CASE REPORT

NORMAL PREGNANCY WITH LITHOPEDION OF 12 YEARS DURATION

C. R. DAS

CASE REPORT

Mrs. S. F. 35 years a Muslim female was admitted in 9th April, 1992 as an emergency with pain to one of the private hospital in Cuttack. She belonged to middle class and was illiterate. Her L.M.P. was not known. M/H previous cycle : $\frac{4-5}{30-35}$ days with normal flow without clots. O/H : She was married for 20 years. She was 7th gravida, 5th para with history of 2 abortions and four living children. 1st-Full term female child-Normal delivery at home - 15 yrs. old. 2nd-Full term male child-Normal delivery at home - 13 yrs. 3rd-She had period of amenorrhoea of 6 months duration. She was admitted to one local hospital with acute pain in abdomen, and fainting attacks. She was given palliative treatment with antibiotics and I.V. fluid by the doctor, a General Practitioner. She was referred to a hospital where services of a specialist was available. She did not go to the referral hospital. Instead she went home where she suffered from abdominal pain for two months. She was relieved from the dull aching pain in the abdomen spontaneously. Following this, she felt a mass in lower abdomen. She did not take any special notice of it as it did not trouble her much. This episode took place exactly twelve years ago. Following this, she had two full term normal deliveries at home, both daughters, 10 years and 8 yrs old respectively. She had aborted twice spontaneously 2 yrs. back. O/E : She was mildly anaemic. Her temp. was normal, pulse was 88/min, B.P.

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120/80 mmHg. There was no oedema. Her bowel and bladder habits were normal. There were no abnormalities in the heart and lungs. P/A : Uterus - Full term. L.O.A., F.H.R. - 142/min, regular Head-5/5th (Not engaged). An irregular bony hard mass of spherical shape, partially mobile of size 9 cm x 9 cm was palpable in suprapubic region. P/V : Cervix : 60% effaced. OS was 5 cm dilated. Head - '2' station. Bag of membrane was formed. Investigations : Blood group - A, Rh Positive, Hb% - 11 gm%. Stool and Urine - NAD. Provisional diagnosis: Twisted ovarian cyst with pregnancy at term. Exploratory laparotomy was done immediately. On Opening the abdomen: The mass was located on the anterior surface of the uterus encroaching both upper and lower segment. Proximally there was adhesion with the omentum and to the round ligament on the left side and distally the broad ligament was covering the mass. The adhesions were released by blunt dissection and the mass (Mummified foetus, 9 cm x 9 cm) was found involving the isthmus of left side tube. (Vide Fig. 1) In between two layers of broad ligament, the lethopedion was removed dissecting left tube; isthmic region. Classical Caesarean section was done and a full term normal living female child was delivered. Bilateral tubectomy was done. The patient was discharged on 13th post-operative day. The peculiarity of this case was the duration of amenorrhoea was six months, pain subsided within two months following which she had two normal deliveries.

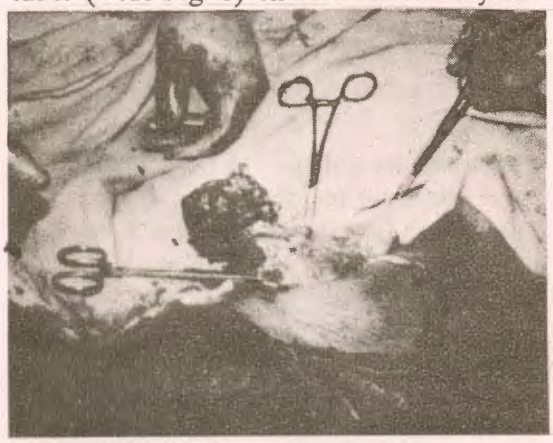

Fig. 1 : Showing the lithopedion as a mass.

SIBLING RIVALRY - IN UTERO

ANITA SANTAMARIA ● NOZER SHERIAR
MEHROO HANSOTIA

Mrs. V.K., 1 gravida 3 para 1 with 1 living issue registered at our antenatal clinic at 8 weeks of amenorrhoea. Clinically the uterine size did not correspond to the gestational age and an ultrasound examination revealed a live intrauterine twin gestation of 8.6 weeks.

All her routine investigations were within normal limits and she was advised a high protein diet with iron and calcium supplementation. Serial clinical examinations and ultrasonograms were performed to confirm adequate fetal growth and development. At 30 weeks gestation the ultrasound showed twin 1 to be 28.5 weeks and twin 2 to be 29 weeks gestation. However, an ultrasound

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done four weeks later showed a two weeks lag in twin 1.

The patient presented at 33 weeks amenorrhoea with preterm labour and was conserved with complete bed rest and parenteral isoxsuprine hydrochloride. A non-stress test was performed, that was reactive for both foetii. On the weekly non-stress test at 35 weeks twin 1 had a reactive non-stress test but twin 2 showed a loss of beat to beat variability with spontaneous decelerations to 60 beats per minute with movements. In view of the non-reactive non stress test and the fact that the patient was more than 34 weeks, the pregnancy was terminated by induction with an oxytocin drip and an artificial rupture of membranes. The labour was uneventful the patient delivering within 6 hours. The first baby weighed 1.480 kgs and was pale, while and markedly anaemic. The second twin weighed 1.840 kgs and appeared plethoric. Both babies were transferred to the neonatal intensive care unit. The placenta was monochorionic diamniotic with blood vessels from both sacs in communication and continuity.

The larger plethoric twin had a haemoglobin of 20 gms% and the smaller anaemic twin had a haemoglobin of 6.6 gms%. On the second day the larger twin developed jitteriness for which a partial exchange of 10 cc blood was performed and was repeated four days later, following which the haemoglobin decreased to 18.6 gms%. The anaemic twin was transfused with 18cc whole blood on two occassions after which her haemoglobin increased to 14.5 gms%. Both the babies were put on expressed breast milk, calcium and multi vitamin drops. The mother and her babies were discharged on the 17th postnatal day, when the larger baby weighed 2.2 kgs with a haemoglobin of 18.1 gms% and the smaller baby weighed 1.8 kg with a haemoglobin of 15 gms%.

