HAEMATOMETRA

(Report of 3 Cases)

by

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Haematometra is commonly seen following surgery on the cervix, such as Fothergills operation for prolapse uterus, cauterisation, conisation, amputation of the cervix, late stages of haematocolpus and in congenital malformation of the vagina and cervix like vaginal and cervical atresia. In cases of transverse vaginal septum high up in the vagina near the cervix gives rise to haematometra. Rarest is, cancer cervix completely blocking the cervical os by cauliflower growth in menstruating women causing haematometra. The following 3 cases are presented.

CASE REPORTS

Case 1

Mrs. I.M., aged 30 years referred from Manganese mine attended G.O.P.D. on 23-12-1978 with the complaint of amenorrhea 5 months, pain in abdomen 5 months and occasional vomiting—8 days. O.H. patient had 3 full term normal deliveries. Last child birth was 4 years back. Patient developed prolapse of the uterus for which she had Fothergills operation and vaginal sterilisation done 3 years back in Medical College Hospital.

Speculum examination showed that the cervix was flush with vagina and external os was not visualised.

Vaginal examination revealed that the uterus was A/V about 12 weeks size, pushed slightly to the right side, soft, cystic, not freely mobile and tender. The vaginal fornices were clear. The provisional diagnosis was haematometra due to cervical stenosis and patient was put for examination under anaesthesia and cervical dilatation on 26-12-1978.

On speculam examination, under anaesthesia a small dimple was visualised at the vaginal vault with multiple adhesions around the dimple. A small probe was passed through the dimple breaking the adhesions and subsequently the os could be dilated upto 14 Duncan dilator. As soon as the cervix was dilated the dark brownish discharge of haematometra started draining and about 80-100 cc's of the blood drained. Patient was put on Streptomycin and Penicillin post operatively and discharged with the advise to report after one month.

She returned after 6 months having the same complained for last 2 months. She required plastic repair of the external os. Since then she had never turned up.

Case 2

Mrs. M.S., 30 years coming from Chindwada was admitted from Gynaec. O.P.D. on 11-1-79 with complaints of amenorrhoea 8 years, married 8 years but no issue. Patient admitted that she had attained menarche at the age of 21 years i.e. 9 years back, had regular cycles of 2-3/30 days average flow but had no periods after marriage. She had no coital difficulty. She also denied any treatment from untrained 'dais'. On repeatedly asking her she admitted that she was not very sure of these regular periods that she had after menarche.

On Examination, she was a well built woman, her general and systemic examinations did not reveal anything abnormal. Her secondary sex characters were well developed. Abdominal examination showed a mass in the suprapubic region, about 6 cms x 8 cms in diameter, tense, not freely mobile, not tender. There was no free fluid in the abdomen.

Speculum examination showed a blind pouch, cervix not visualised and no scarring in any part of the vagina.

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On vaginal examination it was found that the vaginal depth was about 3" and it was admitting two fingers easily and was quite patulous. A mass was felt in the suprapubic region about 6 cms x 8 cms in diameter, cystic not freely mobile, not tender and the fornices were clear.

On these findings she was diagnosed as haematometric due to high vaginal septum and was posted for examination under anaesthesia and excision of the vaginal septum. On 16-1-1979 patient was examined under anaesthesia and findings were same as above. The mass was aspirated with No. 19 gauge needle and thick altered blood about 19 cc's removed easily. A transverse incision was given over the septum which was cut through till the cervix was reached which started draining the typical dark brownish discharge of haematometra. The edges of the septum near the vaginal wall were stitched all round with interrupted catgut sutures to prevent vaginal stenosis at this level. About 150 to 200 ccs of altered blood drained. Patient made good recovery. She was put on streptomycin and Penicillin postoperatively. Patient reported after one month on 1-3-1979 in the G.O.P.D. on the 2nd day of period. Local examination showed uterus A/V. of normal size, firm and mobile. Fornices were clear. On speculum examination external os well visualised and bleeding seen coming out of uterus cavity. Vagina was healthy.

After 3 regular cycles she conceived and delivered a male child of 700 gms by caesarean section. Indication for caesarean was premature rupture of membranes with no progress of labour. She was discharged on 10th postoperative day with the healthy child.

Case 3

Mrs. I.G., aged about 40 years coming from a village near Ramtek attended G.OPD on 28-10-1980 wih the complaints of continuous blood stained vaginal discharge with the history of passing clots intermittently. Since last one month, pain in lower abdomen, mass in lower abdomen and burning in micturition for-last 1 month. She also complained of foul smelling vaginal discharge for last 4 months. There was no history of amenorrhea. Patient had 6 full term normal deliveries, last child birth was 6 years back. Menstrual cycles after the last child birth were 8-10/30 days regular but excessive flow. For last 1 month there was continuous vaginal bleeding. Rest of the general examination and systemic examination did not reveal anything abnormal. On abdominal examination, a mass arising from the pelvis, about 14 weeks of pregnant uteus size, having restricted mobility, firm in consistency and tender on palpation.

On speculum examination, a large cauliflower growth replacing the cervix completely about 1½" in diameter involving the upper 2/3 of the vagina anteriorly and the posterior and lateral fornices. Growth bled on touch. Uterus was about 14 weeks size, firm in consistency and tender on palpable.

She was taken up for drainage of pyometra and biopsy from the cervix on 30-10-1980 under I.V. pentothal. Under anaesthesia the above findings were confirmed. Then uterine sound was passed through the growth to locate the cervical canal and uterine cavity. It went in easily upto 5". Duncan dilators could easily be passed upto 17 number dilator without causing much bleeding, but surprisingly no pus was drained. When vaginal examination was done cervix was admitting one finger easily through which uterine cavity could be palpated. 100 ccs of old blood clots were removed from the cavity which means about 250 ccs of blood was present in the form of clot in the cavity. Cervical biopsy was taken and as there was fresh bleeding vagina was packed.

X-ray chest and I.V.P. was normal. Biopsy report showed features of adenocarcinoma. Patient received antibiotics and blood transfusion and was given full dose of intracavity radium and deep X-ray therapy.