INTRAUTERINE DEVICE AND EXTRAUTERINE PREGNANCY

(Report of 2 Cases)

by

PRAVIN N. MHATRE
SHASHANK V. PARULEKAR
and
V. N. PURANDARE

Introduction

There are previous case reports of ectopic gestation with intrauterine contraceptive devices (IUCD). Two case reports of tubal ectopic gestation with the use of an IUCD encountered at K.E.M. Hospital, Bombay, between January 1982 to December 1982 are presented. The role of proper selection of cases for IUCD insertion and proper education of these patients is stressed.

Case Reports

Case 1

Mrs. M. K., a 23 year old primipara presented in the emergency obstetric section of K.E.M. Hospital, Bombay, in a state of hypovolemic shock. She complained of severe pain in lower abdomen for 4 hours. Her last menstrual period had been 35 days ago. Her past menstrual cycles had been every 28 days, regular, moderate and painless. She had one full term normal vaginal delivery 2 years ago, and had had a CuT-200 mm² inserted 2 months after delivery.

On examination her general condition was poor. Her pulse rate was 132/min, respiratory rate 32/min, and blood pressure 80/50 mm Hg. Her extremities were cold. An abdominal examination showed marked tenderness and guarding in both iliac fossae and the hypogastrium. Free fluid could be demonstrated in the peritoneal cavity. Vaginal examination showed that the uterus was of normal size, with marked tenderness on transverse cervical movements, but no masses in the fornices. A speculum examination showed the threads of the IUCD in place.

Culdocentesis yielded free flow of blood which did not clot. An exploratory laparotomy was performed. A ruptured ampullary ectopic gestation was found on the left side. There was no evidence of pelvic inflammatory disease. Left sided salpingectomy with Coffey's repair and plication of the right round ligament were performed. The CuT-200 mm² was removed.

Case 2

Mrs. D.S., a 24 year old primipara came for vaginal bleeding for 15 days, which had started as normal menstruation. Her past menstrual cycles had been every 30 days, regular. She had a full term normal vaginal delivery 2½ years ago and had a CuT-200 mm² inserted 2 years ago.

Abdominal examination showed minimal tenderness in the right iliac fossa, but no guarding or rigidity. Bimanual pelvic examination showed tenderness on transverse movements of the cervix to the left, a normal sized uterus and tenderness in the right fornix, but no mass in any of the fornices. The threads of the IUCD were seen to be in place on a speculum examination.

A laparoscopy was performed, which showed a leaking right ampullary tubal ectopic pregnancy. Right sided salpingectomy and Coffey's repair and plication of left round ligament was performed.

From: Department of Obstetrics and Gynaecology, K.E.M. Hospital and Seth G.S.. Medical College, Parel, Bombay-400 012.

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UNUSUAL SITES OF PERFORATION OF UTERUS BY CU-T

(Report of 2 Cases)

by

(Mrs.) R. Sofat

and

Mohan Lal Gupta

Case Reports

Case 1

Mrs. B.R., 29 years P_2 A_1 reported for Whitish thread like thing coming out of the anal opening while straining for defaecation. She had Cu-T insertion at Khanna 1½ years ago. About 4 months later since the 1st insertion, she went to some private doctor with the complaint of inability to feel the threads of Cu-T. He put another Cu-T and advised her for an X-ray. The patient did not bother to get the X-ray taken.

One year and 4 months after the second insertion she was admitted to this hospial. X-ray pelvis showed two Cu-Ts—one in position and the second lying obliquely just below the level of posterior fornix.

On inspection, the ends of the threads were seen protruding out of the anal orifice on asking the patient to strain. Digital examination revealed that the vertical limb of Cu-T alongwith threads was projecting through the right lateral aspect of rectum about 5 cm above the anal verge. Through a proctoscope, the vertical limb of Cu-T alongwith threads was clearly seen perforating into the rectal canal 5 cms above the anal margin.

Having caught the threads in a haemostat, the Cu-T was pulled out (Fig. 1). A few drops of serosanguinous discharge came out and the opening collapsed immediately.

On repeat digital examination no defect or induration in the rectal mucosa at the site of perforation felt.

Accepted for publication on 15-5-85.

Case 2

Mrs. A., 20 years old, P_1 A_0 reported 12 days after Cu-T insertion for excessive vaginal bleeding

Patient had delivered a full term female child normally 3 months ago which was followed by secondary P.P.H. for which an evacuation was done.

On examination General appearance and nutrition was moderate. She was looking very pale. B.P. was 110/70 mm of Hg and pulse was 92/mt. regular. She was afebrile. Chest CVS and P/A examination revealed nothing abnormal. On speculum examination bleeding from os was there and Cu-T threads were not seen.

X-Ray pelvis was done and on X-ray, Cu-T appeared to be in uterine cavity only. A check Cu-T was inserted and a repeat X-Ray of the pelvis was done. X-ray report showed second Cu-T in position and first Cu-T was lying tilted near the right border of the uterus.

A laparotomy was carried out the next day. The tubes and ovaries on both sides were normal. Uterus was normal sized deviated to the left side. There was a broad ligament haematoma on right side 3" x 3" in size. The haematoma was drained.

On further palpation it was found that there was a rent along the right lateral wall of the uterus about ½" in length just below and a little posterior to the attachment of right round ligament to the uterus and through this rent the Cu-T was perforating which was removed. Soon after this it was found that the horizontal limb of second Cu-T was also showing into the rent and was pulled out, the rent was repaired in 2 layers and covered with broad ligament. The post-operative period was uneventful.

