CASE-MANAGEMENT DESCRIPTION IN OBSTETRICS AND GYNAECOLOGY FOR MGO

FACULTY OF MEDICINE
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By

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DEDICATED TO

My

Family
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This book is presented for the master degree in obstetric and gynaecology (MGO), Faculty of Medicine, University of Khartoum. It includes a description of case management and short commentaries, on obstetric and gynaecological problems. It also includes long commentary on successful trial of scar at Omdurman Maternity Hospital during the two years 1989 and 1990, and a long commentary on review study of bacteriological findings of patients presenting with vaginal discharge at Soba University Hospital during the two year 1990 and 1991.

The MGO is a well-established degree. Recently part one of the examination has been recognized by the Royal College of Obstetricians and Gynaecologists, UK. It is considered equivalent to part one MRCOG from 1987 and onwards.

During my training I worked as a registrar. My responsibilities included:-

1. Management of patients in referred, antenatal, family planning and gynaecological clinics.

2. Management of the inpatients by careful examination and relevant investigations to establish the diagnosis, then drawing the plan of their management and carrying out their treatment including operative measures, if needed, with the help and supervision of my consultants.
3. Management and follow up of patient in labour and responding activity to the problem that may arise at any time in the intrapartum and immediate postpartum periods.

4. Training of Junior staff, including house-officers, medical-officers, midwiferies students, and other paramedical staff.

5. Covering of emergency cases during the night duties.

Obstetrical Cases:

When first seen, careful history is taken. Obstetrical history includes:

a. Social history
b. Gravity and parity and number of abortion
c. Details about each parity and abortion
d. History of the current pregnancy
e. History of antenatal care clinic attendance
f. Past history, family history and drug history

Gynaecological History Includes:

a) The age at which she had her first cycle menarche.
b) Description of her previous cycles her kath, reeregulating and amount of blood loss.

c) The first day of her last menstruation period is recorded (L.M.P) from which the expected date of delivery (E.D.D) is calculated by Nagele's rule. The gestational age in weeks at the time of presentation is determined.
d) The reliability of these calculate dates depends on the
patients memory, regulating of her cycles and whether she
was using contraception or not.

Careful examination of all systems is then done. Special
attention is payed to the blood pressure. Obstetric examination is
performed to determine the size of the uterus and its correspondance
to the dates in weeks, the lie of the baby, the presenting port and
its position. The foetal heart sounds are recorded as number of
beats per minute. Their regulating and intensity are commented on.
The foetal weight is estimated.

Routine investigation include:- Estimation of the haemoglobin,
examination of the urine and determination of the blood group and
the Rh and factor. The other investigations are performed
according to need. Radiological examinations are not done before
the 3rd trimester, and radioactive studies are contraindicated
throughout pregnancy.

Some Obsterical Procedures:-

1) Artificial Rupture of the Membranes (A.R.M.):

A.R.M. is performed for induction or acceleration of labour.
The patient is requested to empty her bladder. Then she is placed
in the dorsal or lithotomy position. Sterile dressing are used.
The *** is cleaned by an antiseptic solution and careful pelvic
examination is performed to exclude cord presentation. With the
fingers of the right hand in the lewix acting as a guide a sterile Kocher's forceps is introduced through lewix and the foreskins are swytured. The liquor is drained slowly. The amount and colour of the liquor is noted. The station and position of the presenting part are recorded. Cord prolapse is excluded. The fetal heart rate, its intensity and regularity are checked immediately after the procedure since fetal distress may be of its complications.

Episiotomy:

* Advantages: It prevents perineal tears and painful stretch chiefly which may later lead to prolapse, protect the fetal head from compression and decompression and it shorten the second stage of labour.

* Complications: Include bleeding, sepsis, paravaginal haematoma, damage to the bartholins gland and forming write scar tissue leading to dyspareunia and a rigid perineum.

* Indications: The absolute indications are: prematurity, fetal distress, breach delivery, face to pubis delivery, previous colpoperineostomy and in forceps delivery. These are other relative indications there are: Narrow ushpublic angle, splitting of a tough perineal skin, face presentation and when the presenting part is in the premeas for more than half an hour.
* Technique: The patient is placed in the lithotomy position under correlative aseptic conditions. The anaesthesia used is local infiltration by 0.2% xylocaine. It is performed at the point of perineal stanching. It is started at the midline and confined laterally avoiding the oral sphincter (right medio-lateral spadectomy).

* Repair is carried out under a good light source. The local anaesthesia may need to be boosted of the vaginal wall is using during continuous locking chronic catgut not starting at the apex of the spadectomy resuming haemorrhoids. The perineum is closed by interrupted stitches so as to obliterate dead space. The skin is appoximated by interrupted catgut stitches.

Sewerage Section:

Is described in obstetric case no 7.

Special gynaecological examinations:

Pelvic Examination:

Pelvic examination is performed only when indicated. Its purpose is explained to the patient. In our country, it is not done for virgin patients in whom we do rectal examination instead. A chaperon is usually present (e.g. a nurse). The technique is as follows:
1. Inspection looking for: the vulval circumcision, the type of circumcision, presence of apparent bleeding or vaginal discharge, presence of tumors and their gross appearance, presence of lacerations or ulcers. Inspection of the vagina and cervix is their is done by speculum examination. Two types of speculae are used; Sims's and the Kivlehe speulum. The position of the patient is either left lateral or dorsal. The vagina is inspected for discharge, lacerations of tears or abnormal growth. The cervix is inspected for enlargement, erosion, conical and abnormal growth and polyps. A source of good light is essential.

2. Palpation: One finger is introduced first to avoid causing pain and disconfort. The other finger is then introduced if it is not difficult due to circumcision. The vagina is palpated all through for tumors, moisture, temperature and tenderness. The cervix is palpated next for consistancy, surface, length, shape and tenderness (especially on moving it).

The degree of dilatation of the OS in specific cases is commented on the uterine size is estimated by bimanual examination, its direction, consistancy, regularity is noted. Palpation of the adnexae and the neck of Douglas masses and tenderness is done. Finally the examining finger is observed for presence of contact bleeding or offensive discharge.
Per-rectum Examination:

Per-rectum examination is usually used venin circumcised young ladies, in children and in cases with a vaginal septum. It is the best approach for feeding the uterosacve ligaments, the puch of Douglas and the outer pot of the broad ligament. It is used to assess the extent of growth arising from the cervix. Combined rectovaginal examination is of value in lernain cases.

Pre-operative Preparation:

a) Psychological: The operation its benifits and its success rate are explained to the patient. Great attention is paid to the patient's inquiries and careful clear answers are given.

b) Good history: History of acute diseases especially chest infectious, past history of asthma, diabetes or hypertension, past history of surgical operations and uleteral difficulties were encouunted with anaesthesia, formaly history of diabetes or hypertension, history of allergy and hypersensitivity reaction.

c) Proper comprehensive clinical examination: All systems must be healthy, especially the respiratory and cardiovascular systems.

d) Routine investigations usually performed include:

1. Haemoglobin estimation.

2. Urine for sugar and acetone.


e) Special investigations sometimes requested including:
1. Blood sugar testing: In old patients, known diabetic potential diabetics and in patients showing glucosurea on routine investigation.

2. Blood Urea: electrolytes and serum, very ill and concreous patients as a laxine before major surgery.

3. E.C.G: in old patients and patients with cardiac problems.

4) I.V.U in huge abdominal masses, fistula and in patients with cervical fibroid or cancers. Abro in patients with congeital malformations of the genital tract.

5. Liver function test: In patients with past history of serious liver disease.

(I) Pre-natalisation:

1. Pre-operative visit and reassurance.

2. Diazepam 5-10 mg the night before the operation.

3. Atrophic o.b. mg and promethazine song given half an hour before the operation ulim the anaesthetist insuch otherwise.

Post-operative care:-

1. Position: Left crural position to avoid aspiration of vomitus in the early postoperative hours.

2. Observation of the vital signs and recording them on a time based chart. A Fluid Intake - Output is kept.

3. Removed of vaginal pack (if any) after 24 hours and observation of the vagina for bleeding.
4. Oral intake is as permitted as soon as the bowel movements start in abdominal surgery and as soon as the patient is fully conscious in vaginal surgery. Early mobilization is encouraged.

5. Prophylactic antibiotics, injectable for 48 hours then oral for 5 days are given.

6. Post-operative analgesia: Pethidine (100 mg) or morphine (10-15 mg) is given at the time of maximum postoperative pain. It may need to be repeated after 6 hours. Aspirin or paracetamol is prescribed for mild to moderate pain.

7. Routine checking of haemoglobin on the 3rd postoperative day.

8. Enema if needed on the 3rd postoperative day.

9. Removal of stitches on the 7th or 8th postoperative day.
Obstetric Case No. 1

Breach Presentation:

Assisted Breach Delivery, Forceps for the Drowning Head.

Name: A.A.M.
Residence: Wad Elhindi
Age: 27 years
Hospital no: -
Occupation: H.W.
Date of admission: 23/4/89
Date of Discharge: 25/4/89

Obstetric History:
She has married for one year.
Primigravida.

Menstrual History:
Menarche at the age of 14 years. Kata 5/30 she had regular
cycles with moderate blood loss slight dismenorrhea.
L.M.P., = 1.8.88.
E.D.D. = 8.5.89.
she had not used any contraceptive method.

Past History:
She was not known to be diabetic or hypertensive. There was no
past history of serious diseases or surgical operations.
Family History:
There was no family history of diabetes, hypertension, or multiple pregnancies.
Social and Drug History were of no significance.

History of Current Pregnancy:

The patient was a regular antenatal clinic attendant at a local health centre. The first visit was when she was three months pregnant. Her pregnancy proceeded normally without complications; at 35 weeks she was referred to the hospital antenatal clinic. Her general condition was found to be good. She was not pale or jaundiced. Her pulse was 80 per minute, regular and of normal volume; blood pressure was 120/80 mm. Cardiorenal, respiratory and central nervous systems were normal.

Breasts were active with colostrum; nipples were everted and free of cracks. Abdomen was distended; linea nigra was present with visible scars or distended veins. It was felt no areas of tenderness. Uterine size corresponded to dates. The longitudinal and the Breach presented in the left scapular position. The Breach was not engaged. The fetal heart sounds were heard above the umbilicus and were found to be regular and of normal intensity note. There was no lower limb oedema. Her haemoglobin was 78 per cent and her urine examination showed no abnormality. Tonics were prescribed and she was asked to present weekly to the antenatal clinic.
At 37 weeks, she the still had a breach presentation. The baby weight was estimated to be 2.5 to 3.0 kilograms. Clinical pelvic assessment was done the pelvis was clinically adequate. This was confirmed by an erect lateral x-ray pelvimetry which showed: normal pelvic bones, no deformities, well curved sacrum. Breach presentation, pelvic inlet measured 4.5 inches and outlet 4.7 inches.

Ultrasound examination was requested so as to locate the placenta and to exclude gross congenital malformations. It showed a single viable baby with breach presentation. Biparietal diameter was equivalent to a gestational age of 36 weeks ± 1 week; upper segment placenta, average amount of liquor and no gross malformations. The condition was explained to the patient, she was reassured and asked to continue on weekly follow-up. She was instructed to present to the hospital as soon as she felt abdominal pains because she was for hospital delivery.

Management of Labour:

Mrs A.A.M. was admitted to the labour on the 23rd of April 1990. She was complaining of labour pains and show 82 per minute, blood pressure was 100/70 mmHg. All systems were normal breasts examination revealed no abnormalities. Uterus size was equivalent to term, the lie was longitudinal with breach presentation in the left occipitolateral position. It was engaged. Fetal heart sounds were 144 per minute, regular and of good intensity. Amount of
liquor was arverge. Baby's size was estimated to be 2.8 kilograms ± 0.5 kilograms uterine contractions were felt. There was no lower limbs oedema or varicosities. Vaginal examination showed a circumcised vulva. The vagina was moist and warm, convex was centimetrines dilated. The presentation was frank breech at zero station and was well applied to; membranes were intaked.

Investigations:
- Haemoglobin was 78 percent.
- Urine examination was clear of abnormalities.
- Blood group was known to be A Rh -ve a sample of blood was taker for grouping and cross matching.

First stage:

Episiotomy was performed. Oral intake was restricted intravenous fluid were given to ensure adequate hydration. The patients was given pethidaine 100 mg and promethazine 50 mg. Intravenously for sedation and analgesia. A follow-up blood pressure, temperature, intensity of uterine contractions number of uterine contractions per 10 minutes, fetal heart sounds per minute, rate of cervical delation and the station of the presenting part.

The patient was asked to empty her bladder whenever she felt the desire to do so. The first stage of labour, according to the follow-up chart, progressed satisfactorily. It lasted for nine hours.
**Second Stage:**

The cervix was fully dilated, and the breech was 2 centimeters below the level of the ischial spines. Uterine contractions were regular and strong. The patient was bearing down with each contraction. She was transferred to the second stage room and put in the lithotomy position. The vulva was cleaned using savlon. The bladder climbed was emptied pudendal block was performed when the breech up the perineum, decerclage, and an adequate episiotomy were performed. The breech was delivered by aid of maternal efforts. The extended limbs were disengaged. A loop of the cord was delivered gently. The back was kept anteriorly. As the lower edges of the scapulae appeared, the arms were found across the chest. They were delivered one after the other by gentle pressure on the cuboid fossa during uterine contractions and maternal bearing down. The baby was allowed to hang by its weight. A hand was put firmly on the suprapubic area. When the nuchal hair line appeared, a pair of curved oblique forceps were applied from below. Its body. The head was delivered by forward and downwards traction. The cord was cut in between two clamps. Suction of the throat and mouth was done. The baby cried immediately. The second stage lasted for 35 minutes.
Third stage:
The placenta was delivered completely. 0.5 mg of ergometrine was given
intranamularly. There were no injuries to the cervix or
vagina. Uterus was well contracted. There was no immediate post
operative bleeding.
Outcome: An alive and well female baby weight was 2.7 Kg. Apgar score
at one minute was 8.

On Discharge:
24 hours after delivery the patient was in good health.
Episiotomy was cleaned. She was breast feeding her clinical. She was
discharged and asked to come after six weeks.

Postnatal Visit:
She was in good condition. Vaginal examimation was gaining
weight: breast fed and vaccinated. Contraception was discussed and
pills were prescribed.

Comments:
A case of assisted breech delivery, with the use of forceps
for the after-coming head has been presented. Breech presentation is
associated with increased maternal and foetal hazards. Fetal
morbidity is the most important. Cesarean section improves the
foetal outcome, but it increases the maternal morbility.
Proper selection of cases for breech vaginal delivery is the function of a good antenatal clinic. The trend of management is inclined towards elective caesarean section if there is any complication. Routine caesarean section for breech presentation is un acceptable.

For safe breech vaginal delivery one needs a good assessment of the baby's size, a normal pelvis (in shape and dimensions), close observation of the first stage of labour and avoidance of bearing down before full dilatation of the cervix. The head must be delivered carefully; it must not be delivered too slowly to avoid asphyxia nor too quickly to avoid intrapartum haemorrhage. The type of breech presentation affects the management. Footling presentation increases the complications so the are better off with caesarean section. The same applies for a breech with an extended neck.

External cephalic version is associated with complication to both mother and child. The incidence of breech delivery is not affected. This may indicate spontaneous version would probably have occurred if the cases were left alone. The procedure is suitable in cases with mild degree contracted pelvis in whom a trial of labour is to be allowed if the presentation is cephalic.
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   Progress in obstetrics and gynaecology volum 2 (1982).

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ODSTETRIC CASE NO. (2)
ANTEPARTUM HEMORRHAGE DUE TO PLACENTA PREVIA.
MANAGED BY E.U.A. AND EMERGENCY CADAVERIC SECTION.

Name: Mrs. H.A.A.
Parity: Mahyo (Medani)
Age: 33 years.
Occupation: Housewife.
Date of admission: 12/1/89.
Date of Delivery: 16/2/89.
Date of Discharge: 23/2/89.

Obstetric History:
Mrs. H.A.A. was married for four years. She was a gravida 2 para 1. It was a spontaneous, normal vaginal delivery, and full term. The outcome was an alive and well male baby. It was in hospital in 1986.

Menstrual History:
Menarche was at the age of 13 years. Menst 4/28. Her cycles were regular. The blood loss was of moderate amount with no history of use of contraceptive means.

L.M.F. 26.5.1988,
past history, family history and social history were of no relevance to her problem.
History of the Current Pregnancy:

M.A.A. was a regular antenatal care clinic attendant. Her pregnancy was uneventfull she was admitted as an emergency to hospital on the 12th of January 1989 on account of a sudden episode of vaginal bleeding one hour prior to admission. The blood was fresh, bright-red and started while she was lying down. The amount was moderately severe. There was no abdominal pain or other symptoms. On examining her, she was anxious, not pale or jaundicedug.

Her pulse rate was 100/min. It was regular and of normal volume. Her blood pressure was 100/70 mm Hg. The respiratory, cardiovascular and central nervous systems were normal. Abdominal examination revealed a soft abdomen which was not tender. The uterine size corresponded with her dates (35 hours). The fetal heart sound were heard. The rate was 146/min. They were regular and of good intensity. There were clots soiling her clothes and there was a slight amount of blood trickling from her vagina. A sample of blood was taken for haemoglobin estimation, grouping and cross matching. Urine was examined for sugar and acetone. An I/V drip of normal saline was started. 100 mgs of pethidine were given interamuscularly. Two pints of blood were cross matched and kept ready. The vulva was cleaned and a pad was applied to it. The patient was kept in the labour ward under observation according to an hourly follow-up chart. This included: the pulse rate of the
feetal heart sounds and observation of the amount of vaginal blood loss. According to this chart her general condition remained satisfactory. There were no further bleeding episodes. Her haemoglobin was separated of 10 grams per 100 ml. She was transferred to the antenatal ward.

Further Management:

Mrs H.A.A. was reassured and advised for complete bed rest. The possibility of recurrence was explained to her. She was asked to report any episodes of vaginal bleeding, however mild immediately. Three pints of cross matched blood were kept ready for transfusion. On the 16th of February 1989, the patient was 38 weeks plus 3 days pregnant, according to her dates. She was in good general health. The baby was clinically at term. The feetal heart sounds were heard. The rate was 146 per minute. They were regular and of good intensity. Her haemoglobin was estimated at 10 grams per 100 ml. Her urine examination showed no abnormality. She was taken to the theatre for E.U.A. and possibly caesarean section.

Procedure: 2 pints of cross-matched blood were prepared.

When everything was ready for immediate caesarean section, the patient was put under general anaesthesia and in dorsal position with the legs held by two assistants. The abdomen, the vulva and thighs were cleaned. Sterile towels were applied leaving, only, the vulva exposed. The bladder was emptied. The fornices were protected gently. There was fulness in the posterior fornix. The cervix was
soft central, partially effaced and thick. The os was 2 cm dilated. The lower segment was platted using the tip of a finger and going gradually, systematically and gently inwards. Soft tissue was felt on the posterior part about 3 cm from the internal os. There was slight fresh bleeding. The diagnosis of a type I posterior placenta previa was made. An immediate lower segment cesarean section was performed. A female child was delivered. She cried immediately. The placenta, which was in the lower segment, was delivered complete with its membranes. Ergometrine 0.5 mg was given intravenously. The site of the placenta was compressed, and inspected. There was no excessive bleeding. The uterus and abdomen were closed in anatomical layers. The patient was transfused two pints of blood. She recovered smoothly from anaesthesia. She was observed in the recovery room for four hours keeping a chart of her pulse, blood pressure, temperature respiratory rate, the funded level of the uterus and its contractile state and observation of the vagina looking for bleeding. Her general condition was good and so she was transferred to the post-natal ward. Mrs H.A.T. had an uneventful post operative period. She was discharged on the 8th post-operative day. She was advised to come for a post-natal visit after six weeks.
Post-natal Visit:

Her general condition was good. The scar healed. Her baby was well, breast fed and vaccinated. Contraception was suggested. The indication for the operation was examined to her, she was advised to have careful antenatal follow-up during her future pregnancies and all future deliveries must be conducted in hospital.

Comments:

A case of antepartum haemorrhage due to placenta previa has been presented. It is one of the most serious obstetrical conditions. It is associated with foetal and maternal morbidity and loss.

Antenatal care has got a role in its management in two ways:

a) Early suspicion and diagnosis. This is achieved by:

I. History of repeated episode of vaginal bleeding presenting as threatened abortion early in pregnancy.

II. Clinical examination:- Persistent transverse lie in especially suspicious. Unstable lie, breach presentation high presenting part a displaced or difficulty to palpate the head may also draw attention to the underlying cause.

III. Diagnosis of a silent placenta previa by ultrasonic examination done for any other cause.

b) Prevention of anaemia during pregnancy will prevent the serious effects of bleeding in those who develop antepartum haemorrhage.
Abnormal placenta adherence and post-partum haemorrhage are expected complications. The bleeding is from the placental bed, being on the lower segment which is thiner and does not contract efficiently. Cross-matched blood must be held ready. Ergometrine and oxytocin is to be given. Binunial compression is helpful. Hystereotomy is a final measure in cases with uncontrollable bleeding.

E.J.A. is sometimes, associated with severe bleeding from a placenta previa. Cross matched blood must be at hand. Everything must be ready before hand for immediate intervention by caesarean section. The procedure must be done gently and systematically. Ultrasonic localization of the placenta if available may be of great value.

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Practical Obstetric Problems.
OBSTETRIC CASE NO. (3)
PROLAPSE OF THE UMBILICAL CORD.
EMERGENCY CAESAREAN SECTION

Name: Mrs. H.M.S.
Residence: Elthowra (2)
Age: 33 years.
Occupation: house-wife.
Date of admission: 3/12/89.
Date of discharge: 10/12/89.

Obstetric History:-
She was married for 10 years. She was gravida 5 para 4 with no abortions. All her deliveries were at full term spontaneous, normal vaginal deliveries. All were alive and well. The eldest was a male, 8 years old; the youngest was a female, 18 months old.

Nesturial History:-
Menarche was at the age of 12 years. Her cycles were regular, every 30 days and last for 5 days. The amount of blood loss was moderate. There was no history of use contraceptive methods.
L.M.P.: 6.3.89.
Family history and social history were of no relevance.
History of Present Pregnancy:

Mrs H.M.S. was a regular antenatal clinic attendant. The presenting part was found to be a breech near term. She was advised to deliver at hospital and was looked for hospital delivery.

Admission to Hospital:

On the 3rd of December 1989 Mrs H.M.S. presented to the hospital. She was complaining of labour pains. According to the dates of her last menstrual cycle she was 38 weeks plus 4 days pregnant. She was in good general health. She was not pale or jaundiced. Her pulse rate was 98 per minute, it was regular and of normal volume. Her blood pressure was 120/80. Her respiratory and cardiovascular systems were normal. On examining her abdomen, it was soft and free of tenderness. The uterus size was corresponding to term. The lie was longitudinal. The presentation was breech. It was in the left sacro-lateral position and it was not engaged. Fetal heart sounds were heard. The rate was 138 per minute and was regular. The estimated baby weight was 3 kg plus or minus 0.5 kg. Uterine contractions were present. Per vaginal examination revealed a soft cervix which was central and effaced. The internal os was 3 cm. dilated. The presenting part was a complete breech. It was at station 3. The membranes were intact. She was admitted to
the labour wort, being in the first stage of labour. She was advised not to take anything by mouth. Intravenous fluids were given. Her haemoglobin was found to be 11.5 grams per 100 mls. Her urine analysis showed no abnormality. A blood sample was sent for grouping and cross-matching.

Progress in Labour:-

Two hours after admission the patient felt a gush of fluid coming per vag. nux. On examination, the os was found to be 5 cm the umbilical cord was felt in the vagina. It was pulsating. A piece of gauze was soaked in warm water and inserted into the vagina. The foot of the bed was elevated. The condition was explained to the patient. Arrangements for an emergency caesarean were made.

Operative procedure:-

The patient was transferred to the theatre with the foot of the stretcher elevated. Immediately before the induction of the anaesthesia, the foetal heart sounds were heard. They were 144 per minute, regular and of good intensity. An emergency caesarean section was performed (as described in case no. 7). The outcome was a female child who cried immediately. Her weight was 2.8 kg.