The incidence of twin to twin transfusion in 2 to 6 percent of all twin pregnancies is rare and is seen exclusively in monozygotic multiple births with monochorial placentae. This case report highlights the importance of strict, serial antepartum surveillance of every twin pregnancy which must always be considered at the highest risk.

PREGNANCY OUTCOME IN HYPOTHYROIDISM

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S. R. Chakraborty • J. Mallick
S. R. Bhowal

INTRODUCTION

Although anovulation and infertility are common in overt or clinical hypothyroidism, one may come across pregnancy in a diagnosed and treated case besides subclinical type detected for the first time in pregnancy. Three cases of former type, treated in N.R.S. Medical College, Calcutta, are reported and discussed. All of them had been under treatment of Endocrinology unit of the

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I.P.G.M.E.R., Calcutta, for 2-5 years.

Case No. 1

Ms. A.G. aged 25 years, P0+0, attended ANC regularly from 19:10.92. Her LMP was on 30.5.92. For the complaint of swelling of whole body, she was referred to Endocrinology clinic by the visiting physician on 1.2.91. On investigation, she was diagnosed to be a case of hypothyroidism. Her T_3 and T_4 were low and TSH high. Her body weight was 48 Kg and she was advised eltroxin 0.1 mg, 2 tabs and arovit 50,000 unit 1 tab daily. Her thyroid function test values at different period are shown in the table. In third trimester, she was on eltroxin alone, 1½ tab daily. The course of pregnancy and foetal growth were normal and so also routine laboratory tests. Admitted at 39th week, she was induced with oxytocin 4 days after EDD. For failed induction, LSCS was done on 11.3.93. Female live baby weighing 3450 gms was born. On the advice of anaesthetist, she was given eltroxin on the day of operation and the postoperative sedation in half dosage. The recovery was uneventful and she went home on 8th day with healthy baby.

Case No. 2

Ms S.M. aged 30 years, P0+0, married for 2 years 3 months, attended ANC from 24.10.92 with her LMP on 12.7.92. For hoarseness of voice, she attended Medical OPD on 16.9.91, her thyroid profile is mentioned in the table, X-Ray Chest - NAD. She was advised eltroxin ½ tab for 2 weeks then 1 tab daily and isordil 5 mg TDS for 4 months. Besides the problem of voice existing for 4 years, she developed other symptoms like loss of memory, lethergy, swelling of body and suscpetibility to cold by January, 1992 and was referred to the Endocrinology Department. On examination - skin dry, jerks delayed and thyroid gland just palpable. The dose of eltroxin was increased to 2 tabs daily. She was relieved of the symptoms and there was no problem in 1st and 2nd trimester. At 30th week, she had pain in neck and mild dysphagia for which she had check up again the the Endocrinology Department. A small lymph node was palpable in

Table I

Thyroid Function Test Values

Normal : T_3 = 0.7-2 ng/ml, T_4 = 4.5-12.5 mcg/100 ml, T.S.H. = less than IU/ml

	Case 1			Case 2			Case 3		
	T_3	T_4	TSH	T_3	T_4	TSH	T_3	T_4	TSH
1st diagnosis	0.58	1.8	7.0	1.05	6.4	5.84	0.51	2.52	9.0
Last Prepreg	0.92	6.1	3.7	1.2	9.4	3.54	1.38	6.58	3.1
1st Trimester	1.2	6.5	3.1	not done			1.23	5.26	3.0
2nd Trimester	not done			1.35	9.5	2.86	not done		
3rd Trmester	1.3	7.0	2.5	1.7	14.6	3.0	1.57	8.81	2.52

right supraclavicular fossa and all the features subsided with ampicillin. She had weight gain of 11 Kg (39 to 50 Kg), remained normotensive and the routine investigations were within normal limits. She was admitted at 38th week and elective LSCS was done, 10 days before EDD in view of her age and mild CPD. Male live baby was born weighing 3000 gms. The recovery was uneventful.

Case No. 3

Ms L.R., aged 25 years, P0+0, married for 2 years, was admitted on 3.4.1993, being referred by a Gynaecologist of Berhampur District Hospital. Her EDD was on 7.4.1993. From 1979-80, for 2 years, she was given Lugols iodine but no further details of this period could be obtained. She attended endocrinology Department, 5 years back for mild swelling of the thyroid and was advised eltroxin 2 tabs daily for 4 years. She had D&C in January, 1992 for menorrhagia. On admission - mild jaundice +, height and nutrition - average, weight - 68 Kg, thyroid enlarged. Routine blood parameters normal, urine - bile salt and bile pigment present. Thyroid function tests are mentioned in the table. Eltroxin was continued in the same dosage throughout pregnancy. She had LSCS on the same day for mild CPD and unfavorable cervix and a male live baby was born, weighing 3500 gms. She had uneventful recovery.

DISCUSSION

Pregnancy is possible in clinical hypothyroidism when treated properly. In a study of 55 cases having menstrual disorders and infertility, Shahani and Bhate (1982) observed conception in 10 cases with thyroid therapy along with ovulatory drugs in 8 of them. They have high incidence of PET, placental abruption, LBW babies and stillbirths (Davis et al, 1988) but the foetomaternal outcome in our cases was good possibly due to the fact that they were kept more or less in an euthyroid state throughout the course of pregnancy. The babies usually remain normal except in a case of severe hypothyroidisim having radioiodine therapy (Montoro et al, 1981).

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FOETAL SACROCOCCYGEAL TERATOMA

R. Chatter • K. Singh D. Chawla
I. Ganguli

CASE REPORT

Mrs. M. 26 years, primigravida, married for 3 years, presented with 36 weeks pregnancy for antenatal checkup, EDD - 3.2.94. Previously patient was attending antenatal clinic irregularly with local practitioner.

Her first trimester was uneventful. In

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second trimester she had acute pain abdomen for which laparotomy with right salpingo oophorectomy was done under G.A. (for simple ovarian cyst) at 16 weeks of pregnancy by local practitioner.

P/H - Not significant, F/H - Not contributory.

