



CONSORCI SANITARI  
DEL MARESME



# IMPORTÀNCIA DE LA REVISIÓ ANATÒMICA FETAL DAVANT UN HIDRAMNIS

XXXII JORNADA DE DIAGNÒSTIC PRENATAL ECOGRÀFIC

21 DE MARÇ DE 2025

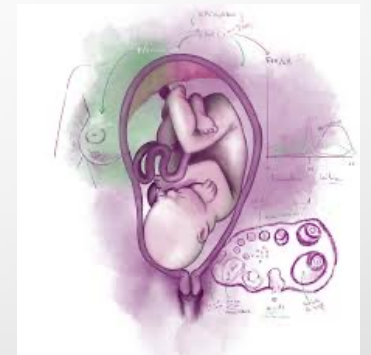
Mònica Blanco Gispert, ASSIR i Hospital de Mataró.

Raquel Cera Guinovart, ASSIR Mataró.

Maya Takeuchi Bigas, ASSIR Mataró.

Teresa Gómez Castello, ASSIR Mataró.

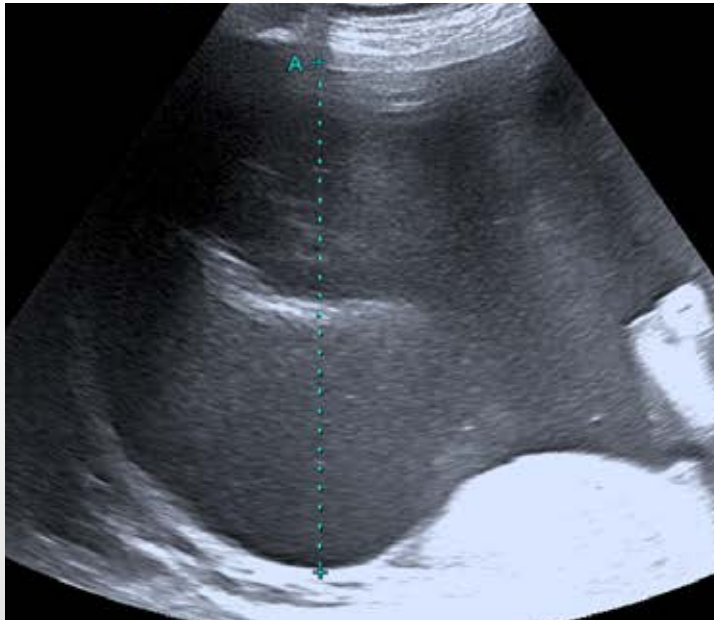
Carlota Rodó Rodríguez, Hospital Universitari Vall d'Hebron.



# CAS CLÍNIC

- Dona magrebí de 30 anys
- No AP, IQ, AMC ni hàbits tòxics
- TPAL 1001 (1 PE)
- Cribratge preeclàmpsia i aneuploïdies: baix risc
- Eco 1T i 2T : normals
- Control gestacional normal a l'ASSIR fins 34.2 SG →



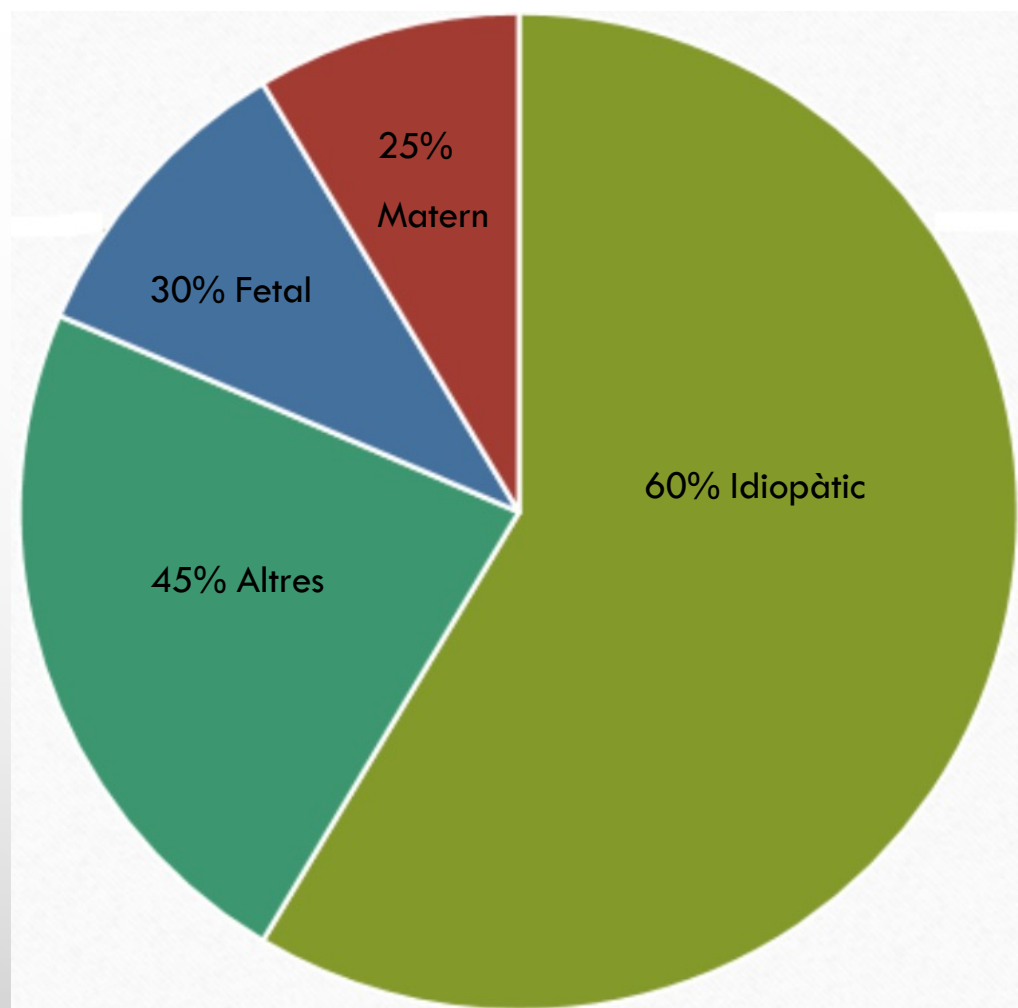


MCV 14 cm (ILA 31cm)



