FAILURE OF INTRA AMNIOTIC SALINE

(A Case Report)

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Introduction

Intra-amniotic saline instillation is one of the methods for evacuating the uterine contents in case of intrauterine death of the fetus once diagnosed. All cases expel the uterine contents within 72-96 hours after IAS. Failure of expulsion after this time needs reconsideration of the diagnosis. One such case where the patient failed to expel the uterine contents due to an intraligamentous pregnancy is presented here.

CASE REPORT

30 years of old Mrs. Sundari was admitted into the antenatal ward in Government Rajaji Hospital on 14-8-1982 with the history of Genorrhoea for 12 months and absence of foetal movements for 2 months. She was married 15 years ago and had one full term twin delivery 14 years ago. Both children were alive.

On general examination patient was not anaemic. Systemic examination revealed nothing abnormal. Uterus was 30-32 weeks size. Head was in the lower pole. Fetal heart was not heard. Milk secretion was present. Vaginal examination revealed that cervix was not soft, os closed. Fetal parts felt through the fornices. Body of the uterus was not made out. Plain x-ray abdomen showed evidence of IUD. With a provisional diagnosis of IUD patient was given Syntocinon drip 10 units in 500 ccs. of 5% Dextrose solution. Total of 20 units was given for 2 days.

There was no response. So 200 ccs of 20% saline was instilled into the amniotic cavity after letting out brown coloured amniotic fluid on 19-8-1982 at 4.00 P.M. There was no response even after 36 hours. Then high titre syntocinon was given. There was no uterine contraction.

On further interrogation patient gave the history of pain abdomen and bleeding PV when she was 2 months pregnant. She underwent D & C outside. This history prompted us to reconsider the diagnosis. Then uterine sound was passed and resistance was felt at 3½ inch length. X-ray abdomen with sound in situ showed evidence of IUD with considerable distance between tip of the sound and the head of the fetus.

Laparotomy was performed on 24-8-1982. Under General Anaesthesia abdomen opened through right paramedian incicion. The sac with the fetus was found in the broad ligament on the left side. The uterus was normal in size and pushed to right side. Right round ligament visualised. Except for the cornual portion of the right tube, rest was not visualised. Right overy could not be identified. The left round ligament was stretched over the sac. The left tube and ovary could not be identified separately. Sac was thick walled, extending behind the uterus to the pouch of Douglas lifting off the descending colon, rectum and sigmoid colon.

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The descending colon was found shifted across the sac anteriorly. Omentum was found to be adhered to the sac anteriorly and to the right side. Sac could not be delivered through the incision because of the adhesions. An incision was made anteriorly and a macerated female baby weighing 2 kgs. was delivered. During this procedure a rent about 1 cm was made in the descending colon and the same repaired. The placenta was very thin and spread over the inner aspect of the capsule and was removed. Only a portion of the sac could be removed and the rest being surrounded by bowels all round. Subtotal hysterectomy was done. Bilateral drain put in and one of which was left to drain the sac. Abdomen closed in layers. One bottle of compatible blood was transfused during surgery. No congenital anomalies were seen in the baby. Post operative period was uneventful.

Discussion

Normally IAS is met with an evacuation rate of 99.6% within 72-96 hours (Keronyl *et al*). In an analysis of 5000 cases of IAS, Kerenyl *et al* found failure in 6 cases of which 3 were pregnancy in accessory born and the other 3 were cases of ovarian cysts diagnozed wrongly as intrauterine pregnancy misled by false positive urine gravindix test. In a similar study in our hospital from August 1978 to July 1981 there were 4 cases of failure. This failure in 4 cases was due to ovarian cyst in one case being mistaken for pregnancy, two cases of cornual pregnancy and one case of bilateral chocolate cyst adherent to uterus. One such case where the patient failed to expel the contents due to Broad ligament pregnancy is presented here.

Though initially IAS put in with a mistaken diagnosis of intrautering pregnancy, failure to expel even after 72 hours and high titre syntocinon drip made us to revise the diagnosis. Also the history obtained retrespectively revealed the possibility of extra urine pregnancy and X-ray abdomen with sound in situ helped to confirm the diagnosis. Since the sac was very close to the uterus, the uterus could not be made out separately from the pregnant sac on bimanual examination. The aspiration of liquor was possible because the needle has gone directly into the sac in the broad ligament. Three conditions to be thought of in prolonged pregnancy. They are anencephaly, extrauterine pregnancy and placental sulfatase deficiency.

Summary

Failure of IAS due to Broad ligament pregnancy is presented here.

Acknowledgement

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