CASE REPORT

TWISTED FULL TERM GRAVID UTERUS IN AN ELDERLY PRIMI

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Mrs. P. an elderly Primi gravida aged 37 years was admitted to Zanana Hospital Udaipur in labour room as a booked patient on 4.5.93 at 11.00 A.M. with complain of Amenorrhoea 9 months, Oedema feet 10 days, strong fetal movements 3 days, expected date was 16.5.93.

Obstetric history - Nil, Marital life 15 years. Menstrual history 3-6/90-120 days, average painless flow. Past history - patient had undergone extensive treatment for infertility and received ovulation inducing drugs on several occassions in the past eight years.

The patient was a booked antenatal case of our institution, presentation was breech till the date of admission as confirmed by sonography repeatedly. She was a diagnosed case of mild to moderate pregnancy induced hypertension. There was no complaint of pain in the abdomen. Since 3 days prior to her admission in hospital she had started complaining of urgency of micturation.

As she was an elderly Primi gravida with pregnancy induced hypertension, elective caesarian section was decided upon. She was admitted to the hospital on 4.5.93. All relevant investigations were within normal limits.

A lower segment caesarian section was performed under general anaesthesia on 5.5.93. On opening the abdomen it was found that there was rotation of the full term gravid uterus by 180 degrees in such a way that the left Adnexa was lying on the right side and the left round ligament was stretched to about eight inches. Initially a nick was made on the lower uterine segment assuming it to be the utero vesical fold of peritoneum, and eventually turned out to be the posterior

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peritoneum. Untwisting of the gravid uterus was carried out and a live baby was delivered by lower segment caesarian section. Uterine and peritoneal incisions were stitched. As the uterus had tendency to retwist, plication of the left round ligament was done.

The patient was discharged on the ninth day with an uneventful post-operative period.

This twisting was because of sudden strong movements of the fetus leading to change from breech to vertex presentation. There were 2 loops of cord round the neck. The patient gave history of strong fetal movements 3 days prior to her admission but there was no pain in the abdomen. Such an asymptomatic twisting of a full term gravid uterus is a rare entity hence this case is being reported.

PREGNANCY INDUCED MYOPATHY

SNEH LATA MISHRA ● VIMLA SHARMA

Mrs. G, 30 years H. F. was admitted on 11.7.93 at J. L. N. Hospital Ajmer, with the complaints of amaenorrhoea 9 months, labour pains since 1 day, difficulty in walking, standing & sitting. She was G3P2. Before this pregnancy she was alright, but as this pregnancy advanced, she felt gradually increasing weakness in upper & lower limbs & ultimately she was confined to the bed. She was admitted to an another Hospital for twenty days, later on she was referred to J. L. N. Hospital, Ajmer for further management at 7 months gestation. As the patient was not in labour at that time a physician was consulted. On general examination, the patient was found averagely built & poorly nourished, mild anaemia was present. Pulse 80/mt, B.P 110/70 mm of Hg, both upper & lower limbs were in semi flexed position. On neurological examination her higher mental functions were normal, cranial nerves were functioning normal. Motor functions were normal in both upper & lower limbs (UL & LL)

	Rt	Lt
Bulk of muscles	UL/LL	UL/LL
	N N	N N
Reflexes		
Planter	Flexor	Flexor
Muscle power	3/5 in proximal muscle in UL & LL	
	5/5 in distal in UL & LL	

There was no sensory dysfunction.

Investigations : Routine investigations were found normal, her Hb 8gm%, AG ratio 3.6/2.6, serum bilirubin 0.6 mg%, SGOT, SGPT, alkline phosphatase 5.4 KA, serum calcium was normal.

On obstetrical examination the uterus was term sized, head fixed, faetal heart sounds were present. She delivered a living child on 11.7.93. The labour was accelerated with syntocinon drip. During the puerperium patient made marvellous recovery. From very second day her

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muscle power improved & she regained her muscle tone, & at the time of discharge from Hospital she was absolutely normal.

The aim of presenting this case is that pregnancy induced myopathy is a rare condition and that this possibility should be kept in mind while attending such obstetrical cases.

COLOUTERINE FISTULA COMPLICATING MEDICAL TERMINATION OF PREGNANCY

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CASE REPORT

Mrs. J. K., 30 years old was para-3 with all FTNDs at home. Her last child birth was one year back. She presented on 23rd Nov., 1990 with the chief complaint of passage of formed stools per vaginum for one week. She had undergone, an M. T. P. following 2 months' amenorrhoea from a private practitioner in Bihar, two weeks prior to admission. Following M. T. P., she developed fever, vomiting abdominal pain distension for which she was treated conservatively in a district hospital. She started passing formed stools per vaginum for which she was referred to us. She did not give history of any other significant illness in the past.