See Fig. on Art Paper VII

BILATERAL TUBAL DIVERTICULA WITH AN ECTOPIC GESTATION

(A Case Report)

by

SHASHANK V. PARULEKAR
SHASHAK H. SHAH
and
(MRS.) N. M. NERURKAR

Introduction

A case of bilateral diverticula of the fallopian tube is presented, one of the diverticula carrying an ectopic gestation. Tubal diverticulum is a rare cause of an ectopic gestation, and there are no cases in the world literature of bilateral congenital tubal diverticula.

Case Report

Mrs. M.L., a 28 years old second gravida first para lower abdominal pain for 4 days and vaginal bleeding for 2 hours. She had one full term normal delivery 8 months ago and was breast feeding the child.

Her general condition was poor, pulse was 114 per minute, blood pressure 80/50 mm Hg. Abdominal examination revealed severe tenderness and some guarding in the hypogastrium and both iliac fossae. Free fluid was present in the peritoneal cavity. On vaginal examination, transverse cervical movements were tender, cervix was closed, uterus was of normal size but deviated to the right, and both fornices had tenderness but no masses. A colpopuncture yielded free flow of blood which did not clot.

An exploratory laparotomy was performed immediately. About 1.5 litres of blood was found in the peritoneal cavity of which 900 ml could be used for autotransfusion. The left fallopian tube showed a ruptured ectopic gestation in a diverticulum about 1 cm from the fimbrial end, which was removed by partial salpingectomy. The right fallopian tube had a diverticulum about 1 cm from the fimbrial normal.

The patient had an uneventiful recovery and was discharged on the 8th postoperative day. Histopathological examination confirmed the diagnosis of ruptured tubal diverticular ectopic gestation.

From: Department of Obstetrics and Gynaecology, Rajawadi Municipal Hospital and T.N. Medical College, Ghatkopar, Bombay 400 077.

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OVARIAN PREGNANCY

by

ARUNA G. RANGNEKAR

and

REVATHI SITARAM

Introduction

Ovarian pregnancy is a rare occurrence even amongst ectopic pregnancies. Considering the rarity of the entity and also the interesting evidence that, this case also supports the newer contention, the following case report is submitted.

Case Report

R.M., aged 30 years, for pain in the abdomen and dyspareunia.

Prior to admission she was being treated as a case of pelvic inflammation.

She was operated for ectopic gestation 10 years back. Following it, she had 3 normal deliveries, last labour being three years back.

She had Cu-T inserted a months back. Following the insertion, bleeding continued upto 30th May, and finally Examination showed that the uterus was normal sized, cervical movements were not-tender, but there was tenderness in posterior and left lateral fornix, and a mass of the size of 3" x 2" was felt in left fornix. Posterior paracentesis was done. Old blood came out confirming the diagnosis of ectopic.

Abdomen was opened and unlike the history given by the patient about being previously operated for ectopic, both the tubes were found to be intact. The source of beeding was found to be left ovary. It was thought to be haemorrhagic corpus luteum, and left salpingo-oophorectomy was done.

Post-operative period was uneventful.

Histopathological report: Tube unremarkable, ovary lodges extrafollicular pregnancy.

From: Gandhi Medical College, Bhopal and Sultania Zanana Hospital, Bhopal.

Accepted for publication on 7-6-1985

See Figs. on Art Paper V

OVARIAN PREGNANCY

(A Case Report)

by

(MRS.) ANITA SINGH

and

(MRS.) ANMOLA SINHA

SUMMARY

Correct diagnosis could not be made even on laparotomy and it was only after examining the specimen on cut-section that foetus became visible.

Case Report

Smt. R.B. devi, 45 years, H.F. was admitted for amenorrhoea of 3½ months with retention of urine for last 28 hours. She was para 2 + 0, both normal deliveries.

The bladder was full upto the umbilicus. Catheterization was done draining 1500 ml. of clear urine. The catheter was left in situ. A small soft suprapubic swelling was just palpable. The abdomen was otherwise soft all over.

A soft lump about 5-6" diameter was palpable through the posterior fornix extending laterally towards left. The uterine body could not be felt separate from the lump.

A provisional diagnosis of retroverted gravid uterus was made. On the second day the patient started bleeding per vaginum which was treated on the line of threatened abortion. But the bleeding persisted and rather increased on the 3rd day. A re-examination was done when the suprapubic swelling had increased in size and lower abdomen was tender. A careful pelvic examination revealed the body of the uterus to be separate from the lump.

Considering her age, negative report of pregnancy test and finding the uterus separate from the lump, a revised diagnosis of twisted ovarian cyst was made.

Laparotomy was done. The uterus was slightly enlarged, right tube and ovary were normal. On left side of the uterus a big mass of about 6" diameter extending posteriorly was present. Loops of intestine, omentum, posterior surface of the uterus and bladder were adherent to it. After careful separation of adhesions thick walled cyst was visible over which left fallopian tube was found stretched. Total hysterectomy with bilateral salpingo-oophorectomy was done.

On incising the cyst it was a surprise to find a foetus of 14 cms. crown heel length inside the cyst (See Figure). The histological examination of the sac wall further confirmed the diagnosis of ovarian pregnancy showing chorionic villi embedded in ovarian tissue.

From: Department of Obstetrics and Gynaecology, Patna Medical College Hospital, Patna.

