CASE REPORT

MANAGEMENT OF THE COMPLICATIONS ASSOCIATED WITH SNAKE BITE IN A FULL TERM PREGNANCY

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Mrs. Mariumbee aged 30 years, G5 P3 Al, was admitted at L.T.M.G. Hospital on 10.8.1995, with a history of snake bite (one hour back) on her left forearm. The patient's relatives had killed the snake which was brought along for indentification (Later identified as a Russel's viper).

Patient complained of severe pain and swelling at the site of bite but on direct questioning gave no history of any constitutional symptoms like nausea, vomiting, giddiness or bleeding from any site. There was no history of difficulty in speaking, breathlessness, convulsions or paralysis. No local treatment had been administered.

On examination, all vital parameters were within normal limits. B.P. was 100/70 mm Hg. Detailed CNS examination revealed no focal or general neurological deficit. RS/CVS were normal.

Local examination of the left forearm revealed a 5 x 3 cms. erythematous lesion with localised induration. There was minimal serosanguinous ooze from the region of the bite.

Obstetric examination (confirmed by USG) revealed a 36 weeks single, viable, intrauterine pregnancy. There was no evidence of retroplacental clots.

On per vaginal examination cervical os was closed and there was no bleeding from the os.

Investigations revealed that the patient had a prolonged bleeding time of more than 5 minutes and clotting time of thirty minutes. Prothrombin time was 42 seconds (control 30 seconds). BUN was 23 mg% and serum creatinine was 1.5 mg. All investigations were within normal limits.

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Accepted for Publication on 12.1.96

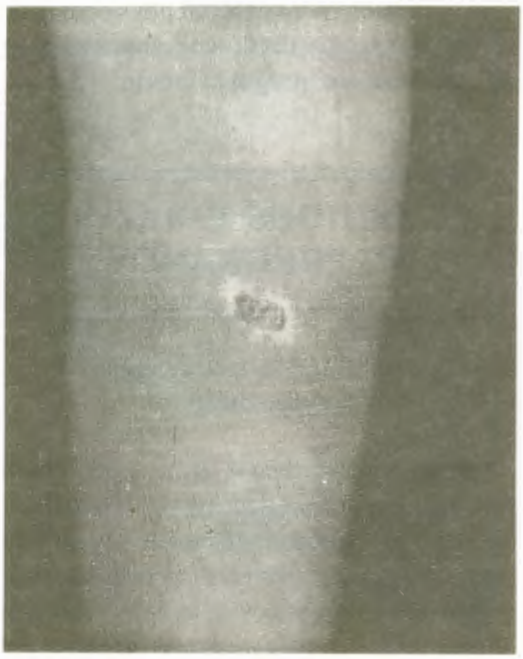

Figure 1.

Since intramuscular injections and NSAIDs are contraindicated in these patients, patient was started on Cap. Cloxacillin and Paracetamol with MgSo4 compresses locally. Tab. Duvadilan was started to prevent the onset of preterm labour (patient had already received 2 injections of Tetanus toxoid).

Patient was immediately started on antisnake venom after test dose of 1 vial in 100 cc of normal saline. Over 1 hour, the full dose of 4 vials in 300 cc of normal saline was given. The dose was repeated 6 hourly till BT/CT was normal i.e. omitted next day after 4 doses. 1 FFP was also given to the patient.

5 days later the patient's B.P. shot upto (140/100) with oedema feet and raised BUN (72 mg%) and S. creatinine (5). With the provisional clinical diagnosis of ?PIH/. Renal failure following snake bite, patient was started on Tab. Luminal and Inj. Phenergan which controlled her B.P.

On D10 of admission patient complained of decreased foetal movements. NST was done which was non-reactive. Repeat NST after 4 hours (Post prandial, in left lateral position with nasal 0_2) showed baseline Bradycardia of 110 beats/min. with absent beat to beat variability.

Therefore an LSCS was done on the patient; keeping fresh blood cross matched. Liquor was moderately meconium stained with Apgar score 6. Intraoperative and immediate post-operative all vital parameters were within normal limits and good urine output was maintained.

