CASE REPORT

PLACENTA PERCRETA CAUSING UTERINE RUPTURE

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Mrs. SW, a 26 years $G_3P_2A_0$ woman from low socio-economic status was admitted on 10.04.93 in Medical College Rohtak as unbooked emergency Case with 28 + weeks pregnancy and leaking per vaginum since 6 hours. There was no history of D and C or any abdominal operation earlier or fever.

General examination : revealed mild pallor and edema feet, pulse 88/m, BP-100/60 mm of Hg.

Per abdominal examination showed fundal height 28 + 2weeks. There was oblique lie of the fetus with head lying on left illiac fossa. FSH - was regular.

Per speculum examination revealed closed external os and dribbling of clear liquor from the cervical os. Routine investigations showed no abnormality. Hb 8 gm%. ABO Rh. - 0 + ., VDRL-negative. High vaginal swab culture - showed no growth.

Patient was kept on conservative therapy with bed rest, raising foot end of bed and antibiotic prophylaxis. Fetal growth and well being was monitored regularly clinically and ultrasonographically weekly. This treatment was continued for 4 weeks. There was sat-

Fig. 1 : Photograph showing rent on anterior surface of uterus just below Rt. Cornu (Artery forceps protruding through the rent.)

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isfactory growth of fetus but leaking p/v continued, though decreased in amount. At 33 weeks of gestation the patient felt mild abdominal pain and abdominal discomfort in the late night. In the morning she suddenly collapsed. There was marked pallor, pulse - 160/m, BP - unrecordable, patient was gasping. Per abdomen - ut - 32 weeks, tonically contracted, abdomen tender and rigid. FHS could not be localised. P/v examination showed Cx os high up, admitting tip of finger, buldge in all fornices, no bleeding p/v. Emergency laparotomy done, after correcting the shock by fluids, 8 units of blood, corticosteroid and plasma volume expander.

At laparotomy : Abdomen was filled with blood clots, nearly 2 litters of blood clots removed from the abdominal cavity. Fundus and upper part of the anterior surface of the body was very thin and a rent was found of size 3 x 2.5 cm. Just below the Rt. cornu of the uterus through which placenta was seen to protrude and with big vessels. Bleeding was occuring from this site and rest of the uterus was intact (Fig. 1).

A fresh still born female baby was delivered rapidly by LSCS as breech. Placenta was tried to be removed manually but failed. Only a part of it could be removed. Brisk haemorrhage started from the separated placental site. Subtotal hysterectomy was performed.

Post-operatively she settled gradually with blood transfusion and Dopamin drip. She had an uneventful recovery. Stitches removed on 8th post operative day which healed nicely. Patient discharged in good condition.

VESICAL CALCULUS AS A CAUSE OF OBSTRUCTED LABOUR

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Case No. 1 : Mrs. Sh., 22 years primigravida, married for 2 years was admitted on 06.12.91 to Medical College and Hospital, Rohtak as emergency Case with 39 + weeks, pregnancy with labour pains for 12 hours. She had H/O recurrent low UTI in the present pregnancy which, however, remained, untreated.

On examination her general condition was good. She was afebrile. Her pulse was 90/PM and BP-130/90 mm of Hg. She was mildly dehydrated.

Abdominal examination revealed - uterine height - 36 weeks, with vertex presentation, 3/5th of the head was palpable per-abdomin. There were good uterine contractions with Bandle's ring in uterus.

Pelvic examination revealed gross oedema of labia and vaginal laceration. Cx os fully dilated and fully effaced, and membranes absent. Vertex was on - 1 station which could not be pushed down as a hard, nonmobile, non tender oval mass of size 5 x 6 cm felt beneath the anterior vaginal wall near anterior F below the presenting part. Clinically it was thought to be a pelvic tumour causing obstruction. (Pre-operative urine analysis

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showed-many pus cells with 8-10 RBC/ HPE).

Emergency LSCS was done and a healthy, 2.85 kg. male baby was delivered. After closing the uterus, urinary bladder was examined. It was grossly edematous and congested and a hard mass was felt within it. Bladder was opened by midline vertical incision (extraperitoneal) and a 6 x 7 cm bladder stone was extracted. Bladder was closed in two layers leaving a foley's catheter in and a rubber drain in retropubic space.

She had a smooth post operative recovery. Drain was removed after 48 hours and catheter removed after 10 days. Subsequent urine culture report came sterile. Stitches were removed after 7 days and wound healed nicely.

Patient went home with her baby in good condition on 16.12.91.

Case No. 2 : Mrs. So., 24 years, $G_2P_0A_1$ married for three years, was admitted on 27.02.92 as an emergency case with 41 + weeks of pregnancy and labour pains with leaking p.v for 10 hours. Antenately she did not have any symptoms suggestive of UTI. On examination her general condition was good and she was afebrile, pulse-88/m, BP - 140/96 mm Hg.

Per Abdominal examination : Uterine height - Term size, vertex presentation, 4/5th of the head was palpable. Uterine contractions 3-4/30' - 40", FHS + R.

Lower segment was distended.

Pelvic examination revealed : 0s-5 cm dilated, 75% effaced, membrane was intact, liquor was clear. Head was high up (-2 station). A mass 7 x 7.5 cm of bony consistency with smooth surface, non-tender and nonmobile was felt arising from Rt. ischiopubic rami which was obstructing the head to descend by decreasing the dimension of pelvic cavity. Pelvic architecture otherwise was gynaecoid. Pre-operative urine analysis showed - Alb + sugar - nil, M/E crystals + 6-8 pus cells/HPF, 10-12 RBC's/HPF.

