OBSTETRICS AND GYNAECOLOGY

CASE RECORDS AND COMMENTARIES

PAUL E. KIHAILE, M.D. (Dar)

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INTRODUCTION

A. OBSTETRICS AND GYNAECOLOGICAL SERVICES AT MUHIMBILI MEDICAL CENTRE.

Muhimbili Medical Centre in Dar es Salaam is the biggest of the three consultant and teaching hospital in Tanzania. The centre incooperates the Faculty of Medicine, University of Dar es Salaam although the latter has its own Dean. The major functions undertaken by the centre are:

1. Serving as the main consultant hospital as it has the largest number of experts in various fields and the larges laboratory. Besides it has the only radiotherapy facilities in the country.
2. Teaching postgraduates and undergraduates doctors, dentists, pharmacists, nurses, midwives and paramedical cadres.
3. Serves as a sonal consultant hospital for Dar es Salaam, Morogoro and Coast regions.

The department of Obstetrics and Gynaecology works independently like other departments namely Medicine, Paediatrics, Surgery, Otolarynxngiology, Psychiatry, Dentistry and Opthalmology. It is devided into 4 firms and each firm has 2 consultants/ specialists and also each firm works independently with its own outpatient clinics, beds and operation schedules.

The department of obstetrics and gynaecology has a total of 363 beds, 67 of which are for gynaecological patients and 296 for obstetric patients. The gynaecological patients are admitted in the 2 wards which are located in the Sewa Haji block at Muhimbili hospital whereas the obstetric patients are admitted at both Ocean Road hospital which is for normal obstetric deliveries and Muhimbili Maternity Block which caters for high risk patients. Although the total number of beds is only 363, the daily average bed state is between 600 and 700 patients.

B. OBSTETRICS SERVICES

The obstetrics services that are offered at the department of obstetrics and gynaecology are:

1. Antenatal care for high risk pregnancies.
2. Intrapartum services at Muhimbili hospital for high risk patients and intrapartum services for normal deliveries at Ocean Road Hospital.
3. Post-natal services for those who had undergone operations or difficulty deliveries.

(i) Antenatal Services

All the patients attending Muhimbili antenatal services are high risk patients, who have been referred from peripheral clinics. The only exception is grade I patients who have to pay a fee before they

are booked irrespective of whether or not they are high risk patients. The peripheral clinics are manned by midwives and rural and maternal aids who screen out the high risk patients and refer them to Muhimbili while they look after normal pregnancies and deliveries only.

At the booking antenatal clinic, the patients identity age, previous and present obstetrics history medical and surgical history are ascertained. Also family history of twins and other chronic illnesses such as diabetes, hypertension heart disease tuberculosis and epilepsy, social history and whether or not she is a smoker, or takes alcohol are ascertained and logether with the initial examination are recorded in antenatal form ..... Urine is then tested for glycosuria, albumunuria, and blood is taken for venereal disease Research Laboratory test (V.D.R.L.), haemoglobin, blood group and rhesus factor. A full physical examination including height and weight is done.

Provided the pregnancy progresses well, the patients are seen at the antenatal clinic once a month until the 32nd week of gestation and then once fortigutly until 36 weeks of gestation and then once weekly until delivery. During each visit the

patient is examined for evidence of anaemia, oedema, weight gain, and blood pressure. The abdomen is palpated and uterine size, presentation, lie of the baby fetal heart sound are noted. The urine is tested for albumin, and haemoglobin is checked monthly.

Three doses of tetanus toxoid are given to the mother at 28, 32, 36 weeks of gestation. Routinely the following age given 200 mg of ferrous sulphate are given twice daily and 5 mg of folic acid daily and 300 mg of chloroquine base weekly until 4 weeks postpartum. The referred patients who have been treated of their diseases which necessitated referral for example anaemia, are sent back to their original c inics. Pelvic assessment of primigravidae is oerformed from 36 weeks of gestation.

B. IN-PATIENTS

Patients with complications during pregnancy requiring admission are admitted to the antental wards. The main causes for antenatal admission according to the 1979 hospital statistics are:

1. Anaemia which constituted 51% of all admissions. These patients are given total dose inferon infusion or blood transfusion depending on the level of haemoglobin and gestational age of the fetus. They are then discharged the following day except if the haemoglobin level was very low

below 7 gm/dl when they are kept in the ward until the level reaches 7 gm/dl or above.

2. False labour 23.0%

3. E.P.H. gestosis 15.9%

4. Pyrexia of unknown origin and malaria 1.3%

5. Prolonged pregnancy 1.1%

Extra investigations that can be carried out in selected inpatients and outpatients are ammocentesis and echogram.

By the time a patient reaches term the decision is already made on anticipated mode of delivery and the place of delivery and the patient is advised accordingly.

(ii) Intrapartum care

All normal deliveries are scheduled to take place at Ocean Road Hospital and indications for delivery at Muhimbili labour ward are:

1. Those still having risk factors and have been reveiving antenatal care at Muhimbili antenatal clinic and

2. Those who develop complications during the intrapartum period. Ocean hospital is manned by midwives, one intern and a resident. All intrapartum complications are promptly refferred

to Muhimbili labour ward as there is an ambulance at Ocean Road Hospital.

The number of deliveries per year is about 30,000 with 50 - 60 of the deliveries occuring at Ocean Road Hospital daily and as 30 deliveries per day at Muhimbili labour ward.

(iii) Admission

All patient who are admitted into the labour ward are first seen by a nurse midwife who takes the history of onset and progress of labour and she makes a preliminary physical examination. Urine is their tested for albumen, sugar, and acetone. The blood pressure, temperature and pulse rate are recorded. She is then examined for evidence oedema and anaemia. The abdomen is then palpated for fundal height, fetal lie, position presentation, and fetal heart rate. The type of uterine contractions are noted. An enema may be given on admission depending on the stage of labour.

In the labour ward, the doctor reviews the history and undertakes a detailed examination of the patient. An initial vaginal examination is then done to determine the state of the cervix, presenting part and membranes. The doctor also examines the size and shape of the bony cage of the pelvis and eventually plans the management of labour. The observation chart used in labour ward was devised by Friedman and Modified by Phillipot then modified

our department to suit our circumstances. It is started when the patient is in active labour and the cervical dilatation has reached 3 cm. Alert and Actions lines are drawn at 3 hours and 7 hours positions respectively on the partogram a copy of which is attached. If cervical dilatation crosses the "Alert" line at any level, it signals arrest of progress. Should the "Action line" be crossed, it calls for action to deliver the baby.

(iv) Second stage of labour

At this stage the contractions are powerful and expulsive in nature and the patient gets the desire to move the bowel. The cervix is fully dilated. The patient is then placed in modified forsal position. She is instructed to take a deep breath and "bear down" strongly and relex in between contractions. As the head distends the perineum a sterile pad is placed over the anus and the perineum is supported. An episiotomy is done if indicated.

(v) Obstetric, Analgesia and Sedation

Pethidine hydrochloride or pethilorphan in doses of 50 mg to 100 mg intramascularly or morphia 10-15 mg intramascularly are used routinely for analgesia and sedation in labour.

(vi) The third stage of labour

The third stage of labour is managed actively. Intramascular syntometrine or intravenous ergometrine 0.25 mg is given at the end of the second stage and the placenta is delivered by Brandt - Andrews method. The placenta and membranes are then checked for completeness and the presence or abscence of abnomalities. The placenta weight and approximate blood loss are then recorded in the labour chart.

(vii) Postpartum care

The infant: After resuscitation the Apgar Score at one minute and if necessary at 5 minutes is recorded. The infant is then examined for any congenital anomalies before weighing it and handing it over to the mother. An infant is sent to the neonatal wart if its condition is poor or if the mother cannot stay with it because she is sick or has undergone an operation.

(viii) Mother

The birth canal is then inspected for any tears or lacerations and any episiotomy is repaired immediately. The uterus is then squeezed so as to expell clots hence facililitating good involution. Post delivery pulse and blood pressure are recorded and the patient is then transferred to the postnatal ward for observation for about 24 hours. After that the babies are vaccinated against tuberculosis and both the mother and baby are discharged. As for those mothers with complications they remain in the postnatal ward until they recover.

(ix) Postnatal care

The patients with uncomplicated deliveries are advised to attend the nearest Maternal and Child Health clinics after 6 weeks whereas those patients with complicated deliveries are told to attend the postnatal clinic at Muhimbili. At the postnatal clinic the mothers general condition including blood pressure urine for albumen, haemoglobin, uterine involution and milk secrection are checked. The mothers are then given a talk on family planning. The infant is checked for growth milestone and general condition, benign neoplasms, malignant neoplasms, infertility, menstrual disorders, tubal pregnancies, and genital fistulae.

Evacuation of the uterus for incomplete abortion is usually done in the side room minor theatre under pethidine 100 mg intravenously and valium 10 mg intravenously. Septic abortions are evacuated in the major theatre under general anaesthesia.

D. SPECIAL PROCEDURES

In the cases that will be presented later in this book, some of the procedures described below may have been performed so that to avoid repitition references will be made to special procedures where necessary.

(i) Urine testing for Gylcosuria

Clinistix reagent strip were used. The impregnated part is dipped into freshly voided urine in a clean container and observed for one minute and the presence of glucose indicated by colour change into blue. This is a screening test and it does not indicate the amount of glucose. Blood sugar should be ordered in positive cases.

(ii) Urine testing for proteinuria

This is done by using albustix reagent strips. The test area of the reagent strip is made of cellulase impregnated with tetrabromephenol bufferred to an acid pH. In the presence of protein the yellow test area turns green.

The test area is dipped into fresh uncentrifuged urine in a clean container and the colour change is compared to the scale on the bottle containing the strips. The amount of protein in the urine is expressed in milligram of protein per 100 mls of urine. The amount of protein is expressed as follows:

Trace - 5 - 20 mg/100 mls
1+ - 30 mg/100 mls
2+ - 100 mg/100 mls
3+ - 300 mg/100 mls
4+ - 1,100mg/100 mls

As the test is quick to perform it is good for handling many patients at the antenatal clinic.

(iii) Procedure of vaginal examination

The examiner scrubs and wears sterile globes. The patient is cautioned about the procedure and placed in modified dorsal position or lithotomy. The vulva is then inspected for any abnomalities including bleeding or discharge and then the right hand picks a swab which was soaked in savlon solution 1:20 and transfers if to the left hand and the left side of vulva is swabbed anteriorly - posteriorly to the four chette. The same procedure is repeated on the right side of the vulva. The labia are then separated by the left hand and with another swab the vaginal introitus is then swabbed antero-posteriorly with the right hand. While still the labia remain separated the index and middle fingers are dipped in chlrohexidine cream and then both fingers are gently introduced into the vagina.

(iv) Bony pelvis assessment

The fingers are introduced as far as the sacral promontory and the distance of the diagnol conjugate is estimated and then the sacral curve is ascertained. The ischial spines are felt for prominence. The fingers are then slowly withdrawn and the subpubic angle measured by its easiness of accomodating the two fingers. The bituberous diameter is measured by the number of knuckles that are accomodated between the two ischial tuberosities.

(v) Urethral catheterization

The hands are scrubbed and a sterile pair of gloves is owrn. The patient is placed in dorsal position with the thighs wide apart and the labia cleaned as described earlier. The urethral meatus is swabbed after separating the labia. Then a sterile catheter is held by a sterile gauze and dipped into chlorhexidine cream after which it is gently introduced into the urethra. Slight pressure is exerted suprapubically to ensure complete emptying and the colur and amount of urine are noted.

(vi) Episiotomy

This procedure is done mainly in the following patients.

1. Most primigravidaw
2. Any resistant unyielding perineum
3. Instrumental deliveries
4. Premature deliveries
5. Breech deliveries

The J shaped or curved posterolateral episiotomy is normally used after scrubbing and wearing sterile globes and sterile instruments. During crowning before the perineum, is excessively stretched 5 to 10 mls of 1% lignocaine is ifiltrated at the incision site. As soon as the presenting part distends the perineum two fingers are inserted into the vagina and the episiotomy is performed between the two fingers using Mayos scissors.

Bleeding vessels are ligated using catgut No. 2/0. The repair is done in 3 layers starting with the vagina mucosa which is first repaired using continuous catgut No. 0 beginning at the apex of the incision towards the forrchette. The fascia and perineal muscles are approximated by interrupted chromic catgut number 0. The perineal skin is approximated by interrupted catgut No. 1.

(vii) Preoperative preparation for laparatomy

The patient is examined and declared fit for surgery. Blood is taken for a preoperative haemoglobin estimation, grouping, and Rh - tying. Usually 2 to 3 units of blood are requested for a major operation. The patient is then instructed to take a light evening meal on the day before the operation. The abdomen, vulva and perineum are scrubbed with water and soap and shaved. Patient going for vaginal operations are given savlon vaginal douches. The patient is instructed to take nothing by month after 10 p.m. on the night prior to operation. The patient is then given soap enema on the night before the operation and in the early hours of the morning before going to the theatre. The patient then gives her written consent on the day before the operation after the operation has been once again explained to her.

(viii) Premedication

Before the patient is wheeled to the theatre, both atropine 0.6 mg and pethidine 100 mg are given intramascularly.

(ix) Induction

Freshly prepared. Thiopentone sodium (Pentothal) 250 mg is given intravenously.

(x) Muscle relaxation

Suxamethonium bromide (Brevedil) 40 mg is given intravenously after Pentothal. Oxygen is given intermmittently by positive pressure for a couple of seconds before a patient is intubated with a cuffed endotracheal tube. When further relaxation is required during the operation injection pancromium bromide (Pavulon) 6 mg is given intravenously.

(xi) Maintenance of anaethesia

This is done by giving oxygen, nitrous oxide, and ether or halathane. Initially they are given by intermmittent positive pressure until the patient can breath herself again.

(xii) Reversal of anaethesia

At the end of operation atropine sulphate 1 mg and then neostigmine 1 or 2 mg are given intravenously and the former counteracts the bradycardial effect of the latter.

(xiii) Short operation

In such procedures like dilatation and currettage, evacuation of septic abortion, or marsupialization anaeshtesia is given by mask after induction with pentothal without intubation.

(xiv) Preparation of the operation site

The patient is placed in appropriate position indended for the operation. If an abdominal operation is to be done, then the patient is placed in dorsal position and the table is tittled to a Trendelenburg position. The lithotomy position is used for vulva and vaginal procedures whereas in high vesico-vaginal and massive fistula, the knee chest position is used.

The surgeon then scrubs and dresses sterile gowns and instruments are checked and if their numbers are correct the surgeon proceeds to close the abdomen. This done by picking the upper, middle and lower ends of the peritoneal incision with spencer well's forceps and the peritoneum is then closed by continous chromic catgut suture No. 0 on a round body needle and the edges of the peritoneum are everted. The rectus is then closed by continuous chromic catgut suture No. 2 on tracher needle and if the patient is obese, the subcutaneous fat is approximated with interrupted plain catgut suture No. 0. The skin is then closed by interrupted silk sutures No. 0 on a cutting needle.

The stitched wound is then cleaned with savlon then flavin in spirit and covered with 2 or 3 layers of gauze and strapped.

After the operation the patient is transferred to the recovery room which has resuscitating facilities and an anaesthetic assistant monitors the general condition of the patient, pulse, blood pressure, and respiration. When the regains consciousness, she is wheeled to the ward.

In the wards, the general condition of the patient, the pulse, blood pressure, and respiration are monitored ½ hourly for 4 to 6 hours then depending on the condition of the patient the observation is reduced to 1 to 4 hourly if the condition is good. Simultaneously the temperature is recorded twice daily and input and output is recorded also.

The site and its neighbourhood is then cleaned with first hibitane 1% or savlon 1:20 solutions, then this is followed with flavin in spirit 1:1,000 or iodine skin preparation. The patient is then drapped in sterile towels having open only the operation site. The sucker is anchored onto one of the towels whenever necessary.

Procedure for opening and closing the abdomen

A midline subumbilical incision is made towards the symphysis pubis. It is then deepened through

subcutaneous fattly layer down to the times alba. A 2 to 3 cm incision is made on the rectus sheath along the linea alba and the edges are picked by Spencer Well's forceps and the incision is extended longitudinally by curred Mayo's scissors. The medial edge of the rectus muscle in view is separated from adjacent tissue to expose the extraperitoneal fat and peritoneum. The peritoneum is picked by two Spencer Well's forceps and is carefully incised inorder to avoid injury to underlying intestines. It is then extended downwards care being taken not to injure the bladder. Bleeding vessels are ligated with plain catgut No. 2/0 or 3/0. On entering the peritoneal cavity, the abdominal walls are retracted with a self retaining or Dyens retractors. The intestines one then packed off gently so as to expose the pelvic organs. The planned operation is then done.

After the operation the number of swabs, gauzes fluids given postoperatively are dextrose/saline or dextrose 5% alternating with normal saline and a total of 3 litre are given in drip form per 24 hours. In cases of electrolytes imbalance the fluids are ajusted according to laboratory results. The fluids are given until normal bowel movements resume and blood is given whenever necessary.

Ambulation

Early ambulation is done by encouraging the patient to sit up on the first post operative day and once the intravenous fluid is removed she is helped about. Oral fluids are started when the bowel sounds resume.

The haemoglobin is checked on the 3rd postoperative day, and the stitches are removed on the 7th day. The patient is then discharged after the wound has healed and the general condition is good. The patients are then instructed to come to gynaecological or postnatal clinics for follow up.

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P A R T O N E

OBSTETRICS CASE COMMENTARIES

INCOMPITENT CERVIX

Name: Mrs. T.Y., 24 years, Mha, Moslem, Grav. 6 Para 1+4

Address: Ilala, Dar es Salaam

Admitted: 11th August, 1980

Operation: 17th August, 1980

Discharged: 16th August, 1980

Summary

Mrs. T.Y. was referred to Muhimbili Medical Centre from one of the peripheral antenatal clinics at 14 weeks gestation with a history of 4 consecutive medtrimester abortion which were followed by a full term normal vertex delivery after insertion of shirodkars stitch. A diagnosis of cervical incompitence was made and after insertion of Shirodkar at 14 weeks, and removal of the stitch at 38 weeks. She had a normal vertex delivery 36 hours later and puerperium was normal.

History of Present Illness

The patient was referred to Muhimbili Antenatal Clinic from Ilala Clinic because she was 3 months pregnant and previously she had had 4 midtrimester abortions and one live baby after a Shirodkar stitch. There was no history of vaginal bleeding discharge or draining.

Last Menstrual Period: 6th April, 1980

Expected date of delivery: 13th January, 1981

Antenatal Care: This was the only visit she made at the clinic at 14 weeks gestation and she was straightaway referred to Muhimbili Clinic.

Obstetric history: She was Gr. 6, Para 1 + 4 with one living baby.

2nd May, 1976 - Aborted a 6 month pregnancy at home village. Preceeded by premature rupture of membranes and then aborted swiftly with slight bleeding. She saw the fetus and it was not macerated. No history of fever, vaginal bleeding, oedema of face or legs. Puerperium was normal.

She subsequently aborted three times at 5 months, 4 months, 5 months gestation respectively. The events were similar to the first abortion and they all accured at home.

May, 1978 - Had a full term normal delivery at Muhimbili hospital after a Shirodkar stitch was inserted. Pregnancy and puerperium were normal and the baby is alive and well.

Menstrual History and Gynaecological History

Menarch at 13 years. Cycles 4 days loss every lunar month, normal flow, regular and painful periods. The pain started 6 months after menarch. Dilatation and curretage was done twice at Kigoma district

due to the pains to 1975 and 1976. No histology results available.

Past Medical and Surgical History

Uneventful. No history of venereal disease or blood transfusion.

Family History

There was no history diabetes, hypertension or heart diseases in the family. She denied any history of twins.

Social History

Housewife. Husband is a messenger with the City Council. She does not somoke nor drink alcohol.

Clinical Examination

The general condition and nutritional status of the patient was good. She was not anaemic, Afebrile (36.8°C) and anicteric. There was no oedema of the extremeties and no generalized lymphadenopathy. Body weight 62 kg and height was 154 cm.

Teeth and Gums: Normal and no dental carries

Neck: No thyroid enlargement

Breasts and Nipples

Well develcped with dark areolar. No lumps felt. Clear fluid expressed.

Respiratory System

Not dyspnoeic. Chest symmetrical. Trachea was central. Lungs well aerated and there were no adventition sounds.

Cardiovascular

Pulse of 74 beats per minuts, regular and good volume. Blood pressure 110/79 mm Hg. Heart size and sounds were normal and there were no murmurs.

Abdominal Examination

There was slight fullness of the suprapubic region; the patient had passed urine 20 minutes ago and the abdomen moved with respiration. The uterine size was 14 weeks. There was no tenderness alicited and the liver, spleen and kidneys were not palpable. Fetal movements were not felt and the fetal heart was not heard.

Vaginal Examination

The vulva and perineum were normal and there was no discharge. Speculum examination showed normal vagina mucosa and the cervix was bluish and paraous. Digital examination revealed a soft, uneffaced, cervix that easily admitted index finger and the membranes could be felt. The uterine size was 14 weeks and the fornices and adnexia were normal.

Impression

A normal intrauterine pregnancy with a past history of habitual abortion at midtrimester due to cervical incompitence.

Investigations

Haemoglobin was 11.6 gm/dl

The total white cell count was 4,600 per annum

The differential was normal

V.D.R.L. was negative

Blood group was B Rhesus positive

No abnormal antibodies detected

Fasting blood sugar was 75 mg/dl

Blood urea 15 mg/dl and serum creatinine 0.5 mg/dl

Urine

Negative for albumin and sugar. Urine examination was normal and culture grew no pathogens.

Plan

In view of the history of cervical incompitence and also because previously she had delivered a normal full term baby after a Shirodkars stitch, it was decided to insert a Shirodkars stitch. The patient was therefore admitted in the antenatal ward.

17th August 1980

The patient was admitted for insertion of Shirodkars stitch. She was still in good, general condition and the previous examination findings were the same.

19th August 1980

Operation: Insertion of Shirodkar stitch.

Premedication

Atropine sulphate 0.6 mg intramascularly

Anaesthesia

Induction: Sodium thiopentone 500 mg intravenously and maintanance on O_2 and nitrous oxide given by mask.

Preparation

The patient was placed in lithotomy position, vulva was swabbed with chlorhexidine solution and then drappings were applied and the bladder catheterized aseptically.

Vaginal examination

The findings were the same

Procedure

The cervix was held by and drawn forwards by sponge holding forceps. A small transverse incision was made at the junction of the partio vaginalis and the roof of an anterior fornix, taking care not to injure the bladder. The same procedure is repeated in the posterior fornix but here the incision is vertical. An aneurysm needle was passed from the posterior incision round the cervix so that its point presents in the anterior wound where it was threaded with nylon No. 3 folded in two layers. The aneaurysm needls was then withdrawn through the posterior incision thus encircling the right half of the cervix. The same

procedure was repeated on the remaining left half of the cervix so that the suture completely encircled the cervix. The suture was then tied posteriorly so that the cervical canal could just take 6 mm dilator.

The vaginal incision were than closed with chromic catgut No. 2/0. Care was taken not to bury the knot of the nylon suture and also ends of the nylon suture were left long to facilitate easy removal of the suture infuture.

Post-operative treatment

Strict bed rest was started for 2 days and she was sedated with phenobarbitone tablets 60 mg 8 hourly for 2 days. Pulse, blood pressure and repiration were checked 2 hourly for 24 hours.

Post-operation progress

The patient remained well. There was no bleeding, draining or low abdominal pain.

She was discharged on the 5th day with instructions to come to the antenatal clinic every two weeks and to continue resting at home. She was told to report to the hospital immediately - she felt lower abdominal pain or started draining or bleeding.

Subsequent antenatal visits

She made 8 more visits subsequently during which the uterine size and weight gain here satisfactory.

She was not anaemic - Haemoglobin remined above 11.4 gm/dl, Blood pressure remained 110/60 mm Hg. The lie was always longitudinal and the presentation cephalic.

Readmission - 5/2/1981

At 38 weeks the patient was admitted for removal of Shirodkars stitch. Her general condition was good and all the findings were as noted earlier.

Removal of Shirodkars stitch

The patient was taken to examination couch and put in dorsal position with legs up. The vulva and perineum were swabbed with savlon solution and Cusco's bivalve speculum was inserted in the vagina and opened up.

The nylon threads in the posterior fornix were identified and gentle traction was applied and the threads cut close to the cervix thus removing the whole of the thread. There was no attendant abdominal pain or vaginal bleeding and the patient was taken back to antenatal ward to continue resting.

6th February 1981 - 6.00 p.m.

About 36 hours after removal of Shirodkar stitch the patient had started draining which was immediately followed by mild labour for about 2 hours ago. There was no history of bleeding or fever.

Clinical examination: Good general condition. Not anaemic and no peripheral oedema. Temperature 36°C. Pulse 80/minute, good volume. Blood pressure 110/70 mm Hg.

The Cardiovascular and Respiratory System: Normal

Abdominal Examination

The fundus was full term. Contractions were moderate. The fetal lie was longitudinal with a cephalic presentation. The head was fixed. Foetal heart was 136 beats per minute and regular.

Vaginal Examination

Vulva and perineum were normal with no discharge. Clear liquour seen coming from the introitus on straining. The cervix was effaced and the cervical os dilatation was 6 cm. The membranes were not felt. The presentation was vertex and the level was 4/5. The position was left occiput anterior with no caput and no moulding. The pelvis was adequate for the baby. The patient was transferred to the labour ward.

She was given routine care as written in the Obstetrics introduction. The foetal heart was checked ½ hourly and the blood pressure and pulse 2 hourly. The next pelvic assessment was at 10.00 p.m.

6th February 1981 - 10.00 p.m.

The contraction had become strong and the patient was having a desire to bear down. On vaginal examination the cervix was fully dilated and the level of the head was 1/5. After 10 minutes she delivered a female baby of Apgar score 10 and weighed 3.3 kg. 0.25 mg of ergometrine was given intravenously after delivery of the anterior shoulder and the rest of second stage and third stage was conducted as written in the obstetrics introduction. The third stage listed 2 minutes. The placenta was normal and complete and weighed 475 gm. The membranes were complete. Blood loss after delivery of the placenta was 200 mls. The total duration of labour was 6 hours and 15 minutes.

Condition after delivery

General condition was good. Pulse 90 per minute good volume. Blood pressure 110/70 mm Hg. The uterus was well contracted and there was no vaginal bleeding. The perineum was intact. The patient was transferred to the postnatal ward after 4 hours.

The infant

The infant had no physical abnomality. After six hours the baby was fed on 10 mls of oral 5% dextrose and she fed well. B.C.G. was given in the ward.

7th February - 9th February 1981

The puerperium: The patient progressed well. The temperature pulse and blood pressure remained normal. The involution of the uterus was satisfactory and lochia was normal. Breasts and nepples were normal and breast feeding was successful. On the 8.2.81 the haemoglobin was 11.4 gm/dl. The mother and baby were discharged with a latter to the district medical officer, Kigoma hospital, as she was going there to see her parents. She was also instructed to report early to antenatal clinic whenever she is pregnant again.

Commentary

A case of cervical incompitence treated successfully by Shirodkars stitch has been described. The diagnosis in this patient was easy because the patient presented with a typical history of consecutive midtrimester abortions that were preceded by premature rupture of membranes followed by relatively swift panless abortion. She had also previously carried a pregnancy to term after a Shirodkar stitch was inserted with minimum bleeding (1). The cause of the cervical incompitence in this patient might have been due to dilatations and curretage - she had had in the past without good indications, for spasmodic dysmenorrhoea (1). Other causes of cervical incompitence are: cervical tear due to traumatic vaginal deliveries or premature

deliveries, anatomical or functional abnomality of the cervix which allow premature effacement and dilatation of the cervix and the rare dysfunctional incompitence which is hardly overcome even with a Shirodkars stitch (2).

The best time to insert the suture is between the 12th and 14th week of gestation. This allows time for any faulty ovum to be expelled and also allows the pregnancy to be securely established. To leave it later may mean that the cervix has started to efface which makes accurate placement of the suture more difficulty (1, 2, 3).

The patient was followed closely at the antenatal clinic fort-nightly and during each visit it was ascertained whether or not - she had had abdominal pain, vaginal bleeding or draining. A vaginal examination was done to find out if the stitch was in position and whether or not effacement and dilation had occured. Fortunately none of the above occured.

Both Shirodkar (2) and McDonald (3) agree that the type of materials used matter less than the technique involved. Shirodkar stitch which places the stitch at the level of the interval os appears clinically more effective than McDonald stitch which is easier to perform and places the stitch at the midpoint of the cervical canal (2, 3). Nylon was used in this patient but mersilene and silk can also be used.

The pregnancy has successfully carried to 38 weeks and removal of the stitch was followed by labour pains a few hours later and a normal vaginal delivery was achieved.

References

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ASSISTED BREECH DELIVERY

Name: Mrs. V.J., 23 year old, Gogo, Gr. 3, Para 2

Address: Kimara, Dar es Salaam

Admitted: 10th July, 1981 , 9.00 a.m.

Discharged: 13th July, 1981

Summary

Mrs. V.J. was referred to Muhimbili antenatal clinic at 30 weeks gestation because she was diagnosed as breech. She was booked for external cephalic version at 34 weeks but on the same day she developed fever due to malaria and had premature labour and breech delivery at 34 weeks. The baby was normal and had an Apgar score of 10 and weighed 2.3 kg. The mother was given chloraquine and she got cured after 2 days. The baby fed well and gained weight normally and by the 14th day she weighed 2.7 kg. They were both discharged and the baby was to continue attending antenatal clinic.

Reason for admission

Premature labour with breech presentation.

Last menstrual period: 15th November, 1980

Expected date of delivery: 22nd August, 1981

Period of ammenorrhoea: 35 weeks

Antenatal Care

The patient was attending regularly at Kimara antenatal clinic where she booked at 16 weeks and subsequently made 8 visits. At 30 weeks she was referred to Muhimbili antenatal clinic because she was diagnosed breech. She subsequently made 9 visits and she was told that external cephalic version would be done at 34 weeks gestation. She had an attack of fever a day before and simultaneously had spontaneous labour. The membranes ruptured spontaneously at the Muhimbili antenatal clinic.

Obstetrics History

This was the third pregnancy. The 1st pregnancy was in January 1978 and she had a full term normal vertex delivery. The child died of measles 10 months later.

The 2nd pregnancy was in March 1979. She had twins and both were spontaneous vertex deliveries at full term and are alive and well.

Menstrual History

Menarch was at 12 years. The periods lasted 3 days every 28 days regular and painful, and normal flow.

Family History

Her mother had twins. There was no history of diabetes, hypertension, heart diseases, tuberculosis nor epilapsy in the family.

Social History

She was a housewife and married to a technician at Harbours Corporation. She occanionally drank beer but did not smoke.