Post Operative Period and Discharge:-

Mrs. H.M.S. had smooth postoperative period. She remained afebrile with no other complaints. The breasts were active with milk and free of abnormalities. All her systems were normal. The uterus
was involuting satisfactory. Her haemoglobin was 10.2 grams per 100 ml. The stitches were removed on the 7th post-operative day. Her wound was clear and healing was satisfactory. The baby was in good general health. She was breast-fed and vaccinated against tuberculosis. The indication for caesarian section was explained to the patient. She was discharged and asked to come in the referred clinic 5 weeks later.

**Post-natal Visit:**

Mrs. H.M.S. presented after 6 weeks. She and her child were in good health. Contraception was discussed with her. She was advised to use contraceptive pills for one year at least. The importance of regular antenatal care and hospital delivery in her future pregnancies was explained.

**Comments:**

A case of umbilical cord prolapse managed by emergency caesarian section has been presented.

The incidence of cord prolapse is one in 200 to 400 deliveries.

The predisposing factors are those related to an ill fitting presenting part to the lower segment.

They include:- Grandmultiparity (4/5 of cases) Polyhydraminous, pre-maturity, twins, abnormal lie and malpresentation. In breech while with flexed breech the risk is tripled. Other predisposing
factors include: Cephalo-pelvic disproportion, occlusion posterior portion, abnormally long cord, low-lying placenta and in borrid are or velamentus placenta.

Cord prolapse increases foetal mortality. A corrected rate of 10.7 (Goldthorp 1967), 16.6 per cent (chart et al 1968) and 1.5 per cent (Bock and Weise 1972) has been reported.

The cause of death is cord compression or vasospasm due to exposure to cold and irritation.

The increased maternal morbidity is due to the type of intervention. The Caesarian section rate is 30-35%.

References:
1. Dewhurst.
   Intergrated obstetric and gynaecology for post graduate.
2. Iron Donald.
   Practical obstetric problems.
OBSTETRIC CASE NO. (4)
ANTSEPTUM HAEZNUKHNS: ABRUPTIO PLACENTAE

Name: Mrs. H.A.M.
Residence:
Age: 36 years.
Occupation;
Date of Admission: 6.9.89.
Date of discharge: 11.9.89.

Obstetric History:-
Mrs. H.A.N. had been married for the last 15 years. She was gravid 8, para 6, with a history of one abortion. All her deliveries were spontaneous vaginal and had been conducted at home. The youngest child was 2 years old. Her abortion was at 3 months gestational age. It was under hospital care.

Gynaecological History:-
Her menarche was at the age of 13 years. Her cycles were every 25 to 30 days. Lasted for 3 to 5 days. They were regular and with moderate blood loss.

L.M.P.: Uncertain, but approximately around the 10th of January 1989.
Past History:-
She was not known to be diabetic or hypertensive with no history of hospitalisation.

Family History:-
Both her parents were hypertensive. There was no family history of diabetes.

Current Pregnancy:-
The patient was going through her 8th pregnancy, with no regular antenatal care follow up. She presented to the hospital on the 6th of September and gave a history of a sudden attack of severe abdominal pain. It was generalized, continuous increasing in intensity and radiating to the back was followed by vaginal bleeding, which was moderately severe and associated with clots. There was history of trauma. The fetal movements were felt up to that morning of the same day of admission.

Condition on Admission:-
The patient was conscious but anxious and restless. She was in pain. She was pale but not jaundiced or febrile. Her pulse rate was 110 per minute; it was regular and of small volume. Her blood pressure was 130/110 mm Hg. Her respiratory and cardiovascular systems were normal. Abdominal examination revealed a tense, rabid abdomen with generalized tenderness. The size of uterus corresponded gestation to 16 weeks of gestation. Fetal parts were difficult to be identified. The fetal heart sounds could neither be heard by a pinnard stethoscope nor by Doppler fetal heart detector.
Management

A diagnosis of antepartum haemorrhage, most probably due to placental abruption was made. Two canulae were passed into two side culibtal veins of the upper limbs. There were used to infuse two drips of 5% glucose in water. Pethidine 100 mg was given intramuscularly. 10 mg of diazepam was given intravenously. Her haemoglobin was estimated and found to be 8 grams per 100 ml. Her urine examination was free of sugar, acetone and albumin. A blood sample was sent for grouping and cross-matching. Emergency preparation of 5 pints of fresh blood was requested. One pint of cross-matched blood was transfused. A follow chart was drawn-up. Soon the patient become calmed down and her general condition improved she was taken to the theatre. Every thing was prepared for caesarian section. Just before induction of anaesthesia careful gentle vaginal examination was done. The cervix was soft, central effaced and thin. The internal os was 5 cm dilated. The presenting part was the head. It was in the left occipitotral position and at station was zero. No placental was encountered the membranes were intact. Artificial rupture of the membrane was performed. The liquor was blood stained. Two I.U. of syntocionne were put in a drip of 500 mls 5% glucose in water, and started intravenously. A pint of fresh blood was running in the other vein. The patient was transferred to labour ward. An half-hourly follow up chart was made. It included:- pulse rate, temperature, blood pressure, respiratory rate and fluid in put and output. She was kept sedated by giving diazepam.
Delivery:

After four hours the patient delivered vaginally. The outcome was a fresh stillbirth male baby. Its weight was 3.1 kg. The placenta and membranes were delivered actively and completely. There was a large retroplacental clot. Massage of the uterus was done till it was well contracted clots were removed from the uterine cavity. 10 I.U. of syntocinon were put into a drip of 5% glucose in water and given intravenously. The vagina was observed for post-partum haemorrhage. The same follow-up chart was checked hourly. A third pint of blood was given. After 6 hours the pulse of the patient was 80/min, her blood pressure was 120/80 and the respiratory rate was 28 per minute. The uterus was well contracted and there was no excessive vaginal bleeding. Her urine output was satisfactory. The 4th pint of blood was being infused. She was transferred to the postnatal ward and put on diazepana 10 mg 8 hourly for the next 72 hours.

Condition on Discharge:

On the 5th postpartum day Mr. H.A.M. was in good general health. Her pulse rate was 80 per minute, her blood pressure was 110/80 and all of her systems were normal. The breasts were not engorged. The uterus was involuting normally. There was no vaginal bleeding or abnormal discharge. The lower limbs were free of tenderness and oedema. Her haemoglobin estimation was 10 grams per 100 ml. Her urea was 20 mg/100 ml. She was discharged and asked to report at the outpatient clinic after 6 weeks.
Post-Natal Visit:

Mr. H.A.M. came after 6 weeks. Her general condition was good. All her systems were normal. Her blood pressure was 120/70. Contraceptive methods were discussed. After explaining the different methods to her, a Cu-t loop was fitted. She was asked to come after one month for checking the IUCD.

Comments:

A case of antepartum haemorrhage due to placental abruption was been presented. It is a serious condition. Fetal loss is high. Maternal mortality and morbidity is due to hypovolemic shock, renal failure or coagulopathy. Post partum haemorrhage must be prevented. Early intervention and aggressive treatment and prevention of complications reduced the maternal mortality rate from 8.7% 60 years ago to 1% nowadays.

Vaginal delivery is the standard and usual management. Adequate quick transfusion by fresh blood keeps the patient alive and prevents hypovolemic and its consequences. Amniotomy stops the process of abruption. Syntocinone is to be given to enhance utrine contractions and to shorter the first stage. Sedation and analgesia are important to alleviate the tension and pain. Caesarean section is indicated when a baby of reasonable size and maturity is found to he alive and distressed.
The aetiology is not clear in the majority of cases. The predisposing factors include: Hypertension and P.E.M., as in the case under discussion, chronic nephritis, folic acid deficiency, supine hypotensive syndrome due to compression of the inferior vena cava by the gravid uterus, trauma, external cephalic version, poor socioeconomic status and sudden decompression of the uterus.
Name: A.R.Z.
Residence: Nor-eldin Village
Age: 20 years
Occupation: H.W.
Date of admission: 9.4.89.
Date of delivery: 9.4.89.
Date of discharge: 14.4.89.

Obstetric History:
She was a primigravida, married for 11 months. The date of her last menstrual period was not known.

Past History:
She was not known to be diabetic or hypertensive, with no past history of hospitalization. She was not known to have had fits and had past history of head injuries.

Family History:
Along history were of no significance.

Social History:
The patient was married to her cousin. He was a farmer. They lived within an extended family. They owned one room only. They had no latrines. They were illiterate. Their village, Nor-eldin,
was a poor area on the Eastern part of Elgazira province. They had no tap water and they used water directly from the Blue Nile. The available health service was a "choosing-station". It was managed by a nurse. There was no trained midwife in the village.

Admission to Hospital:

Mrs A.R.Z. was brought to the obstetric casualty by her relatives. Her husband gave history that she had been unwell for the last three days. She had swelling of the lower limbs of and face. On the day of admission she complained of headache and abdominal pain. She developed generalized convulsion followed by loss of consciousness. Three were no aura or incontinence of feaces or urine. She had three fits before reaching hospital. On examination, the patient was comatose she responded only to painful stimuli. She was cedematous, she not pale, jaundiced or dyspnic. Her pulse rate was 100 per min. It was regular and of normal volume. Her temperature was 37.8°C. Her blood pressure was 170/110 mm Hg. Her system were normal. Abdominal examination showed a uterus size that corresponded to term. The lie was longitudinal. The presentation was cephalic. The foetal heart sounds were heard with a regular rate of 148 per min. The estimation baby weight was 2.5 ± 0.5 Kg. Per vaginal examination revealed a soft, effaced, central and thin cervix. The os was six cm dilated, head was at station zero. The pelvis was clinically adequate. Adiagnosis of antepartum eclampsia in the first stage of labour was made. The patient was admitted immediately to the eclampsia ward.
Management:

1. Nursing:
   The patient was put in the left lateral position with the foot of the bed raised, to avoid aspiration. A patient airway was secured. A Foley's catheter was passed into the urinary bladder so as to keep it empty and to calculate the urine output. Oxygen was ready beside the patient.

2. Drugs:
   a) Diazepam: 20 mg were given intravenously and 40 mg were put in a drip of 5% glucose in water and delivered in through an I/v cannula. The rate was adjusted so as to keep the patient calm and well sedated.
   b) 100 mg of pethidine were given intravenously.
   c) 50 mg of pronethalazine were given intravenously.
   d) 80 mg of laxis (frusinide) were given intravenously.
   e) Benzyl penicillin 2 millions I.U. were given intravenously every 3 hours as a prophylactic antibiotic.

3. Augmentation of Labour:
   Artificial rupture of the membranes was done. The liquor was clear. There was no cord prolapse or bleeding. Syntometrine was set in through another cannula in a big vein. The rate was titrated so as to maintain strong regular contractions with a frequency of three to four per min.
4. Investigations:
   a) Her haemoglobin was 9 grams per 100/mls.
   b) Her blood group was A Rh +ve.
   c) Blood film for malaria was reported negative.
   d) Urine analysis, was free of sugar and acetone. There were
      ++ of albumin.

5. Follow-Up:
   A follow-up chart was drawn. It included: the pulse rate, the
   blood pressure, the temperature, the respiratory rate, level of
   consciousness and state of sedation, comment on outside, input of
   fluids uterine output, urine contractions, cervical dilatation and
   descent of the presenting head.

6. Delivery:
   When the cervix was fully dilated and head of the baby was in
   the perineum, the patient was put in lithotomy position. Episiotomy
   was performed. The baby was delivered by an outlet obstetric
   forceps while the patient was well sedated. The placenta was
   delivered, complete, actively by controlled cord traction. The
   uterus was massaged till it become well contracted. The syntocinone
   drip was kept running. The cervix was examined and found to be
   intact. The episiotomy was sutured.
Conditin after delivery:-

The patient was calm and well sedated. Syntocinone and diazepam drip were running. Her pulse rate was 96/min. It was regular and of good volume. Her blood pressure was 150/100, the uterus was well contracted and there was no abnormal vaginal bleeding. A follow up chart was checked hourly for the next six hours.

Outcome:-

The baby was a male, alive and well his weight was 2.700 Kg. He was sedated. He was managed by suction, mouth to mouth breathing and oxygen therapy.

Discharge:-

Mr. A.R.Z. stayed for five days in the hospital. There were no more fits. Her general condition was improving. On the 5th day her blood pressure was 120/70. The oedema had subsided. Her systems were normal. The uterus was involuting. There was no vaginal bleeding or genital infection. The baby was well. He was breast fed and vaccinated. The condition was explained to the patient. The importance of antenatal care was emphasized. The patient was discharged and asked to come after six weeks.

Post-Natal Visit:-

In the post natal visit Mr. A.R.Z. and her baby were in good health. Contraception was discussed with her. She was given contraceptive pills in form of progestron tablets because she was lactating.
A case of antepartum eclampsia has been discussed. We are still seeing cases of eclampsia. This calls for improvement of our antenatal follow up. The importance of antenatal follow up is to be explained, with great emphasis, to our patients. This is to be done through extension of health education and utilization of all the available educational means including broadcasting and mass media. The health service is to be extended to cover more remote areas.

Eclampsia is a lethal complication. Mortality rate may reach 17.5 percent or more. The causes of deaths are: cerebral haemorrhage, heart failure, renal failure and thromboembolism.

A patient with eclampsia is to be nursed in a special ward. It must be quiet with an indirect source of light. It must have available. Suckers, Oxygen, airways and a tongue depressors. Diazepam and antihypertensive also must be available all the time at the bedside.
OBSTETRIC CASE NO. 46
RETIAINED PLACENTA, MANAGED BY MANUAL REMOVAL UNDER GENERAL ANESTHESIA

Name: Mrs. K.A.A.
Residence: Ambada.
Age: 34 years.
Occupation: Housewife
Date of admission: 4.10.69.
Date of discharge: 8.10.69.

Obstetric History:
The patient was married for six years. She was para two; both
of her deliveries were normal and uncomplicated. Her first
delivery was at hospital in 1984. The second delivery was at home
in the year 1987. All her children were alive and well.

Gynaecological History:
Her menarche was at the age 12. Her cycles were regular coming
every 30 days and lasting for three to four days. The blood loss
was moderate in amount.
L.M.F.: 3.1.89.
E.D.D.: 10.10.69.
Past History:

The patient was not known to be diabetic or hypertensive. No post history of retained placenta or post partum haemorrhage.

Family History and Social History:

Were of no significance to her condition.

History of Present Problems:

Mrs. M.A.A. was admitted to hospital as an emergency on the 4th of October 1989. She had an uneventful pregnancy so far which was supervised regularly at the local health centre. Three hours prior to admission she delivered vaginally at home. She was attended by a qualified district midwife. The outcome was a female baby who cried immediately. The midwife failed to deliver the placenta and she started to bleed vaginally. The blood loss estimated by the midwife was put at half a pint.

Condition on Admission:

The patient was anxious. She looked ill, pale but not jaundiced. Her pulse was 110 per min. It was regular and of normal volume. Her blood pressure was 100/60 mm Hg. Her systems were normal. Abdominal examination revealed a soft abdomen which was free of tenderness. The uterus was at the level of the umbilicus. It was not contracted. The bladder was not full. Per vaginal examination showed a continuing moderate loss of blood. The patient wascircumcised and there was a decerebration wound. The cord was there and it was clamped. There were some clots in the vagina. The cervix was 4 centimeters dilated.
Immediate Management:-

A cannula was inserted in a big vein; 5% glucose in saline was given. A blood sample was taken for grouping and cross matching and haemoglobin estimation. A sterile catheter was passed into the bladder. Fifty ml of urine were drained. A urine sample was sent for analysis. Twenty i.u. of syntocinon were put in a pint of 5 per cent glucose with saline and given by infusion. The rate was 30 drops per min. Three pints of blood were requested and were prepared. Her haemoglobin was found to be 8.6 grams per 100 ml. Her blood group was O Rh-ve. Her urine was free of sugar and acetone. Attempts to deliver the placenta by controlled cord traction during uterine contractions failed. The patient was transfused one pint of blood. It was decided to remove the placenta manually under general anaesthesia.

Operative Management:–

The patient was taken to the theatre. Another pint of cross-matched blood was requested.

Procedure:–

After being anaesthetized the patient was placed in the lithotomy position. Complete aseptic measures were applied. The vulva and the medial aspects of the thighs were cleaned. Sterile twelves were applied leaving the vulva exposed. Manual removal of the placenta was tried once again but failed. The right hand was well lubricated with antiseptic cream and introduced through the
cervix in a cove shaped arrangement. Gently and patiently, adequate dilatation of the cervix was achieved by using the fingers in a fanning movement. The full hand was then introduced in the uterine cavity following the cord. The placenta was separated along its edge by a scissoring movement of the fingers. Simultaneously, the left hand was placed on the fundus to steady the right hand in the uterus. The placenta and membranes were delivered completely and examined carefully. The uterine cavity were explored. All clots were removed. Bimanual massage of the uterus was performed. The uterus was contracted. Ergometrine 0.5 mg was given intravenously. The cervix wound inspected and found to be intact. The circumcision wound was sutured. The second pint of blood was given after the patient recovered from anaesthesia. 10 I.U. of oxytocin and a drip of 5% glucose with saline were infused at a slow rate. The patient recovered smoothly from anaesthesia. She was put on ampicillin 50 mg six hourly for 3 days.

Post-operative follow up and discharge:

A follow up chart was kept including: Pulse rate, blood pressure, temperature, uterus for contraction and vaginal bleeding if any. The patient had a smooth postoperative period. She was discharged 72 hrs after the operation. Her general condition was good. Breasts were healthy and active. She was lactating. There was no vaginal bleeding or genital infection. Her baby was in good health. He was vaccinated. The possibility of recurrence of the condition was explained to the patient. She was advised to have
antenatal supervision of her next pregnancy and advised to deliver at hospital in future continuance.

Postnatal Visit:-

The patient presented six weeks after delivery to the referred clinic. She and her baby were in good general condition. Contraception was advised. The importance of hospital delivery in her future pregnancies was emphasized.

Comment:—

A case of retained placenta, managed by resuscitation and manual removal of placenta under general anaesthesia, has been discussed. It is a serious life-threatening complication of the third stage of labour. Post-partum collapse may occur in retained placentae with or without bleeding.

Being of a recurrent nature, a past history of retained placenta is to ask about. Such cases are to be selected for active management of the 3rd stage i.e. cross of labour and cross matched blood is to be resuscitated. A patent intravenous line is desirable. Ergometrine or syntometrine is to be administered at delivery of the shoulder. The placenta is to be delivered actively by controlled cord traction while the uterus is well contracted.

Retained placenta may occur in 3 circumstances—

a) The placenta separates but is trapped by a constriction ring of the lower segment, or is lying in the lower birth canal.
b) Morbid adherence of the placenta. This is rare about 1 in 4,00.

c) Partial separation due to a combination of factors; poor uterine
action specially in relation to operative delivery and general
anaesthesia. Tentative and ineffective manipulation and partial
morbid adherence in the region of old cesarean or myomectomy
scars.

References:

1. Dewhurst.

Postgraduate Integrated Obstetrics and Gynaecology .

2. Rayan M. Hibbard.

Principles of Obstetrics.
OBSTETRIC CASE NO. (7)

ELECTIVE CESAREAN SECTION.
+ TURAL TICATION-FOUR PREVIOUS CESAREAN SECTIONS:

Name: Mrs. M.A.M.
Residence: Gomuram
Age: 36 years
Occupation: housewife
Date of admission: 13.3.90
Date of operation: 14.3.90
Date of discharge: 22.3.90

Obstetric History:
Mrs. M.A.M. was married for 13 years. She was gravida 5 para 4. Her first delivery was at term. It was an emergency cesarean section after failure of trial of labour. The outcome was a male baby. He was alive and well. The other three babies were delivered by elective cesarean sections. All of them were alive and well. Two of them were females and the last was a male. The youngest was three years old.

Gynaecological History:
Her menarche was at the age of 14 years. Menopause. Her cycles were normal and regular.


There was no history of use of any contraceptive method.
Past History:

She was not known to be diabetic or hypertensive or asthmatic. Family History and Social History were of no significance.

Admission:

She was a regular antenatal care clinic attendant. She was referred to the hospital for operative delivery when she was 38 weeks pregnant. Her antenatal record showed a normal, uneventful pregnancy. Her general condition was good. She was not pale. Her blood pressure and other systems were normal. Her uterine size was at term. It corresponded to her dates. The lie was longitudinal. The presentation was cephalic which was in left occipito-lateral. The fetal heart sounds were heard. The rate was 118 per minute. They were regular and of good intensity. The baby's size was estimated be 3.2 kg. The amount of liquor was average.

Investigations:

Her haemoglobin was 12 grams/100ml. Urine analysis showed no abnormality. Her blood group was O Rh +ve.

Management:

Being pregnant at 38 weeks with history of four previous caesarean sections, she was planned for elective operative delivery.
Preparation:-

The patient was already prepartaed psychologically and she was well oriented about her condition. The concept of tubal ligation was discussed with her. She and her husband agreed. Her relatives donated two pints of blood. They were cross matched and prepared for transfusion needed. The patient was reviewed and all her systems were found to be normal. She was asked to fast overnight.

Premedications:-
1. 5 mg of diazepam were given the night before the operation.
2. Atropine 0.1 mg (0.015 mg/kg body weight) was given.
   Intramuscularly 1/2 an hour before the operation.
3. Oxygen was administered by mask over the 5 minutes before induction of anaesthesia.
4. 5% glucose in saline was running throughout the operation.
5. A Foley's intubating catheter was fixed.

Induction of general anaesthesia was by 250 mg of pentothal. Maintenance was achieved by 50% oxygen + 50% nitrous oxide. Pethidine 50 mg was given intramuscularly after the delivery of the baby. For muscular relaxation 100 mg of succin was given after the effect of succin was over.
Operative Procedure

The patient was put in supine position with a 15° lateral tilt so as to prevent aortocaval compression by the gravid uterus. The skin was cleaned and draped leaving lower part of the abdomen exposed. The old scar was removed. The subcutaneous fat was dissected till the sheath was clear. The sheath was incised longitudinally. The two recti muscles were separated from the midline so as to expose the peritoneum, which was opened longitudinally. The lower part was found to be adherent to the anterior aspect of the uterus. It was dissected carefully so as to avoid injury to the bladder, which was pushed down well away from the lower segment. The lower segment was opened transversely, using the scissors going laterally and curved upwards, towards the round ligments. The membranes were ruptured. The baby was delivered. The placenta membranes were delivered complete. The patient was given 0.5 mg ergometrine intravenously. The uterus was closed in two layers by continuous stitches and penteronized. Using chromic cat gut no 2. Tubal ligation was performed by posteroy's method. Haemostasis was insured. The abdomen was closed in anatomical layers. Vaginal swab was performed.

The patient recovered smoothly from anaesthesia. The outcome was male baby. He cried immediately. His weight was 3.600 Kg. He was active and there was no apparent congenital malformations.
Post-operative period and Discharge:

The post-operative period was uneventful. The stitches were removed on the 7th day. The wound was clean and free of infection. The general condition of the patient and her baby were good. He was lactating and B.C.G. vaccination was performed. The patient was asked to present after 6 weeks for the post-natal visit.

Post-natal Visit:

The patient did not report for antenatal check.

Comment:

A case of elective caesarean section has been presented. The aim of the operation is to provide safety to the mother and her child whenever vaginal delivery is expected to be risky.

The rate of caesarean section is 5-15 per cent. It differs from one centre to another.

Maternal mortality must be less than 1 in 1000. The cause of death is, sometimes, the underlying maternal condition. The main dangers are, anaesthetic accidents, sepsis, thrombembolism and aspiration. The last one is rare nowadays due to good preoperative preparation. The morbidity is increased by the operation, in comparison with vaginal delivery. This due to infections, haemorrhage, and urinary tract injuries.
The perinatal mortality and morbidity depends on the
indication of the operation. It has been decreased were the
indication for operation is ile, placenta previa or breech
presentation. (It has been decreased when the indication is
abnormal).

The anaesthetic problems during caesarean section include:-
1. Foetal depression due to transfer of anaesthetic drugs from the
mother to the bay. Fortunately muscle relaxant do no affect the
baby.

II. Increased risk of inhalation of gastric contents (Mendelson's
syndrome) which is predisposed o by:-

a) Delayed gastric emptying during pregnancy and labour.
b) Increased intragastric pressure caused by the gravid
uterus.
c) The operation is sometimes done as an emergency procedure.
d) Decreased tone of the lower of oesophageal sphinctor and
increased gastro-oesophageal reflux.

