IS-67  Huge acoustic neurinomas presenting in the third trimester of pregnancy: a case report and review of literature

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Objective (s): Brain tumors are the fifth leading cause of cancer-related death in women ages 20 to 39 years, and the different types of brain tumors seen in pregnant women occur with the same relative frequency as those seen in age-matched nonpregnant counterparts. Schwannomas account for 6–8% of all intracranial neoplasms. Vestibular schwannomas rarely present during pregnancy, symptoms may appear or worsen particularly in this period. The clinical picture may include high pitched tinnitus, hearing abnormalities, and in large tumors, brain-stem and cerebellar compression with involvement of additional cranial nerves. Large vestibular schwannomas (also known as Acoustic Neurinomas) present a great challenge in peripartum management of both the mother and the fetus. Methods: We present a 26-year-old woman, with headache, blurred vision, nausea, vomiting and ataxia, diagnosed in the 34th week of pregnancy. MRI demonstrated a huge right side C-P angle region acoustic neurooma compressing of adjacent brainstem and cerebellum and causing obstructive hydrocephalus. Results: A course of antenatal corticosteroids is given and a successful elective cesarean section followed three days later. Due to sudden onset of consciousness loss, she underwent emergent External Ventricular Drainage. Radical tumor surgery was performed one week later. A ventriculo-peritoneal shunt was then inserted. Maternal and fetal outcome were excellent. Conclusion (s): Physicians should in general have a low threshold to obtain a neuroimaging study in a patient in whom there is any concern for an intracranial mass lesion, and the onset of any new focal neurologic deficit during pregnancy warrants immediate evaluation with an imaging study. Acoustic neauromas have sex hormone receptors, which may play a role in accelerating tumor growth during gestation. Decision regarding timing of delivery and craniotomy was not straightforward and required discussion between the neurosurgeon, obstetrician and anaesthetist based on assessment of fetal maturity. The modern neonatal intensive care units and reconstituent surfactant may provide a survival benefit for neonates electively delivered at gestational 28 weeks. Due to a dramatic increase in ICP in such patient with baseline elevated ICP, it can potentially lead to neurologic compromise and cerebral herniation. Insertion of a ventriculo-peritoneal shunt before cesarean section was warranted.

IS-68  Simultaneous uterine and urinary bladder rupture in an otherwise successful vaginal birth after cesarean delivery: a case report and review of the literature

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Objective: Uterine rupture is the most concerned complication while patient choose trial of vaginal birth after Cesarean section (VBAC). By resenting a case of uterine and bladder rupture, we reviewed literature and discussed the risk and management of rupture during VBAC. Methods: We report a patient of uterine and rupture at trial of labor after Cesarean section. And we searched on Medline using bladder repair and uterine rupture as key words only to find a total of 23 such cases having ever been reported since 1991. To Compare the symptoms/signs, the management and the outcomes, we summarized the in formations form the literature. Results: This patient has normal labor course and no any classic sign of uterine rupture during labor. However, we found gross hematuria from the patient by urinary catheterization after closure of episiotomy. She felt well except lower abdominal pain due to uterine contraction at postpartum and began to complain of progressive abdominal pain at ward. The gross hematuria in Foley catheter and oliguria were also noted later. The cystoscopy revealed a direct communication between bladder and uterus. After explore laparotomy, rupture sites over anterior uterus and posterior wall of the bladder were discovered. Having primary repair of both wounds, the Foley catheter was left in place for 12 days. The patient then achieved full recovery and no complication at follow-up for 2 years. The results of literature review was summarized and discussed in this paper. Conclusion: Bladder injury and uterine rupture can happen at any time of labor and the gross hematuria immediately after delivery is the most common presentation. Antenatal ultrasound measuring uterine thickness can offer the information about the risk of rupture and can be helpful for choosing delivery method.

IS-69  Strategy for massive postpartum pulmonary embolism; outcome comparison between 2 cases and review of literature

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Objectives: We compare hereinafter two cases of massive pulmonary embolism after cesarean section in which both patients underwent a pulmonary embolectomy, and derive the appropriate initial approach to massive postpartum pulmonary embolism. Methods: We retrospectively reviewed recent two patients who were diagnosed as severe pulmonary embolism after cesarean section and treated by emergent embolectomy. Results: The surgical approach is currently the treatment of choice for acute massive pulmonary embolism after cesarean section and the indications have been broader than previously. Conclusion: We propose that spiral CT is the best choice regarding the next surgical step, embolectomy, and there is no need to hesitate to decide surgical approach for massive postpartum pulmonary embolism even though the patient seems to be less severe case. Keywords: postpartum pulmonary embolism, massive pulmonary embolism, pulmonary embolectomy, cardiac arrest, initial diagnosis/treatment