**HIDRAMNIS moderat**

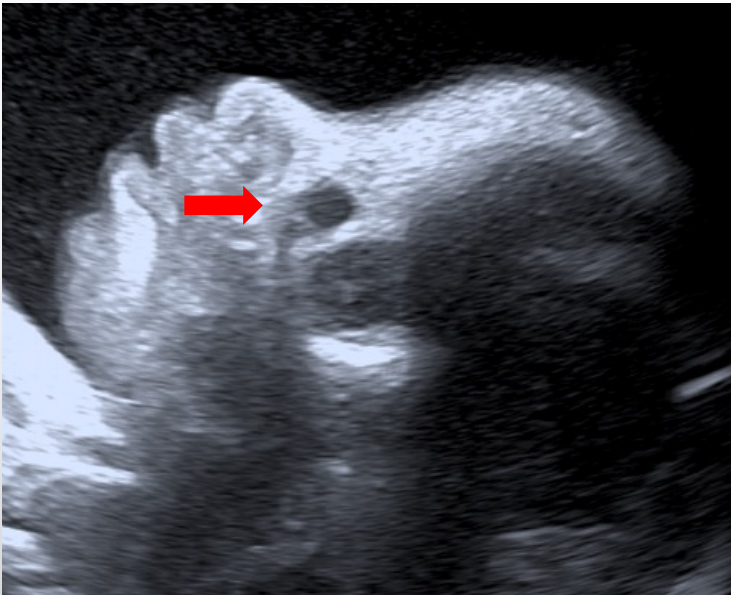
40 % factor causal



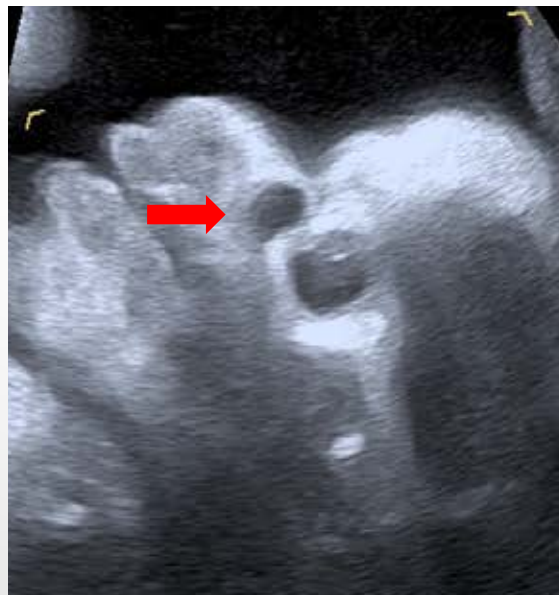
Hidramnis

Protocols medicina fetal – Polihidramnis

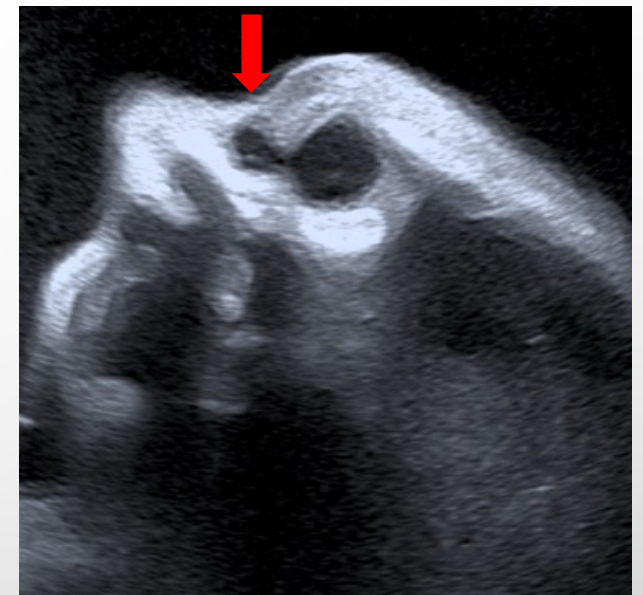
34.2 sg ASSIR Mataró



Pla sagital cranial

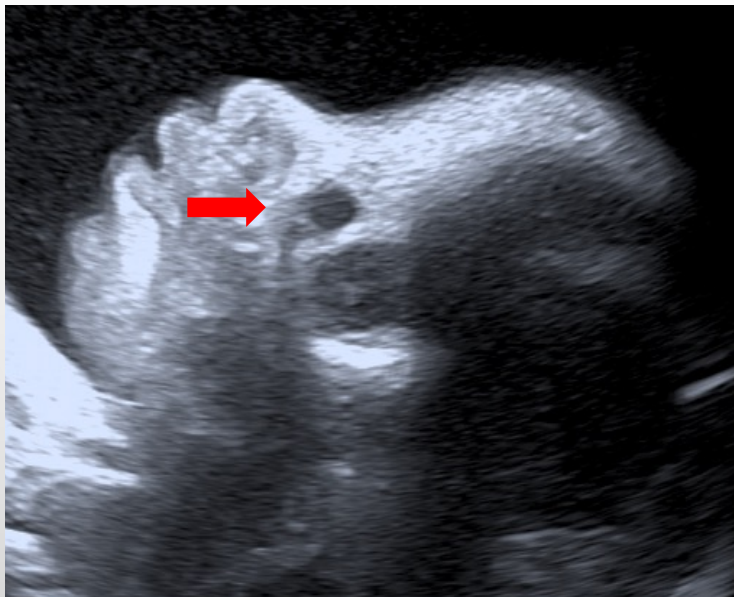


Pla sagital cranial

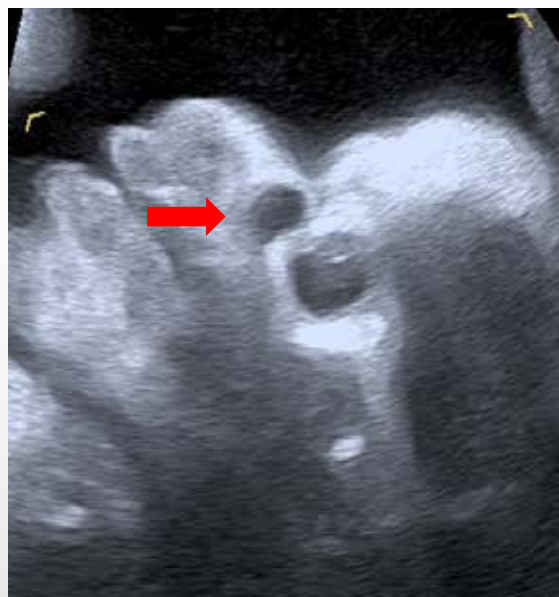


Pla axial cranial

Sospita de **Dacriocistocel** bilateral



Pla sagital cranial



Pla sagital cranial



Pla axial cranial

# DACRIOCISTOCEL

Prevalença Dacriocistocel congènit: 0.1%

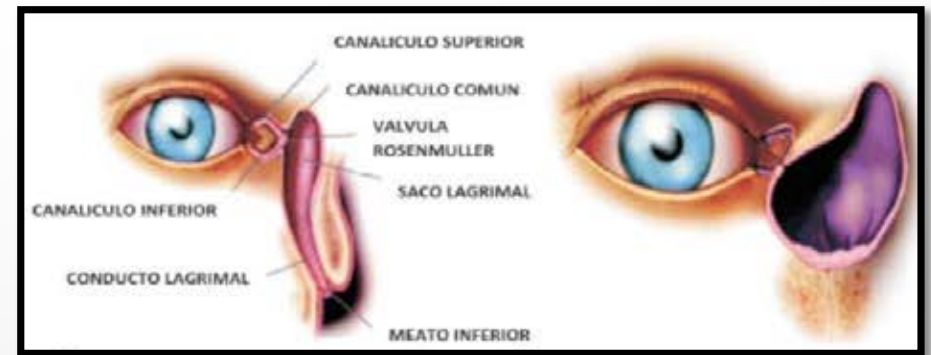
70% obstrucció conducte als 6 mesos → dacrioestenosis  
(Membrana de Hasner/ Rosenmüller)