It is counteracted by:-
1. performing the operation when the patient is fasting.
2. Use of antacids and H₂ receptor blocker.
3. Pre-oxygenation for 3 to 5 min. and avoidance of ventilating
the patient when she is paralysed before intubation.
4. Cricoid pressure so as to close the oesophagus during
intubation (Gottlieb's maneuver).
5. Proper suction before extubation.
III. Supine hypotension syndrome due to compression of the inferior vena cava by the gravid uterus. Its avoidance is by placing the patient 15° to the left.

References:
1. Dewhirst's. Integrated Obstetrics and Gynaecology for Post Graduate.
2. Ian Donald. Practical Obstetric Problems.
OBSTETRIC CASE NO. A
RUPTURED UTERUS
EMERGENCY HEMI-TOTAL HystereCTOMY

Name: Mrs. A.K
Age: 43 years
Occupation: Housewife
Date of admission: 11.1.89
Date of operation: 11.1.89
Date of discharge: 18.1.89

Obstetric History:

The patient was gravida ten, para nine with no history of abortions. All her deliveries were spontaneous, normal and vaginal. They were conducted at home. She had 6 girls and 4 boys. All of them were alive and well and the youngest was two years old.

Gynaecological History:

The patient had her menarche at the age of 16 years. Kanya was 4/3. Her cycle were regular and the blood loss was moderate. There was no history of use of any contraceptive methods.

L.M.P. : Uncertain
E.D.D. : Uncertain

According to her she was nine months pregnant.

Dent History and Family History:

Were not significant.
Social History:

Mrs. A.H. was an illiterate housewife. Her husband was a farmer, they lived in a village, in the southern part of Gaza Province. Their housing condition and income were reasonable.

Admission to Hospital:

On the 11th of April 1989 Mrs. A.H. was brought to the obstetric casualty at Had Medani Hospital, by a village midwife. She gave history of being in labour for the last 20 hours, but labour pains stopped after a period of strong frequent conditions. She also complained of vaginal bleeding. On examination, she was ill and dehydrated. Her temperature was 38 °C. Her pulse rate 100/min, it was regular and of normal volume. Her blood pressure was 90/60, the respiratory and cardiovascular systems were normal. The examination of the abdomen showed a distended abdomen. It was tender on palpation, the uterine size was at term. Fetal parts were easily palpable. Fetal heart sounds were not detectable shifting dullness was demonstrable.

Per vaginal examination showed a circumcised vulva and vaginal bleeding. The cervix was fully dilated. The membranes were absent, the breach presented, it was high at the bism of the pelvis.

Management:

1. Ruptured uterus with foetal death following obstructed labour due to breach presentation of a big baby was put as provisional diagnosis.
2. A large intravenous cannula was inserted in a big vein. 5% glucose in saline was administered at a rapid rate.
3. Blood samples were taken for blood grouping and cross matching. Preparation of 3 pints of blood was requested, two pints of blood were transfused immediately.
4. Her haemoglobin was estimated. It was found to be 5.1 grams per 100 ml.
5. Urinary catheter was passed into the bladder, the urine was clear, it examination showed no sugar or acetone.
6. The anaesthetist was informed, and the theatre was prepared for emergency laparotomy.

Procedure:

The patient was put under general anaesthesia, in the supine position. The skin of the abdomen was cleared using salveo solution, followed by application of spirit. The abdomen was opened in layers through a median subumbilical incision. There was haemoperitoneum. Fetal parts were seen through a rent in the lower segment of the uterus. There was no excessive bleeding, because the site of the rupture was compressed by the partially delivered fetal parts. Both ovaries and tube were healthy. There was no broad ligament haematoma. The bladder was intact. The baby and placenta were delivered through the rent. The site of the rupture was closed. The uterus was delivered through the abdominal incision. Each of the round ligament was cut in between two clamps. The broad ligament was dissected at the site so as to allow clamping of the tube and to preserve the ovaries on both sides. The anterior part of the broad ligament was incised
transversely where it was loosely attached over the lower segment. It was dissected downwards so as to keep the urinary bladder and ureters away from the lower segment. The lateral walls of the uterus were exposed. The ureters were seen and palpated. They were away from the uterus. The uterine arteries were identified on both sides. Each was cut in between 2 clamps, and doubly ligated using no. 2 chromic cat gut. The uterus was amputated at a level just above the cervix. The stump was closed by interpled stitches using no. 2 chromic cat gut. Haemostasis was insured. The visceral peritoneum was closed. The abdominal cavity was cleaned. The abdomen was closed in anatomical layers. The patient recovered smoothly from anaesthesia. During the operation she received the third pint of blood. The catheter showed clear urine. The patient was kept in the recovery room and her general condition and vital signs were observed. The baby was a green still birth, its weigh was 4.1 Kg. She was transferred to the ward after 6 hours.

Post Operative Period and Discharge:

Mrs. A.K.E had a smooth postoperative period. Her general condition was good, she was afebrile, and normotensive. The urine output was adequate and the catheter was removed on the 7th day. The wound was clean and with good healing. Her haemoglobin was 10 grams per 100 ml. She was discharge and asked to come for follow up one month later.
Post Natal Visit:

The patient was in good general health all her systems were normal. On pelvic examination there was no bleeding or discharge. She had no tenderness or pelvic masses. Her haemoglobin was 12 grams per 100 ml.

Comments:

Rupture uterus is one of the most serious obstetric emergencies. The post natal loss is high. In some studies it ranges from 50-75%. The maternal mortality and morbidity is increased. The outcome has been improved significantly by the availability of blood transfusion and potent antibiotics. The incidence of the condition is 1 in 2000. In our country it may be higher but no data are available.

Causes Include:

Obstructed labour in a grand multipara with big baby, malpresentation or abnormal lie; previous caesarean section, the incidence being higher in upper segment scars.

It can be iatrogenic due to improper use of syntometrin or instrumental deliveries.

Prevention is by encouragement of antenatal follow up, and by proper selection of high risk patients who are for hospital delivery. The improvement of the referral system is important. Midwives must have courses from time to time so as to refresh their knowledge and to define the criteria of early referral to hospitals.
References:

1. Deshmukh.
   Integrated Obstetric and Gynecology for Post Graduate.

2. I an Danaid.
   Practical Obstetric Problems.
OBSTETRICAL CASE NO. 9

HEART DISEASE WITH PREGNANCY

Name: N.A.A
Age: 33 years
Occupation: Housewife
Residence: Gzahirah
Date of admission: 8.2.1990
Date of delivery: 14.2.1990
Date of discharge: 21.2.1990

Obstetrical History:
The patient was married for 7 years. She was gravida 4 para 2, with history of one abortion. Her deliveries were spontaneous normal vaginal deliveries at hospital. She had a son and a daughter, her third pregnancy ended in abortion at 3 months of gestation. It was at hospital and evacuation was done.

Gynaecological History:
Menarche was at the age of 14 years, Kata was 4/28, her cycle were normal and regular.

L.H.P: 19.9.69
E.B.D: 25.2.90

Past History:
She was known to be a case of Rheumatic Heart disease since she was 33 years old. She had no past history of hospitalization and was not known to be diabetic or hypertensive. There was no history of orthopnea or heart failure.
Family History and Social History:

Were not significant.

Drug History:

The patient was on regular use of Lasix tablets in a dose of one tablet (40 mg) daily, slow K tablets and a monthly injection of long acting penicillin.

Condition on admission:

Mrs. K.A.A. was regular antenatal care attendant at hospital. She was referred from there for admission on the 4th of February 1990. She had no complaints, she was not dyspeptic. Her pulse rate was 90/min. It was regular and of normal volume. Her blood pressure was 100/70, the apex beat was felt in the 5th intercostal space, just lateral to the midclavicular line. It was heaving in nature. There was a palpable cystolic thrill radiated to the axilla. The first heart sound was muffled. The second heart sound was normal. There was a pansystolic murmur radiating towards the axilla. There were no other sounds. The respiratory rate was 20 per minute. There were no basal crepitations.

The abdomen was distended. It was soft and not tender. The liver and spleen were not palpable. The uterus was at 36 weeks level. The lie of the baby was longitudinal. The presentation was cephalic and it was not engaged. The position was left occipito-lateral. Fetal heart sounds were regular 140/min in rate and they were of good intensity. The baby's size was estimated to be about 2.9 Kg ± 0.9 Kg. The liquor was of average amount. Other systems were normal and there was no lower limb oedema.
Investigation:

Her haemoglobin was 11 gms/100 mls. Her blood group was O Rh+ve. Her urine examination revealed no abnormal constituents.

Management:

The patient was kept of bed rest. A follow-up chart was drawn-up. It included pulse rate, respiratory rate, blood pressure, temperature, examination of chest and abdomen, foetal movement and foetal heart sounds. She was put on tonic basic tablets 40 mg daily; slow K as potassium supplement and benzathine penicillin 2-4 megaunits monthly.

Labour:

On the 8th of February the patient was referred to the labour ward because she had labour pains. On examination she was anxious; she was not pale or jaundiced. Her respiratory rate was 20/min. Her pulse, blood pressure and all systems were normal except of her known cardiac signs. Pelvic examination showed a circumcised vulva. The vagina was warm and moist. The cervix was soft, central, effaced and thin. The os was 5 cm dilated. The membranes were intact and forewaters were formed. The head was presenting. It was at station 7. The patient was assured and told that she was in active labour. Shema was done. The patient was propped up in bed. A blood sample was sent for grouping and cross matching.
Drugs:
1. Pethidine 100 mg intramuscularly as sedative and analgesic.
2. Procaine penicillin one million intramuscularly was given
daily for 7 days as a prophylactic antibiotic.
3. Oxygen, Aminophyllin, lasix injections, Digoxin and morphia
were kept beside the patient.

The first stage of labour progressed satisfactorily
according to a follow-up chart. It lasted for 4 hours when the
cervix was fully dilated and the head was at the perineum, she
was transferred to second stage labour room. She was propped up
in bed and elective outlet obstetric forceps was performed under
 pudendal block and with the aid of an adequate episiotomy and
decircumcision.

Cut-came:

Was a male baby who was live and well. His weight was 2.9
Kg, the placenta and membranes were delivered complete, by
controlled cord traction while the uterus was well contracted.
Bimanual massage of the uterus was performed. Clots were
evacuated digitally from the cavity of the uterus. The patient
received 15 i.u. of syntocinon intramuscularly and lasix 40 mg
intravenously. There was no warning bleeding. The episiotomy and
the decircumcision wound were repaired. The patient was calm and
there were no signs of heart failure, or pulmonary oedema. She
was transferred to the postnatal ward.
Discharge:

The patient had an uncomplicated post-natal period. On the 3rd day she was in good general health. Her respiratory rate was 16/min. Her pulse, blood pressure and all systems were normal. Episiotomy and decircumcision wounds were clean and free of infections. The baby was well. He was vaccinated and breast fed. She was discharged in good condition and asked to present 6 week later.

Post-Natal Visit:

The patient and her baby were in good health. Contraception was discussed, she decided to use a spermicidal agent with the condom.

Comments:

When a lady with heart disease gets pregnant she will need special care. Her antenatal follow-up must be frequent. The aim is prevention early diagnosis and aggressive treatment of any factors that may push the patient into heart failure. Such as infection, especially of the respiratory tract, anaemia and pre eclampsia toxemia. She must deliver in a hospital. The aim is to prevent and treat adequately heart failure, pulmonary oedema and sepsis bacterial endocarditis. The early post partum period and the puerperium are critical and must be managed with great care. If the patient is on oral lasix she must be shifted to the injection form. In post-natal visit a suitable contraceptive method is to be suggested.
Tubaligation is to be arranged if the couple agree. Intrauterine loop is not a contraindication but must be introduced under antibiotic cover starting 24 hours before procedure.

The commonest cause of heart disease with pregnancy in our country is rheumatic. Other causes include: congenital, cardiomyopathy and thyrotoxicosis. In the developed countries incidence of congenital heart disease is relatively higher than that of rheumatic heart disease. For example in Queen Charlotte Hospital, the overall incidence is 1.8 of which 1.2 is due to congenital heart disease and 0.3 is due to rheumatic (Swiet and Fildor 1981).

Maternal death occur more in patients who cannot increase their pulmonary blood flow as in mitral stenosis or in obstruction with in the pulmonary blood vessels.

In rheumatic heart disease the babies are higher but the outcome is not very much affected fatal loss is high in cyanotic heart disease and may reach 40 percent. (Mutton 1974, Clecher 1979). A Fatal death in most cases is one to inadequate placental oxygenation and prematurity.

References:
1. John Studd:  
   *Progress in Obstetric and Gynaecology, Vol. 4.*
2. Desherst's:  
   *Integrated Obstetric and Gynaecology for Post Graduate.*
3. Dan Donald:  
   *Practical Obstetric Problems*
Name: Mrs. H.S.A
Age: 24 years
Residence: El Thawra 21
Occupation: Housewife
Date of admission: 9.6.90
Date of delivery: 14.6.90
Date of discharge: 11.6.90

Obstetrical History:

The patient had been married for 6 years, she was gravida 1 para 2 with history of one abortion, her first pregnancy ended in abortion at 3 months of gestational age. Evacuation was performed, her second pregnancy was uneventful, she delivered vaginally at home, the baby was alive and well, there were no complications, her 3rd pregnancy was normal and she delivered at home, the outcome was a term female baby who was alive and well. After delivery the placenta she developed severe postpartum hemorrhage. She was admitted to hospital and three pints of blood were transfused. No operative intervention.

Gynaecological History:

Menarche was at the age of 11 years, kata 5/30, her cycles were normal and regular.

L.M.P: 7.9.1989
E.D.O: 34.5.1990
Condition on Admission:

Mrs. H.S.A. attended follow up visit uneventful, she was a regular antenatal-care clinic attendant, she was advised to deliver at hospital, the importance of this was explained to her.

On the 19th of June 1950 she presented to hospital with labour pains. Her general condition was good, her blood pressure was 130/80 mmHg. All her systems were normal. Abdominal examination showed a uterine size corresponding to a term pregnancy, the lie of the baby was longitudinal. The head was presenting, and it was 2/5 palpable, the fetal heart sounds were 144 per minute regular and of good intensity, the baby was of average size. On vaginal examination cervix was soft, central eroded and thin, the os was 5.6 cm dilated. The membranes were intact, the head was at station -3.

Management:

The patient was considered as being in the first stage of labour. Enema was done, a pottogram was done. A large-calibre canula was passed into a vein, the patient was asked not to take any thing by mouth. A blood sample was sent for grouping and cross matching, two pints of blood were prepared, here hemoglobin was 12 grams per 100 ml. Her urine was free of sugar and acetone. The first stage of labour progressed satisfactorily when the cervix became fully dilated, she was transferred to the second stage room. Five I.U. of oxytocin were added to the intravenous drip, syntometrin was prepared by adding 0.5 mg of ergometrine to 5 I.U. syntometrin in a syringe. It was given intravenously at delivery of the anterior shoulder, the delivery of the baby was
completed safely, the left hand was placed on the abdomen, the uterus was felt contracted, the right hand held the umbilical cord. It was pulled steadily outwards and downwards while the left hand was pushing the well contracted uterus in the suprapubic area, upwards and downwards. The placenta and membranes were delivered smoothly, they were examined and found to be complete, the uterus was well contracted, the cavity was evacuated of clots by pressing the uterus. There was not vaginal bleeding, 0.5 gm of ergometrine were given intramuscularly and a drip of 10 I.U. of syntocinon was kept running to maintain uterine contractility over a period of 8 hours after delivery, the condition of the patient was observed for 24 hours, she remained well.

The outcome:

Was a male baby alive and well who cried immediately, his birth weight was 3.4 kg.

Discharge:

The patient stayed for two days in the post natal ward, she and her baby were in good health, she was discharged and asked to come after 6 weeks.

Postnatal visit:

The patient was seen 6 weeks later, she was healthy, the baby was vaccinated and breast fed, contraception was advised, she was informed to deliver in hospital in her future pregnancy.
Primary postpartum haemorrhage is (P.P.H.) defined as bleeding of 500 mls or more through the birth canal during the first 24 hours after delivery of the baby. It is a serious but usually preventable, maternal mortality from this cause in a given maternity centre reflects the back of efficient active and proper management of the 3rd stage.

Uterine atony in the 3rd stage of labour is the main cause of P.P.H. other causes include, bleeding birth-trauma, tear and lacerations, uterine inversion and clotting defect.

High risk patients for haemorrhage are those with a past history of P.P.H, retained placenta prolonged inert labour, precipitate labour, deep general anaesthesia, and patient with antepartum haemorrhage.

References:
1. Ian Dowed: Practical Obstetric Problems
2. Dowerest: Integrated Obstetric and Gynaecology for Post Graduate
GYNNECOLOGICAL HISTORY:

Menarche was at 14 years, body was 4/20, her cycles were regular and normal with no history of use of contraceptive methods.

L.H.P : 15.12.1990
R.B.D : 22.9.1991

Past history, family history, social history were not significant.
Drug history:
She was on tonics, there was no history of hyper sensitivity to penicillin or any other drug.

Current Pregnancy:
The first trimester was uneventful, in second trimester she felt quickening at 18 weeks; this was in May 1991. She gave a history of vaginal bleeding when she was 6 month pregnant, for which she was admitted to Khartoum Hospital for one week, the bleeding was mild to moderate and continued for 3 days. In the 3rd trimester she gave a history of another attack of bleeding when she was 8 month pregnant, it was mild and last for 3 days, she was admitted, investigated and discharged.

Admission:
Mr. H.B.M. was referred to hospital from a private clinic. Her general condition was good, here blood pressure was 120/80, her pulse 90/min. It was regular and of normal volume, all her system were normal, abdominal examination showed: A uterine size of 23 weeks, the lie was longitudinal, the head was presenting and it was in the left occipito-frontal position, the foetal heart sounds were heard, the rate was 140/min, they were regular and of good intensity, there was no lower limbs oedema.

Management:
The patient was sure of her dates, her cycle were regular there was no history of use of contraception, the uterus was significantly smaller than dates. A provisional diagnosis of sever
I.U.G.R. was made, the patient's blood group was O +ve.

Her haemoglobin was 8/4 (12.4 gms/100 ml). Her urine analysis showed no abnormalities. A kick count chart was drawn up. On the next day after admission she recorded 7 kicks per 24 hours. Ultrasound examination showed a fundal placenta with grade 3 maturity changes with diminished liquor and diminished fetal movement, the measurements of the biparietal trans abdominal and femur length showed no significant growth in comparison with an ultrasound examination made 3 weeks before. Termination by an emergency caesarean section was decided upon.

Delivery:

The paediatrician was informed and asked to attend the operation, lower segment caesarean section was performed, there was hardly any liquor. The baby was alive and well, she cried immediately, her weight was 1.3 Kg, the placenta was delivered complete with its membranes. It was greenish, small and with multiple areas of infarction.

Management of the Baby:

Immediately after delivery a clean airway was insured, secretion was sucked from the throat and nose, respiration was spontaneous and regular, the fetal heart rate was 150/min. It was regular Apgar score was 7 and 9 at one and five minutes respectively.
The baby was transferred to the neonatal special care unit and was kept in the incubator, it provided a neutral thermal and humidified environment, with regular (O₂) oxygen supply, the blood sugar was found to be 97 mg/100 ml which is normal. A nasogastric tube was placed in for feeding. In the first day she received 192.1 (150 ml/kg/24 hours) of 5\% glucose in water in 8 small divided doses. 1 mg of vitamin K, was given intramuscularly, on supplemental by artificial feed, on the 5th day and onwards, the whole amount given, through the nasogastric tube was breast milk. It was 270 ml in 8 divided doses given three hourly, on the tenth day the general condition was good and her sucking reflex was strong and coordinated with her swallowing. The nasogastric tube was removed and she was breast fed.

Three hourly follow up chart were drawn up so as to observe her temperature, respiratory rate, heart rate, colour, activity presence or absence of convulsions or apneic attacks. A daily weight charge was drawn, on the 15th day the baby was outside the incubator, her general condition was good, no respiratory problems, convulsions or hyper bilirubinemia. She was breast fed, and she was gaining weight progressively.

Discharge:

On the 3rd day the mother was in excellent condition, the baby was active and healthy, her weight was 1.966 Kg, the mother was educated about the baby care at home, contraception was advice, she was asked to complete the vaccination program of baby and was discharge in good condition.
A case of intrauterine growth retardation (I.U.G.R.) has been presented. I.U.G.R. is the 3rd commonest cause of perinatal death, coming after prematurity and congenital malformation.

Death from I.U.G.R. is avoidable, this is achieved by early diagnosis, adequate monitoring and intervention at the appropriate time.

diagnosis is by:

1. Clinical examination:
   a. a fundal level which is obviously less than reliable dates.
   b. oligohydramnios
   c. static maternal weight (or loss)
   d. decrease fetal movement.

2. Ultrasonic examination:
   a. brain sparing phenomenon (there is decrease or static transabdominal growth so as to preserve all the energy for the brain).
   b. decrease subcutaneous fat
   c. oligohydramnios
   d. placental maturity change

3. Test of foetal condition and placental function
   a. urinary or placental central level
   b. plasma placental lactogen
   c. urinary pregnanediol or plasma progesterone
   d. plasma pregnancy specific \( \beta \) -glycoprotein
   e. haemoconcentration in patients with pre-eclampsia.
Adequate monitoring is by:
1. kick count chart
2. serial cardiotocograph to observe the fetal well being.
3. serial ultrasound to follow the growth pattern.

Treatment of maternal underlying condition, if there is one will improve the outcome. Bed-rest is the left lateral position improves the placental blood flow and is one of the crucial items of treatment.

Recent therapy for placental insufficiency includes:
1. Heparin to prevent placental infarcts
2. Betamimetic drugs e.g. ritodrine to relax the uterus and so to increase placental blood flow.
3. d-hydroxyprogesterone sulphate that help in the production of estradiol.
4. aminoacid solution
5. low aspirin does (50-70 mg/day)

Co-operation with neonatologist is essential, the baby must be received in well experienced neonatal unit.

The growth and intellectual power of babies suffering from I.U.G.R. are not negatively affected in the long term.

References:
OBSTETRICAL CASE NO. 12
MALARIA WITH PREGNANCY

Name : R.M.A
Age : 23 years
Residence : Mutri (Gazira)
Occupation : Housewife
Hospital number : 656679
Date of admission : 8.4.91
Date of discharge : 19.4.91

Obstetric History:
The patient was married for 6 years, she was gravida 4 para 1 + two abortion, her first pregnancy was a missed abortion which was evacuated in 1980. She received one pint of blood, her second pregnancy was delivered normally and vaginally in 1983, at hospital the outcome was a male baby who was alive and well. Her 3rd pregnancy ended as abortion at 2 months of gestation, evacuation was done.

Gynaecological History:
Menarche was at the age of 15 years. Date was 4/11, regular cycles with moderate blood loss
L.M.P. : 11.11.86
E.D.D. : 18.3.91

There was no history use of contraceptive method.
Past history, family history, social history: were of no significance.
Drug History:

She was on tonics with no history of hypersensitivity to penicillin or any other drug.

History of Present Illness:

Mrs. Z.M.A. was 21 weeks when she was admitted, she was complaining of fever for the last 3 months. It was a high-grade fever, on and off and was associated with sweating, rigors, severe headache and dizziness.

Systemic Review:

- There was no chest pain cough or shortness of breath.
- There were palpitations, there was no paroxysmal nocturnal dyspnea.
- There was anorexia and loss of weight, there was no abdominal pain or vomiting. Bowel habits were normal.
- Urine was 3/1 day/night with no burning micturition, increased frequency or urgency. The urine was of normal color and there was no haematuria.
- There was no vaginal discharge or vaginal bleeding, there was no pruritis or itching.
- There was no loss of consciousness or fits.

This febrile condition was diagnosed as malaria by examination of a blood film, she received 20 injections of chloroquine, she used to improve for 3-4 days and then recurred.

One week prior to admission, she was admitted to Khartoum Hospital and received ten doses of quinine, she improved for five days but the fever recurred. On examination she was ill, pale and not jaundiced. Her temperature was 38°C. Her pulse was 100/min. It was regular and of normal volume. Her blood pressure was
130/60. All her systems were normal, abdominal examination showed a soft abdomen which was not tender, the liver was palpable 5 cm below the costal margin. It was soft smooth and not tender. The spleen was palpable 4 cm below the costal margin. It was soft and not tender. There was no ascites. The uterine size was at 24 weeks level, foetal parts were felt, fetal heart sounds were heard, there was no lower limb oedema.

