CASE REPORT

PREGNANCY IN A PERI-MENOPAUSAL WOMAN

KAMALA SELVARAJ

Mrs. A, 49 years, married 29 years, reported to G.G. hospital in 1991 as a case of primary infertility. She was in her perimenopause. Her menstrual history was 3/39 days. Her LH and FSH levels were 6 mIU/ml and 7 mIU/ml, respectively. Her initial follicular study showed anovlation. Her husband's sperm count was 90 million with 30% motillity.

Laparotomy the same year revealed omental adhesions. A large fundal fibrold was seen covering the uterus. Ovaries were corrugated. Left ovary had chocolate cyst which was excised. Both tubes were patent. Appendix was inflammed. Myomectomy and Appendicectomy were done.

After myomectomy, patient was advised IVF and ET. As the patient was still menstruating, hyperstimulation was tried with estrogen therapy. She was downregulated with GnRH-a from day20 and hyperstimulated with FSH and HMG (225 IU and 150 IU X 3 days) and 150 IU of FSH and HMG for 2 days. Although no oocytes were produced during the hyperstimulation regime, there was a good endometrial response. Her uterus was grown to 6 X 3 cm. Therefore the patient was advised for a donor oocyte programme. 2 mg and 6 mg Progynova was given from day 1 to day 9 and day 10 to day 13 respectively. Parenteral progesterone (Gestone 25 mg) was started on the 13 day. On the same day three donor occytes were aspirated. Two grade III oocytes and one grade II oocyte were fertilized with husband's sperm. Parenteral progesterone (25 mg bd 50 mg bd) was given on day 14 and day 15. On day 15, three embryos were transferred in their 5-cell, 3-cell and 2-cell stages respectively. ßHCG on day 11 was 24.2miu/ml. Sac was detected on the 39th day. Pregnancy was maintained with parenteral progesterone upto the 19 th week and oral estrogen upto 23rd week, i.e, till placental function was established. she delivered by LSCS a healthy female baby weighing 2kg on 10 th october 1994.

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AN UNUSUAL CASE OF RUPTURE UTERUS

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A Primi gravida of 20 years, came to labour room of district hospital with compliants of, amenorrhoea 9 months,and cessation of foetal movement since 18 days, after a fall from 4-5 feet hight. She gave history of failed induction by syntocinon drip and also laminaria tent insertion one day back in a private clinic.Her general condition was good. BP was 100/70mm Hg, pallor was (++), pluse rate was 120/mt. On abdominal examination there was term size pregnancy with cephalic presentation. FHS was absent.X-ray showed single foetus with Spalding's sign. She was admitted and syntocinon drip was started.After 2 hours the patient become restless.

Her pluse rate was 120/mt persistently. Thinking that infection and septicaemia was setting in laparotomy was done. On cutting the sheath the peritoneum was found to be 1/2" think. It was opened;dead foetus & placenta were in the peritoneal cavity. Peritoneal cavity contained blood mixed fluid. The uterus was of almost normal size and completely inside the pelvic cavity, Uterus had a rent of about 1½" on its funds. Uterus was repaired after removing the foetus and placenta, without any difficulty. There were no adhesions Abdomen was closed in layers. Patient went into shock post-operatively, but recovered with bood transfusions.

So it is deduced that the uterus had ruptured 18 days back due to trauma from fall. Foetus with placenta were then replaced into the peritoneal cavity. Uterus had then involuted back to almost normal size. Peritoneum had thickened due to inflammation caused by irritation.

Rupture uterus due to trauma is unusual, and in primigrawida it is rare. The patient did not give history of curettage or any other operation on uterus. Still more amazing is the fact that the patient survived and was ambulatory after rupturing her uterus for 18 days.

