CASE REPORTS

OVARIAN PREGNANCY

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Patient A.K. 25yrs G $_3P_0A_2$ was admitted in R.H. Patiala with the C/C of amenorrhoea 3mths & 25days. A bout of bleeding 20 days back. Gravindex test became -ve after being +ve. Ultrasonography report was 8wks size gestational sac - without foetal cardiac activity. Her obst. history-1st spontaneous abortion at 3mths gestation. 2nd sp. abortion at same gestation & got D&C done.

On examination - Pulse 80/min BP 120/80mm Hg Resp rate 24/min Temp normal. P/V exam-Cx firm, uterus size multiparous, a mass of about 2" x 2" size could be felt in right fornix a little separate from uterus, cystic, nontender with restricted mobility. Hb 10gms Bt, Ct normal, urine n.a.d.

Provisional diagnosis-? Ectopic Preg ? Ovarian Cyst was made.

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Diagnostic laparoscopy - uterus was normal, left tube & ovary normally visualised. On right side medial end of tube, ovarian & round ligament were traceable. A mass burried in adhesions of gut and omentum was seen.

No free blood in peritonael cavity seen. On laparotomy-mass separated from adhesions. There was ovarian preg, tube was inflammed and adherent on the mass. Right salpingo-oophrectomy done. On opening it contained membranes & placental pieces,

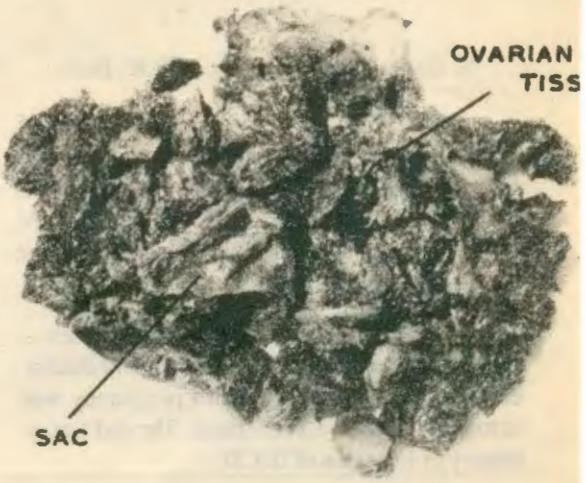

Fig.1-Cut section of ovary showing preg sac.

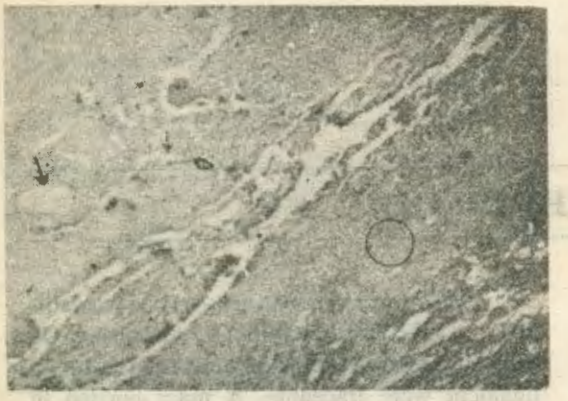

Fig.2-Photomicrograph villi in ovarian tissue.

PRIMARY OVARIAN PREGNANCY

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Mrs. R.D. aged, 25 years, H.N. 294675, was admitted on 24.4.90 for irregular vaginal bleeding since 3 weeks and pain in lower abdomen for 2 weeks. Her L.M.P. was on 10.3.90. Her previous menstrual cycles were regular. She got married 7 years ago.

She had two full term normal deliveries—the first child well and alive and the 2nd died in early neonatal period. Her 3rd pregnancy was ectopic; operated 3 years back. She did't give history of insertion of IUCD.

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On examination, the patient was ill looking, pale, B.P. 110/70 mm Hg.Pulse 88/mins. and temperature was normal. Chest and cardiovascular system were normal.

Examination of abdomen there was no generalised abdominal distension or tenderness. The previous laparotomy scar was healthy.

Vaginal examination showed slight bleeding form the cervical canal and presence of altered blood in the vaginal canal. The uterus was slightly bulky, soft, tender, mobile and anteverted. Cervix was otherwise normal. A tender, firm mas about the size of an egg felt through the Rt. fornix, Exact size could't be determined because of tenderness and poor abdominal relaxation. Left adenaxa was normal.

