AMNIOCENTESIS FOR SEX DETERMINATION AND ITS COMPLICATIONS

(A Case Report)

By

SUGNA V. PANDYA

CASE REPORT

Mrs. M.R., aged 24 yrs; G=3 P=2 both females, was admitted on 13-11-1986 at 9-55 A.M. with H/O 5 months' amenorrhoea and bleeding P/V for 6 days. She gave H/O amniocentesis for sex determination six days back; the sex of foetus was reported as female. She also had fever for 2 days. There was no H/O interference.

On admission patient was conscious, pulse 140/min, regular, B.P. 80/60 mm of Hg and temperature normal. C.V.S. & R.S. revealed only sinus techycardia. Abdominal examination showed uterus of 24 weeks pregnancy, irritable and tender. No guarding or rigidity was felt. Pelvic examination showed external os open, internal os closed and moderate amount of bleeding, Syntocinon drip, Blood transfusion and IV metrogyl were given. She aborted a male foetus at 1.30 P.M. She went into shock at 1.55 P.M. inspite of Blood transfusions. Placenta and membranes were complete and uterine cavity did not reveal any retained product on P/V examination. B.P. come up to 120/80 mm of Hb with dopamine drip. At 3.20 P.M. She collapsed again and started trickling blood per vaginum. There were no signs of internal haemorrhage. Exploration of uterine cavity was done under general anaesthesia, no placental tissue was obtained. Tight uterine packing was done with roller gauze at 4-15 P.M. Pack was found to be soaked with blood and B.P. dropped to 70/50 mm of Hg. B.T. & C.T. were normal. There was no rigidity or guarding in abdomen.

Exploratory Laparotomy under G.A. was performed. About 100 c.c. of free blood was found in peritoneal cavity; uterus was flabby. Rt ovary was gangrenous and there was broad ligament hematoma. Left ovary could not be visualised due to multiple adhesions. Total abdominal hysterectomy with right-salpingooophorectomy was performed. She had 9 units of blood transfusion. Ampicillin and Garramycin were given. Post-operative recovery was uneventful apart from some superficial gaping of wound which healed up after secondary sutures.

Retrospectively, H/O repeated punctures for amniocentesis (done outside) was obtained and we feel, the gangrenous ovary and broad ligament hematoma may have been due to repeated inadvertent pricks for amniocentesis. Amniocentesis for sex determination is not without its razards, nor the prediction of sex is absolutely accurate as can be seen from this case. This patient suffered a heavy loss of male foetus and her obstetric career was sacrificed, not to mention the danger to her own life.

I thank the Superintendent of Smt. S.C.I. General Hospital for permitting me to use the case records.

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RARE COMPLICATIONS ASSOCIATED WITH MTP

By

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After liberalization of abortion, medical termination of pregnancy has become a common procedure. It is however not without danger.

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I present here two unusual complications met with recently after MTP.

CASE REPORT

Case 1

Mrs. S.D., 2nd gravida, 30 years, came in emergency with severe lower abdominal pain and profuse vaginal bleeding. She complained of irregular bleeding for 5 months after MTP done at 12/52 gestation in her native place.

On examination she was extremely pale. Her pulse was 132/mt, B.P. 100/60 mm of Hg. Abdominal examination revealed in ill-defined abdominal lump felt more on the left side than the right. It was firm in consistency, tender with restricted mobility. On vaginal examination uterus could not be felt separate from the abdominal lump. Multiple haemorrhagic nodule were felt in the anterior fornix ½" below the external urethral meatus. Choriancarcinoma was the provisional diagnosis which was confirmed after histopathology and Quantitative pregnancy test.

Her general condition was improved by repeated blood transfusions and other adjuvent therapy and condition treated by methetrexate given orally in a dose of 5 mg thrice daily for 7 days—for the three such courses at an interval of two weeks each.

There was marked regression in abdominal and suburethral lumps. Patients condition improved.

Patient remained in the hospital for three months and was discharged with advice for proper follow-up.

Case 2

Mrs. R.K., 32 years, 2nd gravida was admitted in emergency for profuse vaginal bleeding. She had one MTP done in 1st trimester for profuse vaginal bleeding. She was having irregular bleeding and marked weakness since then, Her previous cycles were reported to be regular.

At the time of admission, she was extremely pale, spleen and liver were enlarged. There was no lymphadenopathy. Pelvic examination was non-comittal except for severe vaginal bleeding.

Investigation Hb% 6.1 gm, Total leucocyte 3,20,000 per cm. Differential Count, Neutrophil 44. Lymphocyte 4%, Monocyte, 1, Myelocyte 50%, Myeloblast 1.0%, total platelet count, 4,80,000. Erythrocytes normocytic, about 30% hypochromic and rest were normochromic, targets cells was not found.

Bone marrow examination showed marked increase in cellularity with increase in cellularity with increase in leucopoisis and depression of Erythropoisis M.E. ratio $15 > 1$.