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A RARE CASE OF SECONDARY POST-PARTUM HAEMORRHAGE

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A 32 years old woman presented at the emergency ward in a state of shock with profuse vaginal bleeding on 26-08-93. She was Para -3, and had undergone emergency cessarean section (LSCS) for non progress of labor in a private hospital on 18-07-93. She had bleeding per vaginum off and on since then, which had increased considerably on the day of admission. The patient was resusitated and a gentle emergency D&C with blunt curette was undertaken. The general condition of the patient did not improve and she continued

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to bleed per vaginum. Therefore, an emergency laparotomy was decided. At laparotomy, uterus was soft and friable. The LSCS scar had given way. The bladder and gut were adherent to the necrotic friable scar area. Both tubes and ovaries were normal. Subtotal hysterectomy was performed. Cut section of the uterus showed area of necrosis. There were no placental pieces.

Histopathology report of the D&C specimen showed only inflammatory and necrotic tissue. Subtotal hysterectomy specimen report revealed chronic myometritis and chronic haemorrhagic endometritis. The postoperative period was uneventful.At one year follow up, she was clinically normal and her Pap's Smear(cervical stump) was also reported as normal.

A RARE CASE OF INVASIVE VESICULAR MOLE

RAHESH DARDE ● ASHWINI BHALERAO-GANDHI
DEEPAK RAO ● A.M. PHATHAK ● M. Y. RAVAL

Mrs. K, 45 years old woman residing in Uttar Pradesh was admitted with complaints of pain in abdomen, irregular bleeding PV and loss of weight since 2 months. She had 7 FIND and last delivery was 4 years back. No method of contraception was practised. On examination, severe pallor was present; per abdominal examination revealed enlarged uterus corresponding to 16 weeks of gestation. Per vaginal examination confirmed the uterine size and internal os was closed. Investigations revealed that Hb was 4 gm% (therefore 3 units of blood were transfused). Blood group was A+ve. USG pelvis and abdomen showed mixed echogenic mass arising from pelvis measuring 17 cm x 12 x 6 cm. Endometrial lining was not appreciated. Ovaries,liver, spleen, kidneys were normal. Ultrasonography impression was of fibroid uterus.

Exploratory laparotomy was carried out on 22-4- 1993. On opening the abdomen, haemoperitoneum was present.Uterus was enlarged to 16 weeks size. Three sites of perforation were found on the uterus, - posterior aspect of fundus, posterior aspect of cervix and lateral part of the uterus at the junction of uterus and cervix. In view of these findings, the diagnosis of invasive vesicular mole was made and abdominal hysterectomy with bilateral salpingo-ooplerectomy was performed and the specimen was sent for histopathological examination. Blood was sent for serum ß-HCG estimation which was found to be 2,00,000 MIU/ml. Histopathological report confirmed the diagnosis of invasive vesicular mole (Fig 1- Microphotograph showing normal myometrium on left side which is invaded by trophoblastic tissue. On the right side of the photograph, cross sections of 2 vili are seen which are avascular villi surrounded by trophoblastic tissue. There is collection of fluid in both these villi.

The patient was started on chemotherapy. Inj. methotrexate 20mg IM OD for

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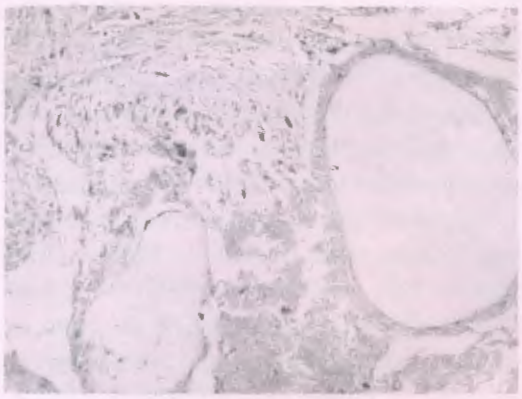

Fig. 1

5 days. Inj Folinic Acid 200 mg IM 6 hrly for 2 weeks. Four such cycles were given at 21 days interval. Serial levels of seum ß-HCG showed falling titres from 2 lacs to 3 MIU / ml. Repeat USG of pelvis and abdomen did not reveal any pathology.