O/E - Average built woman, Pulse 80 p.m. - BP-110/70mm Hg. Systemic examination-NAD. P/A Overdistended uterus with large baby. Cephalic, FHS + regular and longitudinal laparotomy scar in infra umbilical region.

Hb - 11.5 gm. %, Urine NAD, Glucose Challenge test 117 mg. %, Blood group AB +ve VDRL-NR. Doppler - WNL. Ultrasound - SLF, Cephalic 36 = 3 days gestation, with cystic mass of 20 x 15 cm seen arising from lower end of coccyx of foetus, suggesting sacrococcygeal teratoma.

Abdominal delivery was planned, as there was no hydropsfoetalis or hyper placentosis, which suggested good prognosis for the baby.

Fig. 1

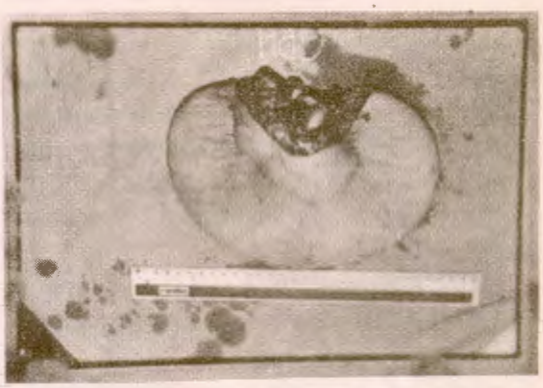

Fig. 2

Patient went into spontaneous labour on 13.1.1994 when LSCS was done under G.A. Female baby of 2.40 Kg. was extracted as Vertex with huge SCT of 27 x 17 x 10 cm weighing 2.5 Kg. Placenta and membranes normal. Paediatric surgeon examined the baby and her tumour was excised with coccyx on same day. Post operative period uneventful. Stiches were removed on day 8 and both were discharged with satisfactory condition. Baby did not have any neurological deficit.

REPEATED ANENCEPHALIC PREGNANCY WITH DIZYGOTIC ANENCEPHALIC TWIN

M. KAPOOR • USHA AGARWAL
ANJU AGARWAL

Recurrence of anencephalic pregnancy

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is very uncommon and it is rarer to see both the foetic anencephalic in twin pregnancy and also being dizygotic. In the present communication such case is described who had three anencephalic pregnancies interspersed by no normal delivery.

Mrs. Kastoori, 28 year old unbooked third gravida was admitted to M.L.B. Medical College Hospital, Jhansi in the department of Obstetrics and Gynaecology on 7.7.1993 with amenorrhoea 7½ months and undue enlargement of abdomen. In past obstetrical history, patient had two repeated home deliveries of 8 months anencephalic babies.

On examination, she was moderately built, pulse 80/mt., B.P. 110/70 mmHg, no pallor, R/S normal, CVS normal.

Per abdomen examination revealed over-distension of abdomen with excess of liquor ammni, proper assessment of foetal parts could not be made and foetal heart sound was not heard. On P/V examination patient was not in labour.

Three litres of amniotic fluid was aspirated in 2 sittings by amniocentesis but foetal head was not palpable.

Fig. 1

Blood group of patient was B +ve, blood sugar and VDRL test were within normal limits. Patient went in labour while doing amniocentesis second time and delivered premature anencephalic dizygotic twin of about 26 wks size with different sexes and without gross abnormalities of placentae (see Photograph). Post-natal period was uneventful.

PREGNANCY WITH HELLP SYNDROME WITH DIC AND RENAL FAILURE

PRABHJOT D. SINGH • JASMINE A. LOPEZ

Pre-eclampsia with Hemolysis (H), elevated liver enzymes (EL), low platelets (counts (LP), termed as HELLP syndrome is often given non obstetrical diagnosis and treatment is modified or withheld.

This case is interesting for reason of its rarity, gravity and for stressing the importance of diagnostic awareness, early recognition and quick aggressive therapy, as poor fetal and maternal prognosis dictate prompt delivery to avoid the potential complications.

A 20 yrs., unregistered woman, gravida 4, para 1 and 2 previous abortions presented in the deptt. of Obstetrics and Gynecology, JJ Hospital Bombay. She complained of epigastric pain associated

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with malaise, anorexia and nausea. Physical examination revealed blood pressure of 160/110 mm of Hg. with otherwise stable vital signs. Abdominal examination showed a uterus of 34 wks. with fetal heart rate of 140/min. There was minimal epigastric tenderness but not hepatomegaly. Cervix was not dilated and not effaced. She was treated by antacids, sedatives and antihypertensives. Blood and urine were sent for lab investigations.

Patient's clinical course were worsened by two eclamptic convulsions in the first 8 hrs. after admission. After second convulsion, patient started bleeding per vaginum and fetal heart sound disappeared. An artificial rupture of membrane was performed when the cervix was 2 cms. dilated and 40% effaced and pitocin was started.

The maternal condition deteriorated progressively with no appreciable response to pitocin and lab reports showed disturbed liver and renal function and evidence of patient going into DIC, fresh frozen plasma and platelets rich plasma was given and in in view of her downfall in clinical course patient was taken for abdominal delivery, which was uneventful.

In the post partum period patient became anuric and the biochemistry showed deteriorating renal function but improvement in hematological status. Under the instruction of nephrologist she was put to haemodialysis and to our great surprise she responded and improved after a single shot of dialysis.

She was discharged on 10th day with normal renal and liver functions and coagulation studies.

It has been rightly said, patient and the obstetrician both ask for help in HELLP syndrome.

A CASE OF PREGNANCY WITH LARGE CERVICAL FIBROID

ARATI BISWAS • SWAPAN SAIN
BASUDEV BANERJEE

INTRODUCTION

An interesting case of pregnancy with big cervical fibroid requiring a special technique of delivery by caesarean section is presented.

CASE REPORT

Mrs. Arati Nath 22 Yards old primigravida with LMP on 25th July '93 and EDD on 2nd May '94, was admitted on 9.4.94 to Calcutta National Medical College and Hospital. Her previous menstrual history was regular, her past history and family history was non contributory. Obstetrical examination, height of uterine fundus was corresponding side 32 weeks, a transverse lie with head on the Lt. A large mass about the size of a foetal head was felt in first pelvic grip, with restricted mobility and firm to feel. On P/V examination a firm mass was felt in P.O.D. & feel. On P/V examination a firm mass was felt in P.O.D. & Rt.

