PROLONGED INTRA ABDOMINAL DEATH OF A TERM FOETUS

G.A. RAMA RAJU • G. MEENAKSHI

A 32 years old illiterate, lower socio-economic tribal woman from Srikakulam District presented with an unusual complaint of 10 months amenorrhea followed by galactorrhea and cyclical periods of one year duration. On enquiry, she had all signs and symptoms of normal pregnancy. At 9 months gestation she had cessation of foetal movements, followed by milk scretion. 2 to 4 weeks later she had onset of regular menstruation.

On examination she had a abdominal swelling consistant with a size of 24 weeks pregnant uterus with restricted mobility. Foetal parts could not be made out. Pelvic examination revealed a normal size uterus distinct from the swelling. Radiological examination revealed an extra uterine pregnancy. Sonography revealed a dead foetus with a deformed cranium with calcification in the abdominal cavity. The sonographic measurements corresponded to a foetus of 38 to 40 weeks gestation.

After routine investigation, including coagulation studies which were surprisingly normal, a laparotomy was performed. Uterus was of normal size. Right ovary and tube were normal. Left tube was dilated and fimbrial ends were spread over the calcified placental mass. Left ovary could not be located. Dead foetus was present in the abdominal cavity. The foetus and placental mass along with the left tube was removed. The delivered foetus weighed 2.5 kgs. The placental tissue was sent for histopathological examination for any evidence of ovarian tissue and no ovarian tissue is found in the histopathological examination.

Department of Obstetrics and Gynaecology, Andhra Medical College, Visakhapatnam.

body by putting a few interrupted catgut stitches in lower border of levators to support the anal canal anteriorly. In the space already created, a cystic mass of collected blood could be felt covered by a thickish tissue and not the thin membranes etc, as is described in the text books. With blunt dissection about 55 cc of thick blood was let out. To our surprise upper 1/3rd of vaginal mucosa was not developed at all. In the dissected space dilated cervix was seen to be flushed with top of the space draining the blood from uterine cavity. No normal vaginal mucosa of vault or upper 3rd of vagina was seen. After all the blood was let out, catheter was put in through the dilated cervical canal and brought out from the MacIndoe's foam rubber mould.

MacIndoe's Vaginoplasty

A total thickness skin graft was taken from the medial aspect of the right thigh, which was stitched all round a mould made of foam rubber. This was placed on the raw space created in between bladder and Rectum to be taken up and function as vagina. The catheter inserted into the dilated cervical canal was brought out through it to make effective drainage of old clotted blood and menstrual flow. The mould was stitched all round the introitus at labial margins.

Post Operative Care

1. Continuous catheterization of bladder for nearly 3 weeks was done. Initial vaginal mould was taken out on 4th day under G.A. when most of the graft was found to have taken up.
2. 2nd plastic mould was kept for 7 days.
3. Under General anaesthesia again examination was done and plastic mould of smaller size was kept till all the oedema and tissue reactions subsided, dilatation of anal canal was also done at the same sitting.
4. Colostomy was closed after about 1 1/2 months of the main operation.
5. 3 months after the operation Primolut-N was stopped and she got her first normal painless period.
6. Plastic mould was kept in for nearly six months regularly. Patient herself was trained to remove and clean the mould whenever necessary.

Post Operative result (Follow up)

1. Patient is getting regular menstrual periods.
2. There is complete control over anal activity.

CHORION-ANGIOMA OF PLACENTA

JAI BHAGWAN SHARMA • NIRMAL GULATI • SUNITA MALIK

Case Report

Mrs. R.K. 25 years old second gravida delivered a full term healthy male baby weighing 3.5 kg.

After 5 minutes of delivery placenta was delivered. It was six hundred grams (600 gm.) in weight and was of circumvallate type with slight eccentric attachment of umbilical cord.

There was a cystic mass about 5 x 4 cms. (Fig. I) on foetal surface of placenta arising from chorion. A blood vessel was seen entering the cystic mass. Placenta was sent for histo-pathological examination and turned out to be a chorion-angioma.

Department of Obstetrics & Gynaecology Medical College & Hospital, Rohtak (Haryana) 124 001.

In this case foetus was not affected by the tumour and grew well. Patient and baby were discharged on 5th day in a good condition.

PREGNANCY AFTER CONSERVATIVE MANAGEMENT OF TUBAL PREGNANCY

PYARILAL TRIPATHY

Introduction

There is significant rise in the incidence of ectopic gestation due to rise in pelvic infection and use of I.U.C.D. Previously salpingectomy was the most opted treatment for tubal pregnancy. But gradually conservative surgery (linear salpingostomy) is prefered in selected case if the diagnosis is made earlier. Very rarely chemotherapy (Methotrexate) is also advocated in such cases with varying outcome. Here is a case report of tubal pregnancy where chemotherapy was given due to patient's reluctance to surgery with successful outcome.

Case Report

Mrs. N.P. 20 years primigravida of 11 weeks pregnancy reported for weakness & dull pain in the pelvis. On examination she was moderately pale, pulse 86/min. B.P. - 110/70 mm. of Hg. Temp. normal, no oedema, uterus was not felt per abdomen. On P/V examination uterus was soft and just bulky. In the left fornix an irregular, tender mass was palpable, rocking sign

* *Department of O & G, District Hospital, Sundargarh, Orissa.*

was positive, Right fornix and Pouch of Douglas were free. Pregnancy test on urine was positive. There was no history of acute pain, bleeding P.V., or fainting attack.

Investigations showed:- Hb-9 gm/dl. DC, TLC, BT, CT and peripheral smear, study were within normal limit. Sickling test was negative. Repeat pregnancy test was positive only with undiluted urine.

Clinically the case was diagnosed to be a case of ectopic pregnancy. She was prepared for laparoscopy followed by laparotomy (if needed). But the patient denied to undergo any surgical interference. Inspite of all efforts to convince her for the operation she did not give way, rather she was prepared to risk herself and leave the hospital. At last she was taken for conservative treatment with methotrexate, blood transfusion I.V. fluid (as and when required) antibiotics, sedation, analgesics and complete bed rest.

Methotrexate 15 mg I.M. daily was given for 5 days and the same was repeated every 2 weeks for six times. The mass was gradually reducing in size, as well as the tenderness and pain. She expelled a decidual cast simulating the uterine cavity (endometrium) after 3 weeks of treatment without any product of conception. Then she was discharged from the hospital and advised to come every 2 weeks for methotrexate injection. The mass completely disappeared after 4 sessions of methotrexate injection and after the further 2 doses were given as an extra precuation (guided by haemogram study). Urine for pregnancy test was negative after 2 weeks of treatment.

After 4 months of the completion of treatment she again conceived (against our medical advice) and at present she is carrying 12 weeks pregnancy with all normal parameters.