The patient was discharged on 28-8-1993 and was followed up on O.P.D. basis thereafter. Serial ß-HCG estimations showed a nil report.

In short, this was a rare case of invasive vesicular mole in a multiparous, elderly women of A +ve blood group, who presented with irregular bleeding PV with pelvic mass leading to clinical diagnosis of fibroid uterus.

PREGNANCY WITH HEREDITARY SPHEROCYTOSIS COMPLICATED WITH MINOR BLOOD GROUP INCOMPATIBILITY

A. AGRAWAL ● S. RAGHAVAN ● S. SWAIN
G RAJGOPALAN ● S. JAYANTHI

Hereditary spherocytosis (HS) complicating pregnancy is uncommon. The incidence of incompatibilities due to minor blood groups is also rare. We herewith present a case of congenital spherocytosis complicating pregnancy associated with the perplexing problem of minor blood group incompatibility.

CASE REPORT

Mrs. S., a 38 year old multigravida around 32 weeks pregnant was admitted to Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER) Hospital Maternity Ward for anaemia complicating pregnancy on 20 th March 1993. She was a known case of congenital spherocytosis for which splenectomy was done in the year 1979 at the JIPMER Hospital. As regards her obstetric history, she was gravida 5, para 3 and abortion 1. In her first pregnancy she had undergone emergency lower segment Caesarean section (LSCS) for cephalopelvic disproporation and delivered a term baby which was alive and healthy. In the immediate

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postoperative period, her haemoglobin level was 8g/dland she received 350 ml of B Rh positive blood transfusion. The second pregnancy resulted in a spontaneous abortion at 12 weeks gestation. In the third pregnancy, she delivered spontaneously stillborn fetus at 32 weeks gestation. The fourth pregnancy was in the year 1991when she underwent a repeat LSCS for foetal distress and delivered a growth retarded baby at 36 weeks gestation, the baby succumbed on the second day in the neonatal nursery unit.

In the present pregnancy she was admitted around 32 weeks pregnancy with severe anaemia. Her preliminary haematologic investigations were as follows: Hb 4/dl, PCV 16%, ESR 68mm in one hour, Peripheral smear : normochromic normocytic anaemia with moderate anisocytosis and poikilocytosis with moderate number of normoblasts and few polychromatic cells, spherocytes, schistocytes and acanthocytes; total white cell counts and platelet counts were within normal limits; osmotic fragility started at 0.6% and was completed at 0.32% (as against controls starting at 0.48% & 0.36 %). She could not receive blood transfusion since none of the B Rh positive blood available at the blood bank could be cross-matched with her blood and hence incompatibility of minor blood group (s) was suspected. The direct Coomb's test on patient's red cell was weakly positive and indirect Coomb's test on patient's serum was positive. The patient's serum contained abnormal serum titre of antibody with 'O' group blood cells. In the mean time, her haematologic parameters further deteriorated, i.e. Hb 2 g/dl, PCV 7% 80 mm /hour and plasma fibrinogen 228 mg%. The fetus died in utero while she was in the hospital. She went into spontaneous labor and delivered a macerated stillborn fetus weighing 1200 g. She developed congestive cardiac failure due to severe anaemia in the immediate postpartum period and was treated with diuretics, digitalis and oxygen. She continued to deteriorate and expired on the tenth postnatal day due to severe anaemia complicated with congestive cardiac failure and pulmonary edema.

Congental spherocytosis is a haemolytic disease because of abnormal fragility of the RBC membranes. Repeated blood transfusions may be the only way of improving the condition of these patients. Splenectomy has been shown to have a definite beneficial effect. Unfortuately, our patient could not be given blood transfusion because of the blood group incompatibility. Facilities like plasmapharesis might have helped to tide over the crisis.

