Congenital hydrocephalus in two pregnancies following the birth of a child with a neural tube defect: aetiology and management*

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SUMMARY A family is described with congenital hydrocephalus occurring in two pregnancies following the birth of a child with a neural tube defect (NTD). Prenatal diagnosis of hydrocephalus at mid-gestation was achieved by ultrasonography. The increased frequency of hydrocephalus among sibs of probands with a NTD and vice versa suggests that, following the birth of a child with either malformation, subsequent pregnancies should be monitored at mid-gestation by amniotic fluid AFP and serial ultrasound examination.

Hydrocephalus is a common major congenital malformation occurring in various populations with an incidence of 0·5 to 1·8 per 1000 births. It is a malformation with both genetic and non-genetic factors involved in the pathogenesis. With the exception of the X linked form and that associated with spina bifida, hydrocephalus is usually sporadic, the overall recurrence risks being low. Cohen et al have recently suggested an increased frequency of hydrocephalus among sibs of probands with a neural tube defect (NTD) and vice versa. This report describes congenital hydrocephalus in two pregnancies following the birth of a child with a NTD.

Case reports

A 34-year-old white female G5 P3 A2 was first seen at UCLA in 1975 following the delivery of a term male infant with an occipital encephalocele who died at 11 days of age (fig 1). Necropsy did not show cleft palate, polycystic kidneys, or external genital ambiguity that might have suggested Meckel syndrome. First trimester elective abortion had been performed in the previous pregnancy.

The third pregnancy was monitored by amniotic fluid α-fetoprotein (AFP) and she delivered a normal male. Amniotic fluid AFP at mid-gestation was normal in the fourth pregnancy, but a stillborn male infant with hydrocephalus was delivered at term. Necropsy examination was limited by gross hydrocephalus and decompression to facilitate delivery but did not identify aqueductal stenosis. Microscopy did demonstrate aqueductal forking and thickening of the medullary vellum.

Amniocentesis and fetal ultrasound examination were performed in the 16th week from the last menstrual period of the fifth pregnancy. The ultrasound study, amniotic fluid AFP, and chromosome analysis were normal and female. At 22 weeks’
gestation, a follow-up fetal ultrasound examination revealed the biparietal diameter (BPD) of the fetal head to be consistent with gestational age as assessed by dates and uterine size. However, a consistent abnormal echo free area in one cerebral hemisphere containing a distinct echogenic mass was noted (fig 2). Therapeutic abortion was performed and necropsy showed a female fetus with bilateral hydrocephalus. Microscopy demonstrated aqueductal forking and thickening of the medullary vellum (fig 3).

Discussion

The occurrence of congenital hydrocephalus in successive pregnancies is a rare event. Mehne reviewed the published reports of the last 500 years and found only 23 instances of successive pregnancies resulting in two or more children with hydrocephalus as the only anomaly. He reported one patient who delivered three successive hydrocephalic infants without other defects. Abdul-Karim et al reported two patients each with three consecutive hydrocephalic newborns and consanguinity in both families. Frohlich et al cited a patient with two successive hydrocephalic offspring.

Several modes of genetic transmission have been suggested for familial cases of hydrocephalus. It has been well established that aqueductal stenosis, the most common pathological type of hydrocephalus, may be inherited in an X linked recessive fashion, although the proportion of males with aqueductal stenosis who have the X linked recessive type has not been established. X linked hydrocephalus may be the cause of 2% of all cases of isolated congenital hydrocephalus, but data to support this estimate have not been presented. Autosomal recessive inheritance has been an alternative explanation where there have been multiple sibs of both sexes affected and is suggested by two reports of consanguinity. Autosomal recessive inheritance cannot be excluded in our family. Forking of the aqueduct and thickening of the medullary vellum, as demonstrated by microscopy, are suggestive of an early developmental defect but fail to clarify the aetiology. Examination for these particular anomalies in other cases may help to subdivide an apparently heterogeneous group of disorders.

Cohen et al reviewed published reports of hydrocephalus in sibs of children with a NTD and conversely the occurrence of the latter malformation after the birth of a hydrocephalic proband. They demonstrated a two- to five-fold increase in the frequency of hydrocephalus (0.21%) among sibs of NTD probands when compared to their stated general population frequencies (0.04 to 0.09%). In
addition, they found a two- to eight-fold increase of
NTD (1.6%) over population frequencies (0.2 to 0.76%),
following the birth of a hydrocephalic child. They
concluded that common aetiological factors may
exist in both central nervous system malformations
and proposed that amniotic fluid AFP assay is
indicated in mothers of
malformations and proposed that
hydrocephalus
Congenital
arising
visualise
the lateral
ventricle in the
uterus.
Failure to
visualise the lateral ventricle in the near hemisphere
was the result of ultrasound reverberation artefact
arising from the proximal fetal skull and did not
indicate a unilateral process. The findings suggest
that the diagnosis of hydrocephalus can be made
before the fetal head becomes abnormally large, and
would support the recommendation that serial
ultrasound studies be performed, initially at the
time of amniocentesis for AFP estimation and
subsequently at 20 to 23 weeks’ gestation. Limita-
tions exist at present for the diagnosis of borderline
cases suggesting that a more precise estimation
should be made of the above changes. Measurement
of the ratio of the maximal width of the lateral
ventricle to the width of the ipsilateral hemisphere
is currently being performed at weekly intervals
in the second trimester of normal pregnancies to
determine the upper limit of the normal range.

We recommend that following the birth of a child
with either congenital hydrocephalus or a NTD,
subsequent pregnancies be monitored at mid-
gestation by amniotic fluid AFP and serial ultra-
son examination.

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