SECONDARY ABDOMINAL PREGNANCY

(A Case Report)

by

PREETI DUBEY

and

P. ROHATGI

SUMMARY

A case of secondary abdominal pregnancy who presented as a case of A.P.H. has been reported.

Introduction

Although secondary abdominal pregnancy is an uncommon termination of ectopic pregnacy it is not rare. An incidence of 1:2559 (Mukherji *et al* 1976) and of 1:21,600 by Kharan and Shah (1976) in India has been reported. In our hospital it is 1:13,400. Unusual cases of recurrent abdominal pregnancy have also been reported (Mohanty 1983).

CASE REPORT

Mrs. Neera, aged 20 years G2 P+O was referred as case of A.P.H. She had severe pain in abdomen with profuse vaginal bleeding following amenorrhoea of 39 weeks.

The last delivery was normal home delivery 2½ years back. Antenatal history revealed H/O severe nausea, vomiting and feeling unwell in first trimester, quickening at 5th month but after 6½ months foetal movements lessened following an episode of severe pain and vomiting at 6½ months. There was no associated vaginal bleeding or fainting attacks. In the third trimester, she had severe pain in abdomen at 32 weeks which was associated with giddiness and vomiting, but no vaginal bleeding.

On vaginal examination placenta was not felt with os 2 cms dilated. Cervix was thick, no bag, presenting part could not be made out or was high.

She was diagnosed as a case of intrauterine death and I/V drip with syntocinon 100 units was given following an enema on the day of admission and on next day, but no contractions could be evoked. Laparotomy was done on 2-3-84 after arranging 1 pint of blood. BT & CT were normal. On opening the abdomen placenta was first seen lying free in the peritoneal cavity with a hole in the centre, attached only at the lower pole to the cornu of uterus which was easily removed. A dead macerated foetus of about 32 weeks gestation with no external developmental abnormality was removed. Uterus was bulky with a cornual rupture and both tubes and ovaries were normal. Interior of the uterus failed to show any rudimentary horn. Rupture was repaired, omentum and intestines were examined, which revealed no injury or bleeding after hot packing. So a drain was put in and abdomen was closed in layers after securing, complete haemostasis.

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MOLAR PREGNANCY WITH CARDIO-MYOPATHY

(A Case Report)

by

S. K. SANDHU

T. D. SHARMA

and

CHITTER LEKHA SINGLA

Introduction

Association of molar pregnancy which is found 1:500 pregnancies in India, with anaemia and pre-eclampsia is well documented. Rare associations of this pregnancy have been mentioned as hyperthyroidism (Norman *et al* 1981) and disseminated intravascular coagulation (Egle *et al* 1975 and Tsakok *et al* 1976). We have not been able to locate any case of cardiomyopathy with acute left heart failure associated with hydatidiform mole in literature to-date and hence is this case report.

CASE REPORT

Patient S, was admitted in Government Hospital for Women/Medical College, Amritsar on 14-1-84 with the diagnosis of hydatidiform mole. She was gravida 2 with a previous full term, normal vaginal delivery three years ago. Her LMP was 1-10-1983 and she complained of repeated bouts of bleeding and excessive enlargement of abdomen. On examination she was toxaemic in look, had 3 + oedema feet and legs, blood pressure 190/120 mm of Hg and haemoglobin 6.5 gm%. Her respiratory rate and pulse rate were within normal limits. She was given repeated blood transfusions. On the 4th day after admission she suddenly developed marked breathlessness and was very uncomfortable. She was transferred to Medicine Department. On exmination she was found to have marked degree of dyspnoea, orthopnoea, oedema legs and feet, pulse 140/minute, blood pressure 190/110 mm of Hg, respiratory rate 58/minute. Electrocardiogram showed sinus tachycardia, generalized ST-segment depression and inversion of T-waves in chest leads. She had coarse crepitations at lung bases. She was given treatment of acute LHF and was also put upon antihypertensive treatment. There was no significant improvement with the above energetic treatment, therefore, it was decided to evacuate the mole. By 27-1-84, the height of the uterus had increased to 32 weeks pregnancy. Abdominal hysterotomy was done for evacuation. She remained stable during the operation, with blood pressure 170/100, pulse 130/minute, respiratory rate 35/minute. Post-operatively she was on antihypertensives for 3 days and digoxin was tapered off in 5-6 days time. Her respiratory rate improved markedly, blood pressure came down to normal and pulse settle by the 5th day. By the end of first week she did not need any treatment whatsoever and repeat electrocardiogram showed complete disappearance of preoperative changes. She was kept in hospital for observation for another 2 weeks and no significant findings relating to cardiovascular system were detected. Patient was discharged on 20-2-84. Repeat follow ups including general physical examination, examination of circulatory system. E.C.G., internal examination and HCG levels showed no abnormality. Todate she has no complaint, whatsoever.

