OVARIAN CYST FORMATION: MANY YEARS AFTER HYSTERECTOMY FOR HEMORRHAGIC COMPLICATIONS IN TWIN DELIVERY

Padhye S*, Karki C*

ABSTRACT

After a subtotal hysterectomy for severe postpartum hemorrhage due to rupture uterus, following complication at internal podalic version and breech extraction for a second twin, in a primipara; a long term follow up and management by a wedge resection of ovary, ovariectomy, and removal of cyst was carried out by the same surgeon in three different Hospitals, so unique in our context, is reported.

Key Words: Twin Delivery, Internal Podalic Version.

INTRODUCTION

Internal podalic version for the second twin may at times complicate to uterine rupture and it becomes mandatory to perform subtotal hysterectomy with ovarian preservation a life saving procedure. One such case is reported.

CASE STUDY

In 1982, Mrs. N. J, aged 22 years, para one with a history of a stillbirth three months back, presented with a history of amenorrhoea of 40 days with negative urinary pregnancy test.

Uterine size increased to ten weeks in the next follow up visit and thereafter she was able to perceive fetal movements at 22 weeks of pregnancy. Considering her previous stillbirth, labor was induced at 39 weeks in Bir Hospital.

She delivered male baby by vertex presentation. Internal podalic version and delivery of second twin was completed in an hour, which lead to severe postpartum hemorrhage resulting in collapse within a few minutes after the placental delivery. Bleeding was not controlled with an ampoule I.V ergometrine. It was diagnosed to be uterine rupture, therefore she was resuscitated and taken to the general operation theatre and due to unavoidable delays of an hour or more, and the abdomen

was finally opened on a single perineal sheet due to unavailability of proper seats, more over till the instruments were ready bleeding was arrested pinching on to the bleeders.

Subtotal hysterectomy was quickly done, preserving the ovaries. Indwelling Foley catheter was kept. Her recovery from anesthesia and the postoperative period were uneventful. She received twelve units of AB +ve blood. She was discharged from Bir Hospital on 13th postoperative day.

Fig. 1 : Ultrasonography of Pelvic Mass.

* Kathmandu Medical College, Sinamangal, Kathmandu, Nepal.

Address for correspondence : Prof. Saraswati Padhye
Kathmandu Medical College, Sinamangal, Kathmandu, Nepal.
Email: smpadhye@info.com.np

After 9 years, she complained of loss of libido and dryness of vagina. A Pap smear was taken and estrogen tablets (evalon) 0.05 mg was prescribed. After one month, she presented with a right cystic mass in the pelvis measuring 90x75-mm (Figure 1) by an ultra-sonogram, just available then in Nepal.

She was admitted for laparotomy at Maternity Hospital as the Ob/Gyn ward of Bir Hospital was closed down in 1985. Abdomen was opened with sub umbilical right para median incision; amidst dense adhesions where both ovaries were found to be cystic instead hydrosalpinx was seen on the left side. So wedge resection of right ovary & left salpingectomy were performed. As per patient's request appendicectomy also was done. Her postoperative period was uneventful and was discharged on 12.5.048. Histology reported normal tube; inclusion cyst in the ovary and chronic appendicitis.

In the year 1994, heaviness of lower abdomen was the presenting complaints when the USG showed left cystic mass of 67x55-mm and a small solid structure of size 26x14 mm floating inside this cystic mass.

In, 1996, Trans-vaginal ultra-sonogram [by then available in Nepal] noted a cystic mass, 53x48 mm on right side and 80-85 and 60-80 mm mass on to the left ovary, which had been gradually increasing in size over the preceding three years period; 1997-1999.

Consecutively the pelvic mass measured 72x56 mm with solitary cyst of 35x30 mm, reported as "ovarian cyst (complex type)" with multiple internal septations finally increasing to 92x68 mm to 107x83 mm with vol. 390 cc (Figure 2).

Fig. 2 : Ultrasonography of Ovarian Cyst.

Mass about 10x10 cm on the right side of pelvis was felt with laxity in perineum and rectocele on the 3rd admission at Katmandu Medical College when larger part of old abdominal scar was excised at laparotomy dissected off the adhesions. A multi-loculated thin walled cyst in the right side and some of

the cystic portion of the left ovarian tissues were removed maintaining the homeostasis.

The stump of the cervix was also removed; thereby completing the surgery after posterior colpoperiniorrhaphy.

The drainage tube and Foley's catheter were removed on the second day. Her postoperative recovery was satisfactory. She was discharged on request with premarine 0.625 mg. daily. After 13 days she attended the clinic with complaints of excessive vaginal discharge.

DISCUSSION

This case report is of historical importance being managed first of all in Bir Hospital and today only few of us know that, this hospital in the past exercised obstetrics and gynaecology services.

The other interesting part is that the same doctor, the first author has followed up the case for twenty long years in three different hospitals Bir /Maternity/Katmandu Medical College.

Before the Ultra-sonogram service was introduced by the pioneer Late Dr. Basanta Lal Shrestha in Nepal, clinical suspicion of multiple pregnancies were confirmed by Roentogram when it was safe to so.

Internal Podalic Version (IPV) is mainly performed in 2nd twin with tranverse lie accomplishing breech extraction. This procedure is done under general anesthesia when the cervix is fully dilated and the membranes are just ruptured. Failure to fulfill these prerequisites is apt to cause maternal death due to rupture of uterus.

The studies have shown that IPV carried out in 32.09% of 81 cases of shoulder presentation with fulfillment of prerequisites in a singleton pregnancy; reported one case of uterine rupture.¹ The fetus was very premature or dead in utero.

Incidence of Rupture uterus can be as high as 1 in 330-500 deliveries and its contribution to the maternal and perinatal mortality can be 4.1 and 2.6% respectively.² In a developing country the incidence can be as high as 1 in 96.6 deliveries³

Emergency Peripartum Hysterectomies are being performed less than 24 hours after delivery in obstetrical practice, for hemorrhage unresponsive to other treatment like placenta praevia, rupture uterus, placenta accreta and atonic uterus.^{4,8} In a community teaching hospital placenta accreta was found to be the most common indication for emergency peripartum hysterectomy.⁵ More than 80% of these hysterectomies were

of subtotal.^{5,6,8} There was significant decrease in mortality and morbidity due to this very reason in 1980-89 than in 1970-79.⁶ Even though the incidence of Rupture uterus is declining in some countries, its occurrence should be suspected if there is unexplained postpartum shock.⁷

Removal of Ovaries in young patients can give rise to menopausal syndrome; hence they are usually preserved although they stand at risk to the development of ovarian tumors 1 in 10,000.

CONCLUSION

Internal podalic version has to be discouraged even in a multiple pregnancy, if there is any doubt in its safety, now that the caesarean is undertaken even for the non-vertex presentation of any of the twins.

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