LYMPHANGIOMA OF OVARY

(A Case Report)

By

R. L. Solanki, H. L. Arora,
V. K. Anand and S. K. Gaur

Introduction

Lymphangiomata of the ovary are rare and are regarded as malformations, that arise from sequestration of lymphatic tissue that fails to communicate normally with lymphatic system and have the capacity to proliferate and accumulate vast amounts of fluid.

CASE REPORTS

B.K., aged 40 years was admitted with intra-abdominal mass on left side of 8 x 8 cms size of 3 years duration. The menstrual history was regular. She was multipara. Abdominal hysterectomy was done with removal of right sided ovarian mass. The specimen of uterus measured 8 x 4 x 4 cms in size. The left ovary measured 4 x 2 x 1 cms in size. The right ovarian mass measured 10 x 8 x 3 cms. The external surface was smooth. The cut surface showed solid and partly cystic mass with honey comb appearance with grey white colour. The cystic spaces contained gelatinous material and wall of the spaces was smooth.

Histopathologically it showed numerous lymphatic channels of varying size and shape lined by flattened endothelial cells with variable amount of smooth muscle in their walls. The connective tissue stroma was present in between lymphatic speces with lymphaid infiltration in nodular form at places. The lymphatic spaces were filled up with structureless homogenous fluid and a few lymphocytes. It was differentiated from adenomatoid tumour by variable sized spaces and negative staining reaction for acid mucopolysaccharides.

From: Department of the Pathology, S.P. Medical College, Bikaner.

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AN INTERESTING CASE OF INTRAUTERINE DEATH OF TWIN

(A Case Report)

By

Gayatri Kar

CASE REPORT

Mrs. M. C., a 24 year old Primigravida came to Gynaecology outpatient department of M.K.C.G. Medical College Hospital for antenatal check up with 16 weeks pregnancy, 6 months after marriage. She was complaining of discomfort and pain in abdomen. Her previous menstrual history was normal with no history of any medication. On examination her general condition was good. She was normotensive with slight dependant oedema.

Height of uterus was 22 weeks' size with slight excess of liquor. History of multiple pregnancy on maternal side was present. So ultrasonography was advised and showed two gestational sacs with normal foetuses. As uterus was irritable, rest and uterine sedatives were given. Investigations like Rh. Typing, VDRL test, Haemogram, stool and Urine examinations were normal.

Gradually she got relieved and was having regular antenatal check up, but on 17-9-88 she came to labour room with history of cessation of foetal movement for 15 days and watery discharge for 10 days. By then the duration of pregnancy was 29 weeks but height of uterus only 26 weeks. Foetal heart sounds were not audible. A per vaginal examination revealed

From: M.K.C.G. Medical College, Berhampur, Orissa.

cervix to be 60% effaced and os 3 cm. dilated. A large bag of membranes was protruding through os. A syntocinon drip was started and she delivered two stillborn preterm macerated male foetuses at 5 minutes interval one by vertex and second by breech. The umbilical cords of both foetuses were entwined at 3 places with knots like a chain. One knot was tight enough to have obliterated circulation. A single placenta was delivered 15 minutes later. The amniotic sacs were necrotic so could not be traced.

This case is reported for its rarity and the fact that two gestational sacs were originally present in sonography but at some stage the the amniotic sacs started intercommunicating resulting in the interwoving of the cords to have resulted in obliteration of the circulation in cords and resulting in intra uterine death of both the foetuses.

EISENMENGER'S SYNDROME WITH PREGNANCY

(A Case Report)

By

M. D. MONDAL, AFTABUDDIN,
G. KINRA AND V. L. BHARGAVA

CASE SEPORT

A 20 years primigravida (V.S.) at 14 weeks of gestation attended the high risk pregnancy clinic at A.I.I.M.S. Hospital, New Delhi, on 15th October, 1984. She was a known case of Eisenmanger's syndrome (Ventricular Septal defect, patent ductus arteriosus with pulmonary hypertension), diagnosed from radiology clinic three years prior to her conception. She was on Digoxin and Dytide since diagnosis and was advised not to get pregnant due to the risk of high maternal and fetal mortality. She reported to hospital at 25 weeks gestation with complaints of cough with mucopurulent expectoration, low grade pyrexia and increasing palpitation of one week duration, and was hospitalised. She was dyspnoeic with a respiration rate of 28/m, had central cyanosis and marked clubbing, Pulse rate was 112/m, collapsing with no difference in peripheral pulses, B.P. was 140/70 mm.Hg. Apex best was at Left 4th. Intercostal space 1 cm. lateral to midclavicular line. S1(N), S2 accentuated with close split, early systolic (grade II/VI) and early diastolic murmur at left 2nd, intercostal space close to sternum. Fundal height was 24 weeks, with good F.H.S. Hb level increased from 14.8 gm% at 14 weeks to 16.0 gm% at 31 weeks of gestation. Symetrical IUGR was diagnosed on serial Uitrasound. Twenty four hours' supervision of specialist obstetrician and cardiologist throughout her stay in the hospital helped monitor her pregnancy and manage repeated worsening of her cardiac status. At 36 weeks + 2 days, she ruptured her membranes; IV syntocinon (2 units at 8 drops/minute) had to be started, 80 mg. I.V. Lasix being given prior. Intensive monitoring was done along with two hourly check-ups by cardiologist. A 1.3 kg. male baby with glandular hypospedias was delivered by low midcavity forceps, Apgar score was 4/10 at 1 min and 9/10 at 5 min. She was discharged on 19th day of puerperium with strong advice for sterilization. Both mother and baby are doing well on 3 years' follow-up.