Previous medical history

Nil significant. No history of venereal diseases.

Previous surgical history

Nil significant. No history of blood transfussion.

Clinical examination

The general condition of the patient and the nutritional status were good. She was not anaemic clinically. She was Febrile - Temperature 38.5°C. She had no pitting oedema or lymphadenopathy and no skeletal deformity. Height was 156 cm and weight was 70 kg.

Teeth and Gum: Normal

Neck: Thyroid not enlarged

Breasts and nipples

Well developed. Dark - areolar. Active. No lumps felt.

Chest

Symmetrical, trachea conetral; percussion note - normal. Air entry normal bilaterally. Breathing - vesicular, no rhochi and no crepitations heard.

Cardiovascular

Pulse 100, rapid but good volume and regular, Blood pressure 110/70. Heart size and sounds normal. No murmurs were heard.

Abdominal examination

Symmetrically distended. The liver, spleen and kidneys not palpable and no tenderness was elicited. The fundal height was 34 - 36 weeks, and the contractions were strong. A singleton foetus with a longitudinal lie and a breech presentation was felt. The foetal heart was 170 beats per minute and regular.

Vaginal examination

Nomal and no discharge. The cervix was 8 cm dilated and no membranes were felt. The position of the breech was right sacral anterior and no cord was prolapsing. The pelvis was adequate for the baby.

Investigations

Urgent blood slide showed malaria ++ Haemoglobin 10.5 gm/dl. Blood group A positive.

Management

The patient was transferred to a delivery bed. The patient was given injection chloroquine 200 mg $\frac{1}{m}$ and this was followed by 2 tablets of chloroquine after 6 hours and then 2 tablets daily for 3 days.

Assisted breech delivery - 10.15 a.m.

The patient was put in lithotomy position and the vulva and perineum were swabbed with savlon solution and the vulva and legs were drapped with sterile towels. Repeat vaginal examination showed a fully dilated cervix and the breech was distending the perineum. An episiotomy was made on the right side as described earlier and as the contractions became strong the legs were delivered easily in a flexed position. The cord was pulled down to rule out a short cord. With further strong contractions the trunk and shoulders were delivered and the upper limbs were delivered by hooking over the elbow with a finger on either side. The head was left hanging while gentle suprapubic pressure aided its descent and further flexion. The contractions also continued to be strong and when the hair line was visible at the subocciptal region of the head, burns - marshall manouvre was done by getting hold of the foetal feet at the ankles, and lifting them together with the fetal trunk through ¾ of the circle and holding them over the mothers abdomen. The left hand controlled descent of the head so that it did not pop out and the mother was instructed to refrain from bearing down while the head was being delivered. At this point the face, nose and chin were visible at the vulva and suction of mouth and nostrile was started and until the baby was delivered. Intravenous ergumetrine 0.5 mg was

given immediately after excluding the presence of a twin. The second stage had lasted 38 minutes.

The cord was cut between clamps and controlled cord traction applied after the uterus had hardened 2 minutes later. Delivery of the placenta was easy. The episiotomy was repaired as described earlier. The third stage lasted 3 minutes and the blood loss was 200 mls.

The baby

The baby was a male with a weight of 2.3 kg with an Apgar score of 10 at one minute. No congenital abnomality was detected and it was rushed to the premature unit in view of its gestation and weight.

The placenta and membranes were complete and weighed 350 gms.

The mother's post delivery condition

General condition was satisfactory. The Pulse was 86 per minute regular and good volume. Blood pressure 120/70 mm Hg, Temperature 37°C.

Puerperium - 8.30 a.m.

The patient felt well, clinically not pale, temperature 37.2°C. Pulse 74/minute good volume. Blood pressure 120/70. Uterus well contracted. She was having savlon sit baths three times daily.

The baby was breast feeding normally and there was no evidence of brain injury.

2nd - 14 Postpartum day

The general condition of the patient remained good. Pulse, blood pressure and temperature were normal. The uterus was involuting well and lochia was slight. The episiotomy was well healed. The baby was feeding well and had gained weight from 2.3 kg at delivery to 2.7 kg. Both the mother and the baby were discharged. The mother was given folic acid and iron for 1 month after which she was supposed to come to the postnatal clinic but she did not turn up.

Commentary

This was a case of assisted breech delivery the labour of which was premature and was most likely caused by fever due to malaria. The mother was booked for external cephalic version at 34 weeks gestation but labour started on the same day.

The baby clinically was of small size presumably due to prematurity and the size of the pelvis was adequate for the baby and therefore the vaginal delivery of the baby was expected without problems. The mother had also a good past obstetrics history. However, in some centres in U.S.A. and Western Europe, caesarean section is preferred to vaginal delivery in premature labour in the breech because of the increased incidence of intracranial haemmorrhage, while delivering the after coming head in premature breech delivery as there is sudden compression and relaxation of the

skull bony (1). Such centres, however, have good facilities for premature babies but at present at Muhimbili Medical Centre the chances of survival of fetus weighing below 2.0 kg are small (3) and it would not be appropriate to recommend routine caeserean section of premature breech.

In this particular case, a generous episiotomy and control of descent of the head were instituted inorder to minimize risk of cerebral haemmorrhage and the possibility of a caeserean section was not thought of as the patient was already in advanced second stage.

Pudental block with lignocaine was not used because of lack of special guarded pudental block needle. Forceps were not applied because the author had no experience in using them although it is the best way of delivering the aftercoming head as it minimizes chances of intracranial haemmorrhage by protecting the head from pressure from the surrounding and controlled delivery of the head is achieved.

The reason why the mother developed malaria while she was on prophyllactic chloroquine is conjectural but studies done in Tanga (3) showed that only 60% of pregnant mothers on prophyllaxis chloroquine admitted taking chloroquine and of these only 35% were positive for chloroquine in the urine when tested biochemically.

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RUPTURED UTERUS IN A PREVIOUS SCAR

Name: R.N., 22 years, Nyiramba, Gr. 2

Address: Temeke, Dar es Salaam

Admitted: 11th August 1979 - 10.00 p.m.

Discharged: 21st August, 1979

Summary

A case of incomplete rupture of previous scar in which a live baby was delivered after an immediate laparotomy was done and the tear was successfully repared. The puerperium was normal.

History of present illness

The patient was referred from Temeke district hospital because she had had a lower segment caeserean section in her first pregnancy and now when labour started at home after a short time she suddenly noticed vaginal bleeding with a few clots and simultaneously and cutting pain in the lower abdomen. The contractions also stopped. A diagnosis of ruptured uterus was made and the patient was referred immediately.

Last menstrual period: 12th November, 1979

Expected date of delivery: 19th August, 1980

Total weeks of ammenorrhoea: 39 weeks

Antenatal care

Patient attended regularly Temeke clinic. She booked at 12 weeks and subsequently made 11 visits. She had no problem antenatally.

Obstetrics history

This was her second pregnancy. 1st pregnancy 1978 - lower segment caesarean section was done because abnormal lie at term. She was not told the exact lie. Baby was 2.9 kg and is alive and well.

Menstrual history

Menarche at 11½ years. The cycles were 3 days every 30 days and were associated with pain which had started 4 months after menarch. They were of normal flow and regular.

Contraception: She was not on any contraception

Family history

No history of diabetes, hypertension, heart diseases, epilapsy, tuberculosis or twins in the family.

Social history

Grade C school teacher who is divorced. Stays with a boyfriend who was responsible for the second pregnancy. Boyfriend is a verterinary assistant. She did not smoke, no drink.

Previous medical history

Nil significant. No history of venereal disease

Past surgical history

Had appendicectomy in 1974. There was no postoperative complication.

Clinical examination

The patient looked ill. She was clinically anaemic but not shocked. Afebrile (36.8°C). No pitting ankle oedema. Height was 154 cm and weight was 65½ kg.

Teeth and gums: Normal

Neck: Thyroid not enlarged and no lymphadenopathy

Breast and nipples

Well developed and active. No lumps palpable.

Chest

Symmetrical; trachea - central; parcussion note - normal; air entry normal - bilaterally, breathing vesicular; no rhochi and no crepitations.

Cardiovascular

Pulse 120 rapid and small volume. Blood pressure 80/60. Heart size and sound normal and no murmurs were heard.

Abdomen

The abdomen was symmetrically enlarged. It was tender especially around the previous scar and there was guarding in the lower abdomen which made palpation difficulty. The uterine size, the lie and presentation were difficulty to ascertain due to tenderness and guarding. Percussion gave a dull note and no fluid thrill was elicited. No contractions were palpable but the fetal heart rate was 100 beats per minute and irregular.

Impression: Ruptured uterus

Vaginal examination

The cervix 2 cm dilately 20% effaced; the discent of the head was 4/5 with intact membranes. The head was presenting and there was slight fresh bleeding per vagina.

Plan: Laparatomy when blood would be ready

First aid management

Blood was immediately sent for grouping and crossmatching and a drip of normal saline was run fast. Red side clotting time was 4 minutes. The foot of the bed was elevated and a nasogastric tube was inserted. Cathetirization showed slightly blood stained urine. The patient was prepared for theatre as described earlier.

Premedication

Atropine sulphate 0.6 mg was given intravenously.

Investigations

Blood group was B positive (+ve)

Haemoglobin 8.0 gm/dl

Urine: Sugar - negative; albumen - negative

Acetone - Nil

11th August 1979 - 10.45 p.m.

Three units of blood were available before the operation started.

The operation

Thiopental 400 mg was given intravenously and also scoline 50 mg intravenously. Intubation was done. Maintanance was with nitrons oxide and oxygen.

Prolonged relaxation was achieved by pavulon and reversing was done with 1 mg atropine and 2.5 mg of neostigmine intravenously.

Findings

There was no haemoperitoneum. A moderate size haematoma under the visceral peritoneum ground the old scar on the lower segment. The fetus was still retained in the uterus. The visceral peritoneum was incised - transversely and haematoma was evacuated. An incomplete tear was evident on the old scar and the membranes were intact. The membranes were ruptured and there was slight muconeum. Female baby Apgar score 6 was delivered.

The placenta was delivered and bleeding was only slight.

The incomplete tear was repared in 2 layers. The first musculodecidual layer was repaired with continuous cutgut No. 2. The second muscular layer was repaired with cutgut No. 2 and this layer buried the first layer. Both the visceral and perietal peritoneum were closed with cutgut No. 0. The anterior abdominal wall was repared in layers using cutgut No. 1 for rectus and silk No. 2 for skin.

Blood loss was estimated at 1.5 litres.

By the end of the operation the patient had received 2 units of blood and 1 litre of normal saline.

The female baby weighed 3.2 kg and had no congenital abnomality on examination.

Immediate post-operative period

The general condition was fair. The pulse was 105 minutes, moderate volume. Blood pressure 110/60 mm Hg.

Postoperative treatment

1. Pulse and blood pressure, were monitored, 1 hourly for 12 hours then 6 hourly. Temperature was monitored 6 hourly.
2. Input and output chart was started
3. Ampicillin injection 500 mg intravenously start. Then 500 mg 6 hourly intramascularly.
4. 5% dextrose 2 litres alternating with normal saline 1 litre daily.
5. Pethidine injections 100 mg 6 hourly for 48 hours.

1st postoperative treatment

General condition of the patient was fair, although she felt pain especially in the lower abdomen. She was not pale Afebrile (37°C). Pulse 90 good volume. Blood pressure 110/70. Chest was clear.

Abdomen: Not distended, soft, bowel sounds heard.

The 2nd - 7th Postoperative day

The general condition of the patient remained good. The pulse, blood pressure, temperature remained normal. She passed flatus on the second day and oral fluids were started and intravenous fluids discontinued after 48 hours. Stitches were removed on the 7th day and the wound was well healed. Her haemoglobin was 10.5 gm/dl.

The patient was discharged on the 10th day on iron 3 tablets daily for 1 month.

A letter was written to the District Medical Officer Temeke explaining what had been done and the treatment she was on.

Commentary

A case of incomplete uterine rupture treated by repairing the tear has been presented. At Muhimbili Medical Centre in 1979/80 there were 26 cases of ruptured uterus, (0.2% of all antenatal admissions) and only 30% of the fetis were salvaged (2). Uterine rupture is common in developing countries because the majority of deliveries still occur at home and it was estimated that in Tanzania about 50% of deliveries still occured at home (1) whereas in Bagamoyo district 70% of deliveries still occured home (2). Such patients normally seeks advice only when labour has failed at home and complications start appearing.

Ruptured uterus is avoidable and if this patient was admitted at term or early in labour for trial of scar this condition could have been avoided. The patient however, waited until she saw that she could not deliver at home. The delay might have been due to transport problems or the traditional birth attendant might have advised her to deliver at home inorder to avoid another operation. Fortunately the delay was not very long and she gave birth to live baby.

Ruptured uterus is managed by either repairing the tear or subtotal hysterectomy (3). The best method between these is the one that takes the shortest time and produces the least shock and in this particular case it was repairing the tear. In the postoperative management continuous catheter drainage is necessary so as to relax the bladder and hence avoid fistula which is a common complication of this condition. Blood was adequately given and this was a fortunate coincidence. Sepsis which commonly complicates this condition was adeuately treated with antibiotics.

References

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TWIN PREGNANCY AND DELIVERY

Name: Mrs. J.H., 24 year old, Ngoni, Gr. 2, Para 1

Address: Sunguratex, Dar es Salaam

Admitted: 9th May, 1980

Discharged: 13th May, 1980

Summary

Mrs. J.H. who had a positive history of twins in the family, was referred to Muhimbili antenatal clinic from Temeke clinic at 32 weeks of gestation because she had twins which were dianosed both clinically and radiologically. She attended antenatal clinic regularly and was advised to have bed rest and iron and folic acid were prescribed. She subsequently went into spontaneous labour at 38 weeks and the first twin was delivered without problem but there was delay in delivering the second twin and syntocinon was used after which a normal vertex delivery was achieved. Puerperium was normal.

History of present illness

The patient was referred from Temeke antenatal clinic because the fundus was bigger than dates and had slight pitting ankle oedema. Patient did not have any urinary symptoms and had no had any vaginal bleeding nor discharge.

Last menstrual period: 2nd October, 1979

Expected date of delivery: 9th July, 1980

Antenatal care

She had antenatal care at Temeke dispensary antenatal clinic where she first reported at 28 weeks gestation and she subsequently made 6 visits.

Obstetrics history

She was Gravida 2, Para 1. On 20th October, 1977 she had a full term normal vaginal delivery at Ocean Road Hospital. Pregnancy and puerperium were normal. Child alive and well.

Menstrual history

Menarch at 12 years. The flow lasted 4 days and her cycles were 28 days, regular and not painful.

Family history

There was no history of diabetes mellitus hypertension, heart diseases nor epilepsy in the family. Her mother was born twins. There was no history of twins in her husbands family.

Social history

A housewife married to a customs officer. She was a non-smoker and non-drinker.

Previous medical history

Nothing significant. No past history of venereal disease.

Surgical history

Nothing significant. No previous blood transfussion.

Clinical examination

The general condition of the patient was good, not anaemic, Afebrile (37°C). Not jaundiced. Nutritional status was satisfactory. Height was 164 cm, and weighed 65 kg. Had slight pitting ankle oedema but no pitting oedema of sacral pad. There was no lymphadenopathy.

Teeth and gum: Were normal

Neck: No thyroid enlargement

Breast and nipples

Well developed. Dark areolar. No lumps felt. Clear fluid expressed.

Chest

Symmetrical; trachea central; percussion note normal. Air entry normal bilaterally. Breathing vesicular. No rhochi and no crepilations.

Cardiovascular system

Pulse 74/minute good volume and regular. Blood pressure 110/70 mm Hg. Heart size and sounds were normal. No murmurs

Abdominal examination

The abdomen was distended and the fundal height was higher than dates. Clinically the pregnancy was 38 weeks whereas by dates it was only 32 weeks Bladder was not distended. Multiple foetal parts could be felt and 2 poles were felt at the fundus. No fluid thrill was demonstratable. Presentation was cephalic and the

head was small for the size of the uterus. Liquour was adequate. The liver spleen, kidneys were not palpable and there was no tenderness.

Vaginal examination

Vulva and vagina normal. No discharge. No haemmorrhoids. The cervix was parous healthy and soft. The head was presenting. The pelvis was normal and adequate.

Impression

Intrauterine multiple pregnancy investigations.

Investigations

Haemoglobin was 11.5 gm/dl. Blood group was O Rh. "D" positive. Venereal disease research laboratory test - negative. The patient was told that twins were suspected and she had to go for X-ray. Plain abdominal X-ray showed two fetis both cephalic presentation. Subcutaneous fat lines and tibial and femoral ossifications centres were not seen. No foetal obnomality was seen.

Treatment

The patient was told that she had twins as proven by X-ray. The patient was advised to rest at home and attend antenatal clinic regularly. Eerrous sulphate 200 mg three times a day and folic acid 5 mg daily were prescribed and she was to report at the antenatal clinic after 2 weeks.

Subsequent visits

The patient was seen two weeks later at 34 weeks and she had no complaint and the antenatal parameters were normal. The mild pedal oedema was still present but the blood pressure was 110/70 and urine was negative for albumin. She said that she had had enough rest at home as she was staying with two sister inlaws and a housemaid who did all the domestic work. She was told to come after two weeks and thereafter weekly and all the parameters were normal. At 38 weeks gestation she reported that she had had mild labour pains since the previous night and she was then admitted to the labour ward.

Labour

The patient was admitted to the labour ward on 5th of May, 1980 at 9.00 a.m. with a history labour pains since previous night and were increasing with intensity as time passed. There was no history of draining nor vaginal bleeding.

Her general condition was good. Haemoglobin was 11.0 gm/dl. Blood pressure 110.60 and pulse 80/minute and good volume. Ankle oedema was slight.

Abdominal examination

Uterine size was full term. Contraclions were moderately strong. The foetal lie was longitudinal and the presenting part was cephalic. Foetal heart was heard 140 and regular.

Vaginal examination

No bleeding or discharge seen. Vulva and vagina were normal. The cervix was fully effaced and 6 cm dilated. Membranes were bulging and they subsequently ruptured spontaneously. The liquour was clear. The presenting part was vertex and the position was ROA. The pelvis was adequate for the baby and spontaneous vaginal delivery was expected.

An impression of established: Labour was made

Investigations

Haemoglobin 11.5 gm/dl. 2 pints of blood were ordered in readiness for postpartum haemmorrhage. The urine was negative for albumin, sugar, and acetone.

Delivery of the 1st twin

The patient was moved on to an obstetric bed where an hour later she started bearing down. She was put in dorsal, position. The vulva and perineum were swabbed with savlon solution in the usual way. The perineum was supported with a pad while the patient was bearing down. The head was delivered easily and there was no cord around the neck. The shoulders were subsequently delivered with ease also. The cord was cut in between clamps. The baby had Apgar score of 10 after 1 minute and weighed 2.7 kg.

The second twin

The abdomen was palpated immediately after delivery of the first twin to find out the lie and presenting part of the second twin. The lie was still longitudinal and the presenting part cephalic. The foetal heart was 144 and regular. The vulva was again swabbed with savlon and a vaginal examination was done. The membranes were bulging and they were ruptured by kochers forceps. The liquour was clear. The presenting part was vertex and position was left occiput anterior and the level was 2/5. Uterine contractions did not start after 10 minutes.

A decision to put up syntocinon 5 units in 500 mls 5% dextrose was made. The drip was started at a rate of 10 drops per a minute and increased half hourly until 60 drops per minute. Strong contractions started after 15 minutes and the second twin was born 30 minutes after the first. The procedure followed during delivery was the same as for the first twin. It was also a male and weighed 2.65 kg with Apgar score of 10 after 1 minute. The second stage lasted 1 hour.

Third stage of labour

The syntocinon drip was made to run faster and ergometrine was not given. Controlled cord traction was started and after 30 secords the cords were noticed to be lengthening and a little gush of blood occured. With one hand kept on the abdomen two separate placentae

were delivered. The placentae were separated and there were two layers of chorion and amnion. The placentae and membranes were complete. The placentae weighed 400 mg and 420 mg respectively. Blood loss was about 400 mls.

Mothers post delivery condition

The general condition of the patient was good. Not pale. Pulse 84/minute regular and good volume. Blood pressure 110/70 mm Hg. The perineum was intact. Both babies were examined and were both found to have no congenital abnomalities. Both the mother and the babies were transferred to postnatal ward after 4 hours.

Puerperium - 8.30 a.m.

The patient felt well. General condition good not pale. Haemoglobin 11.5gm/dl. Afebrile (37°C). Pulse 76/minute good volume. Blood pressure 110/70 mm Hg uterus well contracted and no bleeding. She had started breast feeding the babies. The patient was discharged home with instructions to return to the postnatal clinic after 6 weeks.

At postnatal clinic

General condition was good. Not pale. Pulse 74/minute good volume and regular. Blood pressure 110/60. She was feeding her both babies normally. Hb. 12.0 gm/dl. The patient preferred a lippes loop which was inserted. Her babies had already been seen

at a neonatal clinic and they were normal. She was told to continue taking the babies to the neonatal clinic monthly.

Commentary

This patient was referred to Muhimbili hospital because of the abdomen which was bigger than the size expected by dates. This exaggerated uterine size is due to more rapid uterine growth in multiple than in single pregnancy. Prematurity is much more common in twin pregnancy than singleton and some authors think that the overdistension and stress might lead to prematurity (2). Other authors found that the uterine blood flow is reduced when there is exaggerated uterine distension and that may lead to intrauterine growth retardation especially in late pregnancy.

The value of bed rest is also disputable Donald (2) is of the opinion that bed rest should be recommended at or just before 32 weeks and continued to at least 34 weeks so as to reduce prematurity. Other authors feel that bed rest improves fetal nutrition and hence improves weights of the fetus and the perinatal mortality is reduced but prematurity is not much affected by rest.

In delivering the second twin, the contraction delayed in starting and had to be stimulated by syntocinon. Friedman (3) recommends syntocinon in such

cases. The second twin normally faces more dangers than the first because of malpresentation, a potentially traumatic delivery, fetal distress and relative asphyxia because of the reduced maternal circulation. In Mulago the optimal time between delivery of first and second from was found to be 10 - 15 minutes (1).

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ECLAMPSIA

Name: Mrs. C.Y., 22 years, Zaramo, Christian, Primipara

Address: Mburahati, Dar es Salaam

Admitted: 20th February, 1980

Discharged: 2nd March, 1980

Summary

Antenatal eclampsia at term was managed by valium and apresolirine. Artificial rupture of membranes and syntocinon were stared. The fits were controlled and the patient had assisted vaginal delivery of a baby of Apgar score 8. The puerperium was normal.

History of present illness

History was extracted from the relatives and the referral letter from Kibaha. The patient was referred to Muhimbili hospital from Kibaha health centre where she was admitted because she had fitted at home. It was noted at the health centre that the pregnancy was term. Blood pressure was 170/120 with gross proteinuria, and pedal oedema. A diagnosis of eclampsia was made and the patient was given 10 mg valium intravenous and referral to Muhimbili where during admission she again fitted. As she was fitting the patient was firmly held, mouth gag and airway were introduced. She was given 20 mg intravenous valium and transferred to Obstetrics intensive care ward.

Last menstrual period: 27th May, 1979

Expected date of delivery: 2nd March, 1980

Weeks of ammenorrhoea on admission: 39 weeks

Antenatal care

The patient had made two antenatal visit at 20 weeks and 26 weeks gestation. No abnormal finding was noted at both visits and she did not attend again until she fitted and was admitted to the health centre.

Obstetrics history: Primigravida

Menstrual history

Menarch at 14 years. Cycles were 3 days every lunar month, normal flow regular and not painful.

Social history

Housewife. Does not drink or smoke. Husband peasant.

Family history

No history of hypertension, diabetes, nor heart diseases in the family. No one had twins in the family.

Previous medical history

Nothing significant. No history of venereal diseases.

Surgical history

Nothing significant. No history of blood transfusion.

General examination

Patient had stopped fitting and was stuporous. She had a puffy face and pitting oedema of both legs. She was not anaemic dehydrated or jaundiced. There was no lymphadenopathy. Temperature was 36.8°C. Height 165 cm weight 60 kg.

Cardiovascular system

Pulse 100/minute, regular good volume. Blood pressure 160/100 mm Hg. Jugular venous pressure not raised. Heart size and sounds normal. Murmurs not heard.

Respiratory system

Symmetrical with well developed breasts and nipples. No lumps. Clear fluid expressed from breasts. Trachea - centrally placed. Breath sounds were vesicular and air entry was equal on both sides. There were no adventitions sounds.

Central nervous system

Patient was stuporous. Pupils - equal in size and light reaction - sluggish. Other reflexes were normal.

Abdominal examination

Abdomen was symmetrically distended. Fundal height was full term. Contractions were not felt. Singleton. Fetal lie - longitudinal. Presentation cephalic. Fetal heart heard - 140/minute regular. Liver, spleen

and kidneys were not palpable and there was no tenderness.

Vaginal examination

Vulva and vagina - normal. Cervix - effaced, os dilatation 2-3 cm. Membranes were intact. Presentation - vertex level - 4/5. Position - right occiputal anterior. Pelvic size adequate.

Impression: Eclampsia

(Artificial rupture of membranes was done with a pair Kocher's forceps inorder to effect delivery as soon as possible).

Investigations

Blood Haemoglobin 12 gm/dl

Plateless - 220,000, white cell total 5,100 cu mm^3.

Bed side clotting firm 5 minutes.

Differential was normal

Urine albumin +++ Sugar - negative

Acetone - Nil

Treatment

Valium 10 mg and then 20 mg respectively had already been given at health centre and Muhimbili.

In addition the following treatment was prescribed:

1. Intravenous valium 40 mg in a drip - 500 mls of 5% dextrose solution to run over 12 hours.
2. Ampicillin injection 500 mg 6 hourly.

3. Intravenous apresoline 40 mg in 500 mls dextrose 5% to run slowly at 10 drops per minute until blood pressure fell to 140/90.
4. Foleys self retaining catheter was passed and continuous bladder drainage instituted.
5. Strict input and output chart
6. ½ hourly blood pressure, pulse and respiration and 6 hourly temperature chart.
7. The patient was nursed in obstetrics intensive care unit.

Follow-up

10.00 p.m. - urine output was 50 mls within 2 hours. The patient was well sedated and contractions had not started. She had had no further fits. Blood pressure 140/70. Pulse 90 per minute, good volume. Putness of face and ankle oedema still present. Albuminuria ++

The foetal heart was 140 regular. Vaginal examination showed os - still 2-3 cm and effaced.

Plan

1. Apresoline was stopped
2. The rest of treatment was continued
3. Syntocinon 5 units in 500 mls dextrose 5% was started. The speed was 10 drops for minute increased every ½ hourly by 10 drops until the speed reached 60 drops.

12.00 midnight

Strong contractions felt. Foetal heart was heard 144 regular. Vaginal examination the cervix - 6 cm dilated, level 4/5. No caput. No moulding.

2.00 a.m.

Contraclions still strong. Foetal heart good. Cervix - 8 cm dilated. Level of the head 3/5. Everything was set to deliver the patient by vacuum.

4.00 a.m.

Foetal heart good. Cervix fully dilated. Level of head 1/5. The patient was placed in lithotomy position, the perineum was swabbed with hibitane and the legs and vulva draped.

Vacuum cup size 50 mm diameter was applied and the procedure was the same as described for case No. 9. A male baby with Apgar score 8 was delivered at 4.15 a.m. with the aid of an episiotomy.

Third stage of labour

Ergometrine was withheld because it might have raised the Blood pressure but was kept ready in case post partum haemmorrhage ensured. Placental separation was noted by the lengthening of the cord and it was delivered by controlled cord traction. The placenta was intact and weighed 500 gm.

The membranes were intact.

Blood loss was about 200 mls. The episiotomy was sutured in layers as described earlier.

Post delivery

4.45 p.m. - the patient was well sedated. Pulse 100/minute, good volume regular. Blood pressure 140/80. Uterus well controlled. Birth canal - no tears. The oedema and proteinuria ++ persisted. The treatment prescribed above was continued.

The baby was examined and did not have any congenital abnormality.

The puerperium

8.30 a.m. - 1st post delivery day. The patient condition good. Pulse 80 good volume regular. Blood pressure 140/90. Albumin ++ temperature 37.2°C. Lungs clear. Cardiovascular normal. Abdomen - not distended. Uterus well controlled. Urine cuput was 950 mls whereas the input was 1700 mls since admission. Valium, ampicillin and observations were continued.

2nd post delivery day

8.30 a.m. - the patient was still well sedated and had not had any fits since admission. Oedema subsided Blood pressure 130/80. Pulse 80/minute, regular and good volume. Temperature 37°C.

Chest - clear. Output 2,000 mls of urine. Input 2500 mls fluids mainly intravenous fluids. Urine albumin +

Investigations

Hb 13 gm/dl

Blood urea 12 mg/dl serum creatinine 0.5 mg/dl

Serum Elecholytes - Na 144 meq/l, K - meq/l,

Cl - 99 meq/l, Hco_3 - 23 meq/l

Valium was stopped. Phenobarbitone tablets 60 mg twice daily started. Patient was transferred to postnatal ward.

3rd - 9th post delivery day

Oedema disappeared. Blood pressure remained at 120/80 and from the 5th day no albumin was detected in the urine.

Foleys catheter was removed on the 4th day.

Phenobarbitone was stopped on the 8th day.

10th post delivery day

The patient was well and fully ambulant. Blood pressure 120/80. Pulse 74/minute good volume. Lochia - normal colour and no smell, Hb 13 gm/dl. Urine (-ve) for albumin, sugar and pus cells. The baby was well and feeding satisfactorily.

The patient was discharged home with notes on the discharge explining all the events about her and requesting the doctor incharge at the health centre to do the follow-up including post-natal follow-up 6 weeks later.

Commentary

The case presented was of antenatal eclampsia where an antconvulsant, and anthypertensive were given when the patient first presented. Artificial rupture of membranes, syntocinon and assisted vaginal delivery were done.

At Muhimbili hospital the incidence of maternal eclampsia ~~is~~ was .1...% of all admissions and 76...% are primigravida. ~~The maternal mortality has decreased from ..... in ..... ( ) to ..... in ( ) the foetal salvage.~~

The patient had started fitting again soon in the admission room of the labour ward. It is noted that when the patient was first fitted at the health centre she was given only 10 mg of valium and then transferred to Muhimbili 25 kilometers away. The sedation was not enough and the distance travelled on rough road might have further disturbed the patient. Furthermore no hypertensive drug was given at the health centre although her blood pressure was 170/120 probably because such drugs were not stocked.

More valium was given at Muhimbili and 40 mg put in a drip. Valium is an effective antconvulsant as well central nervous system depressant (2). Apresoline was also given for hypertension as it reduces peripheral resistance thereby causing visodilation and a tail in blood pressure hence averting danger of cerebral haemmorrhage.

