TERM PREGNANCY FOLLOWING BILATERAL TUBAL GESTATION

(A Case Report)

By

MADHURI NITWE, M. J. JASSAWLLA, A. E. DASTUR, M. D. HANSOTIA AND M. N. PARIKH

Introduction

Because of rarity this case of pregnancy following bilateral tubal gestation in whom salpingectomy was done is reported.

CASE REPORT

Mrs. N.P., age 25 years, was admitted in 1½ months amenorrhoea with vaginal bleeding since 1 day and pain in the lower abdomen since 2 days.

Patient was conscious, pulse was 132 per minute. Blood pressure was 110/70 mm Hg. There was marked pallor. Abdomen was soft with no guarding and rigidity. On vaginal examination the uterus was anteverted, anteflexed bulky, smooth and freely mobile. Cervical movements were non-tender, os was open with vaginal bleeding. There was minimal bogginess in the posterior fornix. On laparoscopy the peritoneal cavity was found to be filled with blood.

Patient was explored under general anaesthesia. The uterus was of normal size, the right tube showed an unruptured ectopic pregnancy at the junction of middle and lateral one-third of the tube; the left tube was dilated and enlarged upto the fimbrial end, with bleeding from the tubal ostia. Right salpingectomy was done and the contents of the left tube were milked out through the fimbrial end till the bleeding was appreciably reduced. The right tube containing the gestation sac and products from the left tube were sent for histopathological examination which confirmed the diagnosis of bilateral ectopic gestation.

Eight months later the patient came with two months amenorrhoea. Intrauterine pregnancy was confirmed by clinical examination and ultrasonography. Patient followed up with us regularly till term and delivered normally vaginally a male child weighing 3.7 kg. Postpartum period was uneventful.

From: Nowrosjee Wadia Maternity Hospital, Parel, Bombay 400 012.

Accepted for publication on 3-6-86.

UNUSUAL ANGULAR PREGNANCY WITH SACCULATION AND GROWTH OF THE WALL OF UTERUS TO TERM SIZE

(A Case Report)

By

R. N. BHOWMIK AND RUDRA K. ISWARARY

Introduction

A case where angular pregnancy has gone beyond term with sacculation and growth of that portion of anterolateral wall of uterus near the cornu with a muscular big sac where the fetus went upto 48 weeks with intrauterine fetal death.

CASE REPORT

Mrs. A.C. a 36 year Para 4 + 0 admitted with amenorrhoea for 48 weeks and loss of fetal movement for 2 months.

General condition was low with moderate anaemia. Haemoglobin was 8 gm%. Uterus was 30 weeks size with high floating head. On vaginal examination, cervix was tubular with closed external os and slight blood stained discharge. Ethacrydine lactate 1%, 150 ml. was introduced extraamniotically. As there was no initiation of pain, 60 units of syntocinon was started without any response. Oblique X-ray of abdomen showed fetus lying in front of mothers vertebral column with positive spalding sign and hyperflexion. Blood fimbrinogen was found to be 300 mg%. Laparotomy was decided.

Laparotomy was performed with two bottles of blood. It was found to be a huge muscular sac, least vascular and adherent with parietal

Accepted for publication on 5-8-86.

peritoneum and omentum. Macerated term size fetus was found after incising over the anterior wall of the sac. Placenta was morbidly adherent with the posterior wall of the sac. Sac seemed to be a sacculated portion of a anterolateral wall of uterus on the right side. Rest of the uterus was normal in shape and size. Left tube was normal, ligament normal in relation to uterus while on the right side round ligament and tube were high-up connected with the sac. There was a small communication between the sac and the uterine cavity which admitted tip of the finger. Caesarian hysterectomy was performed. with preservation of left sided tube and ovary. Post operative period was uneventful.

