A CASE REPORT

VIRILISING ACTION OF PROGESTAGENS ON THE FEMALE FOETUS

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A patient Mrs. K. 22 years was admitted on 13.9.89 at 12 noon as an emergency case of 41 weeks of pregnancy in the department of obstetrics MYH Indore with the history of amenorrhoea 9 months. She was GIIP0; had one abortion of 10 weeks and evacuation and curettage was done for that, one year back. Her LMP was 1st December 1988 and EDD 8th September 1989.

The patient was given Inj. Proluton depot (Hydroxyprogesterone caproate) 250 mg. IM weekly from 7 weeks of pregnancy to 36 weeks. Tab. Gestanin (allyestrenol) 1 tds. from 7 weeks of pregnancy to 38 weeks of pregnancy by some private practitioners.

Intrauterine ultrasonography revealed foetus with small fluid filled lesion between the two hips bulging posteriorly about 3.5 x 5 cms. and the amount of liquor slightly less than normal.

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Patient delivered on 21st September 1989 at 4 p.m. by normal labour. The baby was seen by consultant surgeon and diagnosed as a female baby with hypertrophied clitoris (Fig.I). Buccal smear showed female pattern. The 17 ketosteroid level, testetrone level 11 deocycorticosteriod level and serum electrolytes were within normal limits.

Baby with external genitalia.

VOLVULUS OF INTESTINE FOLLOWING DELIVERY

P. MANCHANDA & PUSHPA BHATIA

A 20 year old second gravida patient

delivered normally and two hours following delivery she complained of severe pain abdomen, difficulty in breathing and fever. On examination she was toxic and ill looking, her pulse was 148 per minute, B.P. 120/90 mm. Hg. temperature 38 degree C and respiratory rate 48 per minute.

Per abdomen examination showed that uterus was well contracted.

A tender, ill defined mass was felt in right hypochondrium and umbilical region on right side and above fundus of uterus.

Per vaginum examination showed that uterine cavity was intact. The mass was felt high up on right side and was tender. She was diagnosed as twisted overian cyst and emergency laparotomy was done.

Laparotomy findings: There was free blood-stained fluid in peritoneum. Uterus, both tubes and both ovaries were normal. Distal half of small intentine was gangrenous due to volvulus which was around Meckel's diverticulum and a fibrous band. Resection of gangrenous gut was done till Ileocaecal junction. Ileal opening in caecum was closed. Proximal end of small intestine was anastomosed to transverse colon. Patient's recovery was uneventful.

Volvulus of small intestine after delivery is a rare condition and is likely to be missed unless the possibility is kept in mind. In this patient volvulus of intestine probably occured just after delivery. The patient was diagnosed as a case of a twisted ovarian cyst because that is the commonest condition causing acute abdomen following delivery and she had no symptoms suggestive of gastrointertinal disease.

This case is being reported to emphaise that surgical conditions must also be kept in mind while dealing with delivered patients.

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PARTIAL MOLE WITH FOETUS OF 18 WEEKS GESTATION

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Mrs. S. aged 30 years, G7P4A2L2, LMP not known was admitted with a history of 6 months amenorrhea and bleeding per vaginum for 1 day. Patient also gave a history of passing grape-like material.

On abdominal examination, uterus was 30-32 weeks. Fetal parts were not made out. Fetal heart sounds could not be localised. On per-vaginum examination, bloody discharge was present. Cervix partially effaced, os dilated. Ultrasonography showed a fetus of 18 weeks gestation by femur length estimation and snow-storm appearance suggestive of partial mole.

The surgical procedures done were hysterotomy and removal of placenta with vesicles and fetus. Total hysterectomy with right salpingo-oophotectomy was also done and sent for histopathological examination.

B HCG levels at time of admission was 1920 mIu/ml and on follow up after 2 months 2.1 mIu/ml.

Pathological findings

The surgically removed specimen comprised of uterus and cervix measuring 13x8x6 cms with right adnexa. The uterine cavity was enlarged and measured 10x8 cms. The internal surface was covered with brownish tissue.