This regime has been advocated by Lawson (2).

Ampicillin was given because of the indwelling catheter which made the patient at risk to contract urinary tract infection. The catheter had to be inserted because of the need to detect at the earliest anuria which is a serious complication of eclampsia.

Artificial rupture of membranes was done immediately and syntocinon given when the condition of the patient was stable. This was done because delivery of the baby had to be effected as soon as possible as the longer the interval between the first fit and the delivery, the higher the mortality (4, 5) and some authors recommend caeserean section within 6 - 8 hours if easy vaginal delivery cannot be anticipated (5).

In conclusion, eclampsia is a preventable disease and because EPH gestosis usually does not usually cause symptoms until it is severe, some women with EPH gestosis become lax in attending antenatal clinics.

Effective antendance of antenatal clinic and proper management of eclampsia will reduce the morbidity and mortality associated with this condition. This patient attended the clinic twice only but if she had attended regularly the early signs of the disease might have been discovered.

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ANAEMIA IN PREGNANCY

Name: Mrs. Z.U., 54 years, Digo, Moslem, Gr. 9.

Address: Bungoni, Ilala

Admitted: 8th February, 1980

Discharged: 13th February, 1980

Summary

Mrs. Z.U. grand multiparous presented with anaemia in pregnancy at a gestation of 34 weeks. The anaemia was found to be hypochromic, and microytic with a haemoglobin of 7.5 gm/dl and hookworm ova were found in stool. The causes of anaemia were thought to be due to hookworm, grandmultiparity and past history of postpartum haemmorrhage hemavisole and total dose inferon were given together with oral iron, folic acid and prophyllactic chloroquine. The haemoglobin rose to 10.8 gm and the patient had normal labour and puerperium bilateral tubal ligation was later done.

History of present illness

The patient was referred to Muhimbili hospital from Juwata Clinic with diagnosis of anaemia in pregnancy. The haemoglobin was 7.5 gm/dl and the gestation of the pregnancy was 7½ months. She had also easy fatique, dyspnoea only on exertion and palpitations for 2 months. She denied history of cough, fever, or urinary symptoms. The bowels were normal.

Last menstrual period: 15th June, 1980

Expected date of delivery: 22nd March, 1981

Antenatal care

She first booked at Juwata antenatal clinic at a gestation of 34 weeks and was found to have a haemoglobin of 7.5 gm/dl. All other parameters were within normal limit.

Obstetrics history

She was Gr. 9, Para 7+1. Between 1964 and 1978 she had of full term normal deliveries at Bagamoyo hospital. All the babies are alive and well. 1978 - she had a full term normal delivery at Bagamoyo hospital which was followed by postpartum haemmorrhage. She was given 3 units of blood. The baby is alive and well. February 1979 - she aborted a 3 months pregnancy and was evacuated at Bagamoyo hospital.

Menstrual history

Menarch was at 19 years. The periods were regular not painful and normal flow. There was no history of menorrhagia. The cycles were 3 days flow every 30 days.

Family history

There was no history of diabetes, hypertension, heart diseases, tuberculosis, epilepsy and twins in her family.

Social history

A housewife and her husband is a peasant at Bagamoyo. She had come to Dar es Salaam to see her daughter who was married at Ilala. She did not smoke nor drink.

Previous medical history

The patient had not sufferred any chronic illness. There was no history of jaundice and pain in the bones in the past.

Surgical history

Nothing significant. Had three units of blood in 1978 because of postpartum haemmorrhage.

Clinical examination

Her general condition was satisfactory. She was pale but there was no kolonykia, Afebrile (37.0°C) not jaundiced. Height was 158 cm and weighed 66 kg. There was no ankle oedema or lymphadenopathy.

Teeth and gum: Normal

Neck: No thyroid enlargement

Breasts and nipples

Well developed and dark areolar. Active, no lumps felt.

Respiratory system

Not dyspnoea, chest symmestrical, trachea - central. Percussion note normal, air entry normal bilaterally, Breathing vesicular. No adventitions sounds.

Cardiovascular

Pulse 80 good volume and regular. Blood pressure 120/80. Jugular venous pressure not raised. Heart size and sounds normal. No murmurs were heard.

Abdominal examination

Symmetrically enlarged. The liver, spleen and kidneys were not palpable and there was no tenderness. The fundus was at 30 weeks and corresponded with the dates. The uterus was soft and non tender. The lie was longitudinal and the presenting part was cephalic. The foetal heart rate was 144 and regular.

Vaginal examination

The vulva and vagina normal. No discharge. No haemorrhoids. The cervix was healthy and parous. It was soft and the head was presenting. The pelvis was normal.

Impression: Anaemia in pregnancy

Investigations

Total red cells 4,300 counts. Haemoglobin 7.5 gm/dl. Packed cell volume 29%. Mean corpuscular haemoglobin 21 mg. Mean corpuscular volume 68 ft. Mean corpuscular haemoglobin concentration 25%. Blood slide was negative for malaria parasite. Reticulocyte 0.5%. Sickling test - negative. Peripheral thin firlm: Moderate hypochromic, microcytosis and anisocytosis. This picture was consistant with iron deficiency anaemia.

The total white cell count was 5,100 per cu mm. The differential was normal.

Sickling test was regative. Serological test for sphyllis (V.D.R.I.) was negative.

The stool had hookworm.

The urine was negative for sugar, albumin, and red blood cells. No ova were visible.

Management

As the patient had hookworm she was given levamisole (Ketrax) 3 tablets daily for 3 days. She was also given a full course of antimalaria. Chloroquine phosphate base 600 mg start; then 300 mg after 6 hours, then 300 mg daily for 3 days.

Total dose inferon infusion was prescribed. The dose was calculated from the formula. Weight in pounds x 0.3 x haemoglobin deficiency. In accordance with the formular the patient needed 40 mls of inferon which was put in 1 litre of 5% dextrose. Promethozine 50 mg was given intramascularly to counteract any allergic reaction. Inferon drip was started at a rate of 10 drops per minute every 30 seconds for 10 minutes. There was no allergic reaction and the pulse and blood pressure were within normal range. The drip was then set at 60 drops per minute until the infusion was finished. There was no reaction visible.

The patient was discharged on 13th February, 1980 with a prescription of ferrous sulphate 200 mg twice daily, folic acid 5 mg daily and chloroquine tablets 300 mg weekly and was told for attend antenatal clinic after 2 weeks.

Further antenatal clinic visits

The patient subsequently made 3 more visits to the antenatal clinic. The first visit was 2 weeks after discharge on 27th February 1980 at 34 weeks gestation. She was in good general condition. Clinically she had improved and her haemoglobin was 9.2 gm/dl. She was Afebrile and not jaundiced. Blood pressure 120/80, pulse 80 good volume. She had no pitting ankle oedema. Stool was negative for hookworm and urine was negative for sugar and albumin. She was told to continue with iron, folic acid and anti-malaria and return after 2 weeks. She was again seen after 2 weeks on the 11th March 1980 at a gestation of 36 weeks. Her general condition was good. Clinically she was not anaemic. Red cell count 9,400 cu mm. Haemoglobin 10.6 gm/dl. Packed cell volume 35%. Mean corpuscular haemoglobin 25 mg. Mean corpuscular volume 73 ft. Mean corpuscular haemoglobin foncentration 30%.

All other parameters were normal. Weight gain and fundal height increase was normal. The fundus was 36 weeks by now. The lie was longitudinal and the

presentation was cephalic and there was adequate liquour. Iron, folic acid and chloroquine were continued and the patient advised to return after 2 weeks. She was told to come to hospital immediately if labour started because of her past history of postpartum haemmorrhage.

Labour

The patient was admitted at Muhimbili labour ward on 17th March, 1980 at 10.00 a.m. with a history of labour pain and draining since 1.00 a.m. on the same day. She gave no history of vaginal bleeding nor fever.

She was in good general condition. She was not anaemic (Hb 10.8 gm/dl), Afebrile (36.8°C), and no pitting oedema. Pulse was 86 per minute regular and good volume. Blood pressure 120.80. Urine was negative for sugar, albumen and acetone.

Abdominal examination

The fundus was full term. Contractions were strong - there were 4 - 5 contractions every 10 minutes and each contraction lasted 30 - 40 seconds. The fetal lie was longitudinal and the head was presenting and it was engaged and about 1/5 of 11 could be palpated per abdomen. The foetal heart was 144 beats per minute and regular.

Vaginal examinction

Vulva and perineum were normal and there was no discharge. Clear liquor was still draining per vagina. The cervix was 8 cm dilated and the cervix was well applied to the head. The head was at the level of ischial spines and the position was left occiput anterior. No membranes were felt and there was no caput or moulding. The pelvis was adequate for the baby. 2 units of blood were ordered and erogmetrine was kept ready because of her past history of postpartum haemmorrhage.

After 17 minute the patient preceeded to deliver spontaneously a normal vertex delivery as described in case. Erogmetrine was given after delivery of the anterior should and the placenta and membranes were delivered complete by controlled cord fraction, 2 minutes later as described in case. There was no postpartum haemmorrhage. The baby was a male with Apgar score of 10 at 1 minute. The blood loss was 100 mls.

18th March, 1980 - 9.00 a.m.

Puerperium: The general condition of the mother good. She was not anaemic and her haemoglobin was 10.5 gm/dl. Temperature was 36.8°C. The uterus was well contracted and had normal lochia. Laction started after 12 hours and the baby was feeding normally. There was no congenital abnormality detected.

Both the mother and the baby were discharged after 2 days and the patient was told to attend the postnatal clinic after 6 weeks and she was advised to obtain consent for tubal ligation from her husband also inview of the fact that she was a grandmultipara and had had past history of postpartum haemmorrhage and anaemia.

Iron, folic acid, and prophyllactic chloroquine was continued.

28th April, 1980

Patient was seen at the postnatal clinic. She was on good condition. She was not pale, Afebrile, and anicteric. Blood pressure 110/70 mm Hg. Pulse 80 good volume. Haemoglobin 11.5 mg/dl.

All other systems were normal. The uterus was 14 weeks and the lochia had dried. Consent by both wife and husband was given.

On 29th April, 1980 bilateral tubal ligation was done and the patient was discharged 7 days later in good condition with a haemoglobin of 11.4 gm/dl.

Commentary

Anaemia in pregnancy is prevalent in developing countries (1). The incidence of anaemia in pregnancy among antenatal admission at Muhimbili hospital was 42.2% in 1976 and this rose to 50% in 1979.

Other workers at Muhimbili hospital found similar high figures of anaemia in pregnancy (3).

Anaemia in pregnancy is a preventable condition as shown by low incidences in Europe (4).

The commonest cause of anaemia in pregnancy in Dar es Salaam was found to be hookworm infestation (3) as seen in this patient. Other workers incriminated dietary deficiency in iron and folic acid as the major cause of anaemia (1) but this findings has been disputed because the local food stuffs have been found to be rich in iron and folic acid (3). Repeated childbirths leads to depletion of maternal iron reserves as during each pregnancy a patient has a deficit of about 500 - 600 mg of iron and this is made worse by the poor absorption as only about 10% of the 15 mg of iron found in a good diet is absorbed (5).

As the patient had past history of post partum haemmorrhage more attention was paid in case in recurred. Blood was kept ready and ergumetrine was given after delivery of anterior shoulder. Fortunately it did not occur.

As the pregnancy advances the anaemia becomes more severe if untreated and complications such as cardiac failure, increased succeptibility to infection and prematurity may occur where in folic acid deficiency abraptic placentae and thrombocytopernic purpura, and psendo E.P.H. gestion may occur. Iron and folic

acid treatment cures most of the anaemias in Muhimbili (3) as found in this case. Total dose inferon was prepared because a rapid the patient was not reliable as she did not take regularly the antenatal chemeprophyllaxis of iron and folic acid prescribed.

References

1. Lawson, J.B., Stewart, D.B. (1967): Obstetrics and Gynaecology in Tropics and Developing countries.

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3. Mwanukuzi, E., Nhonoli, A.M. (1972): Anaemic in Expectant Mothers. The E.A. Med. J. Vol 49, pp. 101

4. Donald, I. (1979): Practical Obstetrics Problems. VII, pg. 198 - 221.

ABRAPTIO PLACENTAE

Name: Mrs. U.C., 25 year old, Kwere, Islam, Gr. 5, P_{3+1}

Address: Kariakoo, Dar es Salaam

Admitted: 15th December, 1980

Discharged: 21st December, 1980

Summary

Mrs. U.C. had mild abraptio placentae at term. After blood transfusion, amniotomy and augumentalion of labour by syntocinon a live baby of Apgar score 8 was delivered. A retroplacental clot was seen. The puerperium was uneventiful and the baby did well.

History of present illness

Sudden onset of vaginal bleeding on 15th December, 1980 4.00 p.m. which was associated with a few clots and lower abdominal pain. There was no history of fainting and foetal movements were still felt.

Last menstrual period: 10th March, 1980

Expected date of delivery: 17th December, 1980

Total weeks of ammenorrhoea: 40 weeks

Antenatal care

She was attending regularly Amtullabai clinic where she first booked at 20 weeks and subsequently made

9 visits. She had no problem antenatally except for mild pedal oedema at 30 weeks onwards which was thought to be physiological as the blood pressure, and urine for albumin remained normal.

Obstetrics history

This was the fourth pregnancy. The 1st pregnancy 1970, full term normal delivery, male, weight unknown alive and well. 1972 - aborted at 3 months, preceded by fever which was diagnosed as malaria, was given chloroquine and evacuated. Puerperium was normal. 1973 full term normal delivery, female, weight unknown alive and well. 1975 full term normal delivery, female, weight unknown alive and well.

Menstrual history

Menarch was at 12 years. The flow was normal and lasted 3 - 4 days and her cycles were 30 days regular and not painful.

Contraception: Did not use contraceptives.

Family history

No history of diabetes, hypertension, heart diseases, or twins in the family.

Social history

A house-wife and married to a vendor at the market. She did not smoke nor drink.

Previous medical history

Nil significant. No history of venereal diseases.

Past surgical history

Nothing significant. No history of blood transfusion.

Clinical examination

The general condition of the patient was good. She was clinically anaemic. Afebrile (temperature 36.5°C). Slight pedal oedema. Height was 157 cm and weight 69 kilograms.

Teeth and gums: Normal. No dental caries

Breasts and nipples

Well developed with dark areolar and active. No lumps were palpable.

Chest

Symmetrical, trachea - central; percussion note - normal; air entry normal bilaterally; breathing vesicular; no rhochi and no crepitations heard.

Cardiovascular

Pulse 110, small volume but regular. Blood pressure 100/60. Heart size and sound normal. No murmurs were heard.

Abdomen

Uniformly distended. The liver, spleen, and kidneys were not palpable and not tender. The uterine fundus was 36 weeks, moderately tense, tender and it was a bit difficulty to feel the fetal parts.

The head was presenting and it was fixed in the pelvic brim. The fetal heart was 150, per minute, regular. Moderately strong contractions were felt and the uterus relaxed slightly in between the contraction.

Impression: (i) Mild abraptio (ii) Placenta praevia

First aid management

Blood was immediately taken for grouping and crossmatching and a drip of normal saline was set up and the 1 litre was run fast. The patient was put in a left lateral position. Bed side clotting time was done and it was 5 minutes and the patient was prepared for examination under anaesthesia and the theatre was informed simultaneously.

The fetal heart, blood pressure, pulse were recorded ½ hourly.

The bleeding was now slight and no clots were coming out.

Bed site clotting time was 5 minutes. Urgent haemoglobin was 8.4 gm/dl.

The patient was then sent to the theatre and upon reaching the theatre 2 units of blood were ready 1 hour later. She was given 0.6 mg atropine intramascularly.

Examination under anaesthesia

Two separate trays had been prepared one for vaginal examination and the other for caeserean section incase it turned out to be placenta praevia or both abraptio and placenta praevia occuring at the same time. A theatre nurse had scrubbed and was standingby.

Anaesthesia

Thiopentone sodium 300 mg was used for induction and the patient was relaxed with 40 mg suxamethonium bromide, intubated and maintained on oxygen and nitrous oxide.

Procedure and findings

The patient was kept in lithotomy position and then was swabbed over the vulva, perineum and surrounding area using chlorhexidine. She was then drapped and cathetirized. Two fingers of the right hand were lubricated with chlorhexidine cream and gently inserted into the vagina. The fornices were systematrically examined inorder to detect any boggy mass between the fetal heard and the examining finger. The head was easily felt in all fornices. The cervical os was 6 cm delated and the membranes were bulging. No placenta could be felt on the lower segment on further exploration. The membranes were immediately ruptured with a pair of Kochker's forceps and liquour (without muconeoum)

which was slightly blood stained was drained. Bleeding was slight. The patient was returned to the labour ward.

Management

The management was aimed at treating, shock and then expediate delivery.

Investigations

PCV - 32, Blood fibrinogen 450, bleeding time normal clotting time 5 minutes. Platelete 200,000, fibrim degradalion products - normal; prothrombin time - normal, urine for acetone - nil, urine for albumin - trace.

Management

The patient was given the blood immediately and 2 more units were requested. Dextrose/saline 1 litre was given after the first two pints. The patient was then sedated with 100 mg pethidine intramascularly.

Enhancing labour

2.5 units of syntocinon was put in 500 mls dextrose 5% and started at 10 drops per minute and it was tube increased ½ hourly until it reached 60 drops per minute. The fetal heart rate was monitored every 15 minutes, while maternal pulse, blood pressure was recorded every 30 minutes and a close watch on further vaginal bleeding was made.

Progress of labour

12.00 midnight - general condition of the patient was good. Patient had already received. 2 units of blood 600 mls of dextrose/saline. Contractions were strong. The pulse was 90 good volume. Blood pressure was 100/80. The fetal heart rate was 150 beats per minute and regular. The cervix was 8 cm dilated and the descent was 3/5. The bleeding had stopped.

1.40 a.m. - the patient was having the urge to bear down. Vaginal examination showed that the cervix was fully dilated and the descent of the head was 2/5. Two minutes later the head was distending the perineum. An episiotomy was made and the head was easily delivered. Intravenous ergometrine 0.5 mg was given soon after the shoulders were delivered and the baby was delivered. The baby was sucked immediately and one minute Apgar score was 8. Vit. K, 1 mg was given because of danger of haemmorrhage due to asphyxia.

Bleeding was still slight. The placenta was delivered by controlled cord traction 2 minutes later. A moderate retroplacental clot that measured 300 mls was seen and there was necrosis on the placental bed of about 6 cm diameter. The placenta weighed 500 gm. The baby weighed 3.0 kg and had no congenital abnomalities.

Immediate post delivery condition

The general condition was still good and of the two units of blood ordered only one was available and this unit was started after delivery. The pulse 100 good volume, blood pressure 110/70 mm Hg. The fundus was well contracted and bleeding was minimal. There were no vaginal lacerations.

The episiotomy was sutured as described earlier. The urine output was 100 mls.

Puerperium

8.45 a.m. - the patient felt well. She was not anaemic clinically. Afebrile (temperature 37°C). Pulse 80 per minute and good volume. Blood pressure 120/70. Vaginal inspection showed no bleeding. Input was 2,500 mls and output 1,800 mls, haemoglobin 10.2 gm/dl. Drip was stopped and catheter removed. She was transferred to postnatal ward. Baby was feeding normally.

2nd and 3rd post delivery day

Her condition remained good and she was discharged on 4th day and asked to report at the postnatal clinic. She however, did not turn up.

Commentary

A case of mild abraptio has been described. Abraptio is associated with both high perinatal mortality and maternal morbidity and mortality because of the premature separation of the placenta which leads to anoxia in the fetus and hypovolamic shock together with hypofibrinogenaemia in severe cases in the mother. The hypovolemic shock if prolonged can lead to renal failure (1).

The treatment of this emergency condition consists of: Rapid correction of the hypovolemic shock preparably by fresh blood and delivering the fetus and the placenta as soon as is feasible as it combants the shock and replaces the clotting factors (1).

It is not easy to get blood at Muhimbili Medical Centre and the donors are few compared with the numbers of serious patients requiring blood. This patient was lucky to have a total of 4 units as very often patients with this condition end up getting 2 units only, however serious the condition.

After resuscitating the shock delivery must be expidited as any delay seriously jeopardizes the fetal chances of survival due to anoxia and also the separated piece of placenta and the clot release thromboplestin which might initiate coagulopathy. Amniotomy and augumentation of labour with syntocinon avoids these complications. Ergometrine was given as the uterus

tends to be atonic and cause postpartum haemmorrhage.

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1. Donald, I. (1979): Practical Obstetrics Problems.

VACUUM EXTRACTION

Name: Mrs. Z.A., 17 years, Mluguru, Islam, Prim.

Address: Magomeni Mapipa, Dar es Salaam

Admitted: 7th June, 1981

Discharged: 14th June, 1981

Summary

A case of prolonged second stage in a primipara which was associated with uterine inertia and dehydration was managed by intravenous fluids and vacuum extraction. A live baby Apgar score 8 was eventually delivered and the puerperium was normal.

History of present illness

The patient was referred from Ocean Road hospital because of prolonged second stage for the past 2 hours.

Last menstrual: 30th August, 1980

Ammenorrhoea on admission: 40 weeks

Expected date of delivery: 6th June, 1981

Antenatal care

She attended regularly Magomeni antenatal clinic where she first reported at a gestation of 14 weeks and subsequently 11 visits. She had no problem antenatally.

Obstetrics history: She was a Primigravida

Menstrual history

Menarch at 13 years. The flow lasted 3 days and her cycles were 30 days, regular and not painful.

Family history

The patient gave no family history of diabetes mellitus, hypertension, heart diseases nor epilepsy. There was no history of twins.

Social history

Housewife married to bus driver. She was a non smoker and non drinker.

Previous medical history

Nothing significant. No past history of venereal diseases.

Previous surgical history

Nothing significant. No previous history of blood transfusions.

Clinical examination

The patient looked exhausted, dehydrated, not anaemic, Afebrile (37.2°C). Her nutritional status was satisfactory, Height was 153 cm and weight was 67 kg. No pitting oedema or lymphadenopathy was demonstrated.

Teeth and gum: Were normal

Neck: Thyroid not enlarged

Breasts and nipples

Well developed. Dark areolar. No lumps felt. Clear fluid expressed.

Chest

Symmetrical; trachea central, purcussion note normal. Air entry normal bilaterally. Breathing vesicular. No rhochi and no crepitations.

Cardiovascular

Pulse 100/minute, good volume and regular. Blood picture 120/70. Heart size and sounds were normal. No murmurs.

Abdominal examination

Symmetrically distended. The liver, spleen and kidneys not palpable and there was no tenderness. The fundal height was 38 weeks. Mild, infrequent, contractions were felt. A singleton foetus with a longitudinal lie and cephalic presentation at the brim was felt. The foetal heart was 150 per minute and regular.

Vaginal examination

Normal. No foul discharge. Cervix - fully dilated, and no membranes felt. Presentation - vertex, level $^{1}/_{5}$, position - left occiput anterior, caput + moulding +. Pelvis was adequate for the baby.

Impression

Prolonged second stage due to uterine inertia. Vacuum extraction was planned.

Investigations

Blood haemoglobin 12 mg/dl

Urine: Albuminuria - negative

Cycosuria - negative

Acetone - negative ++

Electrolytes: Na - 140 meg/l; K - 4.2 meq/l;

Hco_3 - Cl

Management

Patient was transferred to a delivery high bed. 1 litre of dextrose 5% was given fast while 50 cc 5% glucose was given intravenously at the same time. She was then placed in lithotomy position. The perineum was swabbed as previously described. Bladder was cathetirized and 100 cc of yellowish urine was drained.

Vacuum extraction

A malmstrom vacuum extractor was used. The vacuum pump and bottle with the attached pressure gauge were connected to a medium cup - by tube and chain attached to the traction handle. After connecting the instrument it was tested by placing the cup on the gloved palm of the hand and it was sucking normally. The cup was lubricated with 1% hibitane cream and inserted into the vagina and applied on the presenting part of the scalp. A finger was introduced into the vagina so as to make sure that no maternal tissue was drawn into the cup.

The pressure was reduced by 0.2 kg per cm^2 stages slowly every two minutes until a pressure of 0.8 kg per cm^2 was reached. Moderately strong contractions had started. With each contraction a pull on the traction rod in the axis of the pelvis and perpendicular to the cup was made. The direction of traction was first downward then horizontally and finally upward. No traction was made in between contractions. As soon as the head started distending the perineum a genorous episiotomy was made as described earlier. The head was then delivered by upward traction and the pressure was simultaneously lowered and the cup detached. The delivery of the baby was completed as described earlier. The baby's Apgar score at 1 minute was 8. The cup was applied for a total of 5 minutes.

Delivery of the placenta

Injection ergometrine 0.5 mg was given intravenously at the delivery of the shoulders and immediately the baby was delivered. After waiting for two minutes the cord was noted to be lengthening and a gush of blood occureed. With one left hand applied to the anterior surface of the uterus and the right hand holding the cord, controlled cord traction was done synchronously with harding of the uterus. The placenta was delivered intact and weighed 520 gm. The membranes were intact.

The blood loss was about 300 mls. The episiotomy was sutured as described earlier. The baby was given Vit. K_1 Inj. intramascularly.

Mothers post delivery condition

The general condition of the mother was good. Not dehydrated. Pulse 90 good volume and regular. Blood pressure 120/70. The uterus was well contracted and the perineum was intact. The baby was normal and had no congenital abnormality. Both the mother and fetus were transferred to the postnatal 6 hours after delivery.

Pueperium

The general condition of the patient was good. Not dehydrated and not pale (Hb. 11 gm/dl). Pulse 80 good volume and regular. Blood pressure 120/80. Temperature 36.8°C. She was mobile. Breast feeding was well.

2nd postpartum day

The general condition remained satisfactory. Blood pressure was 120/80, pulse 72/minute regular and good volume. Lochia was normal and breasts feeding was satisfactory. The patient was discharged home and as she was going to visit her parents at Dodoma, she was given a discharge form and advised to attend postnatal clinic at Dodoma hospital.

Commentary

A case of a primigravida with prolonged second stage and managed by Malmstroms vacuum extractor has been described. The prolonged second stage was due to uterine inertia which was most probably caused by lack of calorie intake and dehydration leading to maternal exhaustion as shown by the presence of acetone in the urine. The patient had been in second stage for more than 2 hours at Ocean Road Hospital allegedly due to lack of transport.

As the patient had also been in labour for more than 24 hours, she had not been eating orally. Also when she was seen at the Ocean Road hospital she was not given intravenous fluids and glucose. This might have given her enough calories and corrected the dehydrations hence lead to resumption of contractions which might have caused spontaneous vagina delivery. Vacuum extraction had to be applied because of the long period she had been in the second stage and thus no time was wasted in waiting for the strong contraction to effect spontaneous delivery.

CORD PROLAPSE

Name: A.R., 18 years, Zigua, Moslem, Gravida 2, Para 0 + 1

Address: Keko Machungwa, Dar es Salaam

Admitted: 7th February, 1981

Discharged: 16th February, 1981

Summary

Mrs. A.R. had Cord Prolopse most likely due to cephalo pelvic disproportion while using admitted into the Muhimbili labour ward from home. The cord was paleating and she was in early labour. An emergency caeserean section was done and a baby Apgar 6 were delivered. The puerperium was normal and baby subsequently progressed well.

History of present illness

The patient came directly from home with the complaints of draining and mild labour pains and prolapse of the cord. There was no history of bleeding.

Last menstrual period: Early May 1980

Expected date of delivery: Mid February, 1981

Antental care

She was attending irregularly Temeke antenatal clinic where she made 3 visits. The first visit was

when she was 24 weeks clinically. No problem was noted antenatally.

Obstetrics history

This was the second pregnancy. The first pregnancy was in December 1981 and she aborted at 2 months gestation and was evacuated at Muhimbili Medical Centre.

Menstrual history

Menarch was at 14 years. The flow leasted 4 days and her cycles were 30 days regular and not painful.

Family history

The patient gave no family history of diabetes mellitus, hypertension, heart disease nor history of twins.

Social history

She was a housewife and married to a messenger at the City Council. She was a non smoker and non drinker.

Previous medical history

Nothing significant. No history of venereal diseases.

Past surgical history

She was evacuated under pethidine and valium when she aborted in December 1979, and had 1 unit of blood.

Clinical examination

The general condition of the patient was good nutritional status satisfactory. She was short, not anaemic clinically. Arebrile (temperature 37°C). No pitting oedema or lymphadenopathy. Height was 148 cm and weight 66 kg.

Teeth and gum: Were normal

Neck: Thyroid not enlarged

Breasts and nipples

Well developed. Dark areolar. No lumps felt and clear fluid expressed.

Chest

Symmetrical, trachea - central; percussion note - normal; air entry normal bilaterally. Breathing vesicular; no rhochi and no crepitations head.

Cardiovascular

Pulse 78 good volume and regular, blood pressure 110/60. Heart size and sounds normal. No murmurs were heard.

Abdominal examination

Symmetrically distended. The liver, spleen and kidneys were not palpable and there was no tenderness. The fundal height was full term and the contractions were mild. A singleton foetus of moderate size 3.5 kg

with a longitudinal lie and cephalic presentation at the brim was felt. The head was free. The foetal heart was 146 beats per minute and regular.

Vaginal examination

The cord was hanging at the vulva and pulsating. Vulva and vagina - normal; Cx - soft, 50% effaced. The sacral promontory was easily reached. The sacral curve was rather flat. Ischial spines were prominent. The subpubic angle was less than 90° and admitted 3 knuckles.

Diagnosis

Cord prolapse in early labour due to disproportion

Management

The cord was replaced into the uterus easily. The patient was immediately put in a genu-pectoral position on a stretcher and the theatre was informed of the urgent caeserean section. The patient was then sent to the theatre and upon arrival she was quickly placed on the operating table and the patient put on deep trandelenberg position. The cord was still pulsating the skin was prepared while the surgeon was scrubbing.

Operation: Caeserean Section

Catheter

A nurse who had scrubbed and wore globes swabbed the perineum and vagina with savlon solution sterile

rubber catheter was then introduced into the bladder aseptically to empty it.

Premedication

0.6 mg of atropine sulphate was given intravenously.

Anaesthesia

Sodium thiopentone 375 mg was given intravenously for induction, and a cuffed endotracheal tube was passed after scoline 75 mg had been given intravenously for relaxation. Maintenance was done with nitrous oxide and oxygen. Ether was given after the baby has been delivered.

Procedure and findings

The anterior abdominal wall and thighs were thoroughly cleaned with savlon solution and then with hibitans in spirit. The patient was then covered with sterile towels except at the site of the proposed incision. The abdomen was opened through a subumbilical midline incision. A Doyen's retractor was put into the peritoneal cavity and an assistant held it so as to retract the bladder downwards. A warm abdominal pack was then inserted on either side of the uterus so as to hold off the intestines from the incision and also to mop up and blood and liqour that might spill into the peritoneal cavity. The peritoneal reflection on the lower segment of the uterus was identified and a transverse incision was made on this visceral peritoneum. The lower edge of

this peritoneum was gently pushed down by blunt dissection with gauze thereby keeping the bladder out of the way.