Discussion

Apparently LHF which occurred in

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this patient was the result of hydatidiform mole. Hypertension being the cause of it seems unlikely because E.C.G. showed no evidence of LV hypertrophy. Probably the mole caused hypertension on one hand and cardiomyopathy on other. This hypothesis is strengthened because of the fact that when mole was evacuated, its toxic manifestations in the form of hypertension and cardiomyopathy resulting in acute LHF disappeared quite soon. Peripartum idiopathic cardiomyopathy is well known but it is a rare condition resulting in cardiac dilatation and heart failure. However, in the present case mole resulted in a kind of cardiomyopathy which completely disappeared within a very short period of one week of evacuation of mole. Since we have not come across such a case reported in literature so far, we suggest taat this complication of mole may be kept in mind.

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PUERPERAL PELVIC ABSCESS CAUSED BY CHLAMYDIA TRACHOMATIS

by

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and

B. L. TAY

History

A 36-year-old Chinese woman underwent elective lower segment caesarean section and bilateral ovarian cystectomy because of primary subfertility, cephalopelvic disproportion and dermoid cysts of the ovaries. A healthy male baby weighing 3430g was delivered in good condition.

She was readmitted 19 days later (26 days post-operation for fever and lower abdominal pain over the previous days. There was no urinary or bowel symptom.

Clinical Findings

On examination, the suprapubic area was tender but without any guarding.

A tender uterus of about the size of a 12 weeks' pregnancy was felt on pelvic examination. The fornices were tender but no mass was palpable. There was tenderness on cervical excitation.

Investigations

Hematology:

Hemoglobin 10.6/dl

Total WBC count 11.8 x 10^9/1

Differential count: Poly 86, Lympho 8, Mono 1, Eosino 1, Reticulo 4

ESR 36 mm/First hour

Biochemistry:

Serum urea and electrolytes: Normal

Microscopic Examination of Urine: Normal

Bacteriology:

No bacterial growth was obtained from the culture of midstream clean-catch specimen of urine or high vaginal swab. Blood culture was taken three times during the febrile stage. There was no bacterial growth from the first and third sample. The second sample was, however, contaminated.

Chlamydia trachomatis was isolated from the endocervical swab. The culture of the latter, however, failed to grow gonococci.

Course of the Disease and Management

The fever, however, failed to settle with Gentamycin reaching a daily peak of 38°C.

Four days later, she complained of mucus discharge per rectum following defaecation. A repeat pelvic examination revealed a small but boggy tender mass in the pouch of Douglas. An ultrasonic scan was performed which indicated the possibility of a pelvic abscess.

A second laparotomy was, therefore, carried out. Multiple small abscesses were found in the right adnexa and the adjoining broad ligament Swabs were taken from the abdominal wall, adnexae, broad ligament and the pouch of Douglas, but no bacterial growth was obtained on culture. An evacuation of the abscess and right adnexetomy was performed. The culture report of the endocervical swab indicating growth of Chlamydia trachomatis was by then available She was, therefore, treated with tetracycline (500 mg 6 hourly for 14 days) in view of positive culture for Chlamydia trachomatis.

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Accepted for publication on 23-3-85.

A CASE REPORT OF RUPTURE OF URINARY BLADDER IN RETROVERTED GRAVID UTERUS WITH RETENTION OF URINE

by

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and

S. P. AGRAWAL

Introduction

One of the major complications of retroverted gravid uterus is retention of urine. Retention of urine is usually preceded by dysuria and frequency of micturation.

Retention due to retroverted gravid uterus which is usually acute occurs in about 13 to 16 weeks of gestation. If the patient sustains trauma to the abdomen either by direct blow or fall, bladder might rupture.

A case of retroverted gravid uterus with acute retention of urine is reported which developed intraperitoneal rupture of bladder due to fall on ground.

CASE REPORT

Mrs. K.D. 30 years old, 3rd gravida was admitted on 4-10-80 in a shocked condition. She had amenorrhoea of 4 months with intermittent retention of urine for last one month for which she was repeatedly catheterised in the village.

36 hours prior to the admission she developed acute retention of urine. About 12 hours before the admission to the obstetrical emergency she had a fall on the ground. Subsequently she felt agonising pain in the hypogastrium and started bleeding per vaginum.

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On abdominal examination:

There was tenderness and rigidity in the abdomen more marked in lower quadrants. Shifting dullness was present, while bowel sounds were absent. On catheterisation a few ml. of blood stained urine came out.

On Pelvic Examination:

Uterus was 14 weeks size, acutely retroverted Cervix was one finger loose and products of conception were protruding through it. Fornices and pouch of Douglas were full. Abdominal paracentesis revealed haemorrhagic fluid in peritoneal cavity. A provisional diagnosis of intraperitoneal rupture of bladder was made and it was decided to do an emergency laparotomy.

