## CASE REPORTS

# REPEATED ECTOPIC PREGNANCIES

V. V. MISHRA • SUDHA P. NAGPAL

A 30 years old patient was admitted at Civil Hospital Ahmedabad in our unit on 19-9-1988 with history of $1^1/_2$ month amenorrhoea and complaints of nausea, vomiting giddiness and fever with rigor since three days; and pain in abdomen since 24 hours.

Her past menstrual periods were normal and regular, last menstrual period was on 7-8-1988. She was fifth gravida with first F.T.N.D. female 12 years alive. Second was right sided ampullary intact ectopic of two months amenorrhoea for which conservative surgery was done (linear salpingostomy which was sutured) on 13-6-82. Third was left sided ruptured tubal ectopic pregnancy of 1.5 month amenorrhoea for which left salpingectomy was done in December 1983 Fourth time she delivered a full term normal male child, alive 4 years old.

Except for mild anaemia (Hb 9 gm %) her vital data were within normal limits. Per abdomen and per speculum examination showed no abnormalities. On bimanual examination, uterus was anteverted, anteflexed, bulky and mobile; small cystic swelling 2 inches in diameter was felt in right fornix and left fornix was clear. Cervical movement was non-tender. USG showed T.O. masss only. Patient was discharged on request on 20-9-88 with medications and advised bed rest.

On 2-10-1988 she was readmitted in emergency with complaints of severe pain in abdomen with guarding and rigidity in right iliac fossa and bleeding per vaginum since four hours. P/S showed bleeding through os. On bimaual examination previous findings were confirmed Hb 6 gm.% TC: 6500, DC: 60, 35,3,2,0 ESR: 32 mm in 1st hour. USG showed empty uterine cavity with right sided T.O. mass of 4 x 4 cm., free fluid in pouch of Douglas.

Emergency laparotomy was done 400 cc of free blood was removed from pouch of Douglas. 4 x 4 cm black mass was removed from fimbrial end of the right tube and sent for H.P.E.

Right tube was transected and ligated. Three units of blood was given.

Post-operative period was uneventful.

Histology of the mass showed embryo surrounded by blood clot. Thus this patient had a total of three ectopic pregnancies.

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# TUBERCULAR ENDOMETRITIS PRESENTING AS A CASE OF SECONDARY POST PARTUM HAEMORRAGE

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## *Introduction*

Only 10 per cent of women with genital tuberculosis have borne children, and it is assumed that they contracted the disease following delivery. In rare cases the disease commences or becomes active immediately after a pregnancy, and in these cases a fatal miliary spread is not uncommon.

A case of tubercular endometritis presenting as secondary post-partum haemorrhage following a full term normal delivery three months ago, with evidence of acute and active pulmonary tuberculosis is being reported for its unusual presentation and rarity.

## *Case Report*

Mrs S.D. a 20 year old primigravida married for one year, attended the antenatal clinic of Kamla Nehru hospital on 15/5/86 at 19 weeks pregnancy with acute pyelonephritis. Her past menstrual histroy was regular. Age of menarche at 14 years, menstrual cycles were 4-5/28-30 days. Her LMP was on 3/1/86 and EDC on 10/10/86. She recieved treatment as an inpatient for acute pyelonephritis and was discharged on 24/5/86. She had a full term normal delivery on 28/9/86 in our hospital. A live born female baby with birth weight of 2.7kg. was born. She was discharged on 3/10/86 after an uneventful puerperium. She reported to the hospital on 18/12/86 (2 1/2 months later) with a history of continuous bleeding per vaginum for the last two months. A pelvic examination revealed bleeding through the os. A retroverted, normal sized mobile uterus. No adenexal masses were felt. A provisional diagnosis of secondary post-partum haemorrhage was made. A D and C was performed on 19/12/86. Plenty of normal looking curettings were obtained. The report was "Tubercular Endometritis" as seen in Fig.1. She came for the report on 15/1/87, she was further investigated: Hb- 7.5 gm%, PCV-20%, TLC-5,900, DLC-P67, L30 and E 3%. ESR-70 mm in 1 hour. X-ray Chest showed bilateral tubercular lesions of both lung fields, more on the left side. She was put on anti-tubercular treatment. As she

