CASE REPORT

INTERVENTIONAL SONOGRAPHIC MANAGEMENT OF TUBAL PREGNANCY.

PRATAP KUMAR ● LAVANYA RAI,
VIVEK MADY

Interventional Sonographic and Parenteral Methotrexate therapy of Tubal Pregnancy.

Mrs. B.R., a 35 year old gravida 2, conceived after 8 years of secondary infertility reported with H/o 45 days amenorrhoea and pain in abdomen for 2 days.

She was treated for abdominal tuberculosis 12 years back. She had been having regular menstrual cycles but with scanty flow.

Her first pregnancy was an ectopic pregnancy for which right salpingectomy was done in 1987. Subsequently, she was infertile for 7 years and was investigated for the same. Diagnostic laparoscopy with chromotubation done on 21.1.94 showed a congested uterus with flaky adhesions over it. Left tube and ovary were normal and dye spill visualised.

Soon after she conceived spontaneously.

She was not anaemic

Vital signs and all systems were normal.

Pelvic examination showed a bulky uterus in mid position

There was no mass or tenderness in the fornices.

- Her blood picture was normal.
- Transvaginal sonography showed an empty uterine cavity but a 16 mm gestational sac was seen outside the uterus on the left side. Fetal pole with cardiac pulsations were visible. Thus the scan was suggestive of ectopic pregnancy.
- BHCG - 10,142 IU/L.

In view of the unruptured tubal pregnancy, conservative management by interventional procedure under transvaginal sonographic guidance was done. A 16 gauge needle was passed through vaginal fornix, into the ectopic sac. Blood stained material was aspirated. Then 25 mgs of

Dept. of Obs. & Gyn. Kasturba Medical College & Hospital, Manipal
Accepted for Publication on 31.1.1995

methotrexate was injected into the ectopic sac. As βHCG levels were high and cardiac pulsations were seen, systemic administration of methotrexate was decided upon. Fifty mg methotrexate and 6 mgs folinic acid were given intramuscularly on alternate days for a total of four doses each. In the repeat scan done 10 days later, the size of the sac had regressed considerably and there was no cardiac pulsations or foetal pole. There was progressive regression of βHCG levels.

This case is presented not only because of the conservative nature and success of the procedure, but also because it was possible to conserve her only surviving tube for future fertility.

"ROBERTSONIAN TRANSLOCATION T(13Q 13Q) IN A FEMALE WITH HISTORY OF RECURRENT SPONTANEOUS ABORTIONS"

PREETHA TILAK ● SHAVANTHI LINCOLN
SAYEE RAJANGAM ● LILLIAN
I.M. THOMAS

INTRODUCTION

Proband was referred with history of recurrent spontaneous abortions. Cytogenetic Analysis showed a Robertsonian translocation (13Q; 13Q). In view of the mother's karyotype being normal. the observed Rt(13:13) has to be 'de novo'. Genetic counselling for the couple included options such as ovum donation or adoption.

Dept. of Anatomy St. John's Medical College, Bangalore.
Accepted for Publication on 31.1.1995

CASE REPORT

A couple (husband 35 years; wife 34 years) with history of 5 recurrent first trimester spontaneous abortions were referred to our lab for cytogenetic investigations. Husband (3rd birth order) and wife (2nd birth order) were born to non-consanguinous parents. Their family history was eventful, except for the occurrence of one abortion, each to the elder brother of the husband and to the younger brother of the wife. Wife was of normal build; she attained menarche at 20 years and her menstrual cycles were regular. She got married at 29th year i.e. in 1988 and the first pregnancy was in 1989. At 2 months of gestation, she had abdominal pain, associated bleeding and spontaneous expulsion of conceptus at home. Later curettage was done. Subsequent pregnancies at an interval of one year resulted in similar spontaneous abortions at 2 months gestation followed each time by curettage.