SYSTEMIC LUPUS ERYTHEMATOSUS (SLE) WITH PREGNANCY

(A Case Report)

By

SUDHA N. TANDON, N. H. TANDON, SUREKHA JOSHI AND PRATIBHA R. VAIDYA

Introduction

Systemic Lupus Erythematosus (SLE), an autoimmune disease of unrelated cause, is one of the uncommon medical diseases during pregnancy. We present here a case report of SLE with pregnancy.

CASE REPORT

G.S., a 22 years old patient having 26 weeks of amenorrhoea with SLE for antenatal check up at LTMG Hospital, Sion, Bombay.

She had no complaints. She was G2P1, her first child had died of some paediatric cause. Her past history was: In July 1984, she had presented with generalized anasarca, anaemia and amenorrhoea for eight months. The positive findings on general examination were generalized anasarca, anaemia, BP 160/110 mm of Hg., weight 40 Kgs., mild hepatosplenomegaly with ascitis and a normal sized uterus on vaginal examination. The positive investigations were as follows: Hb 7.1 gm% severe hypochromia, microcytosis, poikilocytosis with target cells on peripheral smear, 4 + proteinuria and many hyaline, granular and pus cell casts. BUN was 34 mg%, S. Cholesterol 408 mg%, S. Proteins 5.2 gm%, S. Albumin 1 gm%, S. Globulin 4.2 gm%. Antinuclear Antibody test by Immunofluoroscent technique was positive. Rest of the investigations were within normal limits. Renal biopsy was refused by the patient.

On the above grounds, she was diagnosed as Lupus Nephritis with Nephrotic syndrome. She was then put on Prednisolone 60 mgs/day for 2 weeks followed by 80 mgs. on alternate day for further 4 weeks. She was given one bottle of packed cells, Tab Methyl Dopa 250 mgs four times a day, Dytide one tablet daily and Haematenics.

She went in to remission within 4 weeks and at the end of six weeks of therapy she started menstruating. After 2 months she again became amenorrhoeic and her urinary pregnancy test was positive.

On 25-3-1985 at 26 weeks of gestation she was referred for an antenatal check up. Only positive finding on examination was a minimal puffiness of face and her uterus was 24 weeks with a vertex presentation, FHS of 152/min. She was well maintained on 80 mgs. of prednisolone on alternate day, Tab Methyl Dopa 250 mgs. four times a day, Dytide ½ tablet daily, along with other haematinics. The steroid dosage could not be reduced as she would go into a relapse of her symptoms. She came for another check-up 4 weeks later i.e. at 30 weeks. She was lost for follow-up for about 6 weeks, though she continued her treatment.

She went into preterm labour on 5-6-85 (at 36 weeks) and delivered at home a male child of weight 1750 gms who cried immediately after birth. She had no 3rd stage complications. She was then admitted along with her baby to this hospital 6 hours after her delivery. The baby

From: Department of Obstetrics and Gynaecology, L.T.M.M. College and L.T.M.G. Hospital, Sion, Bombay-400 022.

Accepted for publication on 21-7-86.

was small for date, of maturity 36-37 weeks, but was absolutely normal and healthy and had no congenital anomoly. Both mother and child had an uneventful stay of 7 days in the hospital. The mother breast fed her child.

She continued to follow-up with the Physician. Ten months after her delivery, both mother and child are doing extremely well. She is in a state of remission for last 6 months and is off steroid and antihypertensives for last 6 months.

OVERLAP SYNDROME/PRECOCIOUS PUBERTY WITH HYPOTHYROIDISM

By

HITESH I. PARIKH, PRITI H. PARIKH, SHOBHA BARVE AND ASHOK MATHURE

CASE REPORT

Miss H.S. a 9 year old girl attended the Gynec. OPD at the BYL Nair Hospital on 1-2-86 with the complaints of:

(1) Obesity and gradual increase in weight since 6 months. (2) Menarche since 2 months. (3) Distention of abdomen since 1 month.

