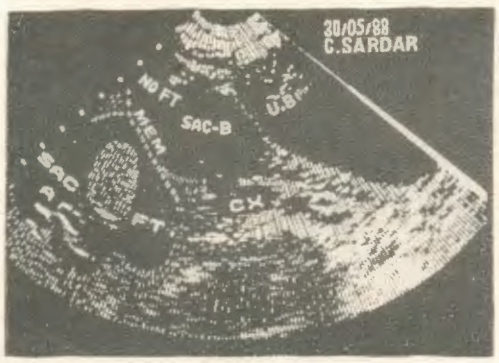
THE DISAPPEARING TWIN

SWAPAN K. KOLE

Mrs. C.S., age 31 years, para-2, abortion - 0, was admitted on 28 May 1988 at 10´ weeks of pregnancy with painless bleeding per vagina for one day. She had approximately 100 ml blood loss and the bleeding was moderate in amount at the time of admission. It started spontaneously and there was no history of similar bleeding during the course of the pregnancy or in previous pregnancies. Examination findings at the time of admission were: pulse 80/min; blood pressure 110/75 mmHg; pallor mild, uterus impalpable abdominally; per speculum-cervix long tubular, external os partially open, fresh bleeding present. She was provisionally diagnosed to be a case of threatened abortion. Vaginal palpation and bimanual abdomino-pelvic examination was abandoned to reduce the change of converting a case of threatened abortion into inevitable one. Investigation reports : Hb 10.2 gm/dl; blood group B, Rh positive; other normal.

Management: She was advised bed rest, diazepam 10 mg intramascularly on admission and then 5 mg orally twice daily, and tablet folic acid 5 mg daily. Sterile vulval pads were supplied liberally. Bleeding gradually reduced and stopped completely in 3 days.

A sonographic examination was done on 30th May to note the condition of the fetus. It revealed : twin pregnancy with blightening of one ovum - sacs with and without embryo were almost of equal size; CR length of the viable embryo 35.7 mm, period of gestation 72 ± 2 days; cervix-tubular; and cervical canal - partially di-



Ultrasonogram (longitudinal scan) at 10 $^{1}/_{2}$ weeks showing two gestational sacs — sac A with fetal echoes and intact membranes and anechoic sac B with a breach in the membranes at the lower end.

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lated (Fig. 1). She was put under observation and there was no problem subsequently. Another lower abdominal sonography was done after one week, which revealed natural growth of the embryo in the normal sac with 12.0 mm increment of CRL and gradual absorption of the empty sac with remarkable reduction of it's size to a more flattened elongated echofree space. She was discharged from the hospital with advice to attend the antenatal clinic regularly.

Antenatal period was uneventful. Sonographic examination was repeated at 18 and 32 weeks. It revealed normal gorwth pattern of the fetus and no congenital malformation She had spontaneous onset of labour at 36 weeks and delivered normally, giving birth to a healthy male baby weighing 2400 gms. After-birth expelled 8 min. after the delivery of the fetus. There was no PPH. Examination of the placenta: intact and healthy with a small projection (4 cm x 2 cm) from the margine of the placenta, connected loosely with the chorioaminotic membranes but intimately with the placenta. It was the remnant of the disappeared twin sac but it could not be dissected into layers. Histological examination showed fatty degeneration and advanced infarction in the compressed spongy chorionic tissue.

Discussion

The problem of diagnostic error by ultrasonography (detecting a false sac) should be kept in mind. To avoid this, USG should be repeated after one or two weeks as done in this case. Diagnois of disappearing twin has clinical importance - (a) patient can be assured of good prognosis of threatened abortion with which she usually presents (b) increased possibility of congenital malformations in the other fetus can be detected early (c) chance of preterm labour is forecasted and (d) possibility of coagulation defect and PPH is predicted. This patient had only one calculated risk i.e. preterm labour which was managed skillfully and the outcome was satisfactory.

