CASE REPORT

A CASE OF HERNIATION OF GRAVID UTERUS.

PARTHA MUKHOPADHYAY ● NABENDU BHATTACHARJEE ● (SMT.) S. DUTTA.

A 26 years old P_{1+0} patient was admitted on 20.1.94 with lump and severe pain in lower abdomen. She had amenorrhoea for some period with unknown L.M.P. Her last child birth was 1½ years back by L.S.C.S. Her general condition was below average. B.P. and Pulse was normal. Lower abdominal wall was rough, blackish in colour, thick and a right paramedian scar mark could be seen over it. Uterus was 28 weeks and was hanging upto the junction of upper and middle third of thigh. Foetal head was palpable at the lower part of lump. It was a huge hernia about 5x5 size and it was irreducible. A diagnosis of irreducible ventral hernia containing pregnant uterus was made. Patient was advised for absolute bed rest U.S.G. on same day revealed a viable foetus with maturity of 32-34 weeks. The uterus became reducible after 7 days.

Anteroposterrior and Lateral view of ventral Hernia.

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Thereafter, an abdominal binder was used but as patient felt severe discomfort, binder was not used.

On 5.2.94 U.S.G. showed foetal maturity of 34 weeks. From 20.2.94 her pain increased again. On 25.2.94 an elective L.U.C.S. with repair of ventral hernia was done. A 2.1 Kg. baby with breech presentation was delivered with good Apgar score. Post operative recovery was uneventful. Patient with baby was discharged in well and good condition.

ABDOMINAL EXPULSION OF A STICK USED VAGINALLY IN AN ILLEGAL INDUCED ABORTION CASE

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Sunil Kumar Panda ● B. Pati

INTRODUCTION

Untrained persons often use different types of sticks in illegally induced abortions among unmarried village girls. Usually the sticks used expel out per vaginum but expulsion of the sticks per abdomen is rare. So, an illegal abortion case with expulsion of sticks per abdomen is hereby reported due to its rarity.

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CASE REPORT

A patient Miss P.M., 19 years unmarried village girl, was admitted into our hospital on dt.04.06.94 with complaints of swelling of abdomen on left side for last 5 days, foul smelling discharge from the abdominal wound for last 1 day and protrusion of a stick from the wound for last 12 hours. The patient gave history of illegal termination of pregnancy of 6 months by an untrained village old lady 2 years back. For termination, she was given 3 slender sticks of bamboo, one on each evening consecutively. She expelled the product

Fig 1 : Photograph of abdomen showing protruded stick from the wound.

Fig. 2 : Photograph showing total lenth of the stick after complete expulsion.

of conception after 72 hours of insertion of first stick with expulsion of 2 sticks per vaginum. Since then she was alright and had forgotten about the third stick. For last 5 days, she developed a swelling on left lumbar region which gradually increased and an abscess was formed. Foul smelling discharge came from the abscess for last 24 hours, followed by protrusion of a slender stick from that wound for last 12 hours for which she came to our hospital. Her general examination findings were within normal limits. Abdominal examination revealed that a slender 5 inch long bamboo stick protruded through that abdominal wound which was discharging pus had about 4" x 4" indurated base. Abdomen was soft with bowel sounds heard normally. No abnormality was found on pelvic examination with normal sized anteverted uterus and normal per rectal findings. A diagnosis of intrabdominal but extraperitoneal abscess with projecting stick was made. While the patient was sent for X-ray of abdomen and pelvis, the stick came out completely spontaneously measuring 7 inches long. Sonography revealed no abnormality. The patient was treated conservatively with higher antibiotics and daily dressing of the wound. After 10 days of admission, the abdominal wound was completely healed and the patient was discharged from the hospital.

PREGNANCY WITH SINGLE VENTRICLE (SV) WITH TRANSPOSITION OF GREAT VESSELS (TGV) WITH PULMONIC STENOSIS (PS)

J. J. KANSARIA ● S. M. TAYADE
C. N. PURANDARE ● J. A. LOPEZ

Single ventricle is an uncommon form of congenital cyanotic heart disease. Cyanotic heart disease is associated with increased maternal morbidity and mortality (30%). Upon reviewing the literature only 7 pregnant patients with this anomaly could be found.

Rohini 20 years old G2 P1 L0 was referred to Sir J.J. Group of Hospitals at 14 weeks of gestation with a known 1/0 cyanotic heart disease due to single ventricle. She was adamant on continuing pregnancy inspite of her first pre-term fresh still birth 34 weeks gestation earlier.

She had Grade III dyspnoea on admission and no other complaints, with a B.P. of 102/50 mmHg and a pulse of 86/min. The neck veins were not distended and the lungs were clear. The heart was slightly enlarged and the apex beat was prominent. A right ventricular lift was noted and a thrill was present at the base. A tricuspid opening snap was heard and

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a Grade III/VI harsh ejection murmur radiated widely from the pulmonic area. There was no edema or clubbing. The uterus measured 14 weeks gestation size.