**Investigations:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Investigation</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.5.91</td>
<td>E.P. for Malaria</td>
<td>Yellow stage of P. falciparum was seen</td>
</tr>
<tr>
<td>5.5.91</td>
<td>Haemoglobin</td>
<td>4.8 gms/100 ml - 58%</td>
</tr>
<tr>
<td>5.5.91</td>
<td>Urine general</td>
<td>No abnormality</td>
</tr>
<tr>
<td>5.5.91</td>
<td>W.B.C. Count</td>
<td>5000/crm</td>
</tr>
<tr>
<td>6.5.91</td>
<td>Urine culture</td>
<td>No pathogenic organism is dated.</td>
</tr>
<tr>
<td>6.5.91</td>
<td>Widal</td>
<td>Salmonella typhi titre 1/20, titre of no significance.</td>
</tr>
<tr>
<td>6.5.91</td>
<td>Liver function test</td>
<td>Total bilirubin was normal. Total proteins = 6.1 g/100 ml. albumin = 3.6 g/100 ml.</td>
</tr>
<tr>
<td>6.5.91</td>
<td>Peripheral blood picture</td>
<td>Showed hypochronic cell</td>
</tr>
<tr>
<td>7.5.91</td>
<td>E.C.G.</td>
<td>Normal except of H.R. of</td>
</tr>
<tr>
<td>110/min</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Management:

1. Combined antimalarial treatment:
   a. Fansidar (sulfadoxine 500 mg + pyrimethamine) (25 mg per a tablet) dose = 3 tablets single dose
   b. Quinine 600 mg in a drip of 5% glucose with normal saline given b.d. for 7 days.

2. Tonics:
   a. injectable iron
   b. Or. folic acid

3. Prophylaxis:
   2 tablets of chloroquine given weekly it was continued till 6 weeks after delivery.

Discharge and antenatal Clinic Follow Up:

The patient stayed for 12 days in the hospital. Her general condition improved, the temperature chart showed no rise for eight consecutive days. She was discharged and asked to come regularly to be seen in the antenatal care clinic. She was advised to continue on oral tonics and prophylactic chloroquine. In the antenatal care clinic her frequency continued normally with no more complications, she was afebrile all through. Her haemoglobin was around 78%, she was advised to deliver at hospital.

Delivery:

On the 23rd of August, she had spontaneous normal vaginal delivery at Soba Hospital. The placenta and its membranes were delivered complete, there were few areas of infarcts. The weight of the placenta was 450 grams, there was no immediate postpartum complications. The outcome was a female baby who was alive and well, her weight was 3.080 Kg.
Post-Natal Visit:

The mother and her baby were in good general condition, her haemoglobin was 85% (12.1 g/100 ml) the baby was vaccinated, breastfed and gaining weight.

Comments:

In our country malaria is the most important medical problem complicating pregnancy. During pregnancy there is increase in the frequency and severity of malarial infection. This is due to a break-down of the acquired immunity, this may be due to the stress of pregnancy or due to the increased protein requirements, leading to alteration of the channels at the expense of the immune system. Dormant exoerythrocytic infections may relapse, the condition tend to worsen as pregnancy advances.

Maternal morbidity increases as a result of high fever, or indirectly, due to anaemia hypoglycaemia and acute pulmonary embolism. Major complications are more common; for example cerebral malaria which is sometimes difficult to differentiate from eclampsia.

Anaemia is caused as a result of destruction of parasitized cells by haemolysis or phagocytosis by the lymphoid-macrophage system. Anaemia is also evident in patients with few parasitaemia. This is due to destruction of non-parasitized cells which plays the major role. This is an autoimmune phenomenon due to production of antibodies. This occurs especially in Plasmodium falciparum infection which is the commonest types of malarial infection in the Sudan.
The outcome of pregnancy is affected by malaria in many ways. It can cause abortion, premature labour, underweight or intrauterine growth retardation or fresh stillbirth; it increase the perinatal morbidity and mortality babies of malarious mother can be delivered with congenital malaria. These effects can be due to pyrexia, placental parasitization or transplacental infection.

Chemoprophylaxis is advisable for high risk patients. Proguanil is the safest antimalarial during pregnancy, but resistant strains of Plasmodium falciparum are present, chloroquine is relatively safe, cheap and well tolerated, the dose is 5 ml/kg/week. (maximum 300 mg/week) prophylaxis of neonates of mothers who had antimalarial prophylaxis is to be considered.

References:
1. J. A. Lawson & P.M. Steward:
   Obstetrics and Gynaecology in the Tropics and Developing Countries.
2. Harrison's:
OBSTETRICAL OBSTETRICAL CASE NO. 13
DIABETES WITH PREGNANCY

Name : C.A.Y
Age : 37 years
Residence : Khaloum
Occupation : Housewife
Date of admission : 14.8.1991
Date of delivery : 15.10.1991
Date of Discharge : 22.10.1991

Gynaecological History:

The patient was married for 16 years, she was gravida 8 para 7, with no history of abortions. All her first five pregnancies were normal. All were delivered vaginally and were alive and well, the 6th and 7th were larger babies in comparison with the previous ones, they were delivered as macerated stillbirth, at term, there was no antepartum haemorrhage or high blood pressure.

Gynaecological History:

Menarche was at 11 years, Kat. was 5/28, her ovulation were normal and regular.

L.M.P : 26.1.1991
L.D.D : 3.11.1991

Past history:

She was not known to be diabetic or hypertensive.
**Family History:**
There was no family history of diabetes, hypertension, or twins pregnancy.

**Social History and Drug History:**
Were not significant.

**Admission to Hospital:**
The patient was referred from a private clinic, she was newly discovered to be diabetic; the diagnosis was confirmed by blood testing. On admission she was 28-29 weeks, pregnant by dates; there were no complaints; on examination her general condition was good, she was not pale, her blood pressure was 120/70. All her system were normal, obstetric examination showed a uterine size of 32 weeks level, which was more than dates. The lie was longitudinal and the baby was in the left, occipitoposterior position, the head was presenting; the fetal heart sounds were heard, the rate was 140/min. They were regular and of good intensity, the liquor was more than average, there was no lower limb oedema.

**Investigations:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Investigation</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.6.91</td>
<td>G.T.T (glucose)</td>
<td>Fasting 250 ml, 100 ml. Urine ++</td>
</tr>
<tr>
<td></td>
<td>Tolerance test</td>
<td>Sugar. 1 hour after 75 mg glucose = 291</td>
</tr>
<tr>
<td></td>
<td></td>
<td>mg/100ml. Urine ++ Sugar no acetone</td>
</tr>
</tbody>
</table>

53
acetone. 2 hours = 300 mg urine + + + sugar.

15.8.91 Urine general Normal except at + of sugar

15.8.91 Hb. % 26.7 gram/ml (75%)

15.8.91 Blood sugar series at 7 am = 119 mg/100 ml
at 11 am = 121 *

at 2 pm = 132 *

at 5 pm = 121 *

at 9 pm = 123 *

25.8.91 Ultrasound Single viable baby transverse lie

biparietal diameter = 85 mm

transabdominal diameter = 90 mm

length, 60 mm. gestational age 32-34

week liquor > average.

25.8.91 Blood sugar series at 7 am = 150 Haemolyses are

at 11 am = 215 samples

at 2 pm = 174 mg/100 ml

at 5 pm = 170 mg/100 ml

at 9 pm = 189 mg/100 ml

30.9.91 Urine general Clear

30.9.91 Stools general Normal
13.10.91 Blood sugar site at 6 am = 108 mg/100 ml
     at 11 am = 162 mg/100 ml
     at 2 pm = 148 mg/100 ml
     at 6 pm = 144 mg/100 ml
     at 9 pm = 122 mg/100 ml

13.10.91 Ultrasound
     Single cephalic viable baby, upper
     segment anterior placenta with
     grade I maturity changes femur

length 72 cm B.P.D. = 93 mm trans
abdominal diameter 108 mm, Sex. bxp
term baby, liquor > Average.
anomalies

12.10.91 Hb%  12.8 grams/100 ml = 90%
15.10.91 Urine  no sugar no acetone
0.10.91 pre-operative R.B.S 170 mg/100 ml
15.10.91 Post operative R.B.S 126 mg/100 ml
20.10.91 Blood sugar 1. Fasting 108 ml/100 ml
     2. 2hrs after meal = 152 ml/100 ml

Management:

The patient was admitted to the hospital. A follow-up chart
was drawn up, it included observation of the kick count. She was
put on soluble insulin, 10 I.U. and t.d.s. 5 days later blood
sugar series (R.B.S) was performed, the reading were not
satisfactory, the aim was to keep the blood sugar around 150
mg/100 ml although the day, the does of insulin was increased
and R.B.S. was done for evaluation of the degree of control. When
the dose reached 25 I.U. t.d.s. the B.S.R. was found to be satisfactory. Other than fetal macrosomia, she had no abnormalities.

Delivery:

On the 15th of October the patient complained of slight abdominal pain and "shakiness". On examination she was well, she was not pale or jaundiced, her pulse was 100 min. Her blood pressure was 125/80. Obstetric examination showed a uterine size of a term pregnancy, the lie was longitudinal. The presentation was cephalic, the fetal heart sounds were heard, the rate was 146/min. They were regular and of good intensity, estimated to be 4.5 Kg + 0.5 Kg. Pelvic examination showed the vagina was moist, warm and healthy. The cervix was central soft effaced and thin. The os was 4 cm dilated. The diagnosis of the first stage of labour was made, the patient was fasting, the morning dose of insulin was not received. Emergency preparation of two pints of blood was requested. Urgent blood sugar examination was asked for. It was 110 mg/100 ml. Her urine was clear. Her haemoglobin was 12.8 gm/100 ml = (90%). The paediatrician was informed and asked to attend the delivery. Emergency caesarean section and tubal ligation was performed. The outcome was a male baby, he was alive and well. His weight was 4.18 kg, he was kept in the neonatal special care unit, he was managed by early feeding, and careful follow-up of his vital signs. His blood sugar was checked daily. He remained generally well with no hypoglycaemic attacks, respiratory problems or convulsions. He was vaccinated and breast fed.
Post-operative Management:

1. Post operative serum blood sugar level was found to be 136 mg/100 ml.

2. She was given intravenous 5% glucose in water. Early mobilization was advised. Oral feeding was allowed 3 hours after the operation and intravenous fluids were stopped.

3. Soluble insulin was reduced to 10 I.U. t.d.s. There were no symptoms or signs of hypoglycaemia.

4. On the 5th day fasting blood sugar was 105 mg/100 ml and the blood sugar 2 hours after a meal was 152 mg/100 ml.

5. The insulin was given as 20 I.U. of zinc insulin and 10 I.U. of soluble insulin as a single dose.

6. On the 8th day the parametrial incision was clean and healed. The mother and her baby were in good health, she was discharged and asked to come after 6 weeks for post-natal visit.

Post-Natal Visit:

She and her baby were in good general health, she was asked to seek the advice of a physician for the supervision of control of her diabetes.

Comments:

A case of diabetes mellitus with pregnancy has been presented. Diabetes and pregnancy have mutual negative effects on each other. Physiological pregnancy is diabetogenic. A pre-diabetic lady may behave as a frank diabetic when she is pregnant. The insulin requirement in diabetic patients is increased and needs to be readjusted as pregnancy advances. Infertility and repeated abortions can be explained by diabetes.
The disease increases the occurrence of polyhydramnios and pre-eclampsia.

Diabetes affects the baby not only during pregnancy and labour but also during the early neonatal period. Congenital malformations are increased by 3-4 times (Malins 1978). They include congenital heart disease spina bifida and anencephaly. They occur more in uncontrolled patients during organogenesis. Other effects include macrosomia, pre-maturity, intrauterine fetal death, fetal distress, birth trauma, R.D.S. fetal hypoglycaemia, hypocalcaemia and hyperbilirubinaemia.

The milestones in management of diabetes include:

1. Integrated clinical approach conducted by an obstetrician, physician and a neonatologist.
2. Control of blood sugar within a narrow range to be started as early as before conception.
3. Using soluble insulin and depending on blood sugar testing for control.
4. Planned delivery. Termination is at 36 weeks inclination is towards vaginal delivery. But caesarean section is to be performed whenever vaginal delivery seems to carry more danger to the mother or her baby.

References:

1. John Studd:
2. Sehwert:
   Integrated Obstetrics and Gynaecology for Post Graduate.
OBSTETRICAL CASE NO 14
PRE-NEONATAL INTRA UTERINE VAGINAL DELIVERY

Name : N.M.A
Age : 26 years
Residence : El Morada
Occupation : Teacher
Date of admission : 18.11.89
Date of delivery : 1.12.89
Date of discharge : 6.12.89

Obstetrical History:
She was a primigravida who was married for 10 months.

Gynaecological History:
Menarche was at the age of 13 years, kena was 5/30, her cycles were regular and normal.
L.H.P. : 11.1.89
E.C.D. : 15.12.89
No history of use of contraceptive methods.

Past History:
She was not known to be diabetic or hypertension with no past history of renal disease.

Family History:
No family history of diabetes or hypertension.
Social and Drug History:

Was no significant

Current Pregnancy:

Mrs. M. J. A. was a regular antenatal care clinic attendant. Her pregnancy was uneventful; her blood pressure records showed normal readings since early pregnancy. On the 16th of November she was referred from the antenatal care clinic for hospital admission, she was 36 weeks pregnant according to the date of the last menstrual period. She was complaining of progressive lower limb oedema. On examination she was generally well, she was not pale or jaundiced, her blood pressure was 150/100. Her pulse rate was 90/min. It was regular and of normal volume. All her systems were normal, the uterine size was at 36 weeks level, the lie of the baby was longitudinal. The head was presenting, it was not engaged, the fetal heart sounds rate was 144/min, they were regular and of good intensity, there was lower abdominal wall oedema. There was lower limb oedema.

Investigations:

1. Urine showed (+) of albumin
2. Her haemoglobin was 11.6 gms (32%)
3. Her blood group was A Rh Positive
4. Liver function test showed normal bilirubin, total protein of 8.5 and albumin of 3.4 g/100 ml.
5. Her urea was 18 mg/100 ml, the Na+ was 136 mg/l and the K+ was 3.8 mg/l.
6. Uric acid was 3.6 mg/100 ml.
Management:

The patient was kept in hospital for complete bed rest, she was put on diazepam 5 mg 6 hourly and low salt diet. A follow-up chart was drawn up; it included: complaints, pulse, rate, blood pressure, temperature, fetal kick count, fetal heart sounds, and urine for albumin. According to this follow-up chart her condition was more or less static. When she was 37 weeks pregnant by dates, clinical pelvic assessment was performed. The pelvis was found to be quite adequate. Sweeping of the membranes was performed daily from 37/4u till she was 38 weeks.

Delivery:

On the third of December, the patient was referred to the labour room for induction, she was 38 weeks pregnant, there were no complaints was. Blood pressure 140/95. The uterus size was at 38 weeks, the lies was longitudinal and the head was presenting, ti was 3/4 palpable, fetal heart sounds were 148/min. They were regular and of good intensity. The estimated baby's weight was 3.8 Kg + 0.5 Kg pelvic examination showed: a soft cervix which was central, effaced and thin, the os was 3 cm dilated, the membranes were intact. The head was in the left occipitofrontal position and at station two. Enema was performed. A canula was inserted into a big vein. The patient was sedated by 5 mg of diazepam given slowly intravenously, 2 1/2 of syntocinon was given in a drip of 5% glucose in water. As soon as uterine contractions became established, artificial rupture of membranes was performed. The liquor was altered by old meconium, indicating chronic fetal distress. Pethidine 100 mg was given intramuscularly. A partogram
was drawn up, the patient was observed closely, the progress of the first stage of labour was satisfactory, it lasted for 8 hours, the second stage was shortened by an elective forceps. The outcome was a male baby who was alive and well, he cried immediately, his Apgar score was 9 and 9 at one and five minutes respectively. His weight was 2.7 Kg. The placenta and its membranes were delivered complete. There were many areas of infects. The uterus was well contracted, there was no immediate post-partum complications. 10 I.U. of syntocinon was given intramuscular, 10 mg of diazepam was given intravenously, the blood pressure was 130/85.

Discharge:

The patient was admitted to the post-natal ward. A blood pressure chart was done-up, she was improving, on the 3rd day the patient’s general condition was good. Her blood pressure was 120/80. All her systems were normal, the uterus was involuting, there was no genital infection, there was no evidence of deep vein thrombosis, the baby was healthy and active, he was vaccinated and breast-fed. She was discharged and asked to present to the post-natal care clinic after 6 weeks.

Comment:

Pre-eclampsia (P.E.T.) is one of the commonest obstetric complications. It occurs as high as 5% of all pregnancies, the incidence increases with certain conditions such as young primigravidae, twins pregnancy, diabetes, hydatidiform mole (up to 50%) and hypoglycemic fetal (up to 50%).
The aetiology of P.E.T. is not well known, there are many theories, objections may be raised to them all in one aspect or another. It is possible that P.E.T. represents different diseased states in different individuals. One of the major features of the disease, appears to be an alteration in the vascular endothelium, rendering it susceptible to:

Immuneological mechanisms, altered coagulation, and vasoactive agents. Still more studies are needed.

P.E.T. increases maternal morbidity and mortality. Its complications include: renal damage, heart failure, cerebral haemorrhages, eclampsia and antepartum haemorrhage due to placental abruption.

Fetal effect of P.E.T. include: intrauterine fetal death, from hypoxia, fetal distress during labour, serve asphyxia at birth, intrauterine growth retardation and prematurity. Referring to Mary's and Friedman's study (1979) the perinatal mortality rate was more than doubled 19.0 per 1000 in women with hypotension and proteinuria compared with 17.2 per 100 in normotensive patients.

The placenta in P.E.T. showed multiple areas of infarcts, the highly vascular villi are replaced by fibrosis. There is acceleration of placental aging process. This is evident by thickening of the syncitium and gradual thickening of the blood vessels in the villous stalk and villi. The fetal-type mesoderm is replaced by fibrous tissue.
References:

1. John Studd:
   Progress in Obstetric and Gynaecology Vol. 1

2. Denherst:
   Integrated Obstetrics and Gynaecology for Post Graduate.

3. John Studd:
   Progress in Obstetric and Gynaecology Volume I.
OBTETRIC CASE NO. 15
MUltipara. PREGNANCY

Name : J.M.K.
Age : 28 years
Occupation : Housewife
Date of admission : 12.7.89
Date of delivery : 12.7.89
Date of discharge : 14.7.89

Obstetrical History:
The patient had been married for the last 3 years, she was
gravid two para one, with no history of abortions. Her first
pregnancy was uneventful, she delivered vaginally in 1987, at
hospital, the baby was a male who was alive and well.

Gynaecological History:
Menarchoe was at the age of 14 years, her cycles were normal
and regular, kata 5/10
L.M.P : 16.10.88
E.D.D : 23.7.89
She used contraceptive pills which were stopped 6 months
prior to the date of her last cycle. During that period she had
regular normal cycles.

Family History:
There was no family history of hypertension or diabetes, her
grandmother had twins.

Past history, social history, drug history: were of no
significance.
History of Current Pregnancy:

She was a regular antenatal care clinic attendant. In the first trimester she had excessive vomiting for which she needed admission twice, during the second trimester she had an uneventful course. It was noted that her uterine size was larger than dates at repeated visits. There were multiple fetal parts and multiple pregnancy was suspected. An ultrasonic examination confirmed that she was carrying twins. Both were viable and active, there were no abnormalities. This condition was explained to the patient and she was asked to report more frequently at the antenatal clinic. She was put on iron and folate tablets, her haemoglobin was never at any time below 70% (10 grams per 100 ml). During the 3rd trimester she had no complaints there was no anaemia, polyhydramnios or preeclampsia. She was advised to deliver at hospital.

Admission to Hospital:

Mrs. J.M.H. was admitted to hospital on the 12th of June 1989, she was complaining of labour pains, on examination she was well, not pale or jaundiced. Her pulse was 100 per minute it was regular and of normal volume. Her blood pressure was 125/85, all her systems were normal, the abdomen was huge, there were multiple fetal parts. A small head was presenting and it was not engaged. There fetal heart sounds were heard clearly at more than one point, the rate was 144-148/min, they were regular and of
good intensity. Uterine contractions were regular at 3
contraction per 10 minutes. Pelvic examination showed a worm
moist vagina, the cervix was soft, central, effaced and thin, the
os was 5-6 cm. dilated, the membranes were intact, the forewaters
was formed, the head was at station +1.

delivery

The diagnosis was twins pregnancy in the first stage of
labour. An enema was done a partogram was drown, she had a
reasonable first stage of labour, it lasted for 6 hours. When the
cervix was fully dilated, she was transferred to the second stage
room and put in the lithotomy position, the bladder was emptied,
the vulva was found circumcised, the vagina was healthy and the
cervix was fully dilated. The head was at station +3, local
anesthesia (0.5% xilocain) was infiltrated in the vulva and
perineum. A canula was passed into a large vein and drip of 5%
glucose in water, was kept running. The first baby was delivered
by maternal efforts during uterine contraction after performing
a deccircumcision and an adequate episiotomy, the cord was cut
between two clamps. Abdominal examination showed the second baby
in an oblique lie with head in the left iliac fossa, the fetal
heart sounds were 167/min and regular. The bladder was emptied
and the lie was corrected by abdominal manouevres. 5 I.U. of
sytococin were added to the drip, the head was fixed at the brim
by the hand of an assistant, controlled artificial rupture of
membranes was performed, so as to achieve show rupture of the
liquor amnii. The liquor was clear. The head descended by
maternal bearing down efforts during uterine contraction. The
second baby was delivered without complication. Two placentae and
their membranes were delivered complete. 0.5 mg of ergometrine
was given intramuscularly. 10 J.I.U. of syntometrine were kept
running through the intravenous line. The uterus was well
contracted and there was no significant vaginal bleeding, the
decircumcision and the episiotomy were then repaired.

The Out Come:

Two female babies were delivered in excellent condition,
they cried immediately after birth, their weights were 2.6 and
2.4 kg respectively, there were no apparent congenital
malformations.

Discharge:

The patient spent two days in the postnatal ward, she and
her babies remained in good health, there were no puerperal
complications. Her babies were vaccinated and breast fed. She was
educated about their care, she was advised to put them at the
breast at the same time; she was discharged in good condition and
asked to come after six weeks.

Postnatal Visits:

The patient came after six weeks, she was in good condition,
both of her babies were healthy, contraception was advised.

Comments:

A case of twin pregnancy has been presented. Twins occur
one in 80 in European pregnancies, the incidence is higher in
Africans.
Gaining two babies out of one pregnancy is not without a high risk. Difficulties are faced during pregnancy, labour, lactation and early childhood. All the symptoms of pregnancy are exaggerated, increased demand, if not met by good nutrition and supplementation will cause anaemia, usually iron and folate deficiency anaemia. Pre-eclampsia increases by three fold. All the difficulties of late pregnancy are exaggerated with increased discomfort backache due to lordosis, oedema, varicosity and haemorrhoids.

During labour twins need active management by an expert obstetrician. Problems are mainly during the delivery of the second twins, malpresentation, cord prolapse, transplacental haemorrhage and manipulation increase the hazards. Post partum haemorrhage must be prevented. The bleeding is from the large placental bed or due to atony of the uterus.

The babies are lighter than average the combined birth weight exceeds 4 kg. There is increase incidence of abortions, premature labour and polyhydramnios, the overall perinatal mortality for twins pregnancies is four times that of single pregnancies it is higher in uniovular than in binovular, and higher in the second than in the first twin.

References:
1. Bryan M. Hibbord:
2. Dewhurst:
   Integrated Obstetric and Gynaecology for Postgraduate.
Definition:
Successful trial of scar means smooth and safe vaginal delivery in a lady with a previous uterine scar, either from a caesarean section or a D & C. Such a trial should not result in an increase in maternal morbidity or mortality. The outcome must be a healthy baby without an increase in the perinatal mortality or morbidity.

Introduction:
In uncomplicated vaginal delivery is known to be safer than an operative one. It is cheaper. It involves less number of staff. Hospital stay is short and can be as short as two hours. For our Sudanese patients vaginal delivery is almost always recommended if possible. It is preferable due to many psychological and cultural considerations. Sudanese families are usually large families and repeated caesarean deliveries limit their parity.

Patient and Methods:
213 patients are included in this study. They were selected from the admissions at Omdurman Maternity Hospital during the years 1989 and 1990. All of them were admitted in the first stage of labour. They had previously delivered by caesarean section.
They were of different age groups. These gravida were ranging between two to eight. All of them had successful trial of scar resulting in vaginal delivery. There were no maternal deaths, or increased maternal morbidity. The lower segment was examined in all cases and found to be intact. Some of these patient were delivered by an elective forceps, some were delivered by an elective ventouse, the rest was delivered unassisted.