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CHRONIC AUTOIMMUNE THROMBOCYTOPENIC PURPURA WITH PREGNANCY

(A Case Report)

By

G. M. NIYOGI, V. D. PATKAR,
R. K. SHAH AND G. N. ALLAHBADIA

Introduction

Autoimmune Thrombocytopenia refers to thrombocytopenia in the absence of toxic exposure or of a disease associated with low platelet levels. Thrombocytopenia may result from a number of disorders. The great majority of cases are of the secondary type and the diagnosis of autoimmune thrombocytopenic purpura should be made only when the causes of secondary thrombocytopenia are excluded. Here we are presenting a case report of autoimmune thrombocytopenic purpura beause of its rarity and clinical interest.

CASE REPORT

Mrs. Y.K., a 28 year old muslim patient came to us with chief complaint of six months amenorrhoea and bleeding from gums for 1 month. She was a second gravida with one previous medical termination of pregnancy done at 6 weeks gestation, 4 years ago. She was asymptomatic till the 5th month of pregnancy when she started bleeding from the gums. A hemogram revealed thrombocytopenia with a count of 10,000/cumm without any clumping. A workup of platelet studies revealed antibodies and confirmed the diagnosis of autoimmune thrombocytopenic purpura. Her bleeding time (IVY's method) was more than 15 minutes. The clot retraction was incomplete. Her serum iron was low 29 mg% (normal 65-140 mg%) and transferrin saturation was 8.8% (normal more than 20%). She had an evidence of an associated iron deficiency anaemia in the form of low haemoglobin, microcytosis, hypochromasia, low MCV and MCH. Besides bleeding from gums there was no history of bleeding from any other site. There was no family history of any bleeding disorder. She gave history of menorrhagia for the last 4 years. She had undergone a MTP 4 years back of 2 months gestation after which she bled for 1 month. She was given 30 injections of Irondextran and was advised blood transfusion. She had an appendicectomy 5 years back and after suture removal on the 7th day there was bleeding from the incision site for 1 month. She had not suffered from any significant major illness in the past. Patient was given Tab. Prednisolone 60 mg daily and Tab. Ranitidine 150 mg twice daily and haematenics. She was admitted under our antenatal care at 38 weeks POG. A per abdomen examination revealed a full term fetus in longitudinal lye with cephalic presentation with regular FHS of 144/min. There was no hepatosplenomegaly. She was delivered by a LSCS at term on 16-6-88. Prior to LSCS patient was given 1 fresh blood and 2 platelet concentrates. Her platelet count before giving the transfusion was 30,000/cumm. Her clotting time was normal (6 minutes). The LSCS was done by a midline subumbilical incision. Operation was uneventful but for a slight excess of bleeding during surgery. She was delivered of a 3.2 kg male child which was large for gestational age. She was given one unit fresh blood the next day. The child revealed transient thrombocytopenia. Both mother and child were discharged on the 12th postoperative day and the subsequent follow up has been uneventful. At present the patient is totally in a state of remission.

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CHRONIC AUTOIMMUNE THROMBOCYTOPENIC PURPURA WITH PREGNANCY

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CASE REPORT OF AUTOIMMUNE HAEMOLYTIC ANEMIA IN PREGNANCY

By

SUSMITA G. DAVE, V. H. MAJMUDAR, NILA MOHILE AND NITA THAKKAR

Introduction

Anaemia in pregnancy is very common in our country, but autoimmune hemolysis causing anaemia is rare. In this condition hemolysis is antibody mediated. There are two types of antibodies.

1. *Warm Type*: These antibodies coat the cells and give a positive direct antiglobulin test at 37°C and are of IgG type. The hemolytic anaemia runs a chronic course but acute hemolytic episodes with hemoglobinuria can occur.

2. *Cold Type*: They act mainly at or below room temperature, are of IgM type and hemolysis is complement mediated.

We present here a case report of sudden anaemia positive for direct antiglobulin test in 8 months pregnant patient.

CASE REPORT

24 years old gravida IV, para I, amenorrhoea 8 months was admitted on 25-9-87 with c/o giddiness, weakness, vomiting, frequency of stool, H/o fever—15 days. O/E Patient fully conscious, Pallor ++, Oedema present, Pulse—110/minute, BP—120/80 mm Hg, C.V. System—Haemic murmur, R. System—clinically NAD, P.A.—Uterus—26 weeks size, V_1, FSH present and regular.

Investigation

Hb—4.2 gm/dl, WBC 11,200/cmm Poly—60%, Lym—30%, 4%—band cell and metamyelocytes 6%—late normoblast, ESR—153 mm/1st hr, Reticulocyte count—30%, Peripheral smear showed extensive spherocytosis and polychromasia. Direct coomb's test positive at 37°C and negative at 20°C. Indirect coomb's test positive in 1:512 dilution. RA test, LE cell were negative, Serum bilirubin, blood urea, and random blood sugar were normal.

Management

Patient was treated with intravenous dexona, Vitamin B capsules. Within ten days haemoglobin increased to 6.7 gm/dl. Steroids were reduced gradually and then discontinued. Patient was discharged with instruction to attend OPD regularly. However she delivered at home, and had PPH on 3rd day and she was readmitted on 4-12-87 in a semiconscious state with pulse 140/min, BP—90/60 and bilateral basal creps. Her haemoglobin was 2.1 gm/dl with direct and indirect coomb's test positive and increased total count. She was treated with intravenous lycortin, Dexona, packed red cells, Mox and continuous oxygen inhalation. Patient had to be maintained on Dopamin drip for four days. She ultimately came out of hemolytic crisis.

Discussion

Autoantibodies of warm type are usually secondary to disease like lymhoma, systemic lupus erythematosus, nonlymphoreticular tumour, viral infection or can be idiopathic without any obvious cause.

Our patient had history of fever for fifteen days and she had gastroenteritis. So it can be secondary to viral infection.