Abdomen was opened by midline incision. Abdomen was full of haemorrhagic fluid and blood clots. 4 cm. long rent was detected in the posterior part of the dome of the bladder. Edges of the rent were trimmed and bladder was repaired by 1/0 chr. catgut in 2 layers. Bladder was drained by indwelling Foley's catheter. Abdomen was closed in layers with 2 corrugated rubber seet drains in both flanks and one drain in cave of Rettzius.

Syntocinon drip was given and evacuation of the uterus was done at the same sitting..

Post-operative period was uneventful. Patient passed flatus after 48 hours. Malecot's catheter was removed after 6 days. The suprapubic urinary fistula closed in next 7 days. The Foley's catheter was removed on 18th post-operative day.

CAESAREAN SECTION FOR BLADDER STONE

(A Case Report)

by

RAJYASHRI SHARMA

and

KUSUM SAXENA

Introduction

Bladder stone causing Obstructed labour, and leading to caesarean section is rare hence this case report.

CASE REPORT

A 20 year old primigravida was admitted as full term pregnancy in labour pains for last 4 hours. Uterus was 40 weeks in size, head was at brim, FHS 140/mt. Cervix was 4 cm dilated fully effaced, bag of water was intact, in the anterior fornix at the level of the lower segment a 2″ x 2″ firm but slightly mobile mass was palpable. Labour progressed for another 8 hours. The lower segment had started to overstretch. Head remained at brim, cervix had dilated to 10 cm. The mass of 2″ x 2″ had descended in the vagina below the presenting part, it was stony hard with irregular sharp edges.

Lower segment caesarean section was performed under general anaesthesia. Alive male child with apgar of 8/10 was delivered.

After caesarean section bladder was palpated. The mass was confirmed to be in the bladder. Suprapubic cystotomy was done.

A single stone of 2″ x 2″ weight 25 gms. light brown in colour with markedly irregular and sharp projections was removed. The patient had an uneventful recovery. She was discharged on the 12th post-operative day.

From: JNMCH, AHU, Aligarh.

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See Fig. on Art Paper VII

HAEMATOMA OF RECTUS ABDOMINES MUSCLE IN LABOUR

(A Case Report)

by

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and

P. ROHATGI

Introduction

Haematoma of vulva, vagina, perineum and broad ligament are commonly encountered during labour but haematorna of rectus abdominis muscle in labour has been less commonly encountered.

The propelling force in labour consists of uterine muscular contractions and subsidiary to it are the diaphragm and the muscls of abdominal wall; those of arms, legs and back lend a certain amount of assistance in the expulsive stage.

Although rupture of retromuscular blood vessels during labour is a great rarity, a number of odd cases have been reported till now. Thomas (1943) Nora Keevil (1943) Dawson (1944), Fahmy (1944) have also described such cases.

CASE REPORT

Mrs. K. P5+O aged 38 years was admitted on 2-7-83 in UISE Maternity Hospital, Kanpur with labour pains since 8 hours following 36 weeks amenorrhoea and breathlessness since 6 hours. There was no H/O dai handling and abdominal massage. But H/o bearing down and straining since last 8 hours. Haemic murmur in all 4 areas. Cephalic presentation, uterine contractions good, abdomen very tender FHS-140/mt regular, P/V examination revealed 6 cms cx partially taken up, membranes absent, head at brim, liquor clear, no C.P.D. pelvis adequate. Her HB was 6.0 mg% urine did not show albumin.

Inj. Deriphyllin 1 amp. I/M 6 hourly was started. A very slow drip was started in order to keep a vein patent. Inj. Epidosin 1 amp I/M was given to promote dilatation.

Patient delivered an alive female child 2½ kg. After delivery the patient remained restless dyspnoeic, her G.C. remained poor pulse 120/mt. BP 90/70 mm Hg lungs clear, P/A examination showed uterus to be well retracted and also a mass extending from left hypochondrium to umbilical region occupying the epigastric, left lumbar region and encroaching the left iliac fossa, separate from the uterus, very tender, mobility and movement with breathing of this swelling could not be elicited. Blood pressure came down to 70 mm Hg. An immediate laparotomy was performed, as a twisted ovarian tumor was suspected. The swelling turned out to be a swelling of subfacial plane. A large haematoma of rectus abdominis muscle was evacuated and bleeding points were searched for. No bleeding point was seen so wound was packed and counter drainage at the lower pole of wound was done.

Patient was given another unit of blood I/V fluid antibiotic post-operatively. Her GC improved, dyspnoea subsided, vitals remained maintained. Post-operative phase was uneventful and afebrile. Stitches were removed on 10th post-operative day. Healing occurred by primary intention and patient was discharged on 11th post-operative day.

