ACUTE HAEMATOMETRA FOLLOWING FIRST TRIMESTER PREGNANCY TERMINATION

(A Case Report)

By

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CASE REPORT

Mrs. S.H., a 30 years old 3rd gravida 2nd para presented for medical termination of pregnancy. The uterine size was of 10 weeks of gestation, which corresponded to the period of amenorrhoea. The pregnancy was terminated under paracervical block by rapid dilatation and suction evacuation. The cervix was dilated to size 10 Hegar's and a No. 8 metal cannula was used. The procedure was uneventful. The total blood loss was about 100 ml. Methyl ergometrine was not given to the patient.

Two hours after the procedure the patient complained of severe pain in lower abdomen. Her pulse rate was 120/min., blood pressure 100/60 mm Hg. The uterus was enlarged to a size of 16 weeks of gestation, and was tender. The abdomen was soft and supple. Vaginal examination revealed the cervix to have closed, with no active bleeding from the os. A real time ultrasonic scan showed the uterus distended with sonolucent fluid.

The cervical canal admitted a size 8 Hegardilator easily. A total of 200 g of blood clots and 100 ml of blood were removed from the uterus. The material evocuated at check curettage showed no products of conception. Methyl ergometrine was administered and the uterus was massaged bimanually, after which the uterus contracted. The recovery of the patient was uneventful and the patient was discharged from the hospital on 4th post-operative day.

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SECONDARY ABDOMINAL PREGNANCY

(A Case Report)

By

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Introduction

Secondary abdominal pregnancy is known for its vague symptoms and clinical presentation. However very few cases of lithopaedion formation are reported. A case of lithopaedion formation following fundal rupture of uterus is reported. Similar case has been reported by Tiwari and Kochhar earlier in Indian Journal.

CASE REPORT

Mrs. R. B., 22 years old, had dull aching pain in lower abdomen for 3 months off and on, with foul smelling vaginal discharge for one month. There was history of passing bones per vaginum.

An oval, hard, fixed mass was felt in right lumbar and right iliac fossa with lower limits well defined and measuring 10 cms x 8 cms with

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crackling sound. There was slight tenderness over the mass.

On speculum examination cervix was drawn up and completely flushed with vagina, with foul smelling purulent discharge from the external os.

On vaginal examination uterine size could not be determined. The abdominal mass was felt separately from the fundus of the uterus.

X-ray abdomen films revealed multiple small bones just beneath right side of abdominal wall in right iliac and lumbar region (Fig. 1). Ultrasonography showed the same findings suggestive of secondary abdominal pregnancy.

On exploration a sac, was found on right side of abdomen adherent to parietal peritoneum and small intestines (Fig. 4).

There was a rent of about 4 cms on the fundus of the uterus more on posterior aspect and a tract was detected connecting the sac to the uterus (Fig. 2). On opening the sac multiple foetal bones were detected with foul smelling purulent material. The sac with its content was separated by blunt and sharp dissection and removed.

Rent of the uterine fundus was sutured in 3 layers.

Intestinal perforation at 2 places was sutured.

See Figs. on Art Paper III

CONGENITAL POLYCYSTIC KIDNEYS IN INFANT BORN OF A DIABETIC MOTHER

(A Case Report)

By

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AMITABHA MUKHERJEE
AND
KALYANI MUKHERJEE

CASE REPORT

M.D., aged 30 years, P 1 + 0, came for antenatal check up at Medical College, Calcutta at her 26th week of gestation. Her L.M.P. was on 29-8-85, the E.D.D. being on 5-6-86. Her last child was delivered normally 10 years back and is living and healthy. She was on combined OC pills for 5 years and had stopped OC about an year before this conception. Her family history revealed her mother was diabetic. Her routine investigations were normal other than the blood glucose. At this time (26th week of pregnancy), her 2 hours P.P. (after 100 gm. glucose) blood glucose level was 172 mg%. Ultrasonography was done and the report showed oligohydramnios but no detectable congenital anomaly. The period of gestation corresponded with foetal age (BPD measurement). She was referred to the diabetic clinic and was alvised diet control only. Her blood sugar (2 hours P.P. after 100 gms. of glucose) came down to 134 mg% within two weeks and a level between 134 mg% to 110 mg% was maintained throughout the rest of her pregnancy. She was admitted to hospital in 36th week of pregnancy when a repeat ultrasound examination revealed gross oligohydramnios with multiple cysts in both the kidneys she went in to spontaneous labour on 28-5-1986 (8 days before the E.D.D.) and normally delivered a male child. The labour was uncomplicated.

A male baby was born weighing 3.6 kgs. with bilateral swellings in the abdomen. The 1-min Apgar score was 7. The condition of the baby deteriorated rapidly and the baby died 3 hours after birth due to cardiorespiratory failure. Catheterisation of the bladder produced no urine.

