CASE REPORTS

SIMULTANEOUS INTRAUTERINE AND TUBAL GESTATION

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Mrs. S.K., a 20 year old primigraida presented on 24th May 1989 with the history of $1^1/_2$ months amenorrhoea and abdominal pain. Her L.M.P. was 9/4/1989. On examination she was pale (hemoglobin of 3 gm%), and in a state of shock. The lower abdomen was tender and guarded. Internal examination revealed a soft cervix, a soft, just bulky uterus with tender cervical movements. Colpopuncture confirmed hemoperitonenum and an exploratory laparotomy was performed. The right tube showed a ruptured ampullary pregnancy.

The uterus was bulky. A right salpingectomy with modified Coffey's suspension was performed and 3 units whole blood were transfused. The postoperative course was eventful and the patient was discharged on the tenth day. Histopathology confirmed tubal gestation. She presented to the O.P.D. again on 7/8/1989 (two months later) with the complaint of persistent amenorrhoea. Clinically she had a 16 weeks size gravid uterus. Ultrasound showed a 16 weeks size single fetus, corresponding to an L.M.P. of 15/4/1989. Thus, in retrospect, the patient had a 5 weeks intrauterine gestation at the time the tubal gestation ruptured. A suggestive sign of intrauterine pregnancy was the absence of vaginal bleeding before as well as after removal of the ectopic trophoblast. The case is presented for the rarity of occurence of simultaneous intra and extra-uterine gestation (1: 15 - 30,000).

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PREGNANCY DURING DANAZOL THERAPY FOR ENDOMETRIOSIS

Biswajit Ghosh

Mrs. P.Z., 26 years old, married for 5 years, trying for a baby, was admitted on her eighteenth day of cycle for laparoscopic examination followed by chromopertubation and endometrial biopsy. Her husband's semen profile was within normal limit. Laparoscopic examination revealed 3 endometriomas - 2 on right and 1 on left utero-sacral ligaments - scoring Stage-I as per classification of Endometri-

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osis by American Fertility Society (1979). Sign of ovulation on the right ovary was noted and the tubes were found healthy. On chromopertubation with 1% methylene blue solution there was free spillage through left tube but no spillage through right one. Endometrium sent for histopathological examination showed secretory phase.

Twelve days after laparoscopy she had her subsequent menstruation and from 5th day of her cycle she was given danazol 200 mg. daily orally continuously for 3 months. After completing the course she came for her next visit complaining of nausea, indigestion and loss of apetite, which develop during last month of danazol course and increased gradually. Pervaginal examination revealed a soft, bulky uterus suggestive of early pregnancy which was confirmed by Urine HCG examination. Continuation of the pregnancy was decided as desired by the couple. EDD was ascertained by a mid-trimester ultrasound examination which also helped exclude any foetal abnormality. Her antenatal period was uncomplicated. She was admitted on 39th week with spontaneous onset of labour with a floating head and partially dialed OS. LSCS was done for dystocia and a healthy female baby weighing 2.7 kg. with Apgar score 8 was delivered. A thorough careful physical and clinical examination of the baby was done, but no congenital abnormally, particularly of external genitalia, was detected. Postnatal morbidities were that the baby developed Ophthalmia neonatorum on 2nd day which was treated by Gentamycin eye drop instillation and the mother had urinary tract infection which was treated with Gentamycin injections.

(The baby attained 12 months age in August, 1989 with normal growth and good health and shows no hindrance in her developmental milestones).

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VON WILLEBRAND'S DISEASE COMPLICATING PREGNANCY

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Introduction

Von Willebrand's disease is rarely encountered in our country, more so in Obstetric practice. A case of Von Willebrand's disease complicating pregnancy is being reported alongwith a brief review of literature.

Case Report

Mrs. L., a 19 year old lady was admitted to this hospital on 16/2/1989. She presented with the history of eight months amenorrhoea and bleeding gums. Her LMP was 2/8/1988. Her previous cycles were regular with excess flow during periods. Her father died of bleeding disorder and a sister also died at 7 years due to bleeding

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disorder. She was diagnosed at the age of 3 years at Thanjavur Medical College to be Von Willebrand's disease (VWD). Patient was born of consanguinous marriage. Patient had received multiple transfusions in the past for menorrhagia and bleeding gums. She was married for one and a half years (non-consanguinous). Investigations done earlier revealed prolonged bleeding time, prolonged clotting time and thromboplastin generation test showed Factor VIII deficiency.

On examination, patient was anaemic, pulse rate 80/minute, B.P. 120/70 mm Hg, pedal oedema was present. Abdominal examination showed 28 weeks pregnant uterus with palpable fetal parts and a fetal heart.

Her baseline investigations were Hb 6.0 gm%, Packed Cell Volume 26%, Total Leucocyte count 14,050/c.mm., Differential leucocyte count N_{80} E_5 L_{13} M_2; ESR 5 mm/Hg, Platelets 3,20,000/cumm; Bleeding time 15'; Clotting time 13', Prothrombin time Normal, Kaolin precipitate Thromboplastin Time (KPTT) - prolonged; Thromboplastin generation time - Suggestive of Factor VIII deficiency; Platelet aggregation with Ristocetin - suggestive of Von Willebrand's disease. Urine routine and culture were normal.

Patient was kept in the hospital and treated with hematinics and calcium. She had preterm onset of labour on 23-3-1989 at 34 weeks gestation and delivered a live male baby weighing 1.8 kg which was small for gestational age. Placenta was retained and had to be manually removed. She lost about 500 ml of blood and was given two bottles of 'O' Rh positive blood. She was discharged from the hospital a week after delivery as she was apparently alright. At discharge uterus was well involuted, there was no bleeding per vaginum and baby was healthy.