ECG showed biventricular hypertrophy, pathological right axis deviation and sinus rhythm.

2-D Echo confirmed the diagnosis of SV with TGV with subpulmonic stenosis.

Cardiac catheterization was not performed.

Blood gases on room air, at admission were on lower limit of normal, with a Hb of 9 gm% and PCV - 35%.

During the antenatal period, she had cyanotic episodes off and on which were treated symptomatically.

Serial ultrasound for fetal growth documented IUGR.

Patient went in spontaneous labour at 37 weeks and was delivered with outlet forceps. An IUGR baby weighing 1.7 kg was born. Intrapartum antibiotic prophylaxis for infective endocarditis was given. The puerperium and the neonatal period were uneventful.

In conclusion, pregnancies complicated by cyanotic heart disease due to single ventricle generally follow a favourable coruse if not complicated by pulmonary hypertension. An organised perinatal team approach with obstetrician, cardiologist and anaesthesiologist is essential for the successful management of this disorder, plus avoidance and treatment of systemic hypotension during the intrapartum period.

AN UNUSUAL CASE OF OBSTRUCTED LABOUR BY MASSIVE BLADDER HAEMATOMA

P. L. Gupta • K. Gokhroo

INTRODUCTION

The obstructed labour is usually caused by malposition and malpresentation of the fetus and by contracted pelvis. The common sequelae of this is rupture uterus. We are reporting an unusual case in which obstructed labour was caused by massive bladder haematoma and the clinical picture was simulating rupture uterus with rupture bladder.

CASE REPORT

A 30 years old primigravida was admitted on 9-2-94 in the Department of Gynaecology and Obstetrics, J.L.N. Medical College, Ajmer with amenorrhoea 8 months, labour pains and bleeding per vaginum 3 days. She had kyphoscoliois with severe anaemia. Her Hb was 6 gm% and B.P. 120/70 mm of Hg, other general parameters were normal.

On abdominal examination uterine contour was distorted and uterus was felt more on left side but foetal parts were not felt superficially. Foetal heart sounds were absent. Bladder was upto 4 cm below the umbilicus. Pervaginum

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examination revealed normal gynaecoid pelvis. Cervix was 3 cm dilated and vertex was at - 3 station. Membrane was absent and there was bleeding per vaginum. On catheterization by Foley's catheter only 10 c.c. of blood stained urine drained. Provisional diagnosis of "Rupture uterus with Rupture bladder" was made.

On laparotomy there was no rupture of uterus and bladder. Uterus was bicornuate with overstretched lower uterine segment and bladder was lifted up. L.S.C.S. was done in usual way. A still born male child of 2 Kg weight was delivered, pregnancy was in the left horn while right horn was noncanalized. 2 Units of blood were transfused. Haematuria persisted for 48 hours inspite of haemostatic drugs and bladder irrigation with betadine solution. On 3rd post operative day extraperitoneal suprapubic cystostomy was done, about 1000 gms of blood clots removed from bladder, but there was no active bleeder. A Malecot catheter was put in the bladder supra pubically while Foley's catheter continued to drain through urethra. Haematuria stopped 48 hours after cystostomy. Malecot catheter was removed on 5th day and Foley's catheter on 7th postoperative day. Her rest of the post operative period was uneventful.

TORSION OF PREGNANT UTERUS DIDELPHYS

S. Moiisin ● S. M. Asiiraf ● Naheed Khan
Sabiiia Hisamuddin ● Tazeen Khan

INTRODUCTION

Uterine torsion is rarely encountered in clinical practice. We are reporting here a case of torsion of gravid half of uterus didelphys.

CASE REPORT

A 20 year patient was admitted with H/O six months amenorrhoea and features of acute abdomen with loss of foetal movements for 3 days. Menstrual history was normal. Her previous pregnancy terminated in a spontaneous delivery of a full term male baby by breech presentation, one and a half years back.

On examination the patient was anaemic but her vitals were maintained. Abdominal examination revealed distension and tenderness in the lower abdomen. Fundal height was 30 weeks, foetal parts and lie could not be made out. F.H.S. was absent. Bowel sounds were not audible. Vaginal examination revealed a vertical septum which was torn in its lower part. Cervix was short, firm, uneffaced and on left side of septum. OS was closed. Patient's U.S.G. showed a 19-20 wks intrauterine pregnancy with no cardiac activity. Hydramnios was

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present. Ascites and multiple fluid levels were also detected.

Laparotomy revealed presence of blood mixed serous fluid in peritoneal cavity. Uterus didelphys was present and a rectovesical fold of peritoneum separated the two uteri. Left uterus with its Fallopian tube and ovary was apparently normal. The right sided uterus was enlarged and dark bluish in colour. Rt. tube and ovary were also congested and bluish.