From: Department of Obstetrics and Gynaecology, G.S.V.M. Medical College, Kanpur.

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A CASE REPORT OF TORSION OF UNICORNUATE GRAVID UTERUS

by

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and

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Introduction

Dextrorotation of the gravid uterus is found in many cases but torsion of sufficient degree to provide acute abdominal symptom is rare. Torsion is usually common with mullerian duct anomalies, that is unicornuate uterus, uterus didelphus, rudimentary horn.

Unicornuate uterus is longer and narrower with poor musculature and perineal attachments, causing undue and excessive mobility. Other predisposing factors are fibroid, ovarian tumours, pendulous abdomen, spinal column abnormality.

Torsion of gravid bicornuate uterus was reported by Jamila in 1980. Torsion with subserous fibroid was reported by Laxmidevi in 1979.

Torsion usually occurs at uterocervical junction. Nesbet and Corner (1956) reviewed literature and collected 107 cases.

CASE REPORT

Mrs. H. N., aged 32 years Gravida IV, para one was admited at Smt. S. C. L. General Hospital, Saraspur, Ahmedabad, on 4-1-1983. She complained of 6 months amenorrhea with pain in abdomen and breathlessness since two days. She had two abortions at 3 months and 6 months gestation respectively. She also gave history of one premature delivery at 7½ months gestation, and a female infant was conceived who is now 1½ year old. During the present pregnancy, she gave history of isthmic encirclage for incompetent cervical os at 5 months gestation at Bombay.

Vaginal examination revealed cervix to be elongated easily admitting one finger, but internal os was tightly closed an somewhat abnormal on palpation. A nylon wire was felt. Fornices were clear but were tender. Foetal parts could not be palpated properly.

Laparotomy Findings

On opening up the abdomen, 150 ml of free blood was found in the peritoneal cavity. The uterus was soft, flabby corresponded to 24-26 weeks of pregnancy. There was a spiral serosal tear of about 2″ on the right anterolateral surface near the fundus of the uterus and another serosal tear on the posterior surface of the uterus. Both were bleeding. The myometrium and decidua were intact. An incision was made on the right anterolateral serosal tear and was extended downwards. A stillborn female baby with placenta was delivered. Inspection of placenta revealed a big retroplacental blood clot. The incision was sutured in two layers. The uterus continued to remain flabby and bleeding continued in the uterus and along the suture line inspite of administration of oxytocies. So the uterus was delivered out of the abdominal cavity and it was found to be incornuate and had undergone torsion of more than 180 degree. On untwisting the uterus, the fallopian tube and ovary were found to be of the right side and were gangrenous because of the torsion.. The left appendages were missing Subtotal hysterectomy with right salpingo-oophorectomy was then performed. She was given five bottles of blood transfusion.

Post-operative convalescence was eneventful.

From: Sheth K.M. School of Post graduate Medicine and Research, Ahmedabad-6 and S.C.L. General Hospital, Ahmedabad.

Accepted for publication on 4-1-85.

Discussion

This case is presented as a diagnostic problem. Any a case of unexplained tenderness of the uterus and worsening of the general condition of the patient despite conservative treatment requires laparotomy. Unfortunately this patient was brought to our hospital after 48 hours and hence the unusual delay sacrificing the gangrenous appendages and uterus.

However, diagnosis is more commonly made retrospectively on laparotomy.

Acknowledgement

We gratefully acknowledge the Superintendent, Smt. S.C.L. General Hospital, Ahmedabad, for allowing to use the hospital data in preparin this case report.

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PUERPERAL INVERSION OF UTERUS

by

GULNAZ
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and
WAZIRA KHANAM

Introduction

Acute puerperal inversion of the uterus is an obstetric emergency. Although it may occur spontaneously, mismanagement of the third stage of labour is generally conceded to be the immediate cause.

Material and Results

Eight cases of puerperal inversion are presented as shown in Table I. Out of these 8 cases 5 were acute and 3 were chronic inversion. Two cases were primigravida and rest were 2nd and above. Age of the patient was between 20-32 years. All patients reported from outside except 1 whom inversion occurred in 3rd stage of labour in hospital whose delivery was conducted by nurse.

Discussion

Manual corrections was done in 4 cases and O'Sullivan's Hydraulic method was done in 1 of the acute cases. Haultain's operation was done in 3 chronic inversion cases. All cases under cover of antibiotic made uneventful recovery.

A point of controversy in management is when to remove the placenta, Shalper (1964) recommended removal before replacement stating that this facilitates the procedure. However, since the myometrium is easily torn, bleeding may be increased and shock aggravated, maternal sinuses are exposed to sepsis, so prior removal carries some risk. O'Sullivan (1945) was of the opinion that immediate replacement of the uterus without removal of placenta will prevent haemorrhage and exaggeration of shock.