However, on D2 following LSCS, patient went into diuretic phase of renal failure. Urine output increased to 3500 cc and S. creatinine increased to 2.5. Patient was managed conservatively as a case of Acute Renal Failure (diuretic phase) with strict monitoring of renal functions output chart, and S. electrolytes.

Patient responded well to the line of management and on D10 following LSCS was discharged with a healthy baby.

TRAUMATIC RUPTURE OF UTERUS IN PRIMIGRAVIDA

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Uterine rupture in a primigravida is a

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Accepted for Publication on 19.1.96

relatively rare event. Trauma sustained to an overdistended uterus due to twin gestation resulting in rupture of uterus is described here.

Mrs. Leela 24 years, primigravida with 8 months gestation, was referred to this hospital from a private nursing home as a case of accidental haemorrhage with twin gestation with intra-uterine death.

Married for 2 years, and treated with clomiphene for infertility, the patient had regular antenatal care during her present pregnancy.

The patient presented at 4-15 a.m. on 2.11.94 with history of slipping and falling in the bathroom at 12-45 a.m. on 2.11.94 after which she did not appreciate fetal movements. There was no history of bleeding per vaginum.

On admission, the patient was restless, pulse 130/min, BP 70 mm systolic. Abdomen was distended; relaxed with multiple fetal parts palpable. Fetal heart was not audible. Cervix was partially effaced with presenting part at -3 station. Sonography revealed twin gestation with fetal death.

Since the patient's condition did not improve with medical management blood was transfused and an exploratory laparotomy was performed at 6 a.m. on 2.11.94. There was a rupture of the uterus extending transversely between the Fallopian tubes across the fundus. Two dead female babies were delivered, one from the abdominal cavity, and the other from the uterus.

There were no retroplacental clots. The uterine tear was trimmed and sutured in 2 layers. The patient recieved 5 pints of blood. She had an uneventful recovery and was discharged on 10th post-operative day with instructions to report back as soon as she became pregnant again.

PEMPHIGUS VULGARIS IN PREGNANCY

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Pemphigus vulgaris is an uncommon bullous dermatosis occuring most frequently in persons between 40 and 60 years of age. As such it rarely occurs during pregnancy. Pregnancy is a factor known to precipitate pemphigus; exacerbation occurs in the first or second trimester. Although the cause and effect relationship is yet to be confirmed, pemphigus in the mother is certainly associated with a significant risk of fetal mortality. It is important that physicians and obstetricians be aware of the natural course of this potentially fatal disease so that prenatal and postnatal care can save both mother and her child. We report the case of a women who had exacerbation of pemphigus vulgaris in the second trimester was managed successfully and gave birth to a normal child.

A 29 years old G2P1+0 lady, who was a known case of pemphigus vulgaris, was registered at 10 weeks of gestation. She had received dexamethasone pulse therapy for pemphigus vulgaris and was in remission for last two years. Her Hb was 11 gm%, blood sugar-84 mg%, blood urea-

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Accepted for Publication on 19.1.96

23 mgm%, VDRL - nonreactive and blood group - B positive. In this pregnancy, she remained asymptomatic till 24 weeks of gestation when she developed painful ulcerative lesions on the lower lip and tongue. A clinical diagnosis of relapse of pemphigus vulgaris was made. She was treated with oral tablets of betamethasone (2 mgms per day) for three months (i.e. till 37 weeks of gestation). She responded well.

She was delivered vaginally of a 2.5 Kgms boy at 38 weeks of gestation. The newborn didnot reveal mucosal or cutaneous lesions suggestive of pemphigus or any apparent congenital malformations.

"AN UNUSUAL CAUSE OF APH"

SHASHI PRABHA ● L.N. TANEJA

A 25 year old second gravida presented in the casuality 18 days before her EDD with history of sudeen onset of fresh bleeding P/V. There was no history of trauma or pain. There were only two antenatal visits at 18 weeks & 37 weeks of gestation. Both were normal routine visits.

On examination, there was no pallor, pulse was 92/min., regular, good volume, B.P. was 120/90 mm of Hg. per abdomen examination revealed a gravid uterus of 38 weeks size. It was neither tense nor irritable or tender. Fetal parts were normally palpable and presentation was cephalic.

