HYDATID CYST OF UTERUS

(Report of 2 Cases)

by

KALAVATI S. PARIKH*, M.D.

and

PARIKH**, M.D.

Hydatid infestation of the female genital tract is a rare occurrence, about 3% of the cases of hydatidosis. We came across 2 such cases in a short period of 2 months. Going through the literature of the last 10 years we traced few such reports. Devi reported a case where hydatid cyst of uterus acted as a cause of obstruction to labour. Sarojini reported a case diagnosed as a fibroid. S. Prem Chandra and S. Ganda Singh diagnosed a case of hydatid cyst of the broad ligament as malignant ovarian tumour. While this paper was being prepared we came across a report of 9 cases by Narayana Rao. The diagnosis was arrived at in all during laparotomy. Crossen, in his Text Book of Gynaecology, describes hydatid disease of the uterus and advocates hysterectomy as the only line of treatment. These two cases are reported for rarity of the condition, and for their clinical interest.

*Lecturer in Obstetrics & Gynaecology.

Professor of Obstetrics & Gynaecology.

M. P. Shah Medical College & Irwin Group of Hospitals, Jamnagar.

Received for publication on 29-6-66.

CASE REPORTS

Case 1

J. V., aged 23 years, was admitted on 16-10-'64 at 11.30 p.m. as an emergency. She was a 4th para, at term, and was in labour since the last 10 hours. She complained of leaking membranes. She had undergone 1 full-term normal delivery and 2 breech deliveries, the first two being livebirths and the third a still-birth. Her last delivery was 2 years ago. General and systemic examination revealed nothing abnormal, excepting slight oedema over feet. Her haemoglobin was 9 gm%. On abdominal examination full-term pregnency with breech presentation was detected. There were mild uterine contractions. Foetal heart sounds were normal. Vaginal examination showed that cervix was 3/4th dilated, membranes absent and breech was high up. Pelvis was adequate. The patient was kept under observation. The uterine inertia persisted and after 12 hours foetal distress developed. Second vaginal examination was done and no progress was noticed. A leg was pulled down with the object of improving uterine contractions and helping the dilatation of the cervix. It was then realised that the part which was thought to be breech of the foetus was a big tumour extending from the rim of the partially dilated cervix over the posterior uterine wall. A diagnosis of cervical fibroid obstructing labour was made and lower segment caesarean section was done. On opening the uterus a bilobed tumour diagnosed as a fibroid, 5" x 3" was seen bulging into the cavity through the

posterior wall of the uterus. The baby was still-born. Her post-operative period was uneventful and she was discharged on 25-10-'64 with advice to come for myomectomy after 3 months.

She was readmitted on ...-1-'65. On examination the supposed fibroid was seen extending up to the umbilicus. She was taken up for myomectomy on 22-1-'65. At laparotomy the "fibroid" felt cystic and there were adhesions on the right side. With a transverse incision at the level of the ovarian ligaments the uterine musculature was cut, line of cleavage was detected and enucleation tried. As dissection was not possible a small incision — ½" was made with the object of reducing the size, and aspiration tried. To our surprise clear fluid with a number of round white cysts came out. Hydatid cyst of the uterus was evidently the diagnosis. Surgeon was consulted and after injection of formaline a number of daughter cysts with a broad capsule were enucleated. The cyst wall was curetted and after excision of the redundant portion the free margin was sutured to the posterior wall of the uterus with a rubber drain. The uterine muscle was sutured and the drainage tube was brought out through the abdominal incision. On exploration no other site of hydatid was detected.

Stitches were removed on the 8th day. The site where the drainage tube was kept did not close beyond the sheath. The wound failed to heal even after 10 days. An internal examination revealed a cystic swelling at the site of the original tumour; simultaneously purulent discharge was noted coming from the abdominal wound. The cystic mass was drained through a posterior colpotomy. This led to healing of the abdominal incision. Streptococci, sensitive to mystaclin, were grown on culture of the discharge. Mystaclin was given accordingly. The colpotomy wound healed well and she was discharged in good condition on 26-2-'65.

Case 2

D. R., was admitted on 30-12-'64 as an emergency for obstructed labour. She was a third para, at term. General and systemic examination revealed nothing abnormal. During abdominal examination 2 soft cystic swellings were detected on the anterior abdominal wall. Margins could be rolled under the fingers and the size was 2" x 2". They were thought to be lipomas. Lower segment caesarean section was done. On opening the abdomen one of the swellings was seen on the parietal peritoneum and 2 were on the visceral peritoneum of the uterus. All the three were removed. On opening the tumours after ...datid cysts rolled out.

...st-operative day another ... appeared in the right lu... ...on. Casoni's test was negative Sur... was consulted who did a laparotomy on 30-1-'65. The uterus was found adherent to the anterior abdominal wall. Three hydatid cysts were found in th greater omentum and were removed. Tw big cysts were present on the inferior sur face of the liver. Ten ml. of fluid wa aspirated and equal amount of formaline was injected into them. After removal of the contents of the cysts they were closed, keeping rubber drains which were brought out through the anterior abdominal wall. The post-operative period was uneventful The drainage tubes were ...moved on th 3rd day. The patient wa ...harged o. the 15th post-operative day

Discussion

Two cases of hydatid cysts, one in relation to the myometrium and the other in relation to the visceral peritoneum of the uterus are presented. The condition is a rare one and is diagnosed generally on laparotomy. When in connection with the uterus it is commonly diagnosed as a fibroid. In our first case it acted as a cause of obstruction to labour. In the second case it was a coincidental finding. The uterus in this case became adherent to the abdominal scar which showed a tendency to fibrosis in this condition. Casoni's test is of doubtful value.