INVESTIGATIONS

Ultrasonographic findings revealed a retroverted; retroflexed normal sized uterus and a normal endometrium. Right ovary was normal, left ovary showed a cystic area (13 mms). No other adenxal mass was seen. Clinical pathological investigations were normal.

Semen analysis of the husband was normal (sperm count 108 million ml.)

Cytogenetic investigations were done on both. Peripheral lymphocyte culture

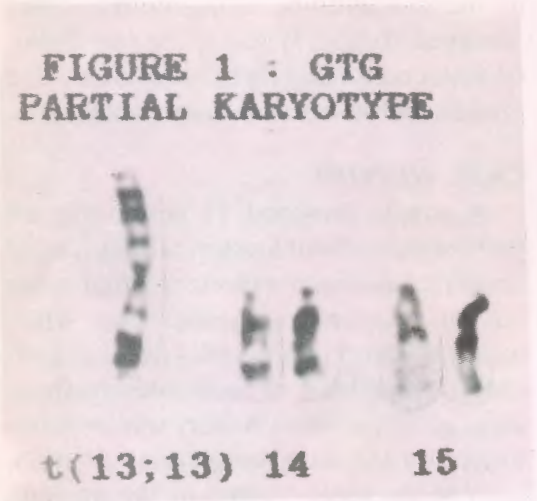

Fig.1

and GTG banding of chromosomes showed 45 chromosomes and Robertsonian translocation (RT) i.e. t(13;13) in the wife. Her karyotype was 45, XX, t(13q;13q) (Figure I). Husband's karyotype was 46,XT. Wife's father is deceased, hence, chromosome analysis could be done only on the wife's mother and the karyotype was 46,xx.

The incidence of chromosomal disorders in all conceptions is 7.5%; in early spontaneous abortions 60% and in livebirths 0.6%. In the last group, the frequency of balanced translocations is one in 500 livebirths, in which, Robertsonian (RT) and reciprocal translocations occur more or less in equal proportions. In surveys among couples with 2 or more abortions the observed frequency of Rts is about ten times higher than in new borns. The risk for the offspring in carriers with Rts, especially between homologous acrocentric (more or less like isochromosomes) is 100%, resulting in monosomy or trisomy zygotes. Trisomy 21 is viable, otherwise, mostly miscarriages may occur. In this report, wife being the carrier of Rt (13;13), has the tendency for recurrent abortions. Because the Rt is balanced, wife is phenotypically normal. Moreover, in view of her mother being normal, the observed Rt (13;13) has to be 'denovo'. In literature, t(13;13) has been reported.

ANTENATALLY DIAGNOSED DANDY WALKER SYNDROME

MRS. R. SOFAT ● DALJIT SINGH
HERMESH SINGH ● AMARDEEP SINGH
B.K.JAIN ● S.SOFAT

Dandy Walker Syndrome consists of developmental anomalies of the fourth ventricle and cerebellum in the form of cystic dilatation of the 4th ventricle and atresia of its foramina resulting in obstructive hydrocephalus, small and superiorly displaced cerebellar hemispheres and absent or hypoplastic posterior vermis. Other anomalies of brain are frequently associated with it, in addition to which other occasional defects include polydactyly, syndactyly, cleft palate, kidneys and abnormal lumber vertebra. A case of Dandy Walker Syndrome with bilateral enlargement of kidneys diagnosed antenatally is reported. NK, 28 years old primigravida came for routine antenatal check up in OPD of Dayanand Medical College and Hospital with term gestation and uneventful antenatal period. Mother is a post-graduate student in genetics and had handled radioisotope

Dept. of Obst. and Gyn. and Paediatrics, Dayanand Medical College and Hosp. Ludhiana, Punjab.
Accepted for Publication on 15.2.1995

Fig.1: Antenatal ultra sonograph showing absent Cerebellar vermis and cystic dialation of fourth ventricle.