Dacriocistocel congènit

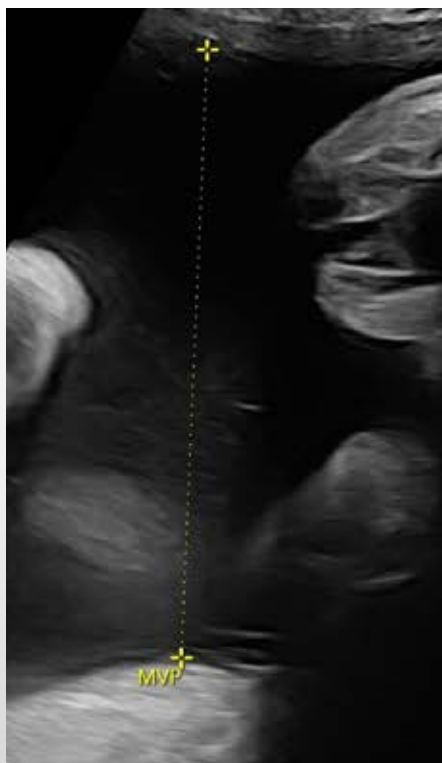
Anatomia

Dacriocistocel

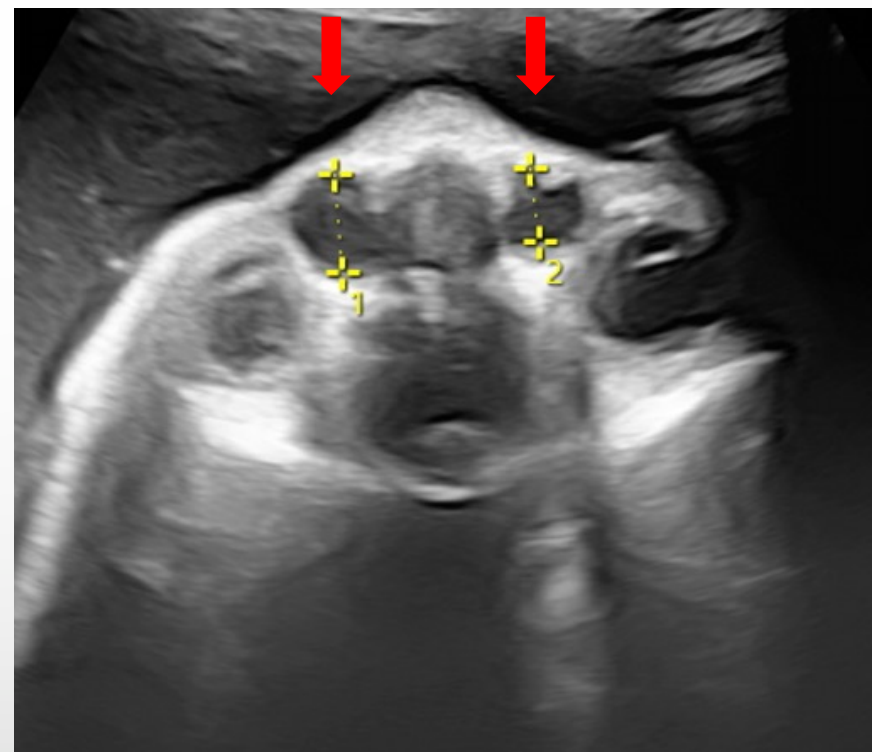


60% resol intraúter

35 sg Hospital Universitari Vall D'Hebron



MCV 10.7 cm

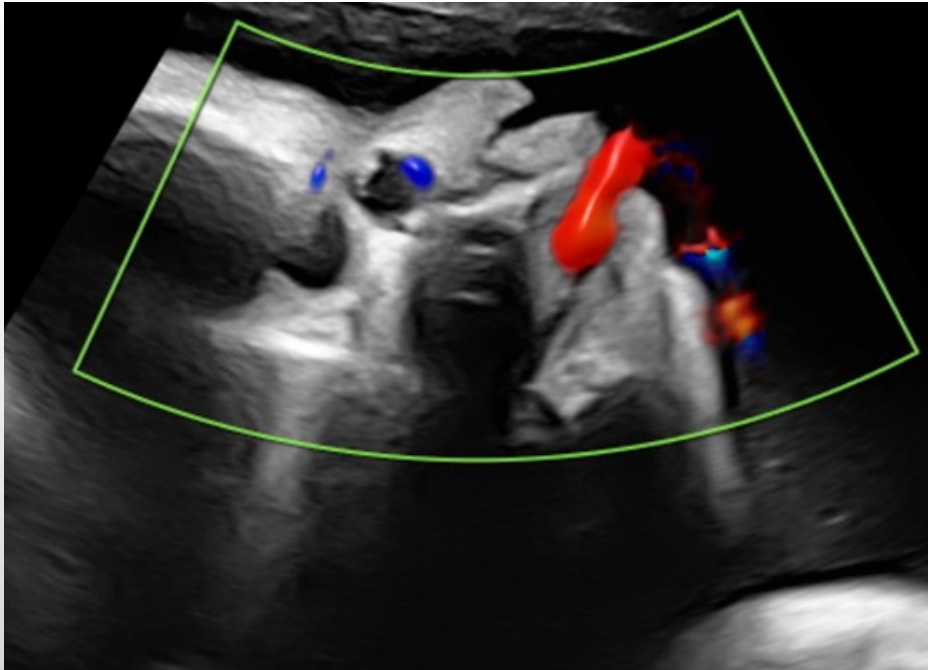


Pla axial cranial: dacriocistocel 9.7 i 7.2 mm

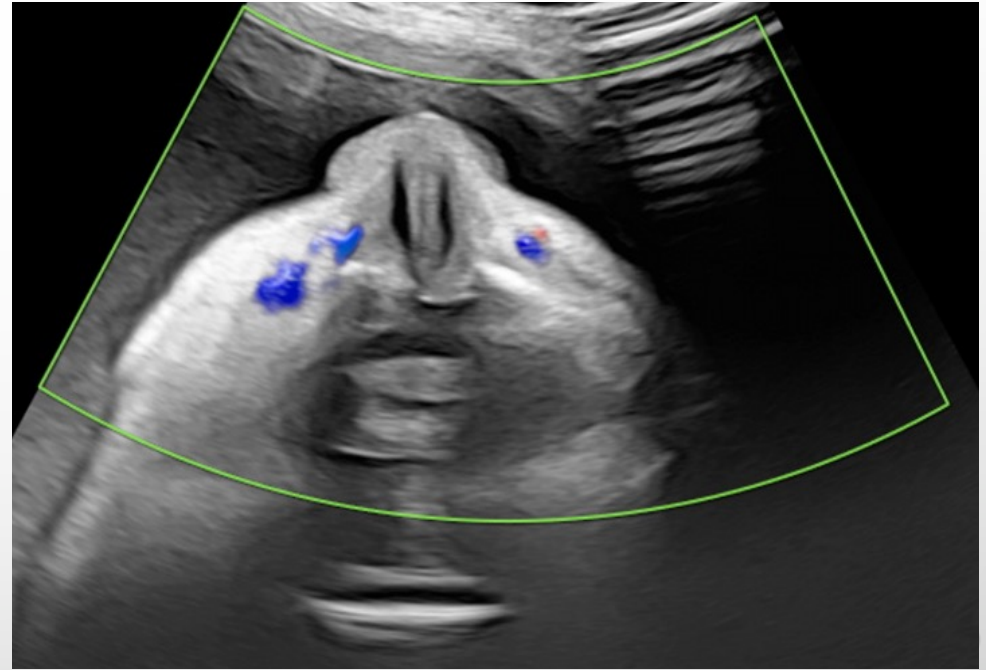
## 35 sg Hospital Universitari Vall D'Hebron



