CASE REPORT

HOLT ORAM SYNDROME

VINITA DAS ● ANJOO AGARWAL
SHALU MAHESH ● ALJA SHUKLA

Mrs. S.D. 20 yrs., Poto, resident of Hardoi, an unbooked patient, was admitted in Queen Mary's Hospital, K.G's Medical College, Lucknow on 11.6.95 as a case of full term pregnancy with leaking P/V for 24 hours. General and systemic examination was normal. Her B.P. was 120/80 mm of Hg. P/A examination showed 34 weeks pregnancy with vertex presentation and normal FHS. Patient was in latent phase of labour but frank leaking was present and membranes were absent. Labour was accelerated by 2.5 units syntocinon drip, but patient did not progress and LSCS was done on 12.6.95 at 10.05 A.M. for non - progress of labour and leaking for 48 hours. Baby was female, 2.2 kg., born at Apgar score of 10. The baby had low set ears and bilateral forearm and wrist deformity. Thumbs were absent in both hands. No other congenital anomaly could be detected. X-ray of the baby's forearms and wrists showed absence of radius and all the carpal bones on both sides (Fig.) There was no history of drug intake during antenatal period. Clinically there was no positive family history. Patient was discharged on 23.6.95.

Fig.

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AN OBSTETRIC EMERGENCY PLACENTA PREVIA WITH PLACENA PERCRETA

M.V. Mataliya ● Debra F.Paes
P.N. Mhatre

Mrs. A.K., a 26 year old Gravida II Para I with 32 weeks of amenorrhea was admitted with antepartum hemorrhage.

An ultrasound done 3 days prior to admission showed a single viable gestation of 32 weeks with a low lying placenta covering the cervical os. The patient had a 2½ years old female child delivered by a Caesarean Section for cephalo pelvic disproportion.

On examination her vital parameters were stable.

Obstetric findings:

PA - 34 weeks

Vertex floating

FHS Regular.

She had a suprapubic bulge which did not recede even after catheterization of the bladder when clear urine was collected.

PV - Minimal bleeding +

The patient was managed conservatively and given steroids.

A repeat ultrasound showed a single viable gestation in cephalic presentation corresponding to 33 weeks with a complete placenta previa with subchorionic bleed with Evidence of Placenta Accreta.

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It was decided to take up the patient for an Elective Caesarean Section at 37 weeks.

Weekly non stress tests performed were reactive.

However, 1 week prior to the planned date of operation, the patient went into labour and had a bout of painless bleeding. She was taken up for an emergency Caesarean Section.

OPERATIVE FINDINGS :

On opening the abdomen, the lower segment of the uterus was thinned out with evidence of placenta percreta at the site of the previous scar. The placenta had invaded the myomtrium and serosa and extended into the broad ligaments laterally. There were large vessels on the surface of the placenta.

A transverse incision was taken on the lower uterine segment, and the placenta was incised to deliver the baby - a Female child 2.3 kgs. However, the placenta did not separate and there was profuse bleeding duo to which the patient went in to haemorrhagic shock and cardiac arrest and was revised with cardiac message, I.V. adrenaline and sodium bicarbonate. A Dopamine drip was started and the patient was given fresh whole blood.

A decision to perform obstetric hysterectomy was taken. The bladder was adherent to the lower uterine segment and while trying to push it down; it was accidentally opened. A sub-total hysterectomy was performed. The bladder was sutured in 2 layers with vicryl.

Pos-top: Dopamine Drip was continued and blood given till the patient stabilised, a total of 7 units of blood was given.

Suture removal was done on day 8 and

the patient was discharged on day 11 with a healthy female baby. Her Hb on discharge was 10 gms. %.

Histo-pathological report confirmed the diagnosis of Placenta Percreta.

THANATOPHORIC DYSPLASIA

ASHOK KUMAR ● D. TAKKAR ●SUNESH KUMAR ● SHARMILA BANU ● PREETIBHARADWAJ

Thanatophoric Dysplasia is a lethal form of fetal skeletal dwarfism with an incidence of 1:10,000. It occurs in two genetic forms - i) recessive one characterised by cloveleaf skull with straight short long bones and ii) sporadic type characterised by short bowed bones with abnormal but not cloveleaf skull. The case presented here fits into the second form. The babies are either stillborn or die in early neonatal period due to associated pulmonary hypoplasia.