Patient was treated with steroids which is initial therapy of choice in patients with autoimmune hemolytic anaemia of warm antibody type. Patient was treated till the antibody titre reached 1:4 dilution. When patient was discharged her haemoglobin was 8.5 gm/dl. Steroid were discontinued by gradual

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withdrawal. No maintainance therapy was given as patient was pregnant. Regular follow up was adviced still patient did not turn up for delivery.

Again when patient turned up in postpartum phase, she was in shock with 2 gm/dl Heamoglobin. Antibody titre was 1:4096 and direct antiglobulin reaction was strongly positive. Patient was transfused with packed red cells. Patient improved and on discharge had Hb 9.7 g/dl. Blood transfusion can be used in patient with severe and fulminant disease as an emergency measure. It's usefulness depends on availability of speific therapy, since the transfused blood is destroyed as rapidly as the blood of patient. Again there is a risk of transfusion reaction from warm reactive antibodies. The red cell destruction by warm antibodies follow an exponential decay curve. So the number of cells destroyed per unit time is a percentage of number of cells present in circulation. So it is advisable to use only as much blood is necessary to stabilise the patient. In addition, circulatory overload was also a problem as our patient was severely anaemic.

High doses of intravenous steroids is the treatment of choice irrespective of pregnancy state of patient.

BILATERAL MICROSCOPIC GONADOBLASTOMA IN A CASE OF STREAK GONADS

(A Case Report)

By

MUKESH AGRAWAL, JATIN PANKAJ SHAH,
AND
SHASHANK V. PARULEKAR

CASE REPORT

Miss P.K., a 17 year old girl presented at our out-patient department with the complaint of primary amenorrhoea. There was no contributory family, medical or past history. She weighed 45 kg and her height was 5'2". She had scanty pubic and axillary hair (Tanner grades P2 and A2 respectively), breast development was poor (Tanner B1) and there was no galactorrhoea. She had no dysmorphic features, no evidence of masculinization or any Turner stigmata. Local examination revealed an intact hymen with a small central perforation through which a sound could be passed into the vagina for a length of 7½ cms. On P.R. examination the uterus and gonads were not palpable. Ultrasonography revealed an absent uterus with normal renal findings. Her Barr Body was 7% and Karyotype 46XX. Laparoscopy was performed which showed a midline peritoneal fold with absent uterus, normal fallopian tubes on both lateral pelvic walls and streak gonads. The left gonad measured 2.5 x 1 x 1 cms and the right gonad 2 x 0.5 x 0.5 cms respectively. A biopsy from the left gonad revealed a gonadoblastoma with karyotype 46XX ruling out mosaicism. Subsequently bilateral gonadectomy was done at exploratory laparotomy and the histopathological report was Bilateral Gonadoblastoma.

It is rare to have a gonadoblastoma with a 46XX karyotype and it is even rarer for the same to occur in a microscopic form in both gonads. It is reasonable to conclude therefore that a laparoscopy and biopsy is mandatory in all cases of streak gonads.

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RECURRENT MOLAR DEGENERATION

(A Case Presentation)

By

VIDYA NAYAK,
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SUMMARY

This is a case presentation of an unusual presentation of repeated Molar Pregnancies and its subsequent management.

CASE REPORT

Mrs. Leela Sheelan aged 26 years was hospitalised on 16.10.88 with history of profuse bleeding p/v, following evacuation of a molar pregnancy by a private sector practitioner. **Married:** Since 6 years. Regular menstrual cycles.

Obstetric history

Ist Pregnancy—Spontaneous abortion at 5th month, passed products and evacuation was done in January 1982. **II Pregnancy:** Spontaneous abortion at 4th month, evacuation was done in November 1983. **III Pregnancy:** Molar pregnancy passed vesicles at 5th month and evacuation was done in December 1984. **IV Pregnancy:** Molar pregnancy at 5th month and evacuation was done by a private practitioner in January 1986. **V Pregnancy:** Molar pregnancy at 7th month and evacuation done by a private practitioner in August 1986. **Generation Examination:** Patient was anaemic, pulse 100/minute B.P. 120/80 mm Hg CVS and R. System NAD.

P/A: Liver and Spleen were not palpable. P/V: Cervix pointing forwards. Os closed. Uterus retroverted and bulky. Fornices were free. There was profuse bleeding p/v. X-ray chest was clear.

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Management

Emergency dilatation and curettage was done. Plenty of blood clots and products with a few vesicles were removed. One pint of B positive blood was transfused. Patient had a course of antibiotics.

Urine gravindex

1 in 100 positive and 1 in 200 negative. Ultrasound on 21.10.86 showed multiple echogenic areas in the uterine cavity. No theca lutein cysts evidenced in ovary.

Seven days later on 23.10.86 a check curettage was done. And a few organised placental bits were removed and sent for histopathological examination.

Histopathological Report was given as necrotic tissue with occasional endometrial stroma.

Two days later, patient started bleeding p/v, and a second bottle and B+ve blood was transfused. Serial ultrasound was done on 28.10.88 and was reported as—uterus 8 cm with multiple cystic areas in the anterior and posterior myometrium. Adnexa were normal.

Urine Gravidex: 1 in 100 positive and 1 in 200 negative.

Management

Patient was started on Methotrexate with serial monitoring of haemogram. But in spite of chemotherapy, patient continued to bleed per vaginum. Hence a 3rd curettage was done. On curetting, the uterine cavity was found to be irregular with profuse bleeding at the time of curettage, and uterine perforation was suspected.

On 18.11.86: Ultrasound was done and following noted: Uterus was normal sized, with a mass close to the uterus near the fundus posteriorly. Probably an inflammatory mass or perforation of uterus was suspected. The ovaries could not be visualised.

Urine Gravindex: was repeated on 19.11.86 and was found to be 1 in 100 positive and 1 in 200 negative.

Management

In spite of three repeated curettings and prophylactic chemotherapy, patient continued to bleed. Hence hysterectomy was resorted to.