35 sg Hospital Universitari Vall D'Hebron  
**Obstrucció NASAL**

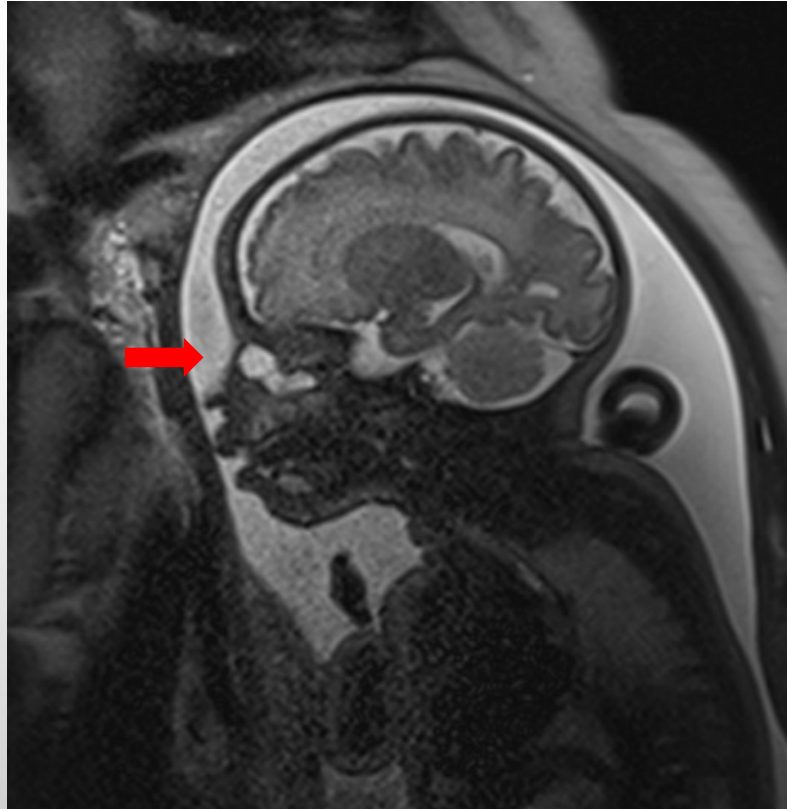


Flux LA boca PRESENT

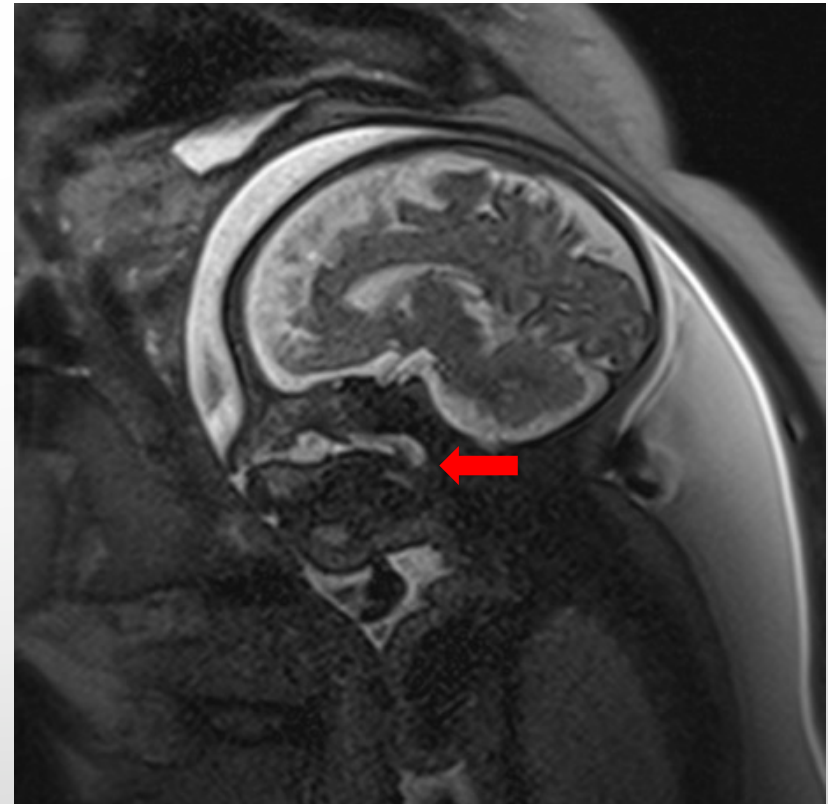


Flux LA nasal ABSENT

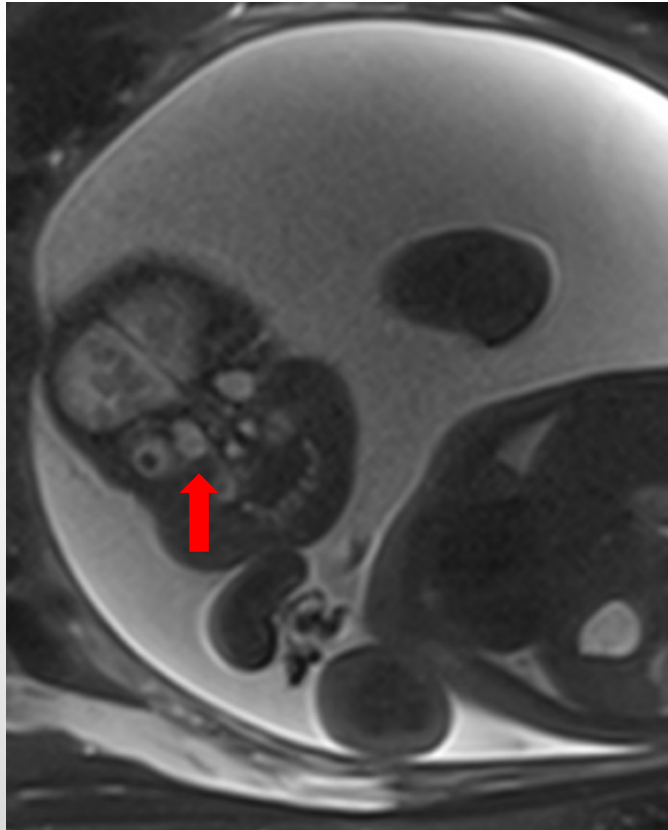
36 sg Ressonância magnética fetal (HVH)