Omdurman Maternity Hospital is the main obstetric unit at Omdurman city. The follow up of labour is covered by a medical staff. That includes registrars and obstetrician who are readily available to interfere when ever necessary.

All patient were scheduled for a trial of a scar during the antenatal period. The patient reported to register at the start of labour. They were managed along the same lines as other labouring ladies, but in addition the following steps were taken:

1. they were asked not to take anything by mouth.
2. intravenous fluids were administered through a large intravenous canula.
3. blood sample was taken for grouping and cross matching.
4. two pints of blood were prepared and kept ready for transfusion whenever asked for.
5. haemoglobin was estimated.
6. urine was examined for sugar and acetone.
7. artificial rupture of the membranes was performed when cervix was effaced and more than 2 cm dilated.
3. A follow-up chart was drawn to include the following:

a. the maternal condition:
   - pulse rate (beats/min)
   - blood pressure
   - temperature
   - state of hydration

b. the fetal condition:
   - fetal heart sounds (rate/min)
   - regularity and intensity
   - presence of meconium

c. the scar condition:
   - tenderness over the lower segment in the absence of conditions
   - vaginal bleeding

d. the progress of labour:
   - uterine contraction (frequency, intensity and duration)
   - descent of presenting part
   - rate of cervical dilatation

At any time during the follow-up, if there is a change in maternal or fetal condition, then termination of the trial of scar is considered and a separate caesarean section is performed.
Results:

The results are summarized in form of tables and histograms.

Table three and figure three show the distribution of patient according to the number of successful trial, including the trial under study, regardless of her parity. For example a lady who is para five may have the trial number one. That is to say her 4th delivery was by caesarean section.

Table seven show the distribution of patients according to indication of previous scar. The unclear and miscellaneous group included one case who had vaginal delivery after three previous scar. Four patients had two previous scars. They delivered vaginally before 36 weeks of gestational age. Their babies were significantly small. In a large number of patients the indication for caesarean section was not known.

Discussion:

Trial of scar is a difficult practical clinical situation. One aims to deliver his patient with the least cost without increasing the risks for the mother or her baby.

When to switch off the trial by deciding its failure is an area of disagreement. While the patient is allowed or reasonable opportunity to succeed, it is obvious that intervention must not be too late. A trial of scar is a matter of judicious assessment from the start. It must be conducted under close and careful follow-up. In a well equipped hospital that is capable of facing emergency problems adequately. The staff available must be experienced in dealing with any intrapartum emergencies that may arise in the course of the trial.

101
<table>
<thead>
<tr>
<th>Age</th>
<th>&lt;20y</th>
<th>20-24</th>
<th>25-29</th>
<th>30-34</th>
<th>35-39</th>
<th>&gt;60y</th>
<th>Total</th>
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<tbody>
<tr>
<td>No.</td>
<td>10</td>
<td>46</td>
<td>72</td>
<td>68</td>
<td>29</td>
<td>4</td>
<td>218</td>
</tr>
<tr>
<td>%</td>
<td>4.6%</td>
<td>21.1%</td>
<td>33.0%</td>
<td>30.2%</td>
<td>9.7%</td>
<td>1.8%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table No. 1

Showing the distribution of successful trial of scar according to the different age groups.
Fig. 1: A histogram showing the distribution of successful trial of new according to the different age groups.
Factors that lead to success or trial of years include:

1. Maternal age:
   The majority of patient were found to be in the age group 25-29 years (62.89%), 34.03% of them in the group from 25-29 years, 30.28% were in the group from 30-34 years. At these age groups the growth of the pelvis is complete and the patients are healthy and fit.

2. Parity:
   61.53% of the patients were para 4 or less, 8.26% were para 5. Only 3.97% were para 6 or more. The uterine muscle fibres are replaced by fibrous fibres. In subsequent pregnancies, Grandmultiparity by itself is associated with an increased risk of uterine rupture in labour seems unwise to add to the potential risks the hazards of scarred uterus. It seems to be safer have such a patient to deliver by an elective cesarean section. Total ligation should never be a reason to direct the balance towards operative delivery, but when such a patient delivers by cesarean section it may be wise to take her consent to performed.

3. Baby size:
   This is one of the major determinants of success. Clinical estimation of the baby's weight is an important skill to be learned. One need to train himself so as to avoid big error. Good estimation can be gained by practice. 91.36% of the babies were 3.6 Kg or less in weight. Only 8.72% were more than 3.6 Kg. One of these babies weighted 4.6 Kg. It is clear that
<table>
<thead>
<tr>
<th>Parity</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>62</td>
<td>41</td>
<td>31</td>
<td>53</td>
<td>18</td>
<td>6</td>
<td>5</td>
<td>2</td>
<td>1218</td>
</tr>
<tr>
<td>%</td>
<td>57.16</td>
<td>34.01</td>
<td>26.22</td>
<td>45.14</td>
<td>8.28</td>
<td>5.19</td>
<td>4.1</td>
<td>0.8</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table No. 2.

Showing the distribution of successful trial of scar according to the parity.
It represents the distribution of the successful trials of dark according to the purity.
<table>
<thead>
<tr>
<th>No. of trials</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of p</td>
<td>101</td>
<td>49</td>
<td>38</td>
<td>15</td>
<td>12</td>
<td>3</td>
<td>218</td>
</tr>
<tr>
<td>%</td>
<td>40.35</td>
<td>22.48</td>
<td>17.45</td>
<td>6.88</td>
<td>5.64</td>
<td>1.38</td>
<td>100</td>
</tr>
</tbody>
</table>

Table No. 5

Showing the distribution of successful trials of sea according to the stand of the trial under discussion.

& the present trial in
A histogram showing the distribution of the successful trials of rain according to the order of the trial under discussion (the present trial).
<table>
<thead>
<tr>
<th>Baby Weight in kg</th>
<th>&lt;2.5</th>
<th>2.5-2.7</th>
<th>2.8-3.0</th>
<th>3.1-3.3</th>
<th>3.4-3.6</th>
<th>&gt;3.6</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>18</td>
<td>42</td>
<td>69</td>
<td>63</td>
<td>32</td>
<td>19</td>
<td>218</td>
</tr>
<tr>
<td>%</td>
<td>8.27</td>
<td>19.27</td>
<td>31.06</td>
<td>28.31</td>
<td>14.68</td>
<td>7.64</td>
<td>7.64</td>
</tr>
</tbody>
</table>

Table No. 4

Showing the distribution of successful arrest of scarps, according to the baby birth weight, in kilograms.
A histogram showing the distribution of the successful trial of bear according to the saby weight.
This patient was a lucky lady who had a good outcome despite wrong assessment. The baby was underestimated because of obesity. Elective caesarean section would have been safer for such a situation. For relatively heavier babies, the degree of adequacy of the pelvis may compact for their size.

Assistance in 2nd Stage of Labour:

55.50% of the patient were assisted, 34.80% by an elective forceps and 20.64% by an elective ventouse for the delivery of the baby. Performing elective forceps or ventouse will eliminate the effect of the opposing factors. These are the force of uterine contractions acting from above and the force of the resistance made by the toughness of the perineum, acting from below. If these force are acting strongly against each other, the increasing intrauterine pressure may escape through the weakest point that will be the site of the scar. Another advantage is that it will lessen the maternal efforts during the 2nd stage.

5. Indication for the Previous Operation:

Regarding the indications for previous caesarean sections, there are two types. They are either for a constant cause, that repeats itself with each pregnancy, or they may be for a non-constant (or actual) cause. In considering a trial of a 2nd the cause of the previous operation must be non-constant. In the group under study, one lady was delivered vaginally after three caesarean sections! Inspire of the fact that she was not tried in the sense of obstetric management. She managed to deliver herself uneventfully! Patient had successful trials of scar after 2 previous caesarean section. All these babies were
<table>
<thead>
<tr>
<th>Gestational Age</th>
<th>&lt;36 weeks</th>
<th>36-37</th>
<th>38-39</th>
<th>40-41</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>9</td>
<td>71</td>
<td>104</td>
<td>34</td>
<td>218</td>
</tr>
<tr>
<td>%</td>
<td>4.18</td>
<td>34.57</td>
<td>47.17</td>
<td>15.59</td>
<td>100</td>
</tr>
</tbody>
</table>

Table No. 5

showing the distribution of successful trial of scar according to the gestational age at the time of delivery.
A bar graph showing the distribution of successful trials of four according to the gestational age at the time of delivery.
<table>
<thead>
<tr>
<th>Mode</th>
<th>Spontaneous</th>
<th>Ventouse</th>
<th>Forceps</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N</strong></td>
<td>97</td>
<td>45</td>
<td>76</td>
<td>218</td>
</tr>
<tr>
<td><strong>%</strong></td>
<td>44.85%</td>
<td>20.84%</td>
<td>36.86%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table No. 6

Showing the distribution of successful trial of scar according to the mode of delivery of the head.
Fig 5.

A histogram showing the distribution of the successful trial of scar according to the mode of delivery.
Table No. 7
showing the distribution of successful trial of scar
assembly of the previous cesarean section.
FIG. 7: A histogram showing the distribution of the successful trials of wear according to the indication of the previous wear.
premature and small. Three of these present late in the first
stage with the head already at the pelvic outlet.

The total number of deliveries at Camaroon Maternity
Hospitals was 13625 during the study period. Successful trial of
scar was achieved in 218 patients. 1.6% of the total number were
spared having a repeat caesarean section.

Summary:

Vaginal delivery is preferable to caesarean section wherever
possible. Most of our patients insist on vaginal delivery whenever
feasible. Patients who are considered for vaginal delivery after
a previous caesarean section must be assessed carefully. The most
important factors to assess the estimated baby weight, which must
be of average size (3.4 kg or less), and the adequacy of the
pelvis. The dangers must be weighted accurately against the
benefits. The procedure is not without its hazards and sometimes
catastrophes can occur. Trial of scar must be performed only in
maternity hospitals where adequate facilities exist, and the
staff is capable of anticipating major problems and intervene
actively to prevent risks to mother and baby.

This study would have been complete if it had included an
account of the patient who failed to deliver vaginally after a
trial of scar in terms of numbers, percentage and
characteristics. A review of the cut come, morbidity and
mortality of mothers and their babies would have shed light on
the cost-benefits of the event. Factors that led to the failure
could have been identified and the criteria of success could have
been defined with better prospecton. The case-records of the
failed-trial patient during the period of study were either not
available and or incomplete so that meaningful results could not be obtained. This is accordance with maximum only success is highlighted.

Reference:

1. Dewhurst:
   Integrated Obstetric and Gynaecology for Post Graduate.
2. Ian Donald:
   Practical Obstetric Problems.
3. Bryan M. Hibbard:
   Principles of Obstetrics
4. Ralph. C. Benson:
   Current Obstetric and Gynaecological diagnosis and treatment
5. James W. Scott:
   Mandatory trial of labour after caesarean delivery; An
   alternative viewpoint. (Obstet. and Gynaecol. 77, 811-814)
   oxytocin augmentation of atrial of labour after a prior
7. S. Arulkumaran et al:
   Uterine activity during spontaneous labour after previous lower - segment caesarean section.
   (Br. J. obstet and gynaecol. 96, 932-938.)
Name       : A.I.A
Age        : 45 years
Residence  : Al-Deem
Occupation : Housewife
Hospital number : 91697
Date of admission : 22.7.91
Date of operation : 25.7.91
Date of discharge : 1.8.91
C/O Heavy cycles/4 years

The patient was para 3 with no history of abortion. All her deliveries were spontaneous normal vaginal deliveries conducted at hospital. All of them were alive and well. The youngest was eleven years old. Her husband died six years prior to her admission.

Gynaecological history:
Her menarche was at the age of 14 years. Katn 8-10/30. Her cycles were regular and normal. For the last four years became excessive, with heavy blood loss with clots and dysmenorrhoea particularly during the first four days. They lasted for 8 days to 10 days and sometimes longer. Two months before started to have intermenstrual bleeding. The blood was bright red and not offensive. There was no history of vaginal discharge. She did not use any contraceptive methods during the last seven years. Her last menstrual was on 27.6.91.

Systemic review:
She had no fever or loss of weight.
CVS she complained of palpitation and dizziness. There was no history of paroxysmal nocturnal dyspnca.
Gest: There was no history of chest pain, cough, haemoptysis or wheezing.
Abdomen: There was no history of abdominal pain, nausea or vomiting. Her bowel habits were normal.

Urinary system: Her micturition was 3/4 day/night. No burning micturition, dysuria or urgency. There was no haematuria.

Central nervous system: There was no history of headache fits or head injuries.

Past History:
She was not known to be diabetic or hypertensive. She underwent dilation and curettage 3 months prior to admission.

Family History and Social History:
Were of no significance.

Drug History: she was on Norodhistarone tablets 5 mg t.d.s. There was a history of hypersensitivity to Penicillin.

On Examination:
The patient was referred from a gynaecologist for admission. She was not pale or jaundiced. Her pulse rate was 80/min, regular and of normal volume. Her blood pressure was 110/80. Her breast examination showed no abnormalities. All her systems were normal. Abdominal examination revealed a soft abdomen which was not tender. The liver and the spleen were not palpable. There was a central pelvi-abdominal mass equivalent to the size of a 16 weeks pregnant uterus. It was firm, irregular, mobile and not tender. It was not attached to the skin. On pelvic examination, the patient was circumcised, there was no apparent bleeding or discharge. The vagina was healthy. The cervix was smooth firm and looked healthy. The os was closed. The uterus was enlarged to a size equivalent to 16 weeks pregnancy. It was irregular firm and not tender. The adnexae and the pouch of Douglas were free of masses and tenderness.
Diagnosis:
The diagnosis of multiple uterine fibroids was made and confirmed by ultrasonic examination.

Investigations:
1. Her haemoglobin was 11.4 grams/100 ml (76%)
2. Her urine was free of sugar and acetone
3. Her blood group was B negative
   Two pints of blood were donated and prepared
4. Chest X-ray was normal
5. Urea level 25 mg/100 ml
6. I.V.U. was normal

Management:
The condition of the patient was explained to her. She agreed to undergo hysterectomy. She was prepared as explained in the introduction. Two pints of blood were cross matched and kept ready.

Operative Procedure:
The operation was performed under epidural anaesthesia and dorsal position. The abdominal wall was sterilized. The patient was covered with sterile towels leaving only the field of operation exposed. An indwelling catheter was fixed through Pfannenstiel incision the abdomen was opened in layers. The uterus was enlarged, mobile and free of adhesions. It was delivered outside through the incision. Both tubes and ovaries were healthy. Two clamps were applied at the two corns of the uterus for purpose of traction and vascular occlusion. The round ligaments were clamped, and sutured by transection. The two layers of the broad ligament were separated. The anterior leaf was cut for a distance about 2 cm while a hole was made in the posterior one using the index finger. A clamp was applied to include the proximal portion of the tube and the ovarian ligament conserving the ovaries. The same procedure was applied to the left side. The peritoneum over the lower segment was cut transversely and it was dissected in the vesicouterine pouch so as to push the
bladder wall below the level of the cervix. The left and right uterine arteries were seen and palpated. They were pushed away from the sides of the uterus. The right and left uterine arteries were identified and palpated. The uterus was pulled to the left side by the assistant. The right uterine artery was clamped in the parametrium with a curved clamp which was placed immediately lateral to the wall of the cervix. Another clamp was placed below the first. The uterine artery was cut in between. The two clamps and the pedicle were carefully ligated by transfixation and doubly ligated and the haemostatic was complete. The left uterine artery was treated in the same way. Chronic catgut No. 0 one was used. The right and left transverse ligament of the cervix was clamped, cut and sutured. The uterine ligaments were clamped, cut and sutured. The uterus became mobile and was pulled upwards. The cervix was palpated by placing the hand anterior and posterior to it. The corners of the vagina were clamped just below the cervix. The uterus was removed using the scalpel. The anterior and posterior walls were held by two Ellis’s forceps. The vagina was sutured by a through and through stitching. The two corners were sutured separately by transfixation. The peritoneum was closed. Haemostasis was checked and found complete. The corners of the vagina were tied to the transverse and uterosacral ligaments on both sides to reduce the domes space area and to provide support to the vault thus prevent vault prolapse. The pouch of Douglas was cleaned. The abdominal cavity was apiece. There was no bleeding. The abdomen was closed in layers. The skin was sutured subcutically using chronic catgut number 60. The patient was in good general health. Her blood pressure was 110/70 mm hg. She was transferred to the recovery room with the epidural catheter in. The uterus was opened, there were multiple fibroid and two submucous polyps. It was sent for histopathology. Estimated blood loss was 200 ml.
Post-operative Period and Discharge:
The patient had a smooth post-operative period. She needed
topping-up of the epidural analgesia to provide satisfactory post-
operative analgesia. The epidural catheter was removed after 24
hours after the operation. The amount and colour of urine was
normal. The bladder catheter was removed in the first 24 hours.
She was allowed to take food. On the fifth day the wound was
inspected. It was dry and free of infection she was a febrile.
Her haemoglobin was 11 g/s (74%). She was taking food and drinks
with normal micturition and normal bowel movements. She was
discharged in good condition.

Histopathological Report:
This was reported "Benign fibro-adenomatous benign endometrial
polypus".

Follow-Up:
Mrs. A.I.A. presented to the referred clinic one month after
the operation. Her general condition was good. Per vaginal
examination revealed a well healed vault which was free of
infection or granulation tissue. There were no pelvic masses.
Her haemoglobin was 12.3 g/s per 100 mls.

Comments:
Fibroid are the commonest tumours of women (20%) of all
women’s uteri examination at death contain fibroid. Not all of
them are symptomatic.

Hysterectomy is the treatment of choice in symptomatic cases
if the lady is above 40 years and she has completed her family.
The acceptance of hysterectomy is a real difficult in the
management of the patients. They think that they are no longer
females without their uterus. The social implications may be more
significant. The husband may take another wife. The
hysterectomy these aspects are to be considered seriously.
Removal of the ovaries, when they are healthy during abdominal hysterectomy for uterine fibroid is not justified. Removal on the assumption that they are a potential site of malignancy is not acceptable. If removed the lady will develop symptoms of abrupt menopause and more seriously the susceptibility of developing coronary heart disease will be increased.

Complications of uterine fibroid includes, general ill health due to anemia, torsion of a pedicle of a subserous polyp, haemorrhage due to rupture of a vein on the surface of the tumour, excites due to mechanical irritation to the peritoneum, sarcomatous changes in 0.2% of cases and degenerative changes.

References:
2. Dewhurst Integrated Obstetrics and Gynaecology for post graduate
Name: R.A.B.  
Age: 15 years  
Hospital No: 101607  
Residence: Kisii.  
Occupation: Student.  
Date of admission: 12.9.91.  
Date of discharge: 16.9.91.  
C/O Abdominal mass, one week  
Abdominal pain, one week

Obstetric and Gynaecological History:  
The patient was single. She had experienced no menstrual cycle in her life prior to admission.

Past History:  
She was not known to be diabetic or hypertensive. No past history of admission to hospital.

Family and Social History: was of no significance.  
Admission to Hospital:

On the 11th of September 1991 the patient presented to the hospital complaining of a lower abdominal mass. It started small in the hypogastric area and gradually and progressively increased in size. It was associated with feeling of heaviness in the pelvic and colicky abdominal pain which was increasing in severity. She gave a history of monthly episodes of mild to moderate lower abdominal pain lasting for 3 to 5 days. There was no nausea or vomiting. The bowel habits were normal. Micturition was normal. On examination the patient was restless and in pain. She was not pale or jaundiced. Her pulse rate was 100/min. It was regular and of small volume. Her blood pressure was 110/60. Her respiratory and cardiovascular systems were normal. Abdominal examination showed a central lower abdominal mass equivalent to the level of a 20 weeks pregnant uterus. It was cystic, tender
and mobile. The spleen and liver were not palpable. Per vaginal examination: the patient was circumcised. There was no apparent vaginal bleeding or discharge. By inspection the hymen was seen bulging and blue in color. Per rectal examination revealed a tender cystic mass which was distending the vagina. There were no other masses. A diagnosis of hematometra was made.

**Investigations:**
1. Hemoglobin was 10 1 grams/100ml.
2. Her urine was free of abnormalities.
3. Her blood group was A Rh 4ve.
4. Ultrasound examination:
   A huge cystic mass containing thick fluid, it occupy the vagina. The ovaries were normal. Both kidneys were normal. A diagnosis of hematometra with early hematometra was made.

**Management:** Surgical removal of the hymen.

**Procedure:**
The condition and the plan of management were explained to the parents. The patient was prepped.

Under general anaesthesia and complete aseptic conditions the patient was put in lithotomy position. Examination under general anaesthesia was performed and confirmed the previous findings. A catheter was passed to empty the bladder. A cruciate incision was made in the hymen. The retroflex dark menstrual fluid was allowed to drain spontaneously. The amount was large. The redundant hymenal tissue was excised using a scissors. The raw edge was stitched in a continuous interdigital manner. There was no bleeding. The patient recovered smoothly from anaesthesia. No pelvic examination was performed to minimize infection.

**Post-Operative care:**
The patient was put on ampicillin capsules 500 mg six hourly and metronidazole tablets (500 mg tds.) She had a smooth post operative period. On the 4th day she was generally well with no infection or fever. She was discharged in good condition.
Follow-up:

The patient presented after two months. She was normal. She had two normal cycles. P.U. showed no pelvic masses. She was given a medical report stating that her hymen was removed on medical grounds.

Comments:

A case of haematocele due to imperforate hymen has been presented. The cause is a defective development of Mullerian tubercle at the point of entry into the urogenital sinus. The presentation is usually after puberty but rarely at the neonatal period, due to retention of fluid and mucous in the vagina.

In such a condition pregnancy and ovarian cysts must be excluded. Cryptovesicohymen can be caused by a vaginal septum which is more common than imperforate hymen.

After drainage of the fluid, protection against infection is mandatory because of the low vaginal resistance to infection. This is caused by a poorly developed epithelium and absence of doderlein bacilli. The protection is achieved by avoidance of introduction of a finger or speculum at the time of drainage which must be spontaneous and covering the patient with broad spectrum antibiotics or combinations.

The condition may be associated with vaginal septa, urethral abnormalities or bladder extrophy. Endometriosis may occur as a complication with subsequent reverse dysmenorrhoea and infertility. Otherwise the outcome is excellent.

References:

1. Jeffcoat.
2. Dewhurst.
   Integrated obstetric and gynaecology for postgraduate.
GYNACOLOGICAL CASE NO: [3]

UPPERED ECTOPIC FERTILITY.

Name: Mrs. I.H.A.
Age: 35 years.
Residence: Elshargara.
Occupation: Housewife.
Date of admission: 21.9.90.
Date of discharge: 29.9.90.
C/O Abdominal pain 1 hour prior to admission.
Vaginal bleeding 1 hour prior to admission.

Obstetric History:
The patient has been married for 8 years. She was para one.
It was a spontaneous normal vaginal delivery, a six years old male baby who was alive and well.

Gynaecological History:
Menarche was at the age of 12 years. Her cycles were regular and normal. L.H.P. was 3-4/10. During the last 5 years she had many attacks of vaginal discharge on and off. For which she was treated as an out patient. Bacteriological investigations were not done.

Past History: Family history and social history were not significant.

Admission to Hospital:
Mrs. I.H.A. was admitted as an emergency to hospital on the twenty first of September 1990. She was brought by her relatives. Complaining of severe lower abdominal pain. It was continuous agonizing and increasing in intensity. There were no known relieving or aggravating factors. It was associated with vaginal bleeding. It was of little amount, bright red and not offensive. She felt dizzy and had a fainting attack. On examination, she was conscious looked ill, pale but was not jaundiced. Her pulse
rate was 128/min. It was regular but of small volume. Her blood pressure was 96/50 mm Hg. Her respiratory and cardiovascular systems were normal. The abdomen was distended; there was generalized tenderness more marked over the lower part, with the maximum point at the right iliac fossa. Rebound tenderness was demonstrated. There was dullness on percussion over the flanks.

Pelvic Examination:-

The vulva was circumscribed. There was slight vaginal bleeding. It was healthy, the cervix was soft and very tender on movement. The size of the uterus was difficult to assess. The right adnexa was very tender on bimanual palpation. The left adnexa was free.