She had the first period on 20th December 1985 and the second on 22nd January 1986. Both periods lasted for 5 days. No history suggestive of galactorrhoea and virilization. Since last one month there was distention of abdomen with a lump in the hypogastric region. History of lethargy and increased sleeping habits. No history suggestive of mental retardation, and intracranial tumour. No history of ingestion of estrogen containing drugs.

On examination Patient is short statured; Height of 115 cms with an expected height of 130 cms. at 9 years; stout built (weight—29 Kg) with puffiness of face. Skin is dry and coarse with no abnormal pigmentation. Chest examination revealed palpable breast nodule with arcola and nipple on same plane (Grade—2 Tanner). Absence of pubic and axillary hair. External genitalia are prepubertal. Abdominal examination revealed a firm nontender, mobile hypogastric mass of 8 x 8 cms size. On P.R. examination the lower margin of mass could just be felt. Other system examination were within normal limits.

Investigations done at Jaslok Hospital:

Hb 11.5 gm. Blood sugar F-84 and PP-406 mg% X-ray chest—N.

Fundus examination—N, X-ray skull—N.

X-ray wrist—Bone age of 9—11 years.

Ultrasound of abdomen. Bilateral Cystic massee in the lower abdomen of 7.5 x 6.5 cm. size. Uterus was smaller than normal.

CT scan of the abdomen confirmed that the masses were ovarian cysts. Kidneys and adrenals were normal.

Initial hormonal studies of FSH and LH showed the levels to be in the menopausal range. Hormonal profile done is shown in the following chart.

In view of the large ovarian cysts an exploratory laprotomy was done on 10-2-86. Bilateral ovarian cysts which were freely mobile were seen. They were thin walled and filled with a yellow fluid. Uterus was normal. Bilateral ovarian cystectomy with appedisectomy was done. Kidneys, adrenals and liver were normal on palpation. Recovery was uneventful. Histopath report of specimen was Follicullar cyst of ovaries with poor cellular cortical stroma lined by granulosa cells. As the exact etiology of precocious puberty could not be pinpointed, a CT scan of the head and further hormonal profiles were done. CT scan of head showed a pituitary macroadenoma with an enlarged sella turcica. Prolactin was on the higher side of normal but estradiol BHCG, DHEA and androstenodion were normal. Thyroid profile showed low T4 levels, normal T3 levels and high TSH levels. This established the diagnosis of primary hypothyroidism. The final diagnosis was thus, "Syndrome of precocious puberty with hypothyroidism".

The patient was put on Eltroxin 4 ug/Kg. once a day. She was followed up clinically once a month and hormonal levels were repeated at 6 months. Her menstruation had stopped one month after starting eltroxin. Repeat CT scan of the head shows that the pituitary adenoma has regressed to about one third the original size. As seen from the chart FSH, LH and

Accepted for publication on 9-12-86.

CHART OF HORMONAL STUDIES

Hormone	Normal Range	DATES Before Exploration 1-2-86	After Exploration 14-2-86	After Eltroxin 22-2-86	After 6 months
FSH	2-8 mu/ml	150	36.3	37.6	10
LH	2-10 mu/ml	241	50.0	40.0	7
Prolactin	20 mg/ml		20.5		
Cortisol	3-12 ug/dl	9.2			
Urine 17 Ketosteroids	2 mgm/12 hrs.	5.2			
B-HCG			50.0		
TSH	2-10 uU/ml		50.0		
T3	90-240 ng/dl		102.0	50.0	12
T4	6.4-13.3 ug/dl		1.44	110.0	102
Free T4	0.8-2.4 ng/dl			1.44	8
Estradiol	0-2 pg/ml		20.0	0.19	
DHEA				0.1	
Androstenodion				0.33	

Thyroid studies are within normal limits. This shows that the replacement dose of Eltroxin is adequate and this will have to be continued life long.