TRANSIENT BUT SUDDEN BLINDNESS FOLLOWING ECLAMPSIA

H.K. Premi • Ashok Kumar

Transient but sudden blindness in patients of eclampsia of severe PIH is a rare complication. Vascular spasm and partial or complete retinal detachment are responsible factors. Prognosis is good and permanent visual damage seldom occurs (Mudaliar and Menon, 1978). The rarity of this complication prompted us to present one such case.

Case Report

Mrs. L.D., a 19 years old booked primigravida with amenorrhoea of 37 weeks and a twin pregnancy was admitted to the antenatal ward on 19/12/1988. Her past medical and surgical history was normal. There was no history of drug intake other than the haematinics. Her pulse was 80/mt, regular. BP was 130/80 mm. Hg. with positive supine pressor test. She had slight pedal oedema and weighed 54 kg. Urine examination was normal and Hb. was 10.5 gm%. VDRL test was non-reactive. Bishop score was 3/13.

The patient reported to the labour room with uterine contractions at 4 a.m. on 30/12/1988. Her pulse was 100/mt, regular. BP showed a marked rise to 190/120

mm Hg. There was 2 + proteinurea. As the patient was being examined she had an eclamptic fit. She was immediately put on Diazepam regimen. Her BP dropped to 150/100 mm Hg. Convulsions did not recur. However, an emergency caesarean section under G.A. had to be performed as the cervix was unfavourable with high presenting part. Two live babies weighing 2000 and 2200 grams were delivered by caesarean section. On regaining consciousness after the surgery, the patient complained of loss of her vision. Her BP recorded 160/100 mm Hg. Optic fundi showed grade - II changes. The entire episode was of grave concern, but the patient started having perception of light after 24 hours. Normal vision returned 72 hours later. Repeat fundoscopic examinations were normal. Her BP remained 130/78 mm Hg. Proteinurea disappeared by the fifth post operative day. She left the hospital on twelth postoperative day.

MASSIVE JEJUNO - ILEAL INJURY FOLLOWING PERFORATION OF UTERUS

B.B. Goyal • Preet Kamal • Paramjit Singh Bedi

Introduction

A case of massive small intestinal injury following abortion is described. Injury to the small or large intestine may occur following perforation of uterus during dilatation and curettage, but injury to almost whole of jejunum and ileum is unknown. The case was operated upon and jejunoileal anastomosis was done. The patient is doing well.

Medical College, Amritsar.

Case Report

A 22 years female was admitted in surgical wards of S.G.T.B. Hospital, Amritsar on 10/8/88 vide C.R.No. 85781 with history of abortion conducted by a Dai 3 days back. She complained of something coming out of her vagina since one day. On examination the small intestine was protruding through the vaginal opening (Fig. I). The patient was anaemic, pulse 140/mt, B.P. 100/70 mm of Hg. and respiratory rate was 30/mt. The abdomen was tender and rigid all over.

Exploratory laparotomy was done. On exploration the foetal parts were lying in the abdominal cavity. There was a tear about 6 cm. in size in the posterior wall of the uterus through which the small intes-

Fig. I The intestines protruding out of vagina.

tine was entering the uterine cavity. Only about 10 cm of proximal jejunum and about 3 cm of terminal ileum were intact. Surprisingly there was no injury to the mesentery. The unhealthy gut was resected. An end to end anastomosis was attempted between the remaining parts of jejunum and ileum. The tear in the uterus was closed with I–O chronic catgut interrupted stiches. Peritoneal lavage done with normal saline, corrugated rubber drains were kept in the pelvis and abdominal wound closed in layers.

Post-operative period was uneventful. Liquids were started orally on 4th post-operative day and solid diet on 8th post-operative day. Barium meal study on 7th post-operative day revealed no leakage from the anastomotic site and outlined only a small portion of small intestine (Fig. 2). Barum meal study was repeated after two months which showed

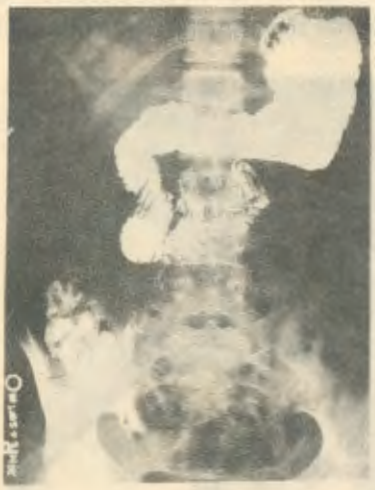


Fig. II Duodenum and small intestine outlined on barium meal study.

Fig. III Barium meal study showing massive hypertrophy of duodenum, jejunum and ileum.

hypertrophy of duodenum, jejunum and ileum (Fig. 3). The patient had no gastrointestinal problem except that she used to pass 3-4 semisolid stools daily. She is having no gastrointestinal problem even after about eight months of operation.

Discussion

Resection of 50% of small intestine is the upper limit of safety. Removal of more than 30-40 cm of terminal ileum leads to intractable diarrhoea. In this case only about 10 cm of jejunum and 3 cm. of terminal ileum were intact. Barium meal study after a period of two months showed considerable hypertrophy of duodenum, jejunum and ileum to aid absorption of food. The patient showed no signs of malabsorption. She used to pass only 3-4 semisolid stools daily. This is very rare case of massive small intestinal resection. No such case has been reported in literature available.

SPLENIC AVULSION DURING PREGNANCY

M. M. Bagree

Mrs. X 20 years old female with six months pregnancy was admitted in the obstetrics ward of this hospital with the diagnosis of pregnancy with acute pain abdomen (Reg.No.791) on 28/1/1989. After clinical examination she was found to be in shock. Her pulse rate being 146/minute, B.P. 80 mm Hg, respiration gasping, were indicating towards internal haemorrhage. Her pelvic examination was found to be normal so the patient was kept on conservative treatment and was referred to us.

On examination we found that the patient was in immense shock with thready pulse, rate not countable, B.P. 80 mm Hg with 4 amp. of Dopamine per pint of I.V. drip (drip running at the speed of 80 drops/minute) and she was almost struggling to breathe. Urgent sonography was done. It was found that the peritoneal cavity was full of fluid (?blood) but the source of this fluid could not beascertained. Uterine boundaries were intact but the foetus had died in utero. Just to give the chance of survival, in case the pathology is found to be correctable, it was decided to explore the abdomen.

The abdomen was explored through a right paramedian incision. The peritoneal cavity was found to be full of blood, clotted at places. The splenic flexure of transverse colon and the greater curvature of stomach and the adjoining part of omentum were echymosed badly. Splenic vein was found to be torn and was bleeding. Splencetomy was done. She was given 5 units of blood during operation and in post-operative period. She succumbed to death next day. A history of jump from 3" height could be elicited. The spleen was four times the normal size.

