Paternal Rare Structural Anomaly Associated With Fetal Trisomy and Non Immune Hydrops: A Case Report

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Mrs. J.D., G0 P0 presented with H/o infertility for which she was treated and in turn conceived. Her pregnancy progressed uneventfully till 24 wks except for weight gain being on the higher side of normal. An early pregnancy scan on USG at 8 wks showed a single live intra-uterine fetus corresponding with the weeks of gestation. At 24 wks on her routine monthly visit, uterus was found to be larger for the weeks of gestation. An USG scan showed a single fetus of 24-26 wks with evidence of marked ascitic fluid in fetal abdomen with bilateral pleural effusion. There was evidence of soft tissue swelling around the scalp and chest wall. There was a marked enlargement of fetal abdomen. Spines revealed no abnormality. Looking at the blood groups of the parents, immune cause of hydrops was ruled out. This pregnancy was terminated and the fetal blood was subjected to cord blood culture. It showed trisomy 16. On subjecting the parents to karyotyping, they were found to be karyotypically normal. But the father was found to have a chromosomal aberration. There was a polymorphic centromeric heterochromatin chromosome 16. A normal karyotype with rare structural anomaly leading to fetal trisomy and resulting in a non-immune hydrops makes this a very rare case.

Pregnancy in Rudimentary horn of Uterus

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Pregnancy in Rudimentary horn of uterus is rare as it is very difficult to make the diagnosis before surgery. This condition is most hazardous to maternal life as rupture of pregnant horn results in severe haemoperitonium. Surgical exploration and excision of accessay horn is advised.

Case Report.

Mrs.V.K, 35 years, 7th gravida, 6FTND, 4 male & 2 females all alive was refered to us as a case of threatened abortion on 28.10.97. She had amenorrhoea of 4 months. Pain in abdomen and bleeding P/V off & on for 1 month, more since 1 day. Her general condition revealed mild anaemia pulse 90/per min. B.P. 120/80 mm of Hg. P/V-os was closed uterus was 14 wk size, soft, there was slight tenderness in anterior and right fornix. Blood stained discharge was present. She had severe pain in abdomen on 29.10.97. At this time her pulse was 140/min. BP. 60 mm of Hg, Abdominal distension was present. With possible diagnosis of ectopic pregnancy she was taken for needling & Exploratory laparotomy after arranging two units of blood.

As needling was positive laparotomy was done . There was massive haemoperitonium (fresh blood) ; both tubes & ovaries were normal. There was bicorunate uterus, rudimentary horn was on right side, of 10 x 12 weeks size soft. There was opening on it through which fresh blood was coming. On cleaning the blood membranes were seen bulging through the opening . Right side sapingo-oopherectomy & removal of Rudimentary horn & left sided tubectomy were done.

She was given 2 units of blood tanfusion and was on dopamine 4 amp in 5% GDW for 2 days postoperative as BP fell to 60 mm of Hg during operation.

Cut Section: Revealed fetus with placenta in rudimentory horn of uterus with normal tube & ovary (Photo) . She had normal post operative period, was discharged on 14th day after operation.