CASE REPORT

CONGENITAL CYSTIC MALFORMATION OF LUNG

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Patient aged 30 years, Gr. II, Para 1 with previous Caesarean scar with amenorrhea 22 weeks attended for routine antenatal checkup. On examination, Pulse-88/mt., BP-120/80 mmHg, Oedema+, Pallor+, fundal height 22 wks., sonography revealed presence of cystic lung over right side. Patient did not agree for termination of pregnancy. However at 28 wks., she had loss of foetal movements. Repeat USG suggested polyhydramnios, foetal scalp oedema, foetal ascitis and large cystic mass in right lung, with normal limbic structures (Fig. 1). Termination of pregnancy carried out by emcradil. Child born was dead. The post mortem exam. of child showed that right sided lung was completely replaced by a cyst (Fig. 2). There was mediastinal shift. Left sided lung was collapsed. Inside the cyst about 100 cc watery fluid was found. On Histopathological examination, it revealed type-I adenomatoid cyst

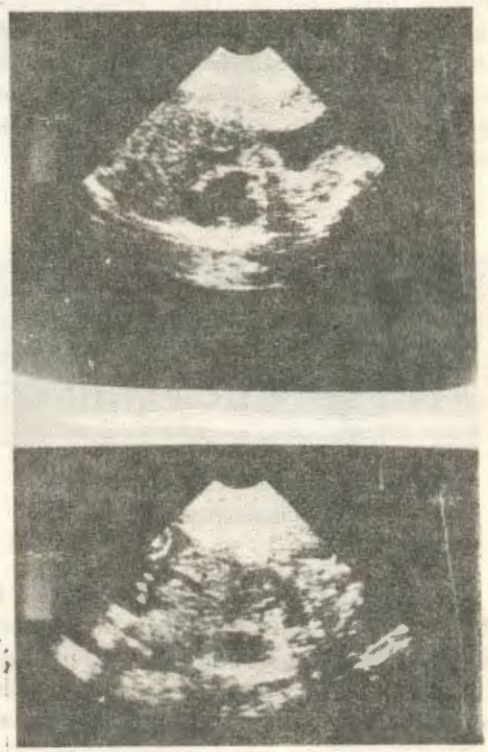

Fig. 1 : USG showing hypoechoic (Cystic) shadow in Pulmonary region.

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Fig. 2 : Postmartum exam. Large Rt. Lung due to cystic mass and atrophic Lt. Lung.

of lung with thick walled cavity.

Congenital cystic malformation of lung is a rare disorder. Three types have been described. Type-1 (cystic), type-2 (intermediate) and type-3 (solid). Type-1 cyst are large enough with mediastinal shift. The mortality rate is 69%. The USG differentiation of these cysts with other mediastinal and lung cysts is difficult if not impossible.

FETAL URETHRAL ATRESIA - ANTENATAL SONOGRAPHIC FINDINGS

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A 20 year old primigravida presented in the second trimester with pain in abdomen since 3 days, and bleeding per vaginum since 1 day. Physical examination revealed a distended tense abdomen and the uterine height was large for date. The general clinical examination was normal. Clinical impression of Hydramnios with ? fetal anomaly was entertained, and sonogram was requested. Sonography showed a single live fetus of 25 weeks gestation size. Cardiac activity was seen. There was severe oligohydramnios. (Fig. 1-A) A large fluid filled structure was seen to occupy the whole of the fetal abdomen. (Fig. 1-B) No floating bowel loops were identified. The abdominal viscerae were compressed, and the fetal

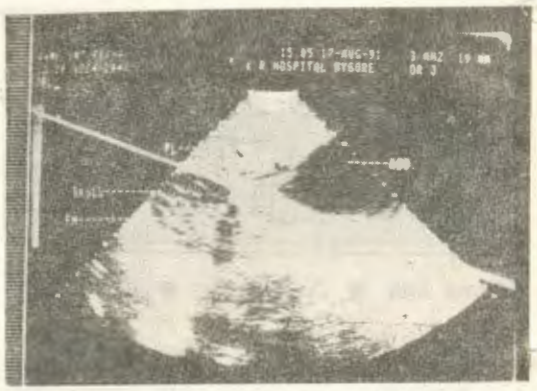

Fig. 1-A : Sonogram of fetus showing oligohydramnios, fluid filled structure in the abdomen, anterior placenta.