The placenta weighed 500 gms. and contained focally fluid filled cysts seperated by normal unaffected placental tissue (Fig.1). Histologically, these cysts consisted of large cisternal spaces within the affected villous stroma. Abnor-

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mal villi were interpersed with normal villous tissue. Minimal trophoblastic hyperplasia was seen.

Partial mole with foetus of 18 weeks gestation

Final Diagnosis: Partial mole in Second Trimester pregnancy.

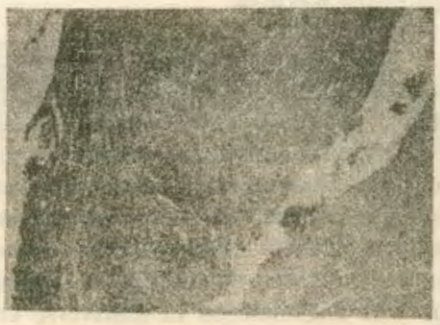
ACTIVE ENDOMETRIAL TUBERCULOSIS WITH COEXISTANT PREGNANCY

B.D. SABHARWAL, RAMA SOFAT, ASHWANI DUGGAL

Mrs. S.K., 22 years old female married for 1 year (Po + O) presented with complaints of 10 weeks amenorrhoea and spotting for two days. Gravindex test done was positive and uterus size corresponded to 6 weeks on vaginal examination. There was no past history or family history suggestive of tuberculosis.

The general physical and systemic examination of the patient was within normal limits. The routine laboratory investigations were also normal except for a raised ESR of 80 mm fall 1st hour (Westergren). There was no radiological evidence of tuberculosis in the chest. After 4 weeks, she had a bout of bleeding. Gravindex test was repeated and it was found to be negative. Evacuation was done and curettings were examined histopathologically.

Sections revealed many chorionic villi with mild stromal fibrosis, syncitial knotting, fibrinous covering and cytotrophoblastic proliferation. Decidual fragments were also present. In addition, well formed tubercles with typical epitheloid and giant cell reaction and extensive caseation were also seen in the endometrial fragments (Fig.1).



Active endometral tuberculosis with coexistant pregnancy

The patient was started on antitubercular treatment. She was reexamined after two months. There was mild thickening of fallopian tube on the right side and cervical erosion on both lips which bled on touch, Pap smear showed an inflammatory smear without any evidence of tuberculosis. Ultrasound scanning revealed a normal uterus and a normal left ovary. There was suggestion of mild pelvic inflammatory disease on the right side. The patient was put on regular antitubercular drug regime with the advice to come for follow up every 3 months. She has now delivered a healthy female baby.

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UNRUPTURED RUDIMENTARY HORN PREGNANCY WITH 26 WEEKS FOETUS

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Mrs. Kanta, 22 years Hindu female, 2nd gravida (with full term normal delivery 1 1/2 years back) was admitted on 17.1.90. She complained of 37 weeks (8 1/2 months) amenorrhoea and off and on bleeding per vaginum for last 5 days. She was not able to tell exactly the date of last menstrual period and any thing about perceiving foetal movements.

On abdominal examination, an intra-abdominal lump was palpable arising from hypogastrium going obliquely towards right side and extending upto the umbilicus (corresponding to fundal height of 26 weeks). It was freely mobile, tender and firm in consistency. External ballotment was absent. Foetal parts could not be felt. Foetal heart sounds could not be localized.

On per-vaginum examination, uterus was retroverted, bulky, soft in consistency and deviated towards left side. The lump was found to be in relation with the right cornu of the uterus. External os was closed but there was slight (+) bleeding from the os.

Ultrasonography was done. It revealed that uterus was of normal size and shape. No evidence of pregnancy or other abnormality was seen in it. There was a dead foetus of 25 weeks size seen in lower abdomen and right side of pelvis (with absent cardiac activity). Placenta showed degenerating changes and liquor was very little in amount. No free fluid or other abnormality was seen in pelvis or lower abdomen. She was diagnosed as a case of intra-abdominal pregnancy.

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Her laparotomy was done and a lump (10x12" size) was seen. It was connected with the right cornu of uterus while the right sided fallopian tube and ovary were found attached to the lump at its other end.