Once the uterus has been replaced the hand should be left in the endometrial cavity until there is firm contraction and intravenous oxytocics are being administered. There was no maternal death in this series but deaths do still occur.

From: Department of Obstetrics and Gynaecology, Government Medical College, Srinagar.
Accepted for publication on 11-12-84.

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S. No.	Age in years	Gravida	Type of inversion	Duration	Place of delivery	Type of mismanagement	By whom	Treatment	Result
1	2	3	4	5	6	7	8	9	10
1.	30	VI	Acute	6 hours	Outside	Pressure Fundal	Untrained midwife	Manual correction under anaesthesis	Discharged well
2.	25	II	Acute	5 hours	Outside	Admitted with shock. Fundal pressure given for delivery of placenta	Untrained midwife	Resuscitated Manual correction under Anaesthesia	Discharged well
3.	24	III	Acute	7 hours	Outside	Fundal pressure given for delivery patient admitted with shock	Untrained midwife	O'Sullivan's Hydraulic Method	Discharged well
4.	20	Primi	Acute	2 hours	Outside	Cord traction in relaxed uterus. Fundal adherental placenta. Patient in shock	Untrained midwife	Manual correction after separation of placenta	Discharged well
5.	32	II	Acute	immediate	Hospital	Fundal pressure and cord traction given for III stage. Spontaneous inversion following delivery of placenta	Nurse	Manual correction	Discharged well
6.	22	II	Chronic	9 months	Outside	Not known	Untrained midwife	Haultains operations	Discharged well
7.	26	III	Chronic	1 year	Outside	Not known	Untrained midwife	Haultains Op. with ligation	Discharged well
8.	25	I	Chronic	2 years	Outside	Following delivery of III stage	Untrained midwife	Haultains Op. with ligation	Discharged well

AN UNUSUAL CASE OF RUPTURE OF THE UTERUS BY PLACENTA PERCRETA

(A Case Report)

by

(MRS.) J. MISHRA

Introduction

Placenta percerata is one of the rarest varieties of morbid adhesion of placenta. The incidence varies from 1 in 900 to one in 1600 deliveries as quoted by different workers (Irving and Hertig 1937, Cunnigham 1937, Aaberg and Reid 1945 and Burke, 1951).

CASE REPORT

Mrs. R.K., Gravida 4, pregnancy 36 weeks was admitted in the Nalanda Medical College Hospital, Patna with acute pain in the abdomen on 6-1-1984. She had similar attack of pain at 20 weeks of gestation following which she had become anaemic. The pain subsided after treatment. 600 ml of blood was also transfused to her to cobat anaemia.

As regards her obstetric history she had 3 full term normal deliveries.

From: Professor and Head, Deptt. of Obstetrics and Gynaecology, N.M.C.H., Patna.

Accepted for publication on 14-11-84.

There was slight oedema of feet. Urine analysis showed no albuminuria.

On obstetrical examination, the size of uterus was compatible with dates. Lie was transverse F.H.S. was 144 per minute. The uterus was tender on palpation.

On pelvic examination the cervix was ½" long, fornics felt full, there was no evidence of external bleeding.

In view of pain in the abdomen, tender uterus and high blood pressure of 150/100 a tentative diagnosis of accidental haemorrhage was made.

After resuscitative measures and essential investigation it was decided to do emergency caesarean section.

On opening the peritoneal cavity, there was haemoperitoneum and adhesions. There was also evidence of lateral and posterior tear of the uterus. Lower segment, caesarean section was done and an alive male child was delivered. It was impossible to deliver the placenta as the placental tissue was adherent to the uterus, had perforated the uterus laterally and posteriorly (Fig. 1) and got attached to the omentum and intestines. Caesarean hysterectomy was done and the placenta was denely adherest to the uterus (Fig. II).

Post-operative period was uneventful.

See Figs. on Art Paper X

CLINICAL PRESENTATIONS OF GRANULOSA THECA CELL TUMOUR OF OVARY

(Report of Seven Cases)

by

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S. MITTAL
and
K. GANESH

SUMMARY

Granulosa theca cell tumours present in a variety of ways due to the following reasons:

(i) capacity to produce hormones.
(ii) potential tumorogenic properties.
(iii) frequent association with a number of common gynaecological conditions.
(iv) occasional occurrence with pregnancy.
(v) tendency to cystic degeneration, torsion and rupture.

Introduction

Granulosa theca cell tumours are not uncommon neoplasms of the ovaries. A brief review of the clinical presentations and the diagnosis of seven cases of granulosa theca cell tumours, who were admitted in Smt. Sucheta Kriplani Hospital, New Delhi, is presented.

Observations and Discussions

The detailed clinical features and diagnosis of these seven cases, are presented in Table I.