On 26.11.86 patient was taken up for surgery

and under general anaesthesia, abdomen was opened by a RPM incision. Uterus was normal in size, with a small fundal perforation close to right cornual end and sealed by omentum. The right ovary contained a corpus luteum cyst about 3″ in diameter. The left ovary was about 4″ in diameter. Abdominal hysterectomy with bilateral salpingo-oophorectomy was done in the usual way.

Histopathological Report: Multiple sections of uterus showed a necrotic nodules with deep down growths into myometrium with occasional syncitial trophoblast formation. In view of urine gravindex and histological findings a diagnosis of choriocarcinoma was made.

Post-operative period was uneventful. **Follow-up:** Three months later, patient came for review. Urine gravindex was negative and X-ray chest was clear.

A CASE OF LEIOMYOSARCOMA OF UTERUS DIAGNOSED AFTER HYSTERECTOMY

(A Case Report)

By

PIKU CHAUDHURI,
PREMA LALL AND SHANKAR KUMAR DAS

CASE REPORT

Case History

Mrs. S.H., 48 years, Hindu female, Reg. No. 1159/CMC/84, P3 + 4, L.C.B.—21 years back, B.P. 110/90, wt—43 kgs, reported with a complain of excessive periods for 3-4 years, occurring every 26-28 days and lasting for 8-10 days, and an almost continuous bleeding for last 2-3 months. Abdominal examination revealed enlarged firm mass about 14 weeks size arising from the pelvis mostly in the mid line, in bimanual examination uterus was felt firm and enlarged (about 14 weeks size) with fibroid. Both right and left ovaries were palpable and normal in size. Dilatation and curettage operation was done 6 months ago. The histopathological report of the curettings revealed no abnormality.

Treatment

Exploratory laparotomy revealed the same findings as abdominal and vaginal examinations and was followed by Abdominal Hysterectomy with bilateral salpingo-oopherectomy done on 19-3-85 at Kimber Nursing Home, Calcutta. The Hysterectomy specimen was sent for histopathological examination. The patient received 600 ml. of blood, group B' Rh D-ve. Post operative period was uneventful. She was referred to cancer follow-up clinic at Thakur Pukur Cancer Hospital, Calcutta where neither radiotherapy not chemotherapy was advised.

Follow-up:

The last post operative check-up on 31-8-88 showed no sign of metastasis.

Histology:

Histology report of the hysterectomy specimen revealed the following:—

Macroscopic Picture: The body of the uterus showed a large tumour about 10 cms. in the longest diameter. The tumour showed areas of softening and degeneration.

Microscopic Picture: Multiple sections were examined from different areas of the tumour. Some of the sections showed a cellular leiomyoma. However, there were areas where the tumour cells showed marked pleomorphism. Many multinucleated giant cell with large hyperchromatic bizarre nuclei were also present. In these areas the leiomyoma had undergone a sarcomatous change.

Sections from the cervix and ovaries did not show any significant abnormality.

Diagnosis: Leiomyosarcoma of uterus.

See figs. on Art Paper II

From: Dept. of Obstetrics & Gynaecology, Calcutta National Medical College & Hospital.
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AN INTERESTING CASE OF TWISTED DERMOID CYST OF OVARY DURING PREGNANCY

(A Case Report)

By

PIKU CHAUDHURI,
GARGI BANERJEE AND SHANKAR KUMAR DAS

CASE REPORT

Case History:

Mrs. H. B. 21 years, M/F, Para 1 + 0, Registration No 1125/85 was transferred to us from surgical ward of Chittaranjan Hospital, Calcutta, where she was admitted on 8-3-85 with a lump in the lower abdomen. On examination a 28 weeks pregnancy was detected along with a cystic lump in the lumbar region. L.M.P. was uncertain—19-6-84 and the E.D.D.—26-3-85. The cystic lump of the size of an orange, palpable in the left lumbar region was fully mobile from side to side with smooth surface and doughy consistency. Patient had a previous delivery of a still born baby on 2-5-83 by elective caesarean section in a district hospital. The cause of death of the foetus was unknown. She was under regular antenatal check up during this pregnancy. An X-ray of the abdomen was done towards the term to detect foetal maturity. X-ray revealed a single mature foetus with multiple teeth characteristic of an associated dermoid cyst of the ovary. On 15-3-85 while waiting for laparotomy in view of caesarean section she developed an acute pain in the abdomen due to the torsion of the pedicle of the cyst. An emergency laparotomy was performed which revealed a cyst of the ovary with twisted pedicle, smooth surface and doughy consistency. Lower uterine caesarean section followed by left ovariotomy was done. A living female baby weighing 2 kgs 200 gms was delivered at 2-20 p.m. The cyst on cut section showed teeth hair and sebacious material characteristic of dermoid cyst. Cystic ovarian tissues were sent for histopathological examination. Post operative period was uneventful and patient was discharged in satisfactory condition.

Histopathological examination of the ovarian cyst tissues revealed dermoid cyst.

See Figs. on Art Paper III

From: Dept. of Obstetrics & Gynaecology, Calcutta National Medcal College & Hospital.
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LYMPHOGRANULOMA VENEREUM

(A Case Report)

By

SUDHA GOYAL, NEERJA GOEL,
NEERA AGARWAL AND RAMA CHAWDHARY

Introduction

Lymphogranuloma Venereum caused by chlamydia strain L_1, L_2, L_3, D_1 is a sexually transmitted disease, rarely encountered in Obst./Gynec practice and occurrence of LGV of inguinal type is still more rare in female patients. This case is presented because of its rare occurrence.