Diagnosis of myloid leukemia was made and patient was referred to Physician for treatment. In this case MTP added insult to injury. However, timely diagnosis helped in proper management.

SUPERFOETATION

By

A. G. Rangnekar and S. Sapre

CASE REPORT

Mrs. B.R., reported with the complaints of lump in abdomen which she noticed after her normal vaginal delivery 24 hours back. She was a second para and had a male child born normally 3 years back.

Examination showed a puerperal uterus of about 22 weeks size pushed laterally by a mass of 32 weeks size gravid uterus which in reality was really a gravid uterus. X-ray taken showed a puerperal uterus along with a gravid uterus (Fig. 1) internal examination showed a patulous cervix on right side and a closed cervix on the left side with a tag of tissue hanging in between the two indicating that it must be a bipartite uterus, the tag representing the vaginal septum which must have been torn during the first labour. Though recently delivered the lochia was very scanty and except for little breast secretions lactation was also not established.

The pregnancy continued uninterrupted and she delivered normally after 21 days. After the birth of this baby the lactation was well established and the lochia was also normal.

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Hysterosalpingography done afterwards showed a double uterus (Fig. 2).

Discussion

A rare case of Superfoetation in a bipartite uterus is presented. Superfoetation is possible in as much as ovulation may take place especially during early pregnancy.

The interval between the deliveries of two foetuses have been quoted differently by different authors. Pavlin (1905) quoted a case where the births were seperated by 17 days while in Bruce and Cumming's (1953) case it was 56 days and in Bhagwat's (1953) case 26 days. In our case the births were separated by 21 days.

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See Figs. on Art Paper III

PREGNANCY IN A PATIENT WITH EBSTEIN'S ANOMALY WITH NORMAL FETAL OUTCOME

By

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Introduction

Ebstein anamoly is one of the rare cyanotic heart diseases with an incidence of 1 in 210,000. There are very few reports of successful pregnancy in patients with this disease. In eleven large Indian reviews of heart diseases complicating pregnancy with a total of 1372 cases there is not even a single case of Ebsteins anamoly reported. We are reporting a case of successful pregnancy in a woman with Ebstein's anamoly, who had an uneventful delivery with a normal fetal out come. Follow up of the child upto the age of nine months revealed normal development of mile stones.

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CASE REPORT

A 20 year old female patient was admitted in the antenatal ward with 8 months amenorrhoea. She was a known case of Ebstein's anamoly diagnosed at the age of 13 years, when she had epistaxis. Since then she was under follow-up. There was no history of rheumatic fever, dyspnoea, palpitations. On examination she was moderately built, with no cyanosis or clubbing. Large waves were seen in the jugular venous pulse. The pulse rate was 78/mt and regular and blood pressure was 110/70 mm of Hg. On auscultation the first sound was split and diminished in intensity. Wide fixed splitting of the second sound with prominent third and fourth heart sounds were heard. A pansystolic murmer with thrill was present in the tricuspid area. Prominent pulsations of the liver were present. Other systems were normal. EKG showed prominent P waves, prolonged PR interval and complete Rt. bundle branch block. X-Ray chest showed cardiac enlargement.

One year ago she had a spontaneous abortion at 24 weeks of gestation. Even during this pregnancy she had spotting per Vaginum at 3rd month for which she was admitted to the hospital for 2 weeks and was treated as a case of threatened abortion. Close supervision was maintained throughout pregnancy. At 32 weeks she developed pedal edema which subsided with bed rest in the hospital. She went into spontaneous labour at 37 weeks of gestation, and was delivered of a live male child weighing 2900 grams by outlet forceps. There was no birth asphyxia and no signs of IUGR. The intrapartum and post partum periods were unevent-

ful. Antibiotic coverage was given for one week post partum. Both the mother and child were followed up for 9 months and found to be normal. Baby's development was assessed periodically on Denver's Developmental Scale and was found to be corresponding to the age in all the parameters-gross motor, fine motor, language and personal social aspects. Physical development also corresponded to the chronological age.

Discussion

Ebstein's anamoly is one of the rare congenital cardiac defects in which the morphogenesis of the tricuspid valve is abnormal. The clinical manifestations of the Ebstein's anamoly are variable depending on the severity of the anatomic changes in the tricuspid valve. Ultimately, however, progressive cyanosis resulting from right to left shunt, symptoms resulting from right ventricular dysfunction develop. Most patients survive to the third decade.

Majority of the reviews of Ebstein anamoly do not mention about the pregnancy in their female patients. Copeland *et al* (1963) who studied 103 women with congenital heart disease had 3 cases of Ebstein's anamoly with a total of 6 pregnancies out of which there were 2 fetal losses. One case of successful pregnancy in a patient with Ebstein anamoly was reported in our country by A. K. Gupta *et al* (1984). Review of Indian literature on heart disease complicating pregnancy did not reveal any other case of Ebstein's anamoly.