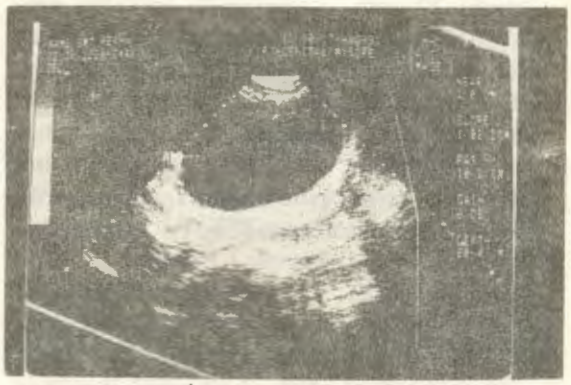

Fig. 1-B : Sonogram showing large fluid filled structure occupying whole of the fetal abdomen.

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thorax and limbs wee compressed between healthy anterior placenta and the posterior uterine wall. Sonographically the differential diagnosis was ? Megalobladder due to bladder outlet obstruction ? Large mesenteric cyst. In view of severe oligohydramnios, and clinical condition of the mother, coupled with poor chances of fetal survival, the pregnancy was terminated by pervaginal para centesis of some amount of fluid from the fetal abdomen, to facilitate per vaginal delivery of the fetus.

CLINICAL POST MORTEM FINDINGS

Gross Appearance

A male fetus with a grossly distended abdomen, compressed thorax, and normal appearing Face and Limbs. At laparotomy, urinary bladder was markedly distended, with the normal ureters stretched on its surface. The kidneys and suprarenals were of normal size and contour. The bladder measured 15 x 9 x 9 cms and weighed 360 Gms. It showed selective dilatation of the superior half, and hypertrohy of the Trigonal region measuring 15 mm in thickness with normal ureteric orifices (Fig. 2). The site of urethral orifice was marked by a dimple of 3 mm size. Probe could not be passed through it.

Histopathology showed normal upper urinary tract. Urinary bladder showed trigonal hypertrophy with passive atrophy of rest of bladder. The proximal urethra was atretic and non conalised and the penile urethra was patent. The final impression was 'Fetal posterior urethral atresia'.

Fig. 2 : Specimen photograph showing trigonal hypertrophy, small arrow pointing to dimple at urethral orifice, large arrow point to thinned out superior half of bladder. Also note normal sized fetal kidneys, ureters and supra renals.

PREGNANCY WITH URETERINE LEIOMYOSARCOMA

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Mrs. K. D., primigravida, aged 33 years, attended OPD on 09.01.1992 with amenorrhoea of 10 weeks. She was suffering from scanty menses for last one year. On exam., a firm, mobile, non-tender swelling extending from pelvis to lower epigastrium was found related to the softer uterus of about 10 weeks size. Pregnancy test was positive. USG was advised.

The patient got admitted on 18.01.1992 with threatened abortion. Bleeding stopped on routine treatment. USG revealed huge

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subserous fibroid on the top of gravid uterus. While under observation, on 28.02.1992, she developed severe upper abdominal pain. The fibroid was found increased in size to reach xiphisternum and was partly cystic and tender. On 02.03.1992, at 18 weeks gestation, emergency myomectomy was done. Pregnancy continued undisturbed. HP exam. revealed leiomyosarcoma. Cellular myoma was excluded by mitoses more than 10 per HPF. There was no evidence of metastasis in liver, lungs or bone marrow and it was decided to continue pregnancy under observation upto 37 weeks for caesarean hysterectomy and a live baby. But very soon patient developed progressive severe anaemia. She required 16 units blood transfusion over next two months. Repeat marrowgram from iliac bone on 11.05.1992 revealed marrow metastasis. There was none in liver or lungs. On 16.05.1992, at 30 weeks pregnancy, Caesarean hysterectomy was done at noon under chemotherapy cover of Inj. Doxorubicin (40 mg), Inj. Decarbizine (400 mg) and Inj. Endoxan (500 mg) given IV the same morning. A grossly premature baby died neonatally. HP from previous uterine scar revealed few malignant cells. There was no evidence of malignancy in the rest of uterus, cervix, tubes, ovaries or in the adherent omentum to uterine scar. Marrowgram on 19.06.1992 showed no metastasis. The patient received 5 more courses of chemotherapy at intervals of 4 to 5 weeks. There was no metastasis and the patient is well upto her recent follow-up.