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lateral fornix, pushing the cervical os to the Lt. side, the mass was continuous with the masss in the lower abdomen.

INVESTIGATIONS

Urine for R/E - NAD
Hb - 11.9 gm%.
ABO Grouping - B (+) ve.
P.P. Sugar - 92 mg%.
USG - on 11.11.93 shows

(1) A large hypoechoic mass suggestive of fibroid seen in the cervical region, on the posterior aspect. The mass measured 85 mm x 79 mm.

(2) Single viable foetus with posterior placenta evident, liquor normal. BPD of 34 mm and FL = 19 mm suggesting 15 weeks 4 days of maturity, corresponding to period of amenorrhoea.

USG on 19.4.94 shows increased size of the pre-existing hypoechoic mass. The mass measures 10.2 cm x 8.1 cm opproximately and the single viable foetus shows transvcerse lie with head on the Lt. side and FL = 6.3 cm suggesting 32 weeks 3 days of maturity. Elective Caesarean section done on 28.4.94. On opening the peritoneal cavity a large cervical fibroid about the size of foetal head was seen occupyign the pelvis. At laparotomy, difficulty experienced to identify the lower uterine segment as anatomy was totally distorted. Tracing the round ligaments and tubes on either side the axis of uterus was found to be oblique. Next to ascertain the incision line, in the nearest possible site of lower segment, to avoid excessive haemorrhage and wound dehisence, loose peritoneum was traced out and cut and incision made just like LUCS in the oblique axis of the

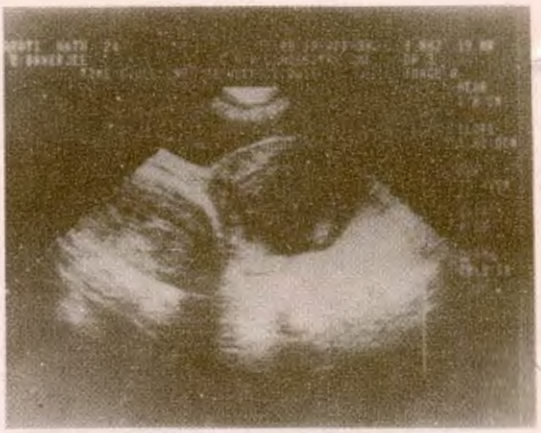

Fig. 1

uterus. Baby was delivered by internal podalic version followed by breech extraction. A living male baby was delivered, Birth Weight 3 Kg. After expulsion of placenta, the uterus could not be exteriorised it was seen that the cervical fibroid originated from the posterior surface, Rt. lateral surface and anterior surface of the cervix. Only the Lt. lateral surface was free from tumor.

Post operative period was uneventful except pain in lower abdomen. But pain and tenderness increased gradually with increased in size of the cervical fibroid mass suggestive of red degeneration of fibroid. The 7th post operative day, the size of cervical fibroid increased to 24 weeks. An urgent USG was done on 13.5.94 and confirmed the process of degeneration, the mass measures 12.1 cm x 8.9 cm approximately, which subsequently decreased on conservative management with analgesics and antibiotics. Patient was discharged with the advice of subsequent removal of the fibroid.

TWIN PREGNANCY IN A CONGENITAL MALFORMED UTERUS

AMIT SENGUPTA

CASE REPORT

A 30 years old Bhutanese woman with previous 5 living issues (Gravida 6, Para 5, Abortions 0) during sixteenth week of her sixth pregnancy was referred to me from one of the peripheral Hospital to the only one national referral Hospital, Thimphu, Capital of Bhutan. She was referred as a case of appendicular lump with pregnancy. On admission, her general physical condition was stable, with a tender pelvi-abdominal mass extending upto right iliac fossa. On pelvic examination, cervix was soft and blue, cervical excitation was present. Uterus was soft of sixteen weeks size. There was a vague soft tender 15 x 15 cm mass adherent to the right side of the uterus, going posteriorly. Patient was subjected to an ultrasound scanning, which revealed a twin pregnancy. One fetus of 12-14 weeks gestation, seen inside the normally developed uterus with the communicating cervix. The other fetus of approximately same gestational age with a separate placenta was localized in a globular mass adjoining the normally placed uterus.

With the diagnosis of extrauterine pregnancy in mind, patient was kept under strict observation, while the operation theatre was being made ready for the emergency laparotomy. The patient suddenly went into shock. Laparotomy revealed a fetus lying in the peritoneal cavity on a pool of blood with the placenta still attached to the ruptured gravid non-communicating rudimentary horn. There was a rent on the infero-lateral surface. The partial resection of this gravid horn was done, along with the tubal ligation of the other side. Pregnancy in the normal uterus was allowed to continue as per the patient's request. She made a remarkable recovery, and her pregnancy continued till term. During these next six months till here delivery, she was given complete bed rest under strict monitoring. She subsequently had a full term normal delivery of a healthy live female baby. Pueperium was uneventful.

COMMENT

The normal continuation of intrauterine pregnancy following the state of shock from a co-existing ruptured tubal pregnancy (Heterotopic pregnancy) have been reported even though many of such intrauterine pregnancies abort.

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PLACENTAL SITE TROPHOBLASTIC TUMOUR (PSEUDOTROPHOBLASTIC TUMOUR) A DIAGNOSTIC, THERAPEUTIC AND PROGNOSTIC DILEMMA

R. Tripathi • R. P. Mathur • V. Zutshi
K. Ganesh

INTRODUCTION

Trophoblastic disease has a variety of clinical presentations and pathological features, both of which are ultimately important in determining biological activity and consequently, prognosis. Most features of Gestational Trophoblastic Disease (GTD) have been well documented but occasionally one is faced with a not so well defined situation which creates a dilemma for the treating physician. One such case is that of the relatively new entrant in the spectrum of Trophoblastic disease - the Placental Site Trophoblastic Tumour (PSTT). We present below one such case and review the current status of the management protocol.