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See Fig. on Art Paper VII

RARE FISTULAE FOLLOWING CAESAREAN SECTION

by

(Mrs.) V. Agrawal

(Mrs.) S. Sapre

and

P. Olyai

Introduction

Obstetric complications after caesarean section are well known. Rarely gynaecological, urological and intestinal complications are seen following this operation. Amongst these may mentioned relative sterility scar endometriosis (Nora *et al* 1956; Martins 1959), utero-parietal fistulae (Rao, 1957), menouria, vesical fistulae (Falk *et al* 1956, Yossef 1957), uterointestinal fistulae (Varadarjan and Vijaya, 1984). Menstrual diversion as well as uterointestinal fistula following abdominal delivery are interesting but rare phenomenons.

Case Reports

Case 1

(Ileouterine Fistula)

Mrs. S., 20 years, gravida 1 with previous normal menses was admitted on 28-1-81 in Kamla Raja hospital attached to G.R. Medical College, Gwalior as a case of full term pregnancy with obstructed labour. She came from village after a long trial given by Dai. L.S.C.S. was done. A male baby wt. 6 lbs. delivered. Post-operative period was uneventful. She was discharged on 10th day.

On 16th day she again came with complaint of parsing faeces per vaginum. On vaginum examination cervix and uterus were normal, non-tender, mobile and fornices were clear. On per speculum examination faecal matter was coming through the os.

Diagnosis was made as a ileouterine fistula. Laparotomy was done under general anaesthesia. Loops of small intestine was found adherent to posterior aspect of uterus. There was no infection. Uterus was well involuted. Ileum was separated from the uterus and holes in the uterus and ileum were sutured in layers. Post-operative period was uneventful and patient discharged on 12th day.

Case 2

(Uteroparietal Fistula)

Mrs. P.S., 30 Years having 3 healthy babies with previous normal menses, was admitted for monthly bleeding from the small hole on the previous scar on the abdomen for last 4 months. She had two deliveries by caesarean sections.

Incisional hernia was present with a small hole in the centre of previous caesarean section scar through which brown coloured blood was coming out. On vaginum examination uterus could not be made out properly. Under anaesthesia a sound was passed through cervix and another through abdominal hole. Both were felt meeting inside the uterus (Fig. 1). Diagnosis of utero-parietal fistula was confirmed by hysterosalpingography. In view of her age, parity and associated lesion hysterectomy alongwith fistulectomy and repair of incisional hernia was done. Post-operative period was uneventful. Patient discharged on 12th day.

From: Dept. of Obstet. & Gynec., G.R. Medical College, Gwalior (M.P.).

Accepted for publication on 2-9-1985.

Case 3

(Uterovesical fistula with Menouria)

Mrs. M., 25 years old para 2 was admitted in Kamla Raja Hospital for incontinence of urine following 2nd caesarean section with monthly haematuria. (Menouria-menses through urethra).

She underwent two caesarean sections for cervical dystocia after long trial. She developed incontinence urine on 7th post-operative day after 2nd caesarean sections. Six months after that she noticed haematuria but no menses per vaginum and was diagnosed as a case of menouria.

On examination her general condition was good. Abdominal scar healed well. On vaginum examination uterus was normal in size. There was no tenderness or abnormality of the bladder or genital system except urine was dribling through cervix. Diagnosis of vesicouterine fistula was made and confirmed by cystoscopy. Hole was seen near the fundus of bladder about 1 cm. in length.

Abdominal transperitoneal route was chosen owing to the high position of the fistula above the level of the uterine isthmus. The fistulous tract between the uterus and the bladder was exposed and divided. Openings in the bladder and uterus was closed in layers. A free omental graft was then sutured to the anterior surface of the uterus to intervene between the closed uterine and vesical opening. Post-operative period was uneventful.

See Figs. on Art Paper VII

UTERINE INVERSION FOLLOWING SECOND TRIMESTER ABORTION

(A Case Report)

by

SHASHANK V. PARULEKAR
SHASHANK H. SHAH
and
N. M. NERURKAR

Introduction

Inversion of the uterus is usually seen after a term or preterm delivery, but not after a second trimester abortion. A case of uterine inversion after a second trimester spontaneous abortion is presented.

Case Report

Mrs. T.M., a 30 years old 4th gravida, 3rd para was transferred to our centre from a peripheral maternity home on 19th June 1985 at 3.30 A.M. She had spontaneously aborted at home after 4 months of amenorrhoea, and was taken to the peripheral hospital for retained placenta. The placenta was delivered with infusion of a litre of 5% dextrose and 10 units of oxytocin, and cord traction. The placenta was normal, and not morbidly adherent to the uterus. The patient continued to bleed vaginally despite evacuation of uterine contents. An inversion of the uterus was diagnosed and she was transferred to our centre.

On admission, she was in haemorrhagic shock, with the pulse not palpable and blood pressure of 50/30 mm Hg. The uterus was 12 weeks' gestation size, with a cup like depression in the fundus. The cervix was 3 fingers open and the inverted fundus could be felt, the remaining uterine cavity being empty. After resuscitation, the anterior and posterior lips of the cervix were held with sponge holding forceps and downward traction was made. At the same time, the inverted fundus was pressed upwards with a gauze, pad held with sponge holding forceps, controlling the degree of thrust with the left hand on the fundus abdominally. After reduction of the inversion, methyl ergometrine was administered intravenously in a dose of 0.2 mg, and the sponge holder was removed only when the uterus was felt to contract. Bimanual massage controlled the uterine bleeding.

