SPONTANEOUS VARIABLE DECELERATION IN PREGNANCY INDUCED HYPERTENSION

by

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Introduction

Variable decelerations occur with uterine contractions causing cord compression. A case is reported of variable decelerations in presence of a relaxed uterus in a patient with pregnancy induced hypertension.

CASE REPORT

Mrs. F.W., a 25 years old 2nd gravida nullipara presented with 8½ months of amenorrhoea and oedema feet for 10 days.

On examination her general condition was fair and her vital parameters were within normal limits except that the blood pressure was 150/90 mm. Hg. There was oedema feet upto ankles but no albuminuria. There was a single fetus in vertex presentation. The amount of liquor amnii was adequate. Her hemogram, renal function tests, and fundus were within normal limits. A nonstress test was performed on 13th June 1986 at 9 A.M. on a Corometrics 115 Fetal Monitor. The baseline fetal heart rate was between 120 and 130 bpm, with a short term variability of 2 to 3 bpm and a long term variability of less than 5 bpm most of the time. The baseline uterine pressure tracing was below the O.mm Hg level on the abdominal tocodynamometer and did not rise above this level at any time during the test. Over a period of 10 minutes, the patient showed 3 severe deceleration patterns resembling variable deceleration pattern. The first two decelerations were preceded by fetal heart rate accelerations. The rate dropped to 80 beats per minute during the first deceleration. The position was with 15° lateral tilt. It was then changed to dead lateral with head low. Despite the position change two more decelerations occurred, the rate dropping to 64 beats per minute during the second deceleration and 56 beats per minute during the third. The test was stopped. An emergency lower segment ceasarean section was performed under controlled general anesthesia at 9.55 A.M. A male child weighing 2550 g was delivered. The Apgar score at 1 minute was 2. The child cried 3 minutes after delivery after resuscitation. The 5 minute Apgar score was 7. The child was shifted to the intensive care nursery. At the time of the caesarean section no abnormality was found in the cord, such as cord presentation, true knots in the cord. The placenta was normal and there was no retroplacental clot. There was no abnormality in the cardiovascular system of the newborn. Both the mother and the child made an uneventful recovery and were discharged from the hospital on the 7th post-operative day.

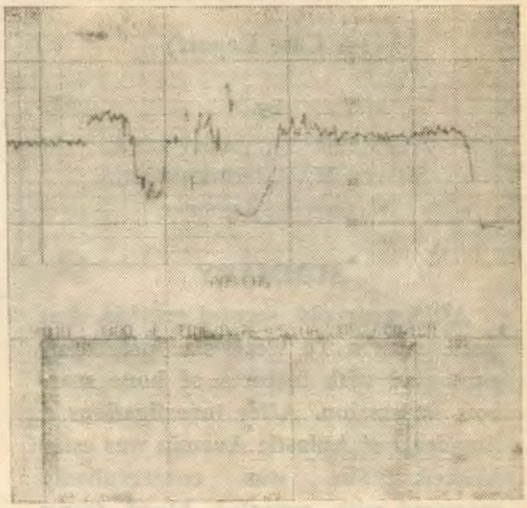

Fig. 1

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APLASTIC ANEMIA IN PREGNANCY

(A Case Report)

By

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SUMMARY

A 28 year old, second gravida, first para, with a 14 week size pregnancy presented with features of bone marrow depression. After investigations a diagnosis of Aplastic Anemia was established. She was conservatively managed with repeated blood transfusions. At 28 weeks of pregnancy she went into spontaneous preterm labour and delivered a fresh stillborn. Following this her haematological condition improved significantly. The rare association of aplastic anemia and pregnancy is discussed.

Introduction

Aplastic anemia in pregnancy is a very uncommon disorder which can have grave consequences to the pregnant woman.

Ehrlich (1888) was the first to report such a case, since then only 30 authentic cases have been reported.