PREGNANCY AND ITS OUTCOME IN A PATIENT WITH RENAL TRANSPLANT

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Mrs. R. R., a 22 years old patient married for 3 years was admitted in the medical ward of our hospital in 1989 with moderate grade fever, anorexia, nausea, puffiness of face and edema feet for 15 days. On admission the patient had a B. P. of 160/100, Hb 8.5 gms%, urine albumin +4, BUN 44 mg%, S. Creathinine 13.8 mg%, Uric Acid 8.2%. USG of kidneys revealed hydronephrotic changes. Renal biopsy showed features of chronic glomerylonephritis. Patient underwent hemodialysis 18 times before a decision was taken to perform renal transplant. Accordingly renal transplant was done with the donor kidney coming from the patient's father. Lymphocyte crossmatching was done 48 hours prior to the surgery. The donor kidney started functioning well on table. Postoperatively patient was started on Prednisolone 40 mg and Azathioprine 200 mg daily, antibiotics, anti-hypertensives. On discharge prednisolone was reduced to 20 mg and Azathioprine to 50 mg. After 2 months the patients BUN was 12 mg%, S. Creatinine 1.5 mg% and B.P. 160/90 mmHg.

Patient presented to us in 1991 with a desire to conceive. We investigated the couple and since husband's semen analysis was within normal limits and she was ovulating we advised planned relations and the patient conceived within 4 months. She was lost to follow-up and the patient presented to us

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again with 8 months, amenorrhoea. On examination her B.P. was 160/100 mm Hg and patient had puffiness of face with edema feet. On obstetrics examination, the uterine height corresponded to 34 weeks POG with a single live fetus in cephalic presentation. Patient was advised admission. Her routine investigations revealed urine albumin +4, Hb 9.5 gms%, BUN 14 mg%, S. Creatinine 1.5 mg%. USG revealed a single fetus of 32 weeks with no IUGR. NST was reactive and Doppler studies showed normal umbilical flow studies. Patient was started on salt restricted high protein diet. Prednisolone and Azathioprine was continued. Tab. Furosemide 40 mg once daily, Tab. Methyl dopa 500 mg 6 hrly, Tab. Nifedipine 5 mg 8 hrly were added. However at 36 weeks POG patient started leaking and hence labor was acclerated with Oxytocin. Intrapartum fetal monitoring was done and patient was started on Injectable Cephalosporins. Patient delivered after 12 hours of leaking and a male 2.3 Kg was delivered by forceps. Baby's Apgar was normal. Postpartum the patient was continued on high antibiotics, immunosuppresants and prednisolone. Lactation was suppressed since patient was on Azathioprine. The baby was preterm with no congenital anomalies.

Patient was discharged on 10th postpartum day with normal renal functions and B.P. 140/90. Patient was advised Male contraceptives. Patient followed 1 month later with normal kidney functions and USG showing normal kidney size and normal corticomedullary ratios.

AN UNUSUAL CASE OF HAEMOPERITONEUM FOLLOWING PLACENTAL ABRUPTION

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An unregistered, 39 yr. old, sixth gravida Mrs. N. K. presented to the labour room of the Sassoon Gen. Hosp., Pune, postpartum and in a state of stock. She had one episode of fresh vaginal bleeding 6 hrs. prior to admission upon which she perceived loss of foetal movements. Within an hour she delivered a term still-born male child at home. Placenta and membranes were delivered. She developed postpartum haemorrhage (PPH) for which she came to the hospital.

On admission, she was found to be averagely nourished and built, very pale, Pulse rate 140/min. thready, Respiratory rate 40/min. B.P. 60 mm Hg. Systolic. The Central Venous Pressure was 4 cm. of water, Hb. 5 gm% and coagulation parameters were within normal limits. No abnormality was detected in the respiratory and cardiovascular systems. Per abdomen the uterus was well retracted and there was no evidence of free fluid in the peritoneal cavity. There was active vaginal bleeding but no signs of trauma were present.

MANAGEMENT

She was resuscitated, started on i.v. Oxytocin and given one pint whole blood. Bimanual uterine massage was given. The vaginal bleeding stopped with the above measures but her vital parameters (Pulse 136/

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