S.P. Medical College, Bikaner 334 001.

OBSTRUCTED LABOUR DUE TO BLADDER STONE

S.P. Nagpal • C.B. Nagori
G.P. Patel • K.G. Tailor

Manjulaben 29 years old was admitted in emergency on 26/1/1989 at 11.30 a.m. to B.J. Medical College and Civil Hospital, Ahmedabad with a diagnosis of Antepartum eclampsia with obstructed labour. She was a primigravida and her E.D.D. was 15/2/1989. She had three convulsions 4 days back for which she was treated at P.H.C. There was history of pain in abdomen since four days and P.R.O.M. of 24 hours. There was history of recurrent abdominal pain and Haematuria since last 2 years.

On examination Pt was concious. Her pulse was 110/minute B.P. was 150/100 mm of Hg. She had mild anemia, no edema with proteinuria ++. Abdominal examination revealed a full term uterus with a live foetus with a vertical lie, cephalic presentation in LOA position and head 4/5th

B.J. Medical College and Civil Hospital, Ahmedabad.

palpable. On pervaginal examination cervix was found 5 cm dilated, fully efaced, membranes absent, P.P. at -1 station caput ++ and moulding +. A mass of 7 x 7 cm size felt in anterior fornix having stony hard consistency, immobile and irregular in shape. Catheter could not be negotiated.

Emergency L.S.C.S. was done on opening the abdomen bladder stone was felt with over stretched lower segment. A male child of 1.650 kg. S.G.A. delivered with good apgar score at 12.30 p.m., 26/1/1989. Retropubic suprapubic cystolithotomy done and brownish 8 x 7 x 6 cm. size oxalate stone was removed. In dwelling catheter was kept for 15 days. Post-operative period was uneventful.

Both mother and baby were discharged in good condition on 15/2/1989.

CERVICAL ENCIRCLAGE IN BICORNAUTE UTERUS WITH RECURRENT ABORTIONS

KEDAR PADTE

Mrs. S.R., a 38 years old patient Gr. VII Para O Abortions VII married for 18 years, presented to Khaunte Hospital, Panaji, as a case of bad obstetric history in January 1987. She had 4 abortions at 10-12 weeks, 2 abortions at 14-16 weeks, and one abortion at 18 weeks. Her hysterosalpingography (Fig. 1) and laparoscopy done on 1982 showed a bicornuate uterus. The tubes and ovaries were normal. She was advised metroplasty at an institution in Northern India. Patient could not go through surgery due to domestic problems and came to Goa. At no time during her previous pregnancies was a cervical encirclage undertaken. Keeping this in mind she was investigated and since no other abnormality except bicornuate uterus was noted, she was advised to come back after conception.

She came for follow-up on 15th June 1987 with history of amenorrhoea of 6 weeks and spotting for 2 days. She was admitted and kept under observation. On examination her pulse was 96/min blood pressure was 90/60 mm Hg. Systemic examination revealed no abnormality.

Obstetric examination showed that uterus was not palpable per abdomen. Vaginal examination revealed that uterus was 6 weeks size and irregular. There was dark coloured blood stained discharge in

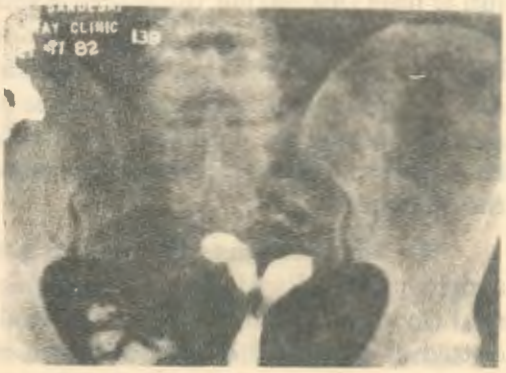


Fig. 1. Hysterosalpingogram: Bicornuate uterus.

Khaunte Hospital, St. Inez-Panaji, Goa 403 001.

the vagina, and no active bleeding could be seen through the cervix on speculum examination. pregnancy test was positive and all other investigations were normal. Ultrasonography done after 12 weeks revealed a single foetus in the right horn. (Fig. 2). Placenta was anterior and normal and foetal cardiac activity was noted. The crown rump length was 5.5 cms compatible with 12 weeks and 6 days gestation. There were no congenital defects. Left horn was empty and showed decidual reaction.

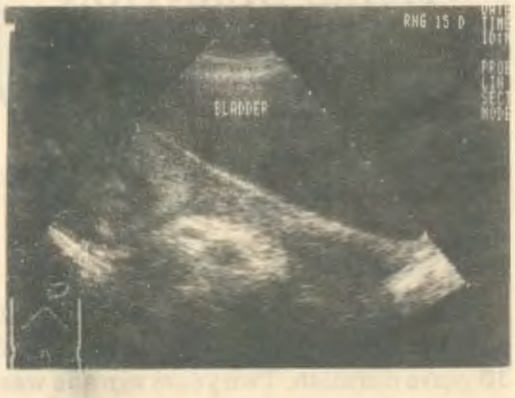


Fig. 2. Ultrasonograph: Right horn of uterus shows fetal pole. Left horn is empty

One week later a cervical encirclage was undertaken (McDonald's Stitch) using 2 strands of No.4 braided silk. Patient was kept on complete bed rest and tocolytics throughout pregnancy.

At 37 weeks, elective caesarean was performed and a 2.8 kg healthy female baby was delivered. Both mother and baby were discharged on the 8th post-operative day.

ICTHYOSIS

ARUNA RANGNEKAR • B. BHARADWAJ

Case Report

Patient M. 45 years age, 8th para was admitted for obstructed labour due to transverse lie. A male child of 3 kg. was delivered by caesarean section.

The appearance of the child was horrifying. The entire body was covered with thick cracked skin forming horny plates disfiguring the facial appearance. The metacarpel and metatarsals were represented as rudimentary buds and the digits were constricted. The orbits were obliterated by chemosis and severe ectropion. The lips were everted and gaping. The ears and nose were flattened. The mobility of the joints was restricted. The palate was high arched and the male external genitalia was not well formed (Fig. I). Marked dyspnoea was present.

Fig. 1. Harlequin foetus — showing markedly thickened, ridged and cracked skin forming horny plates over the body.

The baby was nursed in a humid atomosphere and skin was covered with sofratulle all over. Injectable antibiotics were started and feeding was done through a nasal tube. Chloromycetin applicaps were used to take care of the eyes. Inspite of all the treatment the baby succumbed to death after 48 hours.