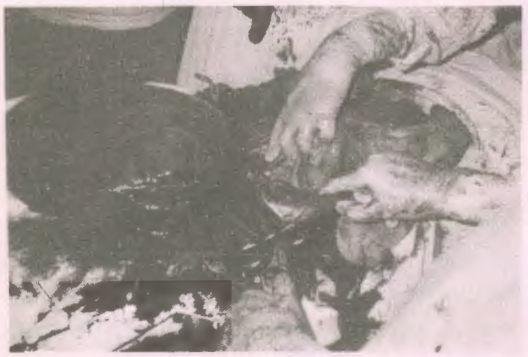

Fig.

This uterus had undergone rotation by almost 180 degress. After untwisting, the uterus was opened; excessive liquor and a foetus weighing 500 grams came out. Pregnant horn was flabby and gangrenous, so decision for subtotal hysterectomy was taken. After removing the pregnant uterus, dilator was passed through the cervical stump and vaginal examination was done by an assistant. A firm cervix on non-pregnant side and a separate opening on Rt. side communicating with affected horn was found with a septum in between. Post operative period was uneventful. Two units of blood were transfused to combat anaemia.

Patient reported to O.P.D. later after she had normal menses. On examination cervix on the Rt. side had reformed and two separate cervices with a vertical septum in between were felt and seen.

PREGNANCY WITH COARCTATION OF AORTA

J. J. Kansaria • S. M. Tayade
C. N. Purandare • J. A. Lopez

Maternal mortality in Coarctation of Aorta may be as high as 17%. Increased intra-abdominal pressure during labour and vaginal delivery may precipitate aortic dissection and rupture of berry aneurysm.

Pramila 22 years old housewife, a known case of coarctation of aorta with balloon dilatation done 2 years back registered on 15.8.94 for ante-natal check up. On admission, she was asymptomatic with a single viable fetus of 32.34 weeks gestation, a B.P. of 150/68 mm Hg in RUL and 120/60 in RLL, pallor but not proteinuria or edema.

On 16.8.94, she developed signs of subarachnoid haemorrhage which was confirmed on C.T. Scan examination of Brain. Digital Subtraction Angiography (DSA) showed spasm of cerebral vessels. She was started on C. Nimodipine 60 mg qds for 1 months. (Only Ca channel blocker which crosses blood brain

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barrier), T. Aldomet and weekly dexamethazone.

USG showed a single viable fetus of 32 weeks mean gestation with mild IUGR and adequate liquor on 20.8.94. 2-D Echo showed a gradient of 40 mm across the coarctation site of the aorta. Cogulation profile was normal.

At 36 weeks gestation in consultation with a team of Neonatologist, Anaesthetist, Cardiologist and Neurologist delivery by elective LSCS was decided upon. Patient delivered a FT IUGR female baby 2.1 Kg with thin meconium stained liquor.

Postnatal period was uneventful. Patient was discharged on T. Ciplar and advised regular follow up and repeat DSA after 6 weeks.

Thus a team approach proved fruitful and rewarding in this high risk patient for both the mother and the baby.

PREGNANCY IN A CASE OF COMPLETE HEART BLOCK

J. R. Chowdhury • J. Mukherji

Mrs. J.M. 38 yrs. Hindu P_{1+0} was admitted at N.R.S. Hospital on 24.6.94 with breathlesssness at 32 wks. of pregnancy. Her first child born normally 5 years back, was alive and well. In August '92 she was admitted at Deptt. of Cardiology of this hospital and her E.C.G. showed 3° AV Block with a narrow ORS complex indicating a probable congenital origin of her complete heart block. she was advised a pace maker which she could not afford.

On admission on 24.6.94 her pulse rate was 48/m regular, B.P. 110/70, Edema 2+ with creps & ronchi at lung bases & temperature 99°F. She was treated for respiratory tract infection with ampicillin and deriphylline. Her Hb was 10.5 CM%, Blood Sugar 81 mg%. U.S.G. on 8.7.94 showed Polyhydramnios with 33 wks, IUGR baby with meningomyelocele. Cardiologist advised her Tab orciprenaline 1 t.d.s. but her pulse averaged around 40-46-/m, B.P. 120/70 to 150/100 throughout her antenatal period.

Patient went into labour at 9 p.m. on 1.8.84 and was put on orciprenaline drip with 27 ampoules in 5% Dextrose drip started @ 10 drops/min. via Microdrip. Her F.H.S. showed fetal distress at 1 a.m. on 2.8.94 and she went on to deliver a fresh still born 1.9 kg female baby with huge meningomyelocele at 1.45 hrs on 2.8.94. the placenta was retained, probably due to the orciprenaline drip. It was removed manually under I.V. Diazepam and separated easily. Throughout her labour and for 24 hrs. post-partum she was on the orciprenaline drip adjusted to keep her pulse rate between 60-70 minute. She was subsequently put on orciprenaline tablets and antibiotic.

After an uneventful 10 days of observation she was discharged.

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Complete heart block without a pacemaker is a high risk pregnancy case deserving greater attention during delivery.

