## A CASE REPORT

# PREGNANCY FOLLOWING CHEMOTHERAPY FOR MIXED GERM CELL TUMOR

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S.D., 18 year old unmarried girl presented to us in June 1987 with an abdominal mass and pain in abdomen of 6 months duration. On physical examination a 10 cm x 10 cm pelvic mass was noticed. On laparotomy a right sided ovarian tumor ith adhesions to the signoid and omentum was found. There was no evidence of macroscopic metastasis in the abdominal organs. The left ovary, uterus and both tubes looked grossly normal. Right sided salping o-oophrectomy with omentetomy and biopsy of the opposite ovary along with retroperitoneal lymph node sampling was performed. Histopathological examination. of the tumor revealed mainly dysgerminoma admixed with elements of endodermal sinus turmor. Omentum also showed microscopic evidence of metastasis.

The left ovary and retroperitoneallymph nodes showed no evidence of malignancy.

Two weeks after surgery chemotherapy with vinblastine 0.3 mg/kg (Maximum 10 mg in a single dose) intravenously on day 1 and day 8, Bleomycin 10 mg/I/V (maximum 15 mg single dose) on day 1 and day 8 and Cisplatinum 20 mg/M from day 1 to day 5 (maximum 30 mg single dose by slow intravenous infusion after adequate hydration). Cycle was repeated after 28 days for 6 courses. Complete blood counts, renal and pulmonary function evaluation were carried outbefore start of next cycle. The patient responded very favourably and after completion of chemotherapy to date she was found to be clinically, biologically and sonographically free of disease. Her menstrual cycles remained regular and she conceived one year after completion of chemotherapy. She delivered at term in Dec. 1989 a healthy normal male baby weighing 2.9 kg with no evidence of congenital anomalies.

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# TORSION OF THE GRAVID UTERUS IN THE SECOND TRIMESTER OF PREGNANCY

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A 30 year old second gravida primipara registered for antenatal care at the K.E.M. Hospital, Bombay at 16 weeks of gestation. Her expected due date of delivery was 22.2.1990. She had one vaginal delivery, a still-birth, the details of which were not available. Thoraco-lumbar scoliosis was noted on systemic examination. Ultrasonography revealed a single 28 weeks sized live foetus corresponding to the period of amenorrhoea. Her hemoglobin was 10.5 gm% and VDRL test was positive (Titre 1:16) for which she was treated with penicillin. Four days after her last antenatal visit at 21 weeks, she presented with the complaints of vomiting, syncopial attack and a feeling of tenseness in the abdomen but no pain. She was hemodynamically stable and was admitted for observation. The uterus was 28 weeks in size, tense but not tender. The fetal parts could not be felt and the foetal heart sounds were absent. The cervix was placed high almost on the right lateral pelvic wall. Twelve hours later, she had another bout of vomiting and complained of epigastric pain. The pulse rate had risen to 120/min., blood pressure was 80/60 mm of Hg. and the hemoglobin had dropped from 9 to 4 gm% in the absence of any vaginal, intra-abdominal or gastro-inteestinal bleeding. Obstetric examination findings were the same. A provisional differntial diagnosis of 1) abruptio placenta (hypotension, pallor, tense uterus), 20 acute hydramnois (tense uterus without pain) or 3) a disturbed advanced extra-uterine pregnancy (gastro- intestinal symptoms, hypotension and cervical displacement) was made. The blood urea nitrogen, serum creatinine, electrolytes, liver function tests and coagulation profile were normal. Hemolytic crisis was ruled out by the absence of hemoglobinuria, hyperbilirubinemia and abnormal RBC forms. Ultrasonography showed a 21 week size dead intrauterrine foetus with normal amount of liquor amnii without any retroplacetal clots, and minimal free fluid in the abdominal cavity which on paracentesis proved to be a transudate.

In view of the patients poor general condition and the lack of evidence of anintra-abdominal catastrophe, it was decided to stabilize the patient and then induce labour. In spite of infusion of 2200 ml of crystalloids and 700 ml of packed red cells over 24 hour, maintaining a CVP at 7-8 cm. of water, her vital parameters and hematocrit did not change and the urine output was only 500 ml. Amniotomy was not possible, hence oxytocin was started. A surgical consultation was sought and a diagnosis of acute pancreatitis was suggested. Repeat paracentesis for amylase estimation revealed 10 cc. of non clotting blood. An exploratory laparotomy was performed under general anaesthesia. There was about 300 ml. of blood in the peritoneal cavity. The uterus was dark blue, congested, with a transversely narrow lower segment. A vertical midline upper segment incision was taken and a 350 gm. foetus was delivered. There were no retroplacental clots. The uterus was then noticed to have undergone dextrorotation through 180 degree. It was unicornuate, with a 3 x 3 cm. size left

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Fig 1
Specimen as seen when the adbomen was opened

rudimentary horn. The right ovary was gangrenous, engorged and situated on the left side due to the torsion. The left adnexal structures were normal. After correcting the torsion, the uterine incision was notice to be on the posterior surface. (Fig. 1) The uterus was flabby but there was no bleeding either from the cavity or from theincision. There was no improvement in its colour. Gangrene of the uterus was diagnosed and in view of the patients poor general condition a sub-total hysterectomy was performed. She was transfused with 1 litre of blood. The post-operative course was uneventful except for a diuresis of 3600 ml. within the first 24 hours,. She was discharged on the eleventh day.

## NEPHROTIC SYNDROME WITH PREGNANCY

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Mrs. S.S., a 23 yrs. Primigravida was admitted on 9-8-89 with 4&1/2 months amenorrhea and a history of Nephrotic syndrome diagnosed at 5 yrs of age. Teh patient was on seteroids since then. After a relapse in 2982, renal biopsy done then showed membranous glamerulopathy. Steroids were continued for another year.