PREGNANCY IN A CASE OF PREMATURE OVARIAN FAILURE (POF) FOLLOWING HORMONE REPLACEMENT THERAPY AND EMBRYO TRANSFER WITH DONOR OOCYTE

KAMALA SALVARAJ

Mrs. X, aged 34 years , married 10

years, reported as a case of primary infertility, to our hospital in 1992. She attained menarche at the age of 17. Initially her menstrual history was 7-9 / 30 days. After marriage there was a gradual cessation of menses (3 to 6 month cycle). From the age of 26 she has been menstruating only on induction with Regesterone. She was classified as a case of POF since she showed very high levels of LH (49.2 mlU / ml) and FSH (40.0 miu / ML). Her karyotype was normal (46 xx). Diagnostic laparoscopy revealed a very small sized uterus (4.3x 2.4) streak ovaries and very badly damaged tubes due to previous pelvic inflammatory disease. However both the tubes were parent. She as tested positive for As Ab in 1:32 dilution, treated appropriately. Her husbands sperm count was 35 milion with 25% motility.

Cyclical hormone therapy was started along with a prolonged course of antibiotics till the uterus reached an optimal size of 6 x 3/5 cm . PROST was attempted in 1993, but failed due to previous salpingitis. Hence the patient was advised to undergo only Embryo Transfer in the future. Meanwhile the hormone replacement therapy was continued and the uterus size was maintained to optimum. In 1994 2mg Progynova from day 1 to day 9,6 mg from day 10 to day 13 and 4 mg for the remaintaing days, was given, parenetral progesterone was given on day 15 and 50 mg BD on day 16, i.e., on the day Embryo Transfer. Three Embryos were transfered, two in 2 cell stage and one in 3-cell stage. ß HCG on day 12 and day 14 was 26 miu/ml. and 106miu/ml respectiely. Pregnancy was maintained with parenteral progesterone upto the 19th week and oral esrogen upto the 23rd week i.e., till placental function was established. Pregnancy continued uneventfully to term.She delivered a healthy male baby weighing 2kg, by LSCS on 19th October 1994.

After three previous cases of missed abortions, this is our first successful delivery in a case of POF and the first of the kind in Tamilnadu.

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PRIMARY VAGINAL CALCULUS OF HAEMATIC ORIGIN

SOPAN N. JATAL

A vaginal calculus is an unusal finding. Primary vaginal calculi are rare & usually reported to be of urinary origin. In Navani & Tesseir (1970) reported 24 cases of primary vaginal calculi. All calculi were of urinary origin. Lewis E. Savel 1964 reported the first case of primary vaginal calculus of haematic origin.It was accompanied by a congential septum in the vagina.

Our case was of primary vaginal calculus of haematic origin, it was accompanied by a small pinhole opening in the imperforate hymen, to form a haematocoplus, which got calcified & formed a stone.

C.S. -A 19 year girl came with complaints of - hypogastric pain at the time

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of menstruation and burning micturation. A year earlier in 1991, she was operated for bladder stone, but the surgeon could not find the stone in the urinary bladder. The finding at physical examination were those of a well developed girl with normal secondary sex characters. On local examination pubic hair distribution was normal, and the clitoris, urethra, and labia majora and minora were also normal. There was a small pinhole opening in the hymen, which was bulging out. P/R examination & bimanual palpation of the uterus suggested the presence of a stone in the vagina, above the hymen.