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Accepted for Publication on 20.1.96

FHS was regular & 142 beats/min.

Per speculum examination revealed free flowing excessive, fresh blood through the os, with no local abnormality. Per vaginum examination was performed because we had an ultrasound report in the previous antenatal visit showing fundal placenta. The os was 2 fingers loose, with vertex presentation, and head at minus three station, fixing.

A diagnosis of revealed APH with a probable fetal origin was made and patient was taken up for an emergency ceasarean section. LSCS was performed under spinal anaesthesia. The baby was delivered by vertex and immediately handed over to the pediatrician. The placenta was fundo posterior, with no retroplacental clots. There was no abnormality observed in the interior of the uterus. A closer examination of the placenta revealed villamentous insertion of the cord, with a breach in one of the three vessels traversing the membranes through which the cord was attached to the margin of the placenta.

The baby was a 3.2 kg male, with severe bradycardia and marked pallor. He was immediately resuscitated, using oxygen with bag and mask after initial oropharyngeal & nasal suction. His heart rate recovered immediately and respiration established. Apgar score was 1, 7, 7, at 1 min, 5 min, & 10 min. respectively. But the child was having respiratory distress. His Hb was 9.25 gm/dl. as against 17 gm% in normal.

Blood was arranged and transfused at the earliest. The child recovered after blood transfusion but due to initial massive blood loss, suffered cortico-medullary ischaemia and a probable renal vein thrombosis of both the kidneys for which he was later managed at AIIMS.

Now the child is three months of age. Both his kidneys have fairly good function. He has been on exclusive breast milk and is 6.5 kg of weight.

UNUSUAL COMPLICATION OF PREGNANCY INDUCED HYPERTENSION (PIH)

LEELA JOSHI

Patient named S. aged 35 years, 2nd Gravida was admitted in the Hospital on 1.8.95 with H/O 8 months amenorrhea and severe pain the perineal region since 2-3 hours. On detailed inquiry, she gave H/o headache and vomiting for two days. There was no H/o convulsions, fever or trauma. The first confinement was L.S.C.S. for post term pregnancy 5 years ago. She was progressing well in antenatal for the present pregnancy. The last antenatal check up was done only 15 days ago and she was normotensive.

On Exam : She was conscious, no pallor, oedema feet ++ Pulse - 84 /mt. BP - 202/122 mm of Hg. PA - Abdominal scar was not tender, uterus not irritable. Foetus with Cephalic presentation and good FHS. On per vaginal exam - There was a small cystic mass on right vag wall with bluish discolouration, patient was not in labour.

Investigation : Fundus NAD. Urine showed Alb ++++ Hb% - 13.9 gm%. Other investigations were within normal range. Ultrasonography did not show any retroplacental bleeding.

Treatment : She was given 10 mg of Nifedipin stat-sublingually to be repeated TDS on monitoring the condition and Diazepam 10 mg stat & 5 mg TDS.

Re-examination : After 12 hours, her BP was not controlled (170/114 mm of Hg). Pulse - 92/mt. Pallor ++ and abdominal scar was doubtfully tender. Local examination revealed that the swelling had extended to whole of the vulva, perineum and laterally upto medial aspect of thigh on affected side.

Immediate drainage of haematoma under G.A. and Laparotomy was decided. Haemetoma drained and about 380 cc of dark blood and blood clots drained.

Though there was no fresh bleeding from the bed, the cavity was very deep and apparently found to be extending up, anteriorly just short of abdominal wall, the cavity was tightly packed and laparotomy started It revealed adhesions of previous C. section, uterus was intact and haemetoma between two layers of broad ligament on the side. L.S.C.S. done, a male child weighing 1.6 Kg with good cry extracted. Part of the collected blood and haematoma from broad ligament drained with small nick on anterior leaf of broad ligament. There were few points of extravasated blood on serosal surface on posterior lower part of uterus. There were no retro-placental clots. Patient stood operation well and post operative period was uneventful for 6 hours when patient had one big bout of atonic pph which was controlled with Inj. prostadin.

Total three bottles of blood and one

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Accepted for Publication on 21.1.96