A transverse incision about 8 cm long was made in the lower segment of the uterus - curving a little upwards on either side. Using index fingers the incisions were extended laterally. The membranes were then opened thus exposing the head which was above the pelvic brim. The right hand was introduced into the uterine cavity on to the vertex and by gentle fundal pressure done by an assistant, the head and rest of the body were delivered. Intravenous ergometrine 0.5 mg was given immediately after delivery. The cord was clamped and cut. The baby was a male weighing 3.700 kg and had an Apgar score of 6 at one minute.

The placenta was delivered manually after the uterus started to contract by gently separating it from the uterine cavity digitally. It came easily and the uterus was well retracted. There was bleeding from the corners of the incision. Green - Armitage clamps were used to control bleeding from the cut edges. The inferior portion of the lower segment was identified and a continuous suture was made through the musculo-decidual tissue from the left corner of the incision to the right corner using chromic catgut No. 2.

The second layer was also continuous through the muscular tissue with chromic catgut No. 2. The first layer was therefore buried. After achieving hemostastis the visceral peritoneum was closed with a contimous chromic catgut No. 0.

The abdominal pack and clots were removed from the pertoneal cavity and the fallopian tubes and ovaries were inspected and found normal.

The abdomen was closed in layers with chromic catgut No. 2/0 for the peritoneum and chromic catgut No. 1 for the rectus sheath both continuous; and interrupted silk for the skin.

A dry dressing was put on the wound and the uterus was gently squeezed to expel blood clots. The vagina was then swabbed using sterile gauze pieces on sponge holder to remove clots from the vagina. Bleeding from the vagine was slight.

The blood loss was estimated at 700 mls and the patient had a pint of blood immediately after the operation.

The placenta and membranes were complete.

The baby was examined and no congenital malformation was detected. The weight was 3.7 kg.

<u>Immediate postoperative treatment</u>

The operation was finished at 1.30 p.m.

The general condition was satisfactory. Blood pressure was 110/70. Pulse 90 good volume and regular. She was on dextrose/saline drip and 1 unit of blood was given afterwards.

Post-operative treatment

1. Blood pressure, pulse, and respiration were checked hourly for 12 hours and temperature of hourly. Vaginal bleeding was checked hourly.
2. Careful record of input and output chart.
3. Pain was relived by 100 mg of intramascular pethidine 6 hourly for 2 days.
4. The patient was kept on dextrose/saline drip 2 litred daily for 2 days.

Puerperium

The puerperium - 8.40 a.m. - last post-operative day. General condition good. Not anaemic clinically and well hydrated. Temperature 37.2°C. Pulse 84 good volume. Blood pressure 120/70 mm Hg. Lungs were clear. The abdomen was soft and not distended. Bowel sounds - present. Lochia was red. The urinary output was 850 mls and input was 1200 mls for the past 14 hours. Haemoglobin was 11.5 gm/dl, urine - no protein, no sugar.

2nd - 3rd postoperative day

General condition was good and the patient was ambulant. She had passed flatus. Her temperature,

pulse and blood pressure remained normal. Chest - clear. Abdomen - soft with full bowel sounds. Lochia was still red. The calf muscles were not tender. Full diet was allowed and ferrous sulphate 200 mg this was prescribed for 3 weeks.

The patient made an uneventful and quick recover. By the 7th post-operative. The blood pressure pulse and temperature remained normal. The lochia had dried and the wound had healed. She was breastfeeding normally. Skin sutures were removed. The patient was subsequently discharged on the 9th day and told to attend postnatal clinic 6 weeks later. Her haemoglobin was 11.8 gm/dl.

Post-natal clinic

Both the mother and baby were well. The mother has a blood pressure of 120/80, pulse 76/minute good volume. She was not anaemic (hb. 12 gm/dl) and urine was negative for both sugar and protein. Menstruation had not resumed and she was not on any contraceptive. The uterus was well involuted and mobile. The baby was breastfeeding well and was attending the neonatal clinic.

Commentary

A case of cord prolapse at 9 cm dilatation of cervical os which was managed by lower segment caeserean section. There were 95 cases of cord prolapse

admitted to the Muhimbili labour ward in 1979/1980 (0.3% of all admission there)[2] of these only 5 were salvaged.

The cause of the cord prolapse in this case was due to disproportion with a high head (1). Other causes quoted in literature are grandmultiparity, placenta praevia, long cord, hydromnios multiple pregnancy and prematurity (1). In cord prolapse the cord may be compressed between the presenting part and the pelvic brim thus causing severe asphyxia or equally important due to exposure of the cord to subnormal temperatures outside the vagina the vessels may undergo spasms (1).

This patient was clearly told to attend antental clinic at 38 weeks where a decision on whether to do elective caesarean section or trial of labour would have been made but apparently this might have scored her and thus she attempted to delivered at home probably under traditional healers and the whole exercise had to be abandoned when the cord prolapse.

It was fortunate that the cord was still pulsating and the fetal heart was still regular.

The patient was immediately put in a genupectoral position. Other workers find this position cumber some and use exaggerated sims position whereas other use Vago's method of distending the bladder with normal saline thus displacing the presenting part and inhibiting the uterine contractions. In all these

methods the patient is also put on exaggerated - Trendelenbergs position on the theatre table.

As cervical dilation was only 4 cm and the patient had disproportion a caeserean section was done immediately.

References

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PLACENTA PRAEVIA TYPE IV AT 32 WEEKS

Name: M.N., 32 years, Mndengereko, Moslem, Gr. 7, P_6

Address: Kawe, Dar es Salaam

Admitted: 9th September, 1979 at 11.00 a.m.

Discharged: 18th September, 1979.

Summary

Mrs. M.N. was referred from a peripheral clinic because she had antepartum haemorrhage at 34 weeks gestation and the fetus was alive. She was managed conservatively up to 36 weeks when she again had another bout of bleeding and examination under anaesthesia was done and placenta praevia was confirmed. Caeserean section was urgently done and the fetus had Apgar score of 8 and weighed 2.9 kg. The puerperium was normal.

History of present illness

Recurrent painless, causeless, vaginal bleeding at 34 weeks which was of sudden onset since 7.00 a.m., 9th September, 1979. Patient changed soaked pads twice. She had a similar episode 5 days ago and changed a pad only once. Foetal movements were still felt.

Last menstrual period: 14th January, 1982

Expected date of delivery: 21st October, 1982

Weeks of ammenorrhoea: 34 weeks

Antenatal case

Patient made the first and only visit at Kawe antental clinic because she had vaginal bleeding and was referred immediately to Muhimbili hospital.

Obstetrics history

This was the 7th pregnancy. The 1st pregnancy was in 1970. She had full term normal delivery at health centre, pregnancy and puerperium were normal. The baby is well and alive.

She subsequently gave birth to 5 more babies at the health centre and all were full term normal vaginal deliveries. She had no problem during pregnancy and puerperium and all the babies are alive and well.

Menstrual history

She did not know her age at menarch. Her flow was 5 days every 30 days - regular and not painful.

Family history

There was no history of diabetes mellitus, hypertension, heart diseases, tuberculosis, epilepsy and twins in the family.

Social history

A housewife and husband is a peasant. She was a non smoker and non drinker.

Previous medical history

Nothing significant. No history venereal diseases.

Previous surgical history

Nil significant. No history of blood transfusions.

Clinical examination

The patient was in good general condition. She was not pale. Not dehydrated and Afebrile, temperature 36.6°C. She had no pitting oedema, skeletal deformity or lymphadenopathy. Height was 157 cm and weight was 68.5 kg.

Teeth and gums: Normal

Neck: Thyroid not enlarged

Breasts and areolar

Well developed breast and dark areolar. Breasts active. No lumps felt.

Chest

Symmetrical. Trachea central. Parcussion note normal bilaterally; air entry normal bilaterally; breathing vesicular. No crepitations and no rhochi.

Cardiovascular

The pulse was 90 good volume and regular. The blood pressure was 110/70. The heart size and sounds were normal and no murmurs were heard.

Abdomen

Symmetrically distended. The liver, spleen and kidneys were not palpable and no tenderness was elicited. The uterine size was 34 weeks and corresponded with date and no contractions were felt. It was soft, no tender and foetal parts were easily felt. The lie of the fetus was longitudinal and was presenting with the head which was high above the pelvic brim. The fetal heart rate was 142 beats per minute and regular.

Inspection of the vulva

Slight fresh bleeding was seen at the introitus.

Impression: Placenta praevia

Immediate management

Blood was taken for grouping and crossmatching and 3 units were ordered to be kept ready incase the patient bled profusely. Intravenous 5% dextrose drip was set. Conservative management was followed as the general condition of the patient was good, the bleeding was slight and the fetus was alive and 34 weeks both clinically and by dates. Examination under anaesthesia was contemplated at 37 weeks. The foetal heart, blood pressure and pulse were monitored ½ hourly and a careful watch for further bleeding instituted.

Investigations

Haemoglobin 10.8 gm/dl. There was no albuminuria and glycosuria. Her blood group was B rhesus position.

1.30 p.m.

Bleeding had stopped. General condition of the patient was till good. She was not pale. Pulse 80 minute, regular and good volume. Blood pressure 110/70 mm Hg. Foetal heart was 140 beats per minute and regular. Patient was transferred to antental ward and the same management followed and ferrous sulphate 200 mg thrice a day and folic acid 5 mg daily were given.

2nd - 13th day in antenatal ward

The patient had no further bleeding since first day of admission. Speculum examination on the 5th day revealed a healthy cervix, parous cervix. Her general condition was good. All the antenatal parameters were within normal limits. Both clinically and by dates the size of the fetus was 36 weeks by the 13th day on the ward. The haemoglobin was 11.0 gm/dl.

14th day - 11.30 p.m.

The patient had sudden onset of moderate bleeding associated with a few clots while a sleep. The bleeding was painless. Examination showed that the patient was still in good general condition. She was

not pale. Pulse was 110 per minute regular and moderate volume. Blood pressure was 110/70 mm Hg.

The abdomen was uniformly distended and the fundus was 36 weeks with fetal weight 3.2 kg soft, non tender and no contractions were felt. The lie was longitudinal and the presenting part high above the brim. The foetal heart was 144 hearts per minute and regular.

Inspection of the vulva revealed fresh bleeding and clots coming from the introitus she had lost about 1 pint.

Immediate management

A decision to do examination under anaesthesia was reached. One pint of blood was transfused while the patient was being taken to the theatre.

Premedication

Atropin 0.6 mg intramascularly as described in the introduction.

Examination under anaesthesia

Two separate trays had been prepared one for vaginal examination and the other for caeserean section should the diagnosis of placenta praevia be confirmed. A theatre nurse had scrubbed and was standing by.

Anaesthesia

This pentone sodium 400 mg was used for induction and the patient was relaxed with 40 mg suxamethonium bromine, intubated and maintained on oxygen and nitrous oxide.

Procedure and findings

The patient was kept in lithotomy position and then was swabbed over the vulva, perineum and surrounding area with chlorhexidine. She was then drapped and cathetirized 100 mls of clear urine was drained. Two fingers of the right hand were lubricated with chlorhexidine cream and gently inserted into the vagina. A boggymass could be felt between the head and the examining fingers in all the fornices so that the head could not easily be felt through the fornices. The cervical os was 3 cm dilated and the index finger was gently introduced and as soon as a soft mass was felt moderate bleeding started and the examination was stopped. The diagnosis of central placenta praevia was confirmed.

The patient was placed in a dorsal position and the surgeon changes gloves and proceeded with caeserean section. The procedure was as described in case .....

The abdomen was swabbed with aqueous chlorhexidine and then flavin in spirit and drapping were applied. A subumbilical middline incision was used to open the abdomen. The whole lower segment was bluish and

covered with distended veins. Wet abdominal towels were used on both sides for packing away the bowels and the rotation of the uterus was corrected using the round ligaments as guides. The distended vessels over the lower segment were cut through clamps and the peritoneal reflects over the lower segment incised. The vessels were ligated and the bladder was gently push down by blunt dissection with a gause. A Doyen's rectraction was inserted so as to hold down the bladder and expore the lower segment.

Then as fast as it was possible a transverse incision was made on the lower segment and it was extended to cut into the placenta and the membranes were punctured and the baby was delivered as swiftly as it was possible using the procedure as described in case ..... The cord was immediately clamped and a male baby Apgar score 8 at one minute was delivered.

The bleeding from the cut placenta was profuse and ergomentrine had simultaneously been given on delivering the baby. The uterus well controlled. The placenta which had occipied virtually the whole lower segment was removed manually by gently separating it from the uterus and it was easily delivered. The uterus remained well contracted and profuse bleeding continued especially on the cut edges. Green-Armitage clamps were used to temperarily arrest the bleeding was done as in case ..... and haemostasis was achieved.

The rest of the procedure was continued as in case .... and after dressing the wound the uterus was squeezed and big clots came out.

Sponge holders with sterile gause pieces were used to remove the clots from the vagina and the bleeding was only slight. The blood loss was estimated at 1,000 mls and the patient was given 2 units of blood both during the operation and in the immediate puerperium.

The placenta and membranes were complete. The baby weighed 3,100 mg and there was no congenital malformation.

1st postoperative day

General condition was good. The patient was clinically not anaemic, dehydrated or febrile (36.8°C). Pulse was 90 regular and good volume. Blood pressure 110/70 mm Hg. The lungs were clear. The abdomen was not distended, soft and bowel sounds were heard. Lochia was red. Flatus had not been passed.

The urinary output was 1,100 mls in 24 hours and the input was 2,500 mls. The haemoglobin was 10.8 gm/dl. The urine had no protein or sugar.

2nd - 7th postoperative day

The general condition continued to be good and the patient was ambulant. She had passed flatus and oral fluids were allowed on the evening of the first

postoperative day. Drip was discontinued on the second day and ferrous sulphate 200 mg three times daily for a week was started.

The stitches were removed on the 7th day and the wound was well healed and the lochia was only slight. Breast feeding was continuing normally.

The patient was discharged on the 8th day with a haemoglobin of 10.9 gm/dl and instructed to come to the postnatal clinic 6 weeks later.

Immediate postoperative case and progress

The general condition of the patient was fair. The blood pressure was 100/60 mm Hg and the pulse was 110 per minute and moderate volume and regular.

Pulse, blood pressure, respiration were checked hourly for 12 hours and then 4 hourly for 24 hours and then twice daily. The temperature was checked twice daily. Observation on vaginal bleeding were made hourly.

The following treatment was also given:

1. 1,000 mls dextrose 5% alternating 2,500 mls of normal saline very 24 hours;
2. Pethidine injection 100 mg 6 hourly for 24 hours and
3. 1 more pint of blood was ordered.

Postnatal clinic - 30th October, 1979

The patient was well. She was not anaemic (11.4 gm/dl). Pulse was 80 regular good volume. Blood pressure 120/70. Urine was negative for sugar and albumen.

No abnormality was detected on abdominal examination. Vaginal examination was normal and the uterus was well involuted the size of 10 week pregnancy.

Commentary

Placenta praevia is associated with both increased maternal and fetal mortality and morbidity. With proper management of this condition MacFee (1) managed to reduce the maternal mortality from 7% to 0.57% and the perinatal mortality from 50% to 23.5% whereas Donald (1) reduced maternal mortality to 0% and perinatal mortality to 10%. This is attributed to proper management of haemmorrhage, shock and anuria.

Expectant management was followed in this patient when she had the first two bleeding episodes which were slight. This was done because the fetus at 34 weeks gestation was still premature and it was alive and well. Prematurity was the leading cause of perinatal mortality at Muhimbili Medical Centre in 1979/1980 (2). Two weeks later at 36 weeks gestation, the patient had heavy bleeding which was life threatening and here a decision to deliver the mother was reached mainly in the interest of the mother fortunately the

fetus was of adequate gestation and size.

Examination under anaesthesia confirmed the diagnosis of placenta praevia. As the patient was bleeding profusely and the fetus was alive and the blood was avilable, no time was wasted and the patient was delivered immediately by lower segment caeserean section through the placenta quickly and deliver the baby. This was done fast and meticuously as after cutting through the placenta any delay in delivering the baby might have exanguinated it.

The immediate danger after this were postpartum haemorrhage and morbid aherence of the placenta (1). Fortunately both of these did not occur and in the puerperium the patient had neither sepsis nor anaemic.

The cause of fetal death in placenta praevia are intrauterine asphyxia duct due to placental seperation, prematurity, fetal abnormalities atelectasis neonotorium and fetal exanguination due to vasa praevia. These many hazards explain the high perinatal mortality in this condition (1).

The use of sonar had not started by then as this would have confirmed the clinical diagnosis on admission and rule out the obvious congenital abnormalities such as hydrocephalus and anacephaly sometimes associated with placenta praevia.

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OBSTETRICS LONG COMMENTARY

The Obstetrics Performance of the Elderly Primigravida

Summary

57 elderly primigravida were studied at Muhimbili hospital between June 1979 and July 1981. Their incidence was 0.11% and the perinatal mortality and morbidity were 166 per thousand and 31 percent respectively.

95% attended antenatal clinic and the commonest antenatal complication was E.P.H. gestosis (25%) where as the commonest intrapartum complication was prolonged labour (16%). Prematurity and congenital anomalies accounted for 18% and 5% respectively. The caeserean section rate was 37% but most of them were emergency caeserean sections done for prolonged labour complicated with fetal distress and only 2 were elective caeserean section. As E.P.H. gestosis and prolonged labour accounted for the increase in perinatal mortality and morbidity liberal use of elective caeserean section in those patients suspected antenatally to have disproportion, or low Bishop Score with E.P.H. gestosis coupled with timely decision to intervene in patients with prolonged labour might have reduced the perinatal mortality and morbidity.

Introduction

A primigravida is considered olderly at the age of 35 years or greater and the oldest primigravida in history is Sarah, the wife of Abraham who bore Isaac at the age of 91 years (5).

In keeping with other series, women with a past history of a spontaneous abortion have been included in this study (1, 2, 3, 12, 13).
A distinction is made between those women who marry late but soon become pregnant and those who after being married for a long time fail to become pregnant despite attempting to do so for several years. Compared with young women, the fertility is reduced in both women but the former group is much more fertile then the latter (16).

The elderly primigravida is labelled high risk and whereas this concept used to apply to maternal mortality in the 18th century, in modern obstetrics it has been shown if proper antenatal care is given to the elderly primigravidas, the maternal mortality becomes similar to figures for younger age group and therefore the high risk concept in modern obstetrics applies to the increased perinatal mortality and morbidity in the elderly primigravidas (13, 2, 14, 15). The findings of increased perinatal mortality and morbidity has been confirmed by several other studies (3, 4, 5, 10), and Hogson (4) compared the performance

of the elderly primigravida with athletic performance where the capacity to undertake it efficiently falls off very rapidly with advancing age. Nortman (5) and Mulcahy (7) noted that with advanced maternal age there was increased fetal and neonatal mortality as well as congenital malformations in the offsprings and Kanes (2) and Morrison (3) examining pregnancies in the elderly primigravida found similar results of more pregnancy complications and poor outcomes with advancing maternal age.

The present study was undertaken to assess the risks of the fetus of the elderly primigravidas and the factors that contribute to the increased risks.

Patients and methods

This was a prospective study which included all the women aged 35 years and above with a pregnancy of 28 weeks and above who were admitted to the labour ward of Muhimbili Medical Centre between June 1980 and May 1982. Women who had aborted once spontaneously were also included in the study. Most of the women knew their ages because they had had some kind of formal education. The few who did not know their ages were asked to recall important events such as the year when the country's political party was founded in 1954 or the year when this country attained

independence in 1961. They were then asked what their ages were during those events and their current ages were calculated by extrapolation. All of them had reached menarch by 1961.

The author was informed of every suspected elderly primigravida and the author personally conducted the interview and follow up of these patients. Antenatal information was extracted from the antenatal card. In the interview and follow up of labour and puerperium the following information was sought: Age, Marital Status, Education, Yeas of marriage whether or not received treatment at the infertility clinic, antenatal complications, intrapartum complications, mode of delivery, puerperium and Apgar Score of the baby and total outcome.

RESULTS

The incidence of elderly primigravida is 0.11%.

Table I: The Perinatal Mortality

Fresh S.B.	6
Macerated S.B.	1
Neonatal deaths	4
Total deaths	11

The perinatal mortality was 166 per 1,000 deliveries. Fresh Still Births accounted for 56% of the perinatal mortality followed by neonatal deaths 35% and macerated Still Births 9%.

Table II: Apgar Score

0 - 3	4 - 6	7 +
3(5%)	15(26%)	39(69)

5% of the babies of the elderly primigravida were severely depressed, and 26% were moderately depressed.

Table III: Age

Age of mothers:

35	36	37	38	39	40+
31(54%)	15(26%)	6(10%)	5(9%)	1(1%)	0

80% of the elderly primigravidas were aged between 35 and 36 years and none was aged above 40 years.

Table IV: Marital Status

Married	Single	Divorced
42(74%)	2(2%)	14(24%)

24 of the elderly primigravidas were divorces and 22% of those who were still married had at least been divorced once

Table V:

History of previous abortion	No history of previous abortion
8	49

14% had previous history of spontaneous abortion and 6 of them were evacuated in hospital whereas only 2 were not evacuated. None of the patients developed sepsis during or after the abortion.

Table VI: Attended Gynaecology Outpatient Clinic for Investigation and treatment

Attended	6(10%)
Did not attend	41(90%)

10% of the elderly primigravidae attended the infertility clinic for investigations and treatment. 3 of them had aborted previously. 30% of the patients underwent tubal surgery whereas 70% conceived without undergoing any operation procedure.

Table VII: Attended Antenatal Clinic

Booked	49(86%)
Not booked	8(14%)

Only 14% of the elderly primigravidas did not attend antenatal clinic regularly and 70% of them developed E.P.H. whereas of86% who attended antenatal clinic only 28% developed E.P.H. gestosis.

Table VIII: Antenatal complications

Hypertension	5(9%)
E.P.H. Gestosis	14(25%)
Eclampsia	4(7%)
Intrauterine growth retardation	7(12%)
Premature rupture of membranes	4(7%)
Post maturity	4(7%)
Anaemia	2(3%)

E.P.H. gestosis and eclampsia combined were the commonest complications during the antenatal period and accounted for 32% of all the antenatal complication, followed by intrauterine growth retardation (12%) and hypertension 9%, postmaturity and premature rupture of membranes each 7%. Anaemia was the least common. Some of these patients had more than one complication. 50% of the patients with intrauterine growth retardation had E.P.H. gestosis also. E.P.H. gestosis, eclampsia, intrauterine growth retardation, hypertension accounted for 40% of the perintal mortality and 30% of the neonatal morbidity.

Table IX: Intrapartum Complications

Prolonged labour lasting more than 20 hours	9(16%)
Fetal distress	8(14%)
Failed induction	6(10%)
Premature labour	7(12%)
Abraptio placenta	5(9%)
Muconeum	4(7%)
Breech	3(5%)
Eclampsia	2(3%)

Prolonged labour (16%) was the leading intrapartum complication followed by foetal distress 14% and failed induction (12%). 50% of the patients with fetal distress had prolonged labour also. 2/3 of the failed induction were done because the patients had E.P.H. gestosis and 1/3 due to postmaturity.

The perinatal mortality associated with both prolonged labour and fetal distress was 50% whereas the perinatal morbidity was 55%.

Table X: Mode of Delivery

L.S.C.S.	21(37%)
L.C.V.E.	3(5%)
A.B.D.	3(5%)
S.V.D.	30(53%)

37% of the patients were delivered by caeserean section and 5% each by low cavity vacuum extraction and 53% had spontaneous vertex deliveries. The commonest indication for caeserean section was prolonged labour with foetal distress (71%) and failed induction accounted for 29%. The perinatal mortality and morbidity among caeserean sections was 35% and 52% respectively. All the 6 babies who underwent assisted breech delivery and low vacuum extraction were depressed at birth and had Apgar Scores of 6 or lower.

Table XI: Weights

1000-	1500-	2000-	2500-	3000-	3500-	4000-
3(5%)	6(10%)	5(9%)	11(19%)	18(32%)	13(23%)	1(2%)

18% of the babies weighed 2 kg and below whereas 56% weighed 3 kg and above.

The perinatal mortality and morbidity among the babies who weighed 2 kg and below were 12% and 15% respectively.

Table XII: Congenital Abnormalities

Present	Not present
3(5%)	54(95%)

3 babies (5%) had congenital malformation. 1 had spinal bifida, 1 anencephaly and 1 cleft plate.

DISCUSSION

The incidence of the elderly primigravidas in most series is less than 4% and the incidence of 0.11% found in this study is low compared with incidences of other series of 0.71% by Lesergie (1), 0.64% by Morrisons (2), 0.63% by Kones (3). Therefore inview of the low incidence of the elderly primigravidas, the experience of anyone individual with the condition tends to be limited (1, 2, 3).

The low incidence of elderly primigravidas found in this study may be explained by the fact that women in most developing countries like Tanzania marry at a very early age of 15 to 17 years whereas in developing countries they marry at later ages hence the proportion of women who marry at 30 years and above is much greater in the developed than developing countries where the majority of women have already been married at the age of 30 years and have given births.

This incidence however, could be higher in developing countries as in these countries a considerable number of deliveries still occur at home uncrecorded and Mkumbwa (18) and Mbilu (19) found that 60% of deliveries in Tanzania occurred at home whereas in Ghana (20) it was 75%.

The perinatal mortality of 166 per thousand was high compared to the perinatal mortality of 42.5% of the general population (9). 80% of the perinatal mortality was due to still births and 20% due to neonatal deaths. Others series have also found that the greater danger to the fetus is posed while in utero and that once the fetus is born alive, the chances of surviving are high (1, 2, 3, 4, 7). Morrisons (2) found a perinatal mortality of 94 per thousand and Hadger (7) 101 per thousand in their series of the elderly primigravidae.

The perinatal morbidity was high 31%. 3 of the babies were severely depressed while 16 were moderately depressed. All these required assisted ventillation. Others workers found similar high perinatal morbidity in the elderly primigravidas (2,3,6, 7).

Beside the increased perinatal mortality and morbidity associated with this condition, it also led to increased broken marriages as shown by divorce rate of 24% and even those who had husbands, 22% had married more than once.

The marital status, education status, years of marriage or treatment at the infertility clinic did not influence the perinatal mortality and morbidity. This has been found by other workers who showed that the fetal outcome is independent of nutrition,

health hygiene, housing, maternal competence, cultural practices or genetic dispositions (2, 6) and that increasing maternal age is the major factor that influences fetal outcome (6, 2).

Only 10% of the elderly primigravidas did not attend antenatal clinic and 70% of these developed E.P.H. gestosis and subsequently 2 patients developed eclampsia. These conditions might have been discovered early at the antenatal clinic and managed appropriately and hence the perinatal mortality and morbidity would have been reduced (11).

During the antenatal period E.P.H. gestosis (25%) was the commonest complication followed by intrauterine growth retardation 12%, hypertension (17%) and postmaturity (7%). 21% of patients with E.P.H. gestosis later developed eclampsia. These antenatal complications accounted for 40% of the perinatal mortality and 30% of the perinatal morbidity. Hypertension disorders as the cause of increased perinatal mortality and morbidity has been shown by Horgers (10) who found an incidence of 7;% of the perinatal deaths whereas Morrison (2) found 61%. Close antenatal monotoring of the mother and also of the fetal growth and well being with a view to timely intervention in the interest of the retus has been recommended in order to salvage these babies (2,3,7).

Unlike other series (2, 3, 15) diabetes, heart diseases, and abraptio were uncommon.

During the intrapartum period the commonest complications was prolonged labour (16%) which was also associated with 50% of the patients with fetal destress. Prolonged labour is common among elderly primigravida (2, 3, 4, 6, 16) but the patients might have had cephalo-pelvic disproportion which, according to Philloportt (12) is very common in the African Primigravida and cause high perinatal mortality and morbidity. Careful antenatal assessment and intrapartum use of the partogram might have avoided the higher perinatal mortality and morbidity 50% and 55% respectively.

The failed induction might have been caused by primary inertia which is common among the elderly primigravida (13).

The incidence of congenital abnormalities of 5% is higher than that of 3.4% by Horger (10) and the general population has an incidence of 2%. The congenital abnormalities which are common in the elderly primigravidas are congenital anomalies and chromosomal trisomies. The latter could be missed at Muhimbili hospital as karyotyping is not done and therefore the incidence of congenital abnormalities could be higher.

The rate of prematurity in the elderly primigravidas in developed countries has been found to be two fold (2, 3, 4) but in these series both the perinatal mortality and morbidity was not significantly increased. In this study there was 1 neonatal death and 2 still births among babies weighing less than 2.5 kg and the perinatal morbidity was 40%. The high perinatal mortality and morbidity at Muhimbili hospital may be explained by the fact that the babies that wighed below 2,000 mg had a perinatal mortality of 50% at Muhimbili hospital (9) whereas in developed countries 90% babies that wighed 1,000 mg and above were salvaged (2, 3, 10). Thus improvement of the neonatal unit at Muhimbili might help to reduce fetal wastage. Babies weighing over 4,000 mg were uncommon (1%), unlike Higson (15) series which showed a rate of 13.7%. This may be because diabetes was common in his series whereas in this study there was none.

Increased caeserean section rate in the elderly primigravidas has been shown by most series (1, 2, 3, 4, 10, 15). The caeserean section rate in this study was 37% compared to a rate of 9.2% at Muhimbili hospital (9). Over 90% of the caeserean sections in this study were done for prolonged labour with fetal distress and failed induction. As mentioned earlier a substantial number of these complications might had been due to cephalopelvic

disproportion which was undetected (11). All these caeserean section were done as emergency procedures and they were associated with a perinatal morbidity of 25% Morrison (2) found a perinatal morbidity of 18%. There were only 2 elective caeserean section done both of which were for breech presentation at term and each had Apgar Score of 10 and both subsequently did well. Liberal use of elective caeserean section in those patients suspected antenatally to have disproportion or patient with low Bishop Score together with antenatal complications such as E.P.H. gestosis, coupled with timely decision to intervene early in labour in patients with intrapartum complications such as prolonged labour might have reduced both the perinatal mortality and morbidity in the elderly primigravida.

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P A R T T W O

COMMUNITY OBSTETRICS

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UTILIZATION OF MATERNAL AND CHILD HEALTH AIDS IN KASULU DISTRICT IN KIGOMA REGION BETWEEN JANUARY 1978 - DECEMBER, 1980

Introduction

Of the 650,000 women giving birth in Tanzania each year only about 50-60% attend antenatal clinic (ANC) at least once and even a lower: Percentage actually deliver under trained supervision (5). A survey carried out in Bagamoyo, Moshi and Dodoma districts showed that 99% of 21,000 women of reproductive age group interviewed had been pregnant in the past 5 years, and 80% in the past 2 years. 20% of these women did not attend ANC and 53% delivered at home without supervision of a trained midwife (14). The Ministry had projected that by 1980 MCH services should reach 90% of mothers and children (6).