The patient made an uneventful recovery after infusion of 4 units of whole blood and crystalloids, monitoring the central venous pressure. Broad spectrum antibiotics were administered. Electrocardiogram and biochemical investigations did not show any damage to the heart or the kidneys.

From: Department of Obstetrics and Gynaecology, Rajawadi Municipal Hospital & T.N. Medical College, Ghatkopar, Bombay.

Accepted for publication on 5-7-1985.

PRIMARY PERITONITIS WITH PREGNANCY

(A Case Report)

by

P. B. PAI DHUNGAT

and

BARDE

Introduction

The incidence of Primary Peritonitis is very rare. Here we report a case of pregnancy in early third trimester with primary peritonitis which was saved by a timely laparotomy and drtinage of the peritoneal cavity.

Case Report

Twenty-five years old, second gravida was under regular antenatal care. She had first full term still birth at her native place 3 years ago. Exact cause of still birth was not known, though it was presumed that it was because of mismanaged labour.

Her last menstrual period was on October 20, 1984. She was admitted on April 19, 1984 at 24 weeks of gestation for pain in abdomen. One day prior to admission she had 103.1°F temperature, acute pain in abdomen and vomiting once.

Her uterus was 28 weeks size. Presentation was vertex. F.H.S. present. She was apyrexial. Her pulse was 100/min. and Blood Pressure 100/80 mm Hg.

By the evening of 19th she had become toxic, with pulse 136/min. and she had tenderness all over the abdomen Foetal Heart sounds were still present and she was diagnosed as a case of acute abdomen with pregnancy.

From: Dept. of Obstetrics & Gynaecology Bombay Hospital, Bombay-400 20.

Accepted for publication on 22-5-1985.

She was treated conservatively with Ryles Tube suction, intravenous drip and antibiotics.

The General Surgeon concurred with the findings and the treatment and the conservative treatment was continued on 19th night and 20th morning and afternoon.

At 8 P.M. on April 20, 1984 she was in premature labour and cervix was dilating. Patient delivered a premature male baby weighing 900 gms. on April 20, 1984 at 11.49 P.M. By died of cardio-respiratory arrest on April 21, 1984 at 9 A.M.

Injection Anti-Rh D was given to the mother as the baby was Rh positive and Direct Coombe's Test was negative.

After delivery her general condition deteriorated so rapidly that the patient became moribund and was having respiratory rate 46/min., high pulse 140 per minute and absent peristalsis. Emergency laparotomy was done under epidural anesthesia and analgesia.

Peritoneal cavity was found to be full of pus on laparotomy. It was looking like a big abscess cavity with all the visceras inside. Pus was thick, yellowish and odourless. It was sent for culture and sensitivity. Pus was drained completely and all the visceras that is stomach, small and large bewel, appendix, Liver, Spleen, lesser sac, Uterus, tubes and ovaries were checked to find out the cause of peritonitis. There was no apparent cause in any of the viscera to account for peritonitis.

Irrigation of peritoneal cavity was done with normal saline and Kamicitine powder was

sprinkled and abdomen was drained, on both the flanks. Abdomen was closed with tension sutures.

During surgery two units of blood were given. After minor problems for two days she got settled nicely and was discharged on May 7, 1984 in ambulatory condition.

Report of Pus—culture and sensitivity
Gram Negative Bacilli +
Gram Positive Cocci +
Zeil stain and fluorescent microscopy—Nil
No growth on culture (7 days)

Acknowledgement

We thank Dr. A. V. Gondhalekar, the Medical Director of Bombay Hospital for allowing us to use the hospital records.

LITHOPEDION FORMATION FOLLOWING INCOMPLETE ABORTION

(A Case Report)

by

SHASHANK V. PARULEKAR
SHASHANK H. SHAH

and

N. M. NERURKAR

Case Report

Mrs. S.S., a 20 years old, came for vaginal bleeding for 2 years, soaking one pad per day partially. She also menstruated normally in this period, 28 to 30 days. The blood lost was foul smelling both during as well as in between menstruation. Her last menstrual period had started on 2nd May 1985. She had 1 full term normal delivery 4 years ago. After that she had a spontaneous abortion after 4 months of amenorrhoea 2 years ago. A check curettage was done, but the details of that were not available.

Pelvic examination revealed an anteverted normal sized uterus. Sharp, hard spicules were found to be projecting from the cervical canal. The fornices were clear.

A plain radiograph of the abdomen and pelvis in an anteroposterior view showed calcific linear shadows, 2-3 cm long and 1-2 mm broad in the uterine area.

A sharp curettage was done under general anaesthesia and multiple, small fetal bones were removed. She was given Ampicillin postoperatively and had an uneventful recovery.

From: Department of Obstetrics and Gynaecology, Rajawadi Municipal Hospital & T.N. Medical College, Ghatkopar, Bombay-400 077.

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HYDATIDIFORM MOLE WITH A COEXISTENT LIVE FOETUS

(A Case Report)

by

AMIT SENGUPTA

and

A. G. GODE

Case Report

Mrs. P., 9th gravida, aged 40 years was admitted for amenorrhoea of about 7 months duration.

On examination general condition poor, patient drowsy, thin built, anaemic, bilateral oedema feet present.

On abdomen examination uterus was 36 week size, more than period of gestation. Foetal parts were felt along with some doughy feeling. No uterine contraction were felt.

