A CERVICAL PREGNANCY

(An unusual Case Report)

By

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Introduction

Cervical pregnancy is an obstetric rarity. An unusual case of cervical pregnancy is presented here with the following notable features: The patient presented at 14 weeks of gestation for routine check-up with no history of bleeding. Clinical examination raised a suspicion of cervical pregnancy which was confirmed as a viable cervical pregnancy on ultrasound scan. Management had consisted of a formal abdominal operation consisting of incision into the cervix and removal of the products of conception. Patient had minimal blood loss post-operatively.

CASE REPORT

On 27th April, 1987, Mrs. M.R., aged 30 years, a primigravida, presented with a history of 3 months amenorrhoea for confirmation of pregnancy. A speculum examination revealed 2 cms dilated os and amniotic membranes were seen. On vaginal examination, cervix was bolloon-ed up with dilated os. Through the membranes foetal parts were felt. Uterus could not be felt very well. Suspicion between incompetent cervix with normal pregnancy and cervical pregnancy arose Ultrasound scan showed the whole cervix ballooned up having a gestational sac with a live foetus of 13 weeks. The placenta was situated on the anterior cervical wall extending upto the internal os. The uterus above the cervix was only slightly enlarged with empty uterine cavity. Thus, diagnosis of cervical pregnancy was confirmed. Decision was made to approach the cervical pregnancy per abdomen. The operation could be linked with hysterotomy and may be called "cervicotomy". The procedure basically involved exposing the anterior surface of cervix by pushing down the bladder; taking 4 stay sutures over cervical surface; making vertical incision over the cervix and pushing the finger through the anteriorly situated placenta, the pregnancy sac was evacuated out. There was a blood loss of about 200 cc. which was effectively controlled by packing the cavity of the cervix and taking some under-running sutures over the placental site. The cervical incision was closed. Patient received necessary blood transfusion. She was closely watched for bleeding. Cervical pack was removed the next day. There was minimal oozing which over a week reduced and then stopped. Care was taken to prevent infection. Daily H_2O_2 cleansing of the cervical cavity was performed which served two purposes: Reducing chances of infection and acting as a styptic agent. Patient was discharged on the 12th day and on follow-up after 15 days she was well and anxiously looking forward to another pregnancy in near future.

See Fig. on Art Paper I

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CERVICAL PREGNANCY

(A Case Report)

By

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CASE REPORT

Mrs. S. S. Devi 30 years was admitted at 8 A.M. on 30-10-85 in a state of shock

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with unrecordable pulse and B.P. and bleeding per vaginum. They were married for the last one year with no history of M.T.P. or abortion. She had two months amenorrhoea and bleeding per vaginum since 8-9 hours. The patient was resusitated, on gentle pelvic examination products of conception were found in the dilated cervical canal. A provisional diagnosis of incomplete abortion was made and patient was taken to O.T. for D and E. On pelvic examination uterus was normal size, cervix dilated and thinned out, products of conception were taken out. Bleeding was checked to some extent. Patient was kept under observation I.V. dextrose and another two units of blood were transfused. The patient was in stable stage but did not show marked improvement till 6 P.M. Fresh bleeding P.V. was persisting and her urinary output was only 5-10 ml. Her condition started deterioting. On P.V. examination uterus was normal size, cervix was dilated with clot in the canal which was removed. She was transferred to O.T. for laparotomy with provisional diagnosis of (a) perforation of uterus (b) cervical pregnancy (c) disturbed cervical fibroid. Under general anaesthesia laparotomy was done, no free blood was seen in peritoneal cavity and uterus was intact. Abdominal hysterectomy was done hurriedly to check bleeding. When the vault was cut and opened dilated thinned out cervix with multiple bleeding points from the raw surface and friable tissue at the margin was seen. With arrest of bleeding after hysterectomy, general condition gradually improved. Six units of blood were transfused during and after the operation. Uterus with cervix was sent for histopathological examination which suggested cervical pregnancy with evidence of chorionic villi in the cervix and no foetal tissue in the uterine cavity. Postoperative period was uneventful and the patient was discharged on 14-11-85.

ADVANCED EXTRAUTERINE PREGNANCY

(Report of 4 cases).

By

NIRMALA KUMARI AND ANUJA ROHTAGI

Introduction

Advanced extrauterine pregnancy is rare. Only few cases of this hazardous complication are reported in literature. We present herewith 4 such cases. Unfortunately all our cases had dead foeteses but no one showed any congenital abnormality.

Case 1

Mrs. K. Devi, 30 years old, 2nd gravida presented in emergency room with 32/52 amenorrhoea, abdominal pain and marked abdominal distension. She complained of cessation of foetal movement and purulent vaginal discharge for one week prior to admission. Her first pregnancy was a male child 10 years old, home delivery.