A provisional diagnosis of Chronic. ectopic gestation was made.

Her Hb level was 58%, total WBC 11,800/cu. mm., ESR 18mm AFEH. Her urinary beta-HCG test was positive in undiluted urine.

With an empty and slightly enlarged uterus.

LAPAROTOMY:

Laparotomy was performed on 29.4.90. On Opening the abdomen, the uterus was found to be slightly enlarged. The left tube and ovary were also normal— probably her previous ectopic pregnancy was a tubal abortion and thus there was no surgical trauma to the tube. There was no hemoperitoneum and all the abdominal and pelvic organs were free of adhesions.

The right ovary was enlarged, cystic in consitancy about 3x4x5 cm. size, which was free without any adhesions or haemorrhage. The right tube with its fimbriated end was normal. The enlarged every was connected to the uterus by the ovarian ligament and to the larteral pelvic wall by the infundibulopelvic ligament.

Right sided salpingo-opporectomy was done. Abdomen closed in layers and proper hemostasis maintained

Fig.1. Ultrasonograph showed a gestational sac in the fimbriated end of the Rt. follopian tube

On incising the mass, a small gestational sac about 2 cm. in diameter came out easily.

Her post operative period was ineventful and we discharged her on the 11th post operative day.

Histological examination of the enlarged ovary confirmed the diagnosis of ovarian pregnancy showing chorionic villi embedded in ovarian tissue.

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ADDISON'S DISEASE COMPLICATING PREGNANCY

ANUPAMA H ● RADHAKRISHNA H ● SARALA DEVI K

Mrs. K.K. aged 30 years, G2, P1, A1, had a fullterm normal delivery 9 years back. 18 months back she was investigated for black discolouration of palms, soles of feet and tongue in some other hospital, and was found to be having addison's disease (Adrenocortical insufficiency). At that time on 22-7-89, the hormonal profile showed.

Serum Cortisol -3.0 ng/dl Normal 6 AM 100-180 ng/dl
8 AM 110-200 ng/dl
4 PM 60-110 ng/dl
6 PM 50-60 ng/dl

ACTH (RIA) - 180 pg/ml (normal 8 AM 10-100 pg/ml)

24-h. Urinary 17 ketosteroids- 5.9 mg/day (normal 5-17 mg/dl females.) Since then she was stabilised on prednisolone 5 mg in the morning and 2.5 mg in the evening. In the same hospital she was examined during the present pregnancy and was advised termination; probably in view of the terato genicity of corticosteroids. She refused termination of pregnancy and came to this hospital.

She was admitted on 21-6-90 with E.D.D. 17-7-90. At the time of admission she was normotensive, of normal height and weight,

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afebrile, vertex presentation. Her investigations were - Blood sugar - 60 mg/dl; urea - 20 mg/dl; Hb-10.0 Gm%; Urinalysis - normal; X-Ray chest and ECG were within normal limits. Ultrasound scanning showed a single normal fetus without any detectable congenital anomalies. Her hospital stay was uneventful except for premature rupture of membranes, following which she had a spontaneous vaginal delivery of a female child 2 weeks before EDD with APGAR score 8 and weight 2.3 kgs. Immediately after delivery she developed hypotension and fever which continued upto sixth postpartum day. Antibiotics and continuation of the same dosage of prednisolone were adequate to control it. The baby did not have any congenital anomalies as was assessed by a pediatrician

The only consistently recorded complication of corrected Addison's disease is a low birth weight and occasionally maternal mammary atrophy leading to feeding problems for the baby.

SHEEHAN'S SYNDROME WITH PARTIAL DIABETES INSIPIDUS

RADHABAI PRABHU ● P.N. KANTHAMANI

Mrs. T. aged 27 years was admitted with the following complaints: amenorrhoea of 5 years duration, puffiness of face, edema feet, loss of weight, loss of appetite, lethargy and on and off fever with headache for the past 5 years and vomiting for the past one week. Bowel habits and micturition were normal.

She attained menarche at the age of 13, and married 7 years later. Her Previous periods were 4/30 regular. She has 1 FTND 5 years ago and one week prior to delivery, she developed signs of severe PIH and was treated with sedatives and antihypertensives. Labour was induced with ARM and Syntocinon drips. There was no postpartum haomorrhage. 4 hours after delivery patient had postpartum eclampsia and became unconscious for which Menon's regimen was started. During treatment there was fall of BP to 80/50 for 4 hours which was restored with IV fluids and cortisone. Patient was discharged well on the 10th day with a normal BP. Patient could not breastfeed the baby as she never established lactation.