Discussion

Overlap Syndrome—Precocious puberty with hypothyroidism is a rare syndrome and only 48 cases have been reported. Generally in children with untreated, hypothyroidism, onset of puberty is delayed until epiphyseal maturation has reached 13 years. Thus, in a child with untreated hypothyroidism, precocious puberty and a prepubertal bone age present therefore a striking appearance and unexpected association. Increased incidence is seen in girls probably reflecting the higher incidence of hypothyroidism in females. All of the affected patients have severe hypothyroidism of long duration with manifestation including retardation of growth and of osseous maturation. Sexual maturation usually includes breast development with sparse pubic and axillary hair. Menstrual bleeding is a common feature. Other features are galalotorrea, skin pigmentation, papilledema and enlargement of sella turcica. The latter is because of pituitary hypertrophy (basophilic cells) due to chronic stimulation by TRH. Due to reasons unknown, the high levels of TRH, cause elevated levels of FSH, LH and prolactin. These in turn cause true precocious puberty. Whatever the derangement, the pituitary hypothalamic regulating mechanism rapidly returns to normal upon treatment with thyroid hormone.

UNDUE LENGTH OF UMBILICAL CORD

(A Case Report)

By

SABUJ SENGUPTA

Introduction

A case is presented where the baby was delivered with the umbilical cord which measured 190 c.m. from the umbilicus to its insertion in placenta.

CASE REPORT

Mr. S.D. 3rd gravida, aged 28 years was admitted with labour pain.

Uterus was overdistended, head not engaged F.H.S-140/min, Regular.

Cervix—effaced, about 2 c.m. dilated. Membranes intact. Head above ischial spines Pelvis adequate.

Spontaneous vaginal delivery of a healthy living female baby at 8.50 a.m. 25-2-75. Birth weight 3 Kg. 250 Gm. No perineal tear. There were four loops of cord round the neck of the baby. The length of the umbilical cord measured 190 c.m. from umbilicus of the baby to its placental insertion. Placenta — looked normal weighing 500 gm.

Inspite of four loops of cord round the neck, there was no foetal asphyxia.

Mother and baby discharged from the hospital in good condition on 27-2-75.

From: Bokaro Steel Plant, Kiriburu Mines Hospital.

Accepted for publication on 7-3-86.

See Fig. on Art Paper V

AN UNUSUAL CASE OF NON-PUERPERAL GALACTORRHOEA FOLLOWING BURN INJURY OF THE CHEST WALL

By

N. N. RAI, GEETA SINHA AND A. SINHA

Introduction

An unusual and interesting case of non-puerperal galactorrhoea is being reported. A review of all available recent literature does not reveal any case of galactorrhoea following burn injury of the chest wall.

CASE REPORT

Smt. K.D., 38 years consulted on 14-4-85 for continuous discharge of milk and itching of the scarred chest wall following extensive burn injury 6 months back (Fig. 1).

Her previous menstrual history was normal and she had infrequent menstruation (4-6 days/ 2-3 months) following last childbirth about 2 years ago. She had 6 children. All spontaneous home delivery.

On the anterior surface of the trunk from infra-clavicular region to umbilicus there was severe degree of burn contracture Apparently there was very little glandular element of the breasts, but nipples could be identified (Figure 2). The milk drops were seen oozing from the nipple almost continuously.

Pelvic examination revealed a normal sized mobile retroverted uterus. Adenexae were not palpable and cervix and vagina were healthy with normal discharge.

She was assured and given a course of Bromocriptine (Proctinal—dosage 2.5 mg. daily to

---

From: Deptt. of Obstetrics and Gynaecology, Patna Medical College, Patna.

Accepted for publication on 5-8-86.

start with and gradually increased to 3 tablets daily). She had Mixogen tablet and injections before in the local hospital without any relief.

On follow-up visit after 2 months she reported complete alleviation of her symptom. Her serum prolactin was within the normal range.