Postmortem of the baby revealed bilateral polycystic kidneys. The right kidney was larger (4" x 3" x 3") than the left (2.5" x 2" x 2") (Fig. 1). There were multilocular cysts filled up with transparent fluid. The other organs like liver, spleen, pancreas, adrenals, intestines, heart, lungs, etc. all appeared to be normal. Biopsy was taken from all these organs. Histopathological report showed polycystic changes in both kidneys. The other organs showed no abnormality. During puerperium, 2 hours, P.P. (after 100 gm of glucose) blood sugar was 138 mg% on the 1st day and 144 mg% on the 7th day when no dietary restrictions were made—thus establishing the liagnosis of chemical diabetes (White's class A) of the mother.

See Fig on Art Paper I

From: Eden Hospital, Medical College, Calcutta.

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QUINTUPLETS

By

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CASE REPORT

Smt. Bimala Devi, 26 years old, Hindu female of low socio-economic status, presented with undue enlargement of abdomen on 28-5-86 with amenorrhoea of 7 months. She complained of breathlessness, pain in abdomen, and swelling of her feet. Her L.M.P. was 5-11-85 and E.D.D. was 12-8-86. She had no previous antenatal check up. On examination there was moderate pallor and oedema, Blood pressure was 130/90 mm. Hg., Chest and C.V.S. was normal. Per abdomen the fundus was upto the xiphisternum and multiple foetal parts were felt. The foetal heart sound could not be located. On pelvic examination, cervix was 50 % effaced and 2 cms. dilated. Membranes were intact. There was slight blood stained discharge. Pelvis was adequate. The presenting part was rather high up.

Laboratory investigations revealed the following data: Blood group 'A', Rh-positive, Hb. 72 %, Routine urine showed trace of albumin. Plain X-ray of the abdomen and pelvis showed five foetal spines and four distinct heads. After 2 days of hospitalization she had spontaneous rupture of membranes followed by feeble labour pains, but the cervix progressively dilated. Labour was augmented by I.V. Syntocinon drip. She then delivered a female baby presenting by the vertex spontaneously. The second female baby followed after 10 minutes presenting by the breech. There was moderate P.P.H., but her general condition was good with normal pulse and blood pressure. The drip rate was accelerated and the delivery of the remaining babies was awaited. Finally due to extreme uterine inertia leading to undue delay, the patient was anaesthetised and the delivery of the remaining three babies was expedited.

The third was a male with brow presentation and was extracted by outlet forceps, after rupturing the membranes. The fourth sac was ruptured and alive male child with transverse lye was extracted by internal podalic version. Finally, after rupturing the fifth sac, the last male child with cephalic presentation was similarly extracted (Fig. 1).

The placentae were finally manually removed. There was no significant P.P.H. The cords of the first two female babies originated from a common placenta. The other three had separate small placenta only apparently fused due to intervening membranous septa. The placenta together weighed 740 gms. The weights of the babies were as follows: 1st female 1.2 Kg., 2nd female 1 Kg., 3rd male 850 gms., 4th male 775 gm. and 5th male 600 gm. All the babies respired normally. The first three spontaneously and the last two after usual resuscitation procedures, but they gradually expired in a course of 5 days.

See Fig. on Art Paper IV

From: Patna Medical College Hospital, Patna.
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LITHOPAEDION FORMATION—ITS CLINICAL PRESENTATION AND PROBLEMS

By

SUDHA DATAR

CASE REPORT

Mrs. Anusaya, aged 35 years, married for 12 years, attended the outpatient department of an Industrial Welfare Centre on 28th May 1986, as she desired Laparoscopic Sterilization. She had four full term normal deliveries. The last delivery was uneventful on 20th April 1986, 5 weeks before the first visit to the Centre. She had no history of pain, nausea, vomiting and other complaints during her antenatal or intranatal period.

On examination, the patient was averagely built, nourished and anaemic. Her pulse rate was 80/minute and blood pressure was 110/70

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mms of Hg. Examination of respiratory and cardio vascular system revealed no abnormality and her laboratory investigations and X-ray chest were normal.

Examination of the abdomen revealed a hard mass in lower abdomen on the right side. Vaginal examination revealed uterus to be of normal size. A hard mass 12 cms x 9 cms felt in the anterior and lateral fornix, appeared probably attached to the uterus. The mass was irregular and felt like projection of corals. As she desired Laparoscopic Sterilization, it was thought to be a good opportunity to see the mass through laparoscope, which would help the diagnosis.