CASE REPORT

Mrs. P.R. a 28 year old, second gravida, first para, was admitted on 10-7-85 at the Bhatia General Hospital with 3½ months amenorrhoea and severe weakness, low grade fever and anorexia. On general examination, she was found to have tachycardia and marked pallor. An ejection systolic murmur was heard at the base of the heart. There was no icterus, hepatosplenomegaly, or lymphadenopathy. On vaginal examination the uterus was found to be 14 weeks size and internal ballotment was present. Her haemoglobin was 2.5 gm% total white count was 2650/mm and platelet count was 70,000/mm as shown in figure 1. Her blood group was AB

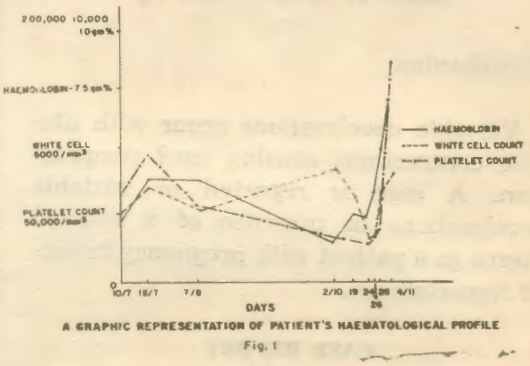

Fig. 1

negative. Routine urine examination was normal. Both direct and indirect Coomb's Test were negative. The Serum Iron Level was 228 Ug/100 ml and Serum Iron Binding capacity was 372 Ug/100 ml. Bone marrow examination showed a hypocellular picture with an increase in the number of fat cells and a decrease in the number of haemopoetic cells. Both leucopoiesis and erythropoiesis were equally reduced. The myeloid-erythroid ratio was 3.2:1 (Normal 2:1). Megakaryocytes were reduced and very few platelet cells were seen. Three packed cell transfusions were given over 8 days and haematinic supplements were prescribed. The patient's general condition improved, her haemoglobin rose to 4.1 gm.%, total white cell count became 3750/mm^3 and platelet count increased to 1,10,000/mm^3. She left the hospital against medical advice on 18-7-85.

The patient was readmitted at the same hospital on 2-10-85 with severe weakness and breathlessness. The uterine size corresponded to 26 weeks of gestation. Her haemoglobin was 1.5 gm.% and total white cell count was 40,000/mm^3. Three units of fresh blood was transfused over three days with diuretics. The patient was then transferred to KEM Hospital on 8-10-85, where she was given Prednisolone orally, in a single daily dose of 60 mg. for 9 days.

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On 24-10-85 due to personal reasons the patient went back to the Bhatia Hospital. The next day, she developed congestive cardiac failure which was treated with digitalis and diuretics. On 26-10-85, the patient went into spontaneous labour and delivered a premature, fresh still-born male weighing 1.1 kg. The placenta and membranes were expelled completely and there was no post partum haemorrhage. During labour the patient received one unit of fresh blood. Following delivery her condition dramatically improved. Figure 1 depicts a graphic representation of the patient's haematological profile, it is seen that the haemoglobin, white cell and platelet counts significantly increased following delivery. The patient was discharged on request on 4-11-85, then her haemoglobin was 7 gm%, total white cell count was 3500/mm^3 and the platelet count was 160,000/mm^3. Six weeks later the haemoglobin had risen to 9 gm%.

Discussion

There is no proof that pregnancy is the cause of aplastic anemia. In most reported cases the two conditions seem coincidently related. However, pregnancy may precipitate or exacerbate the bone marrow depression. This may be due to an immune reaction triggered off by pregnancy causing damage to the bone marrow in susceptible individuals. Fleming (1973) described how 3 patients suffered less severe relapses of aplastic anemia in consecutive pregnancies, which he explained to be the consequence of similiar but not identical antigenic challenge. A humoral factor from the feto-placental unit has been postulated to suppress the bone marrow (Crisp, 1980). There have been reports of a speedy reversal of aplastic anemia following delivery. (Evans, 1968 and Goldstein, 1975) as was also seen in the present case. However, Knispel (1976) after an extensive review of literature states that abortion or premature termination does not appear to be associated with a more favourable outcome. Remission of this disease cannot be expected during pregnancy, but a favourable outcome can be achieved by maintaining the patient with supportive care including whole blood transfusion, platelet transfusions, antibiotics, steroids and a planned term delivery. It is noteworthy that in spite of severe thrombocytopenia there is no record of post partum haemorrhage.

