onemocněním jater, ale u pacientek s dekompenzovanou jaterní cirhózou můžeme očekávat vysokou míru komplikací. Portální hypertenze spojená s těhotenstvím patří mezi vysoce rizikové situace. V obou případech dochází k hemodynamickým změnám, kdy potřeby rostoucího plodu mohou dále zhoršovat portální hypertenzi a tím se zvyšuje riziko krvácení z varixů a dekompenzace jaterního onemocnění. I přes výše zmíněné možné komplikace, mateřsko-fetální morbidita a úmrtnost byla snížena současným vývojem v hepatologii, prevenci krvácení z varixů medikamentózně/endoskopickou ligací, zlepšením transplantace jater a rostoucími zkušenostmi v této problematice.
Prezentujeme případ 31leté pacientky s jaterní cirhózou, která po zavedení transjugulárního intrahepatického portosystemového shuntu (TIPS) úspěšně otěhotněla a těhotenství a následný porod proběhl bez komplikací. Nicméně, 2 roky po porodu, pacientka onemocněla lymfobastickým lymfomem a i přes intenzivní terapii tohoto onemocnění zemřela ve věku 40 let. Nenašli jsme žádnou souvislost mezi jaterní cirhózou a lymfoproliferativním onemocněním.

Klíčová slova: těhotenství, gravidita, játra, cirhóza, varixy, transjugulární intrahepatický portosystemový shunt, lymfom.

Introduction

Liver cirrhosis is the final stage of progressive development of various liver diseases and is associated with significant morbidity and mortality (1). Varices are a frequent complication of liver cirrhosis and a leading cause of mortality in patients with liver cirrhosis, the incidence of varices was significantly higher in patients with Child-Pugh class B/C than in those with Child-Pugh class A (35–43 % vs. 48–72 %) (1). Pregnancy is relatively rare in women with liver cirrhosis (2). Infertility is anticipated in cirrhosis because of the altered endocrine metabolism and anovulatory cycles (3–7). In pregnant women with cirrhosis, the most common and most serious complication is variceal bleeding. Due to worsening of portal hypertension because of increased circulating blood volume and the direct pressure of the gravid uterus on the inferior vena cava, impairing venous return, variceal bleeding occurs mainly during the second trimester and the in the second stage of labor (2). Pregnancy in cirrhosis carries even more risks such as higher rates of spontaneous abortion than the general population (30–40 % vs. 15–20 %), prematurity, pulmonary hypertension, splenic artery aneurysm rupture, abruption placentae, stillbirth, intrauterine growth retardation, postpartum hemorrhage and hepatic decompensation (7, 8). Preconceptional model for end-stage liver disease (MELD) score ≥ 10 had 83 % sensitivity and specificity for predicting liver decompensation during pregnancy (2).

The lymphoblastic lymphoma (LBL) is a rare aggressive lymphoproliferation, with B-lineage differentiation far more scarce than that of T-lineage. An estimated incidence of B-lineage LBL is about 0.1/1,000,000 annually. The overall prognosis of LBL is quite favorable with about half of the patients cured by modern combined chemotherapy regimens (9).

Case report

We describe the case of a 31-year-old female patient who was admitted for primary detection of liver cirrhosis decompensation with developed hepatosplenomegaly, portal hypertension and ascites. At the hospital admission was the patient diagnosed as Child-Pugh B. Extensive ascites can be seen on computer tomography (CT) in figure 1. As part of the differential diagnosis, a transjugular liver biopsy was performed, describing chronic active hepatitis with signs of cirrhosis (Fig. 2a-d), etiologically toxonutritive. Small gastric varices unsuitable for ligation were found on the initial gastroscopy, so we started treatment with non-selective beta-blockers. The patient gradually became stabilized and was released for home treatment. Unfortunately, the patient continued to abuse alcohol and moreover, thanks to noncompliance to therapy after half a year the patient was again acutely admitted for bleeding from the esophageal varices, solved by endoscopic ligation during urgent gastroscopy and followed by the maximum possible conservative therapy. Due to the high risk of rebleeding we indicated TIPS (transjugular intrahepatic portosystemic shunt). For impending acute on chronic liver failure we started treatment with corticosteroids. Control ultrasound and doppler of TIPS showed no sign of flow failure (Fig. 3). Subsequently, the patient underwent anti-alcohol therapy and the disease was compensated for several years with the Child-Pugh A and MELD 7 points. She visited our gastroenterology department every six months and we made an ultrasound of the TIPS and of the liver as hepatocellular carcinoma screening including AFP levels. Despite the irregular menstrual cycle, at 37 years of age the patient had an unexpected pregnancy. The pregnancy proceeded without complications. We made an initial endoscopy at the beginning of pregnancy without

Fig. 1. *Abdominal CT – contrast enhanced, transversal scan. Extensive ascites (arrows) associated with portal hypertension*