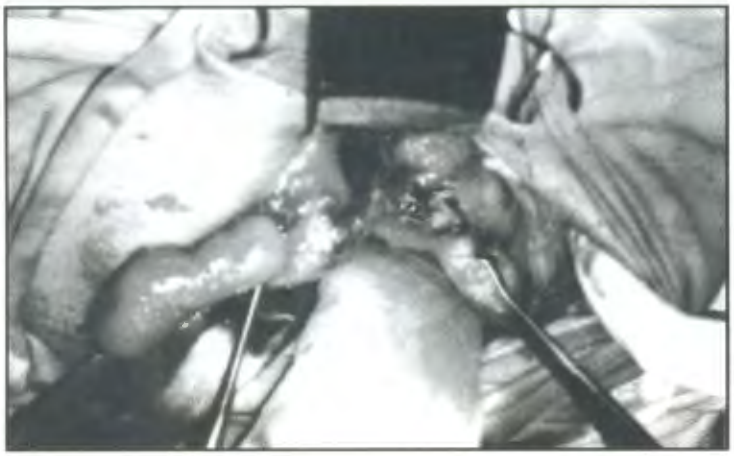
"An interesting case of lithopaedion pregnancy in a bicorpuate Uterus"

Amarish Warty, Mukesh Rathi, S.A. Chiklikar, A.M. Virkud
Dept. of Obst & Gyn., Bandra Bhabha Hospital, Mumbai.

Mrs AB, 25 years old, G5A5L0, came to OPD with complaints of foul smelling vaginal discharge, for the investigations of repeated pregnancy losses.

Past obstetric record revealed that the patient had 5 spontaneous IInd trimester abortions which were accompanied by pain and bleeding prior to the expulsion of the products of conception. The last abortion was at 5 months amenorrhoea 6 months ago. Check curettage, was done after every abortion including the last one. The patient was not investigated for the repeated pregnancy losses till then.



General examination did not reveal anything abnormal except for moderate pallor. Per abdomen palpation did not reveal any significant finding and the abdomen was soft. Per speculum examination showed greenish yellow, foul smelling, purulent discharge with inflammed cervix and vagina. Few small calcified masses were seen protruding through the cervix, attempt to remove which was not successful as they were firmly adherent to the cervix and were filling up the cervical canal. On bimanual examination there was a suspicion of bicornuate uterus with a normal right horn and a soft small left horn. These findings were confirmed by USG which showed calcified material lining the endometrial cavity and cervical canal suggestive of a lithopaedion. After the basic investigations, the patient was taken up for D and C and hysterolaparoscopy. Under anaesthesia, the uterine sound could not be negotiated into the right horn. The internal os easily admitted a No 6 Hegar dilator. Laparoscopy confirmed the findings of a bicornuate uterus with a normal Rt ovary and adhesions between the Rt horn and the omentum. Left sided horn and the tube and ovary were normal. Curretage was attempted under laparoscopic guidance and few foul smelling calcified products were removed. However D and C had to be abandoned on the suspicion of perforation of the

horn. Post-operative recovery was good except for tachycardia for 2 days.

Histopathology report of the products sent showed lithopaedion. A decision for exploratory laparatomy and excision of the horn, if need be was taken. After infusing the patient with one unit of blood pre-operatively and having maintained her on higher antibiotics, the patient was subjected to exploratory laparotomy. Upon visualising the uterus, a perforation on the medial aspect of the Rt horn with the expelled calcified products was noted. The omentum and rectosigmoid was adherent to the right horn, which were separated. Incision was taken below the perforated site on the medial aspect of the right horn and the contents of the uterus were evacuated.

Uterine incision was closed with No.1 Vicryl continuous interlocking sutures, achieving a proper hemostasis. Abdomen was closed in layers as routinely. Post-operative recovery was uneventful.

Unilateral twin ectopic gestation

(Mrs) Neeta Arun Nayak, (Mrs) Suvarna S. Khadilkar, (Mrs) Manik Potwar, (Mrs) Krishna M. Algotar
Department of obstetrics & Gynaecology, Cama & Albless Hospital,V.T., Mumbai – 400 001.

Ectopic pregnancy is not an uncommon pathology, Many have even reported occurrence of combined intrauterine and extrauterine pregnancy, but twin ectopic gestation is indeed rare with an incidence of only 1 in 68 ectopic pregnancies. Only hundred cases have been reported in literature so far and of these in only 2 cases a pre-operative ultrasound diagnosis of unilateral twin ectopic gestation has been made. Here, we are presenting one such case of unilateral twin ectopic gestation diagnosed pre-operatively on ultrasound.

A 30 year old Muslim patient (Reg No-1271/96), residing at Bhiwandi, a gravida-7, para-6, was brought on 27/2/96 at 5.30 pm as an emergency case with 2 months of amenorrhoea and pain in lower abdomen since 2 days. She had an ultrasound report which showed an unilateral right sided unruptured twin ectopic pregnancy with cardiac activity of both twins demonstrable.

There was no history of bleeding per vaginum/fever/ giddiness/ fainting attacks or any bladder or bowel complaints. Her LMP was 2 months back and past menstrual cycles were regular and normal. She had six full term normal deliveries and her last delivery was 2 years back. There was no history of abortion/multiple pregnancy/use of any contraception. There was also no history of any surgery or medical illness in the past.

On general examination, patient was afebrile with a pulse rate of 120/minute and a blood pressure of 120/80 mm Hg and there was marked pallor, Abdominal examination revealed minimal abdominal distension with tenderness