Haemoperitoneum in a case of uterine sarcoma

S. K. Saha, P. K. Bhattacharya, S. Adhikary, K. C. De, M. Sanghamita
Dept. of Obs and Gynae, Eden Hospital, Medical College, Calcutta

Mrs. Kakoli Dutta, 27 years, P1+0, LCB: 2 years, F.T.N.D. - 10yrs., no history of M.T.P. (Delayed child birth after marriage 4 years) was admitted on 22-12-97. with history of menorrhagia for last 6 months, lasting for 8-9 days with history of passage of clots. L.M.P. - 18-12-97 followed by pain in abdomen and fainting attack on 20/12/97. She was admitted with severe pallor on 21-12-97. USG done on 19-12-97.

U.S.G. Findings

Haemoperitoneum, Laparotomy was advocated to confirm the diagnosis. Laparotomy was done on 22.12.97.

Laparotomy Findings were as follows

Massive Haemoperitoneum, Uterus 10-12 weeks size, on posterolateral wall there was one lacerated rent suggestive of perforation following degenerative change in myometrium. TAH was done. 6 units of Blood transfusion was given.

HPE Report

Low grade endometrial stromal sarcoma.

Patient did very well in the postoperative period. She was referred to Tata Memorial Hospital for opinion. She underwent MRI and CAT scan to rule out the possibility of any metastasis. But having detected none of it she was advised to follow up every quarterly. Till date the patient is doing well.

Bilateral Neo-Ureterocystostomy & Repair of V.V.F. & V.C.F. following L.S.C.S.

S. K. Saha, K. Sarkar
Dept. of Obst & Gyn, Eden Hospital, MCH, Calcutta

Mrs. M.K., 35 years P4+0 was admitted in this hospital with the history of continuous dribbling of urine following 3rd postoperative day of her LSCS operation. LSCS was done 8 weeks back. Her precedent obstetric history was as follows:-

She had all previous full term normal deliveries and LSCS was done in her present pregnancy. Indication was obstucted labour. Baby died few hours after birth. Dribbling of continuous urine was complained from 3rd postoperative day.

Examination under general anaesthesia, three swab test and cystoscopy confirmed the occurrence of two large fistulae. One was vesico-vaginal fistula and other was cervico-vaginal fistula.

Urea and creatinine levels were normal.

Abdominal operations were embarked upon as the first resort. The following operations were done-

1. Considering her age and parity a total abdominal hysterectomy with bilateral salpingo oophorectomy which facilitated the repair of bladder fistula.
2. Repair of VVF and VCF.
3. Reconstruction of bladder neck
4. Bilateral neo-ureterocystostomy done with double Z-stents kept in situ

Postoperatively urethral catheter was removed after 3 weeks. Z-stents were removed through cystoscopy after one one month. Patient was cured. In this operative procedure, we sought the help of urosurgeon.

The case is presented as a rare case where VVF and VCF of obstetric etiology was repaired primarily by abdominal route.