CASE REPORT

IVF TWINS WITH FROZEN SPERMATOZOA - FIRST ASIAN REPORT

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Mrs. X, 25 years, childless after 4 1/2 years of marriage, reported to us for guidance - Husband had obstructive azoospermia which did not improve with surgical correction. Subsequent several attempts at donor insemination were not successful. Hence, couple opted for IVF-ET. IVF-ET stimulation regimen started in February'92 with 2 amps of FSH and HMG from D2-D9. There was moderate follicular response. After HCG 5000 I.U. 34 hours earlier, oocyte recovery done and five mature oocytes collected. Insemination done using frozen thawed spermatozoa 1,00,000/oocyte. All were fertilized after 12 hours. Five embryos in four-CELL stage were transferred into the uterine cavity. Pregnancy was confirmed at fifth week with twin intra uterine gestation sacs. Patient had mild pre-eclampsia from the seventh month of pregnancy and threatened labour contractions were noticed around the 33rd week. Preterm labour was suppressed with uterine relaxants and patient went into spontaneous labour at 38th week. She delivered a healthy boy and a girl by low midcavity forceps. Mother and babies are doing well. The children are two years old now.

In IVF-ET, only fresh spermatozoa are commonly used. There have been only very few case reports in the world literature using frozen spermatazoa. The common misbelief is that cryopreservation affects the sperm structure and function, thus lowering fertilization rates. This contention has been disproved by controlled studies and infact, cryopreserved spermatozoa have been recommended even in 'ART' in the present days of HIV prevalence and where the male partners are not able to collect the sample on demand.

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PUERPERAL BILE PERITONITIS

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Mrs. L. 26 yrs. P3 G3 last childbirth 12 days back came to Presbyterian Hospital, Durtlang, Mizoram on 13.2.94 with history of pain in upper and right flank of abdomen, followed by vomiting. Difficulty in passing urine, loose stool and fever with rigor.

On admission BP.110/80, Temp.98'F, pulse 80/min. pallor mild, RS & CVS normal, mild tenderness over epigastric and right hypochondrial regions. Bowel sound normal, no significant distension of abdomen. Treated with antacid and antibiotics. On 15.2.94 General condition deteriorating, Gaseous distension of abdomen, bowel sound normal, tenderness all over abdomen with muscle guarding. No fever, U/S revealed scanty free fluid in POD and flank of abdomen. Culdocentesis done free flow of slightly foul smelling yellowish white fluid aspirated about (5 ml)

Emergency laparatomy done under GA with provisional diagnosis of generalised peritonitis due to ruptured ovarian cyst/ appendicits. Operation findings - non - significant foul smelling free fluid found in peritoneal cavity. All abdominal organs covered with whitish slough. Appendix found normal. Uterus 12 weeks size, tubes, ovaries normal and adherent to broad ligament. Omentum adherent to small and contracted gall-bladder. Pus like yellowish white fluid came out on pressing the adherent gall-bladder.

Cholecystectomy, appendectomy and peritoneal toilet done. Abdomen closed with two drainage tubes. Post operative period uneventful except minimal wound infection. Patient discharged on 32 days of post operative period.

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LOCKED TWINS-A CASE REPORT

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Locked twins is an extremely rare condition, the reported incidence being only once in 90,000 cases. There are several forms of locking described among which locking of forecoming and aftercoming heads is one of the serious varieties of locked twins. One such case is being reported which was successfully managed and both the twins were saved.

A 22 years old patient G_2 P_0 A_1 was admitted to the labour room as an emergency at 5.00 AM on 18.8.94 with history of amenorrhoea of 35 weeks, leaking per vaginum and labour pains for 4 hours. There was no prior antenatal check up. On examination, patient was mildly anaemic, pulse 84/mt, B.P. 130/90, pedal edema + P/A uterus was overdistended with fundal ht at 36 weeks, multiple fetal parts were palpable. P/V cervix 4 cm dilated, fully effaced with breech at - 1 station, mem-

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branes were absent. Pelvis was normal gynaecoid type. Investigations were done. Hb 9.0g%, Urine albumin was ++. Xray showed twin pregnancy with Ist breech and 2nd oblique with head on right side. USG was also done which showed twin pregnancy with Ist presenting as breech and 2nd as oblique, BPD and FL of both twins being 8.7 and 6.6 cm respectively. There were two placentae present - one anterior and the other posterior. Patient was kept for vaginal delivery. At almost full dilatation, patient was shifted to O.T. for delivery. The first twin delivered as breech spontaneously upto umbilicus and then there was difficulty in delivering the shoulder. After the delivery of the shoulder, head got stuck. On P/V examination Cervix fully dilated, Vertex of second twin felt in vagina below the head of Ist twin (locked twins). Immediately GA was given. During this period, the head of the 2nd twin was held and kept up with the hand in vagina to prevent it's further descent during contraction. After giving G.A., the head of 2nd twin was pushed up out of the pelvis with the left hand in vagina and the head of the Ist twin was delivered at 1.03 PM on 18.8.94 (Ist twin was stuck for 10 minutes). On P/V Cx fully dilated, Vx of 2nd twin was at 2 station and bag of waters present. Amniotomy was done and syntocinon drip was started. Vertex descended. The second twin was extracted as vertex with outlet forceps at 1.08 PM on 18.8.94. The weights of the babies were 1.9 kg and 1.8 kg respectively. Both the babies survived and both the mother and the babies were discharged well on 30.8.94.