Laparoscopy under general anaesthesia on 3rd June revealed the uterus normal in size. Left tube and ovary were normal. The right tube and ovary could not be visualised. A mass about 12 cms x 9 cms in size greyish in colour and with irregular surface, with a few blood vessels running over it, was seen on the right side. Through the second puncture, probing of the mass was done which felt hard. A possibility of ovarian tumour was considered. Exploratory laprotomy was performed subsequently. On opening the abdomen a hard mass 12 cms x 9 cms was found attached to the uterus at right corner by a thick pedicle by the side of fallopian tube. Both the tubes and ovaries were normal. This very hard and pinkish grey mass was adherent to the omentum at three places with thin adhesions. The alhesions were ligated and cut. There were no adhesions with the intestines. A diagnosis of abdominal pregnancy with Lithopoedion formation was made. No remnants of cord, placenta or sac were found. The pedicle was ligated and mass was excised. The stump was buried by round ligament. The left tube already ligated through laparoscope was seen. The right tube was ligated. No free blood in the peritoneal cavity was seen. The abdomen was closed in layers. No blood transfusion was required. Post-operative period was uneventful, patient was discharged on 9th post-operative day.

The mass was a dried mummified foetus—A Lithopaedion, weighing 600 gms (Fig. 1). The X-ray of the mass revealed spinal column, ribs and fully developed extremities (Fig. 2). The femur length was 7 cms. The food length was was 4.5 cms. The foetal age therefore was approximately 28-30 weeks.

See Figs. on Art Paper IV

AORTOARTERITIS IN PREGNANCY

(A Case Report)

By

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AND
V. DARADE

Introduction

Aortoarteritis (Takasyu's disease) is a rare disease which is characterised by narrowing of major arteries at their origin from aorta. It is supposedly an auto-immune disease though various bacterial agents including Koch's bacilli are incriminated in the causation of disease.

It affects females more often than males in the ratio of 8:1. It is also often found in age group 20-30 years. It is obvious from the above two facts that it will be associated with pregnancy in some cases, though not many cases are reported.

We are reporting one such case in the present study.

CASE REPORT

Mrs. R.S., a twenty-six years old female presented with tingling and numbness of hands and feet with eight months of amenorrhoea. Her expected date of confinement was 19-9-1984.

Her previous mentrual history was regular. Her obstetric history revealed that she had one full term caesarean section two years ago, the

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child dying within 6 hours of birth due to asphyxia neonatorum.

On general examination her pulse and B.P. could not be recorded from any of the peripheral vessels. She had slight bilateral oedema on her feet; otherwise systemic examination did not show any abnormal features.

The abdominal examination revealed her fundal height corresponding to the gestational age with the vertex presentation. Foetal heart sounds were regular.

The investigations were as follows:
Hb—12.8 Gm%, urine—albumin: negative
Blood group, Rh factor—B Positive
X-ray chest—heart shadow: normal
E C G —Normal
Respiratory function test—normal

The patient was kept under observation with the provisional diagnosis of "aorto-arteritis with pregnancy" and daiy evaluation of her weight, urine check for albumin and hearing of foetal heart sounds twice a day were done.

She was put on adrenocorticoids in the form of Betnosol (2 mg) 1 tablet twice a day, Placentotrophic in the form of Allylestrenol Tablet (5 mg) 1 three times a day, Folic Acid (5 mg) tablet—1 three times a day and diuretic in the form of Lasix tablet one in the morning. She was also advised salt reduced diet.

Cardiologist's opinion was obtained which concurred with the diagnosis and treatment and agreed that further investigations confirm the diagnosis.

The foetal maturity was estimated by repeated ultrasonography and when on sonography it was confirmed that the foetus had reached 37 weeks of maturity on Biparietal diameter, the elective caeserean section was decided and accordingly carried out.

Technically, except for the use of epidural anaesthesia, there was no unusual feature.

During the operation, after the delivery of the foetus, the aortic pulsations were palpated and they were felt up to aortic bifurcation.

The post-operative monitoring was done by C V-P line and other vital data like respiration cynosis etc. till the third day when the patient became ambulatory.

PREGNANCY WITH CUSHING'S DISEASE

By

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Introduction

Cushing's disease is defined as adrenal hyperplasia resulting from increased ACTH secretion by the pituitary. Cushing's Syndrome in pregnancy was first described by Heerveg in 1932. Till May 1984 only 35 pregnancies in 30 patients with Cushing's Syndrome have been reported. Among the reported pregnancies occuring in patients with Cushing's Syndrome, 30% end in spontaneous abortion, 25% in premature delivery and only 45% are carried to term. The timing of fetal death is random and occurs in all the 3 trimesters. There is no increased incidence of congenital malformations. Addisonian crises in the neonate is also rare. Mortality rate in the untreated cases is 50% in 5 years.

CASE REPORT

Mrs. S.G. a twenty year old G_2 PO A_1 came with 4 months Amenorrhoea, bilateral edema feet and increased weight gain. She was obese with a weight of 75 Kg. and her B.P. was 140/100 mm Hg. She had bilateral pitting edema grade II, puffiness of face, buffalo hump with supraclavicular pad of fat, moonface, acne, mild hirsuitism and pink striae on the trunk and extremities. She also had frontal headaches with increased intensity at night. PV examination showed a uterus of 16 weeks in size.

Routine and endocrinological work up was done, the results of which are shown. Hb 9.5 gm%, Urine albumin 1+, BSF 67 mg%, BSPP

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