AN UNUSUAL CASE OF SECONDARY POST PARTUM HAEMORRHAGE FOLLOWING CAESAREAN SECTION

P. MUKHOPADHYAY ● G. BERA ● S. DUTTA
J. MALLICK ● S. K. SAHA

A P_{1+0} 23 years patient was admitted on 28.4.94 with severe bleeding per vagina.

She had her last child birth on 12.3.94 by emergency L.S.C.S in Nursing Home due to A.P.H. at 32 weeks of gestation. A baby of 1.7 kg was born and baby is alive and well. On 1.4.94 she had moderate P.P.H. (Post Partum Haemorrhage) and was treated conservatively. But severe P.P.H. occurred on 16.4.94 and on 27.4.94. Each time she received blood transfusion and uterus was explored but no product of conception was found and material was not sent for histopatholo-gical (H.P.) examination.

After admission, on examination uterus was found just bulky soft & external os was closed and no other pelvic abnormality was found. She was treated with tab. Regesteron, oral antibiotic and iron. On investigation Hb - 8 gm%, B.T., & C.T. within normal limit, serum HCG - 1.6 mIU/ml, U.S.G. revealed no pelvic pathology, X-ray chest was normal.

Fig. 1 : Photomicrograph showing invasion of chorionic tissue within uterine muscle.

But on 10.5.94 again patient had severe bleeding P/V, 4 bottles blood were transfused and tab. Lynoral and tab. Dicynene were added to above regime. E.U.A. was done on 16.5.94. Cervix and fornices were healthy, uterus was just bulky, cervix soft and os tightly closed. Again on 20.5.94 she had another episode of severe bleeding p/v. D/C followed by Laparotomy (if necessary) was decided on 30.5.94. But in the morning of the day of operation she again started severe bleeding. An emergency laparotomy was done. Uterus was found soft and just bulky, previous scar was healthy. A stab. incision was made on lower part of uterus and uterus was explored and bilateral ligation of internal iliac artery was done. Hormone treatment was stopped. H.P. report of endometrium

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showed effect of hormone treatment, no other abnormality. Inspite of all effort she again started severe bleeding on 13.6.94 and went into shock. After resuscitation patient had undergone laparotomy and only a subtotal hysterectomy was possible due to extreme adhesion. H.P. report of uterus revealed invasion of chorionic tissue within myometrium with an inference of placenta increta, no malignancy. She was discharged on 30.6.94 in well and good condition. Thus she had seven episodes of bleeding per-vagina.

CONSERVATIVE MANAGEMENT OF PLACENTA ACCRETA

U. Girija ● K. Umadevi ● B. R. Brinda
N. Sundari ● Ambika

Mrs. K, 22 yrs. was referred to our hospital from a private Nursing home at 10.30 p.m. on 29.6.94 with a history of having delivered a preterm baby at 6 p.m. and presented to us as a case of retained placenta.

She was P_1 with two previous pregnancy losses at 26 and 24 wks. of gestation respectively. She had no significant past or family history contributing to the present problem.

O/E : general condition was good except for mild anemia. All parameters were steady. On abdominal examination, well contracted uterus was felt above the umbilicus. Pelvic examination revealed no active bleeding, the umbilical cord was felt in the vagina and internal os was open.

Patient was taken up for MRP after getting the relevant investigations done. Placenta could not be removed as there was no cleavage patient was kept under observation. She had no active bleeding. Ultrasound scanning was done, which showed a posteriorly situated placenta with no sub-placental sonolucent space. Placenta accreta was confirmed.

Since the patient had no previous live child and the present child was also preterm (1.5 kg) the usual management of placenta accreta ie., hysterectomy was deferred and conservative line of management was adopted. Patient was given higher antibiotics, complete haemogram, renal function and liver function tests were done. She was given Methotrexate 25 mg. alternating with citrovorum factor 4 mg. I.M. Totally 5 doses were given keeping a constant check on blood counts. She had no complications but for a high temperature for 3 days which was symptomatically treated. During the course of therapy she expelled a fleshy mass and had slight bleeding PV for a few days. The uterus remained uninvoluted at 20 wks size.

On 19.7.94 ie., one week after the last dose of Methotrexate under ultrasound guidance the entire placenta was removed easily without any bleeding during or after the procedure. Within next three days uterus involuted and

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became pelvic organ. On 25.7.94, patient was discharged in good health with her preterm baby who was weighing 1.8 kg at the time of discharge.

HALLERMANN - STREIFF SYNDROME

HONEY MARY MATHEW ● JAYDEEP BASU
NIMESH PILLAI ● M. S. URALA

Hallermann-Streiff syndrome is characterised by anomalies of skull, mandible, skin, eyes and also by a disproportionate nanism. We are reporting one such case due to its rarity.

Approximately 150 cases of Haller mann-Streiff syndrome have been reported.

