatologist, pediatric surgeons, and anesthesiologist. An alive female child was delivered by cephalic presentation. Baby head was delivered out first, pediatric surgeons tried to intubate the baby before delivery of body but failed due to large CH and macroglossia. CH fluid was aspirated i.e. around 1 liter to reduce the size of mass but still failed to intubate the baby on table. Baby delivered out completely, spontaneous respiration was present and baby was intubated and then shifted to NICU. Baby died on day 4 of lscs and the cause of death was cardiogenic shock with pulmonary hypertension.

DISCUSSION

CH that develop in the 3rd trimester or after 30wks of gestation or in postnatal period are usually not associated with chromosome abnormalities. Treatment for removal of cystic[3,4] hygroma are surgery or treatment with sclerosing agent which includes picibanil (OK-432), bleomycin, doxycycline, ethanol, sodium tetradecyl sulfate. If diagnosed early in first trimester MTP can be

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offered. A study of 69.7 cases of CH done in 2014 reveled 40.6% fetus where aneuploid out of which turner syndrome was most common and rest 59.4% cases in which aneuploidy was not found[5]

Figure 1:

Figure 2:

CONCLUSION

Today in routine practice among the vast majority of maternal fetal medicine specialist, karyotype analysis and anomly screening are accepted as initial steps in evaluation of fetus with CH. Management choices are limited and its is relatively easy to offer termination of pregnancy to the parents with an aneuploid or a structurally malformed fetus with septated CH.(6,7) outcome of a pregnancy complicated by fetal septated CH is poor.

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