Discussion

Harlequin foetus is a very rare keratinizing disorder inherited as an autosomal recessive trait. The affected inftants are extremely grotesque. Markedly thickened, ridged and cracked skin forms horny plates over the entire body disfiguring the facial appearance and constricting the digits. The infants have respiratory difficulty and sucks poorly because of firmness of skin around its lips. Soon the skin develops fissures which can easily become infected and baby - collodion baby, as it is called succumbs to death within first week of life.

X-linked icthyosis is limited to males and is usually present at birth. Scaling is more pronounced on the scalp, neck, sides of face, trunk and limbs. Unlike icthyosis vulgaris where it is seen on external aspects of extremities and back. The inherited biochemical defect is X linked. Icthyosis is a deficiency of the enzyme steroid sulphatase. Carrier mothers show a placental steroid sulphatase deficiency reflected by low urinary and serum oestradiol values, prolonged labour and insensitivity of the uterus to oxytocin and prostaglandins.

The role of these enzymes play is unknown. The gene for steroid sulphatise is located on the short arm of X chromosome.

The skin biopsios show hyper keratosis, well developed granular layer, epidermal hyperplasia and a mononuclear peridermal prevascular infiltrate.

The prognosis is very poor and genetic counselling must be offered to the parents.

AN UNUSUAL CASE OF PRIMARY INFERTILITY OF 10 YEARS DURATION WITH PELVIC FILARIASIS

K. Jain • Satyavir Yadav • S.K. Mathur • Praveen Mohan Sharma

Case Report

A 27 years old female was admitted with the diagnosis of primary infertility of 10 years duration. Two years ago she was diagnosed as a case of tuberculous endometritis on biopsy by a private practitioner and had taken a full course of antitubercular treatment for 9 months. Endometrial biopsy was repeated and reported to be secretary phase endometrium with no evidence of tuberculosis. Hysterosalpingography later revealed bilateral tubal blockade and she was referred to this institution for diagnostic laproscopy. On laparotomy, left sided fallopian tube was stretched over the ovary and showed complete agglutination and indrawing of fimbrae forming a bulbnous end. On right

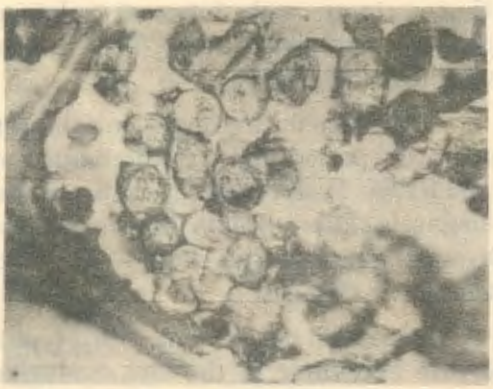
Medical College, Rohtak.

side fimbrae could not be traced and the bulbous end of tube was adherant to the ovary.

An interesting finding in the form of multiple pin head sized whitish nodules over the serosal surface of fallopian tubes and both surfaces of broad ligament was noted. A part of fallopian tube with a serosal nodule was submitted for HPE.

Pathologic Findings

Macroscopically the piece of fallopian tube with its nodule measured 1.2 x 0.8 x 0.4 cms. Histologic examination revealed changes of chronic salpingitis along with a degenerating and partly calcified adult gravid female of filarial parasite (W. bancrofti) in the surrounding soft tissue noudle of the fallopian tube. The parasite showed a thick, acellular, hyaline cuticle. The body cavity was filled with multiple round to oval developing embryos of the size of about 20-30 micron (Fig. 1). Each of the developing embryo was enclosed within its own translucent membranes (future sheath of hatching microfilarae). The parasite was seen lying in an irregular cavity having a thick fibrosed and hyalinised well infiltrated by chronic inflammatory cells, mainly lymphocytes and plasma cells and a few eosinophils. This irregular channel may have been a dilated lymphatic which subsequently had undergone fibrosis and hyalinisation.



The parasite having thick a cellular cuticle and containing multiple developing embryos in its body cavity (H & E x 400).

Microanatomical diagnosis of chronic salpingitis with surrounding soft tissues showing a adult gravid female of W. bancrofti was made. Subsequently peripheral blood film examination, however, did not reveal microfilaremia.

Discussion

Filariasis commonly manifests as lymphangitis, inguinal lymphadenopathy and elephantiasis of external genitalia. Few cases have been reported in literature which remained completely asymptomatic with or without microfilaremia. This asymptomatic state was ascribed to early lympathic obstruction and associated immune suppression in such cases. Though microfilarae have been detected in cervical and endometrial smears, but the presence of adult filarial worms in association with lymphatics of fallopian tubes is an uncommon and unusual finding even considering the fact that lymphatics of fallopian tube drain both in aortic and external iliac lymph nodes.

MAMMOTH FIBROMYOMA OF THE UTERUS

A. K. Bhattacharjee
Prof. R. K. Das

Patient Ms. P.R., 44 years, unmarried, was admitted in the Gynaecology ward of the Guwahati Medical College on 29/9/1988 with the chief complaints of lump in the abdomen for 5 months and irregular bleeding per vagina for 2 months. She gave history of heavy menstrual flow for last 2 years and general weakness for last 5 months.

General physical examination showed marked pallor. Abdominal examination revealed a firm lobulated lump with smooth surface of 34 weeks of gravid uterus size. It had restricted mobility from side to side. The lump occupied the epigastrium and was more towards and the right flank. No free fluid was detected clinically. It was not tender.

Per vaginal examination, could not detect the uterus separately. The lower pole of the lump could be felt through the posterior fornix.

Haematological examination showed Hb% 9.2 Gm%. ESR was 45 mm at the end of 1st hour. Others were within normal range. P.A. view of the chest showed normal study and ECG showed old anterior wall ischaemia. No other abnormality was detected on routine laboratory investigation.

Two units of blood were transfused pre-operatively, raising the Hb% upto 10.2 Gm%. Fibromyoma of the uterus was diagnosed clinically.

Operation was done on 31/10/1988. At laparotomy the lump was confirmed to be of uterine origin. There were two big lumps. One arising from the body of the uterus and growing upwards up to the epigastrium. The other was from the right lateral aspect of the body of the uterus and grew towards the right lateral pelvic wall in between the layers of the broad ligament. Ovaries were found enlarged.

Both the round ligaments were cut and ligated. The tumour on the right side (pseudo broad ligament) was shelled out. This allowed the uterus to be taken out. Hysterectomy with bilateral salpingo-oophorectomy was done. The tumour weighed 8.5 kg. net.

The patient had uneventful post-operative period and was discharged on 17/11/1988. Histopathology confirmed the diagnosis of fibromyoma (liomyoma). The hypertrophied ovaries did not show any neoplastic changes.

Mammoth fibromyoma of this type is a rare encounter in the Gynaecological practice today. A rural background social taboos, fear for operation and prolonged treatment by quacks made it possible in this case. The ovaries were removed in this case with the idea that the case may be lost for followup.