Maternal and child health services (MCH) first started in 1951 and the focus was mainly on nutrition (14) (15). In 1960 Mobile MCH clinics were started with main emphasis on immunization and some primary health services. There was no central coordination in these services and they were unvenly distributed (14). In 1971 a National MCH Coordinating Committee was set up by the then Ministry of Health and Social Welfare and it recommended the provision of

preventive and curative services at all the MCH clinics. (14, 1).

In 1973 abilateral agreement was reached between the government of Tanzania and USAID in which the latter agreed to assist in the training programme of MCH Aids so that they would provide primary health care in dispensaries and health centres (14, 5). The programme started in 1974 with the objectives of training MCH Aids so that they would be able to provide integrated and comprehensive MCH services including antenatal care, with special emphasis on detection of obstetrical at risk factors; conducting normal deliveries with aseptic techniques; postnatal care, health education for mother and infant; immunization, family planning and treatment of minor health problems. Only females were allowed to pursue training and the duration of the course was 18 months for Std. VII Primary School leavers and 9 months for village midwives. (1, 2, 3, 5, 14). By the end of 1973 there were 5 MCH Aids schools operating with an annual output of 60 students. The government aim by then was to build 18 such schools and train approximately 2,000 by the end of 1980 so that each dispensary and health centre is staffed by one MCH Aid (1, 5, 14). By the end of 1980 Tanzania was still 1310 short of reaching the target of 2500 MCH Aids (14, 15).

It was shown in Bagamoyo District that 80 of obstetrical at risk factors can be detected by history and measurement (3) and early detection of these risk factors in Cameroun reduced both perinatal and maternal mortality and morbidity (4). It is important therefore, to determine whether or not the MCH Aids since their inception have influenced pregnant women to attend ANC and deliver in the dispensary and furthermore the outcome of these deliveries.

Objectives

To determine the effects MCH Aids have on the place and outcome of deliveries in Kasulu rural district from January 1978 to December, 1980.

Specific Objectives

1. To determine the number of births in the two dispensaries with MCH Aid services from January 1978 to December 1980.
2. To determine the number of births occurring at home in the villages being served by the two dispensaries with MCH Aid services from January 1978 to Decmber, 1980.
3. To determine the number of women attending ANC run by MCH Aid services and the outcome of their pregnancies from January 1978 to December, 1980.

Methodology

Kasulu district is on the Western part of Tanzania in Kigoma region. The main occupation of the people is farming mainly mazie and beans. The district has a population of 150,000 (18). There are 90 villages and 32 dispensaries. 23 dispensaries are run by the government and 9 by voluntary agencies. There is one MCH clinic in the town and one in each of the 3 health centres. The average distance of house holds to hospital is 26.4 km. in Kigoma rural where as average distance to dispensary is 3.73 km (17). MCH Aid services were first introduced in Kasulu district in 1978. Prior to 1976 MCH services in the dispensaries were run by village midwives and 2 mobile MCH teams. The mobile team services were unreliable because of the frequent breakdowns of the vehicles and the impassableroads during rainy seasons. The village midwives had informal inservices training on MCH services for 12 months in the district and regional hospitals. Due to lack of equipment their services were limited to conducting occasional difficulty deliveries which the traditional birth attendants had failed to manage. Of the 32 dispensaries in the district only 8 (25%) have MCH services that are conducted by MCH Aid service one in each dispensary. A random selection of dispensaries with MCH services was taken as follows:

All the 8 dispensaries with MCH Aid service were numbered. 2 of the 8 dispensaries were picked blindly by a ward attendant who was not involved in the study. The 2 dispensaries picked were Mrufiti and Bugaga. These 2 dispensaries with their surrounding 2 villages formed the study area. The target population was all the mothers aged between 15-45 years who had given birth of 28 weeks gestation or more and have been living in the two villages between January 1978 and December, 1980. With the help of the village Chairman, all the Ten Cell leaders of these 2 villages were identified and numbered ½ (quarter) of all the Ten Cell leaders were blindly picked from each village. All the women belonging to these ven-cell leaders and with the criteria mentioned above were included in the study. The chosen ten cell leaders were briefed by the author on the study and on the time and date of the study and they in turn briefed the women. The women were visited in their homes by the author and the questionnaires filled.

The questionnaire were filled on the day of the study. The first questionnaire dealt with the dispensary and sought information on:

1. Name of village
2. Population of village
3. Female population 15 - 45 years

4. Year the dispensary was built
5. Year of establishing ANC
6. Year MCH Aids started work and number of deliveries per year

The questionnaire on women sought information on:

1. Name of village
2. Name of Ten Cell leader
3. Name of head of household
4. Name of women and whether or not present when visited
5. Education whether illeterate, had adult education, primary education.
6. Occupation
7. Parity
8. Year of delivery, place and outcome of delivery.

Deliveries included those in which the pregnancy had reached 28 weeks gestation or more and the information required has whether the baby was a still birth (SB), died within 7 days or lived after 7 days. A mother who made 3 or more visits to ANC was counted as having attended and if less she was counted and having not attended and the outcome of those who attended ANC and home deliveries were sought.

RESULTS.

The two villages where the study was done with their corresponding dispensaries are:-

1. Mrufiti
2. Bugaga.

Mrufiti is 25 Km away from the Kigoma-Mwanza main road whereas Bugaga is 30 Km along the Kigoma-Mwanza main road.

The population of Mrufiti village was 3154. The female population was 1715. The total population of Bugaga village was 7282. The female population was 4228.

(There were no records of their age groups).

Number of women interviewed at Mrufiti 128

Number of women interviewed at Bugaga 173

Total number of women interviewed 301.

Year both dispensaries were established 1976. Year M.C.H. Aids started work in both dispensaries January, 1978. The total number of deliveries of the 301 women between January 1978 and December 1980 was 376. Total number of deliveries occuring in both dispensaries before M.C.H. Aid was introduced - 0 (no records).

Table I: THE EDUCATION

No formal education	Adult education	Std I - IV	Std. V - VII	Secondary education	University	TOTAL
75	164	46	16	0	0	301

25% of the women did not have any formal education.

Table II: OCCUPATION

	Housewife	Govt. employee	Business	TOTAL
No.	298	3	0	301

The vast majority of women were housewives and peasants.

Only 3 women were civil servants.

Table III: PARITY

PARITY	1 - 4	5 - 7	8+	TOTAL
Nos.	151	97	53	301

The percentage of grandmultiparous with 5 children or more was about 50%

Table IV: DELIVERIES PER YEAR AT THE DISP. SINCE M.C.H. AID STARTED WORK.

YEAR	1978	1979	1980	TOTAL
Nos.	115	125	136	376

There were a total of 376 deliveries over the 3 years among the women studied.

Table V: NUMBER OF VISITS TO ANTENATAL CLINIC

YEAR	1978		1979		1980		TOTAL	
Nos. visits	< 3	> 3	< 3	> 3	< 3	> 3	< 3	> 3
Nos.	6	109	13	112	15	121	34	342

Of the 376 deliveries that occured over the 3 years 91% of the deliveries belonged to mothers who had attended antenatal clinic.

Table VI: LOCATION OF DELIVERY - DISPENSARY (D) OR HOME (H)

Year	1978		1979		1980		TOTAL	
Location	D	H	D	H	D	H	D	H
	23	92	20	105	21	115	64	312

A bigger percentage of deliveries 83% occured at home than in dispensaries.

Table VII: OUTCOME OF DELIVERY EACH YEAR.

Year	1978	1979	1980	TOTAL
Nos. deliveries	115	125	136	376
S.B.	2	2	5	9
Neonatal death	7	4	6	17
P.N.M.R. per 1,000 deliveries	72.5	45.8	74.8	69.1

The perinatal mortality rate (P.N.M.R.) per 1,000 deliveries over the 3 years was high (69.1). The highest rates were in 1978 (72.5) and 1980 (74.8).

Table VIII: OUTCOME OF DESPENSARY DELIVERY.

Year	1978	1979	1980	TOTAL
Nos deliveries	23	20	21	92
S.B.	0	0	0	1
Neonatal death	1	1	1	2
P.N.M.R. per 1,000 deliveries	41.7	47.6	45.4	31.6

Table VIII and Table IX

The P.N.M.R. of dispensary deliveries over the 3 years period was low 31.6 compared to P.N.M.R. of 74.9 among the home deliveries which is more than two times.

Table IX: OUTCOME OF HOME DELIVERIES.

Year	1978	1979	1980	TOTAL
Nos. deliveries	92	105	115	284
S.B.	2	2	5	9
Neonatal deaths	6	3	5	14
P.N.M.R. per 1,000 deliveries	80.0	45.4	80.0	74.9

Table X: OUTCOME OF DELIVERIES OF ATTENDERS OF ANC.

Year	1978	1979	1980	TOTAL
Nos. deliveries	109	112	121	342
S.B	1	1	4	6
Neonatal deaths	5	4	4	13
P.N.M.R. per 1,000 deliveries	52.1	42.7	62.0	52.6

Table XI: OUTCOME OF DELIVERIES OF NON\$ATTENDERS OF AN.C.

Year	1978	1979	1980	TOTAL
Nos. deliveries	6	13	16	35
S.B.	1	1	1	3
Neonatal deaths	2	0	2	4
P.N.M.R. per 1,000 deliveries	333	71.4	.57.9	166.6

Table X and Table XI.

The P.N.M.R. among ANC non-attenders was more than three times, (166.6) compared to that of attenders 52.6 over the 3 years period.

Tanle XII: EDUCATION VS P.N.M.R. OVER 3 YEARS.

	Illiterate	Literates
Nos.	75	226
Nos. deliveries	94	282
S.B	3	6
Neonatal deaths	6	11
P.N.M.R. per 1,000 deliveries	87	56.8

The P.N.M.R. among illiterates was higher 87 than among literates 56.8

DISCUSSION.

75% of the women who took part in this study could read and write. The interviews with them were easy as they kept good records of the years they had given births and the majority of them kept the antenatal cards of all the children they had. The antenatal cards made counter checking of both antenatal and post-natal information they had given about their children possible. 99% of women studied were housewives as the only civil servants in this population were members of staff of the dispensary and primary school. The civil servants had more income and more education hence a higher standard of living than the villagers.

The number of women of high parity was more or less the same as those with low parity. The importance of child spacing was emphasized to the mothers at the antenatal clinics but neither the pills nor the intrauterine devices for contraception were offered. These were available at the district hospital only. Of the 376 deliveries that occured from 1978 to 1980, 340 (91%) had received antenatal care. 312 (83%) of the 376 deliveries occured at home without the supervision of an M.C.H. Aid. The mothers who delivered at home had been told at the ANC clinic of the importance of delivering in the dispensary under the attendance of an M.C.H. Aid but all the same they were defiant and delivered at home.

In Tanzania it is estimated that 60% of the mothers deliver at home (6). In Miono division in Bagamoyo district it was found that 69% of deliveries occured at home under untrained traditional birth attendants where there were no dispensaries in villages and that the figure was lower 53% where the women were near the dispensaries, (7). Another study found 62% deliveries occured at home in Tanzania (8) (14). In Ghana the figure was 75%. Most of these deliveries occured under the supervision of traditional birth attendants (TBA). There were 8 known traditional birth attendants in each village. In Miono division, Bagamoyo there were 6 known TBA's (7). It is estimated that there are 5 TBA's in each village in Tanzania (8). It was also estimated that there were 369 TBA's in Zanzibar in 1967, 1235 TBA'S in Mali in 1976 and 26670 TBA's in Phillipines in 1977. (12) The TBA are elderly ladies who have no formal knowledge of antenatal and postnatal care and do not conduct deliveries aseptically but the society has confidence in them (7) (9) (11).

Some of the mothers might have preferred to deliver at home because the M.C.H. Aids were away each month for one or more weeks. They had to go to the district hospital every month to get their salaries, vaccines and kerosene for refregerations. Formerly this was the duty of the D.M.O. and district M.C.H. co-ordinator but they had to stop because there was only one, serviceable land-rover and the D.M.O. had to use it for both M.C.H. services and other hospital administration duties and the latter got more priority. The women in labour might have been discouraged to go to the dispensary because they were not sure of meeting the M.C.H. Aids where as the traditional TBA's were always available.

Lack of dispensary staff quarters made the dispensary staff either live in the dispensaries or rent local houses which were far from the dispensaries. At Mrufiti dispensary the R.M.A. with his family lived in the house so that during working hours his family would stay outside and prepare meals while the R.M.A. and M.C.H. Aid were attending patients. At night the whole family would move into the dispensary. If a woman came in labour at night the whole family would watch what was going on and some women in labour felt uneasy about this situation and decided to remain at home. In other the dispensary whenever needed. This became difficult at night and during rainy seasons so that the traditional birth attendant became the obvious alternative as they lived nearby.

The attendance to the AN clinic was good (91%) because the mothers understood the importance of ANC. The majority said they attended the clinics because disease like Safura (Anaemia) were treated there. At these clinics powdered milk and other baby foods were offered free of charge for only those women who attended AN clinics. This free offer attracted some of them to go to the clinics and they simultaneously received antenatal care and their children were vaccinated.

The total perinatal mortality over the 3 years was 69.1 per thousand. Among deliveries that took place at home it was 74.9 whereas those which occured in the dispensary under M.C.H. Aid it was 31.6. The perinatal mortality among those women who did not attend antenatal clinic was 166.6 compared to 52.2 among those who attended. The P.N.M.R. in 1978 in Sweden was 9.6, Japan 13.2; Mauritius 51.1, Paraguay, 51.9 and Montserrat 62.5 (13). Therefore developing countries have a higher P.N.M.R. than developed.

As a big percentage of women are attended by the TBA in developing countries, it is clear that the TBA's may play a positive role in reducing the perinatal mortality if they are taught some basic knowledge in delivering primary health care. Of the 8 known TBA's in this population none knew the importance of antenatal and postnatal care and yet these handled 83% of the deliveries in this population. At Miono division, in Bagamoyo (7) the TBA's were found to be illiterate and had no knowledge of both antenatal and postnatal care. They left such care to the mothers and relatives of the women. There is a need to copy the example of Ghana (9), Indonesia (10) and the Sudan (11) where the TBA are taught some basic ANC and aseptic techniques of conducting both deliveries and postnatal care. Indeed in addition to the numerous facilities yet to be built and health workers to be trained in Tanzania there are alot of problems which interfere with efficient use of what already exists and principal among these constraints are logistics and maintenance problems; poor communication and transportation, inadequate data to plan and evaluate with (14). The quality of work of our health workers deteriorates with their prolonged isolation once initial training is achieved as seldom the D.M.O. and district M.C.H. co-orindations pay them any visits or conduct seminars so as to keep them up to date.

The Government decision to consider training the TBA and traditional healers to become Village Health Workers for their own villages might help in reducing the P.N.M.R. as they are workers who are immediately available to 2/3 of the villages (14). As noted earlier only 8 (25%) out of the 32 dispensaries have M.C.H. Aids. 25% of all the MCH Aids posted to the dispensaries in that district

had to leave their places of assignment for one reason or another and the commonest reason was to join their husbands (13). At an M.C.H. Conference in Moshi it was noted that most of the problems affecting expansion and quality of M.C.H. services were due to M.C.H Aids not being selected from rural inhabitants of villages in which they work. Therefore many have left the rural dispensaries; equipment is scarce and 50% of M.C.H. Clinics do not have working refrigerators, vaccination kits, maternity beds and child scales; village leaders are not involved in planning and hence do not encourage women to attend M.C.H. Clinics as expected, and last vehicles for M.C.H. services are being used for other purposes thus leaving the district M.C.H. co-ordinator stranded and cannot visit the M.C.H. Aids (14).

All these problems coupled with the fact that the projected tartet of having 2500 M.C.H. Aids by 1980 has already fallen short by 1319 show that there is a longway to go before the M.C.H. Aids fill all the 32 dispensaries and perform their duties effectively by influencing mother to deliver in dispensary under them and attend ANC. To alleviate this problem the Ministry should implement the proposed training of TBA's soon.

If M.C.H.A work together with trained TBA than the coverage of mothers will be big and P.N.M.R. may get reduced. Kigoma specifically may benefit from this as only 20% of health facilities are integrated with daily M.C.H. services compare to more than 50% in other regions (16).

RECOMMENDATIONS.

As mentioned earlier in the discussion, both the percentage of women delivering at home and the ANC attendance is unlikely to change in the near future (14). This has been made worse by the prevailing world wide economic crisis and as Tanzania is one of the 30 poorest countries in the world the impact of this crisis will adversely the health programmes. As mentioned earlier of the projected target of 21 MCHA for Kasulu dispensaries only 8 are actually at work now covering only 25% of the dispensaries (14). Therefore the P.N.M.R. is unlikely to change in the near future unless the TBA's who attend 2/3 of the villages are articulated in the Primary Health Care. The Government decision to consider to train them is a timely decision.

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P A R T T H R E E

GYNAECOLOGICAL CASE COMMENTARIES

INCOMPLETE ABORTION EVACUATION OF THE UTERUS AND FOLLOW UP

I.P. No. 166019

Name: Miss. G.K., 17 years, Moslem, Prim.

Address: Mikocheni, Dar es Salaam

Date of admission: 1st September, 1979

Date of Operation: 1st September, 1979

Date of Discharged: 4th September, 1979

Summary

Miss. G.V., Secondary School pupil had an incomplete abortion which was suspected to have been induced. After resuscitation, antibiotics and evacuation the patient progressed well and was discharged on the 4th day.

History of present illness

The patient was referred from Mnazi Mmoja dispensary with a history of 3 months ammenorrhoea and sudden onset of lower abdominal pain and vaginal bleeding for 2 days. The lower abdominal pain was cutting in nature and it was radiating to the back. It was intermittent, progressive and she did not know any relieving factors. She vomited once at home but denied any history of fever no discharge. She did not complain of dysurea or frequency and her bowel motions were normal. The pain was followed

a few hours later by vaginal bleeding which was slight initially but became heavy with clots as the pain progressed. She did not see a fetus coming out. She denied that there was any attempt to interrupt the pregnancy.

Menstrual history

Menarch was at 12 years. Her period were 4 days flow in every 30 days, normal, regular and not associated with pain. Her last menstrual period was on the 10th June, 1979.

Obstetrics history

She had not conceived before and was not on any contraceptives.

Past medical and surgical history

She denied any history of venereal disease and she had not undergone any surgical operation.

Family history

She gave no history of hypertension diabetes, heart disease, tuberculosis or mental illness in the family. She denied family history of twins.

Social history

She was single and was a studying at Jangawani Secondary School in Form III. She was staying with her parents both of whom were Civil Servants.

Neither her parents nor the teachers were aware of the pregnancy.

General examination

The patient was in pain. Her nutritional status was good. She was not anaemic, shocked, dehydrated, jaundiced or febrile (temperature 36.5°C). There was no lymphadenopathy nor oedema.

Head and neck: Nothing remarkable

Breasts: Active and no lump was palpable

Chest

She was not dyspnoeic. Chest movements were sysmetrical and air entry was equal bilaterally. Breathing was vesicular with no adventitious sounds.

Cadiovascular

The pulse was 90 per minute regular and good volume. The blood pressure was 120/80 mm Hg. The heart size and sounds were normal. There were no murmurs.

Abdominal examination

The abdomen was not distended and there was no visible mass or peristalsis. The suprapubic region was very tender on deep palpation. There was no guarding nor rebound tenderness. The liver spleen and kidneys were not palpable nor was there any tenderness. There was no free fluid.

Pelvic examination

The vulva and perineum were normal and there was bleeding coming from the vaginal introitus. Speculum examination revealed a normal vaginal with retained produces of conception distending the cervical os. The cervix was slightly bruised on the upper lip. Cervical swab was taken. Bimanually the cervix was effaced and 2 cm dilated. The uterus was the size of 12 weeks pregnancy mobile and tender. The fornices were free and no bulging mass was felt in the pouch of Douglas. There was no tenderness or mass in the adnexia. The bleeding was moderate with clots but no foul smell.

Diagnosis

A diagnosis of incomplete abortion was made but in view of the bruises on the cervix and the fact that the patient was still studying at Secondary School level, the possibility of the pregnancy being interrupted was taken although the patient denied.

Investigations

1. Haemoglobin 11.6 mg/dl
2. Cervical swab results came 36 hours later. No pathogens were isolated.
3. Urine was negative for albumin and sugar.
4. Grouping and crossmatching was done and 1 unit of blood was ordered and kept ready in case the patient bleed profusely.

Treatment

The patient was started on Ampicillin 500 mg intramascularly 6 hourly in view of suspicion of aseptic interruption of pregnancy eventually leading to sepsis.

Premedication

Atropine and pethidine were given as per introduction

Anaesthesia

Induction was done with 300 mg thiopentone intravenously and the patient was maintained on nitrous oxide and oxygen given by mask. Examination under anaesthesia confirmed the previous findings.

An auvards speculum was introduced and the cervix was held by vulsellum forceps and cleaned with hibitone solution after the protruding product of conception had been removed by fingers.

The right index finger was introduced into the uterine cavity and explored it while the left steadied the uterus. Some products of conception were removed.

A sponge holding forceps was then introduced gently into the uterine cavity until it lightly touched the fundus. The blades were opened then closed and rotated at right angle after which the products of conception were extracted. This procedure was repeated several times until no more products

were extracted. The uterine cavity was re-explored with index finger and no more products of conception were felt. At this point a blunt curette was gently introduced into the uterine cavity and the uterus curetted. A gritting sensation was felt and no more products of conception were removed. Bleeding at this point was slight. Intravenous ergometrine 0.5 mg was given by an assistant and the speculum and vulsellum forceps were removed.

A repeat bimanual examination showed that the uterus was well entracted and the size of 8 weeks pregnancy.

Histology

Retained product of conception. No trophollastic activity.

Post operative treatment

The pulse and blood pressure were monitored hourly for 6 hours then 6 hourly for 24 hours. Recurrence of vaginal bleeding was watched for. As she did not bleed much during the operation and she was not anaemic blood was not given. Antibiotics treatment was stopped on the third day.

1st to 3rd postoperative day

The general condition of the patient was good. She was not pale. Temperature 36.7°C/ Pulse 80/minute, good volume. Blood pressure 120/80 mm Hg. The uterus

was well contracted, the cervix was closed and there was no bleeding per vagina. Haemoglobin was 11.3 gm/dl. The patient was discharged on the fourth day and told to attend the gynaecology outpatient department after 6 weeks but she did not turn up.

Commentary

A case of incomplete abortion managed by evacuation of the uterus has been described. This condition is the commonest cause of gynaecological admission and in 1979 alone 72.4% of all the admissions in the gynaecological wards were due to incomplete abortion.

The probable fetal causes of spontaneous abortion are chromosomal abnormalities especially in early abortion; fetal malformation; abnormal implantation and hydatid form mole degeneration and the maternal causes are uterine anomalies; cervical incompitence; fevers such as due to malaria, infections such as syphyllis and rubella, metabolic disorders, and hormonal inssufficiency (1).

In this paricular patient a suspicion of induced abortion was made because of the finding of bruises on the servix coupled with the fact that the patient was studying in a school where pregnancy was not tolerated. The patient denied that she had attempted to interrupt the pregnancy but this sometimes occurs

with such patients and they normally admit when they get life threatening complications such as severe sepsis leading to septic shock. Prophyllaxis antibiotic cover was started while awaiting for bacteriological results on the assumption that if interruption had been done it was not known how aseptic the procedure was. The bacteriological results were negative and after 3 days of follow up the patient condition remained quiet good and she was discharged.

As it has been demonstrated on this case incomplete abortion managed promptly by resuscitation blood and intravenous fluids (if bleeding has been heavy) followed by evacuation by either using suction or sponge forceps and currettage leads to good results with little morbidity. Delay however, leads to shock and sepsis and the morbidity and even mortality is high (2).

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RUPTURED ECTOPIC PREGNANCY

I.P. No. 162347

Name: Miss J.A., 23 year old, Makonde, Moslem,
G. 2, P. 0+1

Address: Kijitonyama, Dar es Salaam

Date of admission: 1st March, 1980

Date of discharge: 10th March, 1980

Summary

Miss J.A. had ruptured ectopic gestation and left salpingectomy was done and she subsequently did well. She was earlier being treated for pelvic inflammatory and infertility for the past 6 years.

History of present illness

The patient attended a private clinic because she had been experiencing vague lower abdominal pain associated with slight vaginal bleeding for the past 3 days after she had had 6 weeks of ammenorrhoea. A pelvic examination was done and then after about an hour she started experiencing severe lower abdominal pain which was cutting in nature and non radiating. The pain was associated with dizziness and the fainted while in a taxi and she was immediately sent to Muhimbili hospital. She also complained of nausea and occasional vomiting for the past 4 weeks. She denied any history of fever, nor dysurea. She did not experience vaginal discharge nor dyspareunia. Her bowels were normal.

Menstrual history

Menarch was at 14 years. Her cycles used to be 5 days loss every 30 days normal flow, regular and not painful initially but since she aborted in 1975 the periods became associated with pain 2 days before the masses. Her last normal menstrual period was on the 15th of January 1980.

Obstetrics history

She was G. 2, P. 0+1. She aborted a 3 months pregnancy in 1976 at home. She saw the fetus and she was not evacuated. She denied any history of fever nor discharge after the abortion. Thereafter she did not conceive until this time.

Contraceptives: She did not use any contraceptives

Past medical and surgical history

She was being treated for chronic pelvic inflammatory disease and infertility at the gynaecological outpatient department. No pathogens were isolated and she denied history of venereal disease in the past. She had not undergone any surgical operation.

Family history

She gave no history of chronic illness in the family. She denied any history of tuberculosis, diabetes, hypertension or hear disease.

Social history

She had been divorced because she could not conceive. She was staying alone and working as a Casual Labourer at Urafiki Textile Mills. Former husband had 3 children with second wife.

General examination

The patient looked ill and in pain. She was anaemic but not shocked. Afebrile (37.2°C), not jaundiced nor dehydrated. She had no lymphadenopathy or oedema of the ankles.

Neck, mouth, and throat: Nothing remarkable

Cardiovascular system

Pulse was 110, rapid, small volume, blood pressure was 100/60 mm Hg. The heart size and sounds were normal and there were no murmurs.

Breasts

The breasts were engorged and secreting. There were no lumps.

Respiratory system

She was not dyspnoeic. The chest was clear

Abdominal examination

The abdomen was distended mainly in the hypogastrium. It was very tender, especially on the left iliac fossa, and there was guarding and rebound tenderness.

Shifting dullness was elicited. The liver, spleen, and kidneys were not palpable and no other mass was felt in the lower abdomen and there were no herniae.

Vaginal examination

The vulva and perineum were normal. There was slight vaginal bleeding coming from the cervical os and the cervix looked healthy. Divital examination revealed a closed cervix and marked cervical excitation. Fornices were free and there was no mass bulging in the pouch of Douglas. The adnexia and uterus could not be palpated because of the severe pain the patient complained of once examination of these structures was started.

Rectal examination

Was also tender and revealed a mass around the left parametric which was connected to a normal sized uterus.

Diagnosis: Rutpred ectopic pregnancy

Management

Immediate laparatomy was planned:

1. Normal saline intravenous drip was started.
2. Blood was sent for grouping and crossmatching and 4 units were requested. Blood group O +ve
3. The Haemoglobin was 7 gm/dl.
4. Urine was sent for pregnancy test but the results were available the following day and they were positive.

Operation: Laparatomy and left salpingectomy

Premedication

Atropine 0.6 mg intravenously and pethidine 100 mg 1 m as per introduction.

Anaesthesia

Induction with thiopentone 300 mg and scoline 60 mg intravenously. Endotracheal tube was passed and maintainance was with nitrous oxide and oxygen.

Procedure

The bladder was catheterized and the abdomen was painted with hibitane solution followed by flavin in spirit and covered with.

The abdomen was opened by a subumbilical midline incision. A blue peritoneum was visible and on opening the perietal peritoneum haemoperitoneum was seen. The blood was bright red and was collected by means of a large spoon and poured into a funnel that was covered by a filter, which was dipping in a bottle with sodium acid citrate solution. The capacity of the bottle was 500 mls. Two such bottles were collected and autotransfused. The uterus was then identified. It was the size of 8 weeks pregnancy. It was drawn up and the lift follopian tube was identified and a rupture of about 3 cm diameter was found at the ampulla and bleeding was continuing from the site of rupture. One homeostasis forceps was applied medial to the site of rupture and the other

forceps laterally thus controlling the bleeding. 500 mls more of blood was collected into a bottle. The remained blood consisted of big clots and it was therefore unsuitable and hence removed by Suchon and mops. The fetus was not identified. The right tube was inspected and some peritubular adhesion were found. Salpingectomy of the left tube was done and the mesosalpinx transfixed and ligated by No. 2 catgut. The raw wound was peritonized by tying mattress sutures which brought the round ligament and broad ligament over the uterine cornu.

The abdomen was closed in layers as (from introduction).

Immediate post operative progress

Her general condition was good. The pulse was 100 good volume. Blood pressure 110/70 mm Hg.

She had been autotransfused 3 units of blood and 1 litre of normal saline.

1st Post operative day

General condition good slight palour Hb 9.5 gm/dl. Temperature 36.6°C. Not dehydrated and no history of vomiting. Pulse 82 per minute and good volume. Blood pressure 120/70 mm Hg. Chest was clear. The abdomen was not distended, soft and bowel sounds were present.

One more unit of fresh blood was available for transfusion.

2nd to 7th Post operative day

Her condition remained good and she was ambulant on the second day. Alternate stitches were removed on the 6th day and the remainder on the 7th day. The incision wound was well healed. The patient was discharged on the 8th day with a haemoglobin of 11.0 gm/dl. She was also given from iron tablets to be taken one tablet three times a day and she was told to attend the gynaecological outpatient department after 6 weeks. She however, said that she was going for holidays at her home village and a letter was written to the district medical officer informing him of her condition.

Commentary

Ectopic pregnancy is a well recognised clinical problem in many parts of the world especially in the developing countries where it is one of the commonest female surgical emergencies (1, 2). However, its prevalence varies in different commonities, depending on certain predesposing factors of which the most significant is pelvic inflammatory disease of all types (3). Septic abortion (induced) and puerperal sepsis are normally blamed for the pelvic inflammatory diseases (3).

This patient aborted at home and was not evacuated. After a shore time she developed secondary dysmenorrhea. It is likely that the patient developed mild infection after abortion and this led to her inability to conceive for 6 years due to total occlusion and cilia damage (3). When she eventually conceived the pregnancy was implanted in the tube. The rupture of the ectopic pregnancy was very likely precipitated by the pelvic examination (4).