She married in 1983 and had a history of infertility for seven years. She had regular monthly cycles and her LMP was 2-4-89. On admission,routine investigations and kidney function tests were normal. Thenephrologists advised a termination of pregnancy, as membranous glamerulopathy with the stress of pregnancy had the worst prognosis. Since all investigations were normal and considering her strong desire to continue pregnancy, she was discharged advising a high protein diet & regular follow ups.

Two months later on 26-10-89 she was readmitted with generalised anasarca. Again, all investigations were normal. A sonography done showed a single fetus of 31 wks gestation. Non-stress test (NST) was reactive. Nephrologists advised infusion of 100 ml of human albumin. Pstient was managed with weekly sonography and NST. A month later, her blood pressure started rising to 160/100 mm Hg. Oral Nepresol 1/2 tablet tds was started; but with little response. Nephrologists advised a termination. But, since neonatologists preferred waiting for another fortnight and with a stable renal function, pregnancy was allowed to continue.

On 7-12-89, an LSCS had to be performed due to two concecutive non reactive NST. Spinal or epidural anaesthesia was deemed difficult due to severe edema and hypotensive renal damage. General anaesthesia could pose problems due to laryngeal

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edema. Patient was graded VE anaesthesia risk. The patient finally underwent an LSCS under general anaesthesia delivering a 2 kg female child with evidence of IUGR. Puerperium was uneventful and they were discharged on the 15th day. She has since lost 23 kgs and is otherwise healthy.

## PREGNANCY IN ACCESSORY HORN

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M.K., 22 F nullipara had armenorrhea of 2 months 11 days. She started having vaginal bleeding and was given conservative treatment by a medical practitioner. She continued to have irregular bouts of bleeding & pain of the treatment. Evacuation was done after which she had attack of severe abdominal pain and was referred here. A provisional diagnosis of ectopic pregnancy was made but due to history of evacuation possibility of inflammatory mass was also considered & diagnostic laparoscopy was done. On laparoscopy there was a mass on the right side 8 cm x 10 cm with increased vascularity. Right tube was attached to the mass. Diagnosis of the pregnancy in the accessory horn was made and laparotomy was done. There was pregnancy in the accessory horn (right side) which was attached to the uterus by a band like structure which had a fine cavity communicating with the uterus. Round ligament and the fallopian tube were attached to the accessory horn. Accessory horn and the right fallopian tube were removed. Post-operative period was uneventful.

Fig I
Showing Pregnant horn No. 1. Non-pregnant horn No. 2 at the time of laparotomy.

Fig. II
Showing the accessory horn on the uterus with attached fallopian tube. The anterior wall has been cut open to show the embryo.

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## A STUDY OF RECURRENT MOLAR PREGNANCY

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### *INTRODUCTION*

Recurrence of hydatidiform mole is uncommon. It is seen in about 2% of cases

(Novak). Sixty cases have been reported with two recurrences and forty six with 3 or more recurrences. The first cases of recurrent H. Mole were reported by van Deursch who reported two cases of recurrent Hydatidiform mole in 1983. In the present series which spans the period from 1980 to 1985 there were 4 cases of recurrent hydatidiform moles amongst 124 incidences of molar pregnancy resulting in an incidnce of 3.22%.

*CASE NO. 1*

Mrs. G.R. 26 yrs., fifth gravida P2+2 was admitted on 20.7.82 with amenorrhoea for 3 months and vaginal bleeding for 4 days.

Past Obstertrical History:

The woman had two full term viginal deliveries with two living children aged 6 and 4. This was followed by a molar pregnancy 1& 1/2 years later which was treated by suction evacuation followed by currettage after days. After 2 years, she had her fourth pregnancy which ended in a spontaneous abortion. No histological examination of the conceptus was done and thus the nature of abortion is unknown.

Examination of the patient:

The general condition of the patient was good. The fundal height corresponded to 20 weeks gestation, but no fetal parts were palpable. On vaginal examination, the cervix was found to admit the tip of finger where blood clots were palpated. No adnexal mass was detected. H.C.G. was detected in the urine at levels of 10,000 IU per litre. Chest skiagrams were normal. The pregnancy was diagnosed to be H. mole which was evacuated by suction and concomitant oxytocin infusion. HCG titres in the urine dropped to below detectable levels within 10 days. Follow-up was regular for 2 years at the end of which the patient opted for permanent sterilisation. A chromosomal study of the molar tissue reported a 45, XO pattern.

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*CASE NO 2*

Mrs. M.M. 23 yrs., 4th gravida, P 1+2 was admitted on 29.11.84 with amenorrhoea for 4 months and moderate vaginal bleeding for 7 days.

Past Obstertric History:

The first pregnancy ended in preterm labour and still birth. The second pregnancy was molar with spontaneous expulsion at home followed by currettage after 7 days. She resumed menstruation soon after evacuation. Three months later, she had her third pregnancy which was diagnosed to be molar at 12 weeks. The uterus was evacuated by suction and associated oxytocin infusion. Follow-up, this time, was regular and satisfactory for 2 years. She was admitted during the fourth pregnancy with amenorrhoea for 4 months and vaginal bleeding.

Examination:

A light degree of pallor was detected. Fundal height corresponded to 20 weeks gestation, but no fetal parts were felt. Vaginal examination detected no significant findings. Investigation included a chest X-ray which was normal and uninary HGG titres of 650,000 IU per litre. Uterus was evacuated by suction and concomitant oxytocin infusion. Urinary HCG titres declined to below detectable levels by 3 weeks.