CASE REPORT

CHORIOANGIOPAGUS PARASITICUS (ACARDIUS ANCEPS)

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Mrs. H., a second gravida aged 24 yrs. reported antenatal check up on 21.04.95 with no complaints whatsoever. She had about 5 months amenorrhoea and routine obstetrical examination revealed no suspicion about twin gestation.

Routine ultrasound revealed twin gestation with hydrops of both foetuses. The placenta was single and interamniotic membrane was thin. The cardiac activity was visible in only one foetus, and the biometry of the live foetus was as follows:-

(Biparietal diameter of 3.6 cms and femoral length of 2.2 cms). There was marked subcutaneous edema around the scalp and trunk and all the four limbs. There were no gross malformations detected.

The Second foetus was also hydropic sans cardiac activity. The cranium thorax abdomen and all four limbs were discernable with marked subcutaneous oedema. Bilateral hydrothorax and marked ascites were present too. The cardiac outline could not be properly made out. A tentative diagnosis of intrauterine death of the foetus was presumed. The other abdominal viscera namely liver, kidneys, stomach and urinary bladder were found to be normal.

Patient refused hospitalisation and reported a week later with intrauterine death

Fig. 1

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Fig. 2

of the other foetus. The pregancy was terminated. The patient delivered twin dead foetus weighing 200 gms and 150 gms respectively. The placenta was single monochorionic, diamniotic with 2 seperate umbilical cord attachments. Vascular anastomoses between the two circulations could not be demonstrated. Postmortem examination revealed one foetus to be acardius anceps with well developed head with brain tissue, imperfect face and body. All four extremities were present with only three digits in each associated with syndactly. Cardia was absent. The pump twin was also markedly hydropic but all the organs were found to be normal.

The clinical implications are that, had the patient reported earlier before the development of hydrops of the pump twin and Doppler study were performed, the artery to artery or vein to vein anastomoses of the foetal circulation could have been diagnosed. TRAP procedure performed at the appropriate time before the development of cardiac failure of the pump twin could have salvaged the pump twin.

PRIMARY OVARIAN PREGNANCY - A CASE REPORT

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Primary ovarian pregnancy is a relatively rare form of ectopic pregnancy. Spiegelberg's criteria for identifying an intrafollicular pregnancy are :

1) The fallopian tube, including the fimbria ovarica, is intact and the tube is clearly separate from the ovary.

2) The gestational sac definitely occupies the normal position of the ovary.

3) The sac is connected with the uterus by the uteroovarian ligament.

4) Ovarian tissue is unquestionably demonstrated in the wall of the sac.

Mrs. S, aged 26 years, married since 3 years, nulliparous, presented to our hospital on 17.5.96 with history of 2 months amenorrhoea and pain for abdomen in 2 days with mild bleeding per vaginum. She had regular menses prior to 2 months.

On examination; pulse was 80/min, BP 120/80mm Hg, no pallor. Abdomen was soft. Per vaginum examination revealed a normal sized uterus with a tender mass in the left fornix.

Investigations : Hb 10gm%, Urine for pregnancy test was positive. Ultrasonography revealed an empty uterus with a cyst 4 x 3.5cm in the left adnexa. With a probable

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diagnosis of ectopic pregnancy, diagnostic laparoscopy was performed on 19.5.96. Uterus and right adnexa were normal. Left ovary was enlarged 4 x 3cm from which a biopsy was taken. Histopathology report revealed large areas of haemorrhagic tissue with chorionic villi.

Laparotomy done on 26.5.96 revealed an enlarged (L) ovary with normal uterus and right adnexa. Sesection of the haemorrhagic portion of the gonad with left salpingectomy was done. The patient was discharged after a week.

Histopathology revealed a rim of ovarian tissue and large areas of haemorrhagic tissue containing chorionic villi, thus confirming the diagnosis of primary ovarian pregnancy.

"DOES NORMAL LABOUR EXCLUDE ACUTE ABDOMEN ?"

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A 21 years old para 1 gravida 2 with 1st normal delivery 16 months ago was due to go for delivery to Madras. Her E.D.C. was 20th of June 1996. Her antenatal routine check ups, and antenatal profile of investigations including previous 2 U.S.G.s were reported normal, she had H/O previous appendicectomy which had left a small Mcburney's scar on the abdomen. On the day prior to leaving for Madras for her delivery, when she went to her obstetrician for routine check up, he found on examination that the cervix was too effaced and dilated for her to travel ; and he admitted her for induction. The induction was started in routine fashion and she was given an enema. Immediately after enema the patient c/o severe acute lower abdominal pain and started behaving irrelevantly. She was brought to me for second opinion in view of her irrelevant behaviour.

