# CASE REPORT

## AN UNUSUAL OUTCOME IN AN RH NEGATIVE IMMUNISED PREGNANCY

S. C. Biswas. ● S. Das.
B. K. Goswami.

Mrs. M. B., aged 36 Yrs., 'A'Rh. negative (Husband 'B' +ve), 8th gravida, para 0-3-4-0 was admitted in NRS Medical College & Hospital, Calcutta on 21st May, 1996 as a case of BOH with 25 wks. of amenorrhoea.

O/H: Within one year of marriage, she had M.T.P. of her first pregnancy, 16 Yrs. back. Her subsequent 3 pregnancies ended spontaneously at 6th to 7th months, giving birth to macerated stillborns in Bangladesh. It is significant to mention that her blood grouping was not done. For secondary infertility she attended R.G. Kar Medical College, Calcutta, where she had D & C, diagnostic laparoscopy with dye test and found to have adhesions in P.O.D. and cornual block. Laparotomy was done on 26.6.87 for adhesiolysis, salphingolysis with correction of cornual block. In 1989, at her 5th pregnancy she was detected to be Rh negative for the first time, but lost the baby at 16 wks. Her sixth pregnancy in 1991 ended in a premature delivery at 34th week. The baby lived for 23 days. The 7th pregnancy in 1993 also ended in macerated stillbirth at 26 wks. During 8th pregnancy she came to us. The foetus was monitored clinically with great emphasis on ultrasonography and indirect Coomb's test. Serial USG done four times in between 18 to 35 wks., showed no abnormality of foetus and placenta,

*Dept. of Obs. & Gyn. NRS Medical College, Calcutta, India.*

the last being on 23.7.96 with foetal maturity of 35 wks. To our utter surprise, her I.C.T. titre came down as follows:-

On 14.3.96 positive upto 1:256, 28.5.96 - 1.128, 24.6.96 - 1:64, 10.7.96 - 1:32 and 26.7.96 - 1:16. Assured by falling I.C.T. titre and USG report, we avoided amniocentesis and did elective LUCS on 2.8.96. A male baby was born with 2.5kg. with blood group AB +ve. Preop-glucocorticoid was given to accelerate lung maturity. The baby is now about 8 months old and healthy. This successful outcome could probably be explained by the theory of Immuno-suppression and immunotolerance. Antibody titre, contrary to general rule, did not rise serially probably due to co-existence of fetomaternal ABO incompatibility, presence of pregnancy induced maternal antibodies (PIMAB) which block the FCy receptor of B cells and heterozygosity of the father.

# AN UNSUAL CASE OF RECURRENT TWIN PREGNANCY.

S. K. SAHA. ● S. ADHIKARI.
M. K. SANYAL. ● SHASHI LATA KABRA.

Mrs. X, aged 25 yrs. Housewife, married for 6 yrs., P3+1, gravida-8, was admitted on 30.07.95 in Eden Hospital. She is a booked case of our hospital for the present pregnancy. She came with H/O amenorrhoea of 8 months. She was carrying a twin pregnancy (Proved by UsG on 27.07.95).

Her past obstetric history was as follows

In 1990 - Delivery of twin babies at Lady Duffrin Hospital, Calcutta, at 8 months of amenorrhoea. This was not diagnosed in the antenatal period as patient never got registered herself earlier. Details of delivery - Both Males. One died after 2 days at Medical College on 17.07.90 due to Septicaemia, one baby is alive.

In 1991 - She had a full term twin vaginal delivery on 03.08.91 at L.D. Hospital. This was not diagnosed antenattly.

Details

1st Baby : 1.9 kg. born at 11.10 hrs. on 03.08.91

2nd Baby 2 kg. born at " 11.20 hrs."

Both babies alive.

Patient never developed any complication due to twin pregnancy except being preterm during the 1st episode and we know that preterm delivery is a common association of twin delivery.

In 1994 - Pt. had a spontaneous abortion at 5 months of amenorrhoea. That time again, there were twin-fetus abortions as stated by the patient. In 1995 - Pt. now came to us, being pregnant

*Dept. of Obst. Gyn. Eden Hospital, Calcutta, India.*

for the 4th time. In the latest pregnancy, USG on 27.07.95. - showed twin gestation. Both living, showing separate sacs. Placenta anterior looks single, liquor average.

Both Breech

1st twin BPD - 7.8 = 30 +

FL = 5.9 = 29+ 30 wks.

2nd twin BPD- 7.8

FL - 5.9 = 28 wks.

Her built and general health was average and her Hb level was 7.8 gm% on admission.

There was no significant past medical or surgical history. No history of twin pregnancy in family in near and remote relatives. Pt. remained in our hospital for about 1 month. She had an uneventful vaginal delivery on 30.08.95.

1st baby Male 2.65 kg. born at 13.05 hrs.

2nd baby Female 2.1 kg. born at 13.50 hrs.

The placenta was dizygotic/ dichorionic, There was no PPH. Discharged after 1 week in a stablc condition with her two healthy babies.