CASE REPORT

A 28 years old second gravida with previous one normal delivery was first seen at 30 weeks of pregnancy in the outpatient department. She gave the history of having taken tablets griseofulvin for 10 days for fungal infection of her hands in the first trimester.

On examination, the height of fundus was corresponding to the gestation of 36 weeks; everything else was normal.

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A trasabdominal sonography revealed :-

a) A single live fetus with cephalic presentation

b) B.P.D. was 7.7 cms corresponding to 33 weeks (Fig 1) and abdominal circumference was consistent with 34 weeks of pegnancy

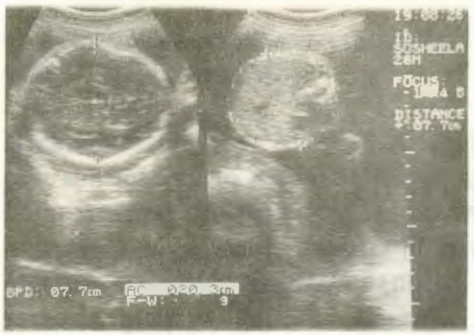

Fig. 1 : Ultrasonograpm showing the BPD of the fetus

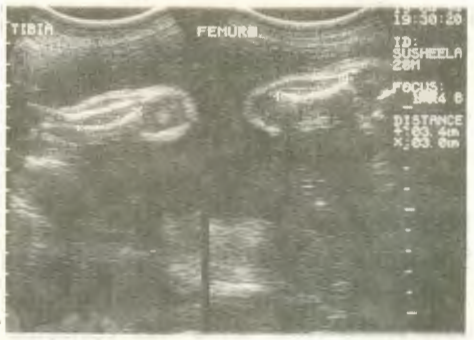

Fig. 2 : Ultrasound picture showing the curved and short long bones of leg.

c) All four limbs were small. The femur (3.4 cms) and humerus (3.0 cms) were corresponding to 20 and 19 weeks of gestation respectively (Fig 2 and 3). The tibia measured 3.0 cms and radius was 3.7 cms.

d) Thorax was narrow with hyperextended spine

e) Polyhydramnios

f) Placenta was fundal and anterior in position

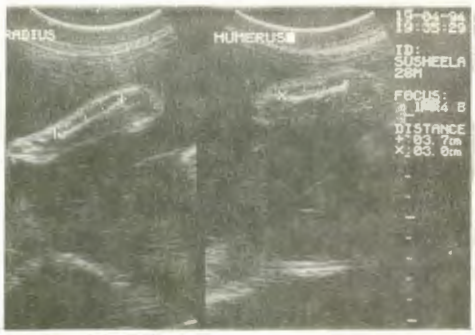

Fig. 3 : Ultrasound picture showing the short radius and humerus.

Fig. 4 : Photograph of the newborn showing narrow thorax.

A sonographic diagnosis of fetal dwarfism in the form of thanatophoric dysplasia was made.

The patient delivered a premature stillborn baby weighing 1.6 kgms after induction of labor. The baby was of short stature, upper and lower limbs were small, head was large and thorax was narrow and tapering (Fig 4).

A RARE CASE OF ACUTE RENAL FAILURE WITH PREGNANCY

P.L. GUPTA ● N. GUPTA ● K. GOKHROO

Acute renal failure may be met with, in a variety of conditions in pregnancy. The more important ones are the Accidental Haemorrhage, severe PPH, Eclampsia, Septicaemic shock and traumatic delivery. Here we are reporting a rare case of acute renal failure in pregnancy due to Malaria caused by plasmodium falciparum.

Mrs. P. aged 30 yrs. gravida 5 para 4 was admitted in J.L.N. Hospital, Ajmer on 31.7.95 in emergency with history of amenorrhoea 7 months, pyrexia 6 days, epistaxis and anuria 3 days. There was no history of pre existing renal disease. She was admitted at Bhilwara hospital on 29.7.95, where treatment for anuria was given but of no positive response. On admission patient was conscious and co-operative Anaemia was present, no oedema feet, temperature 102.4° F, pulse 110/min. and her B.P. was 120/70 mmHg. She was having very slight bleeding from nose. On per abdomen examination uterus was 28 wk size, not tense, nor tender, cephalic presentation, floating. FHS was present: 140/min, regular. There was no vaginal bleeding.