On examination the pulse was 84 per minute, B.P. was 120/80 mm/hg, the uterus was 36 weeks size, the vertex was presenting and the uterus was irritable. F.H.S. were 140 per minute. Per vaginal examination confirmed the vertex presentation, and the cervix was fully effaced and the dilatation was 1 cm. The membranes were intact. With the provisional diagnosis of premature labour the duvadilan drip was started 30 mgs to 500 c.c. of D 5% in W given at the rate of 20 drops per minute. The mild sedation was given in the form of 5 mgs. of diazepam I.M. The patient was comfortable throughout that night and the uterus was relaxed. With all general parameters of the mother being in normal limits, and the F.H.S. 140/min. it was decided to continue the conservative treatment and the paient was treated as a normally labouring woman though in view of the prematurity the duvadilan drip was continued. In view of prematurity, injection decadron 4 mgs. and ampiclox 500 mgs i.v. was also given. In spite of the duvadilan drip the patient went in spontaneous labour the same evening and had an uneventful delivery with the

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healthy female child born at 11-30 P.M. the third stage also being normal. Again all the parameters were normal. The child weighed 2.2 kgs. and though it looked healthy it was transferred to the neo-natal intensive care unit for the expert paediatric care.

She had uneventful fourth stage and was transferred to the ward for routine post natal care. Overnight she was very comfortable though the following morning she complained of pain which was considered as afterbirth pains by the resident doctor as all the parameters were alright. In the same afternoon in spite of antipasmodic she continued to c/o pain and when she was sitting out of bed she had taken an unusual position of buckling up. This position indicated that there might be something wrong with the patient and she was thoroughly examined. Even at this stage pulse was 84/min, B.P. was 120/80 mm. of Hg respiratory rate was 18/min, but abdomen was distended. The immediate thought was that she has distended bladder and she was immediately catheterised. The urine obtained was only 70 c.c. and it was high coloured. It was immediately realised that there is something wrong. At this stage it was observed that peristalsis were absent. As all the other parameters were within normal limits, the case was clinically considered as that of primary peritonitis and the treatment and the investigations instituted. The patient was started on i.v. fluids D 5% in N.S.,; Intravenous antibiotic in the form of cifran 1 gm i.v. metronidazole 1 gm, the patient was advised nil by mouth and pulse and blood pressure were monitored every 1/2 hourly. Though within 4 hours of starting the therapy the urine output improved drammatically and was 200 c.c., per hour the peristalsis was still absent and it was decided that the patient needed institutional care and was transferred to the Bombay Hospital for further investigations and the treatment.

The investigations done were c.b.c., serum electrolytes, s.m.a. 12, serum amylase, plain x-ray abdomen in the erect position, and ultrasonography of the abdomen and the pelvis. The investigations revealed that though the peristals were absent there were dilated loops of intestines with multiple fluid levels in the upper abdomen. There was no free gas under the diaphragm, all the blood reports were normal and w.b.c. was 8800 with polymorphs 78%. While investigations were being processed it was found that though all other parameters were stable the respiratory rate had increased to 26 from 18 and the urine output had decreased to 30 c.c. per minute so it was decided to do laparotomy on her with the assistance of the surgeon.

The laparotomy was done through right paramedian incision and the findings were as follows :

(1) The pelvic organs were normal though covered with inflammatory exudate.

(2) The peritoneal cavity contained about 2.0 L of offensive dark reddish brown liquid. A constricting fibrous band at the previous appendicectomy site had caused gangrene of 75 cms. of terminal ileum, reaching almost

upto the caecum. Gangerenous ileum and caecum were resected. End to end anastomosis between distal ileum and ascending colon was performed.

(3) The peritoneal wash was given with normal saline and diluted betadine solution. The two drains were kept one in each flank.

(4) The case was done under continuous epidural anaesthesia; and postoperatively the epidural was used as anagesia as well.

(5) At the end of the surgery the arterial blood gases, electrolytes, w.b.c. were done and the patient was transferred to the intensive care for continuous monitoring.

(6) With the fluid balance being maintained by adjustment through the central venous pressure, the antibiotic and chemotherapy used being monocef and metronidazole, continuous oxygen being given, the analgesia was maintained by continuous epidural analgesia.

(7) It was strictly seen that attempt and suggestion to use ventilatory support to augment the respiratory function was strictly avoided as O_2 saturation on pulse oxymeter was 96 %.

(8) Over next 6 days the patient's condition gradually improved and gradually we could wean her of the drains, the central venous line, continuous oxygen, intravenous fluids, and catheter. She was started on oral water, then gradually increased to liquids in the form of coconut water, and then the fruit juices, later on the soft diet.

(9) The incision healed by primary intention and the patient was discharged on the 10th day and she is doing well in her first post-op visit.

UNUSUAL PRESENTATION OF ACUTE APPENDICITIS IN PREGNANCY

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Mrs. N, 22 year old female, primigravida at 26 weeks of gestation presented with fever, obstipation and constipation for last two days. On general physical examination, she was afebrile, hydration was fair, had pulse rate of 100/min and blood pressure was 110/70 mmHg. Her abdomen was uniformly distended and there was vague tenderness all over the abdomen, though there was no guarding or rigidity. Bowel sounds were exaggerated. Fundal height of uterus corresponded with the period of gestation and was relaxed. There was no bleeding or discharge per vaginum. Subacute intestinal obstruction was thought to be the first possibility as patient's main complaint was obstipation. Patient was taken up for laparotomy. Abdomen was opened by supraumblical midline vertical incision. Inflammed appendix with multiple pus points was found behind the uterus at the level of umblicus. There was minimal amount of pus in peritoneal cavity. Appendicectomy performed and peritoneal lavage done with normal saline. Histopathology report confirmed acute appendicitis. Her

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