PREGNANCY IN A CASE OF EXTENSIVE TUBERCULAR PERITONITIS

ALAK PAL • PAMPA SARKAR
H. DUTTA GUPTA

Mrs. S.B. aged 28 years had ovariotomy done at the age of 19 years and L.U.C.S. for breech presentation 3 years back was admitted in Eden Hospital, Medical College, Calcutta on 24/11/1988 with huge ascitis and short period of amenorrhoea.

Her menstrual history was normal. She had no specific complaints except abdominal discomfort, evening rise of temperature and rapid loss of weight.

On examination her general health was poor.

On abdominal examination apart from ascitis a firm irregular mass with restricted mobility was detected in lower abdomen.

Internal examination could not detect any pelvic pathology except some nontender nodules in pouch of Douglas.

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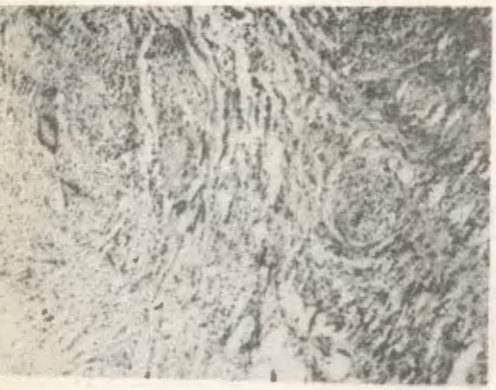


Microphotograph of tubercular granulation ssue from the omentum.

Routine investigations eg. blood, rine, stood etc. could not detect any bnormality.

Clinically it was diagnosed as a case f malignant ovarian tumour with a view f past history of ovariotomy 8 years back.

Photograph of caesarian hysterectomy specimen.

Laparotomy was done on 30/11/1988. On opening abdomen about 5 litres of straw coloured fluid was drained. Intestines and omentum were found to be studded with multiple tubercles. Internal genitalia could not be seen. Biopsy was taken from omentum and ascitic fluid was sent for cytological and biochemical examination.

Histopathological examination proved tubercular ganulation tissue and as such she was put on antitubercular drugs, (3 drugs regime-streptomycin, INH and ethambutol).

Her post-operative period was uneventful. She attended the out-patient department with history of persistence of amenorrhoea. On examination it was found that the uterus was about 24 weeks of gestation. USg was done and revealed a foetus with BPD of 6.5 cm. corresponding to 27 weeks of gestation and an oval mass in the lower part of the uterus the nature of which was doubtful.

Proper inpatient monitoring was done since that time and on 27/5/1989 elective caesarean section was decided.

On opening the abdomen the abdomen was absolutely free from all adhesions. No tubercle was seen anywhere. LUCS was attempted but we encountered an unexpected big fibroid in lower uterine segment (which explained the USG findings).

A male baby weighing 2.4 kg. was delivered by classical caesarean section. In view of the huge size of the fibroid it was decided to perform total hystrectomy.

Her post-operative period was uneventful and she went home on 7/6/1989 with the baby.

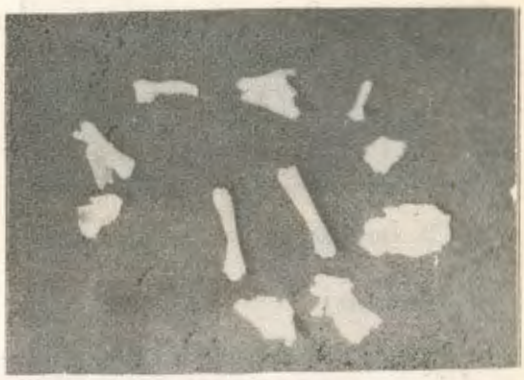
Acknowledgements

We express our gratitude to the Principal and Superintendent, Medical College Hospitals for allowing us to publish this paper.