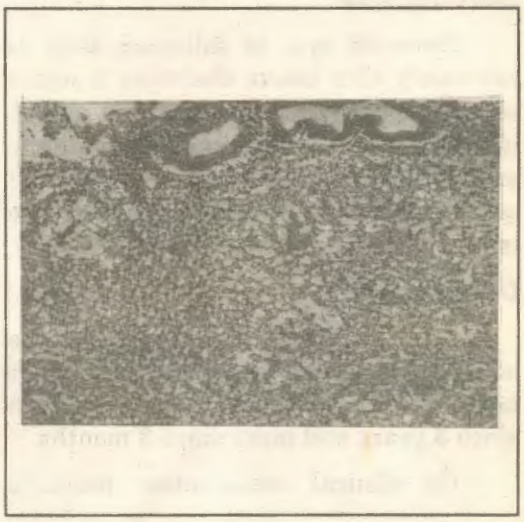

*Fig. 1 shows "Tubercular Endometritis"*

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continued to have heavy bleeding per vaginum, haemostatic doses of a combined pill were given and after the bleeding stopped, tapered to a maintenance dose of one pill per day. She was given cyclical hormonal therapy for three months more.

Follow up investigations and examinations by X-ray chest, haemogram, pelvic examination and a premenstrual biopsy after six months of anti-tubercular therapy showed remission. She has been treated for a period of two years, and has had a regular follow-up at intervals of six months.

## DERMOID CYST OF FALLOPIAN TUBE

RAJESHREE NAHAR • S. BHATT
K. BHAGWAT

### *Introduction*

Dermoid cyst of fallopian tube is extremely rare lesion, therefore it seems worthwhile to report this case. SCIARRA in his Gynaec & Obst., has quoted only one author Zellinger who has reported only 33 cases in the world literature. No such case is reported in the Indian Literature.

### *Case Report*

Mrs. S., 27 years old, Hindu was admitted for dragging type of pain in left lower limb and left lower abdominal pain since 3 years and more since 3 months.

On clinical examination patient's general condition was good and B.P. 120/70 mm. Hg.

Per abdomen no abnormality was detected.

On vaginal examination a mass of about 3" x 2" felt in the left fornix, uterus and right adnexa was normal.

On exploratory laparotomy uterus, both ovaries and right fallopian tube were found to be normal. The left fallopian tube was dilated with the mass of about 4" x 3". Outer surface was smooth and uniform, giving the appearance of dilated tube fimbrial end was normal. Left sided salphingectomy and plication of round ligament was done. Abdomen was closed.

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## AN UNUSUAL CASE OF AUTOHYSTERECTOMY

USHA SHARMA • ABHILASHA GUPTA
G. K. ANEJA

Mrs. K.A., a multipara was admitted in SVBP Hospital, Meerut as a case of hand prolapse of second of the twin with obstructed labour. She had delivered the first of the twin at home 12 hours ago. A caesarean section was now done. Postoperatively she developed fever which became high grade by 4-5th day with development of other signs of sepsis in the form of paralytic ileus and purulent discharge from the drainage site and wound site. She was given broad spectrum antibiotics with I.V. metronidazole. The paralytic ileus responded but tempreature of 100-102°

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persisted, abdominal wound taped upto rectus and purulent discharge per vaginum continued. Daily dressing and vaginal douching was done. On 10th day she complained of nectrotic fleshy pieces being passed P/V alongwith foul discharge. $H_2O_2$ douching was continued and about a week later, while trying to remove the necrotic bit with a sponge holder, a sloughed necrotic uterus came out followed by about 10-15 ml thick foul smelling pus. There was no identifiable piece suggestive of adnexa. Patient made a very quick recovery after that and was discharged in a satisfactory state.

## HUGE INCISIONAL HERNIA AT CAESAREAN SITE

JAI BHAGWAN SHARMA • NIRMAL GULATI
KRISHNA SANGWAN

### *Case Report*

Mrs. V. D., a 25 years old second gravida was admitted with 39 weeks pregnancy with previous history of emergency caesarean section for contracted pelvis.