INVESTIGATIONS

Hb. 4.5 gm.%, TRBC 102 million/cm,

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Blood urea 60mg% uric acid 9.5 mg.%, creatinine 5 mg. % Na 131 MEq/lt S.K. 5.2 MEq/lt S. choloride 120 meq/lt. Blood for M.P. (QBC) revealed plasmodium falciparum (3+) USG showed normal liver, gall bladder kidney, ureter, urinary bladder. No ascites, Ut 30 wk size living fetus in cephalic presentation.

Quinine 600 mg I.V. 8 hrly was started alongwith general regime of acute renal failure specifically 10 amp of Lasix I.V. 6 hrly. Only 5 cc of urine was passed in 24 hrs. Hemodialysis was advised but as facilities were not available in our institution, peritoneal dialysis was decided. The decision for termination of pregnancy was taken. Labour was induced, she delivered a premature living female child of 1.2 kg wt. Peritoneal dialysis was done. Only 15 cc of urine passed. Blood urea increased to 90 mg% and uric acid 10 mg.% and S. creatinine 6 mg.%. Second dialysis was performed after 2 days. This time also only 100 cc of urine was passed. Blood urea rose to 120 mg.%, uric acid 10 mg.% and S. creatinine 6.5 mg.%. Third dialysis was done. This time urinary output increased to 450 cc which gradually increased on subsequent days to 4100 cc in diuretic phase and then decreased to 1500 to 2000 cc per day in the recovery phase. The injection of lasix were also gradually reduced from 10 amp 6 hrly to only 1 amp. per day which was stopped 3 days before discharge. She was discharged on 27.8.95.

On follow up the renal functions and urinary output were normal.

UNUSUAL CASE OF AN OLD RUPTURED UTERUS

BEENA NAIK ● J.T. GOHIL ● S.L. PAGI

A 30 yrs. old patient Mrs. S.R. Parmar coming from Fatehpura, Panchmahals came to Labour room, S.S.G. Hospital, Baroda as an emergency case. She was referred from Santrampur CHS as a case of septic peritonitis with possibly an abdominal pregnancy. Patient presented with H/O amenorrhoea - 9 mths. c/o severe pain in abdomen - 14 days earlier followed by loss of fetal movements since then. For this she was treated at CHC level with intravenous fluids. The pain continued as a continuous, dull ache. Patient was then referred to another CHC, where she was admitted. After 4-5 days, patient developed high grade fever and foul smelling discharge P/V and was then referred to district hospital and thence to SSG Hospital, Baroda. M/H: she had previous regular cycles and her LMP was 9 mths. back. O/H: she was a 5th gravida with previous 4 FTND at home, LD was 2 yrs. back.

O/E : Patient was conscious. Temperature was raised. Pulse was 128/mt. B.P. was 120/70 mm Hg. Patient had tachypnea and was moderately anemic. Respiratory & cardiovascular system were normal. On P/A examination there was generalised guarding and rigidity. Uterine contour was not made out. No uterine contraction. Fetal parts felt superificially upto 30 wks. pregnant

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uterine size. P/S examination: foul smelling discharge through cervix. On P/V examination, both os were open. Clots felt in uterus, rent felt in anterior part just above cervix. Diagnosis kept as an old case of rupture uterus with septic peritonitis.

Patient was taken for laparotomy under antibiotic coverage correcting electrolyte imbalance and keeping 2 units of blood ready. Abdomen opened in layers by subumbilical midline incision. On opening, 100 cc foul smelling pus mixed with old blood was removed from peritoneal cavity. Baby with placenta was lying free in peritoneal cavity, which were removed. Baby was a 2400 g. female, FT (AFD) macerated SB. There was a 6 cm. transverse rent in the anterior part of uterus with ragged and friable edges. The uterus was about 12 weeks in size and lying posterior and to the left of the fetus. The surrounding parametrium and ligaments were extremely friable. Subtotal hysterectomy was done. There was a pyogenic membrane covering the intestines. Amniotic membrane was adherent to parietal peritoneum and was removed as much as possible. Peritoneal levage with 2 lit. of normal saline and betadine given. Drain kept in pouch of Douglas. Abdomen closed in layers. Patient was discharged on 10th post-operative day without any complication.