Unruptured rudimentary horn Pregnancy with 26 weeks foetus

Clamps were applied and lump along with right sided tube and ovary was removed. Its cut-section revealed 25 weeks dead foetus along with placenta Fig.1. Her postoperative period was uneventful.

Histopathological examination confirmed the diagnosis of pregnancy in rudimentary horn.

Rudimentary horn was still unruptured. Foetus might have died at 26 weeks while pregnancy continued even after this period or she might have conceived in the period of lactational amenorrhoea, so that the size of the foetus was small as compared to period of amenorhoea.

FOETAL INTERLOCKING COMPLICATING TWIN GESTATION

SMITI NANDA, SUSHEELA RATHEE

An unbooked 25 year old para 1, was admitted with history of arrest of after coming head

of the baby and breech hanging out for 6 hours. She was 34 weeks pregnant and had planned a home delivery. Finding it impossible to deliver the aftercoming head, Dai referred her to the hospital.

General physical examination was satisfactory except for mild anaemia. On abdominal examination, it was found to be a twin pregnancy with uterine height of 34-36 weeks. Foetal parts were palpable. One head could be felt on pelvic grip. Foetal heart was absent.

At the introitus, a baby presenting as breech was seen hanging with the arrest of aftercoming head. Cord pulsations were absent.

Pelvic examination revealed that the head of the second twin was deeply engaged in the pelvis and the neck of the partially delivered foetus was impacted between the head of the second twin and the symphysis pubis.

As the engaged head of the second twin could not be dislodged upwards out of the pelvis, decapitation was done to facilitate the delivery of second twin. The decapitated head was manually removed from the uterus. Uterus was explored and found to be intact. Babies were fresh still born weighing 1.7 kg and 2.1 kg respectively.

THE USE OF NITROGLYCERINE TO CONTROL HYPERTENSION OF ECLAMPSIA

SEEMA HAKIM, SHAISTA MOHSIN, T.Z. KHAN, RASHID M. KHAN

Patient M, a 21 year old multigravida was admitted to the Obstetric ward with the diagnosis of eclampsia. Her L.M.P. was over 8 1/2 months. Her chief complaints were hemetemesis 6-8 hours, frank convulsions over the last 24 hours and swelling over the feet and legs 10-12 days. She gave no history of antenatal checkups. On examination she had 2+ oedema feet and legs. Pulse rate was 96/min. B.P. 202/116 mm Hg and a respiratory rate of 28/min. Her chest auscultation revealed occassional scattered crepts. Haemoglobin was 8.5 gm% and urine 2+ for proteins. Foetal heart sounds were absent. On vaginal examination she was in early first stage of labour.

The patient was administered a bolus of 20mg diazepam IV and 40mg was added to the drip to be run over the next 6-8 hours. A wide bore Ryle's tube was passed and gastric aspiration done. Following this 50-100 ml of chilled saline was instilled into the stomach. This was done every 3-4 hours. Patient was given Ranitidine 50mg thrice a day I.V. and 3 lit Oxygen by nasal catheter. With this regime, patients convulsions were controlled and gastric bleeding much reduced over the next 12 hours. However gradually, she developed signs of respiratory distress. Her respiratory rate rose to 38/min which was shallow and laboured. Chest auscultation revealed frank crepitations all over. B.P. was 172/106 mm Hg and pulse rate 108/min. It was now decided to shift her to the Intensive Care Unit where her tidal volume was found to be 235 ml, respiratory rate 40/min, pulse rate 112/min, B.P. 178/106 mmHg and C.V.P. + 2cm H2). She was unresponsive to oral commands but showed some movement to painful stimuli. Cardioscopic monitoring revealed sinus tachycardia. The patient was paralysed with 15mg d-tubocurarine, intubated with 8.00mm cuffed endotracheal tube and put on ventilator in the I.P.P.V. mode. Diazepam drip was discontinued but sedation with 0.15 mg buprenorphine and 20 mg promethazine I.M. was continued 6 hourly. 10 mg nifedipine was given sublingually to control her B.P. but its action was found to last only 1-2 hours. Crushed hydrallazine tablet was tried via the Ryle's tube but because of repeated suc-

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