The pouch of Douglas was "full".

Management:-

A diagnosis of ruptured ectopic pregnancy was strongly suspected. Laboratory was decided. A large cannula was passed into the vein and normal saline was transfused rapidly. A blood sample was sent for grouping and cross matching. 3 pints of blood were prepared, cross matched and made ready for transfusion. Through another cannula a pint of blood was transfused. Her haemoglobin was 8 gms/100cc. Her urine was free of sugar and acetone. She was catheterized.

Operative Procedure:-

The patient was in a supine position with two intravenous lines and was put under general anaesthesia. The skin was sterilized. Through a median subumbilical incision the abdomen was opened in layers. There was haemoperitoneum. The uterus was grasped and delivered through the abdominal incision. The right tube was ruptured. The left tube and both ovaries were normal. The right tube was clamped by two long straight clamps and the damaged portion was removed (right salpingectomy). The abdominal cavity and the pouch of Douglas were cleaned. All clots were removed. The right tube was re-inspected. It was not bleeding. Haemostasis was complete. The abdomen was closed in layers. The
patient recovered smoothly from anesthesia. The estimated blood loss was 750 mls. The patient received another two pints of blood. She passed a good volume of clear urine.

Post-operative period and discharge:
The patient had a smooth post-operative period. Her general condition was good. Her haemoglobin was 11.3 grams per 100 mls on the 4th post-operative day. There was no evidence of renal failure or deep vein thrombosis. On the seventh day the stitches were removed. The wound was clean and free of infection. She was discharged in good condition and asked to come after one month.

Follow-up:
After 4 weeks the patient presented to the referred clinic. She was generally well. All her systems was normal. Her haemoglobin was 11.7 grams/100 mls. Histopathological examination confirmed ruptured tubal pregnancy.

Comments:
A case of ruptured ectopic pregnancy has been described. It is a rare priority emergency condition in gynecology. It is one of the most serious conditions in early pregnancy. The incidence varies from one society to another. It is 1 in 500 in United Kingdom and 1 in 20 in West India. The mortality and morbidity is increased due to ectopic pregnancy. Approximately two third will never subsequently bear living child. And at least one out of ten will have a second ectopic pregnancy.

Factors that predispose to the condition are those which lead to delay in the transfer of the fertilized ovum in the fallopian tube. These include gonococcal and tuberculosis salpingitis and intrauterine contraceptive devices. Low-dose progesterone oral contraceptive which do not inhibit ovulation but interfere with fertilization and implantation may increase the incidence. Other associations include: subfertility, past history of ectopic pregnancy, past history of pelvic or tubal surgery, late fertilization and transperitoneal migration of the ovum.
patient recovered smoothly from anaesthesia. The estimated blood loss was 750 ml. The patient received another two pints of blood. She passed a good volume of clear urine.

Post-operative period and discharge:

The patient had a smooth post-operative period. Her general condition was good. Her haemoglobin was 11.3 grams per 100 ml on the 4th post-operative day, there was no evidence of renal failure or deep vein thrombosis. On the 17th day the stitches were removed. The wound was clean and free of infection. She was discharged in good condition and asked to come after one month.

Follow-up:

After 6 weeks the patient presented to the referred clinic. She was generally well. All her systems were normal. Her haemoglobin was 11.7 grams/100 ml. Histopathological examination confirmed ruptured tubal pregnancy.

Comment:

A case of ruptured ectopic pregnancy has been described. It is a top priority emergency condition in gynaecology. It is one of the most serious conditions in early pregnancy. The incidence varies from one society to another. It is 1 in 500 in United Kingdom and 1 in 20 in West India. The mortality and morbidity is increased due to ectopic pregnancy. Approximately two third will never subsequently bear living child. And at least one out of ten will have a second ectopic pregnancy.

Factors that predispose to the condition are those which lead to delay in the transfer of the fertilized ovum in the Fallopian tube. These include gynecocical and tuberuclosis salpingitis and intrauterine contraceptive devices. Low-dose progestagen oral contraceptive which do not inhibit ovulation but interfere with fertilization and implantation may increase the incidence. Other associations include: subfertility, past history of ectopic pregnancy past history of pelvic or tubal surgery, late fertilization and transperitoneal migration of the ovum.
At the acute presentation the diagnosis of ectopic pregnancy is clinical. Whenever the diagnosis is highly suspected laboratory is a must. A negative laboratory is far less costly than missing ectopic pregnancy.

References:
1. Dechurst.
   Ingrated obstetric and gynaecology.
2. Jeffcoat's Principles of gynaecology.
**Case Report**

**Complete Procedures - Vaginal Hysterectomy & Repair**

**Name:** Mrs. J.K.N.

**Age:** 50 years

**Residence:** Lagos.

**Occupation:** Housewife.

**Date of Admission:** 20.10.91

**Date of Discharge:** 28.10.91

**Obstetric History:**

The patient was a widow for the last 6 years. She was para seven. All her deliveries were normal and at home. The youngest was 25 years of age.

**Menstrual History:**

Menarche was at the age of 13 years. She was menopausal for ten years. There was no history of postmenopausal bleeding.

**Admission to Hospital:**

Ms. J.K.N. was admitted to hospital on 20.10.91. She was complaining of feeling of vaginal heaviness for the last three years. The condition was progressive in severity. For the last one year she started to have a mass protruding through her introitus. It was reducible by the finger when she lay down. There was history of offensive vaginal discharge. It was of large amount and associated with itching. It was on and off. For which she was put on some medicines and local ointment when she was seen at the outpatient referral clinic. The condition improved and she was still on the same treatment. Disturbion and bowel habits were normal. She had no stress incontinence or urgency. On examination she was well, not pale or jaundiced. Her pulse rate was 75/min. It was regular and of normal volume. Her blood pressure was 100/70. All her systems were normal.
Pelvis examination:

The patient was circumcised there was no bleeding discharge or bad cystocele smell. She had a huge cystocele. When the patient was asked to cough it became apparent that she had procidentia which also included a huge rectocele. The vaginal skin was healthy and there was no ulceration or abnormal growth. The uterus was reduced manually. Bimanual examination showed a small uterus. The cervix was elongated. The adnexæ and the pouch of Douglas were free of pelvic masses. There was no stress incontinence.

A diagnosis of procidentia in an elderly non-pausal lady was made vaginal hysterectomy and repair were decided upon. The condition and the plan of management were explained to the patient and her relatives.

Investigations:

- Her haemoglobin was 11.9 grams/100 ml.
- Her urine was free of abnormalities.
- Blood group was O Rh negative.
- Her urine level was 27 mg/100 ml.
- Chest x-ray was normal.
- E.C.G was normal.

Operative procedure:

The patient was put under general anaesthesia. She was placed in the lithotomy position. The vulva and the inner aspects of the thighs were cleaned and draped. The bladder was emptied. Examination under anaesthesia revealed a small uterus, there were no pelvic masses. The uterus was pulled outside the introitus using two forceps each on a cervical lip. An sterile catheter was passed so as to determine the level of the bladder boundaries. The cervix was circularly transected at its junction with the bladder. Milieu our vertical incision was made from the circumcision towards the urthral membra. The resectional space was dissected and the vesico-erectile ligaments were divided. The bladder was mobilized and pushed high-up by blunt dissection. The cervix was held upwards by the assistant. The posterior
vaginal wall was separated from the posterior aspect of the cervix till the uterosacral ligaments and the peritoneum between them was visible. The peritoneum was picked and opened. A finger was then introduced in the peritoneal cavity. The fundus was held. It was small and mobile. There were no adhesions. The uterosacral ligaments on the left and right were clamped, cut and sutured. The cardinal ligaments were then clamped, cut and sutured in both sides. On the lateral border of the broad ligament the uterine arteries were clamped, cut, transected and double ligated. The index finger was inserted posterior to the uterus in the abdominal cavity and the fundus of the uterus was angulated forwards. The peritoneum of the uterovesical pouch was identified. It was picked and opened transversely. A stay suture was put so as to identify the peritoneum later. The fundus of the uterus was then delivered through the opening. The ovaries were seen they were small and fibrotic. Two clamps were placed just lateral to the uterus so as to clamp the fallopian tube, the ovarian ligament and the round ligament on the right side. The tissues and vessels were cut in between the two clamps and double ligated. The same thing was done on the left side. The uterus was then removed. All pedicles were rechecked. There was no bleeding. The peritoneum was then closed by continuous running catgut.

The bladder was brought into view. A series of three stitches were placed at different levels lateral to the bladder left and right sides so as to fix the bladder at a higher level. The redundant tissue at the anterior vaginal wall was removed. The anterior vaginal wall was then repaired in a manner that obliterated the dead space. The uterovesical ligament stitches to the vaginal plate.

A transverse was made at the junction of the posterior vaginal wall (red color) and the skin of the perineum (dark color). In the midline a longitudinal incision was made starting from the transverse one and extending into the posterior vaginal wall as far as about 4 cm. The rectum was then dissected from
the posterior vaginal wall. The levator ani muscles was exposed. They were approximated by placing successfully three interrupted suture and ligating them in front of the rectum. The redundant vaginal tissue was removed and the posterior vaginal wall was repaired by interrupted sutures. The perineum was repaired at the longitudinal place in the midline by interrupted sutures. Haemostasis was complete. Per rectal examination was done. There was no under tightness. An indwelling catheter was inserted and fixed. A half-tampon- soaked vaginal pack was inserted in the vagina. The patient recovered smoothly from anaesthesia. The estimated blood loss was about 150 ml. Blood transfusion was deemed no necessary.

Post operative Care:-
1. The patient was put on prophylactic antibiotic in form of ampiclox 500 mg 6 hourly for 2 days.
2. Fluid intake was allowed 6 hours after the operation, for 48 hours.
3. The vaginal pack was removed after 24 hours. There was no bleeding per vaginae.
4. The catheter was removed after 72 hours.
5. The patient was put on laxatives for 7 days.

Discharge:-
On the 6th day her general condition was good. She was not pale and was alert. Micturition was normal. The bowel habits were normal and without difficulty. The perineal wound had healed and well supported. There was no tenderness or haematoma. On per rectal examination there was no tenderness. She was discharged in good condition.

Post operative visit:-
The patient was seen one month later. There were no complaints. Her micturition and defecation were normal. On pelvic examination the vagina was not stenosed, there was no tenderness or infection or bleeding. The rectal mucosa was healthy. The anus was not tight, and there was no tenderness.
A case of recto-vaginal prolapse managed by vaginal hysterectomy plus anterior and posterior colporrhaphy has been presented. Genital prolapse is a common gynaecological problem.

The cause of the condition is weakness of the uterine and vaginal supports. The predisposing factors to this are: age, grandmultiparity, difficult labour with cervical and genital injuries with inadequate repair, pre-mature bearing down, menopause, and increased intrabdominal pressure in chronic cough and obesity. Congenital causes are rare usually the patients are younger. It may be associated with spina bifida or connective tissue abnormalities.

Vaginal hysterectomy by itself is not a treatment for prolapse. Repair must be done. The advantages of removing the uterus are: to enable visualization of the adenexae, better repair and to get rid of a non-functional uterus which is a potential site of malignant growth in an old menopausal lady.

Treatment could be palliative and on operative by using vaginal commissures of different types. They are indicated during pregnancy, immediately after and during lactation, a younger patient who has no completed no family yet, very ill patients in whom the operation is hazardous, to promote healing of a decubital ulcer and when the operative treatment is refused by the patient.

References:-
Name: H.A.S.
Age: 37 years.
Residence: Omurtan.
Occupation: Teacher.
Date of admission: 11.12.38.
Date of discharge: 15.12.38.

Obstetric History:
The patient was married for 3 years. She was gravida two para one. Her delivery was spontaneous normal vaginal delivery at hospital. She had a male baby who was alive and well.

Gynaecological History:
Menarche was at the age of 12 years. Menstrual was normal. Her cycles were regular and normal.
Her L.M.P. was on 2.9.38.
Past History, family history and social history:
Were not significant.

Admission to hospital:
Mrs. H.A.S. presented to the hospital on 11.12.38 as she was complaining of vaginal bleeding for seven days after three and a half months of amenorrhea. The blood was dark in color, of little amount and it was not offensive. There was no abdominal pain. Systemic review revealed no other symptoms. On examination she was not pale or jaundiced. Her pulse was 80 per minute. It was regular and of good intensity. The blood pressure was 120/80 mm Hg. All her systems were normal. Pelvic examination showed a circumcised vulva. The vagina was healthy. The cervix was firm smooth healthy and not tender. The uterus was size 8 weeks pregnancy, and it was antverted. The adnexae and the pouch of Douglas were free of masses and tenderness. Finger examination showed slight bleeding which was dark in color.
Investigation:
1. Her haemoglobin was 12.8 grams/100 mls.
2. Her urine analysis was normal.
3. Her blood group was A Rh positive.
4. Ultrasonic examination showed an enlarged uterus containing a gestational sac. There was no movement and fetal heart was not seen over six were normal.

Management:
A diagnosis of missed abortion was made and the patient was planned for dilatation of the cervix and surgical evacuation under general anaesthesia. Two units of fresh blood were prepared for transfusion on request.

Procedure:
The patient was put under general anaesthesia, placed in the lithotomy position and cleaned and draped. The bladder was emptied. E.U.A. showed a healthy vagina, the cervix was firm, smooth and healthy, the uterus was 8-10 weeks in size, the adnexae and the pouch of Douglas were free. Sims's speculum was put and the cervix was visualized; it was healthy. The anterior lip was held by a forceps. 10 international units of syntocinon were added to the intravenous drip of 5% glucose in saline. The cervical os was dilated using Hegar's dilators of increasing size, starting by the smallest one up to Hegar's dilator no. 8. An empty suction was passed into the uterine cavity opened wide, rotated, closed rotated back and removed. By repeating this maneuver the products were removed each time. A curette was then used to curette the uterine walls in a systematic manner, till the cavity was felt empty. The volvelling was removed. The vagina was swabbed clear and the uterus was bimanually compressed. The patient received 5.5 mg of ergometrine, intravenously. The cervix was re-inspected there was no bleeding. The products were sent for histopathology.
Discharge:

On the next morning the patient was in good general condition. There was no vaginal bleeding. She was put on prophylactic antibiotics. She was discharged in good condition.

Histopathological result: was reported "Products of conception".

Comment:

A case of missed abortion has been presented. Missed abortion is a condition where the embryo or the fetus is dead and retained in the uterus. The baby becomes macerated or mummified and the liquor is absorbed.

The condition may lead to the serious complication of coagulation failure. It is due to escape of thromboplastin from the circulation into the maternal circulation leading to intravascular clotting. This will lead to hyperfibrinogenemia, increased fibrinolysis and increased fibrin degradation products. The danger of it is the difficulty in controlling the bleeding when the patient presents. Other manifestations include epistaxis, haematemesis and ecchymosis. It is helpful to determine the fibrinogen level. The normal level is 150-450 mg/dl. The dangerous level is less than 100 mg/dl. After evacuation hyperfibrinogenemia correct itself in 12 to 24 hours. If replacement is needed, fresh blood is given intravenously. Fibrinolysis is given in hemorrhage associated with excessive fibrinolysis. The dose is 4-6 grams orally or by slow intravenous infusion. Followed by one gram given hourly. The other main trouble is the psychological distress of the mother.

When missed abortion is diagnosed the treatment is evacuation as soon as possible. Evacuation is either medical or surgical. Medical is best by prostaglandine (PGE2 or PGF2) or by synthecron or both, when the size of the uterus is more than 12 weeks. Surgical evacuation needs to be done with certain precautions. Special care is to avoid excessive hemorrhage and prepare for it if it comes to happen.
References:

1. Jettonal
   *Principles of gynaecology*

2. Daburat's
   *Text book of obstetric and gynaecology for post graduates.*
Name: L.A.A.
Age: 25 years
Residence: Alsehata
Occupation: Employee
Date of admission: 2.7.91
Date of discharge: 6.7.91

Obstetric and gynecological history:
The patient was single. Menarche was at the age 13 years. Menses was 6/10. Her cycles were regular and with moderate amount of blood loss. Her last menstrual period was on 21.6.91. There was no history of use of contraceptive methods.

Past History:-
She was not known to be diabetic or hypertensive.
Family and social history were of no significance.

Admission to Hospital:-
The patient was referred to the outpatient clinic complaining of a vulval swelling for the last seven years. It started small but progressively increasing in size over the years. It was not tender. There was no discharge or abnormal bleeding. The patient had been ritually circumcised at the age of 9 years. On examination she was generally well. She was not pale or jaundiced. Her pulse was 72/min. It was regular and of normal volume. Her blood pressure was 110/70. All her body systems were normal on physical examination.

Local examination:-
The patient was circumcised. There was a mass at the upper part of the vulval circumcised scar. It was more or less spherical in shape. It was about 10 cm in diameter. Its surface was smooth. There were no sinuses, ulcers or discharge. On palpation the mass was not hot. It was mobile and not tender. The local lymph nodes were not palpable in the groins.
Management:

- The diagnosis made was inclusion vulval cyst. She was planned for surgical excision.

Investigations:

1. Her haemoglobin was 13.0 g/dl.
2. Urine analysis was free of sugar, acetone and other abnormalities.
3. Her blood group was A+ Rh+ve.

Procedure:

The patient was put under general anaesthesia, cleaned and draped and placed in the lithotomy position. A longitudinal incision was made along the cyst. A line of cleavage was reached. The edges of the skin were held using allis forceps. The tissue around the cyst was dissected using a curved scissors. Care was taken so as not to puncture the cyst till the whole cyst was free all around and removed intact. Haemostatic sutures using chronic cat gut no 1. Stopped all bleeding points in the bed of the cyst. The redundant vulval tissue was excised. The used space was obliterated by interrupted stitches. The skin was closed by interrupted stitches using chronic cat gut no 1. Haemostasis was assured. It was dressed using sterile gauze. There was minimal blood loss. The patient recovered smoothly from anaesthesia. The cyst was opened and found to contain brownish serous material.

Post Operative Care:

1. The patient was put on prophylactic antibiotic in the form of amoxil 500 mg six hourly.
2. Analgesia was provided by an injection of 100 mg of pethidime given two hours after full recovery from anaesthesia. Paracetamol tablets were prescribed to be used as needed.
3. On the 3rd day the wound was inspected and found dry with no haemotoma or infection. Daily dressing was done using saline as an antiseptic solution.
**Discharge:**

The patient had smooth post-operative period. She was stable. There was no wound infection. She was discharged in good condition and asked to report after one month at the outpatient clinic.

**Post-operative visit:**

The patient was seen one month later. She was in excellent condition. The wound had healed satisfactorily.

**Comments:**

A vulval inclusion cyst, also called epidermoid or dermoid cyst, is a benign condition. It is an implantation retention cyst. It arises from portion of skin that has been implanted and become buried during suturing the edges of whatever wound in the vulva. The cyst contains creamy yellowish or brownish jelly-like keratinous debris material. The cyst is lined by stratified epithelium.

The condition is quite common in our patients in the Sudan as being a complication of the traditional practice of circumcision. The condition is more common in multiparas ladies due to decircumcision and recircumcision after delivery.

The cysts are usually asymptomatic. Being benign there is no urgency to treat it. Surgical removal is indicated when they grow big and cause embarrassment, or when there is fear of infection. When they are infected they may lead to abscess formation. The treatment then is evacuation of the abscess and removal of the cyst later on after complete control of infection.

**References:**

1. Jeffcoats

Name: H.A.H.
Age: 30 years.
Residence: Elthawara (a).
Occupation: Employee.
Date of admission: 11.3.90.
Date of discharge: 14.3.90.

Obstetric and Gynaecological History:
The patient was single. Menarche was at the age of 14 years. Menstruation was 4-28 days. Her cycles were regular and normal. L.H.P.: 1.3.91.

Past History:
She was not known to be diabetic hypertensive or asthmatic.
No past history of hospital admission.
Family history and social history:
Was not significant.

History of Present Illness:
Miss. H.A.H. was admitted to the hospital on the eleventh of March 1990. She was suffering from a painful vulval swelling for 3 days. The size of the swelling was progressively in size. The pain was also progressive in intensity. It became so painful that she was unable to move freely. There was no discharge, ulceration or bleeding. The condition was associated with fever and sweating. There was no history of vaginal discharge. Micturition and bowel habits were normal. Other systems were reviewed. On examination, she was restless and in pain. Her face was pale and jaundiced. Her pulse rate was 110/min. It was regular and of small volume. Her blood pressure was 110/70. All her systems were normal.
Local examination:

The patient was circumsized. There was a vulval swelling involving the superior part of the circumsision scar and more towards the right side. It was of an oval shape. It was about 5x1 cm in size. The surface was smooth. The skin over it was shiny and the area around the swelling was hyperemic. On palpation the mass was hot, tense, and very tender. The right inguinal lymph nodes were enlarged and tender.

Management:

A diagnosis of vulval abscess was made. Urgent evacuation was planned. The condition explained to the patient. She was prepared for drainage under general anaesthesia.

Investigation:

1. Her haemoglobin was 12 grams/ml
2. Her urine analysis was free of sugar and acetone.

Procedure:

The patient was under general anaesthesia and in lithotomy position. The vulva was cleaned using saline solution. The patient was covered by sterile towels leaving only the vulva exposed. The mass was examined under anaesthesia and the previous findings were confirmed. Using the scalpel the mass was opened longitudinally from its upper border to the lower one. Large amount of yellowish pus was drained. Using a curette all the pockets of pus were drained carefully. The base was washed thoroughly with normal saline and eusol.

A piece of sterile gauze was put as a pack in the space of the abscess. Stetle dressing was applied to the wound. The patient recovered smoothly from anaesthesia.
Post-operative care:

1. The patient was put on ampicill 500 mg six hourly.
2. 100 mg of pethidine was given when the patient felt maximum pain one and a half hours after the operation.
3. Aspirin was prescribed for analgesia.
4. Daily dressing with Eusal and packing of the dead space by a gauze was performed.

Discharge:

On the 3rd post operative day the patient was comfortable. There was no pain. The area of cellulitis around the abscess had receded. The general condition was good. She was discharged and advised to continue on daily dressing at the local health center. She was asked to come after one month. She was never appeared by more.

Comments:

A case of vulval abscess has been presented. It is one of the common gynaecological emergencies, in our gynaecological practice. The condition is benign but because it is so painful urgent treatment is called for. It is easy to treat but needs general anaesthesia or at least the patient must be on a strong analgesia for example morphine or pethidine. All the pockets of pus must be broken and evacuated to avoid recurrence. Careful daily dressing so as to allow healing to take place from the base to the surface is of utmost importance.

The predisposing factor in the formation of a vulval abscess are, circumcision, vaginal trauma and infection of a hair follicle.
Name: Mrs. M.A.Z.
Age: 33.
Residence: Chandrapur.
Occupation: Housewife.
Date of admission: 24.6.89.
Date of discharge: 29.6.89.

Obstetric History:
She was para nine, with no history of abortions. She had 5 daughters and 4 sons. All of them were alive and well. Her first six deliveries were normal. Vaginal deliveries conducted at home. The seventh delivery was complicated by post partum haemorrhage. The 8th was complicated by P.P.T. and post partum haemorrhage for which she received three pints of blood. Her last delivery was on the 24th of June 1980. It was spontaneous vaginal delivery at 38 weeks and at hospital. She was managed actively and there were no complications. The outcome was a female who was alive and well.

Gynaecological History:
Menarche was at the age of 12 years. Kasa was 5/30. Her cycles were regular and normal. L.M.P. was on 22.6.89.

Past History:
She was not known to be diabetic or hypertensive.
Family and social History: was not significant.

The decision of sterilization:
The patient requested sterilization because she experienced difficulties during her last confinement. After her 8th delivery, she discussed the matter with her doctor. He advised her to use other temporal methods. She tried different types of contraceptive pills. She was not well with them at all. An intrauterine contraceptive device was inserted for two months.
It was removed because she developed severe bleeding. While she was seeking an optical contraceptive method she had her ninth pregnancy. She and her husband expressed a strong desire to have surgical sterilization. They signed a written consent. Post partum sterilization on the third post partum day was arranged.

**Investigations:**
1. Her haemoglobin was 11.6 grams/litre.
2. Her urine was clear.
3. Her blood group was O Rh negative.