Rupture uterus is usually an emergency which requires urgent intervention. This was an unusual case of rupture which had occurred 14 days back and patient presented as a case of septic peritonitis. The uterines being not involved, patient survived as the uterus retracted and the bleeding stopped.

The diagnosis of rupture was missed at PHC, CHC as well as district hospital levels, till she developed septic peritonitis. Laparotomy was delayed for 14 days due to this.

Inspite of this delay, the patient survived and went home without any complication, thanks to antibiotics and blood transfusion.

ISCHIORECTAL ABSCESS - SEQUELAE TO CRIMINAL ABORTION

A. ARUN RAO

19 year old unmarried girl was admitted with a history of high fever, pain and foul smelling discharge from the perineum and the vagina. She gave a history of having undergone illegal II Trimester termination of pregnancy two and a half months ago.

On examination, patient was looking toxic, temperature was 103° F. There were no signs of peritonitis or mass per abdomen. Foul smelling discharge was seen coming out of the vagina and the left side of the perineum through a small fistula. Speculum examination revealed a stick protruding through the external os of the cervix and passing into the upper lateral part of the vagina. On vaginal examination, there was no mass felt in any of the fornices, although they were tender. Vaginal swab of the discharge was sent for culture and sensitivity. There was no significant finding on rectal examination. Ultrasound

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examination confirmed that the uterus was empty.

Fig.

Under triple antibiotic cover, examination was done under anaesthesia . Lower end of the stick had penetrated the left ischiorectal fossa as it could be felt through the fistulous opening at the perineum. A stick of about 15 centimeters in length was gently removed through the vagina (Fig). She was afebrile within 48 hours. The fistulous opening closed spontaneously in 2 weeks when she was discharged from the hospital.

AN UNUSUAL CASE OF VESICO-VAGINAL FISTULA

G. Bose ● S.K. Bhattacharya
A. Mukhopadhyay ● S.K. Saha
S. Adhikari

Traumatic vesicovaginal fistulae are commonly due to direct injury to the anterior vaginal wall and the bladder. This reported case developed a vesico-vaginal fistula due to the thrust of a fall on her perineum- a rare presentation.

F.B. 25 years old, P_{2+0} was admitted to the Gynae ward due to bleeding per vaginum following an accidental fall from the first floor of a building. She fell on her perineum. She also complained of pain over the symphysis pubis. She denied being hit by any sharp object.

Her general condition was stable. Abdominal examination did not reveal any feature of intra-abdominal injury. There was marked tenderness over the symphysis pybis. On vaginal examination lacerated

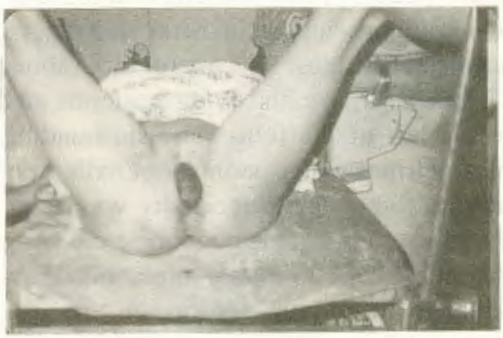

Fig.

wound was visualised on the anterior vaginal wall on its upper half. On digital examination it was found to be about 1" x 1" in size, communication with the bladder. It was confirmed by passing a rubber catheter which could be seen through the vagina.

INVESTIGATION

X-ray pelvis revealed fracture of the left public ramus without displacement.

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Emergency cystoscopy confirmed the presence of V. V. F. at the base of the bladder. The ureteral orifices were free from the site of injury. Routine investigations were within normal limits.

MANAGEMENT

Bed-rest and sedation was advised by the Orthopaedic consultant for her fracture of the public ramus.

