AANP Slide Session 1968

CASE 5

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This 7 lb-5.1/2 oz. male infant was born to a gravida IV para II AB I at 37 weeks' gestation. There was no recorded prenatal complications except for a 26 pound weight gain and an episode of false labor five days before delivery. The fetus was delivered by rotation from a persistent LOT to OA with Keilland forceps. An edematous infant with early maceration was delivered with moderate difficulty. The Apgar was 1, with a heart rate of 60, which increased to 120 following intubation and administration of oxygen. The infant had no spontaneous respirations, and was pronounced dead 30 minutes after delivery. The infant's blood type was A-positive (mother O-positive), hematocrit 15, hemoglobin 5.7 gm.%. A Hemantigen test was negative, indicating no irregular serum antibodies.

A large, pale, edematous placenta weighing 1200 gm. was delivered in fragments. There was an estimated 1000 ml. blood loss. The mother's postpartum course was uneventful, with discharge from the hospital on the third day.

Necropsy of Infant

1. General: The infant was hydropic, pale, and had early maceration over a protuberant abdomen. Weight - 3250 gm. Length - 48 cm. crown-heel.

2. Cranial Cavity: Moderate caput succedaneum. Brain 340 gm, autolyzed.

3. Thoracic Cavity: Lungs: 24 gm. combined, atelectatic. 10 ml. pleural fluid, clear. Heart: 18 gm., pale.

4. Abdominal Cavity: Liver: 550 gm., approximately 90% replaced with grayish purple tumor nodules. Adrenal, right, consisted on a rim of cortex compressed adjacent to a 4 cm. mass weighing 21 gm. The remainder of the viscera appeared grossly normal, aside from pallor, and had weights within the normal range.

5. Sections: H & E-stained placenta, liver, right adrenal and heart.

6. Diagnosis: To be discussed.