X-ray pelvis showed a calcified calculus in the pelvis (Fig.1)

OPERATIVE PROCEDURE

Under G. A. cruciate incision was made through the pinhole a hymenal opening. The calculs was grasped with a - randall stone forceps. A stone about the size of an egg was delivered through the vagina. The vagina on inspection revealed a nulliparus cervix. The vagina was of normal depth and width is bimannual palpation revealed an anteverted, small sized uterus and adnexa

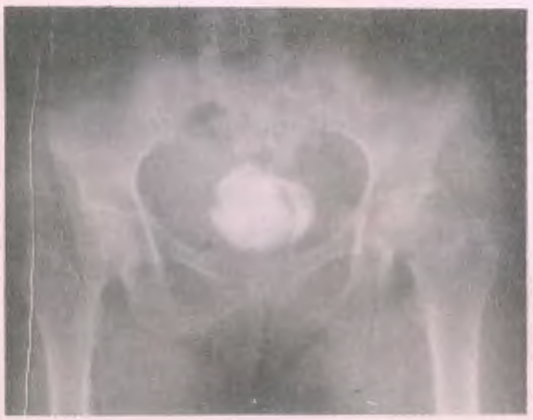

Fig. 1

Fig. 2

normal. There was no evidence of vesicovaginal fistula or an ectopic ureter.

Examination of the stone revealed that it had a thin shell varing from 1 to 2 mm in thickness and having a tannish - brown colour. Underneath the shell was a grayish tan crystalline material mostly arranged in a radial fashion around a firm central core No foreign body was seen in the central core. Chemical analysis of the calculus revealed calcium carbonate. (Fig. 2) Vaginal calculi can be divided into Primary & secondary. A primary vaginal calculus is formed in the vagina, from the deposition of urinary salt, due to continuous urinary leakage into the vagina through a vesicovaginal fistula or as result of urinary incontinence.

Secondary calculi representing the deposition of inorganic salts around foreign bodies introduced into the vagina are more common.

REVIEW OF A CASE OF MULLERIAN ANOMALIES

ASHWINI BHALERAO-GANDHI ● RAJESH DARDE
GAYATRI MALLYA ● M. Y. RAVAL

Miss M, 27 years old unmarried girl came to our O.P.D. with chief compliants of primary amenorrhoea and cyclical pain in abdomen, more so for last 4 months. There was history of diagnostic laparoscopy followed by exploratory laparotomy done in July 1986 in some other general hospital. After this operation, patient bled for few days. But subsequently amenorrhoea and pain in abdomen were re-established. Her secondary sexual characteristics were well developed. Per abdomen, uterus was enlarged corresponding to 16 weeks size. Blind and shallow vaginal pouch was present. She was admitted and thoroughly investigated. Ultrasonography revealed haematometra in a bicornuate uterus. IVP showed no back pressure changes; but indentation on the bladder was seen.

Exploratory laparotomy with vaginoplasty was done on 13th December 1993 under G.A. A space was created between the bladder and rectum, thus deepening the blind pouch of vagina by blunt and sharp dissection. A bulge was seen at the apex of the vagina, but haematometra could not be drained vaginally. abdomen was opened by Pfannenstiel incision. Uterus was found to be enlarged, with a distended horn on the right side. Endometriotic patches were seen on both ovaries, intestines and omentum. The diagnosis of bicornuate uterus with haematometra with atresia of the upper part of the vagina was made. To drain the haematometra, an incision was taken on the fundus of the uterus and chocolate coloured fluid was drained with the help of suction. No communication was found between the right horn of the uterus and the main uterine cavity. So the right horn was excised. A sponge holder was introduced in the uterine cavity through the incision on the fundus.

By the vaginal approach a communication was established between the uterine cavity and the blind vaginal pouch keeping the sponge holder as a guide. Thorough irrigation of the uterine the cavity was done with normal saline. Saline inroduced through the uterine incision could be drained out easily from the new opening created in the vagina. The upper vagina was mobilized and was brought down to be sutured to the lower vaginal edge with interrupted vicryl stitches i.e. a pull through operation was carried out. The uterine incision was

Fig. 1

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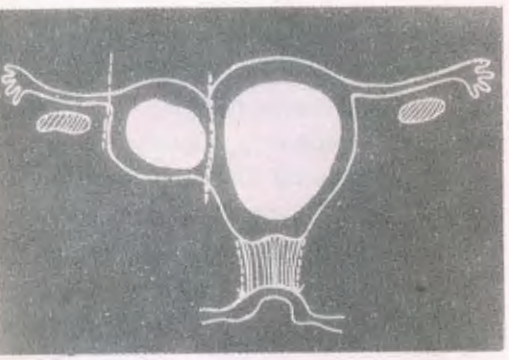