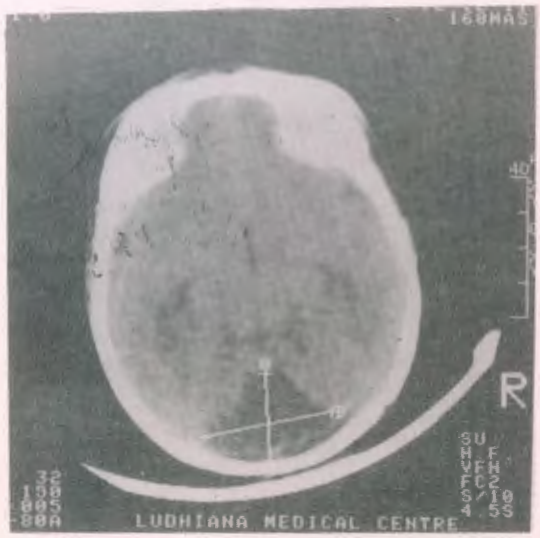

Figure 2: CT Scan showing cystic dilatation of 4th ventricle and absent vermis.

of phosphorous (p_{32}) in the laboratory during first 12 weeks. She had not received any other drug or X-ray exposure. Her general physical examination was normal. On pelvic assessment she had contracted pelvis and elective LSCS was planned due to cephalopelvic disproportion. Ultrasonography was done to rule out any congenital anomaly. It showed full terms fetus in vertex presentation and normal placenta. Liquorpocket was adequate. The ultrasonography also revealed absence of cerebellar vermis and a cystic delation of the 4th ventricle (fig 1) and enlarged kidneys on both the sides. LSCS was done and a male baby of 3.1 kg was delivered. The baby had moderate asphyxia and APGAR score at 1 and 5 minutes was 4 and 7 respectively. Bag and mask ventilation was given during resuscitation. The baby was shifted to SCNU for observation. His activity, feeding passage of urine and meconium was normal.

The baby had a bony defect with a 2.5 cm x 2.5 cm soft, cystic swelling in the occipital region. Impulse was present on crying. The head circumference was 36.5 cm and anterior fontanel was at level. There was no widening of cranial sutures. Both the kidneys were enlarged. At 2 days of age blood urea was 26 mg/dl, serum creatinine 1 mg/dl and normal electrolytes. Intravenous pyelography showed bilaterally enlarged kidneys with normal pelvicallyceal system, ureters and bladder. No definite evidence of infantile polycystic kidneyswas noted. The CT scan of head showed typical features of Dandy Walker Syndrome in the form of cystic dilatation of the 4th ventricle and absent vermis (fig.2) The baby had uneventful hospital stay and was discharged after 8 days and is doing well till date.

ANTENATAL SONOGRAPHIC DIAGNOSIS OF OMPHALOCELE IN A SUB-SEPTATE UTERUS

TAMKIN KHAN ● Z. ARSHAD,
M. KHALID

Omphalocele is a congenital midline defect of the anterior abdominal wall and

is characterized by insertion of umblical cord into a hernia sac containing variable amount of abdominal viscera. The emryology is believed to be abnormal closure of lateral abdominal folds at the 10th week of gestation. The reported incidence is 1:3200 to 1:10,000 births. This case is being reported for its rarity and antenatal diagnosis of omphalocele by ultrasonography.

Mrs. N. K. an elderly female aged 38 years with a bad obstetrical history (G7 P0+6, repeated midtrimester abortions with no live issue) was admitted to our institution with 28 weeks pregnancy and mild PET (B.P. 140/90 mm Hg). Sonography revealed a large echogenic mass in continuity with anterior part of fetal abdomen with evidence of hernial sac covering the mass. Umblical cord was found to be inserted over the mass and the likely diagnosis of omphalocele was made (Fig. 1). Spina bifida was also visualized.