Acknowledgement

We would like to thank:

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2. The Medical Director of the Bhatia General Hospital.
3. Dr. B. C. Mehta—Head of Department of Haematology, K.E.M. Hospital.
4. Dr. Umesh S. Shah—Consultant Physician, Bhatia General Hospital.

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CERVICAL PREGNANCY

(A Case Report)

By

HITESH I. PARIKH, UMA M. SETHURAMAN, NACHIKET M. NERURKAR AND M. R. NARVEKAR

CASE REPORT

Mrs. B.B. a 26 year old Gravida 2 Para 1 came to KEM hospital history of profuse vaginal bleeding with clots for 3 days.

On admission she was drowsy, pale with a pulse rate of 120/min and a systolic blood pressure of 80 mm Hg. The cervix was enlarged with an open external os and blood clots in the cervical canal. Manipulation caused a fresh bout of bleeding. The uterus was anteverted normal sized and both fornices were clear. On the next day she had a fresh bout of profuse bleeding and the examination revealed about 400 gm of blood clots in the vagina. Patient's general condition was very poor systolic pressure had dropped to 50 mm Hg. An emergency exploratory laparotomy was done. The uterus tubes and ovaries were normal but in the lower portion of the uterus there was a mass probably the enlarged cervix. In view of the poor general condition a subtotal hysterectomy was done. After the uterus was removed the enlarged cervical canal showed a necrotic friable mass on the right side. It was embedded in the wall of the cervix just above the level of the external os. The curreted material showed products of conception with a distorted gestational sac. Histopathology report of the specimen showed that the uterus had no products of conception, but the curetted material from the cervical canal showed degenerated products of conception.

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CENTRAL RUPTURE OF PERINEUM

(A Case Report)

By

RAJKUMARI

Case Report

Mrs. A. D., aged 18 years, Primi, delivered at home an alive male baby with history of 4 hours duration of pain and sudden expulsion of the child with a few vigorous contractions, was admitted. On examination her general condition was good. P/A uterus was well contracted and at the level of umbilicus. P.V.P.S. there was a rent in perineum between introitus and anus, both vaginal orifice and anus were intact. On internal examination, there was a rent from the lower part of the posterior vaginal wall and extending externally within the perineum.

With all aseptic and antiseptic precautions the rent was repaired. She was treated with higher antibiotics, perineal antiseptics and analgesics. The repair was unsuccessful dut to infection and the patient was discharged with an advise to come after 3 months for repair operation.

Acknowledgement

I am grateful to Dr. (Prof.) M. Quadros, M.S., M.R.C.O.G. (London). F.R.C.O.G. (London), Emeritus Professor, Department of Obstetrics and Gynaecology, Bhagalpur Medical College Hospital, for her kind suggestion and supervision. I am also thankful to the Supdt. B.M.C.H., Bhagalpur for his kind co-operation.

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See Figs. on Art Paper V

GONADAL DYSGENESIS AND DYSGERMINOMA WITH 45XO/46XX MOSAICISM

By

SUVARNA RAMSWAMY AND KADAMBARI

SUMMARY

10 year old girl with 45XO/46XX Karyotype with dysgerminoma of the right gonad and a left sided streak gonad is reported.