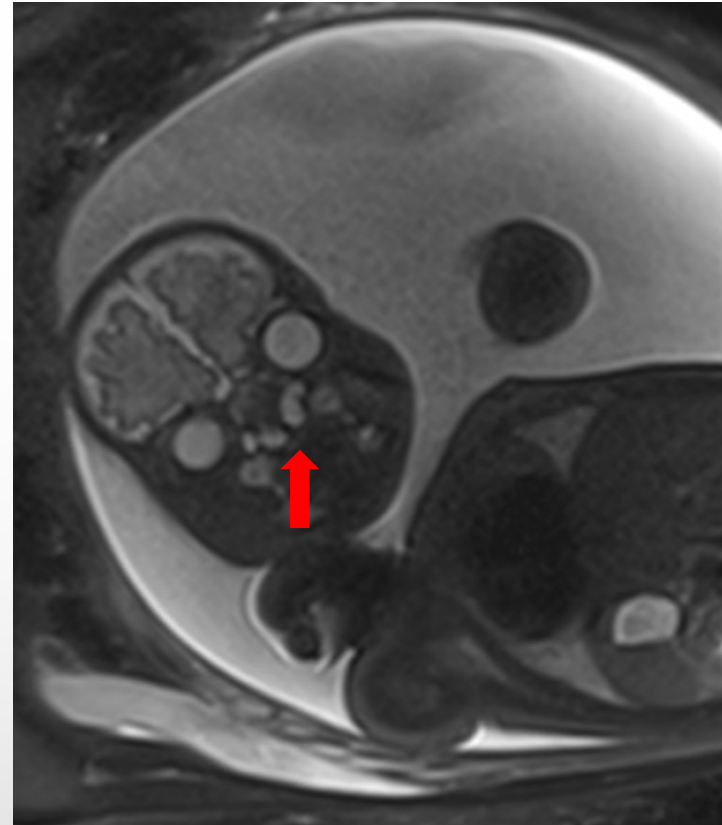
Pla sagital cranial



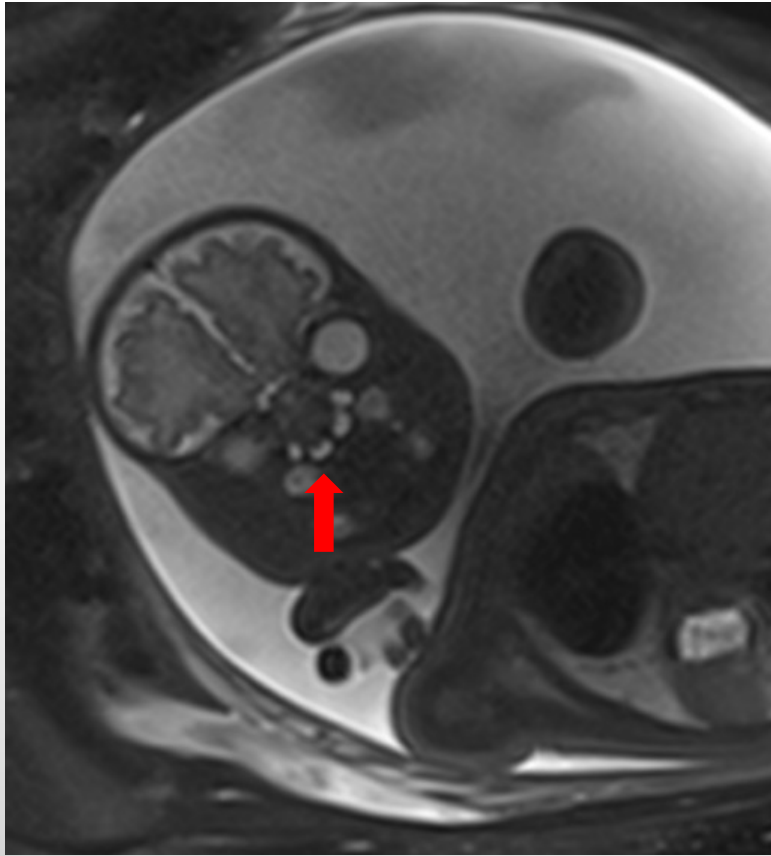
Pla sagital cranial



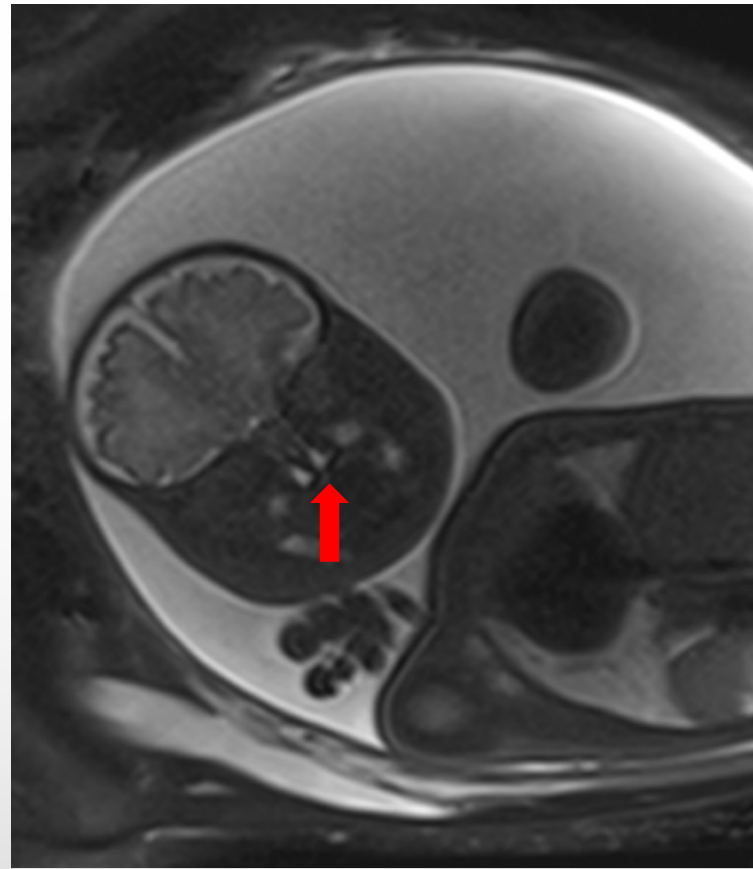
Pla frontal cranial



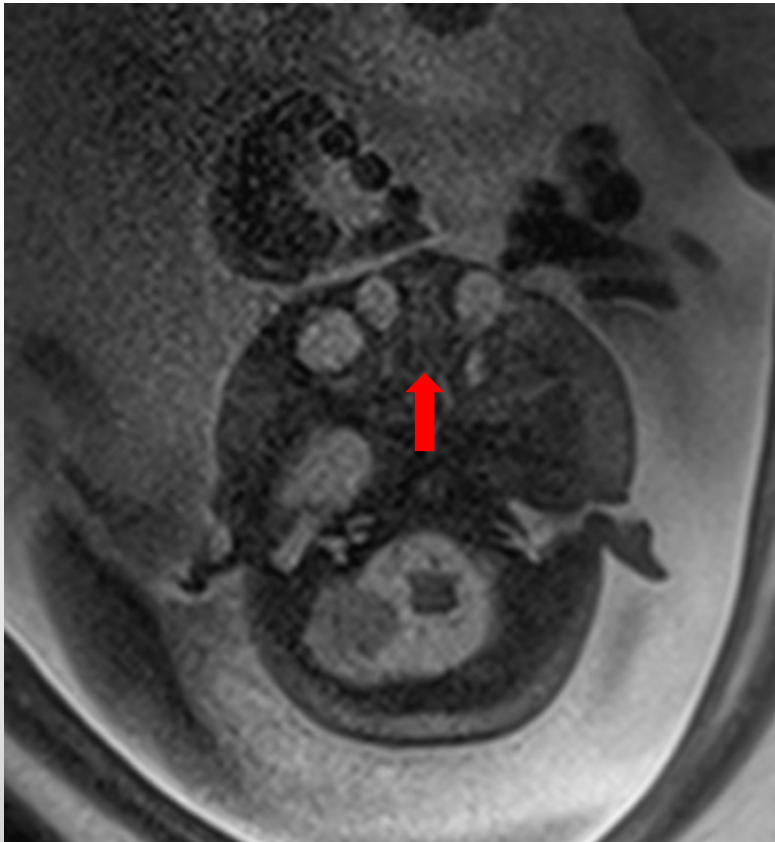
Pla frontal cranial



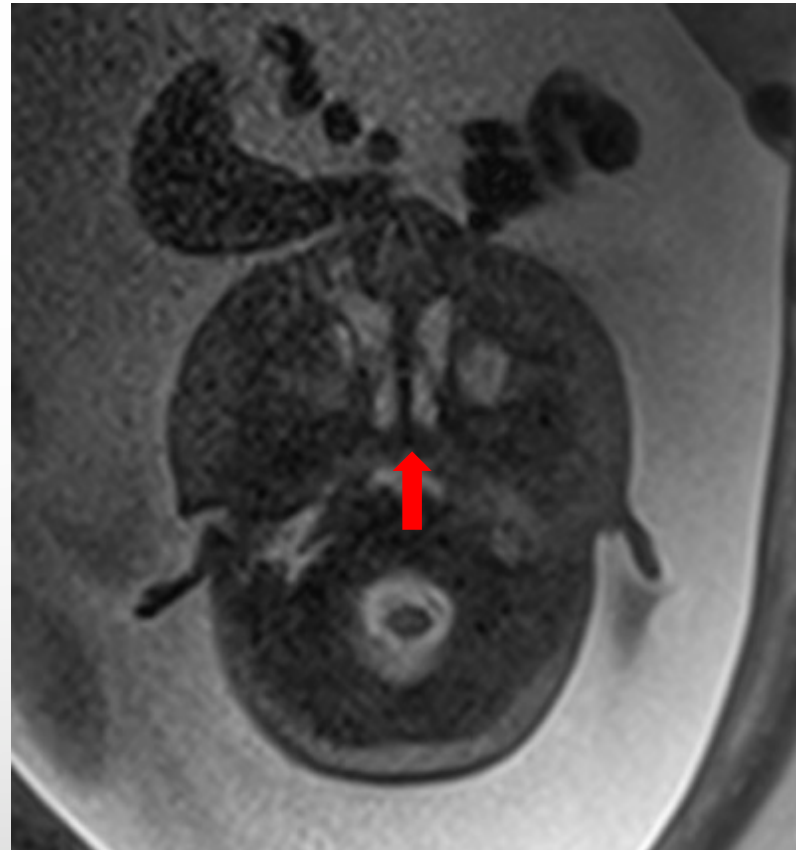
Pla frontal cranial



Pla frontal cranial

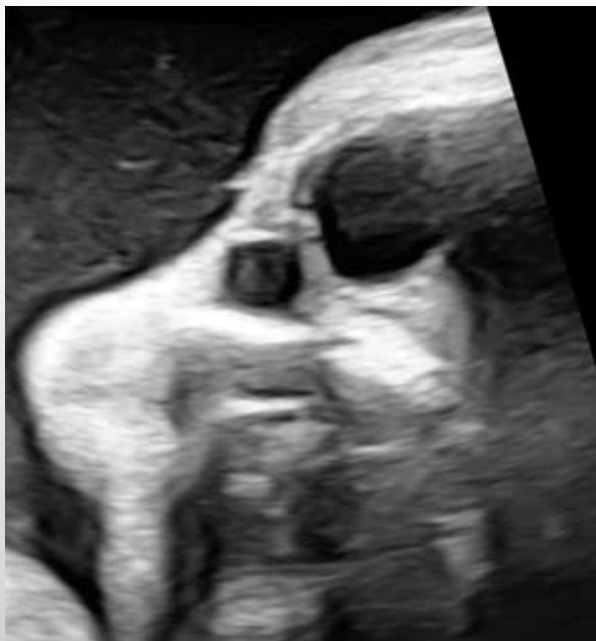


Pla axial cranial



Pla axial cranial