Foetal heart sounds were audible—Rate 140/min, Regular, fetal movements were present.

Locally vulval edema was present.

On vaginal examination revealed cervix uneffaced, Os tightly closed.

Caesarean Hysterectomy was done in view of her being an elderly grand multigravida with severe PET with hydatiform mole and coexisting 28 weeks alive foetus.

On lower segment caesarean section, an alive baby along with the umblical cord attached to the placenta, extracted out. Other gestational sac was found to be intact with molar tissue inside, removed enmass following hysterectomy. Ovaries were normal on both the sides, left as such. Post operative period uneventful.

Patient was discharged on 10th day, and followed up for hydatiform mole for 3 months, when pregnancy test became negative and rest of the investigations were normal. Patient did not come for subsequent follow up.

From: Department of Obstetrics & Gynaecology, Safdarjung Hospital, New Delhi-110 029.

Accepted for publication on 22-7-1985.

OSSIFIED FIBROID OF OVARY

by

ARUNA G. RANGNEKAR

and

(MRS.) B. BHARADWAJ

Case Report

A 30 years young woman came for a lump in the abdomen. Further investigation included a X-ray of abdomen and a gynaecogram and with these investigations, the patient presented herself in the O.P.D. (Figs 1 & 2).

The uterus was normal size. A stony hard mass was palpated in the right fornix, other fernices were normal.

From: Dept. of Obst. & Gynec., Gandhi Medical College, Bhopal.

Accepted for publication on 14-6-1985.

Although the mass was clinically extravesival, bladder sounding was done to confirm it. A diagnosis of calcified uterine fibroid was made. After the routine pre-operative investigations a laparotomy was done. Unlike the clinical impression, the mass was found to be a calcified ovarian tumour. The whole ovary was replaced by a stony hard-mass. The uterus and the other adenexae were normal. Right sided Salpingo-oophorectomy was done, and the stump was peritonized. Abdomen was closed in layers. Post-operative period was uneventful. Histological study confirmed the diagnosis.

See Figs. on Art Paper VIII

ARRHENOBLASTOMA WITH MARKED VIRILISATION

(A Case Report)

by

SUVARNA RAMASWAMY

and

KADAMBARI

A case Report

A 20 year old nulliparous woman presented with hirsutism, deepening of voice and oligomenorrhoea followed by amenorrhoea of 6 months duration each. On Examination she was found to have marked virilisation with clitoral hypertrophy (Fig.). Uterus was normal in size and there was a cystic mass is the pouch of Douglas. Scanning and laparoscopy confirmed the presence of a cystic tumour arising from the right ovary. Laparotomy and right salpingo-ovariectomy was done. Right ovary was the seat of unilocular cystic tumour of 5 cm x 6 cm containing straw coloured fluid with solid areas and tiny papillary excressences. Microscopic examination revealed poorly differeniated arrhenoblastoma with solid and tubular areas and Leydig cells (Fig. 2). Within a month of removal of the tumour patient regained her menstrual cycles with marked regression of hirsuitism. 5 months later patient reported with history of 3 months amenorrhoea and pregnancy was confirmed.

Accepted for publications on 7-6-85.

See Figs. on Art Paper VIII

PREGNANCY WITH STRUMA OVARII

(A Case Report)

by

S. N. TRIPATHY
M. D. RAUT
and
S. MISRA

SUMMARY

A rare case of Pregnancy with Struma Ovarii is reported. Though all of the ovarian tissue was replaced by thyroid elements, there was no clinical and laboratory evidence of thyroid dysfunction either in the mother or the baby.

Introduction

Struma Ovarii is a rare tumour and its association with pregnancy is still rarer.

A case Report

Mrs. S.G., aged 25 years, 2nd Gravida, was admitted for routine antenatal checkup at 18 weeks of pregnancy. She had no menstrual abnormality previously and had one normal delivery 2 years back. On abdominal examination, uterus was 18 weeks size, FHS was heard. There was another firm rounded swelling of about 3" x 3" size present in the left lumbar region with a distinct groove between it and the uterus. Pelvic examination confimed the mass to be separate from the uterus. A diagnosis of Pregnancy with ovarian tumour was made.

From: Postgraduate Department of Obstet. & Gynec., VSS Medical College, Burla, Sambalpur, Orissa.

Accepted for publication on 4-6-1985.

Her Hb was 10 gms %, TLC and DC within normal limits, VDRL—non-reactive, Fasting Blood sugar-80 mg%, Serum Cholesterol was 270 mg%. Left sided ovariotomy was done. The right ovary was healthy. Macroscopically, the tumour was a firm rounded 3" x 3½" mass and on cut section it was a greyish sebaceous like solid mass.. Histological examination showed the whole of the ovarian tissue was replaced by thyroid follicles of variable size lined by single layer of cells and filled with colloid. Histological features were consistent with a diagnosis of struma overii. The post-operative period was uneventful. Pregnancy continued uneventfully and she delivered normally at 40 weeks. The baby did not show any abnormality. Both mother and baby are doing well 4 months after delivery.

Acknowledgement

We are thankful to the Superintendent, V.S.S. Medical College Hospital, Burla for his kind permission to publish this case.

See Fig. on Art Paper X

MALE PSEUDOHERMAPHRODITE OR INCOMPLETE TESTICULAR FEMINISATION

(A Case Report)

by

P. B. PAI DNUNGAT

and

BARDE

Introduction

With the introduction of chromosome culture it is now easy to label the genetic sex of the individual.