This time the patient presented as acute abdomen in shocked condition with pulse 140/mt B.P. 90/50 mm of Hg. Temp. 103°F, Tongue furred and coated. She was A +ve with 5.9 gram %Hb.

Abdominal examination revealed the gestational sac high up and foetus in oblique lie. There was marked tenderness with absence of foetal heart sound. On vaginal examination—cervix was long and closed. Foetal parts were felt high up. Blood stained purulent discharge was present.

Tentative diagnosis of silent uterine rupture was made and laparotomy was undertaken after resuscitating the patient. Copious purulent discharge was present in peritoneal cavity. The uterus could not be defined. Foetal sac was formed of the left tube, the broad ligament and fibrin deposit. A dead female foetus weighing 2.1 kg

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was delivered after incising the gestational sac. The left tube along with gestation sac and placenta was removed.

Patient made an uneventful recovery with blood transfusion antibiotic and other supportive therapy.

Case 2

Mrs. S.K. 28 years old 2nd gravida was admitted with 4 weeks post-dated pregnancy and loss of foetal movement. She had premature delivery 7 years ago, the baby died after 12 hours of delivery.

Her general condition was good. There was suprapubic firm swelling 3" in diameter which was thought to be the subperitoneal fibromyoma. The foetus was in transverse lie with absence of foetal heart sound. On vaginal examination the cervix was ½" long and closed. Vaginal discharge was normal.

She was O +ve with Hb 9.2 gm% and serum fibrinogen 270 mg/dl. Abdominal pregnancy was thought of. Ultrascan was non-committal, Hysterosalpingography showed empty uterine cavity and the foetus lying outside.

Laparotomy was undertaken. The uterus was intact, 6 weeks size with normal right tube and ovary. The left tube was densely adherent to foetal sac indicating left tubal rupture. A dead male foetus weighing 2.3 kg was delivered by opening the sac. The sac and placenta with cord were removed as far as possible. The post-operative period was uneventful.

Case 3

Smt. S. Devi, 24 years old came with secondary infertility. She had two abortions of 8 to 12 weeks of gestation, last one being 2 years back. Her last period was 10 days before admission.

Her general condition was good. There was an irregular lump in suprapubic region of 26 weeks gestation size. On vaginal examination the uterus was felt separate from the lump.

She was A +ve with 5.6 gm% Hb%. On ultrascan presence of dead foetus outside the uterus was seen. Hysterosalpingography showed empty uterine cavity and foetus lying outside (Fig. 1).

At laparotomy, the gestational sac was adherent to the fundus of uterus which had ruptured in early pregnancy. Both tubes and ovaries were intact. A dead female foetus weighing 1.5 kg was delivered. The placenta was removed easily. The post-operative period was uneventful.

The cause of uterine rupture remained unexplained. The rent repaired in the hope of giving her a live child at a later date.

Case 4

Mrs. A. Devi, 28 years, 3rd gravida was referred from surgical emergency with acute abdomen at term pregnancy. Her previous two pregnancies had ended in abortion. Evacuation was done after 2nd abortion 2 years ago. She had no antenatal examination done in this pregnancy.

She looked ill, with marked pallor, pulse 120/mt and BP 90/60 mm. Abdomen was distended and tender on palpation. Foetal position could not be ascertained. Foetal heart sound was not heard. On vaginal examination the cervix admitted one finger and there was slight bleeding, foetal parts felt high up.

Diagnosis of I.U.D. with accidental haemorrhage was made.

Attempt to induce labour with syntocinon drips failed which prompted us to do a laparotomy with the possibility of abdominal pregnancy in mind. On opening of the abdomen, the foetus was seen in the intact amniotic sac which was attached to the fundus of the uterus at small rent. The foetal sac was cut open to remove the foetus weighing 2.4 kg and the placenta was attached partially to the uterus and partially to the omentum which was separated easily. Uterine rent repaired. Both sides ovaries and tubes were healthy and were left behind. Patient made an uneventful recovery and was discharged on 17th post-operative day.

Discussion

Two cases of tubal rupture and two cases of early uterine rupture ending in secondary abdominal pregnancy are described.

With increased incidence of MTP and the intrauterine manipulations one wonders as to why this condition is not more commonly encountered. Diagnosis

still presents problem but a careful history with possibility of such a condition in mind is helpful.

The foetus sometimes can be saved with regular careful check-ups in antenatal period.

PREGNANCY AFTER MALIGNANT OVARIAN TUMOUR

(A Case Report)

By

DALIP KAUR

SUMMARY

Successful pregnancy and delivery by L.S.C.S. is reported in a case of operated right ovarian papillary cystadenocarcinoma followed by chemotherapy.