CASE REPORT

Mrs. A, 22 year old, nulliparous, resident of Shahdara belonging to low socio-economic class was admitted to Gynaecological Ward of G.T.B. Hospital Shahdara on 6-10-88. She presented to us with the complaints of right vulval and inguinal swelling and pain in the right inguinal region for past 4 days. There was no history of any noticeable ulcer in the vulval region or any anorectal symptoms. Past, family and

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marital history revealed nothing significant She attained menstruation at the age of 14 years since then her cycles were regular with normal flow.

She has been married for two years but staying with the husband occassionally.

On Examination

General physical and systemic examination did not show any abnormality.

Local Examination

Inguinal lymph-nodes on right side were enlarged shotty, inflamed and tender which developed into a fluctuating mass over a period of 1 week. Labia majora and minora of same side were also swollen (4 x 5") (Fig. 1) Medial side of labia and urethra did not show any active or healed ulcer. Per vaginum examination was normal. Husband's local examination ruled out any lesions.

Investigations

Haemoglobin—10 gm%, TLC 4900/Cmm. DLC-Poly 55%, Lympho-41%, Eosino—2% Mono 2%, ESR 35 mm/hr, Blood Sugar (R) 85 mg%, VDRL non reactive (both partners) Urine-albumin & sugar—Nil culture from bubo —significant growth of staph aureus, no gonococcus grown.

Immunoperoxidase test by Ipazyme Kit (Savyon diagnostic) for detection of specific chlamydeal antibodies (Ig G antibodies showed a titre of 1:64.

Treatment

In view of clinical diagnosis of LGV, she was treated with heavy doses of tetracycline 500 mg. 6 hourly for 3 weeks alongwith vitamin B-complex. Local application of 1% GV paint and anti-inflammatory drugs were part of therapy.

Course

Patient responded well within 10 days of therapy. Inguinal lymphadenopathy and vulval edema regressed completely (Fig. 2). Patient was discharged after a total stay of 4 weeks in the hospital and was told to have regular follow-up. After a monlh of therapy on her first visit, she was found to be clinically free of disease.

See Fig. on Art Paper I

MISSED GRAAFENBERG RING

(A Case Report)

By

(MRS.) M. B. SHAH

CASE REPORT

A Hindu patient aged 48 yrs. was admitted with missed grafenburg Ring on 19-11-88. Patient menstruated regularly and her L.M.P. was 28-10-88, she was 5th para with no H/O of abortion. In Jan. '67 she had undergone Graafenberg ring insertion. After one year of insertion she had undergone—A.P Repair & vaginal tubal ligation. At that time Graafenberg ring was forgotten. Since Jan '88 she developed frequency and burning micturition. In May '88 D & C was performed to remove Graafenberg ring but could not be removed. On 13-11-88 patient had severe abdominal pain with retention of urine and she passed stone on 14-11-88. At that time the treating-surgeon found broken Graafenberg ring on lower abdominal X-ray. He X-rayed the stone, which showed Graafenberg ring as nidus.

On admission g.c. was good, all systems clinically normal. On p/v Exam, it was anteverted mobile firm normal size. Cervix showed changes of Ch. Cervicitis.

All routine investigations were normal. X-Ray Chest showed old Koch's Lesion, U.S.G. showed empty uterus. In Cystoscopy part of ring was visualized at the junction of ant. wall and fundus of Bladder.

On 29-11-88 laparotomy was performed. On apex of the bladder, there was thickening of the bladder wall and ring was palpated. Ring was incorporated in the wall and removed in

From: New Civil Hospital, Ahmedabad.
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fragments as shown in photograph. The thick portion of the bladder 1" x 2" was excised and bladder was repaired in three layers.

Total abdominal hysterectomy was performed. There was a small while patch of pinhead size an fundus of uterus may be perforation site. Post operative period was uneventful and she was discharged on 7-12-88.

RHABDOMYOSARCOMA OF UTERUS IN 12 YEARS GIRL

(A Case Report)

By

R. B. SHARMA,
G. D. SRIVASTAVA AND V. MATHUR

Introduction

Uterine sarcoma is a rare entity and represents not more than 1% of malignant growth of female genital tract (Jeffcoate's Vth edition). It is more rare before 30 years (Shaws IXth edition). We have seen one case of Rhabdomyosarcoma of uterus in a young girl aged 12 years hence reporting due to its rarity.

CASE REPORT

Miss Allarakhi (A) 12 year old unmarried girl was admitted in this department as a case of lump with complaint of progressively increasing lump in lower abdomen and loss of weight and appetite for one month and pain and fever off and on for last 15 days. Menarche had not yet set in and there was no history of cyclic lower abdominal pain every month. On general examination she was pale and underweight. On abdominal examination a large suprapubic lump 12 cm x 8 cm with ill defined margins, smooth surface and doughy consistency was found. It was tender and temperature of the skin over the lump was raised. Per rectum examination confirmed it to be a uterine lump encroaching on the upper third of the vagina. The cervix could not be felt separately and rectal mucosa was free. Local examination excluded imperforate hymen. On examination under annasthesia, the cervix was found to be completely absent and a bluish mass was bulging into the upper vagina. Needle aspiration revealed altered blood, immediate laparotomy was planned to make an artificial cervix after diagnosing the case to be a haematometra. Her Hb was 7 gm%, Blood group AB-Ve. All other investigations were normal.

On laparotomy: A large highly vascular uterine mass adherent to omentum and adjacent loops of intestine was found which on giving a stab incision revealed friable tissue. Tissue was sent for histopathology and was found to be Rhabdomyosarcoma of uterus of high grade malignancy (see histological plate). Later ultrasound guided fine needle aspiration biopsy confirmed the above diagnosis hence she was subjected for radiotherapy.

See Fig. on Art Paper IV

CHRONIC INVERSION OF UTERUS

(A Case Report)

By

MOHAN A. GADAM, RAJKUMAR H. SHAH,
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AND
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Introduction

In modern Obstetrics, with hospital deliveries and proper management of the

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third stage of labour, it is rare to see a case of acute inversion of the uterus. Much more rare is chronic inversion of uterus following an improper management of the third stage. Presented below is one such rare case.