A case of male pseudohermaphrodite or incomplete testicular feminisation who was being reared as female and had male gonads is reported.

In view of insensitivity of the tissues to testosterone it was decided to continue rearing her as female and bilateral gonadectomy was done which confirmed the gonadal sex as male in this individual.

Case Report

A 23 years old patient was admitted to Bombay Hospital for investigations of primary amenorrhoea. On history elicitation it was found that thirteen female members of her mother's family were also affected with more or less similar problem. The patient concerned had come for primary amenorrhoea and swelling in the left lower abdomen since 6 months.

The clitoris was enlarged, the labia minora were smaller than normal size and the left inguinal region revealed left sided indirect irreducible hernia. There was inguinal hernia with Gonad of 10-12 mm. in size in the sac on the left side. The right inguinal region revealed palpable gonad of 10 mm. size which could be pushed into right labia majora. There was also opening which looked like vagina anterior to which was external urinary meatus. The patient gave history of watery discharge from the lower opening on sexual arousal.

The breasts were well developed Grade V but there was no secretion from the breasts. There was hair growth on upper lip and chin and there were also side locks. Axillae and pubic region also showed profuse hair growth.

Her routine investigations were in normal limits. Her buccal smear was Barr body negative. Cell culture from leukocyte revealed that the patient had 46 XY karyotype in all metaphases proving that the patient was genetically male.

Hormonal assay were as follows:

Urinary assay of Oestrogen	—	11 g/24 hours
17 Ketosteroids	—	18 mg/24 hours
Plasma testosterone	—	7 ngr/ml

Laparotomy was done. Uterus tubes and ovaries were absent. Vas deferens, epididymis and Gonad were present on either side. Bilateral gonadectomy was done and left inguinal hernia was repaired.

Microscopic structure revealed seminiferous tubules with thick hyalinised basement membrane and arrested spermatogenesis. There was associated well marked leydig cell hyperplasia in both the testis.

From: Dept. of Obstetrics & Gynaecology, Bombay Hospital, Bombay-400 020.

Accepted for publication on 16-6-1985.

Acknowledgement

We thank Dr. A. V. Gondhalekar, Medical Director, Bombay Hospital for allowing the use of hospital records.

SPONTANEOUS GANGRENE OF THE TUBE AND OVARY

(A Case Report)

by

SHASHANK V. PARULEKAR
SHASHANK H. SHAH
and
N. M. NERURKAR

Introduction

A case of spontaneous gangrene of the ovary and the fallopian tube, probably following torsion is presented.

Case Report

Mrs. S.R., a 20 years old primigravida, married for 5 months presented with 2 months amenorrhoea and severe pain in the right iliac fossa for 10 hours. She had vomitted 8 times after the onset of pain.

Abdominal examination showed tenderness and guarding in the hypogastrium and the right iliac fossa, but no lumps or free fluid. Bimanual pelvic examination revealed that the uterus was of 8 weeks' size, soft and retroverted. The cervix was closed and the transverse cervical movements were tender to the left more than to the right. A 3 cm diameter, tender mass was felt in the right fornix, while the left fornix was clear. Colpopuncture was negative. Her haemoglobin was 11.5 gram%.

As her condition worsened a laparoscopy was performed, which showed the right ovary to be gangrenous along with the right fallopian tube. The uterus was of 8 weeks' gestational size. The left tube and ovary were normal. An exploratory laparotomy with right salpingo-oophorectomy was performed. At exploration, the right ovarian vessels were found to be thrombosed. There was not torsion of the right ovarian pedicle. Patient had an uneventful recovery posi-operatively.

The histopathological examination of the ovary showed haemorrhagic infarction, and so also the fallopian tube.

From: Department of Obstetrics and Gynaecology, Rajawadi Municipal Hospital & T.N. Medical College, Ghatkopar, Bombay-400 077.

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FOREIGN BODY IN THE URINARY BLADDER

(One year after induced criminal abortion)

(A Case Report)

by

SHASHI KHARE

Introduction

Cases of induced criminal abortion are still reported from villages of India frequently. Few cases are reported in the literature where foreign body was detected in the urinary bladder within few days. Patient reported for urinary symptoms in the hospital after one year after abortion induced by a dai and a foreign body herbal root was found in the urinary bladder.

Case Report

Smt. B.B. was admitted on 26-4-1985 for burning micturation, dysurea for last 15 days and haematuria for last 2 days. She had amennorrhoea for 2 months about one year back for which she had gone to a dai in her village for induction of abortion. Dai put some stick after which she had burning micturation which subsided without treatment within few days. After 3 days she had vaginal bleeding for 4-5 days, for 1 year her cycles were regular. On vaginal examination, a small cord like foreign body was felt in anterior fornix. Uterus was retroverted, normal size mobile, no mass, no induration. Urine examination was normal, culture sterile after 24 hours. Blood urea was 23 mg% X-ray shows stick like foreign body in the pelvis (Fig. 1). Utero-cervical length was normal and no foreign body detected. Bladder sounding was done, foreign body was felt in the urinary bladder.

Laparotomy was done foreign body (Herbal root) 6 cm x 2 cm (Fig. 2) was removed by suprapubic cystostomy, Bladder stiched in two layers.

From: Dept. of Obstetrics and Gynaecology, Medical College, Jabalpur (M.P.).