Age, Parity and Association with Pregnancy: all these patients were in the ages 19 to 53 years. Of the 7 cases, 5 had 2 to 5 normal deliveries. Two of the 7 cases were associated with pregnancy. The second patient (case 6) was 2½ months pregnant and her two earlier pregnancies, had ended in spontaneous first trimester abortions.

Symptoms: Three of the 7 cases had irregular and/or prolonged bleeding per vaginum while 2 patients had amenorrhoea, one due to associated pregnancy and another due to recent delivery. Two patients, however, had normal menstrual cycles.

Four of the 7 cases presented with mass and/or pain in abdomen and 1 patient complained of distension of abdomen.

Signs: In the present study, size of these tumours ranged from not palpable

From: Lady Hardinge Medical College, New Delhi.

Accepted for publication on 19-12-84.

TABLE I

Clinical Features, Diagnosis, Treatment and Histopathology Report of Seven Cases of Granulosa Theca Cell Tumors

S. No.	Name	Age in yrs.	Obstetric history	Menstrual history	Presenting complaints	Clinical findings		Provi-diagnosis
						P/A findings	P/V findings	
1.	Shanti	36	3 F.T.N.D. LD-14 Yrs.	Regular 3-4/30 days	Pain abd. 1 year Mass abd. 4 months	5 x 6″ cystic mass	Ut NS, Mass abd. tipped through Rt. fx, other fxs free	Twisted Ovarian Cyst.
2.	Indiri Devi	22	1 F.T.N.D. LD-1 month	Lactational amenorrhoea Prev. cycles regular	Pain abd. and vo-miting off and on-20 days. Pt. no-ticed mass abd. at 6 months of preg-nancy during an attack of acute pain abd.	4 x 5″ cystic mass	Ut NS, Fxs free	Twisted Ovarian Cyst.
3.	Birma	40	3 F.T.N.D. LD-5 years	Regular 3-4/30 days	Gradually increasing mass abd. and fever-1½ months	Ascitist Nodular mass in lower abdomen	UT NS, 4 x 2″ size nodular mass in Rt. iv, Nodular hard masses in post and lf. fxs.	Malignant Ovalian with second-aries
4.	Anita	19	Unmarried	Irregulal 10-15/22-25 days-1 year	Distension of ab-domen and Ano-rexia 20 days	Ascitis +. Vague hard mass up-to ant. sup. iliac spine-Rt. side and 2″ below Costal margin lf. side	Cx small, Ut not felt separate from mass, all fxs full	Solid Ovarian ? Malig-nant
5.	Gyan Devi	53	5 F.T.N.D.	Irregular prolonged 25-30 days/ 20-120 days	Irregular and profuse bleeding PIV-2 years	N.A.D.	Ut MPS, fxs free	? DUB ? CA body uterus

TABLE I (Contd.)

S. No.	Name	Investigations	Revised diagnosis	Type of Operation	Histo-pathology report			Remarks
					Rt. Ovary	Lt. Ovary	Uterus	
1.	Shanti	—	Twisted Ovarian Cyst	Total abdominal hystrectomy with bilateral Salpingo-ovariotomy	Granulosa theca cell tumor	Serous cystadenoma	Proliferative endometrium with Leiomyoma	Lost to follow up
2.	Indiri Devi	—	Twisted Ovarian Cyst	Rt. sided Ovariotomy	Cystic Granulosa theca cell tumor with infraction and twisting	—	—	Lost to follow up
3.	Birma	—	Malignant Ovarian with secondaries	Total abd. hystrectomy with Rt. sided salingo-ovariotomy and lf sided salingo-oophrectomy with partial omentectomy	Granulosa cell tumor	Normal	Proliferative endometrium with myohyperplasia	Lost to follow up
4.	Anita	X-ray chest Pl. effusion Rt. side Pap's Smear, Pleural and peritoneal fluid-Negative for malignant cells	Meig's Syndrome	Total abd. hystrectomy with rt. sided salpingo-ovariotomy and lf sided salpingo-oophrectomy	Granulosa cell tumor	Normal	Normal	Alive and well at time of publication (more than 8 years)
5.	Gyan Devi	D & C (3 times) Proliferative endometrium	DUB	Total abd. hystrectomy with bilateral salpingo-oophrectomy	Seedling Granulosa cell tumor	Normal	Proliferative endometrium with small leiomyoma	Died after 15 months of secondaries

TABLE I (Contd.)