Provisionally a bony pelvic tumour or a vesical calculus causing obstructed labour was diagnosed and an emergency LSCS was done under antibiotic cover. A 2.3 kg., asphyxiated male baby was delivered. After closing the uterus, pelvic cavity and bladder were palpated in search for the origin of the mass. A hard mass was felt through the congested and edematous bladder. Extraperitoneal cystolithotomy done and a 6.5 x 7 cm size bladder stone removed. After irrigation bladder closed in layers leaving a Foley's catheter in. A corrugated rubber drain put in space of Retzius which was removed after 48 hours.

She, however, had a stormy post operative period. She had fever from 3rd PO day onwards. Urine culture showed growth of Klebciella sensitive to norfloxacillin. Antibiotics were changed and intermittent bladder irrigation done. Patient became afebrile. There was gaping of wound in the lower half when atitches were removed on 8th day. Daily antiseptic dressing was done. Catheter was removed after 10 days. Secondary stitches were put in abdominal wound, which were removed after 10 days. Wound this time healed well. Baby developed septicemia and neonatal jaundice which were treated.

Patient went home with her baby, both in good condition on 23.3.92.

PREGNANCY WITH HYDATID CYST OF BLADDER

SNEH LATA MISHRA • VIMLA SHARMA
MANJU GURG

Mrs Geeta, 40 years Hindu female and residing in rural area was admitted with 5 months amenorrhoea and was willing for termination of pregnancy as it was failure of abdominal sterilization.

Her past M.H. was regular with normal blood flow. Past personal and family history was not significant. On examination the patient was poorly built and nourished. Abdominal examination revealed enlarged pregnant uterus of 20 weeks size. There was a solid mass of 4" x 4" size in left iliac fossa by the side of the uterus. It was non-tender and mobile. On bimanual examination uterus was found enlarged to twenty weeks size and a rounded mass was felt in the left fornix which was separate from the uterus. A diagnosis of pregnancy with solid ovarian tumour was made. As the patient was willing for termination, hysterotomy with removal of ovarian tumour with sterilization was decided upon. Routine investigations were within normal limits. Ultrasonography showed a single viable foetus of 20 weeks gestation and left adenexa showed a solid mass of 7.25 x 5 x 5 cm size adjascent to uterus with cystic areas inside. No evidence of calcification was seen.

On opening the abdomen uterus was enlarged to 22 weeks size, there was a semi-solid mass in left iliac fossa adherent to omentum colon and bladder (Fig. 1). Lower segment hysterotomy was done. Adhesions of the tumour with omentum colon, were separated. To our surprise tumour was arising from the left lateral wall of the bladder and not from ovary as both the ovaries were normal and healthy. The tumour was removed. Abdominal sterilization was done. Abdomen was closed after proper haemostasis.

Fig. 1 : Hydatid cyst attached over urinary bladder

Fig. 2 : Cut Section of hydatid cyst with multiple daughter cyst

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Gross examination of tumour : Tumour was 6" x 6" in size with smooth walls. Cut section showed infected daughter hydatid cysts (Fig. 2). Histopathology confirmed the diagnosis. Patient was given a course of Mebendazole. she recovered uneventfully.

CERVICAL ECTOPIC PREGNANCY

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Treated by Single Dose Methotrexate therapy. (Modified Bagshawe Protocol)

Cervical pregnancy is a rare variant of ectopic pregnancy. In app. 50% of cases, the patients undergo Abd. Hysterectomy. For a young pt. who wants to maintain her fertility, a more conservative treatment is highly desirable.

Our case report is rare, as we have adopted the methotrexate - folinic acid of the *modified Bagshawe protocol* (a 1 day treatment) and have successfully treated the cervical pregnancy MEDICALLY with preservation of reproductive functions.

A 20 years nulligravida, Mrs. S.D., presented in the Gyn. OPD of New Civil Hospital, Surat on 19th April, 1993 with H/o 2 MA followed by Bl. P/V, Scanty in amount from past 10 days. No C/o cramping pain in abd. and no other positive history.

O/E : G/E and S/E - N
P/A - NAD
P/S - Bleeding through Cx. canal. Ext. Os open, A small clot seen at Ext. os
Cx. - Extremely vascular and thinned out.
P/V - Ut., AV, NS firm.
Cx. - Barrel shaped, thinned out, Ext. os-open.
Fx. - free.

USG - revealed - a normal sized uterus with thick echogenic endometrium, 8 wks. single gestational sac seen in the cx. below the level of closed int. os. Fetal pole seen with normal cardiac pulsations. Both ovaries - N.
Diagnosis : Cervical Ectopic Pregnancy.
Patient was admitted. serum ß HCG - 5800 IU/ml.

Since the pt. was nulligravida and was very keen to preserve her reproductive function we preferred to treat her with single dose methotrexate therapy; the whole regime was adopted from obst. & gyn. survey, July, 1990, Vol. 45, No. 7, 405-414.

Baseline investigations were done. High Antibiotics Ceprofloxacin and Metrogyl were started. Total dose of 390 mg Methotrexate was given within 12 hrs. according to the prescribed regime (130 mg. IV in 30 min., followed by 260 mg. in circulation in 12 hrs. IV.) on 21st April, 1993 Pt. was watched for Methotrexate toxicity.

On next day morning (22.04.1993),

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