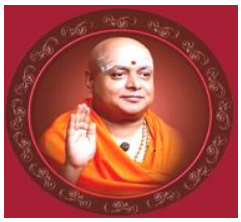
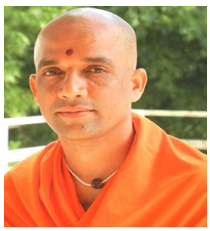




JANANI- MOTHER IS LIVING GOD

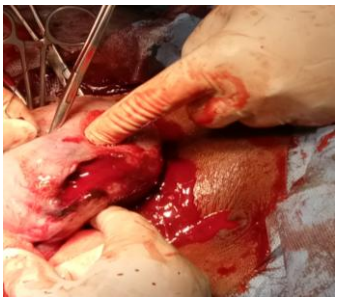
Volume- 7 **Issue-2/2017**

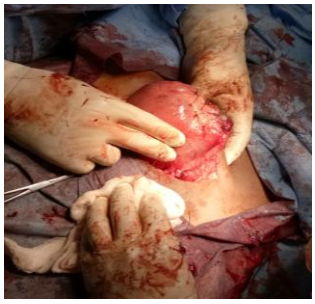
Newsletter -Department Of OBG

FUNDAL RUPTURE DURING PREGNANCY ON SCARRED UTERUS : A CASE REPORT

INTRODUCTION:Uterine rupture although rare is a serious obstetric catastrophe especially in developing countries with grave sequelae to both the mother and the fetus.It refers to complete disruption of all uterine layers including the serosa. The postulated risk factors include previous caesarean section or other uterine scars, uterine anomalies, grand multiparity, injudicious use of oxytocin, fetal anomalies, obstructed labour and rarely intrauterine manipulations like instrumental evacuation.The immediate complications include bladder rupture, hemodynamic instability, shock, peripartum hysterectomy and maternal and fetal mortality. In most cases which occur in the hospital, timely laparotomy results in safe delivery of the baby and repair of the uterus. We hereby report a case of uterine rupture in a patient with a previous history of uterine fundal rupture.

CASE REPORT:A patient aged 24 yrs, G3P1L0A1 with history of instrumental evacuation in first pregnancy, followed by spontaneous uterine fundal rupture in the subsequent pregnancy at 7th month with a dead fetus.In this pregnancy she was admitted at 31weeks POG and was monitored closely. Patient was taken for elective caesarean section at 37weeks & delivered a single live term female baby of 2.6 kg.A fundal rupture at previous scar rupture site was noted and rent was sutured.





DISCUSSION: Uterine rupture is a major obstetric complication occurring without warning. it should be kept in mind especially in the presence of predisposing risk factors mentioned earlier.Clinical presentation of uterine rupture cases can be extremely variable.The commonest presentations among patients with scarred uterus were found to be abnormal cardiotocogram findings with variable or late decelerations, blood stained liquor, acute abdomen pain and shock. -Our patient had none of the above clinical features. In such cases high level of suspicion for uterine rupture should be maintained in light of the patient past history.

CONCLUSION : Uterine rupture constitutes a major risk factor for fetomaternal morbidity and mortality. Previous history of rupture is a potential case for repeat rupture at the same site. The key steps for successful management of uterine rupture include prompt diagnosis followed by definitive surgical management with concurrent maternal hemodynamic stabilisation[3]

HOLOPROSENCEPHALY : A RARE CASE REPORT

INTRODUCTION :

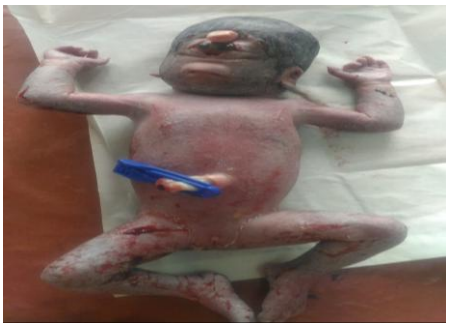
Holoprosencephaly is the most frequent malformation of the prosencephalon which represents the absence or incomplete division of the prosencephalon during the 4th and 8th week of gestation. Its incidence is estimated to be 1 in 16000 live births and 1 in 250 spontaneous abortions .