Introduction

The neoplastic potential of a dysgenetic gonad is considered very low if the patient's Karyotype does not contain a Y chromosome. Majority of the tumours in patients with gonadal dysgenesis have been gonadoblastomas. Though Mayer stressed on the association of gonadal dysgenesis with dysgerminomas, analysis of many a large series of dysgerminomas failed to show any such relationship. The few cases of dysgerminomas that have been reported with gonadal dysgenesis have been in patients with a Y chromosome. There have been exceptionally few cases reported without a Y chromosome. The case communicated here is another rare example of dysgerminoma with contralateral streak gonad with 45XO/46XX Mosaicism.

Case Report

A 10 year old girl was admitted with history of pain and a lower abdominal mass of 3 months duration. On Examination the patient was short statured and of thin build. No Turner stigmata were present. Secondary sexual characters had not appeared. External genitalia were feminine and infantile. Clitoris was normal. A firm globular mass about 20 cm. in diameter was present in the suprapubic region. Pelvic examination revealed a normal vagina and cervix. The lower pole of the mass was felt through the fornices but uterus could not be identified separate from the mass. Ultrasonic scanning showed solid and cystic areas in the tumour without any calcification. Plain x-ray of abdomen also did not show any areas of calcification. I.V.P. was normal. Karyotyping of the peripheral blood showed mixoploidy of 45XO/46XX with predominance of 45XO cell line (80%). No individual chromosomal abnormalities were noted. Laparotomy was done and the findings were as follows. The right gonad was replaced by a solid, tumour with the pedicle twisted and with dense adhesions with multiple loops of bowels. The left gonad was represented by a streak 2 cm. X 0.5 cm. in size present in the normal ovarian position. Fallopian tubes were present on both sides with an infantile uterus in the midline. The tumour was removed after releasing the adhesions and a biopsy was taken from the left streak gonad.

The tumour was greyish in colour with irregular nodular surface spherical 9 cm. in diameter with the cut surface showing areas of haemorrhage. On microscopic examination the tumour showed alveolar structures composed of large cells with eosinophilic cytoplasm and centrally placed large vesicular nuclei. The alveoli were separated by thin connective tissue stroma infiltrated with lymphocytes. No calcification was seen anywhere. The section from the streak showed only connective tissue stroma without any follicular apparatus.

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A RARE CASE OF UTERUS DIDELPHYS WITH MISLEADING PRESENTATION

(A Case Report)

By

P. K. Nath Barbhuiya

SUMMARY

A case of uterus didelphys with obstruction at the level of cervix on one side and presenting with dysmenorrhoea and subacute intestinal obstruction is being reported. The case is reported as there were misleading findings.

CASE REPORT

G. Dey, 16 years old PO+O was admitted in the surgical ward of M.J.N. Hospital with absolute constipation and pain abdomen. The patient had her menarche 4 months back and there was history of dysmenorrhoae for 4 months. Her L.M.P. was 5 days back and she was in period at the time of her admission and examination. After conservative treatment she was referred to us as a case of lump in lower abdomen which was pressing on the rectum. On examination a lump upto 16 weeks size was detected in the lower abdomen. On vaginal examination a globular swelling bluish in colour and protruding outside the vagina was found on the anterior vaginal wall which was extending from just below the urethra upto the vault and pressing on the posterior vaginal wall. The lump was very tender. There was also bleeding from the vagina and not from the lump.

E.U.A. was done next day. Due to huge swelling posterior fornix could not be seen on speculam examination. The lump was separate from the bladder and urethra as bladder was catheterised. Drainage of the lump done and chocolate colour discharge came out. Then carefully the obstructing septum was excised. After drainage of the lump and excision of the septum a healthy cervix was found behind the lump from which menstrual blood was coming out.

There were two cervices, one in continuity with the excised margin of the septum and the other behind it.

After 10 days speculum examination was done and two horns of uterus and two cervices were clearly identified after introducing two dilators in two cervices.

In the post operative period the patient recovered well and was discharged on 12th day.