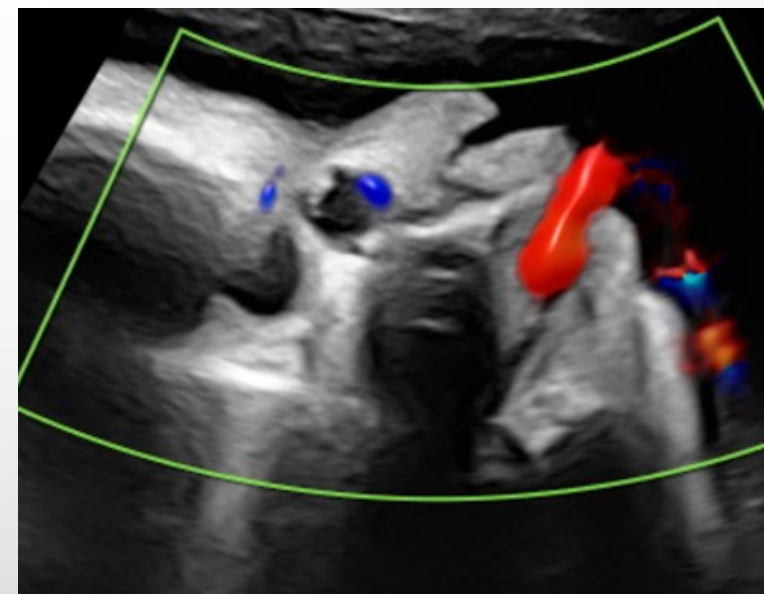
36, 37 sg Eco Hospital Universitari Vall d'Hebron  
Dacriocistocel bilateral + hidramnis moderat + obstrucció nasal 2°



Pla axial cranial



MCV 13cm

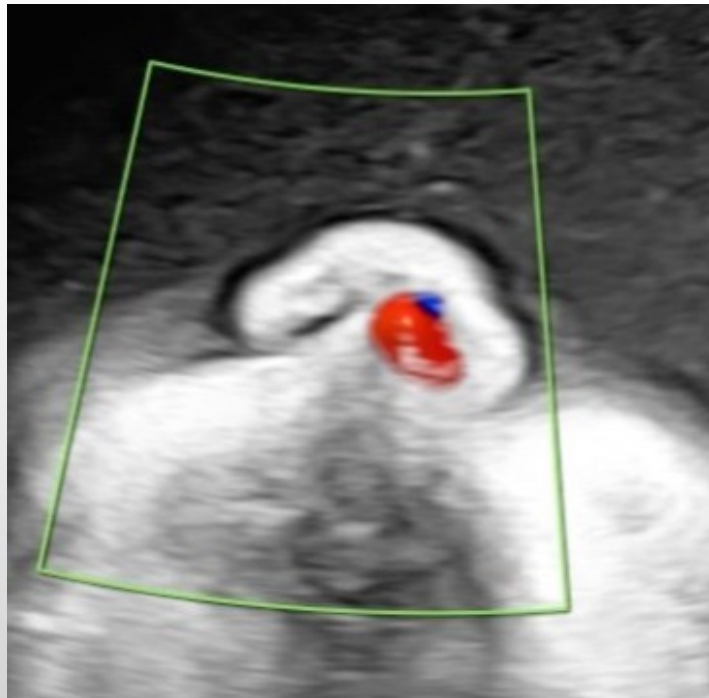


Flux LA nasal ABSENT

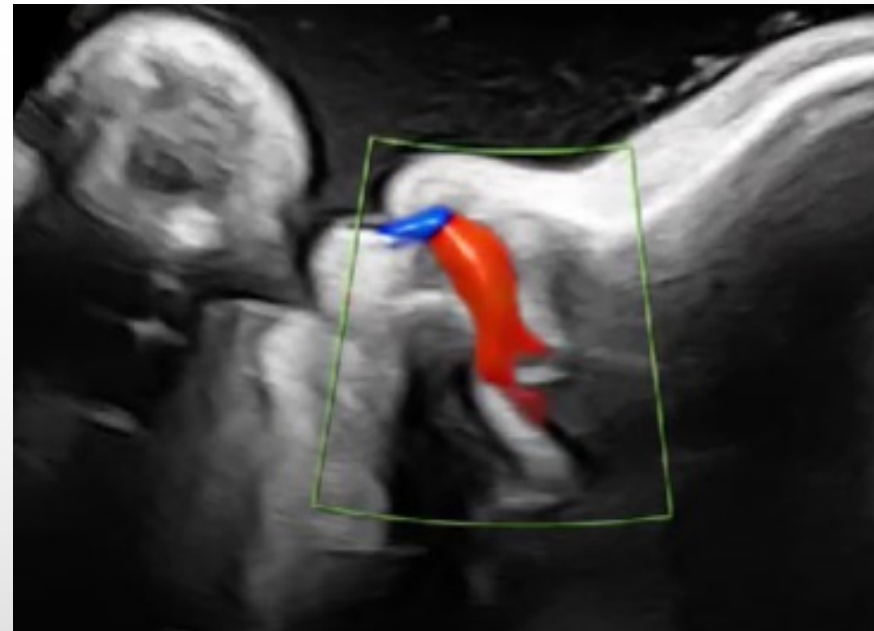
## 38 sg Hospital Universitari Vall d'Hebron



38 sg Hospital Universitari Vall d'Hebron  
Obstrucció nasal ???