CASE REPORT

A 27 year old multipara, M., was admitted to the Gynaecology department of Lok Nayak Jai Prakash Narain Hospital of Maulana Azad Medical College for profuse vaginal bleeding occuring two months after a spontaneous abortion, no records for which were available. Vaginal examination revealed a normal uterus with bilateral ovarian cysts. A provisional diagnosis of Hydatidiform mole was made. A chest skiagram was normal and pregnancy test in urine was positive in 1 : 200 dilution. A currettage was performed and as the histopathology report confirmed the clinical diagnosis the patient was discharged with advice for regular follow up. After one month the patient was readmitted with a history of moderate vaginal bleeding for 15 days. Examination revealed an enlarged uterus corresponding to eight weeks pregnancy and ovarian cysts of the same size as at prior admission. A repeat chest skiagram was again normal and pregnancy test was positive in the same dilution as earlier. A repeat curettage specimen revealed only secretory endometrium with no trophoblastic or atypical cells. At this time the patient was given three courses of methotrexate prophylactically after which both ovarian and uterine size returned to normal. She was again discharged with advice for regular follow-up. She was found to be clinically normal for six months after the second curettage when she opted to undergo a laparoscopic sterilisation because she was repeatedly warned against another pregnancy. A routine laparoscopic sterilisation was performed and no pelvic abnormalities were detected at that time. She remained asymptomatic for twenty months following the sterilisation. About two years from the time of initial presentation to the hospital, she presented with abdominal

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distention. Her menstrual pattern had remained normal in the intervening period. Clinically she was found to have moderate ascites with a ten week size uterine enlargement. Ultrasonography revealed an enlarged uterus with an area of hypoechogenicity of 10 x 25 mm size in the region of the fundus. No evidence of any other intra-abdominal pathology was detectable. Ascitic tap showed evidence of a transudate with degenerating mesothelial cells. A chest skiagram was still normal; serum beta - HCG was 8 mU/Ltr. and endometrial aspiration revealed the presence of secretory endometrium with blood clots and inflammatory exudate only and no trophoblastic cells could be identified. In view of her past history, her low socio-economic and literacy status it was decided to perform hysterectomy. Except for the presence of about 2.5 ltrs. of straw coloured ascitic fluid no other intra abdominal pathology was detected apart from the ten week size uterus. A routine hysterectomy was performed. The uterus measured 10 x 6 x 2 cms with a spherical growth four cms in diameter at the fundus, the cut surface of which was greyish white with areas of haemorrhage. On microscopic examination marked proliferation of intermediate trophoblastic cells was seen. The mitotic count was five per ten randumly selected high power fields. A few gaint cells, small areas of necrosis and abundant fibrinous myometrial invasion (1.5 cm) but no serosal involvement. In one focus, invasion of the vascular wall was seen but no invasion of the lumen could be identified. Dense lymphocytic infiltrate was present in several foci. No chorionic villi could be identified.

The patient had an uneventful postoperative period. No serum beta-HCG could be detected in a sample taken three months after the surgery. The patient has done well for four years after hysterectomy.

The authors wish to highlight this case because it is felt that an awareness of PSTT as a distinct entity must be generated both amongst gynaecologists and pathologists. Moreover, on a retrospective analytical review of this case, including all previous admissions, the following questions came to mind and we thought it may be worth while to share our doubts and dilemmas in the hope that an eventual consensus of opinion may be able to be developed for the optimum management of this infrequently documented problem.

(1) Could the diagnosis of PSTT have been made earlier, either on clinical or pathological grounds ?

(2) Can PSTT be diagnosed on a currettage specimen or is a hysterectomy specimen necessary for diagnosis ?

(3) What, if any, ancillary diagnostic techniques can be used other than pathologic criteria ?

(4) Can the therapeutic options be conservative or is an aggressive approach essential in realising optimum results ?

(5) Is there any role of chemotherapy or radiotherapy as a primary therapeutic mode in the management of PSTT ?

(6) Is this a benign or malignant entity or is it a grey zone in between ? What is its biological behaviour and prognosis and on what grounds should it be predicted ?

ACUTE PYOGENIC PERITONITIS FOLLOWING CuT INSERTION

J. Mukherji • J. R. Chowdhury

Mrs. A.K., 20 yrs., Hindu Female (P_{2+0}) with LCB 10 months and 2 living issues was admitted on 29.4.94 with acute pain in abdomen, high fever and vomiting for 3 days. She was referred by a State General Hospital where she was admitted the day before. She gave a H/O. CuT insertion on 26.4.94 by a P.H.N. following cessation of her 1st period after childbirth. (LMP - 22.4.94). She was well for 1 day but started having lower abdominal pain from next morning; She attended the State General Hospital on 28.4.94, after her pain had increased along with Fever and vomiting. Her CuT was promptly removed (28.4.94) and she was hospitalised. On increase of her symptoms next day, she was referred to our Institution. Her past obstetric history revealed two uneventful home deliveries and she gave no history to suggest past pelvic infection. Her husband too denied having any evidence of sexually transmitted disease.

On admission, her pulse was 150/m, BP - 120/90 mmg Hg, Temp. - 99°F. Her abdomen was rigid, distended and tender with no peristaltic sound and marked rebound tenderness. Pelvic findings were inconclusive due to acute tenderness. Proof puncture revealed frank pus from all abdominal quadrants. She was put on drip, suction, antibiotics and after surgical opinion a laparotomy was carried out on 30.4.94. On opening the abdomen, peritoneal cavity was seen full of Pus. About 1900 ml of pus was collected in the sucker jar. Small gut, looked congested and so were the tubes and ovaries. No injury obvious on the uterine wall; whole of the abdomen was explored by extending the incision upto the epigastrium. Liver, stomach, omentum, whole of gut including appendix were explored without any positive findings. Peritoneal lavage was done and abdomen was closed with 2 drains. She was given 2 bottles of blood. Suction tube and drains were removed on 3rd postoperative day, when her abdominal peristalsis returned to normal and soakage ceased. Stitches were removed on 8th day, Patient was discharged on 10th day.

Acute pelvic inflammatory disease is commonest immediately after insertion of Intrauterine Device. But generalised peritonitis with accumulation of about 2 litres of frank pus within 3 days of IUCD insertion must be rare.