CASE REPORT

K.A. a 20 year old primiparous patient was admitted at the L.T.M.G. Hospital with complaints of a mass coming out per vaginum since her delivery 9 months back and irregular bleeding per vaginum since 3 months. She gave history of a difficult preterm delivery at 8 months gestation resulting in a still born baby. She had been unconscious after delivery and was resuscitated and managed conservatively by the attending doctors at the rural hospital. She was discharged from the rural hospital after 5 days.

Six months after her delivery, she started having bleeding per vaginum off and on and felt a mass coming out per vaginum for which she consulted a private practitioner who examined her and referred her to our hospital. On examination, she was averagely built and poorly nourished and her vital parameters were normal. Systemic and abdominal examinations were also normal. Local examination showed that there was a mass projecting from the vagina which was crimson red in colour. On per speculum examination the cervix appeared to be dilated and the mass, which bled on touch, appeared to be coming out from the cervix. A uterine sound was introduced between the cervix and the mass and was moved all around it, but could not be negotiated beyond 2.5 cms. of the cervix. Per vaginum examination was then performed and the cervix was felt to be dilated with the mass protruding through it. The uterus could not be felt on bimanual examination and a dimple was felt just above the cervix. A clinical diagnosis of chronic inversion of uterus was made.

Preoperative routine investigations were done and an examination under anaesthesia, laparoscopy and reduction of inversion under general anaesthesia was planned. On laparoscopy, the cornual structures were partially drawn into the uterine dimple, confirming the clinical diagnosis. Attempts were made to reduce the inversion bimanually under anaesthesia but without success. Therefore an abdominal operation (Haultains) was contemplated to reduce the inversion.

The abdomen was painted and draped. A suprapubic transverse incision was made and the abdomen opened in layers. The uterus was brought into the incision and attempts were made to reduce the inversion with the help of Allis' forceps, unsuccessfully. A vertical incision was then made on the posterior rim of the cervix and the uterine fundus was approached and reduced by introducing a finger through the incision. The incision on the uterus was then sutured in two layers by using chromic catgut. An omental graft was then used to cover the incision posteriorly on the uterus. Hemostasis was confirmed and the abdomen closed in layers. The postoperative period was uneventful and she was discharged from our hospital.

The patient was followed up till 6 weeks after the operation. She had normal periods during the course of follow up, and on examination the uterus appeared to be normal.

CHORIONIC—CARCINOMA WITH VAGINAL METASTASIS

(A Case Report)

By

V. D. PATKAR, G. M. NIYOGI,
G. N. ALLAHBADIA AND S. NIKUMBH

CASE REPORT

Mrs. K. K. a 25 year old patient, second gravida, married for 1 year, was brought to our emergency on 6-8-88 in a state of hypovoleamic shock. She was transferred from a peripheral hospital with history of profuse bleeding per vaginum for one day for which she was transfused with 2 units of blood before the transfer.

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The patient gave a history of two abortions one of which was induced at 2 months' gestation prior to her marriage at a primary health centre. The second was a spontaneous abortion of 4 months gestation at her native place following which she bled per vaginum off and on for 2 months. A curettage was done at the peripheral hospital for an incomplete abortion and the patient was transfused with 3 units of blood. Subsequently, one month following this, she had another bout of bleeding, following which she was transferred to our hospital.

On examination, the patient was in shock with pallor ++ Bimanual examination revealed an irregular, elongated firm, nontender mass arising from the pelvis, extending towards the right iliac fossa. The uterus could be palpated separately from the mass and was bulky, firm, nontender and deviated to the left. Per speculum examination revealed a rent in the right lateral vaginal wall about 2" away from the introitus going upwards, showing an organising haematoma at its core. There was a small rent in the left lateral vaginal wall.

A clinical diagnosis of broad ligament haematoma was made and the patient was treated conservatively for 2 days.

An examination under anaesthesia done 2 days later showed that the rent had increased in size. The anterior vaginal wall was totally eroded as shown in the picture. Also there was a fresh excrescence at the posterior fourchette. A frozen section and subsequent histology of the tissue taken from the rent and the excrescence at the posterior fourchette revealed a chorio carcinoma. Laparoscopy revealed bilateral theca lutein cysts and a bulky uterus with an irregular surface.

Other investigations done were Hb 6 gm% CBC—within normal range, serum HCG levels were more than 2,00,000 m IU/ml. X-ray chest: NAD; Brain and Liver scan showed no evidence of metastasis.

After correcting the anaemia with multiple blood transfusions the patient was put on one course of methotrexate with leucoviron. During her stay in the ward, patient used to have profuse bouts of bleeding intermittently and was treated with a total of eight units of blood and packing of the vagina for twenty four hours twice.

On 13-9-88 after completion of the first course of chemotherapy a repeat serum ß-H.C.G. estimation showed a level of 1,92,000 mIU./ml.

It was now decided to put the patient on multi agent regime. But before the second course could be started, the patient succumbed to a massive bout of bleeding and expired on 29-9-88.

Autopsy revealed a carcinomatous growth involving the uterus and the vaginal, Brain and liver were normal, lungs showed evidence of koch's infecion.

See Fig. on Art Paper IV

POST-CAESAREAN SECTION UTERO-ABDOMINAL FISTULA

(A Case Report)

By

K. K. SANDHOO AND DALJIT K. HANS

CASE REPORT

G.K. 25 years F Para 3 had caesarean section 2 mths back in some private nursing home and was referred to R.H. Patiala as a case of burst abdomen. Patient had previous 2 normal deliveries at home. This time she went into spontaneous labour at term. Local dai attended on her for 36 hrs. and referred her to a near by town where some private doctor kept her for 12 hrs. According to the patient during this time foetal movements ceased. She was again referred to another private nursing home in the same town where caesarean section was done and a congenitally malformed baby was extracted. On 4th post operative day patient developed high grade fever and foul smelling discharge per vaginum which subsided in 4-5 days. Stitches were removed on the 9th day and she was discharged on 13th day. She was advised dressing every alternate day. This

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continued for 1½ months but the wound did not heal so patient was sent to R.H. Patiala.