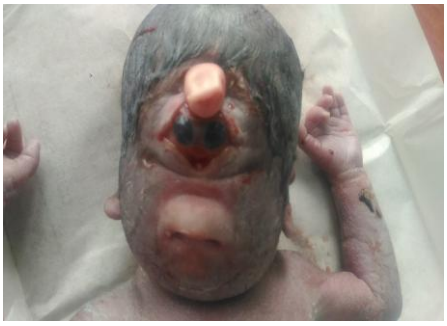
It is classified in 3 types, according to the degree of cerebral involvement: alobar , semilobar , lobar. The clinical features vary very much, depending on the severity of holoprosencephaly.

CASE REPORT:

A 34 year old G2P1L1 with a 12 year old Male child born by LSCS had come to our OPD at 5 months of amenorrhoea for regular antenatal check up. She had no risk factors and had taken folic acid supplements regularly. Anomaly scan done outside showed microcephaly , scan was repeated which showed - monoventricle, single orbit, absent cavum septum pellucidum , 3rd ventricle, corpus callosum , proboscis , polyhydramnious -f**eatures suggestive of alobar prosencephaly**.

Decision was taken for termination of pregnancy and the patient underwent preterm vaginal birth after caesarean at 26 weeks period of gestation delivering a female child of 1.1 kg with proboscis , cyclopia.





DISCUSSION:

Alobar Prosencephaly means the complete absence of division of the prosencephalon structures. It is the most severe form. The etiology of HPE includes genetic and environmental factors. Among the environmental causes there are: maternal diabetes mellitus, maternal alcoholism, in utero infections with CMV, rubella or toxoplasma, some drugs (retinoic acid, cholesterol synthesis inhibitors).It can be transmitted in an autosomal dominant way. Also, it is associated in 40% of cases with numerical chromosomal anomalies, the most frequent one being trisomy 13. The clinical features vary very much, depending on the severity of holoprosencephaly. Cyclopia, proboscis and cheilo/palatoschisis are associated with severe forms of Holoprosencephaly.

Prenatal diagnosis of this includes:1. Ultrasonography, The diagnosis could be made in most cases of alobar and semilobar holoprosencephaly after 17 weeks of gestation, when the production of cerebrospinal fluid starts. 2.Fetal MRI , 3.Cytogenetic analysis. 4.Molecular analysis of fetal DNA. P**r**ognosis is dependent upon the degree of fusion and malformation of the brain, as well as other health complications that may be present. Alobar and semilobar forms are lethal. Children born with lobar HPE can survive for years, but encounter a lot of neurologic manifestations and severe mental retardation

CONCLUSION:

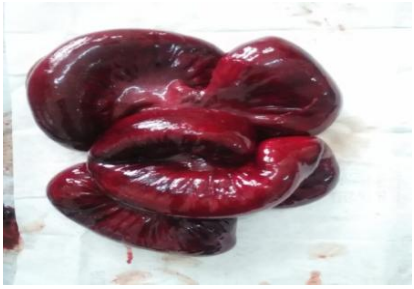
Sonography is most helpful in the prenatal diagnosis of holoprosencephaly especially of alobar type and is the decisive modality for the management and follow-up of such cases, so that the mother can opt for termination of pregnancy and the doctor can decide for a

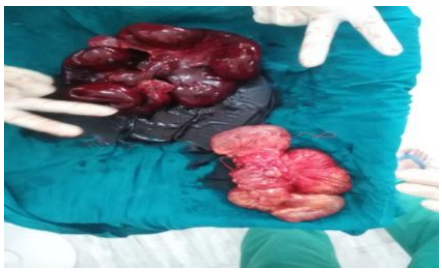
vaginal delivery rather than caesarean section. In this case the diagnosis was established before preterm birth, but too late for offering the parents the possibility to decide the opportunity of feticide.

HEMOPERITONEUM IN YOUNG FEMALE AND DIAGNOSTIC DILEMMA – A CASE REPORT

BACKGROUND : Spontaneous hemoperitoneum is defined as the presence of intra-abdominal haemorrhage from a non traumatic cause. It usually presents as acute abdomen with shock. Hence, it is pertinent to include spontaneous hemoperitoneum in the differential diagnosis of acute abdomen. Our aim is to discuss and review the literature on the diverse etiology associated with spontaneous hemoperitoneum that presents as acute abdomen. Hemoperitoneum may occur in various emergency conditions. It can be traumatic – liver or spleen injuries, non traumatic – complication of surgery, anticoagulation therapy, blood dyscrasias, tumors - hepatocellular carcinoma or vascular metastatic disease. Gynaecological causes include rupture or hemorrhage of ovarian cyst, ruptured gestational sac of ectopic pregnancy, hepatic hepatoma in HELLP syndrome, systemic vascular diseases.