Dept. of O & G, Guwahati Medical College, Guwahati

LEIOMYOSARCOMA ARISING FROM LEIOMYOMA IN UTERUS

NISHA NADKARNI • MOHANRAY V. MALLYA • D.N. BUHARIWALLA ANIL PINTO

Clinical History

A 43 years old female presented with complaints of pain in abdomen/fullness of lower abdomen and history of profuse flow during menses. Her menstrual history was 6-8/26-35 days, irregular cycle with dysmenorrhoea.

Her obstetric history was Gravda II Para II.

On Per abdomen examination, there was a midline firm mass 24 weeks size arising from pelvis, having smooth surface and mobile.

Per speculum examination showed that cervix was apparently healthy.

Pervaginal examination showed that the mass was continuous with uterus and moved with uterus.

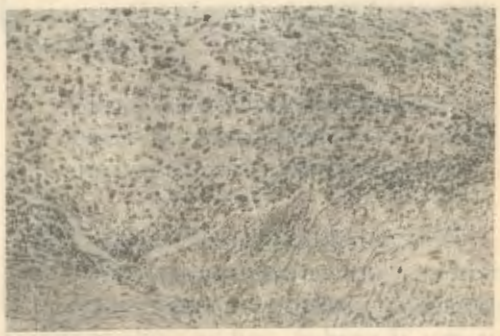
A provisional diagnosis of fibroid uterus was made and patient subjected to simple hysterectomy with bilateral salpingo-oopherectomy in view of patient's age.

Pathology

Gross Appearance

The specimen comprised of uterus with bilateral adenexa measuring 20 x 18 x 14 cms. The external surface showed nodularity which was more present at the isthmus and the cervical region.

On cut section there was a large well circumscribed mass measuring about 14 cms in diameter in the wall of uteus. The mass completely obliterated the endometrial cavity and was extending at places uptil the serosa. The tumor showed whitish whorled appearance with areas of hemorrhage, necrosis and myxomatous degeneration. Multiple smaller masses were seen scttered throughout the uterine wall. The entire cervix was replaced by greyish white homogenous mass.



Photomicrograph showing Leiomyosarcoma arising from Leiomyoma (H & E x 200).

Microscopic Appearance

Multiple sections from the tumor mass comprised of spindle shaped cells arranged in interlacing fashion, whorls and parallel bundles. The cells showed scanty cytoplasm and large hyperchromatic nucleus. Fair number of mitotic

Dept. of Pathology and Dept. of Obstetrics and Gynaecology, Goa Medical College, Panjim, Goa.

figures and bizarre pleomophic cells were seen. Scattered areas of myxoid degeneration, hemorrhage and necrosis were seen. Sections studied from the cervix showed diffuse infiltration by pleomorphic tumour cells. Sections from the vessels showed evidence of tumor emboli. Sections from the fallopian tubes and ovaries were unremarkable. The ommentum showed no evidence of metastasis.

Final Diagnosis

Leiomyosarcoma arising from leiomyoma infiltrating into the cervix.

MAJOR VESSEL INJURY DURING LAPAROSCOPY

SHETH S.S.* • A.N. MALPANI
S. KHANDEPARKER • M. RAUT
D. VANARASE • P. NADKARNI

The ability to make a prompt diagnosis of vascular complication, with the willingness to perform an emergency laparotomy, if needed, and an understanding of the vascular anatomy are essential, if we are to successfully prevent and manage vascular injury occurring during laparascopy. Details of two cases with aortic injury are presented.

Department of Obtetrics & Gyneacology, K.E.M. Hospital & Seth G.S. Medical College, Bombay

Case 1: Mrs. SF, a 34 years old gravida 3 para 3 was scheduled for medical termination pregnancy with laparoscopic tubal ligation under general endotracheal anaesthesia. The Verres needle was introduced by a junior resident doctor. Aspiration gave a few drops of blood. However, since only a few drops were obtained, the bloody aspirate was attributed to passage of the needle through an abdominal wall vessel and the finding was ignored. Air was then insufflated. The 7 mm telescope was then introduced through trocar sleeve and an attempt was made to visualise the pelvic structures. At this point, the anaesthetist noted that the patient had become pulseless. A quick look through the telescope did not reveal any blood. The telescope was promptly removed, and cardiopulmonary resuscitation initiated promptly. The patient was successfully resuscitated with external cardiac massage, and a rapid IV infusion was started. At this point, the senior author (Sheth) was called in. The consultant noted that the patient was markedly pale. In view of the episode of unexplained hypotension, and the sudden developement of marked pallor, a provisional diagnosis of vessel injury was made and it was decided to explore the patient urgently with a call to cardiovascular surgeon to promptly attend. The abdomen was opened through a generous midline incision. Though there was no free blood in the peritoneal cavity, there was a huge retroperitoneal clot overlying the aorta. While awaiting the arrival of the vascular surgeon, no attempt was made to disturb the clot and

LEIOMYOSARCOMA ARISING FROM LEIOMYOMA IN UTERUS

NISHA NADKARNI • MOHANRAY V. MALLYA • D.N. BUHARIWALLA
ANIL PINTO

Clinical History

A 43 years old female presented with complaints of pain in abdomen/fullness of lower abdomen and history of profuse flow during menses. Her menstrual history was 6-8/26-35 days, irregular cycle with dysmenorrhoea.

Her obstetric history was Gravda II Para II.

On Per abdomen examination, there was a midline firm mass 24 weeks size arising from pelvis, having smooth surface and mobile.

Per speculum examination showed that cervix was apparently healthy.

Pervaginal examination showed that the mass was continuous with uterus and moved with uterus.

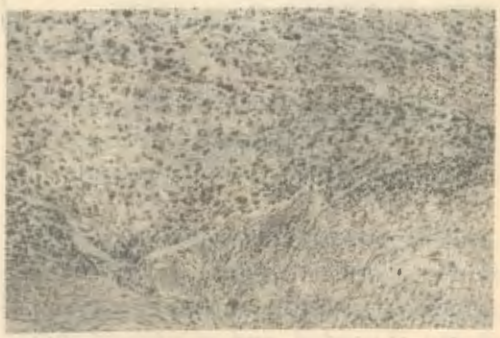
A provisional diagnosis of fibroid uterus was made and patient subjected to simple hysterectomy with bilateral salpingo-oopherectomy in view of patient's age.

Pathology

Gross Appearance

The specimen comprised of uterus with bilateral adenexa measuring 20 x 18 x 14 cms. The external surface showed nodularity which was more present at the isthmus and the cervical region.