AN UNUSUAL CASE OF MISSED ABORTION

VIBHA RANI • R. SATYAWATI

Mrs. S.B. aged 48 years, para 6+0+1, 3 male and 3 female babies, all term normal home deliveries had amenorrhoea of 4 months duration with usual symptoms of pregnancy. Eleven years ago, she took some indigenous drug with the help of a village dai, for terminating the pregnancy secretly. She had severe abdominal cramps and bleeding from vagina which continued for many days. Symptomatic treatment was given in a referral hospital, as she had not revealed the fact about her pregnancy, and the 'medicine' she had taken to procure a miscarriage. Although bleeding stopped gradually, her menstrual cycle was never regular, she suffered episodes of polymenorrhagia frequently. She also developed whitish discharge per vagina and consulted several doctors at regular intervals. She was diagnosed to be a case of cervicitis and vaginitis and given various vaginal pessaries and antibiotics for this. Ultimately, abdominal hysterectomy was advised and she was admitted to our hospital on 4/9/1987. On pelvic examination, the cervix was unhealthy, the uterus anteverted, and there was no palpable, adnexal pathology. Pap smear showed inflammatory cells. A total abdominal hysterectomy was performed for polymenorrhagia and persistent cervicitis. The length of the uterus was 3". The tubes and ovaries were healthy. Cut section of uterus revealed multiple small fetal bones, Fig. 1 buried into the endometrium in the posterior wall of uterus. A few recognised were of femur, ribs and parietal bones.



Foetal bones after they were taken out on sectioning of the uterus a few recognisable one – partial frontal bone & ribs.

The cases is interesting as even after 11 years after abortion, the bones were not autolysed and had the patient given correct history in the beginning, a simple D & E could have solved the problem.

D.M.C.H. Darbhanga
Acepted for publication on 12/10/1989.

AN UNUSUAL CASE OF FAILURE OF MEDICAL TERMINATION OF PREGNANCY

D.D. DONGAONKAR • L. KALAMKAR

Introduction

An unusual case of repeated failure of MTP in a parous woman due to failure of diagnosis of bicornuate uterus is reported. The diagnosis was made on ultrasound examination and was confirmed at laparotomy.

Mrs. V.R.N. aged 30 years, G4 P2 A1 reported at Cama Hospital on 24/6/1987 with a request for a 16 week MTP and sterilization. She gave history of MTPat 8 weeks with CuT insertion done elsewhere on 30/4/1987. Following this she had vaginal bleeding for 15 days with persistent nausea and vomiting. On examination at the same clinic the uterus was found to be bulky, anteverted, soft and CuT thread was seen. The CuT was removed and a curettage was done on 7/5/1987. No products were obtained and CuT was reinserted. Since her amenorrhoea, nausea and vomiting persisted USG was done which reported a 16 week live foetus with presence of CuT.

She reported to us on 24/6/1987. Examination revealed 16 week uterus with doubtful external ballottment and CuT thread was seen. Possibility of pregnancy with a bicornuate uterus or a fibroid was considered.

Repeat USG on 26/6/1987 showed a bicornuate uterus with a 16 week live foetus in the right horn and CuT in non-gravid left horn.

CuT was removed easily. Extraamniotic instillation was attempted, but the Foley's bulb could not be distended. Since Emcredyl instillation was not possible, PGF2 alpha was given i.m., 1 ml 3 hourly till 10 ml were given. Patient failed to abort. Laparotomy with a view to hysterotomy and sterilization was planned and carried out on 2/7/1987.

Laparotomy showed a bicornuate uterus with the right cornu enlarged to 16 weeks size with the normal adnexal attachment but a low insertion of the round ligament, and the left horn was the size of the normal uterus and the adnexa were normal. There was a small stalk connecting the two horns. Hysterotomy was done through a transverse incision and the products removed. The connecting stalk was explored for a communicating channel but there was no demonstrable communication. The posterior wall of the gravid horn appeared unusually thin. As there was no communication with the cervix, the gravid horn was excised and modified Pomeroy's sterilization was done on the left side. Post operative period was uneventful and the patient discharged on 9th day.

Discussion

Although there was a history of two attempts at MTP and CuT insertion, it become evident that the non-gravid horn of the uterus was curetted on both the occasions. However, histopathology reports not being available, possibility of

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