AN UNUSUAL INTERESTING AND RARE CAUSE OF FETAL DISTRESS

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Umbilical cord complications occupy first place in the etiological factors contributing to still births, and have a key role in the etiology of fetal distress during labor. We present an interesting case where ultrasound demonstrated the fetus holding a segment of the cord and timely management led to an optional outcome.

A 26 years old primigravida was admitted at 39 weeks of gestation for safe confinenent. Her antenatal checkup in first and second trimester was uneventful. In the early third trimester the fetus was diagnosed to have mild intrauterine growth retradation. Fetal monitoring was started from 34 weeks onwards in form of fetal movement score, weekly nonstress test and biophysical profile. Her investigations of hemogram, urine studies, blood sugar and kidney functions were all within normal limits. Elective caesarean section was planned for her at 41 weeks in view of a Manning's score of 6/10, scanty liquor and an unfavourable cervix with Bishops score of 3. However the patient had spontaneous fetal heart drops to 60-80 per minute. An urgent ultrasonography revealed that the fetus was holding its

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umbilical cord in the hand. The degree of these decelerations seemed severe and rhythmically persistent. An emergency caesarean section led to the birth of a 2.3 kg male baby with an APGAR score of 9/10. The baby was holding its umbilical cord. The probable mechanism of rhythmic pattern of fetal heart drop could be the cord compression leading to fetal hypoxia and consequent loosening of the grip of fetal fist. The mother and the baby had a normal postoperative course.

Fig.1

A RARE CASE OF ANAPHYLACTIC REACTION WITH PROSTAGLANDINS

DAMYANTI SHARMA ● DAYA ● NEERU

Ghanwati, 36 yr. G.O.AO, was brought to the casualty of Pt. B.D. Sharma Medical College, Rohtak in a state of shock on 6.10.94. She presented with amenorrhoea of 2-1/2 months, fever for 1 month & abdominal distension and respiratory distress for five days. These symptoms developed following MTP by some private practitioner by carboprost injection I/M. There was no history of instrumentation.

On examination, general condition was poor, she was severely anaemic & emaciated. Pulse was 136/mt & systolic BP was 70 mmHg. She was afebrile and had laboured breathing.

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Fig.2

B/L rhonchi and crepitations were heard in the chest. Abdomen was distended with sluggish bowel sounds. Bladder was full. 800 cc of haemorrhagic urine was drained by single catheterisation. On local examination of external genitalia, third degree uters vaginal prolapse, cystocoele & rectocoele were present. Cervix was blue with anterior

Fig.3

Fig.4

lip swollen. On per vaginum examination, uterus was 10-12 weeks, firm, all fornices were tender. A provisional diagnosis of ? reaction to prostaglandins ?? septic abortion ??? Disseminated TB was kept.

Patient was thoroughly investigated Hb-8gm%. BT-1'40" CT-3'35". Complete haemogram showed neutrophilic leucocytosis. ESR - 110 mm/1st hr. Bl urea - 60 mg%. S. Electrolytes - Na + was 124 meg/L - K+ was 3.2 meg/L Mx test was - ve. Urine M/E was full of RBCs. Urine c/s was sterile. On USG - impression was incomplete abortion. Foetal parts & placenta were seen in the uterus. There was no fluid in the pouch of douglas. On admission, X-ray chest showed B/L homogenous opacities in middle & lower zone.

Physicians made a diagnosis of ? tuberculosis ? Pneumonitis - ? Pyogenic ?? Tubercular ??? Viral. She was put on antibiotics, steroids and bronchodilators. After this treatment, patient improved, but remained febrile for 2 weeks. The very next day of start of above mentioned treatment, X-ray chest started showing clearance of previous opactities and urine also became clear. Repeat X-ray on 4th day was absolutely clear. Patient expelled something P/V on 8.2.1995. Evacuation was done on 11.2.1995. Patient was discharged in good condition on 26.2.1994 on haematinics. The case is being sent for publications due to the rare but known side effects of Prostaglandins.