Thirty four year old second gravida had a spontaneous vertex delivery at 38 weeks gestation at our rural outreach centre and was transferred to our hospital on the second post-natal day for evaluation of the infant. The male neonate weighing 1,885 gms at birth with a length of 45 cm and head circumference of 29 cm had history of convulsions. He was the second born son out of a nonconsanguineous union. The antenatal course of the mother was uneventful. There was no history of antepartum, intrapartum or post partum complications in the mother. There was no history of drug intake during pregnancy. Family history was not significant. The infant had difficulty in sucking. On examination, a small for gestational age infant with micrognathia, high arched palate, a left shallow orbit and right anophthalmia were observed. Muscle tone was normal and cardiovascular, respiratory and central nervous system examinations were normal. Routine blood count, CSF examination and metabolic work-up for convulsions were normal. The TORCH screen carried out on the mother too was normal. Infant received supportive treatment and was discharged after a week with advice to the mother for regular follow-up.

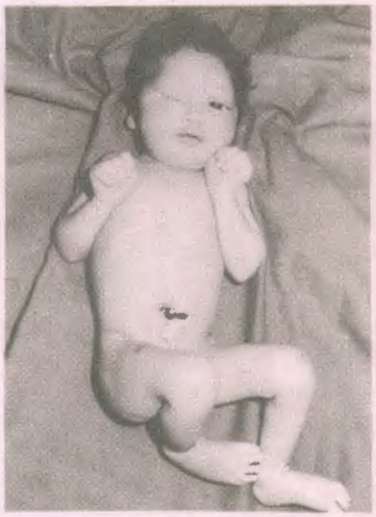

Fig. : Photograph of the neonate showing anophthalmia

This case demonstrates an example of Hallermann-Streiff syndrome as evidenced by the small size, micrognathia, high arched palate and right anoph-

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thalmia. It may also be associated with hypotrichosis and cutaneous atrophy of the scalp. The occurrence is sporadic and the cause is often unknown.

AN UNSUAL CASE OF MUCOCOLPOS DUE TO IMPERFORATE VAGINA IN A GIRL AGED 4 YEARS

G. N. Modi • M. S. Patel
Prachi Renjhen

INTRODUCTION

Vaginal atresia occurs in various degrees and forms. More frequently the vagina is obstructed by thinner membrane situated low in the vagina just above the hymen. This condition is known as imperforate vagina. Ordinarily these patients don't have any complaints till they start menstruating.

Our patient, a four year old girl presented with retention of urine which was diagnosed to be due to mucocolpos which was result of imperforate vagina. This is a very rare condition.

CASE REPORT

Baby J, aged 4 years, was admitted in paediatric ward on 8.4 94 in our hospital with chief complaints of retention of urine. On catheterisation 500cc of clear urine was drained.

On examination a lump was found in umbilical and hypogastric region. It was cystic nontender, mobile from side to side, arising from pelvis, extending 1 finger breadth above umbilicus (7 cm in diameter).

Examination of genitals revealed single urethral opening. Vaginal opening was absent. There was no bulging at the site of vaginal opening.

USG report showed normal liver, gall bladder, spleen, mild to moderate hydronephrosis in both kidneys, well defined cystic mass about 5.6 x 3.9 cm with internal debris, no septa or calcification suggestive of ovarian cyst.

Exploratory laparotomy was done on 9.5.94 which revealed that the cystic mass was distension of vagina. Uterus, both ovaries and fallopian tubes were normal. A 18-G, needle was introduced and thin yellowish coloured fluid about 200cc was aspirated.

Patient was called for regular follow up. She was again admitted on 9.8.94 with the same complaint of retention of urine and mass in lower abdomen. Sonography revealed a cystic mass 10 x 5.7 x 5.1 cm posterior to bladder. There was no collection within uterine cavity.

She was examined under anaesthesia and a 16-G needle was passed through the lower end of imperforate vagina and 170cc of clear mucus was aspirated. The opening was enlarged and dilated by Hegar's dilators. There was a septum of 4-5 mm at the lower end of vagina. Vaginoscopy was done and cervix and vagina were found to be normal. Patient was given a course of antibiotics and was called for regular dilatation of vaginal opening.

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PRIMARY AMENORRHEA WITH UTERUS DIDELPHYS AN UNCOMMON PRESENTATION

P. L. GUPTA • N. GUPTA

INTRODUCTION

Haematometra due to imperforate hymen or to transverse vaginal septum is well known. However, uterus didelphys with primary amenorrhea associated with haematometra with congenital absence of cervix and complete vaginal atresia is a very rare complication. This case is reported for its rarity.

CASE REPORT

Mrs. G. 15 years old married girl attended Gynae OPD of J.L.N. Hospital, Ajmer with complaints of primary amenorrhea and pain in lower abdomen for 1 year and inability to have sexual intercourse since marriage. She was the only child of her parents. Her mother does not have any positive history of drug taking during her conception. On general examination her height was 150 cm. and span of her hands was 160 cm., with long fingers. Her middle finger was 9 cm long. Distance between xiphi sternum to symphysis pubis was 32 cm and from umbilicus to symphysis pubis was only 7 cm. umbilicus was flat. Breasts were under developed; axillary and pubic hairs were normal. No lump was felt abdominally. On vulval examination the urethral opening was small and was situated just below the clitoris. Vagina was not formed and no vaginal orifice was seen. On per rectal examination a pelvic mass of 3" x 3" was felt anteriorly.