**Procedure:**
The abdomen was cleaned carefully and sterilized by spirit. The patient was covered by sterile towels leaving the field exposed. Local anaesthesia was infiltrated in the area below the umbilicus. A small transverse incision, about three centimetres long, was made below the umbilicus. The subcutaneous fat was dissected using an artery forceps when the sheath was clear local anaesthesia (xylocaine 0.25%) was infiltrated. The sheath was picked and opened transversely. The peritoneum was exposed. It was held by two artery forceps. It was opened longitudinally. The patient felt severe pain due to traction of the peritoneum for this she was supplemented with a mask that provided oxygen and nitrous oxide in a ratio of 50: 50%, till she was sleepy. The right tube was visualized by placing two small retractors. It was picked out through the abdominal opening by the use of an untouched tissue forceps and Ellis's forceps. The tube was identified by the presence of the fimbrial end. A loop was clamped, cut and transected. Another stitch was placed below the first. There was no bleeding. It was pushed back into the peritoneal cavity. The same procedure was applied to the left tube. The abdomen was then closed in anatomical layers. The skin was sutured subcutaneously using No 0 cat gut. The patient recovered smoothly.
Post-Operative and Discharge:-

The patient was put on ampicillin as a prophylactic antibiotic and paregoric for analgesia. She had smooth post-operative period. On the second day she was in good general health. Her pulse and blood pressure were normal. The abdomen was soft and slightly tender. She was discharged and asked to come after 6 weeks for the postnatal visit.

Post-natal Visit:-

Mrs. H.A.Z. and her baby were in good health. The baby was lactating and was vaccinated. The wound healed nicely. There were no complications.

Comment:-

One has to think twice before deciding to perform permanent sterilization. The removed ovule, at some time when the situation is changed, may regret it. At the same time when it is really indicated it must be done without hesitancy. It is one of the measures of protection against maternal death.

The advantages of post partum sterilization on the third post partum day include:-

1. Pregnancy is excluded beyond doubt.
2. Very light anesthesia and sometimes local, can be used.
3. The tubes are easily accessible through a very small incision because the uterus is an abdominal structure.
4. Short hospital stay.
5. Easy to convince the couple.

Its disadvantages include:-

1. Not suitable for exhausted and very ill patient.
2. The tissues are hypervascular.
3. Higher chance of infection.
4. A lady may later change her mind and regret the event.

References:-

Ralph C. Benson.
GYNAECOLOGICAL CASE NO. 4
INCOMPLETE ABORTION

Name : M.M.S.
Age : 32
Residence : Al. Sahafa
Occupation : Housewife
Date of Admission : 5.3.91
Date of Discharge : 6.3.91

Obstetrical History:
The patient had been gravida 5 para 4 with no history of abortions, all her deliveries were normal, vaginally and not complicated. The last delivery was two years prior to admission.

Gynaecological History:
Menarche was at the age of 12 years. Menstrual history was 6/30. Her cycles were normal and regular. The blood loss was moderate.

L.M.P. : 2.1.91
P.N.D. : 9.10.91

Past History:
She was not known to diabetic or hypertensive, and with no past history of any serious disease or hospitalization.

Family History and Social History:
Were not significant.

History of the Present Illness:
Mrs. M.M.S. was admitted to the hospital urgently on the 5th of March 1991. She was complaining of vaginal bleeding and abdominal pain after a period of two months amenorrhoea. The condition started by slight vaginal bleeding, became profuse. It was bright red blood associated with clots and passage of flabby products. The abdominal pain was colicky in nature, felt at the supra public area and radiating to the back. There was no history of acute illness or fever. There was no history of trauma.
examination she was restless. Her clothes were soiled with blood and she was not pale, her pulse was 120/min, regular and of small volume. Her blood pressure was 100/60 mmHg. All her body systems were normal, she had a slight tenderness at the supra pubic area.

Pelvic examination showed a circumcised vulva with significant amount of bleeding rolling the vulva and the thighs. The vagina was full of clots and products of conception. They were removed digitally. The cervix was soft, smooth and healthy. The os uteri was dilated and it admitted one finger easily. The uterus was about 8 to 10 weeks in size, anteverted, soft and slightly tender, the adnexa and pouch of Douglas were free of mass and tenderness.

Immediate Management:
A blood sample was sent for grouping and cross matching. Large size cannula was inserted in a suitable vein, 5% glucose saline was administered at a rapid rate. 0.5 mg of ergometrine was injected slowly intravenously, the vulva and the thighs were cleaned a pad was put to observe the amount of bleeding. Urgent preparation of two pints of blood was requested.

Investigation:
- Her blood grouping was O Rh +ve
- Her haemoglobin was 70%
- Her urine was free of sugar and acetone.

Operative Management:
The patient already fasting, the vaginal bleeding lessened. After receiving two pints intravenous fluids, her general condition improved, she was prepared for evacuation under general anaesthesia.
PROCEDURE:
Ten mg of diazepam were given. 100 mg of Ketalar (ketamine) was administered intravenously. The patient was put in a lithotomy position. The vulva and thighs were cleaned by savlon. The patient was convened by sterile towels and the vulva was left exposed. Examination under general anaesthesia was performed after emptying the bladder. The previous findings were confirmed. While the left hand was supporting the fundus, the index finger of the right hand was introduced into the cavity of the uterus so as to separate the products of conception from the walls and met them free in cavity. A Sim's speculum was placed in the vagina. Clots were removed from the vagina. The anterior lip of the cervix was grasped with sponge holding forceps. The products of conception were removed from the cavity by using an ovum forceps. The uterine walls were curedtted gently and systematically using a sharp curette so as to remove the rest of the products and to insure that complete evacuation was achieved. Bleeding stopped. 0.5 mg ergometrine was injected intravenously, bimanual compression of the uterus was performed. It was contracted. The cervix was reinspected by retracting the posterior vaginal wall using a sim's speculum. There was no bleeding. The patient recovered satisfactorily from anaesthesia.

Post Operative Period and Discharge:
The general condition of the patient was good. Her pulse rate was 90/min. It was regular and normal volume. Her blood pressure was 110/60, her haemoglobin was 65%, there was no vaginal bleeding, she was discharged on prophylactic antibiotics and tonics. She was asked to come after one month but she was never seen again.

Comments:
A case of incomplete abortion has been presented. Abortion is one of the most serious gynaecological complication. It must not be taken lightly because it is potentially dangerous leading to maternal morbidity and sometimes maternal mortality. The hazards increase when it is complicated by severe hypovolemic and infections especially in association with criminal abortion.
In complete abortion is to be treated by evacuation after adequate resuscitation of the patient the use of ketamin as anaesthetic is suitable the commonly raises the blood pressure which is useful in aborting patients. It produces dissociative anaesthesia in which there is profound analgesia with high sleep, when given intravenously it act after three seconds. The effect may last up to 20 minutes, which is enough to complete the operation. Emergency delirium is controlled by given diazepam.

Reference:
1. Dewhurst Integrated Obstetric and Gynaecology.
2. Laurence, Clinical Pharmacology.
Name: Miss I.M.M
Age: 34 years
Residence: Ontario
Occupation: Employee
Date of Admission: 7.6.90
Date of Discharge: 15.8.90

Obstetrical and Gynaecological History:
The patient was single. There was no history of sexual practices, her menarche was at the age of 14 years. Katz was 5.4.36. Her cycle was regular, but became excessive during the last two years. Her last menstrual cycle was on the 30th of April 1990.

Past history, family history and social history: were of no significance.

Admission to Hospital:
Miss I.M.M was seen regularly in the gynaecological out-patient referred clinic. She was admitted on the 8th of May 1990. Her problem was heavy periods, which started two years prior to admission. Her cycles were associated with severe blood loss. She used to change the sanitary pads about 5-6 time per day, she passed large clots and experienced sever dysmenorrhoea. She complained of lower abdominal colicky pain. Her period lasted for 6-8 days, there was no history of bleeding from any other site. There was no history of use of contraceptive pills or regular intake of any drug. Her micturition and bowel habits were normal. Systemic review revealed no other symptoms. The patient was very much distressed and embarrassed by her problem. She took 5 days off work every month. On examination she was not pale or jaundiced, her pulse was 90/min, regular and of normal volume. Her blood pressure was 120/70. All her body system were normal. Per rectal examination revealed a bulky from uterus, which was irregular in contour and mobile, there was no tenderness. The adnexa were free of masses, the cervix was not enlarge.
Investigation:
1. Her haemoglobin was 10.2 g/100 ml.
2. Urine analysis was free of abnormalities.
3. Her blood grouping was ORh
4. Chest X-ray revealed normal findings.
5. Ultrasonic examination showed a single uterine fibroid which was about 5 x 7 cm in size. It was intramural and partially submucous. Both ovaries were of normal size. There was no cervical fibroid.

Management:
A diagnosis of a uterine fibroid causing severe menorrhagia and dysmenorrhea was made. The patient was planned for a myomectomy operation, the condition was explained to her, the remote possibility of hysterectomy was discussed with the patient. Her consent to the procedure was taken. She was prepared for a myomectomy operation as any major abdominal surgical operation. Three pints of cross matched blood were prepared and kept ready for transfusion whenever needed.

Procedur:
The patient was put under general anaesthesia. The abdomen was cleaned and draped with sterile towel, leaving the operative field exposed.

A catheter was inserted and the bladder was emptied. The abdomen was opened in layers through a Pfannenstiel incision. The uterus was delivered through the abdominal incision. It was equivalent to the size of a 10 weeks gestation in size and firm. There was a single anterior wall fibroid. Both tubes were healthy, both ovaries were of normal shape and size. A transverse incision was made in the anterior uterine wall. The line of cleavage between the fibroid and the uterine wall was reached. The fibroid was enucleated using the index finger, till it was free all around and was removed. The cavity was opened and inspected, there were no endometrial polyps or submucous fibroid. The uterine walls were curtailed, care was taken to avoid implantation of endometrial tissue in the myometrium. The cavity
was closed by intrusted sutures. The dead space was closed by suturing from the base upwards in layers that approximated the uterine muscle. Haemostasis was complete. The surface of the uterine incision was covered by peritoneum using chromic cat gut no. 60 with automatic needle. The uterus was kept in the antverted position by a plication of the round ligaments using chromic cat gut No. 1. The abdomen was closed in anatomical layers. The patient recovered smoothly from anaesthesia, there was clear urine, the catheter was removed.

Post Operative Period and Discharge:
The patient was put in prophylactic antibiotics. She had smooth post operative period. There was light vaginal bleeding. All her systems were normal. Her haemoglobin was 10.0 g/100 ml. Stitches were removed in the 6th day. The wound healed satisfactorily with no infection. She was discharged on good condition, and asked to come after one month for follow up.

Histopathology Results:
- Benign leiomyoma
- Early proliferative endometrium

Follow Up:
The patient presented to the gynaecological out patient clinic after 6-7 weeks. She had a normal cycle one week prior to her presentation. She was in good health.

Comments:
A case of uterine fibroid treated by myectomy has been discussed. In myectomy it is a must to preserve the patient reproductive function of the internal genital organs. It is pointless to perform a complicated myectomy if the risk is reproductive failure.

Myectomy is preferable to hysterectomy in young patient who have not yet completed their families. When the presenting symptom is infertility in a lady who ovulates and has patent tubes and in a lady who had one or more early abortions.
It is of great importance to minimize the possibility of occupancy of adhesions of the bowel to the myomectomy scar. This is achieved by performing anterior uterine incisions and transvaginal removal of posterior one. Avoidance of posterior wall incisions as far as possible removal of multiple fibroid through one uterine incision by lateral tunnelling good peritonealisation and by insuring an anteflexed position of the uterus by placement of the round ligaments.

References:
Shaw's Text Book of Operative Gynaecology.
SOMATIC CASE NO. 11
VAGINAL BLEEDING IN AN 8-YEAR OLD
CHILD COMPLICATING RITUAL CIRCUMCISION

Name: S.S.A
Age: 8 years
Residence: El Fao (40)
Occupation: Student
Date of Admission: 11.4.89
Date of Discharge: 15.4.89

c/o vaginal bleeding one day prior to admission

History of Present Illness:
The patient was ritually circumcised two days prior to admission, one day later she developed vaginal bleeding which started mild and then progressed. It was bright red, continuous and associated with clots. There was no charge in small or vulval pain, she had palpitation, breathlessness and dizziness. There was no fever or other symptoms.

Past History:
She was not known to have any chronic disease, there was no history of abnormal bleeding from any site or wound.
Family history and social history were not significant.

Drug History:
She was not on drugs, there was no history of hypersensitivity to any known drugs.

On Inspection:
The patient was frightened, restless and pale but not jaundiced. Her pulse was 110/min. It was regular and of small volume, her blood pressure was 60/50. Her respiratory rate was 40/min. All her system were normal. Local examination showed a recently circumcised vulva. The vulva and thighs were sordid with blood and clots, there was no bad smell, hyperemia or tenderness. Inguinal lymph nodes were not enlarged.

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Management:

1. A blood sample was sent for blood grouping and cross matching, preparation of two plates of blood was requested.
2. A butterfly needle was inserted into a good-size vein, 5% glucose with 0.45 normal saline was administered.
3. Her haemoglobin was 8 grams/100 ml.
4. Her urine analysis was normal.
5. A follow-up chart was drawn up, it included the pulse rate, the blood pressure, the respiratory rate, the temperature and the amount of vaginal bleeding (estimated from a pad which was firmly applied to the vulva).
6. As soon as the blood was ready a pint was transfused at the rate of 15 drop per minute.
7. Prophylactic antibiotics were administered (Augmentin 250 mg 8 hourly).
8. Antitetanus serum was given after testing it for hypersensitivity.
9. After four hours the general condition of the patient improved, but the bleeding was not adequately contracted. It increased in severity as soon as the pad was removed.
10. The patient was prepared for exploration of her vulval wound under general anaesthesia.

Procedure:

The patient was put under general anaesthesia and in lithotomy position. The vulva and thighs were washed by savlon and sterilized by spirit. The sutures were removed. A catheter was fixed in the bladder. The clitoris, both labia minor and inner margins of labia majora had been excised, at circumcision. The clitoral artery was seen. It was the source of bleeding. It was clamped by an artery forceps. It was ligated and secured, the bleeding was controlled, the decircumcision was repaired. The patient recovered smoothly from anaesthesia, her urine was clear.
Post Operative Care and Discharge

The patient was put on prophylactic Ampiclox 250 mg six hourly; there was no further bleeding. The wound was free of infection. She was discharged on a fourth day in good condition. She was asked to come after two weeks, but she defaulted.

Comments:

A case of vaginal bleeding in a child has been presented. It was due to circumcision. Circumcision is one of the most dangerous cultural practices in our society. In spite of the change in beliefs about concepts, circumcision of females is still practised; there is a shift, however, towards less aggressive types of circumcision.

Complication of circumcision are many, the immediate ones include; bleeding, infection and urine retention. The long term ones include; bad healing with excessive scarring, formation of inclusion cysts, difficult vaginal practice, difficulties at labour, psychological and sometimes psychiatric complications.

Prevention is to be a prered by structured and objective educational programs. There are many voluntary associations which are doing quite a good work in this field.
Gynaecological Case No. 11
Cervical Polyp—Polypectomy

Name: Mrs. A.M.E
Age: 20 years
Residence: Cabra
Occupation: Housewife
Date of Admission: 11.10.90
Date of Discharge: 12.10.90

Obstetrical History:
The patient has been married for 4 years, she was para one, her delivery was normal vaginal delivery conducted at hospital. She had a female child who was alive, well and was three years old. There was no history of abortion.

Gynaecological History:
Her menarche was at the age of 12 years. Her cycles were normal and regular, but for the past eight months prior to admission her periods became irregular and excessive. Her last menstrual period was on the 2nd of October 1990.
Past history, family history and social history were not significant.

History of the Present Illness:
Mrs. A.M.E. presented to the gynaecological casualty with a history of irregular vaginal bleeding for eight months. It was recurrent irregular, excessive intermenstrual bleeding, the blood was bright red but sometimes dark in colour, mild to moderately severe, and occasionally post-coital. There was history of vaginal discharge. It was watery, yellowish, offensive and of large amount, it was sometimes associated with itching. There was no period of amenorrhoea. The micturition and bowel habits were normal. On examination she was slightly pale, but not jaundiced. Her pulse was 90/min, regular and of normal volume. Her blood pressure was 110/70. All her systems were normal. Pelvic examination showed a circumcised vulva. There was no apparent...
bleeding or discharge. The vagina was felt smooth healthy and not tender, the cervix was firm and smooth. There was a finger-like structure felt protruding through the os uteri. The uterus was normal size and anteverted. The adnexa and the pouch of douglas free of masses and tenderness. There was blood on the examining finger.

**Speculum Examination:**

The vaginal walls were inspected and were healthy. The cervix was healthy with no erosion. There was a polyp protruding out through the external os. It was about 3 centimetres in length, it was ulcerated with a slightly bloody surface.

Rectal examination showed normal findings.

**Investigations:**

1. Her haemoglobin was found to be 12 gms/100 ml
2. Her urine analysis was free of abnormalities
3. Her blood grouping was AB Rh +ve
4. High vaginal swab culture showed growth staph aureus bacteria sensitive to tetracycline.

**Admission to Hospital:**

The patient was treated at the out patient, referred clinic, she was on tetracycline capsules and tetracycline ointment for local application. On the 12th of October she was in a good health. The vaginal infection was controlled, and repeat culture came back negative for bacterial growth. She was booked for operative management.

**Operative Procedure:**

The patient was put under general anaesthesia in the lithotomy position. She was cleaned and dropped. The bladder was emptied, examination under general anaesthesia confirmed the previous findings. A sim's speculum was put to retract the posterior vaginal wall. The anterior lip of the cervix was held by a vaselium. The polyp was seen protruding through the
external os. It was caught by an ovum forceps, and twisted till it was detached from its base. There was no bleeding. Using Beger's dilators the cervical os was dilated systematically. The uterine wall was curetted. The vagina and cervix were re-inspected. There was no bleeding. The patient recovered smoothly from anaesthesia. The polyp and the curettings were sent to histopathology.

Post Operative Care and Discharge:

The patient was put on prophylactic antibiotics. The vaginal bleeding stopped. All her system were normal. Her haemoglobin was 11.5 g/100 ml. She was discharged and asked to come after one month.

Histopathological Result:
1. Benign endocervical polyp
2. Proliferative endometrium no evidence of malignancy.

Follow Up:

The patient presented one month after discharge. She was healthy. There was no abnormal vaginal bleeding or discharge.

Comments:

A case of cervical polyps, managed by polypectomy and histopathological examination has been presented. Polyps are common. They are either uterine or cervical. The uterine include endometrial polyps, fibroid, adenofibromatus, adenomyomatus and placential polyps. The cervical include mucous polyps and fibroepithelial polyps.

The tumour are usually benign. They are not known to be pre-malignant and rarely does malignant change occur in them. It is mandatory to send the specimen for histopathology to exclude a polypoidal mass occurring in carcinoma of the endometrium.

Recurrence may occur but usually this is due to incomplete removal, in this case it might have been beneficial if the polyp has been cauticercaled.

References:

Dewhurst's integrated obstetrics and gynaecology for post graduates.
GYNAECOLOGICAL CASE No 13
THIRD DEGREE PERINEAL TEAR

Name: R.M.A
Age: 31 years
Residence: Kudusian
Occupation: Housewife
Date of admission: 2.2.69
Date of operation: 9.2.69
Date of discharge: 16.2.69

Obstetric History:
She was para one. She delivered vaginally at home. She was attended by a traditional birth attendant. The cut came was a full term, male baby, he was alive and well. The delivery was complicated by perineal injury.

Gynaecological History:
Menopause was at the age of 42 years. Kala 4-6/30. Her cycles were regular, normal and the blood loss was moderate amount. She was lactating for four months and she was not menstruating.

Past History:
She was not known to be diabetic or hypertensive.

Family history, social history and drug history: were of no significance.

History of Present Illness:
The patient had an obstetric injury during her delivery four months period to admission. The delivery was at home, it was a difficult one, attended by a traditional birth attendant. The "midwife" tried to repair the perineal tear, after two days it become swollen and painful. There was slight bleeding and purulent discharge. The patient started to lose control of faeces and flatus. Micturition was normal. Systemic review revealed no other symptom. On examination the patient was well, she was not pale or jaundiced, the pulse was 78. It was regular and of normal volume. Her blood pressure was 120/70. All her systems were normal.
Pelvic Examination

The patient was circumcised, the vaginal orifice was patent. The posterior vaginal wall was deficient. The sphincter was also deficient anteriorly. There was no apparent bleeding or discharge. On palpation the vaginal wall was healthy anteriorly and at both sides. Posteriorly it was tough with excessive retraction. It was continuous with rectal mucosa. There was no tenderness. The cervix was smooth firm and healthy. The uterus was of normal size and it was anteverted. The adnexa and the pouch of Douglas were free of masses and tenderness.

Per-Anal Examination

The anal sphincter was loose. The sphincter grip was completely absent, the anterior part of it was continuous with the posterior vaginal wall. The rectal mucosa was healthy. There was no tenderness.

Management

The diagnosis made was third degree perineal tear. The plan was to repair it after proper preparation.

Investigation

1. Her haemoglobin was 12.7 g/100 ml
2. Her urine examination was free of abnormalities.
3. Her blood group was A Rh positive
4. Vaginal swab culture showed no growth
5. Stool general was free of abnormalities

Pre-Operative Preparation

The patient was admitted to hospital for 6 days before the operation. She was put on fluid diet. During last three days preceding the operation enema was performed twice a day. The patient was put on oral Flagyl tablets (500 mg t.d.s.) as well as vaginal tabs. She was given gentamycin 80 mg T.D.S intramuscularly pre-operatively, she was also on neomycin one gram 6 hourly orally so as to sterilize the bowel. On the evening
before the operation the patient was given 10 mg of diazepam intravenously. On the day of the operation washout of the vagina was performed. Two pint of blood were prepared and kept ready for transfusion if needed.

Procedure:

The patient was put under general anaesthesia, and placed in lithotomy position. The vulva, vagina and inner aspect of the thighs were cleaned by savlon and sterilized by spirit. The patient was covered by sterile towels leaving only the valva exposed. The bladder was emptied. Examination under anaesthesia confirmed the previous findings. The torn edges of the perineum were held by littlewood’s forceps and was put under stretch by the assistant. A transverse incision was made between the two points. The posterior vaginal wall was then dissected and separated from the underlying scar tissue. Tilt the levator ani muscles were exposed. Bleeding points were clamped and ligated. A longitudinal midline incision was made on posterior vaginal wall. The redundant vaginal tissue was removed. The edges of the two sphincter were identified and sutured using chronic cat gut No. 1. The levator ani muscles were put under tension and approximated in the midline by three sutures using No. 1 chronic cat gut. The edges of posterior vaginal walls were repaired by interrupted chronic cat gut sutures. The superficial muscles and fascia were sutured by interrupted stitches. The skin was closed by interrupted cat gut stitches in the longitudinal plane.

Vaginal examination revealed a reasonable pelvic floor and well formed perineum. Per rectal examination showed a well formed and sphincter and rectal mucosa. There was no undue narrowing. Hæmostasis was complete. A lubricated vaginal pack was inserted. An indwelling catheter was fixed.

The patient recovered smoothly from anaesthesia.
Post Operative Care:
1. The patient was allowed oral fluids when she was fully conscious.
2. As prophylactic antibiotics she continued to take gentamicine 60 mg T.d.s for 5 days and 500 mg t.d.s. for 7 days and was also on ampicillin 500 mg 6 hourly for 5 days.
3. Laxatives two tablets in the evening for 5 days.
4. The pack was removed after 24 hours, there was no bleeding, the catheter was removed as well.

Discharge:
On the 7th day the patient's general condition was good. All her systems were normal. The wound was clean and nicely healed. Her haemoglobin was 12.0 g/100 ml. She was discharged and advised to avoid sexual intercourse for the coming three months. She was informed firmly to have proper antenatal follow up. Her future pregnancy section was explained to her.

Follow up:
The patient presented to the gynaecological out patient clinic one month after the operation. There was no continence of faeces or fluid, her general condition was good. The wound was completely healed and free of infection.

Comment:
A case of third degree perineal tear has been presented. The defect involved the perineal skin, subcutaneous tissue, the superficial and deep perineal muscles and the anal sphincter. The cause was a difficult labour which was not supervised by a trained midwife. This is a commonest cause, other causes may include: post coital injuries in cases of rape or violent intercourse in when the patient is tightly circumcised, direct trauma, cephalopelvic disproportion, malposition, badly performed episiotomy or precipitate labour.
Repair can be performed at the acute stage if the patient present within 24 hours, otherwise it is to be performed after 4 to 6 months when the infection has completely disappeared for the success of the operation. Sepsis before, during and after the operation must be prevented at all cost. A watchful care of constipation and coital injuries is important.