Because of a history of recent rupture autrotransfusion has contemplated and therefore after resuscitation with normal saline a laparatomy was done immediately without haiting for crossmatched blood. As blood is scarce is most developing countries autrotransfusion and salpingectomy is often life saving (3). This patient had no child and therefore before total salpingectomy was done the right tube was checked and some peritubular adhesion were seen. She was advised to attend the infertility clinic for further investigations with a view of finding out whether or not tubal surgery would benefit her.

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CARCINOMA OF THE BODY OF UTERUS

I.N. No. 163670

Name: Mrs. V.E., 60 year old, Christian, Nullipara

Address: Singida

Date of admission: 15th September, 1980

Date of operation: 29th September, 1980

Date of discharge: 26th December, 1980.

Summary

Mrs. V.E. who was obese and nulliparous presented with post menopousal bleeding and a presumptive diagnosis of carcinoma of the endometria was made and later confirmed histologically. Total abdominal hysterectomy and bilateral salpingo-oophorectomy was done and followed two weeks later by both external and internal irradiation.

History of present illness

The patient was referred from Singida Government hospital and admitted in Muhimbili hospital through the casualty department with the complaints of postmenopausal bleeding 6 months which was followed by vaginal discharge 3 months later.

The postmenopausal bleeding was irregular and occurred every 5 to 7 days and would last for about

7 days. The discharge was foul smelling but unassociated with itching. She denied any history of abdominal pain, dysurea, or frequency. She denied history of hot flashes and sweating and she did not take any drugs micturition and bowel motion were normal.

Menstrual history

She did not remember her age at menarch but said that it was not delayed. The cycles had been 5 days loss every 30 days; the flow was normal, regular and not painful. She reached menopause at the age of 50 years (10 years ago).

Obstetrics history

The patient had never conceived and denied history of taking any contraceptives.

Past medical and surgical history

Patient denied any history of chronic illness or taking Oestrogens related substances in the past and she had never been operated before.

Family history

Patient denied any history of diabetes, hypertension, heart diseases, or tuberculosis in the family.

Social history

She was a housewife. Her husband is a peasant at Singida and he is married to a second wife who has 8 children.

Examinations

She was an elderly obese woman of good nutritional status. She was clinically anaemic but not jaundiced and Afebrile (37°C). There was no ankle oedema or lymphadenopathy.

Head and neck

Teeth and gums were normal. There was no thyroid enlargement.

Breasts

They were atrophied but no lumps were palpable.

Respiratory system

Chest was symmetrical. The trachea was central. Percussion was bilaterally reasonant and air entry was normal bilaterally. There were no adventitions sounds.

Cardiovascular system

The pulse was 80 per minute, regular and good volume. The blood pressure 130/90 mm Hg. The Jugular venous. Pressure was not raised. The heart size and sounds were normal.

Abdominal examination

The abdomen was uninformly distended probably due to obesity and moved with respiration. Palpation was difficulty in view of the obesity but no tenderness was elicited. The liver, spleen and kidneys were not

palpable and there was no tenderness around these organs.

A suprapubic non-tender mass, the size of 14 weeks pregnancy was palpated. It had a nodular surface hard and mobile both transversely and longitudinally. Free fluid was not demonstrated.

Vaginal examination

The vulva was atrophied and there was no evidence of bleeding nor discharge. Speculum examination revealed an atrophic vagina with pale, thin mucosa. The cervix was mulliparous and healthy. Bimanual examination revealed a firm closed servix. The uterus was bulky and of the size of 18 weeks. It was hard, mobile and non tender. The fornices were free and no tenderness or masses were felt in the adnexia.

Rectal examination

The rectal mucosa was normal and the parametric were not thickened, and there were no masses on the pouch of Douglas.

Diagnosis

A diagnosis of endometrial carcinoma stage I with a uterine fibroids was made.

Management

A fractional currettage was planned so as to confirm the diagnosis and then extended total abdominal

hysterectomy with bilateral salpingo-oophorectomy to be followed by radiotherapy was planned.

Investigations

1. The Haemoglobin level was 10.5 gm/dl. PCV - 35%. M.C.H. 25 pg., M.C.V. - 98, M.C.H. C - 32%. The peripheral firlm was normocytic, normochromic. The total white cell count was 5,100 per Cu mm and the differential was normal.
2. Grouping and crossmatching was done and 2 units were requested so as to try raise the patient's haemoglobin and also to have blood ready incase the patient bleed heavily on expectedly per vagina.
3. Urine microscopy and culture were negative
4. Stool did not show any parasites
5. Papanicolaou smear showed grade I smear
6. Chest X-ray showed no evidence of chest involvement
7. Blood urea was 10 mg% and creatinine was 0.6 mg%
8. Intravenous pyelography showed that the kidneys were functioning normally and there was no evidence of compression of the ureters or hydroureters. The bladder was normal.

Fractional curretage

Premedication, induction and maintanance of anaesthesia was done as described in the introduction. The patient was placed in lithotomy position. The

vulva and vagina were swabbed with hibitane solution and drapped with sterile towels.

Procedure

Examination under anaesthesia confirmed the earlier findings. An auvard speculum was inserted and the anterior lip of the cervix held by vulsellum. The cervical canal was curretted first and the curretting put into a bottle with 10% formaldehyde and uterus was sounded down to 8 cm. Hegars dilators lubricated in hibitane were used to dilate the cervix starting with No. 4 and dilated up to No. 8. Fractional currettage was done gently and a few currettings obtained were put into a second bottle of 10% formaldehyde and sent for histology.

Histology report

The curretting from the uterine corpus in the second bottle showed a differentiated adenocarcinoma where as those from the cervix were normal. A diagnosis of carcinoma of the uterus stage I AG_1 with uterine fibroid was made.

In view of the histological report it was decided to do extended hysterectomy with bilateral salpingoophorectomy to be followed later by radiotherapy. Before doing this it was decided that her haemoglobin be raised. 2 units of packed cells were given slowly within 48 hours. Her haemoglobin checked 6 days later was 11.5 gm/dl.

The decision to do the operation was explained to the patient and she approved. 2 more units of blood were requested.

29th September 1980 - Operation

An enema was given the night before the operation.

Anaeshtesia

Premedication and general anaesthesia was given as described earlier.

Procedure

The patient was put in lithotomy position. The bladder was emptied by cathetirization done under aseptic conditions as described .....

A swab on a sponge forceps was dipped in chlorhexidine and the vagina was cleaned. The external os was closed with interrupted No.1 catgut sutures. The abdomen was swabbed with acqueous chlorhexidine followed by flaviane in spirit and drapped. The abdomen was opened through a right paramedian incision extended 5 cm vertically. The intestines were packed off with abdominal packs.

Findings

There was no evidence of extrauterine spread. The uterus was the size of a 18 weeks pregnancy with multiple small subserous and uterstitial fibroids. It was mobile and firm. Both ovaries were atrophic

and the tubes were normal but there were a few paritubular adhesions extending to the ovaries. The liver, draphragm, omentum and peritoneal cavity were not involved and the paraortic and pelvic nodes were not enlarged.

The tubes were clamped at the fimbrial ends so as to prevent retrograde spillage of carcinoma cells into the peritoneum. Total abdominal hysterectomy with bilateral salpingoophorectomy was done as described in case No. .... except that in this patient the upper third of the vagina was removed together with the uterus. The uterus together with some paraaortic and pelvic nodes were sent for histology. The vaginal vault was closed with continuous No. 2 catgut and after fixing the cut ends of the round ligaments to the lateral corners of the vaginal cuff, peritonization of the pelvic floor has done carefully with No. 0 cutgut suture avoiding the ureters. The appendix was inspected and found normal and the abdomen was closed as in ..... The blood loss was 800 mls.

Pathology

Gross - The uterus was opened as soon as it was removed from the abdomen. A few submucous fibroids were seen. The endometric appeared normal. The ovaries and tubes looked normal.

Histology

A confirmation of earlier findings of well differentiated adenocarcinoma was made. There was no invasion of the myometria, cervix, avaries and parametria or lymph node. Also a diagnosis of leiyomyoma of the myometria was made.

Immediate post operative care

The pulse, blood pressure, temperature and respiration were monitored hourly for 24 hours and then twice daily. A strict input and output chart was started and the catheter inserted earlier was connected to a bag. Urine output was recorded hourly for 6 hours and then 4 hourly.

2 units of blood were given and then dextrose/saline 2½ litres was continued daily. Pethidine 100 i.m. was given 6 hourly for 48 hours.

1st Post operative day

The general condition of patient was good. She had passed 1,200 mls of urine. She was not anaemic. Temperature 37°C. Pulse 90/minute, regular and good volume. Blood pressure 120/70 mm Hg. The abdomen was not distended, and not tender. The bowel sounds were present. There was no vaginal bleeding.

2nd to 8th Post operative day

The patient progressed well. Her haemoglobin on the 3rd day was 11.4 gm/dl. The pulse, blood pressure and temperature remained normal. On the 7th post operative day the stitches were removed and the wound had healed well.

The patient was booked for radiotherapy.

Radiotherapy

Preparation - The haemoglobin was 11.4 gm/dl. The urine for microscopy was normal and the culture grew no pathogens.

Radiotherapy was then started.

External Radiation - 16.10.1980

This was given in the radiotherapy department daily for 5 days every weeks for a total of 5 weeks. On each visit 200 rads were given and a total of 4,000 rads of external irradiation was aimed at. The external radiation was given by directing a cobalt beam to the pelvis in a antero-posterior direction and a total of 2,000 rads were given. The haemoglobin was checked and found to be still 11.4 gm/dl. The white cell count was 5.300 per Cu mm^3 and the differential was normal. Urine culture grew no pathogens.

Again 2,000 rads of external irradiation were given making a total 4,000 rads. The haemoglobin was again checked and it was 11.5 gm/dl. The total white

cell count was 5,500 per Cu mm^3, and the differential was normal. Urinalysis was normal and culture of urine grew no pathogens.

Simultaneously the partient was started on internal irradiation and 400 rads were given once weekly for 5 weeks and a total of 2,000 rads were given. By the end of radiotherapy treatment the patient had received 4,000 rads of external irradiation and 2,000 rads of internal irradiation making a total of 6,000 rads.

A letter was then written to the District Medical Officer of Singida explaining what was done and the follow up management that was required.

Commentary

The incidence of carcinoma of the body of the uterus at Muhimbili hospital was 3% and 3.2% in 1976 and 1979 repectively and a similar low incidence was shown in Kampala but in most Western countries carcinoma of the endometria has become the most common gynaecological malignancy but the mortality for the disease is much less then for ovarian and cervical malignancies (1). The patients with carcinoma of the corpus are normally elderly patients

in there 60's and they may be obese, milliparous or low parity, diabetic or hypertensive. They normally complain of postmenopausal bleeding and discharge or if they have not reached menopause they would complain of menorrhagia or perimenopausal bleeding and discharge. This patient presented with the former complaints and was also obese nulliparous with fibroids. The presence of fibroids might be associated with nulliparity but whether they cause infertility or are the effect of it is not known (2).

This picture was suggestive of endometrial carcinoma and the other likely condition was cancer of the cervix which was excluded after doing papanicolau smear and fractional currettage. The tumour was staged I AG_1 because it was limited to uterus and the uterine was 8 cm and histology showed a well differentiated adenocarcinoma. 70% of the cancer of the uterus are discovered early in stage I unlike cancer of the cervix because of the presentation of irregular bleeding after menopause which a patient cannot easily ignore.

Treatment of endometrial carcinoma stage I AG_1 disease is by total abdominal hysterectomy and bilateral salpingoophorectomy. The tubes are tied at the fibrial and so as to prevent spillage of cancer cells into the peritoneum cavity as this cumour may spread by implantation. The cervical canal was also closed so as to prevent spillage of cancer cells into the vault and also the upper ½ of the vaginal vault was

removed as the vault is a common site of recurrence. However, it has been found that the closure of the cervix and the removal of the upper 2/3 of the vault did not alter the vault recurrence rate (3).

Radiotherapy to the vaginal vault reduces the incidence of vault metastases after operation to between 1 and 2% and Jeffcoate (2) since he adopted radiotherapy treatment, did not see a vaginal metastasis for 20 years. External irradiation to the pelvis achieves a better local control of tumour although Conray (3) found that whether or not external irradiation was given no effect on the 5 or 10 year survival rates was found.

In advanced in operable endometrial cancer progesterone may be used and it has been shown to supress metastasis in the bones, lungs and liver.

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BARTHOLINS ABCESS

I.P. No. 162428

Name: Miss K.T., 18 year old, Mluguru, Christian

Address: Kariakoo, Dar es Salaam

Date of admission: 1st February, 1981

Date of discharge: 3rd February, 1981

Summary

Miss. K.T. had Bartholins Abscess caused by neisseria gonococci which was sensitive to penicillin. Mansupialization was done and penicillin given and the patient got cured.

History of present illness

The patient was referred from Mnazi Mmoja dispensary with the complaint of severe right vulva pain and swelling associated with a whitish vaginal discharge for the past three days. The swelling and pain had been increasing with time. The discharge was not foul and was not itching. She denied any history of fever, dysurea and frequency.

Menstrual history

Menarch at 13 years. Menstrual flow was 3 days loss every 28 days, normal, regular and not painful. Her last menstrual period was 15th January, 1981.

Obstetrics history

She had never conceived before and was not on any contraceptives.

Past medical and surgical history

There was no history of veneral diseases in the past.

Family history

She gave no history of chronic illness in the family.

Social history

She was single and working in a bar. She had no permanent boyfriend.

General examination

The patient was in pain. Her general condition and nutritional status were good. She was not anaemic and afebrile, temperature 37°C. There was no pedal oedema or lymphadenopathy.

Head and neck

Teeth and gums were normal and there was no goitre.

Breasts: Normal. No lumps

Respiratory system

The patient was not dypnoeic. Chest was symmetrical. Trachea was central. Percussion was bilaterally resonant. Breathing vesicular and no adventious sounds.

Cardiovascular system

The pulse was 80, regular and good volume. Blood pressure was 110/70 mm Hg. Heart size and sounds were normal and there were no murmurs.

Abdominal examination

The abdomen was scaphoid and not tender. The liver, spleen and kidneys were not palpable and no tenderness was elicited over the areas. No fluid thrill elicited or hernias seen.

Vulval examination

Inspection revealed a vulval swelling of about 5 cm diameter occupying mainly the posterior aspect of the right labia majora covering the vaginal introitus. The swelling was red, hot, very tender, and cystic. On the medial aspect of the swelling there was an opening through which the yellowish white pus was coming out. The Bartholon's gland on the left side was not affected. On milking the urethra yellowish pus came out also.

Vaginal examination

This was omitted because of the severe pain the patient was complaining of and tenderness.

Diagnosis: Bartholin's abscess (Right side)

Plan: For marsupialisation

Investigations

Haemoglobin 12.5 gm/dl. Total white cell count 6,500/Cu mm. The differential was normal. V.D.R.L. negative. Urinalysis was normal and culture grew no pathogens. Pus swab culture results revealed neisseria gonococci sensitive penicillin.

Operation: Marsupialisation of Bartholin's abscess

Premedication

Atropine 0.6 mg and pethidine 100 mg were given in the ward just before the patient was sent to the theatre.

Induction was done with sodium thiopentone 300 mg intravenously and the patient was maintained on nitrous oxide and oxygen by mask.

Procedure

The patient was placed in lithotomy position. The perineum, vulva, vagina were swabbed with hibitane solution and drapped with sterile towels. The partion of the abscess that was pointing was identified and using a sharp point blade a circular incision of about 2 cm diameter was made in the inner side of the abscess cavity on the vaginal side of the hymenal ring with the help of Allis forceps one which was placed superiorly and the other inferiorly so as to include the both the abscess skin and wall and retract themlaterally. About 100 cc of foul smelling pus was drained. A pus swab was taken for bacteriological examination. Finger exploration of the abscess cavity was done and the walls were found to be smooth and other small abscesses were palpable.

The edges of the new stoma were primmed and then Allis forceps were applied to the edges of the skin and abscess wall and 7 interrupted cutgut No. 2

sutures were applied circumferentially at about 1 cm apart. There was no bleeding from either the abscess cavity nor the edges and an aperture of about 2 cm diameter was left. Anaesthesia was discontinued and the patient taken to the ward.

Bacteriological results

The pus swab taken during the operation was found to have grown neisseria gonococci also sensitive to penicillin.

Post-operative treatment

1. Procaine penicillin fortified 1.2 run intramascularly daily for 7 days was started.
2. Savlon sit baths twice for 5 days.
3. Morphia 15 mg intramascularly 8 hourly 2 doses were given.

1st Post operative day - 8.00 a.m.

The patient general condition was good and the pain had decreased. Temperature was 37°C. Pulse 80/minute. Blood pressure 110/70. Vulval inspection showed the oedema had substantially decreased and the cavity was open and clean. She was walking satisfactorily.

She was discharged at midday and advised to continue penicillin injections at the dispensary and savlon sit baths twice daily for 5 days. She was also told to return after 10 days for check up.

Follow up - 11.2.1982

The patient came to the Gynaecology Clinic and she felt well and was walking normally.

Inspection of the vulva showed that the abscess cavity had no loculations and it had been covered with healthy mucous membrane. The edges were well healed and palpalion revealed no induration.

Vaginal examination

Vulva and perineum were normal and there was no discharged. Speculum examination showed a healthy cervix and vagina. The uterus was normal size, anteverted and mobile. No tenderness nor masses were revealed in the adnexia. The fornices were free.

The patient was discharge from the clinic.

Commentary

This was a case of Bartholin's Abscess treated by marsupialisation, antibiotics and savlon sit baths.

The commonest organism isolated in this condition is neisseria gonococci (1, 2) as shown in this patient. Sometimes secondary invaders such as E. Coli, Staphylococci aureus and anaerobes are isolated (1). Marsupialisation with a wide incision was done as an emergency in the theatre because delaying this procedure might have resulted in spontaneous rupture of the Bartholin's Abscess and subsequently recurrence rate is high and that due to scarring dyspareuma

might have ensued (2). Penicillin was started simulataneously while waiting for the culture and sensitivity reports on empirical grounds as neisseria gonococci is the commonest organism. The culture and sensitivity confirmed both the organisms and treatment. Post operative follow up was assential to ensure that no loculations were formed and the cavity healed from below upwards.

The next steop that was to be done in the follow up was to ask her to bring her partner for examination and treatment but because she did not have a regular partner this was not found possible. She was therefore advised to attend the venereal disease clinic to check up regularly.

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SUCCESSFUL REPAIR OF VESICO-VAGINAL FISTULA OF OBSTETRICS ORIGN

I.P. No. 165399

Name: Mrs. P.I., 18 years old, Mha, Moslem, P.1

Address: Mwandege, Kigoma

Date of admission: 5th April, 1980

Date of operation: 19th April, 1980

Date of discharge: 7th May, 1980

Summary

Mrs. P.I., sustained vesico-vaginal fistula 4 months ago after prolonged obstructed labour at home for 3 days after which assisted vaginal delivery was done in hospital and she delivered a macerated still birth continuous catheter drainage was maintained for 1 week only. A mid-vaginal fistula was found at examination under anesthesia with minimal fibrosis and fixity and a successful repair was done. The patient was advised against coitus for 3 months and told to attend antenatal clinic when she would again conveive so that elective caeserean section could be planned.

History of present illness

The patient was referred from Kigoma Regional hospital with a diagnosis of vesico-vaginal fistula which she sustained 4 months ago after difficult prolonged labour at home which started on 11th December, 1979.

She had been in labour for 3 days at home before she was sent by her relatives to a health centre where she was straight away referred to a regional hospital. There the delivery was assisted but the procedure was not stated, and the baby was a macerated still birth. A catheter was inserted but two days later she started leaking urine all the time. Further catheter drainage for 4 weeks did not stop the incontinence and after removal of catheter the patient was not voiding any urine.

She had fever in the puerperium for 3 days but denied any history of abdominal pain nor foul lochia. The fever was treated with chloroquine (penicillin and chlorophenicol) and was cured. She had no postpartum haemorrhage. Her bowels were normal.

Obstetrics history

P_{1+0} - She was primipara. She did not know the date of the last menstrual period but she said the pregnancy had reached 9 months and that the antenatal period was uneventful. She did not attend antenatal clinic.

Menstrual history

Menarch was 4 years to the time of admission. Her period were regular and not painful and the patient had not resumed menstruation since delivery The cycles used to be 4 days loss every luna month.

Past medical and surgical history

It was uneventful with no history of operations.

Family history

There was no history of tuberculosis, diabetes or any other chronic illness in the family.

Social history

Housewife and husband was a peasant. Both are illeterate.

General examination

Her general condition was good with a good nutritional state. She was short (144 cm), not anaemic, anicteric, afebrile (36.8°C) and not dehydrated. She had no ankle oedema or lymphadenopathy. She could walk without difficulty.

Mouth, throat and neck

Nothing remarkable. No thyroid enlargement or lymphadenopathy.

Breast

Normal and well formed. No lumps felt and they were not active.

Chest

Not dyspnoeic, trachea central. Chest symmetrical and air entry normal bilaterally. Breathing was vesicular with no adventitious sounds. Percussion was resonant bilaterally.

Cardiovascular system

Pulse was 76/minute regular, good volume. Blood pressure was 110/70 mm Hg. The heart was normal size and both sounds were normal with no murmurs.

Abdomen

No distended and no tenderness was elicited on palpation. The liver, spleen and kidneys were not palpable and not tenderness was elicited. There were no other masses palpable or hernia. No free fluid was demonstrable.

Vaginal examination

The vulva and skin were excoriated and wet with a smell of the urine.

The perineum was intact. Vaginal examination, digital examination showed no vaginal stenosis. Examination in sims lateral position showed clear urine coming out of a midvaginal fistula of about 1 cm diameter. The vaginal mucosa around the fistula was healthy and there was no fibrosis and the fistula was not fixed to the pelvic bone.

Cervix: Parous, firm and closed. No cervical excitation.
Fornices: There was no scarring and no masses felt.
Uterus: Anterverted, normal size, mobile.
Adnexia: Normal

Rectal examination

Normal and the external anal sphicter was normal.

Lower limbs

Gait was normal with normal muscle ion and power. The reflexes were normal with no sensory loss.

Planned management

As 4 months had already passed since it was caused, a repair was planned after investigations and examination under anaesthesia.

Investigations

Haemoglobin was 11.5 gm/dl. The white cell count was 5,000 per cu mm^3, with a normal differential count. The erthrocyle sedimentation rate was 6 mm/hour.

A pipette specimen of urine showed: Protein - trace. Pus cells - 2 per ml. Culture grew no pathogens. Blood group B Rh. D - positive. Blood urea 10 mg% and serum creatinine 0.6 mg%.

Intravenous pyelogram: Upper urinary tract normal. Ureters not dilated and no evidence of stenosis at the distal end. No evidence of calculi.

Examination under anaesthesia

Is essential inorder to assess the site, size, state of the surrounding tissue, fixity of the tissue to the bone and to decide on the technique and ideal position of repair.

Anaesthesia

As described earlier. Thipentone 300 mg intravenously for induction and maintenance on oxygen and nitrous oxide.

Procedure

The patient was placed in lithotomy position and skin around the vulva was swabbed with chlorhexidine and drappings were applied. An anvard speculum was inserted and a mid vaginal fistula about 1 cm diameter was seen. A metal catheter was inserted and the urethra was intact and communicated with the bladder. No other fistula was seen. The tissue around the fistula looked healthy and there was no fibrosis around the fistula. The posterior vaginal wall was intact and the uterus and its appendages were normal. It was found unnecessary to use methylene blue. Rectal examination revealed no defect in the anterior rectal wall. It was decided to repair the fistula in lithotomy position.

Operation - 19.4.1982

Repair of vesico-vaginal fistula

Anaesthesia

Premedication was with 0.6 mg atropine. Induction was on thiopentone 400 mg intravenously and the patient was relexed with scoline 60 mg intravenously and intubated. Maintenance was with oxygen and nitrous oxide, and the patient was rersed with 1 mg atropine and 2.5 mg prostigmine.

Procedure

The patient was placed in lithotomy position, swabbed with chlorhexidine, drapped and the labia minora were held apart by silk sutures to open the introitus. The fistula was identified and 5 mls of 1:200,000 adrenaline was infiltrated between the vaginal wall and the bladder wall all around to minimize bleeding and facilitate easy identification of tissue place of dissection. Using knife and then Mcindoe's scissors the vaginal skin was dissected away from the bladder for about 1 cm in all directions so as to achieve adequate mobility. Bleeding was minimum and homoestasis was achieved. The bladder wall was repaired transversely by interrupted stitches No. 2/0 extrachronic catgut. While inserting these stitches the mucosa was no penetrated and in the process of tying them starting at the lateral angles on either side, the edges were inverted towards the inside of the bladder. 6 stitches were place. A second layer of interrupted stitches using the same material was inserted. This layer of sutures in the bladder wall picled up the back of the vaginal flaps to obliterate dead space and slid the intact vaginal wall over the bladder repair line.

This closure was then tested by inserting a catheter and instilling about 40 mls of dilute methylene blue. It was water tight. The vaginal wall

was closed with chronic catgut No. 2/0 and these sutures consolidated the repair by picking up the underlying bladder wall. An indwelling Foley's catheter with a 10 mls blue was inserted and connected to a sterile plastic beg for continuous bladder drainage.

Post operative treatment

Continuous bladder drainage was maintained for 14 days. The urinary output was measured hourly for the first 48 hours so as to delect any blockade of the catheter early and the urinary output was aimed at 100 mls per hour of dilate urine so as to wash out the bladder. This was achieved by giving 3 litres of dextrose/saline intravenously as the patient could not swallow sufficient fluids to achieve this during the first 24 hours. Thereafter orange juice and tea were given so that the input per day was aimed at more then 3 litres fluid input and output was satisfactory.

The patient was nursed in bed and was given 100 mg of pethidine p.r.n. for the first 24 hours. 3 injections were given.

100 mg of furadantion tablets were given three times daily for 14 days.

The patient did not need blood transfusion as bleeding was slight.

1st post operative day

The general codnition of the patient was good as she felt comfortable. She was not anaemic, afebrile (37.2°C). Pulse 86 per minute regular and good volume. Blood pressure 120/70 mm Hg.

Chest: Clear

Abdomen

Not distended and no tenderness elicited. The catheter was draining satisfactorily. The input of fluids was 2,800 mls in 18 hours and the output was 2,500 mls. Plenty of oral fluids were encouraged to be taken.

2nd - 13th day

The post operative course was uneventiful. Continuous catheter drainage was satisfactory.

14th post operative day

The catheter was removed. The bladder required a period of retraining and a bed pan was offered hourly at first for 24 hours and then duration was increased as the distensability of the bladder improved.

22nd post operative day

A test of cure of the repair was done under general anaesthesia by instilling methylene blue via catheter into the bladder and no leakage was seen.

Then in the ward while awake the bladder capacity was measured and found to be 150 mls.

7th May 1980

Patient was discharged. All this time she did not experience stress incontinance. She was advised to refrain from intercourse for six months so as to allow proper healing. It was also emphasised to her the importance of attending antenatal clinic early at a gestation of 3 months when she next got pregnant so that she could be prepared wellin advance for elective caeserean section. A letter was written to the District Medical Officer Kigoma explaining what had been done and the instructions given to the patient.

Commentary

A case of mid vesico-vaginal fistula which was successfully repaired has been described.

In the African, vesico-vaginal fistula is a common problem and in most cases it is due to obstructed labour for several days at home due to cephalopelvic disproportion (1, 2, 3, 7). As it has been shown in Dar es Salaam the average height of an African primigravida is 148.5 cm (4) and height below 150 cm is associated with contracted pelvis (2,7). Prolonged obstructed labour leads to pressure necrosis and eventually the bladder wall and vaginal wall may slough off leaving a fistula (2, 3).

The majority of such patients did not attend antenatal clinic or they underwent unsupervised labours as demonstrated by this patient. Ignorance, inadequate facilities and transport have been cited as major causes also (1, 2, 3).

Continuous catheter drainage for up to six weeks is recommended in such patient when they first present (1, 2, 5). This leads to spontaneous closure or reduction in size of the fistula. This patient had only 1 week of catheter drainage at the regional hospital.

Lawson, (2, 5) recommends that 3 to 6 months must elapse before repair of obstetric fistula is attempted as by this time the inflammation around the fistula will have subsided; tissue planes of dissection can be identified; the fistula will had reduced in size and the blood supply will be good.

The success of repair ranges from 40.4% in Dar es Salaam (6) to 74.3% in Ghana (7). Besides personal experience (2) success is also attributed to fibrosis, scarring around the fistula and fixity to bony pelvis, size of the fistula and infection of tissues and urinary tract (1, 2, 3, 6, 7). Besides, mid-vaginal fistula are the easiest to repair when not associated with the unfavourable factors mentioned above (8).

Post operatively continuous catheter drainage was instituted so as to relieve tension off the suture line. Plenty of fluids were also given so as to produce dilute urine which would wash away any debris and clots that might have blocked the catheter. To minimize urinary tract infection nitrofurantoin was given as long as the patient had an indwelling catheter.

The repair was a success according to the oriterion used by most surgeons of continence both during day and night time (3, 6). The criterion of complete cure advanced by Coetzee et al (3) has the following:

1. Full continence all the time with the ability of the bladder to hold at least 170 mls of urine.
2. Lack of stress incontinence
3. Absence of dyspareunia.
4. No traumatic ammenorrhoea.
5. Patient should be able to bear children.

Stress incontinence after repair of vesico-vaginal fistula can be just as bad as the original fistula and it normally occurs after repair of juxta urethral and massive fistula (8). This patient fortunately did not develop stress

incontinence Massiw (6) found that traumatic ammenorrhoea of duration ranging from 8 months to 5 years occured in 46.8% of the patients in his study and it is attributed to severe endocrine upset and most of these patients resume menstruation after a successful repair (2, 6). It is hoped that this patient will resume menstruation after some time.

After a successful vesico-vaginal fistula repair a caeserean section is preferred in delivering the patients in subsequent pregnancies (1. 2. 3, 5).

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MULTIPLE MYOMAS TREATED BY TOTAL ABDOMINAL HYSTERECTOMY

I.P. No. 169052

Name: I.C., 45 years, Chagga, Christian, Para 1+1

Address: Kisiju, Coast Region

Admitted: 1st July 1980

Operated: 2nd August, 1980

Discharged: 12th August, 1980

Summary

A case of fibroid with left tube-ovarian mass, and pelvic adhesions and menorrhagia, was treated by total abdominal hysterectomy and left salpingo-oophorectomy. Although the patient had also secondary infertility, the complications already mentioned and the advanced age made her chances of conceiving small. The left ovary was preserved as it was normal and the patient had not reached menopause. The patient subsequently made good progress.