S. No.	Name	Age in yrs.	Obstetric history	Menstrual history	Presenting complaints	Clinical findings		Provi-diagnosis
						P/A findings	P/V findings	
6.	Sheela	24	G_3 (Po+2) 2 abortions, of 2½ month each. Last abortion 8 months back	Amenorrhoea 2½ months Prev. cycles 3-4/30 days	Fever and pain abd. 1 month Gradually increasing mass abd. 1 month	Nodular, irregular mass upto umbilicus, firm to cystic in consistency	Cx firm, Ut shifted to rt. side, size not made out, mass 6 x 7" sl. tender, in lf and ant. fxs	Malignant Ovarian tumor
7.	Laxmi	32	2 F.T.N.D. LD-4 years	Continuous bleeding PIV-2 months	Irregular bleeding PIV-5 months, continuous bleeding PIV-2 months	Supra-pubic mass of 14 weeks size uterus	Ut NS, deviated to rt side, cystic mass, mobile in lf, fx, separate from uterus	? Ovarian tumor ? Ovarian Cyst

TABLE I (Contd.)

		Investigations	diagnosis Revised	Type of Operation	Histo-pathology report			Remarks
					Rt. Ovary	Lt. Ovary	Uterus	
6.	Sheela	Pregnancy test-Positive in undiluted urine. X-ray chest multiple diffuse opacities with pleural effusion Rt. side.	Chorio-calcinoma	—	Post-mortum biopsy from abd. mass showed granulosa cell tumor.			Pt. developed intracranial and pulmonary haemorrhages and expired on the 15th day after admission
7.	Laxmi	X-ray abdomen-Soft tissue mass no calcification	Ovarian tumor	Total abd. hysterectomy with Rt. sided salpingo ovariotomy and lf sided salpingo-oophrectomy and partial omentectomy	Granulos Cell	Normal	Proliferative endometrium	Lost to follow up

clinically to filling almost whole abdomen. In one case with normal sized ovaries, seeding granulosa cell tumour was detected on histopathological examination only.

The consistency of these tumours ranged from solid to cystic. Three of the 7 cases had undergone complete cystic change and were diagnosed as ovarian cysts while 1 of these was found twisted at laparotomy.

Associated findings: Two of the 7 cases had associated leiomyoma.

Provisional diagnosis: Correct initial diagnosis of malignant ovarian was made in 2 cases. One patient was diagnosed as DUB due to ormal pelvic findings with menstrual disturbance. Two cases were diagnosed as ovarian cysts due to the clinical signs and symptoms of twisted ovarian cysts. One patient with pregnancy was confused with chorio-carcinoma due to positive pregnancy test, multiple diffuse opacities on X-ray chest and rapidly fatal clinical course of the disease. Lastly, 1 patient was diagnosed as Meig's Syndrome due to solid ovarian with pleural effusion and ascites both of which were negative for malignant cells.

A CASE REPORT OF PRIMARY CARCINOMA OF THE FALLOPIAN TUBE

by

(Mrs.) K. Sarojini Devi

S. Banerjee

and

K. Bharathalakshmi

Introduction

Primary carcinoma of the fallopian tube is one of the rare malignancies of the reproductive tract. Emgeaa (1948). The disease is insidious in character and of high grade malignancy.

CASE REPORT

(Mrs.) M. S. aged 50 years was admitted for foul smelling white discharge and pain in abdomen of 3 months duration. She had 5 normal deliveries. All investigations were normal. Total abdominal hysterectomy with bilateral salpingo-oopherectomy was performed on 25-8-1984. At laparotomy, left tube was found to be thickened, and right tube was retort shaped, with closed fibrial end. There was a small white nodule, on the wall of the right tube for which much attention was not paid at that time. The histopathological examination of the right tube showed adenocarcinoma at the site of the nodule which was in the wall of the tube (Fig. 1, 2) patient was reviewed on 20-9-1984 and referred to radiotherapist for post-operative irradiation which she is undergoing at present.

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See Figs. on Art Paper XI

LIPID CELL TUMOUR OF THE OVARY

(A Case Report)

by

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and

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Introduction

Lipid cell tumour of the ovary is an extremely rare neoplasm and accounts for less than 0.1 per cent of all ovarian tumours. Not more than 100 cases have been reported in the English literature (Scully, 1981). A similar case encountered by us recently in a young girl is reported.

CASE REPORT

A 12 year old girl presented with intermittent headache of 10 days duration. She was in the premenarche age group. Examination revealed an overweight obese girl with normal mile stones of development. Blood pressure was 130/90 mm of Hg. A nodular mass 5.5 x 3 x 2 cm in the left pelvic region was detected. It was thought to be an ovarian tumour on detailed examination. Radiological and routine investigations were within normal limits. Urinary 17 Ketosteroids were increased to 25 mg/24h. She developed change in her voice while in the hospital. A clinical diagnosis of a functional ovarian tumour was made. A left ovarian tumour was removed at operation.

On gross examination the tumour was yellowish-orange, solid, lobulated and measured 3.5 x 3.3 cm. It was not capsulated. Cut surface was solid and focal areas of red-brown discolouration alternating with yellowing-orange areas were seen.