She was admitted in surgical ward. According to surgeons blackish necrosed tissue was covering the lower part of the wound which was excised and the patient was referred to gynae. OPD.

Utero-abdominal fistula was suspected as abdomen was open in the lower part of incision for about 4 cms. She was kept for EUA. On EUA sound passed through the cervix came out of the abdominal wound. Diagnosis was confirmed aand laparatomy planned On laparotomy abdomen was opened in the upper part along the healed wound and explored. A longitudinal rent was present in the anterior wall of uterus, edges of which were adherent to the edges of abdominal wound. At the base of the wound the whole of the posterior wall of uterine cavity was seen. Omentum, coils of intestines were adherent to the fundus of the uterus, posteriorly and on both sides to broad ligament. Tubes and ovaries were buried in the adhesions. All adhesions were separated and uterus was dissected out from the abdominal wall. Subtotal hysterectomy done as bladder was adherent to the cervix anteriorly. In post operative period the wound took longer to heal.

See Fig. on Art Paper IV

PAPILLARY ADENOCARCINOMA OF FALLOPIAN TUBE

(A Case Report)

By

SUMAN SARDESAI AND M. S. BHAVIKATTI

CASE REPORT

A 52 years old female Mrs. G. B. was admitted on 25th Aug. '88 w ith C/o brown coloured vaginal discharge since 1 month prior to admission. There was H/o lower abdominal pain, off and on. She was nulliparous patient and attained her menopause 15 years back. On examination general condition was good. Her vital data was within normal limits. Per Abdominal examination revealed no positive findings. No ascities. On her speculum examination atrophic cervix deviated to rt. side. No active P/V bleeding through os. Per Vaginal examination, Ut. RV NS, mobile. A mass was palpable in Lt. fornix separate from the uterus and cystic in consistancy. Rest of the fornices were free. Because of the age of the patient and presenting symptoms her provisional diagnosis of ovarian malignancy was made, and patient was investigated. Her Hb% was 11 gm%. Blood group was 'A' +ve. Ultrasonography report suggested bulky uterus with fluid in uterine cavity, Echofree mass in Lt. fornix. No S/o ascities. Patient was posted for diagnostic curettage for post-menopausal bleeding and P/V under G.A. Under G.A. previous P/V findings were confirmed On dilatation of Cx free flow of brownish watery discharge was seen. The fluid was collected and sent for cytological examination. Curettage was done but material was not obtained. Cytology report of uterine fluid suggested only mononuclear cells but no malignant cells.

After above investigations, patient was posted for Exploratory laparotomy. On laparotomy, uterus was normal size. On rt. side big haematosalphinx with flimsy adhesions to surrounding structures was seen. It could be easily separated from the surrounding structures, diameter 8 cm. x 5 cm. On rt. side a small haematosalpinx was seen. Total abdominal hysterectomy with bilateral salpingo-oophorectomy was done. Ovaries were seen in its normal position, which were atrophic. On Gross examination Lt. sided haematosalpinx was opened which was filled with brownish watery discharge and papillary growth was seen in the middle portion of the tube (Figs. 1 & 2). Rt. sided haematosalpinx was small and showed a papillary growth at one site. Uterus was cut opened which showed smooth cavity. HPR suggested Papillary adenocarcinoma of Lt. fallopian tube. Rt. tube and ovary showed normal histology. Uterus—myometrium and

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endometrium normal. Thus, the diagnosis of Carcinoma of fallopian tube was established. Post-operative period was uneventful.

See Fig. on Art Paper V

UTERUS DIDELPHYS WITH UNILATERAL IMPERFORATE HEMIVAGINA WITH HEMATOCOLPOS AND IPSILATERAL RENAL AGENESIS

(A Case Report)

By

J. I. FIDVI AND U. S. GUHE

Introduction

Complete duplication of uterus and cervix with an imperforate hemivagina is rare condition, which is invariably associated with renal agenesis on same side as is the vaginal obstruction.

CASE REPRT

A 17 year Hindu girl was referred by practicing gynaecologist for admission and management in hospital with the diagnosis of ovarian cyst. The patient was subjected to ultrasound examination by the referring doctor which indicated an ovarian cyst.

At the time of admission her main complaints were—

(i) Lump in abdomen 12 months which is increasing gradually.
(ii) Pain in Abdomen during menses 12 months.
(iii) Difficulty and retention of urine off and on: 6 months.

She was unmarried adolescent and had attained menarche at 13 years of age. Her menses were regular 1-2/30 days scanty flow. Last menstrual period was 22nd February 1988.

General examination did not reveal anything abnormal and secondary sex characters were well developed. Per abdomen, a mass was found to arise from pelvis about 16 weeks size, cystic, non tender, with restricted mobility in upward direction. Liver, spleen were not palpable.

Per speculum examination—Vagina apparently normal, bulging right vaginal wall upto introitus, no discoloration of the bulged vaginal wall and cervix could not be visualised. P^{V} Cervix lifted high up and pushed to the left, uterus exactly not made out.

Plain x-ray abdomen for Kidney & Urinary Bladder revealed absence of kidney shadow on Rt side. This was confirmed by I.V.U. It was thought that a non-functioning hydronephrotic kidney in pelvic region can be cause of suspected mass. In view of these findings surgeons were consulted to opine and exclude a hydronephrotic pelvic Kidney which in surgeons opinion also could not be excluded. A repeat ultrasound checkup for excluding a pelvic hydronephrotic kidney was inconclusive.