On Examination patient was conscious, severely anaemic with edema feet and puffiness of face, CVS, RS-normal. Pulse and BP could not be recorded, skin was dry, scaly and icthyiotic, axillary and public hair were absent, breast and external genitalia were atrophic. There was no goitre, coarse voice was present and there was delayed deep tendon reflex. Pelvic examination revealed an atrophic cervix and uterus. A provisional diagnosis of Sheehan's Syndrome was made.

Investigations: Hb-5 gms%, Urine specific gravity-1010, GTT-Fasting-73 mg%, 1/2 hr-84 mg%, 1 hr. 100 mg%, 1 1/2 hrs-65 mg%, and 2 hrs-62 mg%, cone view of sella normal and Vaginal smear showed atrophic pattern.

TSH - .0000 (Range. 25-5.2 micro units.ml)

LH - .694 Miu/ml. (5-20 miu/ml)

FSH- .423 miu/ml.

Serum Cortisone - 1.66 micro gms/100 ml. (5.25 micro gms/100 ml.)

Hypotension was treated with blood, IV fluids and tab. prednisolone 5 mg. tds. After 15 days of treatment BP touched normal, and the patient was started on tab eltroxin 1/2 od. Now she presented with severe polyuria and polydypsia, so partial diabtes insipidus was also sus-

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pected and a water deprivation test was done. Inspite of fluid deprivation urine output continued to be 150-200 ml/hr. and the specific gravity was 1004-1006. So partial diabetes insipidus was confirmed.

After 2 months of treatment with prednisolone and eltroxin patient was started on cyclical estrogen and progesterone therapy and the response is god with regular withdrawal bleeding. The next step is to induce ovulation is this patient with gonadotrophins.

AN UNUSUAL CASE OF ACCIDENTAL HAEMORRHAGE FOLLOWING SNAKE BITE.

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INTRODUCTION

Accidental haemorrhage is commonest obstetrical emergency. Snake bite venom causing accidental haemorrhage is rarest cause of the problem.

Case Report : Mrs S. aged 35 years, Gravida 5th presented herescIf with history of six and half months amenorrhoea, abdominal pain and loss of foetal movements; was admitted to Umaid Hospital in April '89.

She gave history of snake bite and was admitted in General Government Hospital Medical ward for three days. She was given 140 units of Anti-Snake Venom and one unit of fresh blood.

On Exam: PA- Uterus was tense, 32 weeks size, presentation could not be made out. Foetal heart sound could not be localised. Height and girth of abdomen were 30 cm and 90 cm respectively. There was no bleeding per vaginum. Pulse and blood pressure were normal, but bleeding time and clotting time were more than 15 minutes .

Two hours after admission, she started bleeding per vaginum profusely. She was diagnosed as a case of accidental haemorrhage with both concealed and revealed haemorrhage.

She bled profusely after artificial rupture of membrane. Immediately, abdomen was opened. Peritoneal cavity was full of dark coloured blood. Couvelaire uterus with haematoma on left broad ligament showing sign of rupture was seen. Caesarian hysterectomy was done. As patient had continuous fresh bleeding, multiple catgut sutures were applied in pelvic peritoneum. Drain was put in abdominal cavity and abdomen was closed.

Throught the operation her pulse and blood pressure were normal and 1 unit of fresh blood was given. She was put on corticosteroid, epsilon amino caproic acid and botropace with routine treatment. She had two bouts of bleeding per vaginum after operation (i.e 2 and 5 hours). After second bout, she was pulseless and blood pressure was un-recordable for 4 hours. She was immediately given high doses of corticosteroid with 4 ampoules Dopamine in drip. Two units of fresh blood was given. On third post operative day, epsilon amino caproic acid and corticosteroid were stopped with tapering dose.

On ninth day abdominal stitches and drain were removed. patient was cheerful and was on normal diet from sixth day onwards.

Venoms are likely to cause an immediate catastrophy in human beings. In this patient, instead of venom being neutralised by anti-snake venom, patient developed accidental haemorrhage after one week of bite.

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