Discussion

This case could not be diagnosed at first as the findings were misleading. The patient was having usual menstrual bleeding though there was dysmenorrhoea and gradual swelling on the abdomen. The bulging on the vagina was too tense to detect another cervix behind the bulging from which menstrual blood was coming.

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See Fig. on Art Paper V

AMYLOIDOSIS OF VAGINA

(A Case Report)

By

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Introduction

Amyloidosis is a rare disease and amyloidosis of vagina is very rare. Standard text books give description of amyloidosis

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of larynx, lungs and also of heart, kidney, liver etc. but give very brief description of vaginal amyloidosis. This case is reported due to its rarity.

CASE REPORT

Mrs. M.D. 38 years came for something coming out per vagina for last 6 months with the difficulty in coitus and red staining vaginal discharge off and on.

Pelvic examination revealed a more or less circular ulcerated firm mass partly soft at places, 2½" x 2" arising from the lower part of posterolateral wall of vagina, with a well defined margin and a very small pedicle. Cervix was healthy, uterus was retroverted.

A clinical diagnosis of vaginal fibromyoma was made.

Under general anaesthesia the mass was removed from its root and the remaining area was cauterized. The mass was sent for histopathological examination.

Gross appearance of the mass—the tumor was firm but soft at places due to ulceration.

Histopathological examination revealed that the tissue contained amyloid deposits. (Fig. 1).

Discussion

Symmers (1956) classified amyloidosis as generalized secondary amyloidosis, generalized primary amyloidosis and localized amyloidosis. Localized primary amyloidosis is the rarest form of amyloidosis which is confined to a single organ or system. The sites of localized lesions are upper respiratory tract specially the larynx, the lower respiratory tract, the bladder, the skin and the mucous membrane of the orifices like mouth and vagina (William Boyd). Regression of primary amyloidosis is unknown and if it at all happens the process is very slow as it is engulfed by the foreign body giant cells around the amyloid tissue. Localized amyloidosis is nearly always of infiltrative variety.

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See Fig. on Art Paper VI

ICHTHYOSIS UTERI

By

(A Case Report)

P. R. MALUR, B. R. DESAI AND
S. J. NAGALOTIMATH

Introduction

Of the many causes, of post-menopausal bleeding, which invariably has to be distinguished from adeno-carcinoma of the endometrium, is one condition of senile endometritis. Such a condition rarely shows patchy or the entire corporeal surface being covered with metaplastic squamous epithelium. One such case encountered by us is reported.

CASE REPORT

Mrs. R. 55 years of age came to a private nursing home with the complaints of white discharge, since one year. She had attained menopause 5 years ago. She had 4 full term normal deliveries. Her last delivery was 15 years ago. She had never used an intrauterine contraceptive device.

She was moderately built and nourished and not anaemic.

O/E. Per speculum—The Vaginal mucosal folds were rather oedematous, blood stained discharge was present. The cervix was atrophic

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and healthy. The uterus was retroverted and of normal size. Repeated vaginal smear studies showed an inflammatary pattern. Following local antiseptic therapy the smears were repeated. Smears studied later showed no evidence of malignant cells. Diagnostic laparascopy was undertaken which did not help much.

Fractional currettage was done. The material curetted was very scanty. Histopathological studies showed few small clumps of squamous cells and no endometrial tissue. Since her symptoms continued a total hysterectomy with bilateral salpingo-oopherectomy was carried out and submitted for histopathological examination.

On cutting, the entire endometrial surface appeared to be covered with a greyish white, thick sheet like structure which was wrinkled at places. The fundal region showed a papillary growth with a thick pedicle. This growth was greyish while in colour. The myometrium at the site of the growth appeared normal. The greyish white sheet was seen to reach the external os of the cervix.

Microscopic Examination:

Multiple sections studied from different areas of the uterus showed normal myometrium covered with metaplastic squamous epithelium. The growth in the fundus consisted of squamous cell papilloma. There was no evidence of malignancy. (Fig. I and II).

See Figs. on Art Paper VI