At last a decision was taken for exploratory laparotomy, where the diagnosis was very clear. There were two uteri with a fallopian tube and an ovary. The rt. uterus was sitting on the ballooned vagina, which was tapped, confirming the diagnosis of hematocolpos in the rt. imperforate vagina. (Fig. 1). Rt. kidney could not be located at all and hence it was absent.

Lithotomy position was adopted for drainage of hematocolpos. A cruciate incision was given on the bulging vaginal wall just above the introitus to drain the hematocolpos.

See Fig. on Art Paper IV

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MCKUSICK KAUFMAN SYNDROME

(A Case Report)

By

A. B. MUTHAL AND M. B. DESHMUKH

CASE REPORT

A 22 year patient of Primary amenorrhoea was admitted with history of faecal discharge per vaginum since birth. Due to faecal contamination at intercourse she was left by husband. On examination the patient was phenotypic female with grade V breast development. Cardio vascular examination revealed Aortic stenosis with regurgitation. Echocardiography confirmed the congenital bicuspid aortic valve. Respiratory system and abdomen were normal. Secondary sex characters were well developed and external genitalia were normal. Speculum examination revealed faecal matter in vagina and rectovaginal fistula of 2 cms diameter just below the blind vault of vagina which was 6 cms in length. There was no fibrosis around the fistula. Vaginal examination did not reveal the presence of cervix or uterus. On rectal examination. Rectovaginal fistula was confirmed and the gonads were felt at the lateral pelvic wall with the vesicorectal fold of peritoneum in the centre and neither uterus nor cervix were felt. Ultrasonography confirmed the findings. Karyotype of patient was 46 XX. Biochemical renal function tests were normal. Intravenous pyelogram revealed absence of pelvicalyceal system on left and normal renal function on right and normal bladder. Retrograde pyelography confirmed congenital absence of left kidney.

After due preparation of the patient, repair of rectovaginal fistula was done under general anaesthesia. The post operative period was uneventful. RVF healed well and patient was discharged on 10th Post operative day.

Mullerian duct anomalies are known to occur in association with variety of other problems. Mckusick Kaufman Syndrome is an autosonial recessive disorder. It includes Mullerian duct anomalies, congenital heart disease, anorectal anomalies, post-axial polydactylae, syndactylae. Till now 29 cases are reported in World literature including one by Jabs & Associates in 1982. The case is being reported for its rarity.

From: Dept. of Obstet. & Gynaecology, Govt. Medical College, NGP.

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ADENOCARCINOMA OF FALLOPIAN TUBE

(A Case Report)

By

ANIL PINTO, M. N. PAL, (MRS.) E. DIAS
(MRS.) NISHA S. NADKARNI
AND
KAREN RODRIGUES

Introduction

Adonocarcinoma of the fallopian tube is very rare only 1000 cases having been reported to date (Benedet, 1977). Only 0.2 to 0.5% of all primary genital malignancies arise in the tube.

CASE REPORT

Mrs. M.F. 47 years old, known hypertensive came with the complaint of continuous bleeding P.V. for 2½ months.

Her prior menstrual history was normal. She was a Para-IV, all FTND the L.D. 20 years back. Patient was a known hypertensive and was on tab. adelphane 1 O.D. for the past ten years. Prior to admission, she had undergone a D&C in a Private Nursing Home. The histopathological report was not available.

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On general examination the only abnormality detected was a B.P. of 150/110 mm.Hg. Her respiratory and cardio-vascular systems were normal.

Pelvic examination findings were as follows: The uterus was anteverted 12 weeks size, separate from the uterus in the left side was a mass about 3" in diameter with restricted mobility. The (right) sides parametria were free.

A clinical diagnosis of fibroid uterus with ovarian tumour was made. Patient was subjected to a routine battery of investigation, Hb, PCV, Tc, Dc, Urine R/M, Urine C/S, FBSL, Bl. Urea, Sr. Creatine, X-ray chest, X-ray Abdomen IVP and EUA, with fractional curettage. The histopathological report showed a proliferative endometrium.

The patient was subjected to a Laparotomy—the findings on the table were as follows: Uterus had a fibroid on the anterior wall 2" x 2" with a lateral extension on the right side. The right adenexa was normal. On the left side and extending posteriorly to fill the pouch of douglas was a tumour. The tumour mass was partly cystic and partly solid. The mass was fixed with adhesions to the sigmoid colon. A total abdominal hysferectomy with bilateral salpingo-oopharectomy and debulking of the tumour on the left side was done-together with an omental biopsy. A provisional diagnosis of fibroid uterus with tube ovarian malignancy was made.

The post-operative course was uneventful. The patient was discharged on the 14th POD and referred for external radiation.

Microscopic (Histology)

Papillary adenocarcinoma of the fallopian tube. Ovary from the same side showed no evidence of infiltration. The right tube and ovary show no significant pathology. Section of the cervix showed a chronic non-specific cervicitis. The wall of the uterus revealed a leiomyoma. There was no evidence of infiltration in the uterus or cervix. The omental biopsy showed no evidence of malignant infiltration.

Discussion

Carcinoma of the tube is almost never diagnosed pre-operatively. Adnexal enlargements generally are interpreted as ovarian neoplasia, inflammatory disease, pedunculated fibromas etc. In this particular case, a pre-operative diagnosis of fibroid uterus with an ovarian tumour was made. Goderian and James (1956) reports that in only 2 of 577 cases was a correct diagnosis rendered before surgery.

Cytopathologic study of vaginal smears may lead to the early diagnosis of an occasional tubal malignancy (Fidler and Lock, 1954). Laparoscopy and ultrasonography may help one to achieve the diagnosis nevertheless, in the patient with any suspicion of intrapelvic disease. laparotomy with definitive therapy is the most appropriate approach.

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