In a patient with successful repair the plan of delivery for future pregnancies is of utmost importance to prevent recurrence of her injury. The patient must have proper antenatal care. Careful assessment is needed at this. With any degree of disproportion the delivery is to be by elective caesarean section. If vaginal delivery is possible then a generous episiotomy is a must.

References:
1. Jeffrey
   *Principle of gynaecology*
2. Shaw's
   *A text-book of operative gynaecology.*
GYNACOLOGICAL CASE NO 14
OVARIAN CYST-LAPAROTOMY

Name: S.A.S
Age: 19 years
Residence: E. Thawra 5
Occupation: Student
Date of admission: 30.6.90
Date of operation: 5.7.90
Date of discharge: 12.7.90

Obstetrical and Gynaecological History:

The patient was single. Menarche was at the age of 11 years. 
Menstrual cycles were regular, the menstrual blood loss was moderate and there was occasional dysmenorrhoea. Last menstrual period on 23.6.1990.

Past medical history, family history, social history and drug history were of no significance.

History of Present Condition:

The patient noticed a lower abdominal mass for the last 8 months. It started in the epigastrium area and then increased in size. It was associated with dull pain which was on and off. There was a feeling of heaviness in the pelvis. She had no fever, nausea, vomiting or loss of weight. Bowel habits and micturition were normal.

On Examination:

The patient was generally well, she was not pale or jaundiced, her temperature was 37.0°C. Her pulse rate was 76/min regular and of normal volume. Her blood pressure was 120/70 mmHg. Respiratory and G.V.P. system were normal. Abdominal examination revealed a distended infra umbilical area. The umbilicus was inverted and the abdomen moved normally with respiration. There were no scars, discoloration or visible veins. There was mass equivalent to the level of a 14 weeks pregnancy. It was cystic, mobile and it was tender. The mass was pelvi-abdominal. The spleen and liver were not palpable. There was no evidence of free fluid in peritoneum.
Rectal Examination:
There was no anal stenosis or tenderness. The rectal mucosa was normal. The uterus was felt and was of normal size. A cystic mass was felt separate from the uterus.

Investigations:
- Her hemoglobin was 12.5 gm/100 ml.
- Her urine was clear.
- Her blood group was O Rh +ve.
- An ultrasound scan of the pelvic organs showed a normal sized empty uterus; right ovary was normal in shape and size. The left ovary was replaced by a cystic mass; it was measured 10 cm x 8 cm at it was unicocular. There was no ascites cross-section.

Management:
A diagnosis of left ovarian cyst was made. Laparotomy was decided upon. Two pints of cross matched blood were prepared. The condition was explained to the patient and her relatives.

Operative Procedure:
The patient was put under general anaesthesia, the abdomen was cleaned and draped leaving only the operative field exposed. The abdomen was opened through a paramedian incision. The uterus was of normal shape and size and position. Both tubes were smooth and healthy, the right ovary was of normal shape and size. The left ovary contained a cyst which was a smooth surface and free adhesions to adjacent structures. Its size was about 10 x 10 cm. There was quite a good amount of healthy ovarian tissue. The cyst was delivered easily through the abdominal incision. It was isolated by sterile gauge-packs. The mesovarium was held by a bowel clamp. The ovarian cortex was opened around the base of the cyst. Aline of cleavage was reached. By blunt dissection the cyst was removed, from the ovarian cortex and the space left by the cyst removal was closed by interursum sutures using chromic cat gut no 00, with complete haemostasis. The abdominal cavity was cleaned. The abdomen was closed in layers, blood loss was minimal. The patient recovered smoothly from anaesthesia, the cyst was opened and found to contain clear fluid.
Post-Operative management and Discharge

The patient was put on prophylactic antibiotic in the form of Ampiclox 600 mg six hourly for five days. She was allowed to orally on next morning. She was given 6 pints of 5% glucose in water during the first post operative day. She received pethidine as analgesia two hour after the operation when she was feeling abdominal pain. She spent an uneventful postoperative period of seven days. On the seventh day the stitches were removed and the wound was clean and nicely healing. Her haemoglobin was 129/100 nil. She was discharged in good condition and asked to report after one month to the out patient clinic.

Histopathological Results:
A benign serous cystadenoma.

Follow-Up:
Miss S.R.S. was seen in the referred out patient clinic one month after the operation. She had no complaints and had normal cycle. Examination revealed no abnormality. P.R. showed normal finding.

Comments:
A case of an ovarian cyst in a young single lady has been presented, persistent small cysts and cysts which increase in size during follow up must be treated like large cysts. The best treatment is surgical removal because:

1. The nature of the tumour will be diagnosed with certainty.
2. Any ovarian tumour is suspected to be malignant till proved otherwise.
3. By so doing complications are prevented, mainly torsion and rupture. There were present as an acute abdomen and need emergency intervention.
A serous cystadenoma is a thin-wall cyst. Often translucent usually unilocular but occasionally daughter cysts may be present in the wall, unilateral or bilateral (in 50%). The outer surface is smooth but sometimes the outer surface may contain papillae, so called exophytic. They may cause ascites, with implantation of fragments of the tumour, in the peritoneum thus looking more suspicious of malignancy.

Histologically the lining cell are cuboidal or columnar and they are ciliated. The stroma may contain paramesone bodies which are calcium deposit.

Reference:
1. Toledo’s: Principles of gynaecology.
2. Devahastin’s: Integrated obstetrics and gynaecology for post graduate.
GYNACOLOGICAL CASE NO. 12
HYDROAEMATOMA MENSES

Name : Mrs M.A. Al Aila
Residence : Barakat (Wad Medani)
Age : 20 years
Occupation : Housewife
Date of admission : 9.6.89
Date of discharge : 23.6.89

Obstetrical History:
The patient was para one; her first delivery was normal and vaginal, conducted at hospital in 1987. She had a male baby who was alive and well.

Gynaecological History:
Menarche was at the age of 14 years. Rate was 3/32. Her cycles were normal and regular. Her L.M.P. was on 4.2.85. There was no history of use of contraceptives.

Past History:
She was not known to be diabetic or hypertensive.

Family history, social history and drug history:
were not significant.

Admission to Hospital:
Mrs. M.A. presented to the gynaecological out patient on the 9th of June 1989. She was carrying a pregnancy of 14 weeks according to her dates. She developed vaginal bleeding for one week prior to admission. It was recurrent and neither severe nor associated with pain. On the day of admission the bleeding became profuse and it was associated with colicky pain. On examination she was restless and anxious. Her pulse rate was 110/min, regular and small volume. Her blood pressure was 140/90 mm Hg. All her body systems were normal. The abdomen was soft and the uterus was felt at the level of 14 weeks gestation. It was slightly tender. Pelvic examination showed a circumcised vulva. There was apparent
Active bleeding calling the vulva and the thighs and the legs. The vagina was healthy. The cervix was soft and the OS was 4 cm dilated. The uterus was 16 weeks in size. There were bilateral ovarian cystic mobile masses; each was about 7 cm in diameter. The clots were removed from the vagina. There were vessels mixed with the blood clots.

Management:

The diagnosis made was abortion of hydatidiform mole. A blood sample was taken for grouping and cross matching. Her blood group was A Rh pos. Three pints of cross matched blood were prepared. Her haemoglobin was estimated and found to be 8.5 g/100 ml. Her urine examination was free of abnormalities. A large X canula was passed and 5% glucose in normal saline was transfused at a rapid rate. 14.1.0. of syntocinon, diluted in a pint of normal saline were kept running through another canula, intravenously at the rate of 60 drips per minute. Two pints of blood were transfused. A follow-up chart was drawn up. After three hours the bleeding stopped. During this period the patient expelled a large quantity of mole tissue. It was kept in formaldehyde and sent for histopathology.

A pregnancy test was done and found to be positive in a dilution up to 1/500. The uterine size diminished to that of about 12 weeks gestational size.

Further Management:

The patient was kept in the gynaecological ward. Her general condition improved. There was slight vaginal bleeding. Her blood pressure was 140/80 mmHg. She was put on Ampicillin 500 mg 6 hourly, Flagyl tablets 500 mg three times a day, (3 hourly) and ergometrine tablets 0.5 mg 3 hourly for five days. She was improving steadily.

Operative Management:

On the 7th post abortion day. The general condition of the patient was good. The uterine size was equivalent to 8.10 weeks gestation. The patient was taken to the theatre and an evacuation was performed under general anaesthesia. The curettage was sent for histopathology.
**Histopathological Results:**

Typical hydatidiform mole with no evidence of malignancy.

**Discharge From Hospital:**

The patient's general condition was improving. There was no further vaginal bleeding. Her haemoglobin was 10 g/100ml. Her urea was 71 mg/100 ml. Pregnancy test was positive undiluted and negative at 1/100 dilution. A chest X-ray revealed normal findings.

The patient was put on contraceptives and discharged. She was asked to come after one week. The condition and importance of regular follow-up were firmly explained to her. The possible complications were discussed.

**Follow-up:**

After one week the patient came with no complaints the bleeding had stopped. She was in a good health. The blood pressure was 120/80. Pelvic examination showed a normal sized uterus which was anteverted and mobile the adnexa were free of masses. Pregnancy test was negative. The patient was followed in the same manner monthly for one year and then 3 monthly for another year, during which time there was no evidence of persistent trophoblastic disease.

**Comment:**

A case of hydatidiform mole has been presented. The patient was aborting so the initial management was to accentuate that process. If suction curettage was available it could have been proper in such a case. Hydatidiform mole is a neoplasm of the trophoblast. It involves the lamnham and syncytium. It is potentially malignant. The incidence is higher in southeast Asia about 1 in 200-300. It is least in Europe, about 1 in 2000-2500. Our area's incidence is something in between.

The cornerstone of management of molar pregnancy is early evacuation and close follow up. The main goal is prevention or early detection and proper treatment of recurrence or occupancy of choriocarcinoma. The incidence of choriocarcinoma development is 2 - 17%.
Follow up by:

1. History of abnormal bleeding, or amenorrhoea and history of haemoptysis.
2. Clinical examination to see the size of the uterus and to look for adnexal masses.
3. Investigation, pregnancy test. If human chorionic gonadotrophin activity can be checked by radio immunoassay is far more sensitive than pregnancy test.

There is a place for chemotherapy in Hydatidiform mole. These include, the invasive mole and 5% patients with high risk of developing choriocarcinoma especially when follow-up is difficult to arrange. The criteria of the Charing Cross Hospital for starting chemotherapy include:

a. High level of human chorionic gonadotrophin (HCG) 4 weeks after evacuation.

b. Progressive increase HCG at any time after evacuation.

c. Any detectable level of HCG not showing tendency to disappear 4–6 month after evacuation.

d. Evidence of metastasis regardless of the level of HCG.

References:

1. Jeffcoat: Principles of gynaecology
2. Devhurst: Integrated obstetric and gynaecology for post graduate.
Introduction:

178 laboratory results of high vaginal swab cultures from patients presenting with vaginal discharge at Soba University Hospital during a period of 14 months (from 1.9.99 to 31.12.99) have been reviewed. Their distribution according to the causative agent has been worked out. The drug-sensitivity of each isolated organism has been determined.

Vaginal discharge considered in this study has not been classified according to any clinical characteristics. It included any vaginal discharge which was significant to the treating doctor to request investigation.

Objectives:

The proper management of any infection must aim at identification of the cause, and determination of the drug sensitivity and resistance to it. This facility is expensive and is not always available, one need to start with a drug while awaiting results. Knowing the pattern of drug sensitivity may be a good guide when a certain infection is suspected. There is also need of knowing the pattern of the different causative organisms in a certain area.

Methods, Materials and Patient:

The patients presented to the gynaecological referred clinic at Soba University Hospital with vaginal discharge. They were of different age groups, most of them in the 25 years to 35 years group; taken from all of them. A wet preparation and stained slides were examined under microscopes. Culture were made and the growing organisms were studied and identified. The drug sensitivity and resistance of each isolated organism was determined. The drugs tested were those which are available and
<table>
<thead>
<tr>
<th>Organism</th>
<th>Non</th>
<th>Bacterial</th>
<th>Candida</th>
<th>Trichomonas</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>78</td>
<td>58</td>
<td>41</td>
<td>1</td>
<td>198</td>
</tr>
<tr>
<td>%</td>
<td>43.82%</td>
<td>32.58%</td>
<td>23.03%</td>
<td>0.56%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**TABLE No. 1**
Showing the invading organism in 198 high vaginal swabs.

<table>
<thead>
<tr>
<th>Bacteria</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staph.</td>
<td>18</td>
<td>31.03%</td>
</tr>
<tr>
<td>Coliforms</td>
<td>13</td>
<td>22.41%</td>
</tr>
<tr>
<td>E. coli</td>
<td>10</td>
<td>17.24%</td>
</tr>
<tr>
<td>Proteus V.</td>
<td>9</td>
<td>15.51%</td>
</tr>
<tr>
<td>Klub Sierra F.</td>
<td>4</td>
<td>6.90%</td>
</tr>
<tr>
<td>Gonococcus</td>
<td>2</td>
<td>3.45%</td>
</tr>
<tr>
<td>B.H. Streptocci</td>
<td>2</td>
<td>3.45%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>58</td>
<td>100%</td>
</tr>
</tbody>
</table>

**TABLE No. 2**
Showing the distribution of 58 cases of bacterial infection according to the species isolated.
Fig (1)
A Histogram Showing the Incidence of Disease
In Two High-Vigorous Groups

[Bar chart showing incidence of disease in two groups]
relatively less expensive. They included gentamicin, tetracycline, chloramphenicol, ampicillin, neomycin (cotrimoxazol) ampicillin, erythromycin and piperacillin B.

**Results**

The results are summarized in form of tables and histograms. Table no A was obtained by calculating the frequency of each drug sensitivity of seven organisms that had been isolated.

**Discussion**

In 78 cases (41%) the result was negative, they did not show any organisms on direct microscopic examination and there was no growth in the culture media. The possible explanation in these cases may be misinterpretation of a normal section and taking it for pathological discharge. This is especially so in anxious patients who are usually difficult to convince by their doctors. This non infective discharge is physiological. The source is from vaginal discharge (from Bartholin's sebaceous duct and apocrine glands), vaginal exudation, cervical mucous secretions, uterine secretions and fallopian tubes secretion. Thus discharge tends to increase and to be noticed by the patient at the time of ovulation, premenstrual, during pregnancy and during sexual arousal. Leucorrhrea, probably, is the commonest cause of negative results. It is an exaggerated form of a non infective discharge. The patient usually complains of a brownish discharge soiling their underwear, the source is mainly cervical. It is seen when the estrogen stimulation of the cervical glands is excessive, as in early childhood, puberty and in patients who are using contraceptive pills. It is expected when the cervical glands mass is increased as in cases of erosion (cystoid) and in vaginal adenosis where the squamous vaginal epithelium is replaced, in some areas, by the columnar secretory epithelium. Leucorrhrea also occurs when the cervix is overstimulated by irritants for example due to excessive and regular douching, the main differentiating clinical character is that leucorrhrea is never offensive and it never causes pruritus. The absence of pus cells in the examined discharge is the main bacteriological characteristic.
<table>
<thead>
<tr>
<th>DRUG</th>
<th>SENSITIVITY 1/2 %</th>
<th>RESISTANCE No %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ampicillin</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>Gentamicin</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>Chloramphenicol</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Tetracycline</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Septrin</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Polymyxin B</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Erythromycin</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Ampicillin</td>
<td>3</td>
<td>15</td>
</tr>
</tbody>
</table>

*TABLE No.3*
showing the distribution of 18 cases of septic  
crosses injected according to the drug sensitivity  
and resistance.

<table>
<thead>
<tr>
<th>DRUG</th>
<th>SENSITIVITY 1/2 %</th>
<th>RESISTANCE No %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gentamicin</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Tetracycline</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Chloramphenicol</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Ampicillin</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Ampicillin</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Septrin</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Erythromycin</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Polymyxin B</td>
<td>5</td>
<td>13</td>
</tr>
</tbody>
</table>

*TABLE No.4*
showing the distribution of 13 cases of pneumonia injected  
according to the drug sensitivity and resistance.
Fig. (4)
A Histogram Showing The Distribution of 13 Cases of Proteus Infection According To The Drug Sensitivity & Resistance

- Sensitivity
- Resistance

Drugs: Gentamicin, Tetracycline, Ampicillin, Ampicillin, Polyanoin, Polyanoin
Good bacteriological techniques including examination of the swab immediately, when it is wet, will lessen the chances of false negative results.

Pyogenic organisms were isolated in 58 cases (32-58 per cent). This is higher than expected, because the majority of patients fall in the group of child-bearing age, who are naturally protected against bacterial infections due to the action of oestrogen on the vaginal epithelium. It leads to growth, maturation, and exfoliation of the squamous cells lying the vagina, these cells are rich in glycogen. They are acted on by the lactogenic bacilli to produce lactic acid. The pH of the vagina is kept as low as 4-5. This is in favour of the growth of Boderlein’s bacilli which are the normal flora of the vagina that will cooperate for growth with other bacterial species. Oestrogen also supports the vaginal epithelial cells and keeps them moist and more resistant to break down, the primary bacterial infection is so rare and it occurs in the extremities of life, in children or in the postmenopausal age. Pyogenic infection can occur as secondary event in cases of erosion, cervical polyp, malignancy or in cases of erosion, sloughing endometrial fibroid polyps.

Fungal infections were attributed to in 48 cases (22.0%). They were seen in the gram stained preparations as filaments or spores. The number could have been higher if cultures in special media were used; for example Sabouraud’s media or Nickerson’s media. The chance of infection is higher when there is a carbohydrate rich medium so the infection increase in relation to glucosuria. They flourish when the competing bacteria in the vagina is reduced by the prolonged use of antibiotics, candida infection also occurs in a patient after the treatment of trichomonas vaginalis. In the presence of mixed infections the trichomonas is dominant and keeps candida under check restricting its growth.

Only one case of trichomonas vaginalis has been isolated (0.56%). This is far less than expected. The cause of this may be faulty techniques. For the diagnosis of trichomonas vaginalis
<table>
<thead>
<tr>
<th>DRUG</th>
<th>SENSITIVITY No. %</th>
<th>RESISTANCE No. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gentamicine</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Tebramycin</td>
<td>44</td>
<td>6</td>
</tr>
<tr>
<td>Sephlin</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Chloramphenicol</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Ampicillin</td>
<td>-</td>
<td>10</td>
</tr>
<tr>
<td>Ampicillin</td>
<td>-</td>
<td>10</td>
</tr>
<tr>
<td>Erythromycin</td>
<td>-</td>
<td>10</td>
</tr>
<tr>
<td>Polymyxin B</td>
<td>-</td>
<td>10</td>
</tr>
</tbody>
</table>

**TABLE 5**
Showing the distribution of 10 cases of E. coli injection to the drug sensitivity and resistance in No. and percentage.

<table>
<thead>
<tr>
<th>DRUG</th>
<th>SENSITIVITY No. %</th>
<th>RESISTANCE No. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gentamicine</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td>Chloramphenicol</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Tebramycin</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Ampicillin</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Amoxicillin</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Sephlin</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Polymyxin B</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Erythromycin</td>
<td>-</td>
<td>9</td>
</tr>
</tbody>
</table>

**TABLE 6**
Showing the distribution of 10 cases of Proteus injection according to the drug sensitivity and resistance.
A Histogram Showing The Distribution Of 2 Cases Of Protein
infection According To The Drug Sensitivity & Resistance

- Sensitivity
- Resistance

Drugs: Streptomycin, Penicillin, Polyoxin B, Erythromycin, Chlormphenicol, Neomycin, Neupen, Ampicillin, Neopen, Streptomycin B
the sample must be transferred to the laboratory immediately. It is better if the sample is taken in the laboratory by pipette, this is then added to a drop of saline on a slide and examined immediately under the microscope. The slide must be warmed, stained and covered with glass slip. The trichomonas will be seen moving in a positive test. One examination is never conclusive, several testing may be needed to find the parasite. The direct microscopic test is very unreliable. The alternative is the cultural method. The media used is kupferberg's or feinberg-whittington, the later media inhibit the growth of all organisms except, trichomonas and candida albicans because it contains streptomycin and penicillin. This method is twice as effective as the direct microscopic method.

Among the bacterial infections isolated staphylococcus was found to be the highest (31.03%). It is one of the commonest vagina bacteria in children and old ladies, it is expected to be present whenever the vaginal secretions is made, by whatever factor, alkaline. The relatively free use of the penicillin group antibiotics, to which some strains of staph, are resistant, may be a contributory factor in the presence of the infection in pregnant women. Staph. aureus are known inhabitants of the nose. Up to 80% of nursing personnel have been found to harbour potentially pathogenic staphylococci. If it is a possibility, however a bit remote that some of these cultured swab may be due to contamination from the medical staff.

Accidental contamination of the swabs by touching the vulva or perineum must not occur—such faulty swabs are to be discarded.

The next commonest organisms isolated were coliform (22.45%) and E. coli (17.2%).

Only two case of gonococci were confirmed by culture (3.4%). This is rather a low percentage, gonococci grow poorly in ordinary media they are extremely susceptible to drying. This fact is to be considered carefully in transporting and dealing with swab. Moreover gonococci are cultured with a better chance if the sample are taken from the cervical gland, urethra or
TABLE No. 4
Showing the distribution of 44 cases of Klebsiella injecting according to the drug sensitivity and resistance.

<table>
<thead>
<tr>
<th>DRUG</th>
<th>FREQUENCY %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gentamicin</td>
<td>37</td>
</tr>
<tr>
<td>Chloramphenicol</td>
<td>31</td>
</tr>
<tr>
<td>Ampicillin</td>
<td>30</td>
</tr>
<tr>
<td>Tetracycline</td>
<td>28</td>
</tr>
<tr>
<td>Septra</td>
<td>2.3</td>
</tr>
<tr>
<td>Ampicillin</td>
<td>18</td>
</tr>
<tr>
<td>Erythromycin</td>
<td>14.4</td>
</tr>
<tr>
<td>Polymyxin B</td>
<td>11</td>
</tr>
</tbody>
</table>

TABLE No. 8
Showing the frequency of sensitivity of the 58 isolated organisms.

1. Two cases of B.H. were sensitive to: Septra, Gentamicin, Ampicillin, Ampicillin, and Erythromycin. and resistant to: Tetracycline and Polymyxin B.
2. The two cases of carcinoma were sensitive to: Ampicillin, Ampicillin and POLYMIXIN B and resistant to: Septra.
Fig (3)

Histogram Showing The Frequency Of Sensitivity To The Isolated Organism
Bartholin's glands. Gonococci can be diagnosed in a gram-stained smear by their characteristic kidney shaped gram-negative diplococci. However, these may be masked by a heavy flora of commensal organisms. Experience is needed in the identification of gonococci in a stained slide. Because of all these difficulties failure to grow the organism cannot be looked upon as a definite evidence against their presence.

The frequency of antimicrobial sensitivity of the organism has been determined regardless of the infective organism (see Table 8 and fig. 8).

Cefazolin is found to occupy the top of the list (93%) followed by chloramphenicol (61%) and Ampiclox (59%). The least sensitivity was to polymyxin B (19%) and erythromycin (24%). Such an information can be utilized when the treating doctor needs to start treatment in the absence of the facilities of culture. The drug susceptibility for each individual organism is put in order (see Table and fig. 3, 4, 5, 6, and 7) this will help in selection of a drug when a certain infection is suspected clinically.

Conclusion:
A scientific approach to the treatment of patients with vaginal discharge is to include the identification of the infective organism and the determination of the drug susceptibility. This is not always available in specially our district communities. A blind use of antimicrobial agents will be wiser if it follows logical guidelines.

Recommendations:
1. Carrying prospective clinico-bacteriological studies to determine the pattern of infection and the pattern of drug susceptibility, in different centres, so as to determine guidelines which can be followed when the treating doctor is compelled to start treatment blindly.
2 Whenever trichomonas vaginalis infection is suspected clinically, the request for investigation must state this clearly, so that special techniques are to be used for the establishment of the diagnosis with least chance of false negative results.

3. Whenever gonococcal infection is suspected, cervical and urethral swabs are to be taken. The bacteriologist is to be informed because special techniques are needed, culture is to be carried in serum with 5-10% carbon dioxide and in an anaerobic conditions.

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