CASE REPORT

Mrs. P.S. aged 26 years, para 0 + 0 was admitted in the obstetrical ward of Rajendra Medical College Hospital, Ranchi on 9.10.1987 for safe confinement with full term pregnancy. Past history revealed that a laparotomy was done on her on 9-4-1986 for a lump in abdomen of 6-7 months duration with occasional pain, Bilateral mucinous ovarian cysts were detected. Right ovary had multioculated cyst measuring 10 x 8 cms with a small fungating area, which was removed. Right sided salpingectomy was done. Left ovary had small cyst containing mucinous material measuring 1 x 2 cms with intact capsule Cystectomy was done. Uterus was normal. Patient had no ascites. Histopathological examination of right ovary revealed papillary cyst adenocarcinoma. Left ovary showed no evidence of malignancy. She was put on chemotherapy containing cyclophosphamide (500 mg) I.V. and 5 F.U. (500 mg) I.V. weekly with a total eight doses.

She had a dramatic recovery and after a period of 8-9 months she conceived and was admitted at Rajendra Medical College Hospital, Ranchi on 9.10.1987 for safe confinement carrying a full term pregnancy. On 10.10.1987 she had watery discharge per vagina.

On per abdomen examination, head was not engaged, F.H.S. was regular. Per vaginum examination showed closed cervical os, liquor was draining, so L.S.C.S. was done and a normal live healthy female baby was delivered. Post-operative period was normal and after a fortnight she was discharged from the Hospital.

See Fig. on Art Paper III

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DYSGERMINOMA OF OVARY-COMPLICATING PREGNANCY

(A Case Report)

By

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CASE REPORT

Mrs. T.S., 24 years old H.F. was admitted on 28.4.86 with the complaints of pain and gradually increasing swelling over lower abdomen for last 4 months. She had amenorrhoea for 3 months. The pain was dull aching in nature and was persistently felt. The swelling was felt initially over the region of hypogastrium and gradually it had occupied the umbilical and left hypochondric region.

M.H: Her previous cycles were regular, L.M.P. was 28.1.86 O.H. P_2 + 0 L.C.B.—3 years.

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Examination

The patient was thinly built, weighed 35.0 kg and mildly anaemic. Abdominal examination revealed a mass arising out of pelvis occupying umbilical and Lt. Hypochondric region. It was approximately 30 cm x 25 cm in size with restricted mobility, irregular surface and varigated consistency lower pole of the mass could not be reached. There was no evidence of ascites.

Vaginal examination: Bluish discolouration of vagina and cervix, uterus was 12 weeks size, soft. Irregular mass could be felt through both the fornices. Nodules were felt in the pouch of Douglas.

Provisional diagnosis of malignant ovarian tumour in pregnancy was made and decision for laparotomy was taken.

Operative findings

Laparotomy was done on 5.5.86. Uterus was 12 weeks size. An irregular mass of varigated consistency arising from the left ovary, 25 cm x 20 cm in size was obtained. Another similar mass was found on the right ovary, 8 cm x 6 cm in size. The left fallopian tube was found adherent to the surface of the left ovary where as the right one was found healthy. The omentum was adherent to the left ovary and also to the posterior surface of the uterus. Few nodular deposits were found on the posterior surface of the uterus and also in the omentum. There was no free fluid in the peritoneal cavity. The appendix was found to be enlarged and adherent to the Rt. ovarian mass. The liver surface was found free of any deposit. Periaortic lymphnodes were not found enlarged. Total hysterectomy, with gestation sac in situ, with bilateral ovariotomy and salpingectomy were done. Partial omentectomy and appendectomy were also done. The specimens were sent for histopathological examination.

Pathological examination

A. *Gross appearance*:

(i) Uterus cut opened, showed the gestation sac with a well developed foetus and placenta.

(ii) Bilateral ovarian tumours, 25 cm x 20 cm on the Lt. and 8 cm x 6 cm on the Rt.

B. *Microscopical examination*: Dysgerminoma of both the ovaries. Metastatic infiltrations were found to the omentum and the appendix.

On subsequent follow up, the patient was given telecaesium irradiation in 22 fractions from 12.6.86 to 18.7.87. She is under regular follow up and keeping good health.

POLYHYDRAMNIOS ASSOCIATED WITH THENATOPHORIC DWARF

(A Case Report)

By

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Introduction

Many fetal abnormalities are usually associated with polyhydroamnios and there have been sporadic reports of an association between fetal dwarfism and polyhydroamnios. Thenatophoric Dwarfism has become the prototype of lethal neonatal dwarfism since its delineation. It may be readily recognised by its radiological features. It has been diagnosed in utero by Campbell (1971). There have been few reports from the west, about ultrasonic diagnosis in utero. In view of the paucity of reports, we are prompted to report a case. Only 5 cases of polyhydramnios with thenatophoric dwarfism have been reported so far.

CASE REPORT

A 32 years old female was admitted with 32 weeks pregnancy. She had previous history of a uterine fibroid which was not operated upon. The

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