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Letter to the Editor

Nausea and Vomiting in the Second Trimester of Pregnancy: Not Only Hyperemesis Gravidarum

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We present the case of a 23-year-old female who was 23 weeks pregnant and presented to the emergency room of our Obstetric Department in nausea and vomiting that had been worsening over the course of 2 months with loss of eight kilograms in clinical presentation compatible with hyperemesis. On admission, value lab tests showed hyponatremia, increased transaminases, and mild increase in inflammatory markers. She also complained of tingling on the one side of the face and upper limb tremor worsening over the course of two days. Over the next 10 days prior neurological symptoms were exacerbated much, also the patient developed significant occipital headache, diplopia and hypoesthesia in the territory of the right trigeminal nerve. On physical examination she was fully conscious and oriented with ocular motility permitted in all segments but mild right eyelid ptosis. She had correct tests of cerebellar function but rightward deviation in the walking trajectories. We performed a MRI of the brain that revealed a large vascularized cystic lesion in the right cerebellar hemisphere and hydrocephalus with inferior displacement of the cerebellar tonsils (Figure 1). A multidisciplinary approach was activated and the neurosurgeon's team attempted a decompression of the brain stem with an external ventricular shunt. Then the patient underwent a successful resection of the tumour with regression of prior symptoms and without any new neurological deficit. The woman has attended our follow-up visit without any relapse of the tumor for all the duration of pregnancy. She had a spontaneous delivery of a healthy female baby at 38 weeks of gestational age, Apgar score 9 at the first and the fifth minute. The management of patient with an Intracranial Disease (ID) occurring during pregnancy presents a challenge, as it requires a balance of maternal safety and neonatal considerations. ID is accompanied by a strong emotional impact, since this event occurs in young patients, going through special periods of their lives [1]. Headache is very frequent in normal pregnancy and it is a common sign shared between several ID. Cerebral Tumour and Subarachnoid Hemorrhage (SAH) (most common ID requiring surgery), during pregnancy, may be confused with eclampsia after the 20th week of gestational age, because of seizures and consciousness alterations or like in our case, the ID mimics the hyperemesis. Differential diagnosis remains critically because only an early and correct diagnosis can give at mother and son a possibility to survive [2]. Neurosurgical operations are the cornerstone of treatment for these ID. However the optimal timing of surgery during pregnancy is still a matter of debate [3]. There is no class I evidence for management of these complex patients but experiences described in majority of reports indicate that: If the patient presents stable neurological

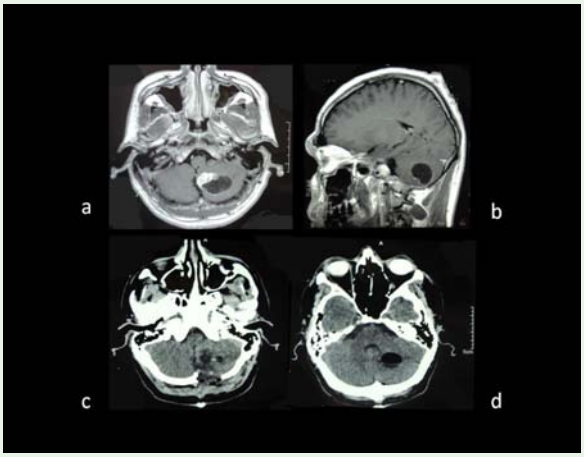

Figure 1: (a/b). Pre Surgery Brain MRI with medium of contrast. (c/d). Post Surgery Brain MRI with medium of contrast.

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conditions, brain surgery may be deferred until gestational period reaches the 30th week. After that, the delivery can be either vaginal or a caesarean section, depending on obstetric criteria. If the patient presents Brain Oedema (BO), but is neurologically stable, cortisone is prescribed to control the BO as well as to accelerate fetal lung maturity. If there is aggravation of neurological symptoms during the follow-up period of fetal maturation, craniotomy is performed immediately. In conclusion, current data suggest that treatment by standard protocols including surgery, during pregnancy, appears to allow a term delivery and a higher probability of a vaginal delivery. No evidence of a higher risk of hemorrhage due to natural delivery is reported in literature.

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