The vasico-vaginal fistula was repaired immediately by vaginal approach by edge-paring method. 3-0 vicryl suture was used for repair of the bladder. 2-0 vicryl was used for repair of the vaginal wall. A foley's catheter was left in-situ for 14 days for continuous drainage. Antibiotic was given.

The patient made an uneventful recovery. The catheter was removed after 14 days. She was found to be continent of micturition.

At 6 weeks follow-up check, the patient was well with no urinary problem. Her check X-ray of pelvis showed healing of her public ramus fracture.

CERVICOVAGINAL MELONOMA

DILJOT MALHOTRA ● SARLA MALHOTRA

A 55 year old para 9 woman, post menopausal for 4 years attended the out-patient department with complaint of bleeding per vaginum of 5 months duration. The bleeding was slight in amount and there was no intervening vaginal discharge. Loss of weight and appetite of 2 months duration were reported. A cervical biopsy had been performed 2 weeks prior to reporting to this institute which had been reported as malignant melanoma.

Physical examination revealed a thin built woman with no lymphadenopathy. The systemic examination was unremarkable. No melanoma was noticed at any other site. Abdominal examination was normal. On local examination, external genitalia were normal but atrophic. A speculum examination showed a black pedunculated growth with irregular surface, 3 x 3 x 4 cms in size (Fig. 1) arising from the lower

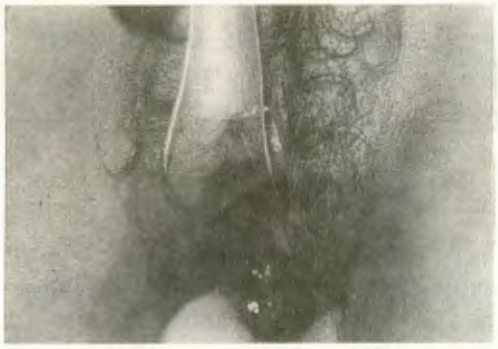

Fig. 1 : Pedunculated melanoma arising from the vagina

1/3rd of the posterior wall of vagina. Raised, circumscribed, multiple black skip lesions of 0.5 - 1 cm is size were present all over the upper 1/3rd of vagina, including vaginal vault and both cervial lips. On bimanual pelvic examination, uterus was small and mobile with no mass or thickening in any fornix or pouch of Douglas. On rectal examination, rectal mucosa was found to be free.

A diagnosis of cervicovaginal melanoma

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was made and the cervical biopsy slides were reviewed by the pathologist at our hospital. Microscopic examination showed sheets of malignant cells which were round in shape with moderate to marked nuclear pleomorphism. Cells contained melanin with evidence of marked cellular necrosis. Therefore, review confirmed the tumour to be a malignant melanoma.

Investigations revealed mild anaemia, a normal chest X-ray and a normal abdominal ultrasound examination. Palliative radiotherapy was planned but the patient did not report for radiotherapy and was lost to follow up.

FATAL CASE OF POST COITAL TEAR

BEENA NAIK ● J.T. GOHIL ● S.L. PAGI

A patient named K.N.B., F/21 yrs. coming from Sankheda, Baroda was admitted on 12.8.95 in SSG Hospital, Baroda with history of post coital tear - 15 days back. C/O pain in abdomen - 7 days and c/o vomiting - 3 days. She had regular menstrual cycles and had her LMP 7 days back. She had been married for 7 months and was nulligravida.

O/E : Temperature was raised. Pulse was 120/mt. Blood pressure 120/80 mm Hg. Patient had tachypnea and was moderately anemic. Respiratory system showed harsh breath sounds. On per abdomen examination guarding and rigidity was present. Bowel sounds were absent. P/S examination bucket handle tear was seen in posterior fornix with foul smelling pus discharge coming through it. Cervix was normal. On P/V examination cervix was firm, uterus was retroverted, its exact size could not be determined. Rent was felt through the posterior fornix. Fullness and tenderness was felt in all fornices. Immediate laparotomy was decided upon for her peritonitis. On opening, one lit. of frank pus was drained. Adherent intestines were separated and pus pockets opened up and drained. There was a 5 cm. rent seen posterior to uterus in between the attachment of the 2 utereosacrals. This was sutured taking 3 interrupted sutures with 1.0 vicryl. The uterus was normal in size and surface. Both tubes and ovaries were congested and oedematous. Intestines were traced and multiple serosal tears were sutured. Drain was kept in pouch of Douglas. Abdomen closed in layers. Post-operatively patient developed hypostatic pneumonia on 3rd day and fecal fistula on 9th post-operative day. Patient expired on 10th post-operative day because of septicemia with fecal fistula.