INVESTIGATIONS

Her Hb was 10 gm%, TLC 7,500/mm^3, blood urea 22 mg%, blood sugar fasting 84 mg%, ESR - 40 mm in 1st hour X-Ray chest NAD, E.C.G. - T.W.N.L. Her blood group was O +ve U.S.G. showed uterus filled with blood with absence of vagina and both ovaries to be small in size. Rt kidney was absent.

On diagnostic laparoscopy a complex mass was seen in the pelvis but exact pathology could not be identified due to adhesions. So laparotomy was performed. On laparotomy abdomen was opened with Pfannenstiel incision, there were adhesions of omentum anteriorly. After seperation of adhesions two uteri were seen. The left uterus, tube and ovary were rudimentary. The right uterus was about 6 weeks size and soft, Right tube was blocked at cornual end but right ovary was normal. Cervix was absent. On aspiration of the right uterus, chocolate coloured blood aspirated and diagnosis of haematometra was made. Abdomen closed in usual way. Vaginoplasty was done by dissecting the space between bladder and rectum. Vault was reached but there was no cervix. The incision was made in the lower most dependent part of the uterus and typical chocolate coloured blood was drained. The cut edges were everted by sutures and a malecot cathater was put

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in the uterus. On 3rd post operative day the cathater was removed and vaginal mould was inserted. On discharge patient was instructed to use the vaginal mould but after 2 months she again came with complaint of dysparenuia. On vaginal examination uterus was normal size but vagina was slightly stenosed. Vaginal dilatation was done. she was mensruating regularly .though bleeding was less.

A CASE OF CONGENITAL ADRENO-GENITAL SYNDROME

ABHA SARKAR • R. SARKAR • A. GHOSH

Miss B.S. 14 years old girl was admitted at S.S.K.M. Hospital on 3.11.93 for difficulty in passing urine for last 8 days and a long phallus like male penis since birth. She was brought up as a female child. Mother gave no h/o drug therapy when she was carrying her. No other family member suffered from similar problem. She did not receive any related drug since birth.

On examination : she looked to her mother, apparent age was below normal. Ht. 4'-5", Wt. 30 Kg. BP 110/70 mm of Hg. Secondary sex characters as breast-development and axillary hair were absent, pubic hair scanty with male type of distribution. External genitalia - dark looking empty scrotal fold with a long phallus (4 cm x 2 cm) and normal looking glands penis without urethal opening. The prepuce was short but could be retracted over the glands. The urethal opening was just below the root of phallus (Fig. 1). No vaginal opening visible. A fused ridge from urethral opening upto anal rugae with a mild anterior-posterior depression could be seen. No palpable gonad/testes found in vulva or groin.

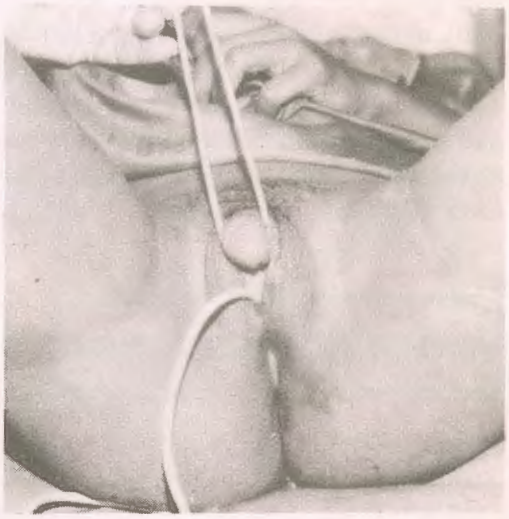

Fig. 1 : Catheter in urethral opening below the root of phallus without any vaginal orifice of 'A case of Congenital adreno-genital syndrome'.

Her sex chromatin was positive, 17 Ketosteroid was 24 mg/24 hours urine and Ketogenic steroid was 22 mg/24 hours urine. Serum electrolytes were within normal limits. U.S.G. - Adrenals were of normal size. Diagnostic laparoscopy revealed hypoplastic thin walled uterus (5 cm x 2.5 cm x 0.5 cm) with two thin fallopain tubes of normal length and porcelein white pre-pubertal ovaries on both sides

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(3 cm x 1 cm x 0.5 cm) I.V.P. reports - NAD. Chest X-ray - NAD. But her bony age (in X-ray pelvis and hand) was raised around 18 years. Other usual investigations of blood, urine etc. were within normal limits.

She had undergone amputation of phallus with plastic repair of clitoris and vagino-plasty operation was done dissecting out the blind lower third of vagina to open into the hollow pouch of upper two-third of vagina at the same time. She was given Tab. Prednisolone 5 mg. thrice daily to continue life long without failure.