On examination - General condition was good. Pulse 80/mt, B.P. 130/88 mmHg. Heart/Chest - NAD.

On abdominal examination - Abdomen was distended markedly, uterus was term size, cephalic presentation. Uterus well relaxed. F.H.S. 140/mt regular. There was a big 10 x 8 cm incisional hernia with positive cough impulse (Fig. 1).

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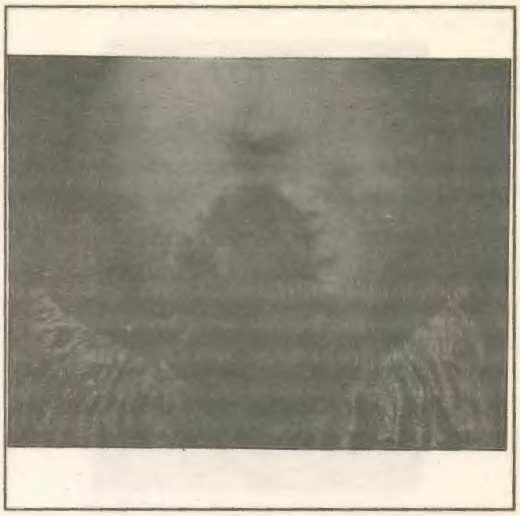

*Fig. 1 showing huge incisional hernia at LSCS site*

### *Investigations*

Hb 11 gm%, BT 2 min, CT 4 min. Urine - NAD. Blood group O +ve.

Elective LSCS and repair of incisional hernia done with non absorbable sutures. Gut and omentum were lying underneath the skin.

Postoperative period was uneventful excepting for slight stitch infection and patient was discharged on 10th day in a nice condition. Baby was healthy at discharge.

## ACARDINS AMPHORUS

SHIVBHAGWAN AGARWAL • LILA AGARWAL

A Case of Acardins Amphorus: It is not unusual for twins to differ in weight

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*Fig. 1 shows acardius amphorus*

and size from each other and sometimes the difference is considerable. In uniovular twin there is always a certain area of placenta where extensive anastomosis between the two vascular pattern exist. As the result of this anastomosis many anamolies may arise. The heart of one foetus is stronger and may overpower that of the other, through the placental vessel anastomosis. If this occurs the weaker heart receives less blood, and less nutrition and foetus remains undeveloped. It is called, Acardius. An Acardins amphorus is a monster with a rudimentary head, and in this case extermities are well developed. Acardins amphorus only occurs in univoular twin pregnancy.

Mrs. D.P.A. age 28 years para II was admitted on date 12/9/1989 at the Nursing Home. She had previous Classical Caesarean Section for transverse presentation at Gujarat. She was taken for L.S.C.S. under anaesthesia. A female live child delivered as breech, 2nd foetus was also delivered as a breech. It was an acardins amphorus. She had uneventful recovery and was discharged on 8th postoperative day.

# THORACOPAGUS DOUBLE MONSTER

PREM SINGALA • DALJIT K. HANS

Conjoined twins are very rare. The reported incidence is 1:50000 normal 1:100000 abnormal birth. It results due to incomplete division of inner cell mass. They are monozygotic twins and may be joined at various levels.

## *Case Report*

Mrs. V.R. aged 23 years Gravida 2 Para 1 was admitted in Rajindra Hospital Patiala on 31st August 1989 with the h/o Amenorrhoea 5 months and acute distension of abdomen 15 days. She was married for $2^1/_2$ years had one FTND $1^1/_2$ years alive female. LMP was 1st April 1989.

*Past history* — She was a diagnosed case of RHD with MS, MR & AR and was taking treatment before conception in the form of Digoxin, Lasix, Penidure LA 12 & Potchlor.

*On examination* — Patient was moderately built and poorly nourished. Aneamia +, no cynosis. Pulse 98/min, BP 120/80, resp rate 23/min. Oedema feet was nil. In CVS - Mid systolic and diastolic murmur in Lt parasternal area was present.

*On local examination* — Height of uterus more than period of amenorrhoea 30-32 weeks, tense ? multiple parts palpable. Investigations - HB 9 gms BT 1'20" CT 3'15". Urine n.a.d. Blood gr B Rh+.

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