after 90 minutes of delivery of twin A and after ligating the cord of twin-A with delayed absorbable suture material close to the external os and cutting it.

Postoperatively cefotaxim 1g was given intravenously 12 hourly till 17th February, 2005. Ritodrine drip was continued for 48 hours and thereafter ritodrine 10 mg was given orally till 36 weeks of gestation. Micronised progesterone 300 μg was given vaginally daily till 4th March, 2005 and thereafter reduced to 200 μg till 32 weeks of gestation. During her 20 days of postoperative her cervical status by sonography and coagulation profile were monitored biweekly. She was advised bed rest along with hematinics and oral tocolytics. She had her regular antenatal check ups profile were monitored biweekly. She was advised bed rest along with hematinics and oral tocolytics. She had her regular antenatal check ups

Figure 1. The placentas.

Bowel prolapse through colporrhexitis - a complication of home delivery

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Key words: colporrhexitis, posterior fornix rupture, labor complication

Introduction

Genital tract injuries occurring in the process of labor are not rare. The common injuries are perineal lacerations, extension of episiotomies, and vaginal and cervical lacerations. The uncommon injuries are rupture of the uterus. Occasionally the edematous anterior lip of the cervix gets compressed between the head and the symphysis pubis resulting in necrosis and detachment. More rare are annular or circular detachments of the cervix and vagina-cervical lacerations extending upto or opening into the peritoneal cavity. Books do refer to such type of injuries, but many authors, except few, do not describe colporrhexitis or vault-rupture causing evisceration of the intestinal loops.

Discussion

Literature shows that intertwin delivery interval ranges from 41 days to 153 days. We were able to achieve an intertwin delivery interval of 137 days in our peripheral rural setup. The important risks associated with the asynchronous delivery of twins include, coagulopathy and ascending infection that may end up in chorioamnionitis. Since we don’t have a definite management protocol for this particular clinical scenario yet, in this particular case we used surgical as well as medical modalities for prolonging the intertwin delivery interval. There are also few other case reports where, the successful nonsurgical management of this situation has been described. Such situations are rare. Our case show that if the first fetus of a twin is delivered in the first half of pregnancy and if the uterine contractions cease we can allow the intrauterine second fetus to continue pregnancy keeping a watch on the fetus and the mother.

References


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Case report

A 22-year old woman was brought on 1st December, 2003 from a district hospital attached to our medical college, from a distance of 35 km. She was a second para, who had delivered a full term male baby just 1 hour 40 minutes back. Her delivery was conducted by her mother-in-law at home in their village. After the baby’s birth, as the placenta did not come out, the mother-in-law attempted removal of placenta by putting her hand into the genital tract. When instead of the placenta some abnormal thing came out, a jeep was hired and the patient brought to the district hospital. She had history of an uneventful home delivery 3 years back.

She was grossly pale and in agony. Her pulse rate was 126 per minute, and blood pressure 100/70 mm of Hg. She had purulent discharge from her left ear. Abdominal palpation revealed that the uterine height was corresponding to 24 weeks. The uterus was well retracted and in the midline. Liver and spleen were not palpable. At the vulva, loops of intestine were seen lying outside (Figure 1), there was a trickle of blood and the woman did not allow internal examination.

She was immediately posted for examination under anesthesia. Her hemoglobin was 6 g/dL, urine had no sugar or albumin, and blood group was O Rh positive. Two units of whole blood were arranged. After necessary consent, she was explored vaginally under general anesthesia. She was...
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Figure 1. Photograph showing loops of intestine lying outside the vulva.

induced by ketamine, scoline and maintained by gas, oxygen (7.5 cuffed endotracheal tube), and pavulon. The intestinal loops lying outside were irrigated with povidone iodine diluted in sterile normal saline (no definite proportion). The intestinal loops showed neither any evidence of injury nor any fecal smearing. The placenta was in the cervical canal and was removed manually. A rent was felt in the posterior fornix through which intestines were protruding out. After rewashing, the loops of intestine were repositioned into the peritoneal cavity through the rent in the posterior fornix by gentle pushing. This was facilitated by slight trendelenburg position. The rent in the posterior fornix was fully visible after intestinal reposition. It was a 6 centimeter posterior colpotomy like transverse wound. It had ragged edges. The two ends of the linear laceration were caught with Allis’s tissue holding forceps and angles were sutured separately with chromic catgut No.1, leaving its ends long for traction and identification. Rest of the laceration was repaired with continuous locking suture. The long ends were cut short after confirming hemostasis. Vagina was packed with rolled gauze for 6 hours. She received two units of compatible whole blood, 2 liters of lactated Ringer’s solution, and 500 mL of 6% hydroxymethyl starch in normal saline during the procedure. Intubation-extubation interval was 1 hour 25 minutes.

The patient was kept nil by mouth for 24 hours and received intravenous cefotaxime and metronidazole. She recovered well and was discharged on 7th day. She was advised to consult ENT specialist for her right otitis media.

Discussion

Rupture of the vaginal vault or colporrhesis, a laceration causing separation of cervix from the vaginal fornix, is a rare type of genital tract injury. Colporrhesis is known to occur both in nonpregnant and pregnant state. In nonpregnant state coitus and force by foreign bodies are known to cause such injuries in already weakened vagina because of postmenopausal atrophy and previous surgery. Those related to pregnancy occur during labor, spontaneously or as a result of trauma. Spontaneous colporrhesis occurs from excessive retraction of the uterus pulling the cervix from its vaginal attachment. The traumatic varieties occur as complications of forceps delivery and manual removal of placenta. In our case it is difficult to infer if the posterior fornix laceration had occurred spontaneously or because of the mother-in-law’s hand thrust into the vagina to remove the placenta. Such obstetric practices of conducting labor by untrained people still continue in the developing countries. This is due to illiteracy, poverty, lack of awareness, want of medical facilities, and inconvenience or reluctance to use available medical services.

Although in such cases where peritoneal cavity is opened a laparotomy may be thought more appropriate, we suggest that the case should be individualized as regards the route of repairing the vaginal laceration. Cases where injury to bowel is not suspected, vaginal closure of rent as done in our case would be more appropriate and even technically easy. Closing a posterior fornix wound by abdominal route after retracting the just emptied huge uterus anteriorly to expose the recto-uterine pouch would be technically difficult. The intactness of bowel can be known by inspecting it and injury to it is a remote possibility if sharp instruments are not used or when the laceration occurs spontaneously.

Key words : pheochromocytoma, pheochromocytoma in pregnancy, hypertensive crisis

Pheochromocytoma in pregnancy – fetal movement kick-starting hypertensive crisis

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Introduction

Pheochromocytomas are catecholamine secreting tumors arising from chromaffin cells of the sympathetic nervous system (adrenal medulla and sympathetic chain). Pheochromocytoma during pregnancy is rare with a prevalence of 1 in 50,000 to 54,000. Along with hypertension, either sustained or paroxysmal, the classic triad of headache, palpitations and excessive sweating is common, but less so in the pregnant than in the nonpregnant state. In pregnancy, the diagnosis is often overlooked because it is rare and the clinical picture often resembles preeclampsia. We report a case of pheochromocytoma which was diagnosed during second pregnancy.

Case report

A 19 year old woman presented in the 24th week of her second pregnancy with a history of uncontrolled hypertension, headache and giddiness since 16th week of gestation. She was having regular antenatal check up at our...