On regular monthly check up her breast-disc appeared after 4 months, axillary hairs and dense pubic hairs also developed. She started menstruation after 6 months of treatment.

UNUSUAL FOREIGN BODY

SATISH DHAMANKAR • GANESH SHINDE
Y. S. NANDANWAR

CASE REPORT

Mrs. M.K., aged 27 years, was admitted on 1.6.94 with history of pain in left iliac fossa for last 3 months, following a procurred abortion of 2 months gestation (conceived during lactational amenorrhea) by a female health worker in rural Uttar Pradesh.

There were no bladder or bowel symptons.

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On Examination

P.A. Vertical cord like structure was felt along left lateral border of rectus muscle in the parietes.

P.S. N.A.D.

P.V. A round cord like structure felt in the anterior fornix at the base of the bladder. Uterus anteverted, normal size, other fornices clear.

Investigations

Plain X-ray abdomen AP & lateral view showed a radio opaque, around 20 cm, long curved image which was extending from the right iliac fossa to the left iliac fossa. Ultrasonography showed empty uterine cavity with normal adnexae and a tubular structure extending from the ileocecal junction, along the base of bladder and entering the abdominal wall on the left side upto the loin. Kidneys were normal.

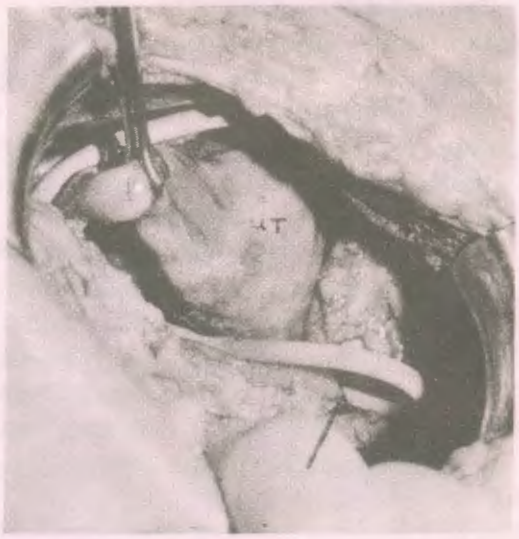

Fig. 1 : Foeign body enmeshed within loops of bowel and omentum (Shown by Arrow, ut-uterus)

C.T. Scan revealed the foreign body of a tubular nature, lying most of its length extraperitoneally, with dense adhesions at places. C.T. Scan was done to trace the course of foreign body so as to help in deciding the approach from a particular point.

Laparoscopy was contemplated knowing its limitations. Laparoscopy showed multiple dense omental adhesions intraperitoneally and the foreign body could not be located. Another approach vaginally, through the anterior fornix (Uterovesical fold) was tried as the foreign body was felt to be just at the base of bladder. But due to the dense adhesions, we abandoned it lest causing injury to the bladder.

And thus the decision to go ultimately by the conventional method i.e. laparatomy was made. Here too, we tried to locate the foreign body on the left side in the preperitoneal plane, however though it was felt, it was enmeshed in dense adhesions with vascularity all around, thus forcing us to open peritoneum and search for it intraperitoneally. After a good hunt we could locate it's tip densely enmeshed within loops of bowel and omentum at the ileocecal junction. On traction a faded simple rubber catheter just walked out to its total length without any obvious bleeding as shown in the photograph.

It is a known fact that the list of foreign bodies found in procuring abortions is unending. To this patient's good fortune, this was a relatively inert material foreign body (probably because she reported to a paramedic). Though clinically, we could suspect it to be a catheter since it was felt along most of its length quite superficially, we had to limit ourselves during our various ways of approaches for its removal due to the dense adhesions around it.

The symptom and the length of foreign body made its removal mandatory. In retrospect, we conclude that though the foreign body appeared simple and uncomplicated, it was wiser to investigate with the different modalities, for proper orientation and ultimately approaching it by the most conventional method, keeping patient's safety in mind.

ACTINOMYCOTIC TUBO-OVARIAN MASS

M. V. Mallya • N. S. Nadkarni
S. Menezes • A. Kamathi

CLINICAL HISTORY

A 45 year old female presented with pelvic and abdominal pain. Per abdominal examination revealed presence of right side pelvic mass. There was no abnormality of the menstrual cycle.

An exploratory laparotomy showed presence of right side tubo-ovarian mass. The patient was subjected for total abdominal hysterectomy with bilateral salpingo-oopherectomy and the mass sent for histopathological examination.

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Macroscopic Examination (Photograph 1)

The specimen consisted of uterus and cervix measuring 7 x 6 x 4 cms with bilateral adenexa.