On cut section there was a large well circumscribed mass measuring about 14 cms in diameter in the wall of uteus. The mass completely obliterated the endometrial cavity and was extending at places uptil the serosa. The tumor showed whitish whorled appearance with areas of hemorrhage, necrosis and myxomatous degeneration. Multiple smaller masses were seen scttered throughout the uterine wall. The entire cervix was replaced by greyish white homogenous mass.



Photomicrograph showing Leiomyosarcoma arising from Leiomyoma (H & E x 200).

Microscopic Appearance

Multiple sections from the tumor mass comprised of spindle shaped cells arranged in interlacing fashion, whorls and parallel bundles. The cells showed scanty cytoplasm and large hyperchromatic nucleus. Fair number of mitotic

Dept. of Pathology and Dept. of Obstetrics and Gynaecology, Goa Medical College, Panjim, Goa.

figures and bizarre pleomophic cells were seen. Scattered areas of myxoid degeneration, hemorrhage and necrosis were seen. Sections studied from the cervix showed diffuse infiltration by pleomorphic tumour cells. Sections from the vessels showed evidence of tumor emboli. Sections from the fallopian tubes and ovaries were unremarkable. The ommentum showed no evidence of metastasis.

Final Diagnosis

Leiomyosarcoma arising from leiomyoma infiltrating into the cervix.

MAJOR VESSEL INJURY DURING LAPAROSCOPY

SHETH S.S.* • A.N. MALPANI
S. KHANDEPARKER • M. RAUT
D. VANARASE • P. NADKARNI

The ability to make a prompt diagnosis of vascular complication, with the willingness to perform an emergency laparotomy, if needed, and an understanding of the vascular anatomy are essential, if we are to successfully prevent and manage vascular injury occurring during laparascopy. Details of two cases with aortic injury are presented.

Department of Obtetrics & Gyneacology, K.E.M. Hospital & Seth G.S. Medical College, Bombay

Case 1: Mrs. SF, a 34 years old gravida 3 para 3 was scheduled for medical termination pregnancy with laparoscopic tubal ligation under general endotracheal anaesthesia. The Verres needle was introduced by a junior resident doctor. Aspiration gave a few drops of blood. However, since only a few drops were obtained, the bloody aspirate was attributed to passage of the needle through an abdominal wall vessel and the finding was ignored. Air was then insufflated. The 7 mm telescope was then introduced through trocar sleeve and an attempt was made to visualise the pelvic structures. At this point, the anaesthetist noted that the patient had become pulseless. A quick look through the telescope did not reveal any blood. The telescope was promptly removed, and cardiopulmonary resuscitation initiated promptly. The patient was successfully resuscitated with external cardiac massage, and a rapid IV infusion was started. At this point, the senior author (Sheth) was called in. The consultant noted that the patient was markedly pale. In view of the episode of unexplained hypotension, and the sudden developement of marked pallor, a provisional diagnosis of vessel injury was made and it was decided to explore the patient urgently with a call to cardiovascular surgeon to promptly attend. The abdomen was opened through a generous midline incision. Though there was no free blood in the peritoneal cavity, there was a huge retroperitoneal clot overlying the aorta. While awaiting the arrival of the vascular surgeon, no attempt was made to disturb the clot and

further bleeding controlled by applying manual pressure to the aorta, proximal to the clot. The vascular surgeon, who arrived within 15 minutes of the call, incised the peritoneum and evacuated the clot to find a small 5 mm injury on the anterior surface of the aorta. The bleeding was controlled by the application of a vascular clamp proximal to the injury, and the injury repaired with 4-0 prolene.

After ensuring hemostasis, the abdomen was closed in the routine fashion. It was felt that the injury was most probably caused by the Verres needle. The patient required a total of 14 units of blood and made an uneventful recovery.

Case 2: Mrs. XX, a 19 years primigravida weighing only 36 kg with a height of 4'8" underwent a diagnostic laparoscopy for a misplaced IUCD. Under General anaesthesia, a Verres needle was introduced by a resident doctor. The intraperitoneal position was confirmed by the saline test. Peritoneal cavity was insufflated with air through an ordinary electric pump. The Verres needle was removed with adequate abdominal distention and a trocar-cannula was inserted.

As the telescope was put into the peritoneal cavity, the anaesthetist announced that the patient's peripheral pulses had disappeared, and that the blood pressure was unrecordable. No blood was seen through the laparoscope. The laparoscope was promptly removed, and cardiopulmonary resuscitation initiated immediately. The patient was successfully resuscitated, and stabilised by rapid intravenous infusion through a central venous line inserted. The procedure was abandoned. The possibility of a vascular injury was considered, and a diagnostic abdominal paracentesis performed by the senior author (Sheth). As this was negative, it was decided to observe her. Close monitoring showed that she was getting paler after 1 1/2 hours of observation. Repeat abdominal tap was positive with a free flow of non-clotting blood. With a tentative diagnosis of a vascular injury an exploratory laparotomy was immediately performed through a midline incision. 100 gms of blood clot was find in the abdominal cavity. There was a massive retroperitoneal hematoma dissecting into the bowel mesentery. A cardiovascular surgeon opened the retroperitoneal space and, on removing the hematoma, found a 5 mm diameter puncture would on the anterior wall of the aorta, just above its bifurcation. It was felt that the wound had most probably resulted from the tip of the Verres needle. The puncture wound was closed with 4-0 prolene, and hemostasis achieved. The patient was given 4 units of blood intra-operatively and 3 units post-operatively. She had an uneventful recovery and was discharged home on the 10th post-operative day.

CLOMIPHENE INDUCED HYPERSTIMULATION OF THE OVARIES SIMULATING RUPTURED ECTOPIC PREGNANCY

H.K. Premi • Ashok Kumar

Women vary in their sensitivity to Clomiphene and even small doses sometimes overstimulated the ovaries to make them the seat of pain, enlargement, cystic change, haemorrhage and multiple ovulation (Jeffcoate, 1975).

Case Report

Mrs. S., aged 26 years who was put on clomiphene (50 mg OD x 5 days) for unexplained primary infertility by a private practitioner for 4 cycles presented on 4/6/1987 as a case of acute lower abdominal pain, 6-8 weeks amenorrhoea and slight bleeding P/V. On examination a rising pulse and falling BP with pelvic findings suspicious of a ruptured ectopic pregnancy were detected.

On culdocentesis 5 ml of dark altered blood from pouch of Douglas, was aspirated and a diagnostic laparoscopy showed pelvic haematocele. This was followed by laparotomy. There was enlargement of both the ovaries, each 5 cm in diameter and there was bleeding from the left ovary which required stitching. Both tubes and the uterus were normal. There was about 500 ml of blood in the pouch of Douglas. Patient was transfused one unit of blood in the O.T.

This ususual case is presented to highlight the fact that the administration of these fertility pills without proper follow up may mimic at times a ruptured ectopic pregnancy.