See Figs. on Art Paper III

CERVICAL PERFORATION AND DISPLACED CU T

(Reports of 2 Cases)

By

ANITA KOCHAR AND ANITA KANT

Introduction

Two cases of Cu T displacement and cervical perforation are being presented.

CASE REPORT

Case 1:

Mrs. S.S., 28 years old, attended the OPD on 24-6-85 for dysmenorrhoea. Cu T was inserted 2 months back. A speculum examination revealed that Cu T threads were seen and bleeding was through the cervical os and from behind the cervix also. Cervix was held with volsellum and pulled gently. One limb of Cu T was seen protruding through a small perforation in the posterior wall of cervix through which blood clots and even products were coming out. Cu T was pulled out easily from the external os. Uterus was found to be 6 weeks in size anteverted and soft. Suction evacuation was done and perforation in the posterior wall of cervix closed with catgut.

Case 2:

Mrs. P.K., 27 years old attended for vaginal bleeding following an attempt made by a doctor to remove a displaced Cu T—an hour back. On examination Cu T threads were not seen. Cu T was not felt on uterine sounding also. X-ray abdomen without and with a uterine sound in position revealed a shift in position of the Cu T (Figures 1 and 2 respectively) which appeared to be lying in pelvis anterior to the sound. Under anaesthesia an irregularity was felt in the anterior wall of cervix just below the internal os. On detailed examination this was found to be a horizontal tear about 2 cms. wide opening into the uterovesical pouch. On laparotomy Cu T was found imbedded in the omentum. There was an old haematoma at the site of cervical tear. Uterovesical pouch was opened and the tear repaired, the edges of the tear were friable. Peritonization was done. Post-operative period was uneventful and patient discharged on 10th day.

See Figs. on Art Paper IV

From: Department of Obstetrics and Gynaecology, Escorts Ltd. Medical Centre, Faridabad.

Accepted for publication on 21-5-86.

VAGINAL ANUS

(A Case Report)

By

M. L. SHOLAPURKAR, A. S. GANDHI AND Y. S. KULKARNI

Introduction

A case of vaginal anus without any abnormality of genital/urinary tract is presented below.

CASE REPORT

Patient, 19 years old, unmarried, primi, was admitted as emergency case with labour pains in the Obstetric Department of General Hospital, Solapur, on 29-1-86.

On abdominal examination patient was full

From: Department of Obstet. and Gynaec., Dr. V. M. Medical College, Solapur.

Accepted for publication on 2-6-86.

term pregnant with vertex presentation L.O.A.

Local examination showed normal development of labia majora/Minora, but it was noticed that anus was absent at the normal site, and rectum opened in the vaginal canal. Sphincter around the opening was normal with good control.

Patient was given epidural analgesia for painless labour. Later baby was delivered by outlet forceps by **lateral episiotomy** as second stage was prolonged and there was foetal distress. Male baby weight 2.6 Kgs. apgar score 9 was born. Patient was discharged on 6th day when episiotomy wound was healed well. She is advised transplantation of anus at proper site later.

See Figs. on Art Paper III

INTRA PELVIC NEURILEMOMA

By

P. L. Sai and D. Devi

Introduction

Since Morgagni first described retroperitoneal pelvic tumour various benign and malignant pelvic tumours have been described (Kaulkarni *et al* 1981). Most of these tumours are malignant and among the benign tumours neurofibromatosis has been reported by Radhakrishnan *et al* (1978) and a giant neurofibroma by Kulkarni *et al* (1981) and Devi and Sai (1985). No case of neurilemoma has been reported in the available literature.

CASE REPORT

Mrs. B.P.D. was admitted to the first surgical ward of S.C.B. Medical College and Hospital on 14-8-82 with a lump in the abdomen.

On interrogation the patient revealed that she was having an abdominal lump since one month which was increasing in size. Apart from this there was no other complaint. Her menstrual history was normal. She had attained menopause seven years back. She had two children, the last being born 17 years back.