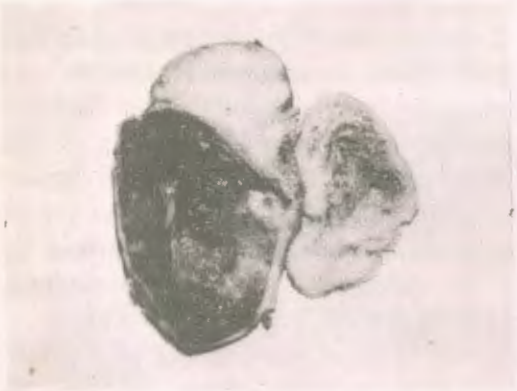

Fig. 1 : Photograph showing tube-ovarian mass with partly cystic and solid areas.

Cut section of the uterus showed a small seedling leiomyoma. The right tubo-ovarian mass measured 10 x 7 x 5 cms in size. Cut section of the mass showed variegated appearance, comprising of blackish areas due to haemorrhage, cystic areas and yellowsih white solid areas.

The left side ovary was of normal size and did not show significant gross pathology.

Microscopic Appearance (Photograph 2)

Multiple sections studied from the tubo-ovarian mass showed fibrocollagenous tissue enclosing circumscribed granulomas with lumped mass of ray fungus in the center surrounded by acute and chronic inflammatory cells at places forming microabscesses. Fair number of foreign body giant cells and foamy histiocytes were also seen. The colonies of actinomyces showed hematoxylinophilic filamentous centre and a peripheral radiating arrangement of eosinopholic clubs. The colonies were PAS positive. GRAM staining done showed the central branching filaments to be gram positive.

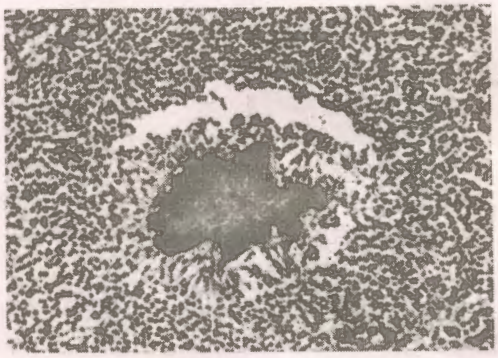

Fig.2 : Photomicrograph showing granuloma with colonies of actinomyces in the center.

Sections from the uterus, cervix and left ovary were unremarkable.

ACKNOWLEDGEMENT

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ENDOMETRIAL STROMAL SARCOMA OF UTERUS

RAMA JOSHI • D. SHARMA • M. KUMAR

Mrs P.M., 60 yrs old, P_{6+0} menopausal for 10 yrs was admitted on 20th April '94 with the complaint of excessive and

irregular vaginal bleeding for 6 months without significant weight loss. She had menorrhagia in her last 15 reproductive years and was not investigated for it. She was moderately anemic and her systemic examination was within normal limits. P/A examination revealed soft to firm, mobile nontender suprapubic mass of about 1 wks size of pregnant uterus. Vaginal examination revealed the uniformly enlarged uterine mass with

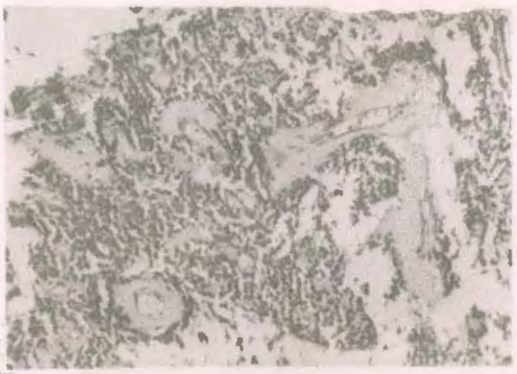

Fig.1 : Showing Endometerial stromal Sarcoma Haemangiopericy-tomatous pattern. H & E X 125

normal cervix and clear fornices. There was no organomegaly, no ascitis and no lymphadenopathy. Hence a clinical diagnosis of myoma uterus with ? carcinoma endometrium or sarcomatous change was made. X-ray chest was normal and ultrasound suggested a degenerated fibroid. On diagnostic D &C an irregularity was felt in uterine canal and no curetting could be obtained. On laparotomy there was a uterine mass with normal adenexa. Total abdominal hysterectomy with bilateral salpingoophore-ctomy was done. On cut section it had a lobulated fleshy mass of about 8 cm diameter occupying the uterine canal. Microscopically sections taken from representative sites of the lobulated mass established the diagnosis of endometrial stromal sarcoma. Haemangiopericy-tomatous pattern was prominent having branching vascular spaces with marked hyalinisation around the wall (Fig. 1). Few endometrial glands with stromal proliferation merging with the myome-trium upto 1/2 portion were seen. Tube and ovary were unremarkable. Postoperative radiotherapy was given to whole pelvis. There is no evidence of disease for last two years.

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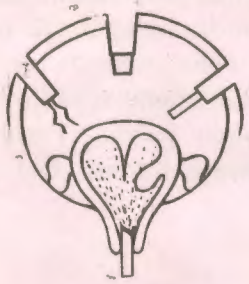

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