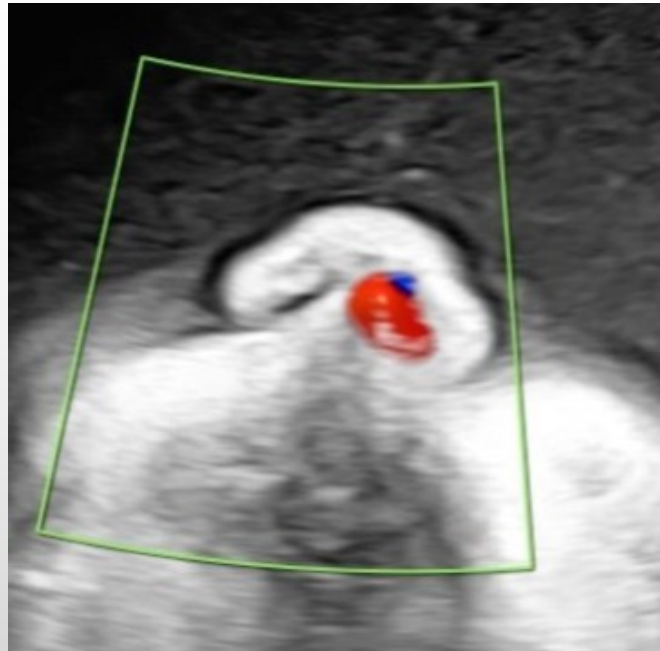
Pla axial cranial



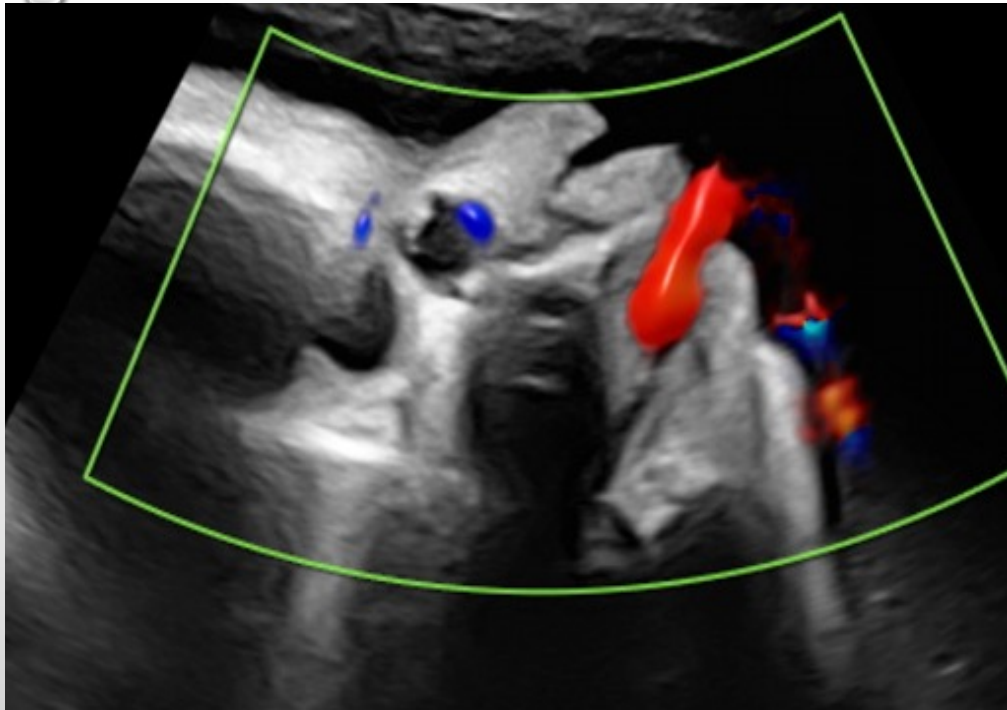
Pla sagital cranial

38 sg Hospital Universitari Vall d'Hebron  
Estudi Doppler color

**Dacriocistocel** ESQUERRE + **permeabilitat coana** DRETA

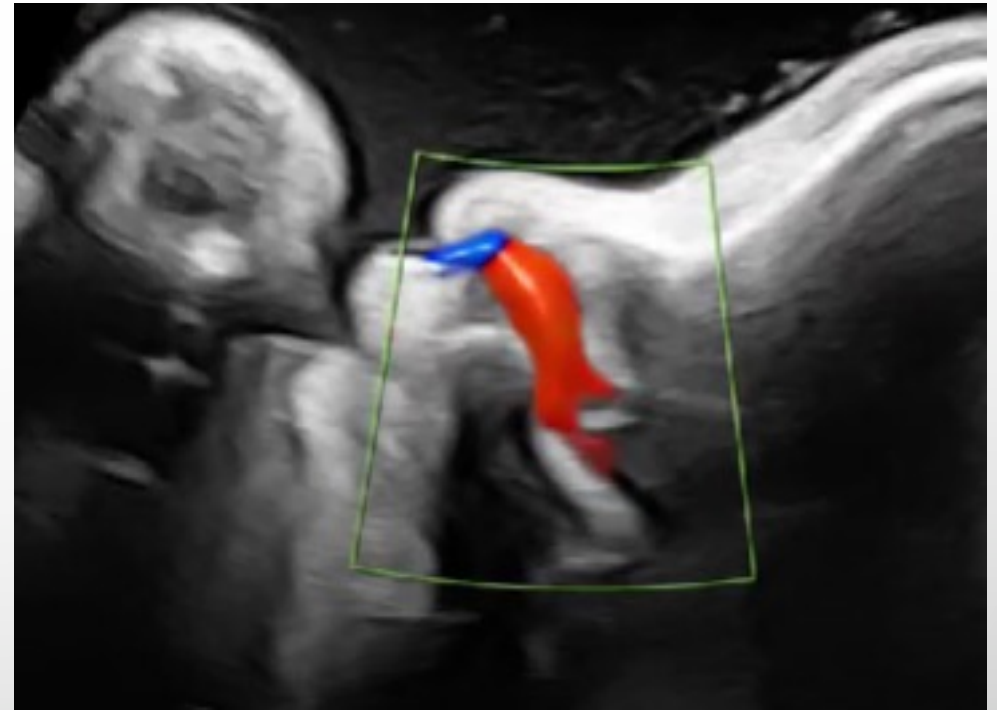


Eco 35,36,37sg



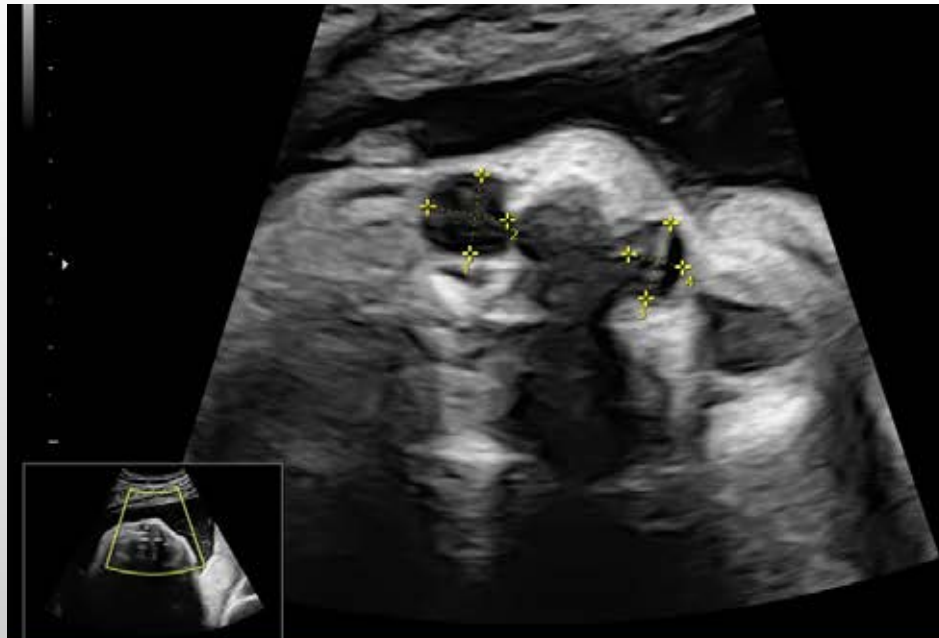
**ABSÈNCIA** flux amniòtic NASAL

Eco 38sg

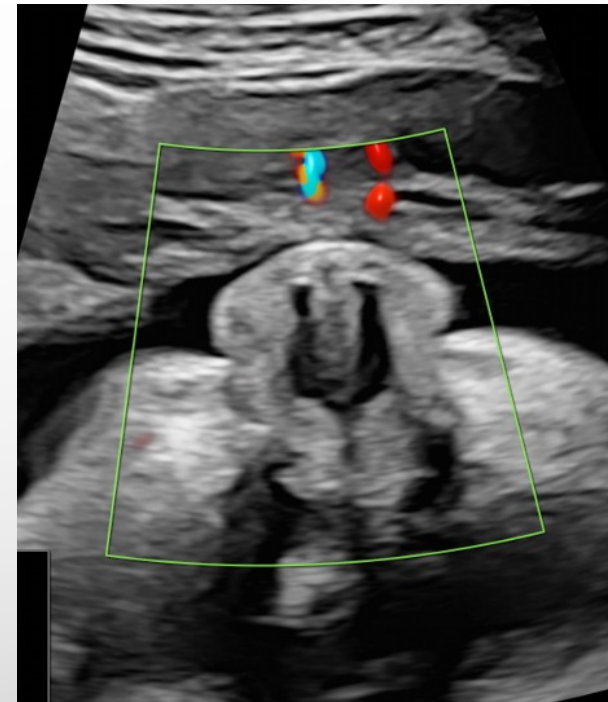


**PRESÈNCIA** flux amniòtic NASAL

39 sg Hospital Universitari Vall d'Hebron



Dacriocistocel de 8.5 i 7.5 mm



ECO 3D



35 SG



36 SG



37 SG



39 SG

Resultats:

Part eutòcic a les 40.2 setmanes

Nena de 3695g

Apgar 7/6/8 → CPAP

PH 7.34 / 7.37

EF: palpació dacriocistocel esquerre



N  
A  
I  
X  
A  
M  
E  
N  
T

Dia 1



Dia 2



Dia 6



Dia 7

ALTA

Dacriocistocel

DacrioCISTITIS

DacrioCISTITIS sense millora

Endoscòpia nasal

Massatge + ATB

Dacriocistorrinostomia

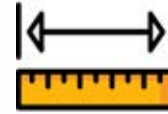
Dacriocistocel

BILATERAL (esquerre ++)

## Consideracions generals dacriocistocel



Diagnòstic tardà (3T)



Mida: 7.5mm



Freqüència

Eco 2D: quist en la porció inferior  
medial de la cavitat orbitària +  
**NO** captació **Doppler color**



**60%** resolució intraúter



Associació **HIDRAMNIS**

## Diagnòstic diferencial

- Atrèsia de coanes
- Dacriocistitis
- Massa nasal
- \*Encefalocèle anterior
- \*Quist dermoide
- \*Hemangioma facial
- \*Glioma nasal
- \*Mucocèle (Fibrosis quística)



Tractament → període neonatal

## Mèdic

Dacriocistocels NO complicats



Antibiòtic gotes + massatge ocular



## Quirúrgic

Dacriocistocels COMPLICATS



Incisió i drenatge  
+/- antibiòtic

Compromís respiratori

**DACRIOCISTITIS**

**CEL.LULITIS**

Dacriocistocels grans



Case report

## Congenital bilateral dacryocystocele

Pedro Carneiro de Sousa , Marta Neves, Delfim Duarte, Paula Azevedo

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<https://doi.org/10.1016/j.anoel.2017.10.006>