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KRUKENBERG'S TUMOUR IN a 19 YEAR OLD PATIENT

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Miss M.A, a 19 years old female,

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came to the hospital with distention of the abdomen and symptoms of feeling of fullness in abdomen and dyspepsia for 6 months. On examination a mass was felt in the abdomen which on laparotomy revealed itself to be bilateral ovarian tumour masses. The ovaries were replaced by bossulated tumour masses measuring 20 x 10 x 10 cms on the right side and 10 x 10 x 18 cms on the left side. There were multiple peritoneal seedlings also seen. No obvious primary tumour was found in the stomach, colon or other sites, but subsequently the primary was seen to be an occult carcinoma of the stomach.

On histopathology, the gross examination revealed that the ovaries were replaced by bossulated tumour masses having a greyish white homogenous appearance and were soft to firm in consistency. Cut section was greyish white in appearance with mucinous areas at places. Microscopically, the typical appearance of adenocarcinoma with signet ring cells in a loose fibrous Stroma were observed (fig. 1)

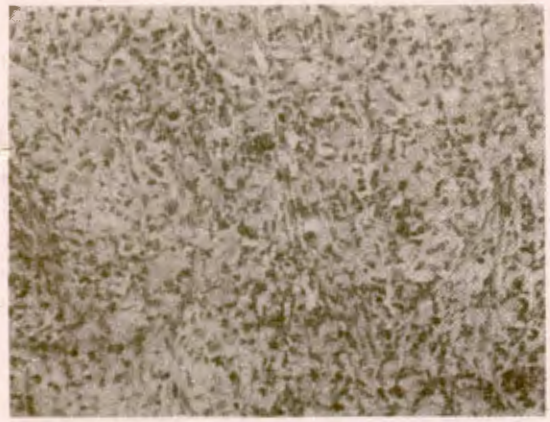

Fig. 1 : Microphotograph of Krukenberg's tumour, high power to show the signet ring cells. (H&E, x 400).

After initial improvement patient's condition steadily declined and she died after 11 months due to the malignancy of the tumour.

EXTRAMAMMARY PAGET'S DISEASE OF THE VULVA

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V. R. Janaki • Patrick Yesudian

CASE REPORT

A 72-year-old lady presented with complaints of an itchy, slow growing, reddish plaque on the vulva of 10 years duration. The plaque had initially started on the right side of the vulva as an erythematous patch and slowly extended to involve the right thigh and parianal region.

On examination there was a large erythematous well defined atrophic plaque with hyperpigmented borders involving the right labia majora, labia minora and extending on to the right inguinal region and perinal region (Fig. 1). The vaginal introitus was narrowed.

Per rectal and sigmoidoscopic examinations did not reveal any lesions in the anal canal.

Skin biopsy was done from the plaque which showed clusters of large rounded cells in the epidermis compressing the basal cells (Fig. 2) Dermis was silent.

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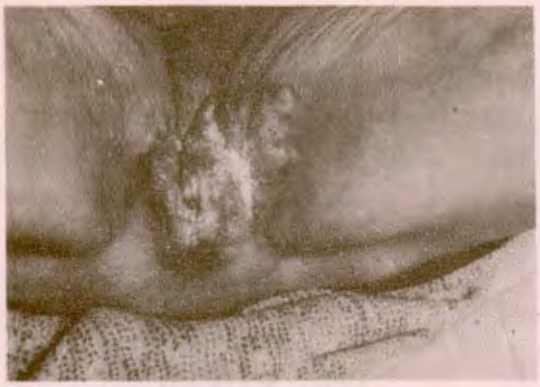

Fig. 1 : Atrophic plaque involving the vulva and the right thigh.

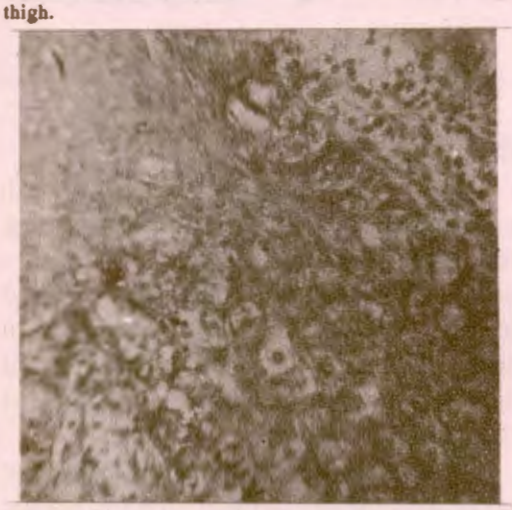

Fig. 2 : Photomicrograph showing paget's cells in the epidermis.

Differential diagnoses like Pagets disease, Bowen's disease were thought. The large rounded cells showed PAS positive material inside the cytoplasm. So it was diagnosed as extramammary Paget's disease.

Wide excision and skin grafting was done by the plastic surgeons. This case is reported for its rarity.

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DE NOVO T (X; 12) IN A WOMAN WITH PREMATURE OVARIAN FAILURE

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SRIDEVI HEGDE ● THOMAS I. M.

SUMMARY

Proband, 24 year old woman with secondary amenorrhoea, gonadal dysgenesis and infertility was referred for cytogenetic investigations. She was of normal build and her secondary sexual characters were normal. Her menarche was at 14th year. Her menses were irregualr and became regular with cyclical hormones.

During her married life of 2 years, she had been treated for ovulation & pregnancy. Husband's semen analysis was normal. Her karyotype was 46, X, 5(X;12) (q24; q24). The karyotypes of her husband and parents were normal. The infertility in the proband may be due to the breakpoint in X, in the critical region for ovarian maintenance.

We report for the first, time, from India, the clinical & the cytogenetic data, a 23 year old woman, with premature ovarian failure & a denovot (X;12) (X-autosome translocation) has been reported. This finding is in conformity with the other findings in literature ie in females, with breakpoint in x between brands Xq13 - Xq26 may exhibit gonadal

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failure.