Our patient had one spontaneous abortion and was treated for threatened abortion during this pregnancy, she delivered a live child at 37 weeks. She had relatively good prognostic features like absence of cyonosis, heart failure and arrhythmias. The baby born to her was healthy and follow up upto 9th months showed normal development.

This report suggests that heart disease in pregnancy though a potentially dangerous disorder can be successfully managed without jeopardising the maternal and fetal outcome. So each case should be assessed individually before taking a decision regarding continuing the pregnancy or not.

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ANTENATAL DETECTION OF CONGENITAL HEART BLOCK IN THE FOETUS

By

G. PARIMALA, D. PRATIBHA AND SHAJAHAN

CASE REPORT

Kalavathy, aged 28 years, III Gravida, with previous caesarean section, was admitted on 9-6-1983 with a history of 9 months amenorrhoea and loss of Foetal movements of one day's duration at Government Maternity Hospital, Hyderabad.

Obstetric History: She had first L.S.C.S. for prolonged labour, child alive 8 years old; second was an Intra-uterine death, cause not known.

During the present pregnancy, she was attending antenatal clinic regularly and was investigated—Hb% = 10.0 grms%; urine showed no albumin, no Sugar; Blood Sugar 64 mgm%, Blood urea 17 mgms%, Blood group. A positive, Blood VDRL—non reactive.

At the time of admission: Pt. was normotensive, Not anaemic; All vital data being normal.

From: Government Maternity Hospital, Sultan Bazar, Hyderabad.

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Obstetric Examination showed uterus with a broad fundus, 36 weeks cephalic presentation with foetal Heart 110/mt regular with good tone. In view of history of loss of foetal movements and foetal heart being slow, 5% Dextrose drip was given and patient kept in lateral recumbent position. Patient started appreciating foetal movements. Daily monitoring showed that the Foetal Heart continued to be between 80-90/mt and the maternal pulse being 110/mt. Hence a congenital cardiac disease was suspected in the baby and the patient was referred to Cardiology Department where a Foetal Echo-Cardiography was done and found to be having bradycardia.

Scanning showed single foetus with cephalic presentation with BPD 8.7 cms (37 weeks gestation with placenta in anterior and upper part and foetal heart movements 80/mt regular, On 5-7-1983 labour set into and as the foetal heart rate came down to 64/mt with variability, LSCS was done. A live Female 2.4 Kg, was delivered with an Apgar (10). Post-operative period was uneventful and the wound healed well.

Condition of Baby at the time of Birth: Vigorous, Apgar (10) C Bradycardia 60/mt, regular, no extrasystoles; N.N. reflexes brisk. Lungs clinically clear; liver and spleen not palpable—A provisional diagnosis of sinus Bradycardia—? Congenital heart Block was made and baby was referred to cardiology Department. ECG showed congenital complete Heart Block with Heart Rate 64/mt regular.

Baby continued to put on weight with heart rate 64/mt and all other activities were normal. Baby is attending cardiology department and is doing well. Mother is also investigated for Rheumatoid activity and found to be negative.

ACUTE LEUKAEMIA AND PREGNANCY

By

J. I. FIDVI

Introduction

The association of pregnancy and Leukaemia is rare. As early as in 1845 Virchow first reported a case of leukaemia during pregnancy. The statistics reveal that 1 in 1000 pregnancy is complicated by malignant disease (Rothmen *et al*, 1973). Leukaemia is rare in females as compared to males and rarer still during reproductive period of women's life. The incidence of Leukaemia in pregnancy has been quoted as 1 in 75000. Most reports are confined to illustration of a solitary case.

In this hospital during the last 6½ years a total of 30628 confinements were recorded and a single case of leukaemia was encountered which is detailed below.

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CASE REPORT

A 25 years old Hindu female was referred to Indira Gandhi Medical College & Hospital, Nagpur by a General Practitioner as a case of Leukaemia for further management. The same day i.e. 27-2-1987 the patient was admitted in Medicine ward with H/o bleeding gums, burning in micturation, weakness and easy fatigue. She gave H/o Haemoptysis a month back and recurrent vomitting for almost 4-6 weeks. She also had H/o bleeding per vaginum off and on for 3 months.

The patient was found to be grossly anaemic with Hb 4 gm%, her BP was 120/80 mm of Hg there was no lymphadenopathy or edema over feet. Gross tachycardia of 120/minute was present. There was gingival hypertrophy with active bleeding. CVS examination revealed soft systolic murmur. Liver was palpable 5 cms whereas spleen was not palpable and there was no CNS involvement.

The TLC and DLC on admission was 30,000/cu mm, DLC-Blasts 70%, Lymphocyte 24%, Polymorph 5%, Monocyte 1%. The diagnosis of acute lymphoid leukaemia was confirmed by above peripheral smear and bone marrow aspiration.

She was treated with standard regime of vincristine, adriamycin and prednisolone initially and subsequently put on methotrexate and cytocine arabinoside while prednisolone was continued. With the above treatment the blast cell count dropped to less than 2%. The plastelet count was ranging between 40000-60000. During