On general examination, she was found to be of average built. Her pulse rate was 82/min, blood pressure 130/90 mmHg. She had no other abnormality. Per abdominal examination revealed a lump in the hypogastrium extending to the umbilical region, which was of the size of 30 weeks pregnant uterus. The swelling was cystic and its movement was restricted in all axis. There was a knobby mass in the hypogastrium in front of the cyst to the left of the midline which was 3″ x 2″ (8 cm x 5 cm) in size and hard in consistancy. Around the cyst, the flanks were found to be tympanic. The liver and spleen were not palpable and there was no evidence of free fluid in the abdomen.

Pelvic examination done on 16-8-82 revealed the lump to be of 26 weeks size. Uterus was anteverted, normal size and pushed to the left. The posterior fornix and right lateral fornix was full with the cystic lump felt separate from the body of uterus.

At laparotomy, the cystic swelling was located in the pelvis below the pelvic peritoneum adherant to the posterior wall of the uterus. The uterus and ovaries were found to be normal. The cyst was enucleated and sent for histopathological study (A schematic diagram of the cyst is seen Figure 1).

The histopathological study (Fig. 2) was found to be consistent with a neurilemoma which had undergone cystic degeneration.

See Figs. on Art Paper IV

From: S.C.B. Medical College, Cuttack and M.K.C.G. Medical College, Berhampur.
Accepted for publication on 21-5-86.

UNILATERAL OVARIAN AND PARTIAL TUBAL AGENESIS

(A Case Report)

By

BIMAN KR. CHAKRABARTY AND
GOUTAM HALDAR

Introduction

Incidental discovery of absence of one sided ovary and the lateral part of fallopian tube during laparatomy is a rarity. Only 5 such cases have been reported in English literature, of which one is from India. One such rare case is reported here.

CASE REPORT

Mrs. S. D., aged 21 years, married for one and half year, para 0 + 0 C/o excessive bleeding, P/V during period—1.½ years. Swelling lower abdomen—two and half months. Pain lower abdomen—one and half years. History of present illness.

The patient complained of excessive bleeding with pain during periods. She noticed a swelling in the lower abdomen for the last two and half months.

Fulness in suprapubic region. No definite mass palpable.

Uterus was normal in size. A mass 3" x 2" was attached to the left lateral wall of uterus. It could not be separated from the uterus.

At laparotomy uterus was normal in size. There was a cyst in the left ovary 4" x 4", which was occupying the pouch of douglas. Right ovary, the fimbrial and ampullary end of right tube were absent. Left tube was normal. Both the ureters and kidneys were normally placed.

Patient made an uneventful recovery and has been regularly menstruating.

From: Eden Hospital, Medical College, Calcutta,
Accepted for publication on 21-5-86.

PRIMARY CARCINOMA OF FALLOPIAN TUBE

By

TARA GUPTA, RAKSHA ARORA AND
ASHA GOEL

Introduction

Primary carcinoma of the fallopian tube is a gynaecological rarity. The first case of Primary Carcinoma of the fallopian tube was reported by Orthmann in 1888. Since then there have been several reports of this uncommon malignancy of the female genital tract. The signs and symptoms are usually inconsistent and non-specific.

The incidence has been diversely estimated as 0.16 to 1.6% of all cancers of female genital tract and gonads.

Rare case of Primary Carcinoma of fallopian tube is reported in post-menopausal nulliparous woman.

CASE REPORT

Mrs. S., 50 years old, was admitted in Kamla Nehru Hospital, Simla on 14-2-1981 for swelling and pain in lower abdomen for the last 3 months.

Abdominal examination, revealed a firm nodular mass reaching upto the level of umbilicus arising from pelvis, non tender with restricted mobility. There was no evidence of free fluid in the peritoneal cavity.

On vaginal examination, uterus could not be made out separately and seemed to be incorporated with multiple, non tender masses continuous with those felt per abdomen. A provisional diagnosis of multiple uterine Leiomyomas or bilateral malignant ovarian tumours was made.