METASTATIC SQUAMOUS CARCINOMA CERVIX TO PERITONEUM

P. Fernandes • S. Singhal
A. Gupta • G. K. Rath
V.L. Bhargava

Introduction

Tumour spread from squamous carcinoma cervix is generally restricted to the pelvic and the para-aortic nodes. Distant metastasis in unusual, lung and bones being the common site. Although the peritoneum is a known site for metastasis from ovary, its occurrance in a case of squamous carcinoma of the cervix is a medical curiosity. This report briefly highlights a case of squamous cell carcinoma of cervix presenting with a solitary peritoneal deposit.

Case Report

V.K., a 50 years old female was diag-

All India Institute of Medical Sciences, New Delhi.

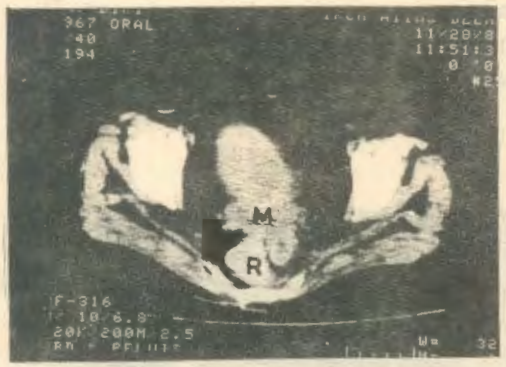


Fig.1 CT Scan of pelvis showing a large soft tissue mass (M) arising from the cervix and invading anterior rectal wall (R) as well as indenting the bladder.

Fig.2 CT Scan of abdomen revealing a soft tissue mass (M) situated on the left side and arising from the inner surface of the anterior abdominal wall.

nosed as a case of squamous carcinoma of cervix staged IIIB in March 1988. She received a radical course of radiotherapy. Seven months later, she presented with anorexia and pain in the upper abdomen. Examination revealed an irregular, mobile, non-tender mass in the epigastrium and left hypochondrium. She had evidence of loco-regional disease on pelvic and radiological examination (Fig. 1). Her hemogram, biochemistry and chest x-ray were within normal limits. A CT scan of the whole abdomen showed a large soft tissue mass situated on the left side and arising from the inner surface of the anterior abdomnal wall, consistent with a peritoneal deposit (Fig. 2). A CT guided aspiration cytology from the mass confirmed its metastatic origin. As the patient could not afford chemotherapy, the prognosis was explained.

ABDOMINAL CACOON

ARUNA RANGNEKAR

Patient H, a 24 years female reported with the complaints of a gradually increasing lump in abdomen of seven months duration and pain in abdomen for the last two days.

Though married, she did not have any children. Previously menstrual history was normal but of late had secondary amenorrhoea of seven months duration. Systemic examination did not reveal any abnormality. Abdominal examination showed a cystic tender lump of 24 weeks

size gravid uterus arising from the pelvis. Uterus was separate and normal in size.

Sonography (Fig. 1) showed a huge well defined cystic mass in the pelvic and umbilical region. It was multilocular. Both the ovaries could not be visualised separately. Uterus was normal size and empty and pouch of Douglas was clear.

Routine investigations did not reveal any abnormality, x-ray chest was also clear. On aspiration of the mass straw coloured fluid came out and biopsy cytology turned out to be acellular. Keeping in mind the possibility of tuberculosis, and endometrial biopsy curettage was also done.

A provisional diagnosis of ovarian cyst was made and it was decided to defer the laprotomy pending histopathological report but patient had to be laparotomized in emergency due to symptoms of acute abdomen. Lot of spurters were encountered when the abdomen was opened indicating the presence of adhesions inside. When recti were retracted and an attempt was made to lift up the peritoneum it was seen to be adherent with the thick capsule of the cystic mass arising from the pelvis and reaching upto the level of umbilicus. This was thought to be the cyst wall and an attempt was made to seek the proper clevage by blunt dissection. In this process the cyst wall burst emptying about 1.5 litres of straw coloured fluid and matted loops of intestines, uterus and adnexa was found to be inside it. These structures showed obvious evidence of tuberculosis. The membranes was excised as much as possible and abdomen closed after the adnexa was biopsied.

Post-operative period which was uneventful was covered with anti-tubercular drugs and patient was discharged on 9th post-operative day with the advise to continue antitubercular treatment. Histopathology confirmed the diagnosis of tuberculosis.

Fig. 1 Sonogram — showing multilocular cystic mass in umblical and pelvic regions

ENDODERMAL SINUS TUMOR OF OVARY

B.R. NILGAR • M.A. TELANG

Introduction

Endodermal sinus tumor is highly malignant rapidly growing germ cell tumor. It accounts for one percent of all ovarian tumors; It is second commonest germ cell tumour. Thus this case is being presented for its rarity.

Mrs. B.G.K., 35 years housewife of Bailhongal, was admitted on 15/10/1988 for white P.V. discharge, dull aching lower abdominal mass since three months. Last

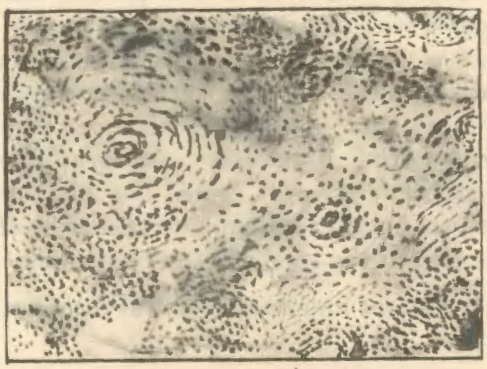
period 20 days prior to admission. Past cycles regular.

On Examination

Emaciated, anaemic patient with bilateral inguinal nodes, no edema. P/A Mass extending from pubic symphysis to umbilicus with restricted mobility irregular surface, variegated consistency, no ascitis. P/V: Cervix drawn up and visualised with difficulty. Uterus not felt separate from mass. Hard immobile mass felt in both fornices extending into pouch of douglas. I.V.P.: Bilateral hydronephrotic kidneys with hydroureter. U.S.G.: Both kidneys hydronephrotic. Encapsulated cystic mass with solid areas. Uterus displaced anteriorly. F.N.A.B.: Plenty of polymorphs, no malignant cells.

Laparotomy

Tumor from pelvis with purulent discharge; surface irregular, variegated, Uterus normal size; Tubes on both sides enlarged; No free fluid. Mass adherent to omentum and rectum. Colostomy done since rectal injury while releasing dense adhesions.



THE RETICULAR PATTERN OF ENDODERMAL SINUS TUMOR SHOWING TYPICAL SCHILLER-DUVAL BODIES

Colostomy closed with no complications. A sub total abdominal hysterectomy with Bilateral salpingoophorectomy done. Later secondaries noticed at colostomy site. Biopsy confirmed the diagnosis.