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ON EXAMINATION

She was a young lady, average built with mild anaemia. She was afebrile, pulse-80/mt, regular, B.P. 110/70 mm of Hg, and had no pedal edema. Respiratory and Cardiovascular systems were normal. Abdomen was soft with no distension/ guarding/rigidity or tenderness. There was no shifting dullness and no masking of liver dullness. Abdomen was resonant and bowel sounds were normal. On per vaginal examination, uterus was normal in size, retroverted, nontender. There was thickening in both fornices and mobility of uterus was restricted. There was no mass in the fornices. On per-rectal examination, rectal mucosa was free and there was no fecal matter on the examination fingers.

Patient's complete haemogram, kidney and liver function tests and blood sugar were normal. X-ray chest was normal. Plain X-ray abdomen was normal. Barium enema was done (Fig. 1) in which the rectum and distal sigmoid colon was seen getting distended with Barium. There

Fig. 1 : Barium Enema : Showing a stricture in the distal sigmoid - colon.

was a structure in the distal sigmoid colon with no fistulous connection visualised. Hysterosalpingography was done (Fig. 2). The contrast (Conray) injected into the uterus immediately escaped into the sigmoid colon by a fistulous connection. The uterus was normal in size. There was no spill of contrast into the portion of sigmoid colon and rectum distal to the fistula connection. However, the contrast passed readily into the sigmoid colon and descending colon proximal to the fistulous connection. Based on the above findings, a diagnosis of colouterine fistula with a stricture in the distal sigmoid colon was made and a 3 step surgery was planned.

The patient underwent a preliminary transverse colostomy on 20th Dec., 1990. The colostomy functioned well in the post operative period. The patient was discharged on the tenth post operative with full instructions on colostomy care.

The patient was readmitted a month later for a second stage laparotomy. At laparotomy [Fig 3(1) & 3(2)] uterus was found to be normal in size and inflammed. The sigmoid colon was adherent to the posterior surface of the uterus. A colouterine fistula was present on the posterior surface of uterus which was 2 inches long and one inch wide. Adhesions of the Sigmoid colon to the uterus were seperated and the fistulous tract was excised. Then a total abdominal hysterectomy was performed to remove, a constant source of infection since the uterus was inflammed and the patient

Fig. 2 : Hysterosalpingography : Showing a colouterine fistula.

Fig. 3 (1) : Sigmoid colon is adherent to posterior surface of uterus with colouterine fistula.

Fig. 3 (2) : Taken after dissection of the fistula demonstrating the rent in the posterior uterine surface.

Fig. 4 : Barium enema before final stage colostomy closure - showing no evidence of stricture with complete patency of sigmoid - colon

had completed her family. Resection of strictured segment of sigmoid colon with an end to end anastomosis of the Sigmoid colon was carried out. The transverse colostomy continued to function well in the post operative period. The histopathological report of the uterus and the fistulous tract revealed only chronic inflammation. The patient was discharged and readmitted a month later for a final stage colostomy closure. Prior to the final step surgery, a Bartium enema was repeated (Fig. 4) which showed a free flow of Barium into the sigmoid colon and the descending colon with no evidence of stricture in the Sigmoid colon. The patient underwent a final stage colostomy closure and she started defecating normally from the fifties post-operative day. She was discharged one week later fully cured of the problem.

PERMANENT END COLOSTOMY AFTER INDUCED ABORTIONS

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ARUN GUPTA ● NEERA AGARWAL

This case is reported to provoke a review of the prerequisites for M. T. P., its legal aspects and awareness amongst medical fraternity so as to minimise traumatic sufferings of women.

CASE REPORT

A young patient 17 yr. age ? Miss R admitted in casualty on 17.11.92 with history of ammenorrhoea 5 months, history of fall followed by bleeding p/v 6 days and acute pain in abdomen for 4 days which started after some interference by a local doctor. Important point was that different history was obtained from patient, ? husband and her relatives.

On examination, pallor +++, pulse 120/minutes, BP-100/60, other systems were normal, P/A examination revealed generalised rigidity all over, marked tenderness. ? 20 weeks size uterus felt, Bowel sound absent, per vaginal examination revealed a 2 cm rent in anterior vaginal wall very close to cervix through which loops of intestives protruded in the vagina. Bleeding +, uterus not made out due to tenderness. On P/R examination, a rent was felt in anterior rectal wall, finger

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