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See Figs. on Art Paper IX

FOREIGN BODY IN THE UTERUS

(A Case Report)

by

ANITA SINGH
ANMOLA SINHA
SNANTI SINGH
and
GEETA SINHA

Introduction

A case of foreign body, two broken pieces of a blue plastic ball pen is reported.

Case Report

Smt. R., 36 years old, para 5+0, was admitted for pain in abdomen and irregular vaginal bleeding for 3 months following 12 weeks abortion at home.

The uterus was retroverted, firm, 6 to 8 weeks pregnancy size with restricted mobility. Right adnexae were palpable and tender. There was slight bleeding.

After 72 hours of antibiotic coverage with oral Ampicillin (500 mg 8 hourly) and Metronidazole (400 mg 8 hourly) evacuation was done under intravenous calmpose and Epontol anaesthesia. Pieces of old placental tissue came out on curetting, which was confirmed later by histopathological examination. However, during this procedure, some foreign body was felt lying at the fundus extending from one cornua to another. An attempt was made to remove it which proved futile, as the instrument slipped over the foreign body.

Laparotomy was done. The uterus was bulky and the omentum as well as loops of intestines were adherent to the right tube, ovary and back of uterus. Left tube and ovary appeared normal. Adhesions were separated gently and as the clamps were being applied over the tubo-ovarian ligaments, bluish, round plastic foreign body started protruding through both uterine cornu. Total hysterectomy was done with foreign body in situ.

Cut-Section: On opening the uterine cavity it was astonishing to see two pieces of a blue plastic ball pen lying inside the cavity (See Figure).

The patient had an uneventful recovery and during convalescence, she admitted the introduction of a ball pen by local abortionist for procuring abortion.

From: Dept. of Obstetrics & Gynaecology, Patna Medical College Hospital, Patna.
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See Fig. on Art Paper IX

CRYPTOMENORRHOEA: A NEW CAUSE

by

SHASHANK V. PARULEKAR
SHASHANK H. SHAH
and
N. M. NERURKAR

Introduction

Cryptomenorrhoea is due to an outflow tract obstruction e.g. imperforate hymen, transverse vaginal septum, noncanalization of cervix or lower uterine cavity etc. A new cause is presented.

Case Report

Miss B.L., a 14 years old single girl presented on 10th May 1985 with pain in the hypogastrium for 6 months, which was cyclical in nature initially, occurring every month for 5-6 days. During the last 1 month, it occurred every 4-5 days for 5-6 days at a time, and was colicky in nature. She had primary amenorrhoea, though her secondary sex characteristics had started developing 1½ years ago.

On examination her general condition was fair and her vital parameters were within normal limits. The secondary sex characteristics were well developed. The external genitals were normal. The hymen was normal with a hole in the centre admitting the tip of a finger. Abdominal examination showed no abnormality. Rectal examination showed that the uterus was of the size of 8 weeks' gestation, the cervix was directed forwards and the fornices were clear.

A gentle speculum examination was done under general anaesthesia on 11th May 1985, which showed the cervix to be 2 cm dilated, well effaced, with a bluish membrane bulging through it, upto the external os. The membrane could be stripped easily from the uterine wall all around the uterine cavity for upto 3-4 cm from the external os, i.e. as far as the finger could easily go. Thick, dark altered blood was aspirated from the cavity beyond the membrane with an 18 gauge needle on a syringe. The membrane was pulled down with haemostats and excised. About 200 ml of thick, dark, altered blood was drained. A strip of endometrium lining the uterine wall beneath the membrane was removed with a curette for histopathological examination.

Histopathological examination of the membrane showed smooth muscle lined by endometrium like lining with very few endometrial glands on one side of the membrane only, covered by layers of red blood cells. The outer surface of the membrane had no epithelial lining. Histopathology of the endometrial strip showed endometrial glands in proliferative phase.

From: Department of Obstetrics & Gynaecology, Rajawadi Municipal Hospital & T.N. Medical College, Ghatkopar, Bombay-400 077.

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RUPTURE OF UTERO-VESICAL POUCH

(A Case Report)

by

GEETA SINHA
PUSHPA ROY
and
ANMOLA SINHA

SUMMARY

An interesting case of omental hernia through utero-vesical pouch following handling of fodder cutting machine (weighing 60 kg) in a multiparous woman is being reported.

Case Report

Smt. S.D., in her forties presented for protrusion of a mass through the introitus and dragging pain in the lower abdomen for 10 days She was in agony and a foul smell emanated from her.

A thick elongated mass with lower part gangrenous was presenting through the introitus. It was 4" x 2" approx. blakish, fleshy to feel and was filling the vagina. A full bimanual pelvic examination could not be performed.

Her menstrual history was normal. She had 6 full term normal deliveries.

A provisional diagnosis of degenerated fibroid polyp was made.

Laboratory examination revealed Haemoglobin 6 gm%, TLC 7000/cmm. ESR by Westergren method was 17 mm in 1st hour.

A small piece from the side of the protruding mass was taken for histopathological examination without anaesthesia. Report—Chronic inflammation of connective tissue—no further details possible because of extreme degree of degenerative changes. Antibiotic (Ampicillin 500 mg 6 hourly and Metronidazole 400 mg thrice daily continued and she was given repeated blood transfusion and haematinics.