H.P.R.

Lt ovary: Reticular pattern with loose meshwork of spaces lined by cuboidal cells with scanty cytoplasm. Hyaline bodies seen. Schiller duval bodies seen - endodermal sinus tumor with infiltration into tubes (Fig. 1).

Post-operatively secondaries noticed in suprapubic region. Patient extremely emaciated and general condition poor; So chemotherapy could not be started; patient discharged in a moriband state.

Discussion

Endodermal sinus tumour also known as Teilum tumor, is second commonest following dysgerminoma. More common in young white females sixteen to eighteen years old. It is defined as germ cell tumour showing selective growth of the yolksac endoderm. Since it is rapidly growing, it may not be revealed by pelvic examination done one week before laparotomy. Duration of symptoms is for two to three months and presents with abdominal pain and swelling. It is associated with pregnancy and also with teratoma, dysgerminoma, choriocarcinoma, and is known to undergo torsion and rupture. Tumor is unilateral, 8-25 cms in size, rubbery in consistency. Cutsurface shows haemorrhages and necrosis. Microscopically it shows 5 features: Reticular type. labryinthine, polyvesicularvitelline, alveolar - glandular, solid. Diagnosis are schiller duval bodies with epithelial cells arranged around capillary, as seen in this case. Tumor

marker is alpha feto proteins found in hyaline bodies. Prognosis is poor with death occurring in 5 1/2 to 9 months.

MENOURIA

M.B. Deshmukh • S.S. Fusey

Mrs. S.G., 28 years was admitted after prolonged difficult labour for true incontinence of urine following vaginal delivery at P.H.C which was conducted without any operative interference.

On admission patient was in a good condition. Systemic and abdominal examination was normal. Uterus was 16 weeks in the midline. Speculum examination revealed the healthy cervix and vagina, while the urine was coming out through the cervix. There was no slough or fistula over the anterior vaginal wall.

On vaginal examination uterus was 16 weeks. Internal Os was open and a rent admitting a finger was felt about 3 cms above the internal Os on anterior wall through which the finger easily went into the bladder.

Diagnosis of high vesico-uterine fistula was clinically suspected. The patient was put on continuous catheterisation under cover of antibiotics for two weeks. Patient was subsequently discharged and was called for repair of true incontinence after 3 months.

Patient resumed her menses and gave history of passing blood during menses through urethra. Methylene blue test was done 3 months after delivery, when it was detected that the dye was coming out from the cervical canal. There was no other fistula detected. Hysterogram revealed communication between the uterus and the bladder just above the level of internal Os. The repair operation was undertaken by an abdominal route. On opening the abdomen, uterus and both adenexa were normal. Uterovesical fold of peritoneum was incised and the bladder pushed down. An oblique 2 cms rent in the isthmic region communicating with the bladder was visualised. The rent in the uterus was repaired and bladder was closed in layers after proper mobilisation. Uterovesical fold of Peritoneum was sutured after interposing the omental graft between the two suture lines.

Bladder was catheterised for two weeks. The fistula healed well and there was no true incontinence.

A year later she reported with severe strangury and dysuria and patient was treated with urinary antiseptic. The presence of bladder stone was suspected as patient continued to have the recurrence of symptoms. Plain X-ray abdomen confirmed the diagnosis - Suprapubic Cystolithotomy was done. The bladder stone of 5 x 2.5 x 2.5 cm. The puckering of the scar at the level of isthmus was felt.

Patient had an uneventful recovery.

Department of Obstetrics & Gynaecology, Govt. Medical College, Nagpur.

MALE INTERSEX DUE TO 5α REDUCTASE DEFICIENCY

D. PRATIBHA • SULTANA KHAN

The mode of inheritance of steroid 5α reductase deficiency is thought to be autosomal recessive. This results in abnormal sexual development only in males. The patients resemble phenotypically the perviously described cases of pseudovaginal perineoscrotal hypospadias syndrome and Type 2 familial incomplete male pseudohermaphroditism. Due to the deficiency of 5α reducates there is a failure of dihydrotestosterone formation in the urogenital sinus and urogenital tubercle at the time of sexual differentiation of male embryo that leads to ambiguity of external genitalia.

Institute of Obstetrics & Gynaecology, Govt. Maternity Hospital, Afzalgunj, Hyderabad 500 002.

Case Report

Miss. A about 18 years was admitted on 28/4/1988 in Govt. Maternity Hospital, Hyderabad for primary amenorrhoea. Patient noticed enlargement of the clitoris, growth of facial hair, moustache and breaking of voice since one and a half year. She is the sixth child in the family, all siblings being normal. No history of similar problem among the relatives.

On Examination

She was 159 cms in height, there was no breast development, axillary and pubic hair present, moustache and facial hair present but not marked (Fig. 1). The appearance of the external geitalia was that of a female with clitoromegaly, Gonadal swellings in the labia majora, inguinal hernia on the left side, presence of vagina of 4 cms. depth and the urethral orifice

Fig. 1 Absence of breast development and presence of moustache

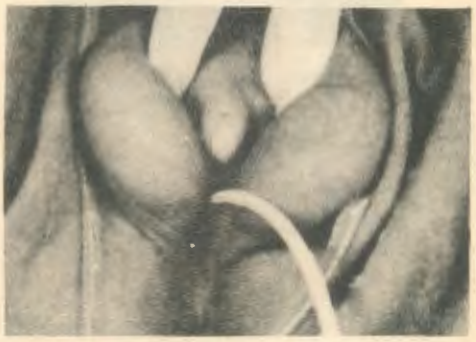


Fig. 2 Enlarged Clitoris, Gonads in the Labia Majora and Urethral Meatus 1cm below the Clitoris.

was 1 cm below the phallus (Fig.2).

Investigations

Buccal smear - negative for sex chromatin, Karyotype - 46 XY, I.V.P. - normal, on Ultrasonography - uterus and ovaries were not made out, Both kidneys normal, no suprarenal masses. On Laparoscopy, uterus, fallopian tubes and ovaries were noted to be absent, there was a fold of peritoneum between the Bladder and rectum. 17 K.S. - 21.0 mg/24 hrs., F.S.H. - 14 miu/ml, L.H. - 22.0 miu/ml, Testosterone - 3.0 ng/ml, Estradiol - 20.0 pg/ml.

Management

The patient was briefed about her condition and she decided to continue the sex of rearing. Bilateral orchidectomy, Repair of inguinal hernia, clitoroplasty and exclusion of reddundant labial (scrotal) skin was done on 14/6/1988 (Fig. 4). Estrogen replacement therapy (ERT) was started (Fig. 3). Both testes showed maturation arrest.

Fig. 3 Breast Development after ERT

Fig. 4 Specimen of Testes, Epidydimis and Vas Deferens