Fig. 2

closed in 2 layers with vicryl stitches (1st continuous, 2nd interrupted.) the right sided cornual structures were fixed to the right side of the fundus. Abdomen was closed in layers. Postoperatively cefazoline, metronidazole and gentamycin were given for 10 days. Danazole 200 mg BD was started Repeated dilatation of the vagina was carried out. She was discharged on 16th January 1994. Serial follow - up was done. Last follow-up was on 15th march 1994. On enquiry, patient had mensruated once. On examination, the communication between the uterus and the vagina was patent and adequate vaginal length was present. The entire blade of the Sim's speculum could be inserted easily in the vagina.

MAYER ROKITANSKY KUSTER HAUSER SYNDROME WITH RIGH RENAL AGENCIES

ASMITA P. AGASHE ● JAYSHREE RAMKRISHNA
ASHA K. PHADKE

Mayer Rukitansky Kuster Hauser (MRKH) syndrome is a relatively common cause of primary amenorrhoea, second only to gonadal dysgenesis. One third of the patients of MRKH syndrome have associated urinary tract abnormalities.

Mrs. GRS, aged 16 years, married for two months, presented with complaints of failure to menstruate and difficult and painful intercourse. She gave no history of cyclic abdominal pain or any abdominal lump. She was 149 cms tall. Axillary, public hair and breast development were normal for her age. Physical examination did not reveal any lump in the abdomen or any swelling in the inguinal region. External genitalia were feminine and normal in appearance. The vagina ended in a blind small pouch of about two cms. in depth. On ultrasonography, the uterus and vagina were not visualised. Both the ovaries were visualised and normal in size. Intravenous pyelography showed absence of the right kidney (Figure 1). The left kidney, left ureter and urinary bladder were normal. X ray chest and intravenous pyelography plates showed no abnormalities of verte-

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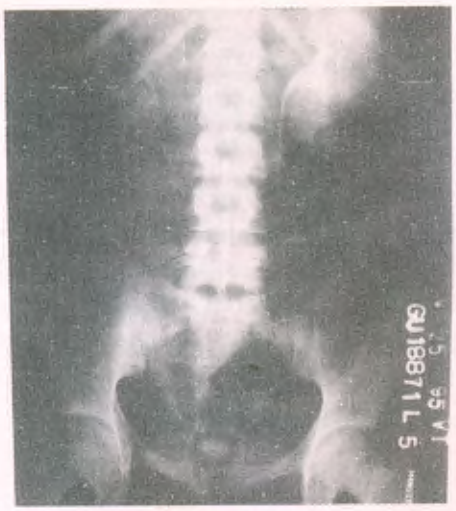

Fig. 1 : Intravenus pyelognaphy plate showing absence of right kidney.

brae or ribs. Her karyotype was 46xx. Laparoscopy revealed total absence of uterus and presence of rudimentary fallopian tubes and bilateral normal ovaries.

A McIndoe vaginoplasty was carried out using amniotic membrane as a graft. Amniotic membrane was obtained fresh from a patient operated on by caesarean section. Vaginal mould made up of styrofoam and condom covering the styrofoam was inserted after creating a new vagina of 10cms. depth. It was kept for two weeks and then removed. On inspection the new vagina was healthy. A new mould was reinserted. The patient was explained to keep it for 6 weeks continuously, removing it only at the time of urination and defecation, thereafter she inserted the mould at night for 12 months. Later on when regular intercourse is taking plac, the mould is not required. The need for adoption of a child was explained to the patient. Using amniotic membrane as a graft is advantageous over the skin graft because there is no permanent scar on the patient's thighs.