History of present illness

The patient was referred to Muhimbili Medical Centre gynaecological outpatient clinic from Kibaha Health Centre with the complaints of lower abdominal swelling for the past 2 years and heavy monthly period for 1 year.

The lower abdominal swelling had been gradually increasing in the past 2 years and for the past 1 year she could feel a hard mass in the lower abdomen. She simultaneously started to experience painful heavy periods. The pain occurred 2 to 3 days prior to menstruation and subsided towards the end of the periods. The pain was colicky, non radiating with no known aggrevating or relieving factors. It was associated with nausea but not vomiting. She could not go to her farm during the attacks. The periods were heavy and associated with clots but there was no history of fainting. She denied history of dysurea, frequency haematuria, fever, dyspareumia, vaginal discharge or post coital bleeding. She was not losing weight.

Menstrual history

Menarch was at 14 years. The cycles used to be 3 to 4 days loss every 28 days normal flow, regular and not painful. For the past year the cycles have been 6 to 7 days every 28 days, heavy with clots the size of groundnuts, painful but regular. The last menstrual period was 15th June, 1980.

Obstetrics history - P. 1+1

1961 had a full term normal delivery at a health centre. Pregnancy and puerperium were normal and the baby is alive and well.

1963 aborted a 3 months pregnancy at home. Patient was not evacuated but she did not have fever

or foul discharge after evacuation.

She had never been on any contraceptives.

Past medical and surgical history

There was no history of any major illness or surgical operations. No history of venereal diseases.

Social history

Housewife. Husband owns a small shop in the village. Does not drink or smoke.

Family history

She denied history of diabetes, tuberculosis or any other chronic illness.

Clinical examination

She was in good general condition and not anaemic, jaundiced or dyspnoeic. There was no oedema or lymphadenopathy. Temperature was 37°C.

Head and neck: No abnormality was detected

Breasts

Well developed without any masses or secretions

Chest

Normal chest with normal bilateral air entry.

Cardiovascular

The pulse was 76 per minute, good volume. The blood pressure was 110/70 mm Hg. The heart was not enlarged and the sounds were normal.

Abdominal examination

There was fullness of the hypogastrium despite the fact that the patient had passed urine just before the examination. The abdomen moved with respiration. A mass of a size of 18 weeks, firm, multinodular with limited, tender, mobility. The left iliac fossa was also tender. There was no guarding or rebound tenderness. The liver, spleen and kidneys were not palpable and there was no free fluid present.

Vaginal examination

The vulva and perineum were normal and there was no discharge. Speculum examination revealed a parous cervix which was healthy. The vaginal walls were normal. On digital examination the cervix was firm and closed. The uterus was the size of 18 weeks pregnancy firm and multinodular with limited mobility. There was tenderness on moving the uterus and cervical excitation was positive. The fornices were normal. The left adnexum was tender a mass could be felt extending to the uterus. The right adnexum was normal.

Rectal examination

It was normal and earlier findings were confirmed.

Diagnosis

Uterine fibroid with left tubo-ovarian mass and pelvic inflammatory disease. It was explained

to the patient that she had to undergo total abdominal hysterectomy and that she would not menstruate or conceive after that and she consented.

Plan

As the patient was staying far, she was admitted for investigations for 1 week after which she was discharged and told to come after 5 weeks for hysterectomy.

Investigations

Haemoglobin was 10.5 gm/dl.
White cell count was 4,500 per Cu mm.
The differential count was normal
Blood group was B positive
Blood urea was 15 mg% and serum creatinine 0.5 mg%

Urinalysis was normal and culture was sterile. Endocervical and urethral swabs for microscopy, culture and sensitivity showed no pathogens.

Intravenous pyelogram showed normal functioning kidneys ureters and bladder were normal.

Pre-operative treatment

Fersolate 200 mg t.id. were given daily for one month so as to raise her haemoglobin.

Folic acid 5 mg was also given.

1st August, 1980

The patient was admitted for total abdominal hysterectomy. Her general condition was good and the haemoglobin was 11.5 gm/dl. There was no sugar or protein in the urine. Blood pressure was 120/80 mm Hg. and pulse 80 good volume. 3 pints of blood were requested and the patient was shaved and given simple enema the night before she was to be operated on 2nd August, 1980 at 8.00 a.m.

2nd August, 1980

Operation - Total abdominal hysterectomy with left salpingo-oophorectomy.

Premedication

Atropine 0.6 mg and pethodine 100 mg intramascularly.

Anaesthesia

Induction: 400 mg thiopentone and relaxed with 40 mg suxamethonium and than intubated. Maintenance on oxygen, nitrous oxide and other 4 mg Pavulon was given for prolonged relaxation. The patient was reversed with 1 mg atropine and 5 mg neostigmine.

Procedure

The bladder was emptied by aseptic cathetirization. The vagina was swabbed with chlorhexidine solution. The abdomen was swabbed with equous chlorhexidine and followed by flavine in spirit.

The abdomen was opened through a subumbilical midline incision. The findings were:

1. Uterine fibroid mass of 18 weeks size of pregnancy, with multiple subserous and intramural myomas.
2. Left tubo-ovarian mass
3. Adhesions tethering the left tubo-ovarian mass and uterus to the bowel, peritoneum, and omentum. There was no free fluid and except for slight peritubular adhesions on the right tube, the right ovary was normal and all other organs were normal.

The adhesions were released using Mclndoe scissors and blunt dissection as gently as possible and the bowels omentum and peritoneum were separated from the uterine fibroid and the left tubo-ovarian mass. A myomectomy screw was inserted into the fibroid uterus and the tumour was delivered out of the abdomen. A self retaining and Doyens retractors were inserted so as to provide good view of the organs. The round ligament on the right side was doubly clamped with Kocher's artery forceps and cut in between the forces and ligated with chromic catgut No. 2, leaving a length of catgut on the round ligament. The infundibulopelvic ligament was also clamped by three Kochers artery forceps and cut in between the middle and distal clamps. Chromic catgut No. 2 was put on the proximal infundibulopelvic ligament and a second ligature was applied again just

distal to the first. The uterus was then drawn over the left side and clamps were applied over the ovarian ligament and the Fallopian tube and the tissues between the clamps divided. The same was done to the round ligaments. Chromic catgut No. 2 used to ligate the pedicles.

The fascial planes of the broad ligament were separated by finger dissection and the anterior leaf was devided with Mayos Scissors first downwards then transversely to the opposite side and the bladder was pushed down. The peritoneum was stripped from the upper surface of the broad ligament as far as possible, care being taken to identify by palpation the position of the ureter. The above procedure was repeated on the left side.

The uterus and the left tubo-ovarian mass were then pulled over to the right side and the uterine vessels on the left side were clamped triply and cut between the upper most Kocher's forceps and the one next to it. The lower ends of the blood vessels doubly tied with No. 2 chromic catgut which had been fixed in the paracervical tissues. The left ureter was identified and traced to the bladder before applying Kochers to the parametria tissues very close to the cervix and its tip at the level of the

left lateral fornix. The parametria was divided medially with a scapel and the sutures applied as before. The same procedure was done on the right. The pertitoneum over the bladder was drawn upwards to expose the vesicouterine ligament which was cut through transversely with a scapel to open the vesicocervical space. The pillars of the bladder (colliscus vesicae) were divided. The bladder was further mobilized and displaced downwards from the cervix and upper vagina. The uteroscral ligaments were both clamped, divided in between clamps and ligatured with chromic catgut No. 2. The lip of the cervix was identified by bimanual palpation and pulling on the cervix upwards a stab incision was made into the vagina anteriorly just below the cervix. The vagina was then cut around close to the cervix with Mayo's scissors so that the uterine fibroid mass together with the left tubo-ovarian mass were removed. The vagina vault was held with Allis forceps and the vaginal angles on either side held with Hawkin's clamps so as to ligate the paravaginal plexus of veins.

The vaginal vault was then closed with mattress sutures of catgut chromic No. 2. After fixing the cut ends of the round ligaments to the lateral corners of the vaginal cuff, peritonization was done with continuous chromic catgut No. 0, care being taken not to injure the ureters.

The abdominal packs were removed and the appendix was inspected and found normal, swab and instrument count was done and found normal. The abdomen was closed in layers as described in ..... Blood loss during the operation was 800 mls.

The patient was transfused with 3 units of blood after the operation.

Post operation treatment

Pulse, blood pressure, respiration were monitored hourly for 12 hours. Then 6 hourly for 48 hours. Temperature was recorded 6 hourly.

Continuous catheter drainage was started and the output of urine was recorded hourly for six hours, then six hourly. 2½ litres of dextrose/saline were given in the first 24 hours. Pethidine 100 mg 6 hourly was given for 48 hours.

Macroscopic examination of the mass

The mass removed weighed 0.75 kg. Besides the subserous fibroids., there were intramural and submucous fibroid which distarted the uterine cavity. The left tube and ovary are connected by a cavity and there was clear fluid.

Histology report

Leioyomyoma: The endometric is in proliferative phase. The tube and ovary show evidence of chronic inflammation.

Post operative progress

1st post operative day: General condition was fair. There was no vaginal bleeding. She was not anaemic. Temperature 37°C. Pulse 88 per minute good volume. Blood pressure 130/80 mm Hg. Chest clear. Abdomen was not distended; soft and not tender. Bowel sounds present. Urinary output was 1,500 mls in 24 hours. Oral sips were encouraged and the catheter was removed.

2nd to 7th Post operative period

The condition of the patient remained good. Flatus was passed on the second day and ambulation was also started on the second day. Pulse, blood pressure, and temperature remained normal. Haemoglobin on the 3rd day was 11.8 gm/dl and the alternate stitches were removed on the 6th day and the remaining stitches on the 7th day. The wound had healed by first intention and no haematomas or abscesses developed in the pelvis. The vaginal vault healed well. The patient was discharged in the 10th post operative day with instruction to return at the gynaecological clinic after 6 weeks.

Follow up - 30.9.1980

The patient reported at the clinic. Her general condition was quite good. Her haemoglobin was 12.1 gm/dl. The abdominal scar was well healed and so was the vaginal vault. The pelvis was normal.

Commentary

A case of multiple uterine fibroid with left tubal ovarian mass and pelvic adhesions has been described. The patient also had secondary infertility. Firbomyomata is the commonest occuring tumour African women (1) and poses a problem in management because it occurs in young age group commonly in association with chronic inflammatory disease which lead to tubal blockede and infertilty. Such patients although they might also have huge fibroids, they are often reluctant to undergo total abdominal hysterectomy and prefer myomectomy which sometimes leads to recurrence of a new crops of myomas and more adhesions.

Her chances of conceiving were reduced because of her advanced age, tubo-ovarian mass and adhesions leading to tubal blockade and the multiple fibroids. Myomectomy was therefore discouraged in view of the above and the concurrent chronic pain and menorrhagia. Fortunately after explanation the patient agreed to a total abdominal hysterectomy and left salpingo-oophorectomy. The right ovary was preserved because it was normal.

The cause of infection in this patient might have been post abortal. When she aborted in 1971 she was not evacuated and since then she did not conceive and the chronic lower abdominal pain started.

It might have also been a sequela of gonococci salpingitis which is common (1) although the patient denied any history of fever, lower abdominal pain, dysurea, and vaginal discharge before this problem started.

Subtotal hysterectomy is rarely done because the retained cervical slump might be the source of symptoms such a bleeding discharge and cervical malignancy. It is occasional done in patients with extensive pelvic adhesions such as those seen with pelvic abscess and endometriosis or subtotal hysterectomy may be done in a patient with a poor general condition who cannot stand prolonged surgery as this procedure is easier and carries less risks of injury to the ureters (2).

Vaginal hysterectomy was not preferred because of the big size of the tumour with the adhesions and also as there was suspected ovarian pathology inspection of these organs was possible through the abdominal route (2).

The right ovary was conserved because the patient was not menopausal and it was normal.

References

1. Lawson, J.B. and Stewart, D.N.: Obstetrics and Gynaecology in the Tropics and Developing Countries 1967.
2. Jeffcoate, T.N.A. (1974): Principles of Gynaecology.

MOLAR ABORTION

I.P. No. 171766

Name: Mrs. B.A., 33 year old, Nyiramba, Christian,

$P_5 + 1$

Address: Msasani, Dar es Salaam

Date of admission: 5th September, 1979

Date of discharge: 22nd September, 1979.

Summary

Mrs. B.A. was referred from peripheral clinic because she had ammenorrhoea of 18 weeks but fundal height was 22 weeks and she developed irregular vaginal and eventually aborted a mole. Evacuation was done twice at 7 days interval. The pregnancy test became negative after two weeks and the chest X-ray were normal. Follow up at the gynaecology clinic for 1 year revealed no history of irregular bleeding or ammenorrhoea, chest pains or cough. The pregnancy test and chest X-rays were peristently negative.

History of present illness

The patient was referred from Mnazi Mmoja dispensary and admitted through the Casualty Department. She gave a history of 4½ months ammenorrhoea which was followed by painless on and off vaginal bleeding for the past 2 weeks. The patient did not seek medical advice until 5th September, 1979 at about 4.00 a.m.

when the bleeding became heavy with big clots and it was associated abdominal cramps. The clots were of the sixe of an egg and resembled pieces of meat.

She denied seeing any products of conception.

Antenatal care

The patient had not attended antenatal clinic and she had not felt fetal movements throughout this pregnancy.

Obstetrics history

This was the 6th pregnancy and she had 5 living children. Her 1st pregnancy was in 1968 and she gave birth to a full term normal delivery at Ocean Road Hospital. The baby is alive and well. She subsequently gave birth to 4 more babies at Ocean Road Hospital. All were full term normal vertex deliveries. She had no problem antenatally and in the puerperium.

Menstrual history

Her age at menarch was 14 years. The last normal menstrual period was mid May 1979. Ammenorrhoea of 16 weeks on admission. The cycle used to be 3 days loss every 30 days. It was regular and not painful.

Family history

No history of chronic illness in the family

Social history

Housewife. Husband is a vendor at Msasani market.

Previous medical and surgical history

Nothing significant

General examination

The patient was weak and felt dizzy. She was anaemic, not dyspnoeic, anicteric, not dehydrated and no oedema lymphadenopathy. Temperature was 37.2°C. Pulse 110 low volume but regular. Blood pressure 90/50 mm Hg.

Breasts

Well developed and active. No lumps palpated.

Respiratory system

Trachea central. Chest symmetrical. Air entry was normal bilaterally. Breathing was vesicular and there were no adventitions sounds. Percussion was resonant bilaterally.

Cardiovascular system

The heart size and sounds were normal. There were no murmurs.

Abdomen

Distended mainly in the hypogastrium, with a uterine size equal to 22 weeks pregnancy (Period of Gestation was 16 weeks). The uterus was soft and non tender and no fetal parts were felt. The fetal heart was not heard. No other mass was palpable and

the liver, spleen and kidney were not palpable and there was no sign of free fluid in the abdomen.

Vaginal examination

Bleeding was continuing with clots. The vulva and perineum were normal. The vagina skin was pale. The cervix was soft and the os was 4 cm dilated. Grapelike vesicles started coming out and were mixed with clots. The fornices were clear. The uterine size was 22 weeks and no massess were palpable in the adnexia.

Diagnosis: Hydatid form mole being aborted

Management

10 units of syntocinon was put in 1 litre of 5% dextrose and drip started intravenously. 1 litre of plasmogel drip was also started. Blood for grouping and crossmatching was simultaneously taken. After 90 minutes 2 units of group O positive became available. The patient was sent for evacuation as described in ..... In the theatre before evacuation was started a large mole was expelled. Thereafter bleeding was slight. Evacuation was done very gently using a placental forceps and thereafter a blunt currette was used gently. Scanty endometrial tissue was obtained. Both the aborted mole and the scanty tissue were sent for histology.

Investigations

Baseline pregnancy test was positive at a dilution of 1/400 and the 24 hour urinary gonadotropin was 700,000 units/24 hours.

Haemoglobin was 7.5 gm/dl. The urine had no albumen and no sugar. Chest X-ray showed no evidence of metastases or other lung diseases.

Histology of aborted mole

Hydatid form mole with little trophoibilastic activity. No evidence of malignancy.

6th September, 1979

2 more units of blood were available and transfused. Her general condition was good. She had mild palour. The pulse was 80 good volume and regular. The blood pressure was 120/80 mm Hg. Temperature was 36.8°C. There was no bleeding per vagina.

7th Sept. - 12th September, 1979

She had another pint of blood. Her general condition remained good. Haemoglobin rose to 10.5 gm/dl.

13th September, 1979

Dilatation and curretage was done again. Induction was with thiopentone 500 mg intravenously and maintained on nitrous oxide and oxygen. The patient was placed in lithotomy position cleaned, catheterized and drapped.

Vaginal examination

Vulva and vagina - normal. Cervix was patulous and admitted tip of a finger. Uterus was slightly bulky 6 - 8 weeks.

The fornices were clear with no cystic masses and there were no masses in the adnexia or tenderness.

Dilation and curratage was done as described in ..... Scanty endometrial tissue was obtained and sent for histology. Bleeding was slight.

2nd histology report

Clotted blood mixed with decidue and villi. No trophoblastic activity noted.

13th September, 1979

General condition of patient remained good. She was not anaemic and was afebrile. Pulse was 80 good volume. Blood pressure was 120/80 mm Hg. Haemoglobin was 11.5 gm/dl. Pregnancy test was repeated and found positive at a dilution of 1/40 and simultaneous. Human chronic gonodotropins was 30,000 IU per 24 hours.

14th - 19th September, 1979

The patient condition remained good. Pregnancy test was repeated and found negative on the 19th September, 1979.

20th September, 1979

The patient was discharged and told to attend the gynaecology outpatient clinic as follows:

i. Once monthly for 6 months.

ii. Thereafter once very two months for 6 years and

iii. Thereafter once every three months for 1 year.

She was asked to postpone pregnancy for 2 years and during this time she was put on noriday contraceptive pills.

22nd October, 1979

General condition of patient was good. These was no history of ammenorrhoea, irregular bleeding, chest pain, cough headaches or blurred vision. On examination she was no anaemic. Pulse 80 good volume. Blood pressure 120/70 mm Hg. Chest was clear with vesicular breathing and the breast were normal and not lactating. Per abdomen the uterus was not palpable vaginal examination revealed normal size uterus, anteflexed and mobile. The cervix was healthy and closed. The fornices were free and there were no adnexal masses.

Subsequently the patient made 7 more visits for a period of about 12½ months and she did not come again. During all the visits no abdormal finding was detected.

Commentary

The incidence of hydatidform mole was 1/2,000 in U.K., 1/1,500 in Kampala, 1/200 in Far East (1).

The disease occurs more common in elderly gravid women of high parity (1, 2).

The diagnosis was made easy because the patient expelled spontaneously the vesicles. The patient was evacuated in the theatre under syntocinon using placental forceps and gentle currettage. The use of this regime is not favoured by some authors because trophoblastic tissue is easily spread. Suction evacuation, which is not available at Muhimbili hospital is preferred. As for those patients who have completed there families and are over 35 years old total abdominal hysterectomy (1,2) is recommended. This patient, however, categorically refused a total abdominal hysterectomy as she wanted more children.

Most authors feel that prophyllactic methotraxate before evacuation under syntocinon is not worth it as the drug is toxic and deaths have been reported from drug reaction.

The pregnancy test became negative on the second week after admission. The patient was then briefed on the importance of coming for follow up and she was told to come at the gynaecology outpatient department

once monthly for six months then once every two months for six months and thereafter once very three months for 1 year. She was also put on the pill during this time so as to avoid pregnancy which might have confused the picture. During the follow-up at each visit she did not have a history of irregular bleeding nor ammenorrhoea and the pregnancy test was persistently negative for 1 year. 2 Chest X-rays done at 3 months interval were negative and the patient had no chest complaints. Sensitive radio immuno assays tests some of which detect B-subunit of human chronic conadotrophin thus defferentiating it from luitenizing hormone, have been recommended when pregnancy test becomes negative. This test is not available at Muhimbili hospital.

After 1 year the patient did not turn up for another 1 year. Dewhurst (1) feels that a patient can be allowed to get pregnant after 1 year.

References

1. Dewhurst, C.J. (1976): Integrated Obstetrics and Gynaecology for Postgraduate.

2. Novak, E.R. and Weedruff, J.D. (1967): Gynaecological and Obstetrics Pathology.

TORSION OF A DERMOID CYST TREATED BY SALPINGO-OOPHORECTOMY

I.P. No. 165685

Name: Mrs. R.D., 25 year old, Nyamwezi, Christian, P. 4

Address: Oysterbay, Dar es Salaam

Date of admission: 6th June, 1980 - 8.00 p.m.

Date of operation: 6th June, 1980 - 10.00 p.m.

Date of discharge: 14th June, 1980

Summary

Mrs. R.D. was a knwon patient with an ovarian cyst and had had two mild attacks of lower abdominal pain which subsided spontaneously before she had a severe attack of lower abdominal pain and a laparatomy was done. Torsion of left ovarian cyst was found but it was not gangrenous. Left salpingo-oophorectomy was done and bisection of the cyst and histology revealed that it was benign dermoid cyst. The patient did well in the post operative.

History of present illness

The patient was admitted to the gynaecological ward through the casualy department with the complaints of sudden onset of lower abdominal pain for the past 12 hours. The lower abdominal pain was mainly felt in the left iliac fossa. It was colicky intermmitent,

non-radiating and there were no aggrevating or relieving factors. It was simultaneously associated with nausea and vomiting. The patient vomited four times before admission and the colour of the vomitus was clear.

She had had two similar attacks in the past month but they were mild and unassociated with vomiting. The attacks subsided spontaneously.

She denied any history of fainting, vaginal bleeding, fever, cough, pregnancy of micturition or dysurea. She had passed stool once since the onset of symptoms.

Past medical and surgical history

The patient admitted that she was diagnosed as having a ovarian cyst 2 months ago at a private clinic. There was no history of surgical operations.

Menstrual history

Menarch was at 14 years of age. Menses - normal flow, regular and associated with lower abdominal pain 2 days before the start of the period and the pain was worse during the first 2 days of the flow and then subsided thereafter.

The pain started after insertion of lippes loop 4 months ago and the loop was removed 2 months ago at a private clinic because of the pain. The patient

was then put on tetracycline and she subsequently got some relief.

Obstetrics history - P. 4 + 0

1st pregnancy 1968, full term normal delivery at Ocean Road Hospital. Baby alive and well. Pregnancy and puerperium were normal. She subsequently gave birth to three more children. All were full term normal deliveries at Ocean Road hospital and there were no complications during pregnancy and puerperium.

Family history

There was no history of tuberculosis or any chronic illness in the family.

Social history

An accountant with the National Bank of Commerce. Husband works with Ministry of Finance.

Clinical examination of the patient

The patient was in pain. Not anaemic, Afebrile, anicteric. No oedema, and no lymphadenopathy.

Mouth, throat and neck: No abnormality detected

Chest: Not dyspnoeic normal

Cardiovascular system

Pulse 110 per minute, regular, good volume. Blood pressure 120/80 mm Hg. Heart - normal.

Abdominal examination

There was moderate distension over the lower abdomen and the abdomen moved with respiration but no visible peristalsis. The lower abdomen and especially the left iliac fossa was very tender and there was guarding. It was difficulty to palpate for any mass in the lower abdomen because of the tenderness and guarding. Rebound tenderness was demonstrated in the lower abdomen. There eas no evidence of free fluid in the peritoneum and there were no hernia. The liver, spleen, and kidneys were not palpable.

Vaginal examination

Vulva and perineum were normal and there was no discharge or bleeding. On specullum examination the vaginal walls were normal. The cervix was parous and healthy. On digital examination the cervix was firm and excitation pain was present. The fornices were tender especially the left but they were free. No mass palpable in the pouch of Douglas. A cystic extremely tender mass, about 5 cm diameter was felt in the left adnexia. It was difficult to continue with the palpation of the mass in view of the pain and tenderness. The right adnexia was slightly tender but there was no mass. The uterus was normal size, ant-verted and very tender on mobility.

Rectal examination

No abnormality was detected in rectum. Earlier findings were continued and a mass in the left iliac fossa was felt.

Diagnosis

A preliminary diagnosis of Tortion of the ovarian cyst was arrived at and the following differential diagnoses were kept in mind:

1. Ruptured extopic pregnancy
2. Acute salpingitis

Investigations

1. Haemoglobin 12.5 gm/dl.
2. White cell count 4,700 per Cu mm. The differential count was normal.
3. Urinalysis was normal. Culture of the midstream grew no pathogens.
4. X-ray of abdomen - no fluid levels, no gas shadows were seen.
5. Blood group A positive
6. 2 pints of blood were booked

Management: Emergency laparatomy was considered

6th June, 1980 - 10.00 p.m.

Left salpingo-oophorectomy. Premedication. Atropine 0.6 mg and pethidine 100 mg intramascularly.

Anaesthesia

Induction was with thiopentone 350 mg and 40 mg suxamethonium bromide, and intubated. Maintenance was on oxygen, nitrous oxide, and other.

Procedure

The patient was kept in a dorsal position and the vulva and vagina were swabbed with savlon solution.

The bladder was emptied by means of a catheter inserted aseptically.

The abdomen was then swabbed with acqueous chlorhexidine and then with flavine in spirit and drappings were applied.

A median subumbilical incision was made.

Findings

1. Clear fluid was present
2. Left ovarian cyst, about 5 cm diameter which had twisted two turns on its long padicle. The cyst was hyperemic but had not become gangrenous. There were peritubular adhesions extending from the left tube to the ovarian cyst, the uterus and peritoneum.
3. The uterus, right tube and ovary looked normal.
4. The appendix was normal

The fluid was sucked out and the adhesions released. The cyst was delivered out of the abdomen, untwisted and left salpingo-oophorectomy done by clamping the infundibulopelvic and ovarian ligaments and the tube with Kocher's forceps. Caution was exercised while clamping the infundibulopelvic ligaments so as not to injure the ureter on that side. The cut ends were then tied with catgut No. 2. Hemostasis was achieved and the abdomen was closed in layers. The left ovary and tube were sent for histology.

Macroscopic appearance of the cyst. The cyst was bisected in the theatre, and gelatinous material mixed with hairs was seen. The bisected cyst was sent for histology.

Immediate post operative care

1. Pulse, blood pressure, and respiration were minitored hourly for 6 hours. Then six hourly for 24 hours and then twice daily. The temperature was recorded twice daily. Input and output chart was started.
2. 2½ litres dextrose saline was given daily for 2 days.
3. Pethidine 100 mg i.m. was given six hourly for 2 days.

1st post operative day

The general condition was good. Flatus not yet passed. The patient was not anaemic; Afebrile (37.2°C). Pulse 8.4 per minute, regular, good volume. Blood pressure 120/70 mm Hg. Chest - clear. Abdomen not distended, soft, and bowel sounds present. Oral sips were started.

2nd to 7th post operative day

Progress was good. The patient was ambulant on the second day and had passed flatus. Haemoglobin was 11.5 gm/dl. The skin sutures were removed on the 7th post operative day. The wound had healed nicely. The patient was discharged on the 8th post operative day with instruction to report after 4 weeks.

Histology report

Macroscopy: Cyst with greasy and hairy materials

Microscopy: Features consistent with Dermoid cyst (Benign leratoma).

Follow up - 30.7.1980

The patient came for check up. She felt well and had one period was painless and normal flow. She had not experienced any attacks of abdominal pain again skin to the ones she had before the operation.

The abdominal wound had healed well.

Vaginal examination

The vulva and perineum were normal. Speculum examination. The vaginal walls were normal, and the cervix was healthy. On digital examination the fornices were not tender and free. Both adnexia were not tender and there was no mass. The uterus was normal size ant-verted, mobile. The patient was discharged.

Commentary

A case of torsion of a dermoid cyst treated by left salpingo-oophorectomy has been discussed. Torsion of ovarian cyst normally occurs when the cyst is benign of moderate sixe and long pedicle. Interaction and infection of the cyst may occur as the blood supply is cut off. This did not occur in this patient. The diagnosis of torsion of on ovarian cyst was easy because this patient knew that she had an ovarian cyst some months before torsion occured as the diagnosis was made at a private clinic. She claimed that she was not told of the necessity for operation to remove the cyst. She subsequently had two attacks of severe abdominal pain which were not associated with bleeding and the pain later subsided spontenously. The patient unfortunately did not seek medical advice as the pain had been due to twisting of the cyst and later untwisted thus alleviating the condition. The patient

thought it was due to secondary dysmenorrhoea although the pain was one week after menstruation.

The other possible conditions which could have caused acute abdomen were thought of and these included ruptured ectopic gestation as the patient had been on a loop and it was removed because of secondary dysmmenorrhoea associated with irregular bleeding. The patient however, was not anaemic and there was no history of ammenorrhoea. Signs of pregnancy were no found.

Acute salpingitis was also considered but since the patient had no fever or vaginal discharge it was disregarded.

Dermoid Cyst commonly occur in young women and they are normally unilateral in about 90% of the patients (1). The chances of a dermoid cyst becoming malignant is 1% (2). This patient was fortunate in that only one ovary was involved.

References

1. Dewhurst, C.J. (1976): Postgraduate Obstetrics and Gynaecology 44: 777 - 778.

2. Novak, E.R. and Woodruff (1974): Gynaecological and Obstetrics Pathology, p. 400

IMPERFORATE HYMEN ASSOCIATED WITH HAEMOTOCOLPOS

InP. No. 173687

Name: Miss. C.C., 17 year old, Gogo, Moslem

Address: Msasani, Dar es Salaam

Date of admission: 5th November, 1980

Date of operation: 7th November 1980

Date of discharge: 11th November, 1980

Summary

Miss C.C. presented with cyclical lower abdominal pain and lower abdominal swelling and had not had her menarch dispite the fact that both her twin sisters who were younger, had menstruated.

An imperforated hymen leading to haemotocolpos was diagnosed and after cruciate incision she was cured. She subsequently had two normal monthly periods.

History of present illness

The patient was admitted through the casualty department with the complaints of lower abdominal pain and swelling for 6 months and failure to menstruate.

The patient had been noticing for the past twelve months cyclical lower abdominal pain which used to occur at the beginning of every month for about 3 days. The pain was collicky and was gradually increasing every month. It was associated with vomiting and there were no known aggrevating

or alleviating factors. Six months later she started noticing a lower abdominal swelling that was gradually increasing in size. She did not complain of urinary symptoms and her bowel were normal.

Although she was 14 years she had no started menstruating. Her two young sisters who were twins and aged 14 years had already started their periods.

Menstrual history

The patient had not commenced menstruation yet

Obstetrics history

Nulliparous. No history of abortion

Past medical and surgical history

She did not suffer from any chronic illness and had not undergone any surgical operation.

Family history

There was no history of diabetes, tuberculosis, mental illness, hypertension and heart diseases in the family.