Two weeks after her admission her Hb% was 10.8 mg%. She was examined under anaesthesia. Bimanual pelvic examination was made. Uterus was normal size. Adnexa was not palpable. Portio-vaginalis of the cervix was normal and smooth and the mass was found to be fixed anterior to the cervix. An attempt was made to separate the root of the mass from all sides by gentle dissection. To our horror surprise the mass suddenly disappeared as soon as it was released from the sides. A hole admitting two fingers with rolled marging was seen, in the anterior fornix through which peritoneal cavity could be reached. An emergency laparotomy was done. There was no free fiuid in the peritoneal cavity. On exploration omentum was found to be gangrenous in the lower part and there was a hole in the utero-vesical pouch with rounded rolled margins. Pelvic organs were and healthy. The diagnosis of perforation of the utero-vesical pouch was evident. Omentectomy about 1" above the degenerated portion was done. Tubal ligation by Pomeroy's technique was also done.

She told that while moving a fodder cutting machine (weighing about 60 Kg) when she moved forward while moving the handle, she felt a sudden agonising pain in the lower abdomen; she felt that something gave way and fainted with pain and fear. She had no medical care at this stage, recovered after sometime and found that there was some bleeding and a mass hanging out per vaginum. The patient had an afebrile post-operative recovery and she did not develop serious complications. Abdominal wound infection occurred followed by wound dehiscence for which secondary sutures were put. She did not turn up for follow-up examination.

From: Dept. of Obstet. & Gynec., P.M.C.H., Patna.

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MULLERIAN MIXED TUMOUR OF UTERINE CORPUS

(A Case Report)

by

KANWAL GUJRAL
NEERJA GOEL
and
B. G. KOTWANI

Introduction

Mullerian Mixed Tumour (MMT) has always been an interesting challenge to the pathologist and clinician because of its rare occurrence (Fenton *et al* 1952, Badib *et al* 1969), intermingling histological behaviour, highly malignant and varied biological manifestation.

Case Report

Mrs. R.R., aged 50 years, Para 1 was admitted for postmenopausal bleeding of 2 months duration. She experienced heaviness and pain in lower abdomen for past 1 month.

She had one FTND, 30 years back.

Per/Abdomen: A mid line, firm to soft, non tender mass arising from pelvis about the size of 16 weeks gravid uterus was felt.

On Vaginal examination cervix was healthy. Bleeding through os was present. Cervix was flushed with vault. The swelling felt per abdomen appeared to be enlarged uterus of 16 weeks size. A lobulated mass was felt (4″ x 4″) through posterior fornix. Ultrasound confirmed the mass to be uterine.

Patient was subjected to total abdominal hysterectomy with bilateral salpingo-oophorectomy. There were bilateral hematosalpinx of 4″ x 1½″ size each adherent to posterior surface of uterus and gut. Ovaries were normal. Post-operative period was uneventful.

Gross pathology: Uterus enlarged (14 x 8 x 5 cms), serosal surface normal. Uterine cavity was filled with plenty of polypoidal masses showing focal areas of degeneration and necrosis. Gross invasion of myometrium was less than ½ of the thickness.

The section showed marked cellular picture composed of round spindle and oval cells, the nuclei of which were hyperchromatic and showed various degree of mitotic activity. Intercellular connective tissue was scanty. Blood vessels were thin walled. Few giant cells were seen having several nuclei with granular eosinophillic cytoplasm, changes characteristic of sarcoma (Fig. 1).

The glandular or carcinomatous element was represented by undifferentiated and few well differentiated glands with hyperchromatic nuclei (Fig. 2). Adjacent to this the heterologous element here was cartilage (Fig. 1). Myometrial invasion was less than half of the thickness.

From: Department of Obstetrics & Gynaecology, Sir Ganga Ram Hospital, New Delhi.

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See Figs. on Art Paper X

UNUSUAL PRESENTATION OF CERVICAL FIBROID

(A Case Report)

by

ALKA KRIPLANI

and

SNEHLATA MISHRA

Introduction

A huge cervical fibroid suddenly coming out through the vagina producing clinical picture of inversion uterus is described. In our knowledge, such sudden spontaneous expulsion of a large fibroid has not been reported before.

Case Report

Mrs. N., aged 32 years, was admitted for passing blood stained dirty white vaginal discharge for 6 months and excessive periods (6-7/28 days) for 2 months. There was no urinary or bowel symptom. Her past cycles were regular (3-4/28 days).

She was thin built, severely anaemic. On abdominal examination, a firm mass corresponding to 14 weeks pregnant uterus was felt suprapubically.

On speculum examination an infected mass, 3 x 2½ inches, filling the upper part of the vagina was seen the same mass was felt with rim of cervix stretched on its right side. Uterus was firm, mobile, nodular and enlarged to 14 weeks pregnant size.

On 22-5-1985 when she went to toilet to pass urine, she noticed a big mass suddenly coming out of the vagina. She complained of pain in the lower abdomen. Per abdomen uterus was not palpable any more. Lying outside the introitus was a big irregular mass. A provisional diagnosis of acute inversion of uterus with fibroid was made. However, examination under anaesthesia revealed that the fibroid was arising from a wide area on the left side of the cervix. Cervix was dragged upto the level of the introitus. Cervical canal admitted one finger easily. Uterocervical length was 3½". As there was no pedicle, incision was made on the cervix near origin of the fibroid and it was shelled out by cutting at places under direct vision. Bleeding was controlled by catgut sutures.

From: Department of Obstetrics & Gynaecology, Lady Hardinge Medical College & Smt. S.K. Hospital, New Delhi.

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See Fig. on Art Paper X