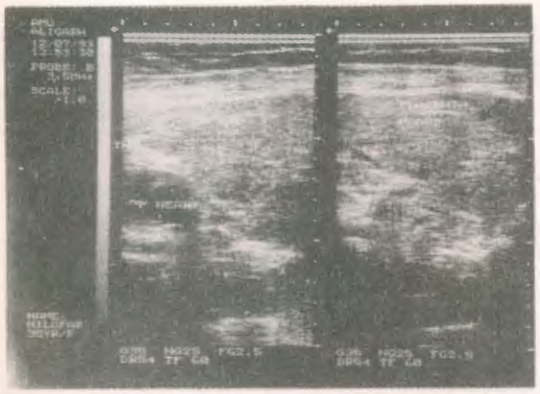

Fig. 1 : USG of fetal abdomen showing omphalocele with hernia sac (arrow) containing non dilated bowel.

Inspite of hospitalization and intensive therapy, she developed severe PET with impending eclampsia at 36 weeks of pregnancy. As she was an elderly female with severe PET with impending eclampsia with antenatally diagnosed omphalocele, an elective caesarean was planned. Caesarean section is preferred in omphalocele as rupture of its sac during delivery is associated with a septic course.

Fig.2 : Photograph showing omphalocele

A lower segment caesarean section was performed. The uterus was found to be sub-septate and a male baby with omphalocele with unruptured sac was delivered with difficulty (Fig. 2). Cord pulsations were present. The baby was handed over to the paediatrician and paediatric surgeon. However baby could not be revived due to associated lung hypoplasia and cardiac malformations.

Dept. of Obst. & Gyn. and Radiodiagnosis, J. N. Medical College, Aligarh.

Accepted for Publication on 15.2.1995

PREGNANCY IN NON-COMMUNICATING HORN - RETAINED FOR 9 YEARS - DETECTED AT DELIVERY FROM OTHER HORN

B. SAMANTA S. K. ● BHATTACHARYA

INTRODUCTION

Genito-urinary developmental defects are not infrequently associated with obstetric problem. Here is a report of rare case of retention of dead foetus in a non-communicating uterine horn-detected a normal delivery from the other one after a span of nine years.

CASE REPORT

Mrs. S.K. 27 years St. PO + 0, was referred from Surgical side for swelling of abdomen with amenorrhoea. The patient, a tribal women from a remote village of Jhargram S.D. (Dt-Midnapore) gave H/O gradually increasing abdominal swelling for last 4-5 months with amenorrhoea for years together. She was married for 11 years with H/O pregnancy 9 years ago - followed by labour pain. But she could not deliver. A local doctor told that she had not attained date of delivery & advised her to attend district hospital. She did not attend hospital, her pain subsided - followed by loss of foetal movement & decrease in abdominal size. She took it as mistaken pregnancy. Her periods took long to return. Since then, she had an abdominal lump with occasional abdominal ache which she did not care; otherwise she was in good health till this episode of gradual swelling of abdomen. This chance of pregnancy was out of her mind.

O/E she had an irregular abdominal swelling with palpable foetal parts &,FHS. An X-ray revealed twin pregnancy with IUGR in one foetus. She was advised rest & admitted.

After about 1 month of hospital stay, she developed labour pain delivered one mature baby of 2.5 kg., but the second baby was not delivered. On examination, besides an empty puerperal uterus, she had an adjoining firm mass of 26 weeks size. A repeat X-ray revealed a complete foetal skeleton. Patient said that she is harbouring this lump since her first misdiagnosed pregnancy.

Laparotomy was done after thorough haematological examination. The firm mass palpable per abdomen was left horm of uterus containing a mummified foetus (550 gm) in sac. A thick band of non-canalised tissue connecting it to the right horn that contained the viable foetus, was seen. Left tube & ovary were normal & attached to left horn. The non-communicating horn was removed in toto and dissected later on.

This is an interesting case of pregnancy in a non communicating left horn - died in the womb - mummified & retained for as long as 9 years followed by pregnancy on the Right - horn, that was delivered normally.

Dept. of Obs. & Gyn. Eden Hospital, Calcutta.
Accepted for Publication on 31.1.1995