Patient was admitted the same evening with history of profuse bleeding per vaginum. She was very pale with a haemoglobin of 6 gm%, 2 units of matched blood given on admission. She continued to have bleeding on and off, (hematocrit estimation was repeated thrice a week) 3 units of fresh plasma and 3 units of fresh blood were transfused over the next one month. After she stopped bleeding, she was kept in hospital for 10 days and then discharged.

CONGENITAL HEART DISEASE — A RARE VARIETY

RAGINI MEHROTRA • A.K. ASTHANA

Congenital Heart disease leading to intrauterine death is not a rare entity in Obstetrical world. One such case having a rare variety of intracardiac developmental anomalies is being reported which was diagnosed antenatally.

Mrs. A.M. 25 years old house wife, primigravida, regular attendant at the antenatal clinic reported at 24 weeks for inability to appreciate fetal movements until then. An Ultrasonography showed a normal live fetus corresponding to 24 weeks pregnancy with normal cardiac activity and no congenital anomalies. Her fetal heart sound was not heard till the end of 33 weeks. Thereafter on 9/2/1989, at 34 weeks, her fetal heart rate showed

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bradycardia and regularly irregular rythum. Her Ultrasonography after two days showed a single fetus of 34 weeks with a silent heart showing only two main chambers. Further details could not be defined because of silent heart.

Patient delivered a macerated still born female child weighing 2.0 kg with no apparent congenital abnormality.

Autopsy revealed apparently normal looking heart with absent inferior Vena Cava and congested liver and lungs. The Heart was desected and the findings were as follows:-

1. Absent Atrial septum.
2. Transposition of great vessels.
3. High ventricular septal defect
4. Pulmonary veins draining into pulmonary trunk.
5. Absent inferior Vena Cava.

CRANIOTHORACOPAGUS MONSTER

AMITA GUPTA • YUDHISHTER VIR GUPTA
KASTURI LAL

A 30 years old G3,P2 with satisfactory obstetrical outcomes was admitted as an emergency at 30 weeks gestation with abdominal discomfort of two weeks duration in the Department of Obstetrics and Gynaecology, Medical College, Jammu dated 30/4/1988. The patient had no exposure to radiation or any drug during this pregnancy. Her general physical examination did not reveal any abnormality except anaemia. Obstetrical examination revealed an unduly enlarged abdomen. Foetal details could not be made out but some hard mass could be ballotted in the right iliac fossa. Initial skiagram of the abdomen did not provide us any worthwhile information because of its poor quality. The patient was put on sedation and complete bed rest. Another skiagram, after amniocentesis, was asked for the next day. In the meantime she ruptured the membranes and delivered a conjoined twin monster as breech, all the four legs coming together into the vagina. There was no complication of third stage of labour. The twins were united from head to the level of umbilicus. There was a single head, face and neck. The chest was roated and united, from the front, the abdomens were separate. There were 4 upper and four lower limbs. Placenta was relatively bigger. The single umblical cord showed four arteries and one vein on cut section. The post mortem was not permitted. Mother had an uneventful puerperium and was discharged after 3 days.

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PERFORATING MOLE

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Introduction

The invasive mole or chorio-adenoma destruens, a rare entity, behaves like a locally malignant growth invading so deeply that it may perforate the uterine wall.

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Such a case of chorio-adenoma destriens has been seen in S.N. Medical College, Agra and is being reported here.

Case Report

Mrs. Madhulata, 22 years old was admitted with complaints of bleeding per vaginum off and on and pain in abdomen following Dilatation and curettage done 4 months back.

She was a primigravida with 2 months gestation at that time.

On examination : Her general condition was low. Pulse rate was rapid and feeble. Blood pressure was 94/72 mm of Hg., respiratory rate was 46/mt. She was very pale. Heart, lungs were clinically normal. On per abdomen examination, the abdomen was very tender. Rebound tenderness was present and there was rigidity.

On per vaginum examination the uterus was retroverted, size corresponding to 6 weeks gestation, both the fornices were clear. There was no fullness in the posterior fornix. Her Hb was 4.8 gm%, TLC - 12,200/cmm, DLC P88 L12, Blood group was B +ve. Other investigations were normal.

Laparotomy was done. The abdomen was initially opened by a small, median, vertical incision. A small niche was made in the peritoneum by which we confirmed the presence of blood in the whole peritoneal cavity. The median incision was extended. The blood in the cavity was sucked out and the uterus was then identified and held. Two old perforations, one present in midline at fundus of uterus and the other about 2 cm below and laterally to the first, were seen each measuring about 1/2" x1". The margins were irrgular and old products of conception were seen protuding out through these perforations. A few muscular fibres and peritoneum was found bridging these 2 perforations. These were cut and continuity between the two was established. The contents of the uterine cavity were cleaned out. The tissue removed was sent immediately for histopathological examination. The uterus was repaired in layers. Because of the pathology both the fallopian tubes were also ligated, after taking the consent of the relatives on medical grounds. A drain was put in the abdomen and abdomen was closed in layers.

Pre-operatively patient was given 2 units of blood.

Post-operatively, she was kept on I/V fluids, injectable antibiotics and blood. Her dressing was changed 12 hourly. She developed slight fever with chills and rigor for which anti-malarial therapy was given.

The drain was advanced on 2nd post-operative day and removed on 3rd day. The rest of her post-operative period was uneventful. Her stitches were removed on the 10th post-operative day and were found to be healthy.

Her biopsy report revealed the tissue to be degenerated products of conception with a few syncytiotrophoblasts, necrosed tissue and blood clots. Evidence of molar tissue.

The patient was discharged on the 15th day from the hospital.