CASE REPORT : A 20 year old P1L1A1 came to the casualty with complaints of acute onset of lower abdominal pain with vomiting since morning. On examination, she was pale, vitals were stable. On abdominal examination – diffuse abdominal tenderness with guarding present, bowel sounds were present. On bimanual examination – right forniceal tenderness present. Investigations – UPT – negative, beta HCG – 1.93 microIU/ml. Ultrasound showed – moderate hemoperitoneum with edematous bowel loops with left ovarian cyst of size 3*4 cm. She was taken up for emergency laparotomy on the same day in view of significant guarding , rigidity and hemoperitoneum. On laparotomy – hemoperitoneum of 800ml of altered blood was drained. Pelvic structures were normal. Gangrenous bowel of 60cm was identified and resected. The gangrene was due to volvulus with constricting bowel at the root of mesentery. Peritoneal drain was placed in pouch of douglas. Total drain output was 350ml. Drain was removed on post operative day 8. Post operative period was uneventful.





DISCUSSION : In general, intraperitoneal or retroperitoneal hemorrhage may be secondary to blunt trauma, aneurysmal rupture , solid organ malignancy , or inflammatory erosive processes ; however, it may be idiopathic as well. The various causes of spontaneous hemoperitoneum are classified into following based on source of bleeding: **Gynecological** -Rupture of ovarian cyst, Rupture of ectopic pregnancy, Retrograde menstruation – physiological, Endometriotic cyst rupture Metastatic disease like gestational trophoblastic tumour, Pregnancy/Post partum spontaneous hemorrhage -rupture of uterine vessel, Hemorrhagic corpus luteum cyst/torsion, HELLP syndrome, Uterine perforation.

Hepatic, **Splenic, Renal, Adrenal**, **Gastrointestinal, Vascular & Arterial**, **Anticoagulation**, **Idiopathic**

CONCLUSION: Spontaneous hemoperitoneum SHOULD BE considered in the differential diagnosis of patients who have acute abdomen with falling hematocrit and with signs and symptoms of hypovolemia with associated positive history of a predisposing condition to avoid a dangerous diagnostic delay and culmination into a catastrophe. The source of bleeding may remain elusive even after careful autopsy dissection given the absence of intravascular pressure. Definitive treatment is laparotomy. There is no specific clinical symptoms, signs, radiological findings, early surgery is the key for successful management of small bowel obstruction. Imaging is essential in nontraumatic hemoperitoneum in that it establishes the diagnosis of hemoperitoneum and helps identify its primary etiology. ultrasound may be considered if the patient is too unstable to be transferred to the CT room.CT is however superior as it can point to a specific organ as the source of bleeding, detect active hemorrhage (extravascular and intravascular).

DEPARTMENT NEWS

- Dr. Divya Alamelu secured 7th Rank in RGUHS MS examination conducted in the year 2017

all other postgraduates passing out with flying colours giving our department a 100% result.

CONFERENCES AND CME:

KSOGA 2017 was held in Shivamogga in November 2017
Paper and Poster Presentations were made by Postgraduates

1. Fundal rupture during pregnancy on scarred uterus – By Dr Bharathi Peta
2. One anomaly look for another- An interesting case series of urogenital anomalies –By Dr Nikitha Jain
3. Cutaneous Manifestations in pregnancy- By Dr Parvathi Chokkam

AICOG 2018 was held in Bhubhaneshwar in January 2018
The following papers and posters were presented by postgraduates

1. Study of Mifepristone and Misoprostol Vs Misoprostol alone in midtrimester termination of pregnancy in tertiary care hospital- By Dr Vyshali.R
2. Abortus in periphery missed at periphery – By Dr Manjula.S.Padmaraj.
3. Cutaneous Manifestations in Pregnancy – By Dr Bharathi Peta
4.

Felicitation of Dr Vimala

Department of OBG – Welcome gathering for Freshers