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Case report

## Neonatal respiratory distress secondary to bilateral intranasal dacryocystocoeles

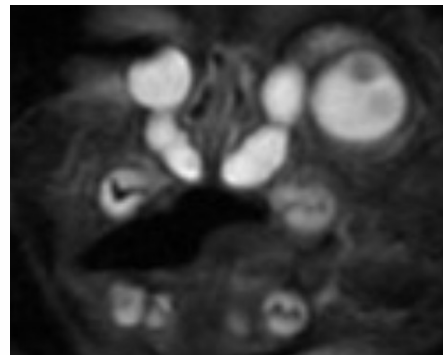
David S. Leonard , Michael O'Keefe , Helena Rowley , Joseph P. Hughes

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<https://doi.org/10.1016/j.ijporl.2008.09.011>

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## DISCUSSÃO

Newborns have an obligatory and exclusive nasal breathing. Therefore, an obstruction at this level can lead to respiratory distress, demanding an orientation plan for treatment in urgent care setting [1].

Infants are obligate nasal breathers for the first 2–6 months of life. During that time nasal obstruction can cause significant respiratory embarrassment. Although unilateral obstruction may be asymptomatic, or present with feeding difficulties and sleeping disturbance in older infants, bilateral obstruction typically presents in the neonatal period with respiratory distress and intermittent desaturation events. Differential diagnosis includes a variety of congenital malformations, inflammatory ...

### Conclusion

Nasal obstruction causes respiratory distress and compromise in neonatal patients. Causes include inflammatory conditions, tumours and hamartomas and congenital malformations. Nasolacrimal duct cysts with intranasal extension represent a rare congenital cause of neonatal respiratory distress. These rare congenital abnormalities are caused by obstruction of the nasolacrimal duct at both the valves of Hasner and of Rosenmuller. They can be either unilateral or bilateral, and mode of presentation ...

Prevalença dacriocistocel congènit < 0.1%



Fetus/nadó respirador **N A S A L obligat**



Possibilitat distres respiratori/apnees perinatales



Diagnòstic prenatal dacriocistocel → Planificació atenció neonatal



Tractament precoç neonatal, curs benigne, bon pronòstic

## CONCLUSIONS



GRÀCIES