Microscopic examination revealed round to polyhedral cells arranged diffusely or in nests and columns separated by a rich net-work of vascular sinusoids (Fig. 1). The columnar cell pattern at places simulated the structure of places simulated the structure of adrenal fasciculata. Cells contained abundant clear lipid rich cytoplasm and a round vesicular nucleus. Cells from the reddish brown area were rich in lipochrome granules. Reticulin fibers were seen surrounding individual cells or groups of cells. No mitosis or cell atypia was present. There was no evidence of vascular invasion. A diagnosis of lipid cell tumour of the ovary was made based upon above findings. Urinary ketosteroids and blood pressure returned to normal post-operatively.

The case presented typical features of a lipic cell tumour of the ovary such as obesity, hypertension and raised urinary ketosteroids. Young age of the patient and normal glucose tolerance were the atypical features. Blood pressure and urinary ketosteroids returned to normal post-operatively indicating the hormone secreting nature of the tumour.

Histogenesis of this neoplasm is disputed and origin from adrenal cortical rests, hilar leydig cells or stromal lutein cells has been proposed (Serov *et al*, 1978). Most of these are associated with virilisation, obesity, abdominal striae, hypertension or abnormal glucose tolerance, but some have been non functioning. Only about 20 per cent of these behave in a malignant manner with distant metastasis.

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See Fig. on Art Paper XI

PERFORATION WITH COPPER-T 200

(Report of 3 Cases)

by

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and

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Introduction

Many of the perforations caused by Copper-T are cervical perforations. The present report records 3 cases of perforations with copper-T 200—2 cervical perforation and 1 uterine perforation.

CASE REPORTS

Mrs. M. A. 24 years old female cme in March 1983 with the history of vaginal discharge and dysparcunia. She was Para 1, had a made baby by L.S.C.S. in Marcm 1981. H/O Copper-T insertion, 6 weeks postpartum. 1½ years after copper-T insertion she developed menorrhagia and dyspareunia. Bimanual vaginal examination revealed a retroverted, retroflexed mobile non-tender normal size uterus with clear fornices. On P/S examination nylon threads were seen coming out of the external os. and the whitish tip of the Copper-T stem was seen to be just protruding from the posterior surface of the cervix at 12 O'clock position about 1 cm. below the posterior fornix. The thread was pulled out with an artery forceps and the Copper-T could be removed without any difficulty through the cervical canal. There was no bleeding from the site of the perforation. Patient came back for follow up after 3 months and the site of perforation was well healed.

Case 2

Mrs. S.K., 24 years old female was admitted in Dayanand Hospital, Unit I on 23-11-1983 with the history of amenorrhoea of 7 weeks. Previous 2 deliveries were by L.S.C.S.

Patient had Copper-T inserted in May 1983. Inspite of it's presence she conceived and went to a practicing gynaecologist for removal of Copper-T and M.T.P. It seems that attempt at removal of copper-T failed. When patient was seen by us thread was not visible or felt and uterus was RV, RF, enlarged to 6-7 weeks size and soft. Tip of the Copper-T stem was felt through right lateral wall of the cervix at 8 O'clock position about 1 cm. above the external os. !It was felt to be lying just below the cervical epithelium (Partial perforation. A gentle attempt was made to pull and remove the Copper-T with a curette but it failed .Then a very small nick was made on the protruding tip of the verticle limb of the Copper-T, which was thus exposed and pulled out with an artery forceps without any resistance. M.T.P. was completed by suction evacuation. Patient made an uneventful recovery.

Case 3

Mrs. M.K., a 23 years old female P3 had Copper-T insertion in December 1983, 6 weeks after a normal vaginal delivery. Patient had lactational amenorrhoea and requested Copper-T removal which was tried but the attempt failed and patient had excessive vaginal bleeding. After this plain X-Ray abdomen was taken which showed Copper-T in the pelvis. For the complaints of lower abdominal pain and vaginal bleeding she consulted us in May 1984. On pelvic examination, cervix was downwards and backwards. Uterine size could not be made out because of tenderness in all the fornices. P/S

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Revealed bleeding through Ext. Os and Copper-T thread was not seen.

After 2 months pelvic findings were normal and hysterosalpingography was done which showed presence of Copper-T outside the uterus.

On 24-7-1984 Laparotomy was done. Operative findings showed a linear healed scar 1" on the posterior surface of the uterus ½ cm. to the left of midline where a loop of omentum was adherant. In this piece of omentum copper-T was felt. Copper-T thread were seen coming out of this scar on the posterior surface of uterus. Adherant loop of omentum and Copper-T were removed (Fig. 2). Both ovaries and tubes were normal. Her post operative period was uneventful.