CASE HISTORY

The proband, a case of secondary amenorrhea, premature ovarian failure and infertility was referred, to our lab for cytogenetic investigations. She, the first child, to non-consanguinous parents, was born in 1970. On physical examination, her height was 160 cms and she weighed 50 kg. Her secondary sexual characters were normal. Turner stigmata were not apparent. She attained menarche at 14 years. This was spontaneous and this lasted for 5 days. Thereafter her cycles were irregular and have occurred at every 4-6 months interval. From her 18th to 22nd year, with hormones, she had regular menstrual cycles. i.e. once in 28 days. She got married at 22nd year. Once again, her cycles became irregular & she had to take cyclic oestrogen & progesterone therapy. There was no history of similar cases in her family.

INVESTIGATIONS

(i) Laparoscopy showed normal uterus and bilaterally normal and patent uterine tubes. Chromotubation also confirmed the patency. But ovaries were small in size. (ii) Ovarian biopsy revealed only fibrous tissue, no ovarian tissue and she was diagnosed as having gonadal dysgenesis. (iii) Endocrine evaluations are post menopausal FSH - 152 IU/L, LH 35.86 IU/L; Prolactin - 2 ng/ml; progesterone 0.22 ng/ml. Semen analysis of the husband showed a sperm count of 67 million/ml.

Cytogenetic investigations were done on the proband, her husband and her parents. It included : peripheral lymphocyte culture method; banding techniques (GTG) and X-inactivation study. Clinical photographs and dermatoglyphics were also done.

CYTOGENETIC FINDINGS

GTG banded chromosome preparations shows t (X;12) in the proband. She had apparently balanced reciprocal translocation between the long arms of X and 12, with breakpoints at q24 in both chromosomes. Her karyotype is 46, X, t(X;12) (q24; q24) (Figure 1). The karyotype of her husband (46,XY) and her parents are

Fig. 1 : GTG - Partial Karyotype 46, X, t (X, 12) (q24; q24).

normal. Hence, the translocation is de novo. X replication study revealed that the proband's normal X replicated late. The dermatoglyphic features were : Rt : Thumbo and index figures = whorl and the rest ulnar loop; Lt: Thumb whorl and the rest ulnar loop. Wide 'atd' angle; distally placed axial triradii and ulnar loop in the hypothenar areas were observed in both the palms. Loop patterns were seen in the I_3 (Rt) and I_4 (Lt) interdigital areas in the palms.

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CARCINOMA OF THE FALLOPIAN TUBE

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MAITREYAN V. ● RAJKUMAR T.

INTRODUCTION

Mrs VP, 67 years old female was admitted with complaints of watery discharge per-vaginum of about 10 weeks duration. The discharge was foul smelling, unassociated with blood or pain. There was no history of constitutional symptoms, cough, abdominal swelling, hemoptysis, fever, drug intake or any neurological disturbances. She sought some medical consul and was referred here. Her past medical history wasuneventful. She attained menopause 18 years ago, and her age at menarche was 14 years. She has 5 full term normal deliveries and last child birth was 29 years back. There were no abortions.

Clinical examination revealed her to be in Performance status I (ECOG), having mild anemia with clinical examination of chest cardiovascular system, Breasts and Central nervous system normal. Her abdominal examination revealed a vague resistance palpable in the right iliac fossa. P/V examination showed congested cervix, healthy vagina, with Uterus in mid-position having restricted mobidity, 6 weeks in size and irregularly enlarged. A doubtful mass was palpable in right adnexal region. Investigations done revealed Hemoglobin 10 g%. Total leucocyte count 700/m³. Differential Lecocyte count having polys 49%, Lymphos 50% Eosioos 1% and platelet count 250,000/m³. Her Erythrocyte sedimentation rate was 45 mm/H (West). Biochemistry, Urine examiantion, Chest x ray and electrocardiogram were normal. Ultra-sonography of abdomen done showed Uterus of normal echotexture but bigger for Post-menopausal are measuring 7 cms in length. A cystic mass partially solid in texture seen on right side of the Uterus measuring 4 x 5 cms. Small cystic masses were seen in the left adnexal region and an ultra-sonographic impression of bilateral adnexal tumor was made. She was operated and per-operative details revealed no ascites, both ovaries were identified, atrophic, and did not contain cancer. There was a mass in the region of right tube haivng papillary processes on the surface with involvement of capsule and the left tube ended in a bulbous mass. Liver was normal. Subdiaphragmatic peritoneum was normal. Panhystrectomy with bi-lateral salphingo-oopherectomy was done along with omentectomy and appendectomy.

Histo-pathologically gross examination revealed a right tubo-ovarian mass measuring 6 x 4 x 3 cms with Uterus and cervix measuring 5.3 x 6.5 cms. Endometrium, myometrium, parametrium, serosa and cervix appeared normal. A part of left otube 2.5 cms was seen attached to Uterus. There was 9 x 5 x 5 cms omental tissue, without any nodules. Microscopy showed endometrium, myometrium showing proliferative phase and without any

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tumor. Parametrium was normal and endocervix revealed chronic cervicitis and no tumor. Left and right parametrial edges were normal. Left tube revealed chronic inflammation and no tumor was seen. Both the ovaries were identified, atrophic and no tumor was seen Bits of right adnexal masss revealed features of moderately differentiated Adenocarcinoma grade II nuclear grade II. Examination of the omentum showed minimal adipose tissue, with no tumor. Appendix and anterior and posterior ectovesical edges were tumor free. With these observations and investigations, patients was diagnosed to have moderately differentiated Adenocarcinoma of right Fallopain tube Nuclear grade II, grade II. Stage IA and was planned for pelvic radiation therapy.

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A RARE CASE OF EMBRYONAL RHABDOMYOSARCOMA IN ADULT

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MATHUR S. K. ● KALRA K.

Sarcomas of the vagina are extremely rare. Pure rhabdomyosarcomas of the female genital tract generally occur during infancy or childhood. Here is presented a rare case of embryonal rhbdomyosarcoma in an adult female which presented as a vaginal growth probably a recurrence from retroperitoneal soft tissue sarcoma.