*From: Kamla Nehru Hospital, I.G. Medical College, Simla-*171 002.
Accepted for publication on 22-5-86.

Laparotomy Findings:

An exploratory laparotomy was done on 11-3-1981, there was no free fluid in the peritoneal cavity. A big tortuous left sided tubal swelling containing haemorrhagic fluid and adherent to anterior surface of uterus was seen. The right tube was small, swollen with a closed bulbous fimbrial end, while separating the left tube burst and yellowish, haemorrhagic, dirty fluid containing fleshy pulpy material came out of it which made the suspicion of cancer of fallopian tube. Total hysterectomy with bilateral salpingooophorectomy was done. Post-operative period was uneventful and was discharged on 14th post-operative day and sent for post-operative radiotherapy because of spillage, though it was stage 1.

Histopathology:

Fallopian tube shows that the lining epithelium is replaced by treelike papillary processes crowding towards the centre of lumen. Papillae are lined by several layers of epithelium showing heavily stained nuclei with frequent mitosis. Muscular wall was thinned out and showed occasional islands of malignant cells. Micro section from uterus, cervix both the ovaries and right fallopian tube showed normal histology.

See Fig. on Art Paper V

A CASE REPORT OF ARRHENOBLASTOMA OF OVARY IN A YOUNG ADULT

By

K. SAROJINI DEVI, UMA AND SHAILAJA

Introduction

A case of Arrhenoblastoma is reported from Gandhi Hospital attached to Gandhi Medical College, Hyderabad, Andhra Pradesh, India.

From: Gandhi Medical College, Hyderabad (A.P.).

Accepted for publication on 7-3-86.

CASE REPORT

W.B., a 21 years old nulliparous woman was admitted for distension of abdomen since 8 months, general weakness and frequent episodes of bleeding per vaginum since 3 months.

History of present illness:

The distension was increasing and was associated with weakness.

No family H/o any Gynaec. Pathology. She was a nulliparous woman married for 2 years. There was no H/o any miscarriages either. She attained Menarche at the age of 14 years. Her last normal period was in November 1984.

Dark hair was present on the chin and upper lip. Axillary Hair Normal. Voice feminine. Breasts were well developed. There was no hair on the chest. Supraclavicular lymph nodes were not palpable.

There was uniform distension of the abdomen below the umbilicus. A mass was felt in the Midline and right lower quadrant, movable from side to side. It was not tender and the surface was smooth.

Bimanual Examination of the Pelvic Organs:

Clitoris was enlarged. Vulva was adult type. Pubic hair had feminine distribution. Introitus admitted 2 fingers. Vaginal Canal was average length. Uterus was retroverted and normal in size.

Investigations:

Plain X-ray of abdomen: Soft tissue shadow consistent with swelling arising from pelvis. X-Ray skull—Sella Turcica normal. Buccal Smear—Positive for sex chromatin. Urinary—17—Ketosteroids 6.5 mg/24 hrs. Vaginal Smear—Atrophic pattern.

A provisional diagnosis of functioning Ovarian tumor most probably masculanising type was made because of the virilising sign.

Treatment Given:

On opening the peritoneal cavity a right sided ovarian tumor partly cystic and partly solid and pedunculated was seen. Left adnexae normal. Uterus was slightly bigger than normal size. The tumour was removed by right ovariotomy by clamping and cutting the pedicle. Raw area was peritonised.

Large cystic mass pale yellow, multilocular.

Cut section showed multilocular cyst filled with amber coloured fluid greyish homogenous solid area at one place.

Microscopy:

Suggestive of Arrhenoblastoma. Primarily sertoli cells were seen which were well differentiated. Patient came for post-op. check up after 2 months. Again she reported on 3-7-1985 i.e. 4 months after surgery H/o Amenorrhoea and pregnancy was confirmed.

See Fig. on Art Paper VI