A post coital tear developed into a fatal case of septic peritonitis due to lack of a timely intervention.

In the absence of suturing proper antibiotic coverage could have possibly prevented this septic peritonitis.

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A RARE OCCURRENCE OF DIPHALLUS ALONG WITH TWO ECTOPIC ANUSES IN A NEW BORN BABY

KAMALA SIKDAR ● ADITI DAS

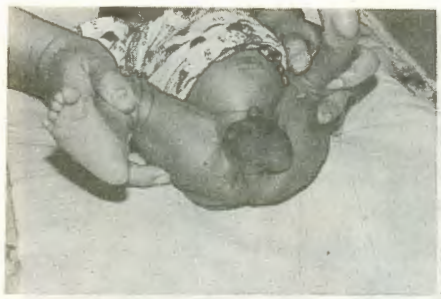

Fig. Showing Diphallus with two Ectopic annses shown by two arrows in a new born baby.

Sm. P.R. 28 yrs. H.F, Stenographer, married for 3 years and 3 months conceived for the first time with E.D.D. on 29.11.93. She had D_4 and C operation for infertility in January 1993.

Her built, nutrition, and general health were average. She attended A.N.C. regularly with routine investigations. She was Rh negative. There was no pregnancy complication till 26.10.93 when mild hydramnios was clinically detected and was confirmed by U.S.G. showing normal foetus at 35 wks. of gestation. Pregnancy continued beyond term without any complication and hydramnios diminished. U.S.G. on 6.12.93 also showed normal foetus at 41 weeks of gestation. Labour was induced by cerviprim on 9.12.93 and she delivered a male baby by outlet forceps on 10.12.93 at 10-10 A.M., weighing 2.75 kg. The baby had double penis and two ectopic anuses (or low fistulae) in the right side of perineum (fig) with thick ridge of tissue of 1.5 cm. in between two ectopic anuses. The baby was otherwise normal, could pass urine through double penis simultaneously. There was no difficulty in passing meconium and stool. These perineal fistulae seems to be arising from a bowel which ends above levator ani. There was no anal membrane or anus at the site of normal position of anus. The baby was sent to a well equipped hospital for further investigation and management.

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NEONATAL FOLLICULAR OVARIAN CYST-A CASE REPORT

R.J. SINGH ● HARMESH SINGH

This female neonate was born normally to a 28 years old primigravida mother with uneventful antenatal period. The infant weighed 3.050 kg. The cry was immediate and apgar score was 7 at one minute. Abdomen was distended and a large abdominal cystic mass was detected. There was no other obvious congenital anomaly. She passed urine and meconium normally. Feeding and activity was normal. Routine blood and

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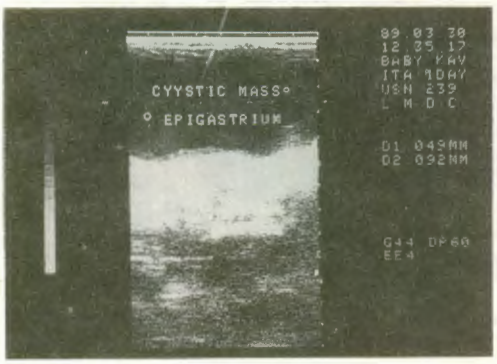

Fig. : Ultrasonograph showing Unilocular cystic mass in the epigastrium.

urine tests were normal. Barium meal examination was suggestive of mesenteric cyst. Ultrasonography showed a unilocular cystic mass (fig). At laparotomy a 12 cm x 8 cm x 8m sized, thin walled, right ovarian cyst containing serosanguinous fluid was found. There was no normal ovarian tissue. Right fallopian tube and left ovarian structures were normal. Right oophorectomy was performed. Post operative period was uneventful.