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CASE REPORT

A 29 years old married female reported to the department of obstetrics and gynaecology, Medical College and Hospital, Rohtak in January 1994 with the complaint of foulsmelling discharge per vaginum for the last 5 months. Patients has had her total abdominal hysterectomy done in some private nursing home of Gaziabad because of metromenorrhagia and the histopathology revealed extensive adenomyosis. 3 years later, she was admitted to the surgical ward in August 1990 with the complaints of swelling and pain right leg along with low grade fever off and on for the last 2 months, and a lump in the abdomen and vaginal discharge for one week. On P/A examination an illdefined fixed, somewhat tender, fixed, firm to hard mass was felt in the suprapubic region reaching almost upto the umbilicus. On P/V examination same mass was felt arising from the lateral pelvic wall about 4 cm above the introitus and more so on the right side and the mass was multinodular. Same mass could be felt projecting into the rectum on P/R examination but the overlying mucosa was free. A probable diagnosis of retroperitoneal tumour with deep vein thrombosis was made and the patient was put on antibiotics, anti-inflammatory drugs and heparin and was investigated further. USG showed a hypoechoic mass posterior to the urinary bladder with right kidney

showing grade III hydronephrosis. FNAC was done which was inconclusive. Mean while the tumour size increased and the patient developed difficulty in passing urine. She was then operated upon for B/L obstructive nephropathy. Left sided, nephrostomy was done on 29.9.90 along with biopsy from the inoperable retroperitoneal mass followed by right sided nephrostomy on 7.10.90. The histopathology of the tumour biopsy revealed soft tissue sarcoma (Fig. 1) and the patient was given palliative radiotherapy for 5 days and then

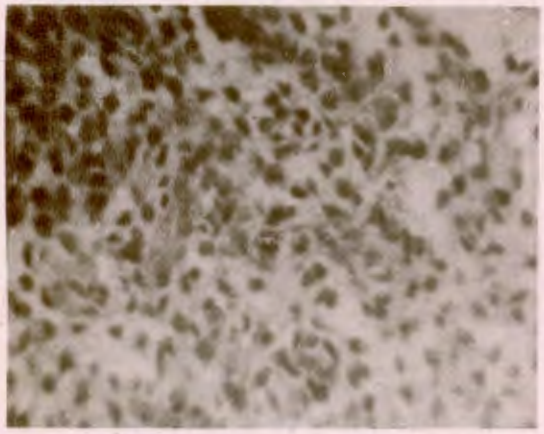

Fig. 1

sent home. Patient remained symptom free for 3 years and then she started having four smelling discharge per vaginum and on 11.1.94 in the midnight the developed pressure sensation in the perineum and saw something coming out of vagina. She was admitted to the gynaecological ward on 27.194 and on E.U.A. done on 28.1.94, the findings were : P/S a hecrotic growth seen in the vagina (Fig. 2), P/V a necrotic friable growth about 10 x 7 cm felt arising from the vault almost filling the whle of vagina. Half of the growth could be taken

Fig. 2

out and sent for histopathological examination.

H.P.E. Vaginal growth showed histological features compatible with embryonal rhabdomyosarcoma (Fig. 3)

Fig. 3

USG lower abdomen done on 7.2.94 revealed a large hypoechoic mass with irregular margins, of the size of 12 x 7 cm seen posterior to urinary bladder. Presence of this mass supports the diagnosis of recurrence of the same soft tissue sarcoma which now presented as a secondary in the vagina.

AN UNUSUALLY LARGE LEIOMYOMA WITH EXTENSIVE HYALINIZATION

USHA MANAKTALA • VINITA • P. CHADHA

Mrs B, 45 years, house wife, para 5, was admitted to Gynecology ward of LNJPN Hospital, New Delhi with C/o progressive enlargement of abdomen with loss of weight for 2 years and difficulty in walking and breathing for 6 months. She was referred from Moradabad as a case of Hydramnios. Her Menstrual cycle was normal, 3-4/30 days.

Patient was anaemic, emaciated of 5 '1" height and 62 kg weight. She could walk with great difficulty and was unable to lie supine due to massive abdominal enlargement. Abdominal examination revealed uniform huge enlargement, which was due to a cystic mass arising from pelvis and was extending up to xiphisternum. On vaginal examination, the cervix was pushed up, uterus could not be made out separate from an irregular non tender cystic mass filling whole of the pelvis and abdomen. A provisional diagnosis of malignant ovarian tumour was made.

Apart from a low (10 gm%) Hb, routine investigations were within normal limits. X-ray chest showed both domes of diaphragm elevated with obliteration of CP angles. USG abdomen revealed normal liver, spleen, Kidneys and left ovary, right ovary could not be visualised. A huge multiloculated cystic mass was seen arising from the pelvis, filling whole of the abdomen. Free fluid was present. Ascitic fluid cytology showed no malignant cells. FNAC of the mass revealed mesenchymal tissue ? fibroid.

On laparotomy, the abdomen was filled with a huge thick walled, cystic mass arising from pelvis. Left ovary and tube were seen stretched on it, while the right ovary could not be identified. The uterus could not be demarcated. The mass was lifted out of abdomen with great difficulty by the help of two assistants because of its shear weight and size. Extensive adhesions with gut and ureters on both sides was another technical hindrance for its removal. Lower pole of the mass was solid and cervix was attached to it. Free fluid was present in abdominal cavity.

On gross examination, it was a thick walled lobulated irregular tumour of 20" x 26", weighing 22 kg, filled with mucinous fluid. Both ovaries were seen attached to its surface. A solid area was present in lower part which appeared to be the uterus.

On HPE the uterus showed proliferative endometrium with a large Leiomyoma of the uterus showing extensive hyalinization and cystic (mucinous) degeneration. No evidence of malignancy seen. Both tubes and ovaries were normal, cervix showed chronic cervicitis.

COMMENTS

This case is reported because of the extraordinary large size (22 kg) of tumor

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and the diagnostic dilemma. It is rare for whole of the leiomyoma to show hyaline degeneration. Its cystic nature posed a problem in clinical diagnosis. Great difficulty was experienced to hold and lift the tumour out of the abdominal cavity during surgery. Despite technical difficulties, the patient remained stable in itnra as well as post-operative period and left the hospital in good condition.