Few things are to be noted in this case

1. She had two preterm deliverics and one abortion which are common complications of twin gestation.

2. Pt. tolerated all the pregnancies very well.

This case of twin pregnancy is presented because of its rarity of delivering twin for four consecutive times.

# LOCKED TWINS

ANITA KANT. ● INDU TANEJA.

Locked twins is a rare complication, the incidence being about : 90,000 deliveries and only 1:817 twins is a case of locked twins. A primigravida, 26 years old, was admitted with full term pregnancy with labour pains, and arrest of aftercoming head after delivery of the baby by breech 3 hours back at home. On examination, patient was pale, dehydrated, BP was 160/130 mm of Hg, oedema was present over feet and on abdomen. Uterus was 30 weeks size of pregnancy, foetal parts were palpable and foetal heart was heard. Breech was hanging at vulva with undelivered head. On per vaginum examination, cervix was

Fig. 1.

*Escorts Hospital & Research Centre, Faridabad.*

fully dilated and head of second foetus felt at 'O' station by the side of neck of first foetus. Caesarean section was done immediately and second baby delivered, while the first baby was delivered per vaginum (photo 1). Second baby was alive and both mother and baby did well post-operatively.

## COLPORRHEXIS IN PRIMIGRAVIDA

K. Umadevi ● Rajini Uday. ● Sheela

A 25 year old primigravida booked at early weeks of gestation and her antenatal follow up was uncomplicated. She went into spontaneous labour at term. There was evidence of sudden severe fetal heart deceleration in the second stage of labour which had lasted for an hour. A decision was made to perform a forceps delivery immediately. There was a gush of fresh blood before the application of the forceps. The cervix was fully dilated and the cephalic presentation was in the occipito anterior position and the presenting part was at the level of + 3 station The left and the right blade were applied easily and also locking and traction were easy. A live male baby was delivered weighing 3.25 kgs with an Apgar of 7 & 9. Placenta was delivered with controlled cord traction Uterus was well contracted too. There was fresh bleeding from the vagina. Exploration demonstrated bilateral cervical tear & left lateral vaginal vault rupture of 8 cms. length (Complete colporrhexis). Fortunately there was no broad ligament haematoma or active bleeding. Cervical & vaginal tear were sutured by interrupted catgut suture. Vagina was packed with roller gauze soaked with hemlock and saline. She received three units of fresh blood on the table. Her puerperal period was uncomplicated & she was discharged well after 10 days.

There was evidence of precipitated or obstructed labour in our case. There is a possibility that the injury to the vaginal vault had been initiated with the head remaining in the vagina for an hour. The fresh vaginal bleeding even before the application of the outlet forceps could account for this. This case has been reported to highlight the fact that even a trivial provocation such as application of an outlet forceps even in a primigravida could have precipitated the colporrhexis. As an Obstetrician one has to be wary of the fact that danger is always around the corner while dealing with any pregnant woman

*Dept. of Obst & Gyn M S Ramaiah Medical College, Bangalore 560054 India.*

# A RARE CASE OF HERNIATION OF GRAVID UTERUS THROUGH THE INCISIONAL HERNIA SITE.

S. K. Saha. ● R. Bhattacharya.
M. K. Sanyal. ● K. C. De.

Mrs. X, 26 yrs. old primigravida was admitted in the Gynae. Deptt. Medical College, Calcutta on 1st October, 1996. She had a history of 8 months amenorrhoea, her LMP was not remembered by her. She was married for 2 years.

O/E. - Her general condition was poor. Pallor-marked degree, B. P. - normal, mild oedema of both feet present. Past history of abdominal operation - 5 yrs. back was obtained. But exact nature of the operation was not known. Post operative wound infection and incisional hernia history were given by the patient. Abdomen was uniformly enlarged upto umbilicus, flanks full, central part of abdominal swelling was ulcerated (10 cm. x 10 cm. area) and blackish gangreneous skin was found, no scar mark detected in the abdomen. No rectus muscle could be palpated. F.H.S. could not be auscultated. P/V. Cx-tubular, os-closed, no bleeding PV was found. But dribbling was detected.

*Dept. of obst. Gyn., MCH, Eden Hospital and Medical college, Calcutta, India.*

Fig. 1.

Emergency U.S.G. done - Intrauterine pregnancy of 34 weeks was detected, liquor adequate. The foetus was viable with normal cardiac activity.

Considering the distress of the patient due to gangrenous skin, decision for laparotomy and LUCS was taken. 'O' shaped skin incision given, gangreneous skin excised. Findings after incising the skin and peritoneum, - gravid uterus was found to have eventrated through a moderately tight ring of incisional hernia. Male baby was delivered by LUCS, uterus closed in layers. After dissecting the layers of the abdominal wall meticulously, incisional hernia was repaired by double breasting operation. Post-operative period was uneventful. Though the baby was premature, it survived well. The patient was discharged from the hospital after 2 weeks.

This case is presented as a rare case of herniation of the gravid uterus through the incisional hernia site with gangrene of the overlying skin possibly due to impairment of blood supply due to over stretching of the underlying skin.