Social history

She was not married and she had been living with her parents since she completed standard VII primary school education in 1978. Her parents were both working at the Post Office Headquarters. She had twin sisters and three brothers and all were in good health.

General examination

Her general condition was good. She was not anaemic, jaundiced or dehydrated. There was no oedema of the legs or lymphadenopathy. Temperature was 37°C. Voice was femine and the pubic and axillary hair was normal and of femine distribution.

Head and neck: Nothing remarkable

Breasts

Normal development and no lump was palpable

Respiratory system

She was not dyspnoeic. Breath sounds were normal

Cardiovascular system

The pulse was 80 per minute, regular and good volume. The blood pressure was 110/70 mm Hg. The heart size and sounds was normal and there were no murmurs.

Abdominal examination

The abdomen was distended in the suprapubic region and was moving with respiration. There was a mass in the suprapubic region which was arising from the pelvis and the size of 16 weeks pregnancy. The mass was tender firm mobile with a smooth surface. There was no free fluid in the abdomen. The liver, spleen and kidneys were not palpable and no tenderness was elicited and no hernia.

Pelvic examination

The vulva was well developed and there was no discharge nor bleeding. The clitoris was of normal development.

The vagina introitus was closed by a thin membrane which was dark and bulging forward.

Rectal examination

A cystic tender mass bulging anteriorily was felt in the vagina and the mass was continuous with the mass palpated in the suprapubic region. There were no masses in the pouch of Douglas.

Diagnosis: Imperforate hymen with haematocolpos

Plan: Excision of the vaginal membrane

Investigations

1. Haemoglobin 12.5 gm/dl.
2. Urinalysis and culture, normal.
3. Blood urea 15 mg/100 mls and serum creatinine 0.8%.
4. Pregnancy test was negative.
5. Intravenous pyelogram: The excretion of both kidneys were normal and no abnormality was detected in the upper urinary tract and lower tract. The bladder was normal.
6. The chest X-ray was normal.

Anaesthesia

Induction was done with thiopentone 300 mg and scoline 60 mg both intravenously. The anaesthesia was maintained with nitrous oxide and oxygen.

Procedure

The patient was placed in lithotomy position, cleaned with savlon catheterized and drapped with sterile towels. Inspection of vulva and rectal examination was repeated and confirmed the earlier findings.

A cruciate incision was made through the hymen into the vagina as follows: A small vertical incision of 1 cm diameter was made into the centre of the bulging hymen. Blood and clots were allowed to drain without exerting pressure on the uterus. The incision was then widened and another incision was made at right angles to it. The redundant hymenal tissue was excised with scissors.

About 100 cc of blood mixed with clots was collected. Neither a peculum nor instruments were used and a pelvic examination was not done. A sterile pad was applied to the vulva.

Post operative treatment

The patient was nursed in semi-fowlers position so as to allow further drainage of remaining blood from the vagina. The sterile pad was changed

regularly as soon as it was soaked with blood. Crystalline penicillin 2 run six hourly intramascularly and then intramascular Procaine Penicillin Portified 1.2 run for five days.

1st post operative day

The general condition of the patient was good and she was cheerful. She was not anaemic and afebrile, temperature 37°C. The pulse was 80 regular and good volume. The blood pressure was 110/70 mm Hg. There was no distension of the suprapubic region and the abdomen was soft and the mass was of the size of 12 weeks pregnancy. There was brownish discharge which was not foul, coming from the vagina.

2nd to 4th post operative day

Her general condition remained good she remained afebrile. The mass was no longer palpable per abdomen. The brownish discharge was only slight and she used to change her pad only once a day. She was discharged on 11th November, 1980, and instructed to come for follow up after 8 weeks.

Follow - up - 17.1.1981

The patient was seen at the outpatient gyhaecology department. She had had two periods on 5th December, 1980 and on 3rd January, 1981 both of which lasted for 3 days. The blood loss was normal

and it was not painful. Vaginal examination showed normal vulva and the vaginal introitus could admit 2 fingers. The cervix was normal and the uterus was of normal size ant-verted, and mobile. The fornices were free and the adnexiae were not tender and no masses were palpable.

The patient was instructed to come again after 3 months but she did not turn up again.

Commentary

A case of imperforate hymen leading to haematocolpos which was treated by a cruciate incision has been described.

The history of cyclical lower abdominal pain associated with primary ammenorrhoea and the fincing of a suprapubic mass and a bulging dark hymen was suggestive of haematocolpos. The patient however, did not complain of urinary symptoms especially urinary retention which occurs because of the tumour interferes with urethral vesical junction hence the opening of the internal urethral sphicter. Urinalysis blood urea and creatinine and intravenous pyelogram were all normal. These investigations were done so as to rule urinary tract abnormalities which are sometimes associated with this condition.

An aseptic technique was used in making the cruciate incision into the hymen and introduction of speculum and instrument into the vagina as well as

a pelvic examination were avoided because of the risk of introducing infection. The vagina had been closed by the hymen to the exterior and thus it was lacking protective Doboder Lein's bacilli. Hence there was little natural resistance to infection. The retained blood was allowed to drain slowly without exciting pressure and antibiotic cover was given for fear of infection.

The patient did well after the operation and she subsequently had two normal painless periods.

References

1. Howkins, J., Hudson, N.C. (1977): Shaw's Textbook or Operative Gynaecology.

2. Jefficoate, T.N.A. (1974): Principles of Gynaecology

UTEROVAGINAL PROLAPSE

I.P. No. 168511

Name: C.C., 45 year old, Mkwere, Moslem, P_9

Address: Magomeni Kondoa, Dar es Salaam

Date of admission: 1st October, 1980

Date of discharge: 23rd October, 1980

Summary

Mrs. C.C. had second degree uterovaginal prolapse and a cystocoele. Anterior colporrhaphy, bilateral tubal ligation and Fothergill repair was done. She subsequently did well.

History of present Illness

The patient reported to the gynaecology clinic with the complaints of a mass coming down through the vagina for the past 18 months and for the past 6 months she developed backache, lower abdominal pains, frequency and dysurea but there was no history of stress incontinence.

She denied any history of vainal discharge or bleeding, chronic cough or constipation. She did not at any time, participate in heavy manual work such as height lifting.

Menstrual history

She did not recall her age at menarch but it was not delayed. Her periods tested 4 to 5 days every 30 days, normal flow, regular, and not painful.

Obstetrics history

She was P_8. Could not recall the dates of the deliveries but said the first born was about 25 years old and the last born was about 5 years. All were full term normal deliveries at home and She had no problem during pregnancy and puerperium and did not have prolonged and difficulty labour.

She did not use any contraceptives.

Past medical history

Patient had no history of chronic cough, constipation nor venereal diseases.

She had never undergone any surgical operation.

Family history

There was no history of diabetes, hypertension, mental illness or tuberculosis in the family. No body among her sisters had a similar problem.

Social history

She was a housewife and her husband who used to be a peasant died in 1978 of fever. She was a non smoker and not drink.

General examination

She was good general condition. She was not anaemic, jaunded, afebrile and had no oedema. There was no lymphadenopathy.

Mouth and throat: Normal

Neck

No thyroid enlargement and no lymph glands enlargement

Breast

Normal and no lump was palpable. No axillary node enlargement.

Respiratory system

Respiratory rate 12 per minute. The chest was symmetrical and the trachea cental. Percussion note resonant bilaterally. Air entry normal bilateraly. Breathy - vesicular with no adventitions sounds.

Cardiovascular system

Pulse 76 per minute, regular. Blood pressure 130/80. Heart - normal.

Abdomen

It was scaphoid and there were no scars. On palpation it was soft and there was no tenderness elicited. Liver, spleen and kidneys were not palpable and no tenderness was elicited. No other masses were palpable. There was no ascites and no hernia.

Vaginal examination

The vulva and the perineum were normal. There was neither discharge nor bleeding. The patient was asked to cough and the cervix was seen at the introitus. It was slightly oedematous but reducible.

No ulceration or keratinization was seen. There was no stress incontinence of urine.

The patient was then examined in the left lateral position using a sims speculum. The findings were as noted earlier, the vaina mucosa was normal. There was no discharge. On hearing down there was a moderate size cystocoele. Digital examination was then performed with the patient in the dorsar position. The uterus was retroverted, normal size and mobile and the adnexiae were normal. The uterus and anterior vaginal wall were supported digitally and the patient was asked to bear down. No prolapse of the posterior vaginal wall was seen.

Rectal examination

The mucosa felt normal with no masses or ulcers palpable. The glove was not blood stained. The anterior rectal wall did not prolapse with the uterus.

Diagnosis

2nd degree uterovaginal prolapse with a cystocoele.

Planned management

1. Investigations
2. Repair of a cytocoele
3. Bilateral tubal ligation which was requested by the patient.
4. Fothergill repair 2 weeks later.

Investigations

1. Urinalysis normal. Culture no growth
2. Haemoglobin 11.4 gm/dl
3. Blood urea 25 mg/100 mls. Serum creatinine 0.6 mg/100 mls
4. White cell count 5,000 per cubic millimetre with normal differential.
5. Chest X-ray - normal
6. Intravenous pyelogram - normal upper urinary tract. No hydroureters. The bladder appeared normal size.
7. Cervical cytology - grade I smear

Preparation for operation

Blood was sent for crossmatching and 3 units were available for the operation at the blood bank.

The patient was given an enema the nigh before the operation and the vulva and perineum were shaved.

Premedication

Intramascular atropine 0.6 mg and pethidone 50 mg were given before she left for theatre.

14.10.80 - Anterior Colporrhaphy and Fothergill Repair under general anaesthesia

Anaesthesia

Induction: Thiopentone 300 mg I.V. and scoline 40 mg intravenously. Cuffed endotracheal tube was inserted and the patient was maintained under nitrous

Investigations

1. Urinalysis normal. Culture no growth
2. Haemoglobin 11.4 gm/dl
3. Blood urea 25 mg/100 mls. Serum creatinine 0.6 mg/100 mls
4. White cell count 5,000 per cubic millimetre with normal differential.
5. Chest X-ray - normal
6. Intravenous pyelogram - normal upper urinary tract. No hydroureters. The bladder appeared normal size.
7. Cervical cytology - grade I smear

Preparation for operation

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Induction: Thiopentone 300 mg I.V. and scoline 40 mg intravenously. Cuffed endotracheal tube was inserted and the patient was maintained under nitrous

oxide, oxygen and ether.

Procedure

The patient was placed in lithotomy position and the vulva, perineum and vagina were swabbed and drapped and the bladder was catheterized. Examination under anaeshtesia was done and confirmed the previous findings. The cervix was pulled down with a vulsellum forceps and dilated up to Hegars No. 8. The uterine cavity was curetted scanty currettings were obtained and sent for histology.

The labia minora were retracted and held by sutures which were fixed on the skin of the thighs. The cervix was held by vulsellum and pulled forwards. To minimize bleeding at the site of incision 10 mls of 1:100,000 adrenaline was infiltrated under the vaginal skin around the cervix.

The anterior vaginal wall was incised by a semicircumferential skin incision at the function with the cervix. The vaginal wall was then incised in the midline as far a about 1 cm from the urethral meatus. The bladder was then mobilized from the vaginal wall and from the anterior of the cervix using Mayo's scissors. A metal catheter was then placed so as to identify the margins of the bladder.

Interrupted cutgut No. 0 sutures were used to draw together the vesicle fascia so that the cystocoele was obliterated. The vesico-uterine pouch was identified and slit transversely. The uterus was delivered and bilateral tubal ligation was done no after identifying the tubes.

A posterior incision was then made commencing at the lower lateral right angle and encircling the cervix so that it ended on the opposite side. The vagina wall was dissected off and pushed up so as to form flaps to cover the stump of the cervix later. The small enterocoele sack was identified opened and transfixed at its highest point after the opening had been drawn down as low as possible. Its neck was tied and cut and the two uterosacral ligaments were approximated in the midline by 3 transfixing catgut No. 2 sutures. So as to close the gap between them and present recurrence.

A pair of Kocher's forceps were then applied to the cervix on either side so as to clamp the cervical branches of the uterine arteries and the cervix was amputated just below. The cervix was transfixed and the tissues contained in the lateral forceps were ligated on each side.

The cervical stamp was covered with flaps of vaginal wall using invaginating No. 1 catgut sutures. Catgut No. 1 suture was passed through the vaginal mucosa on the left side to pick up the cardinal ligaments and

then passed through the cervix into the cervical canal and again brought through the vagina mucosa a little lower than before. The same suture was then passed over to the right side and the same procedure was repeated. The suture was then drawn together and the whole of the raw surface of the stamp was covered. The redundant anterior vaginal wall was excised and the new edges sutured together with interrupted catgut No. 1. The ensure that the cervical canal was patent a sound was introduced and it passed easily. The bladder was catheterized and the urine was found clear.

A pack was left inside the vagina so as to control oozing and a self retaining bladder catheter was inserted.

Pathology report

1. Currettings: Normal endometria in secretory phase
2. Amputated cervix: Chronic cervicitis with no evidence of malignancy.

Post operative management

Continuous bladder drainage was instituted. The pulse, blood pressure, respiration, temperature input and output were closed monitored as described in the introduction. She was given:

1. Dextrose 5% 2 litres alternating with 1 litre of normal saline daily.
2. Inj. Pethidine 100 mg PRN 6 hourly.

3. Injection Ampicillin 500 mg 6 hourly for 6 days.

4. Senohot tablets 1 tds for 7 days so as to soften the stool.

1st post operative day

General condition was good she was not anaemic. Afebrile. Pulse 82/minute regular good volume. Blood pressure 120/80 mm Hg. Chest was clear. The abdomen was normal appearance with no tenderness. Urine draining well and clear. The input was 2,600 mls and the output was 1,600 mls. The vagina pack was removed and there was no bleeding.

2nd to 4th post operative day

General condition remained good. Haemoglobin 11.4 gm/dl. Urine for microscopy was normal and culture did not grow any pathogens. The catheter was removed and the patient continued on ampicillin.

5th to 8th post operative day

No complaints, micturition was normal. The wound was well healed. The patient was discharged on the 8th post operative day and instructed to come for follow up.

Follow up

She was seen 5 weeks later and she felt well. There were no symptoms of prolapse and the micturition was normal, vaginal examination showed the bladder and

uterus to be well supported. She was advised that she might need caeserean section for her futre deliveries to avoid subsequent period injuries.

Commentary

The patient presented had second degree prolapse with cystocoele. This case mighr have been caused by reated unsupervised child births at home and therefore leadint to over stretching of the pelvic supports with resultant genital prolapse. The overstretching of the pelvic supports might have been worse during the first delivery which occured at an early age at home and very likely without an episiotomy.

Old age might also have contributed to the weakness of the pelvic supports.

She did not complain of chronic cough at anyone time origine history of lifting heavy things and therefore straining was an unlikely cause.

Urine examination and kidney function had to be done as urinary tract infection might have necessitated treatment first before the operation and in case of kidney danger or congenital malformation palliative treatment using pessaries might have been considered.

Anterior colporrhaphy was done because the patient had symptoms of dysurea and frequency and the urine was sterile. A Fothegill operation was done and

about 3 cm of the elongated cervix was removed. This was done without fear of future obstetrics complications because tubal ligastion had already been done.

The patient had no enterocoele and therefore posterior colporrhaphy was not done and posterior colpoperiniorrhaphy was considered unnecessary. Morever this operation may lead to shortening of the vagina and this patient still had goitus.

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GYNAECOLOGY LONG COMMENTARY

Combined Vesico-Vaginal and Recto-Vaginal Fistulae

Summary

26 combined fistula of obstetrics origin and 3 due to cervical malignancy were studied between May 1980 and May 1982. 83% of the obstetric combined fistulae occurred in women of 150 cm or below after their first delivery and all 26 women delivered still births. The cure rate was 54.6%. 88% of the combined fistulae were the massive type with considerable scarring and in 30% of the massive fistulae the urethrae were distroyed. The commonest complications after repir were vaginal stenosis (73%), blocked catheter (15%), haemorrhage (18%), stress in continence (12%) and 2 patients had cryptomenorrhoea and both had subtotal hysterectomy. All the combined fistulae of obstetric origin were secondary to obstructed labour due to cephalopelvic disproportion and therefore prevention of obstructed labour could climinate this condition.

All the 3 patient with combined fistulae due to malignancy had advanced cervical malignancy and were in poor general condition with uraemia and could not stand any palliative treatment.

Introduction

Combined vesico-vaginal and rectal-vaginal fistulae in developing countries usually occur in short women who give a history of incontinence of both urine and faeces after prolonged obstructed labour for several days at home (1. 2. 9, 12). The resultant vesico-vaginal fistulae are usually massive ones with extensive scarring and therefore very difficulty to repair whereas the corresponding recto-vaginal fistula are usually the high type which open into the posterior fornix. Such high rectoal-vaginal fistula require a defunctioning colostomies so as to divert the faeces away from the vaginal before attempting to repair the vesico-vaginal fistulae (1, 2, 9).

A considerable number of patients stay with these colostomies for a long time because of the high failure rate associated with the repair of the massive vesico-vaginal fistulae (1, 2, 3).

The high failure rate coupled with the complications of vaginal atenosis and occasionally crystomenorrhoea leave these women with little hope of conceiving again and hence divorce rate is high among them. An appreciable number of the women are therefore left miserable throughout their lives (1, 9).

Obstructed labour occurs in these patients due to contracted pelvis, (1, 2, 3, 4, 5, 12) and in the African primigravida, Gebbie (1966) showed that maternal height had a direct relationship to the true diagonal conjugate and that women whose heights were below 150 cm required more assistance at delivery due to cephalopelvic disproportion. Everett (1972) found that the mean height of an African primigravida in Dar es Salaam was 148.5 cm and therefore the problem of cephalopelvic disproportion together with its fearful complications is a rest one. As the resources of most developing countries are scarce, prevention is the only immediate solution by adequate provision of antenatal, health education and improvement of services in peripheral dispensaries (9, 13).

The objective of this study is to ascertain the cure rates and complications that are associated with combined fistulae.

Patients and methods

All patients who were admitted to the gynaecological wards of Muhimbili Medical Centre with a history of faecal incontinence together with leakage of urine between May 1980 and May 1982 were included in the study. The author was informed of such cases and carried personal interviews with the patients.

A careful history was taken so as to ascertain the cause of the incontinence. The number of attempts to repair both the VVF and RVF were found out both by questioning and through the records. Attempts made both at upcountry hospital and Muhimbili Medical Centre were included. Their ages, parity, and heights were found out. The patients then routinely underwent the following investigations. Full blood picture; urine for direct microscopy and culture and sensitivity - the urine was collected by a pipette; blood urea and creatinine and intravenous pyelogram. If haemoglobin was found low it was corrected by either haematemics or blood depending on the type and severity of the anaemia. Urinary tract infection if detected was treated first before embarking on repair.

Examination under anaesthesia was then done to confirm the presense of the combined fistula and also to note the site, size, condition of tissue around the fistulae, the fixity of the tissues to the surrounding bone and the operative approach and technique. All attempts to repair the fistulae were done three months after injury. The patients whose fistulae were less than three months and those whose repair had broken down were given appointments to come after three months for readmission.

Patients with both VVF and high RVF had defuncioning transverse colostomies done first before VVF was repaired and if it was successful and examination under anaesthesia was done normally 16 days later to confirm the healing.

The RVF was then repaired and an examination under anaesthesia was also done 16 days later to confirm healing and the colostomy was closed if healing had occurred.

In patients with combined fistulae the vesico-vaginal fistula is repaired first as repairing both fistulae at the same time will invdve taking tissue to fill vaginal defects opposite each other thus producing tension which normally results in vesico-vaginal fistulae breaking down first. Also repairing the rectal-vaginal fistulae first might result in vaginal stenosis thus limiting access to the anterior vaginal wall.

RESULTS

Total number of patients with combined vesico-vaginal and rectal-vaginal fistula was 29.

Table I: Ages

10 - 14	15 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45-49	50+
2 (6%)	20 (69%)	3 (10%)	1 (1%)	1 (1%)	0	0	0	2 (7%)

75% of the patients were aged below 20 years.

Table II: Heights

135 - 139	140 - 144	145 - 149	150 - 154	155 - 159	160 - 164
0	3 (10%)	21 (73%)	3 (10%)	2 (7%)	0

83% of the patients were below 150 cm

Table III: Parity

P_1	P_2	P_3	P_4	P_5	P_6
23 (23%)	2 (7%)	0	1 (3%)	1 (3%)	2 (7%)

In 80% of the patients the combined fistula followed first delivery.

Table IV: Cause of combined fistulae

Obstructed labour	26	90%
Malignancy	3	10%

26 of the combined fistulae were due to obstetric causes and 3 fistulae were due to malignancy.

Table V: Types of Obstetrics vesico-vaginal fistulae

Massive fistulae	23	88%
Juxta cervical	3	12%

Lawson (1967) classified the fistulae between the bladder and urethra and the vagina into the following anatomical groups:

Juxta cervical fistula
Opening either into the anterior fornix or the cervical canal and as the defect is close to the trigone, the ureteric orifices may be near the edge.

Mid-vaginal fistula
Neither the trigone above nor the sphictor below are invoved and fixity to bone is unusual.

Juxta-urethral fistulae
Involve the bladder neck and proxinal part of the urethra, damaging the urinary spicter mechanism.

Massive fistulae

A combination of all three types. The anterior lip of the cervix and most of the anterior vaginal wall are missing, and tissue loss extends from bladder neck to trigone. The ureteric orifices are often in the edges of the fistulae and inverted bladder wall may prlapse through the defect.

Vault fistula (Post hysterectomy)

The fistula is usually in the midline of the vaginal vault, and may involve the trigone.

Combined fistulae

In which one of the above types of bladder fistula is combined with a fistula between the rectum and vagina that is recto-vaginal fistula.

The recto-vaginal fistulae - are further classified into high and low types and those which occur after third degree tear. All the 26 fistula due to obstetric causes in this study were the high type and in 88% of the patients they were associated with massive vesico-vaginal fistulae with considerable scarring. The urethral were destroyed in 1/3 of the massive fistulae and artificial reconstruction of urethrae were done and martius and omental graft were used to support the new urethrae but there was success in only 30%.

Table VI: Types of Obstetric Rectal-vaginal Fistulae

High	26	100%
Low	0	0
3rd degree tear	0	0

All of the rectal vaginal fistulae were high fistulae with moderate fibrosis but they were not fixed to the sacral bone.

Table VII: Obstetrics significance of combined fistulae

Assisted vaginal delivery	17	65%
Spontaneous vaginal delivery	5	15%
Uterine rupture	2	8%
Destructive operation	1	4%
Not known	1	4%

65% of the patients with combined fistulae had assisted vaginal deliveries, compared with 15% who had spontaneous vaginal delivery. The assisted vaginal deliveries were done in health centres and district hospitals. 2 patients had ruptured uteri at home and were sent to Regional hospital where both underwent subtotal hysterectomy after which the combined fistulae were noticed. 1 patient had a caeserean section done in a district hospital because attempts to deliver her per vagina failed. The patient had severe postoperative sepsis and later a combined fistula. The 1 destructive operation was also done in a district hospital after which a combined fistula developed. None of the babies was born alive.

Table VIII: Complications before repair

Excoriation	24	92%
Ammenorrhoea	17	70%
Foot drop	2	4%

excoriation of the vulva was present in 92%. All the patients who had successful repair of the vesico-vaginal fistulae were also simulataneously cured of excoriation without using any other specific treatment.

62% of the patients had traumatic ammenorrhoea which lasted for a period between 6 months and 7 years. 91% of the 11 patients who had successful repairs saw their periods between 2 months and 6 months after successful repairs whereas only 1 patient saw her period after examination under anaesthesia and none had spontaneously onset of periods. This condition is thought to be due to psychological causes which follow the traumatic labour and combined fistula and hence many patients resume menstruation when the fistulae are cured.

Table IX: Operations

Colostomies	26	100%
No colostomies	0	0

All 6 patients with combinef fistulae of obstetrics origin had defunctioning colostomies. All these had high recto-vaginal fistulae. Transverse colostomies were done instead of sigmoid colostomies because the latter might interfere with repair of rectal fistulae.

Table X: Position of repair of vesico-vaginal fistulae

Knee chest	19	73%
Lithotomy	3	12%
Transversical	4	15%

The knee chest position was used in 73% of the repairs. All these patients had massive fistula with bladder mucosa prolapsing into the fistula and thus the knee chest position enabled the mucosa to be reduced. The lithotomy position was used in 3 patients and all had juxtacervical fistulae. The transversical route was used in 4 patients. All had massive fistula associated with vaginal stenosis due to previous repairs.

Table XI: Position of repair of rectovaginal fistulae

Vaginal route	14	54%
R.V.F. not repaired because VVF still present	12	46%

54% of the rectovaginal fistulae were repaired by the vaginal route but 46% of the recto-vaginal fistula were not repaired because the corresponding vesico-vaginal fistula had not been successifully repaired.

Table XII: Cure rates of VVF and number of attempts

Numbers of operation(s)	1	2	3	4
Number of patients	14	7	3	2
Cured patients	9	4	1	0
Cure rates	64%	43%	33%	0%

The overall cure rate was 54.6%. 64% of the vesico-vaginal fistulae were cured after first attempt; 43% of them after the second attempt and 33% after the third and none after fourth attempt. This has been shown by other series of Lawson, (1967), Coest Zee (1966) and Masawe (1978) who found that the first attempt to repair a fistula had the best chance of success as repeated attempt produce more scarring and further impairement of blood supply to the tissues. The time taken to cure the fistula ranged from 3½ months to 4 years with 1 patient being cured after 4 years and ¾ within 1 year. Of the fistula that failed, ½ of them had been attending hospital for 1 year of more.

Table XIII: Cure rates of R.V.F. and number of attempts

Numbers of operation	1	2
Number of patients	13	1
Cured patients	13	1
Cure rate	100%	100%

The recto-vaginal fistulae were repaired in 65% of the patients and 13 fistula (95%) were cured on the first attempt and only 1 fistula was cured on the second attempt. More of the fistulae was repaired through the abdomen.

12 recto-vaginal fistulae could not be repaired because their corresponding vesico-vaginal fistula were not successfully repaired. 92% of the failed vesico-vaginal fistulae had been repaired more than twice and they were thus associated with massive scarring, fixity and stenosis so that the chances of curing them were low.

Table XIV: Complications associated with repair of combined fistula.

Blocked catheter	4	16%
Calculi	4	16%
Haemmorrhage	2	8%
Stress incontinence	3	12%
Vaginal stenosis	19	73%
Cryptomenorrhoea	2	8%
Divorce	22	84%

Blocked catheter

16% the urethral catheters where blocked within 48 hours after repair at night for more than 12 hours. In 3 patients the vesico-vaginal fistula subsequently broke down whereas in 1 patient the fistula healed.

Calculi

16% of the patients had bladder calculi and all of them had had one more previous repair using chromic catgut in the past. Repair of these fistulae had to be posponed for 4 weeks after removal of the calculi and ½ of them were cured.

Haemmorrhage

1 patient whose fistula was repaired by transversical route had haemmorrhage into the bladder 6 hours after operation. She presented with sudden onset of severe lower abdominal pain and fever and on examination she had techycardia, raised temperature and a tender suprapubic mass. The clot was evacuated in the theatre after attempts to remove it by irrigation of bladder failed. The patient subsequently did well and the fistula healed. The second patient who was repaired through the vaginal route had secondary haemmorrhage on the 6th postoperative day. Blood transfusion was done and irrigation of bladder. Haemmorrhage stopped but the repair broke down after 36 hours.

Cryptomenorrhoea

2 patients developed cryptomenorrhoea after the cervices were completely buried by adhesions. Both of had been cured of the combined fistula but had developed vaginal stenosis. They later developed cyclical severe spasmodic lower abdominal pain which was associated with a tender suprapubic mass. The pain and mass increased after each cycle and eventually subtotal hysterectomy was done and the diagnosis of haematometra was confirmed. They subsequently did well.

Stress incontinence accured in 12% of the patients who had had successful repairs of the vesico-vaginal fistulae. All the patients with stress incontinence had had massive fistula initially. In 2 patients the fistulae had been repaired after the first attempt and 1 patient after two attempts. In all of them the stress incontinence was so severe that they were all booked for operation to correct it.

Vaginal stenosis occurred in 65% of the patients who had had successful repair and in 92% of the patients who had unsuccessful repair. ½ of the first group had had more than one attempt before closing the fistula whereas in the second group ¾ of them had had more than one unsuccessful attempts. In the later group chances of future success were small because of inaccessibility of the fistula coupled with fibrosis around the fistula and fixity to the bony pelvis.

The divorce rate was high among the patients with combined fistulae. Only 16% of the 26 patients were still married. 1/3 of them had been abandoned and their husbands had married other women.

Combined fistula due to cervical malignancy

The 3 patients with combined fistulae were due to advanced cancer of the cervix stage IV with extensive involvement of both the bladder and rectum. They were all elderly and in poor general condition with raised blood urea and creatinine. They could not withstand any palliative treatment including palliative irradiation and their relatives took them home.

In difficulty combined fistulae that occur in elderly patients after irradiation of genital malignancy, Blaikley (1965) recommended colpocleisis but the rectal fistula has to be lower than the vesico-vaginal fistulae otherwise faeces will occumulate in the bladder. If the recto-vaginal fistula is higher than the vesico-vaginal fistula it should be drawn out so that it is lower than the latter. The anal sphicter must be intact so that most of the urine passes through the urethra and a little urine passes with the faeces through the competent anal sphicter. The patients with advanced cervical malignancy could not however, stand any palliative treatment like this one.

DISCUSSION

The majority (80%) of the combined fistulae occured in short women after their first delivery, and 83% of the had beights of 150 cm or below. All of them delivered still births. The association of contracted pelvis with heights below 150 cm in African primigravidae has been shown by several studies (6, 9, 10) and the combined fistulae of obstetric origin is secondary to severe prolonged obstructed labour for several days due to cephalopelvic disproportion (12).

The cure rate of 54.6% of combined fistula is low compaired with that of Lawson (1972) of 66% and Mati (1982) of 64.7% but 75% of the cured patients did not fulfil the criterion of Coetzee and Lithgow (3) of a successful cure of a vesico-vaginal fistulae. In our unit the criterion for successful cure is less strict and is usually limited to anatomical closure of the fistula with restoration of continence (1, 13) but in a society where the women status depends on her reproductive ability, cure is best judged by continence together with reproductive functions namely coitus and ability to produce children. Vaginal stenosis occured in 73% of the successful repairs and cryptomenorrhoea due to closure of cervix because of ahdesion in 8% and the patients with

cryptomenorrhoea subsequently underwent subtotal hysterectomies due to haematometra and hence they could no longer conceive again. These complications, pulus the high failure rate of 45% and the long delay ranging from 3½ months to 4 years before the fistulae were successfully repaired might have been responsible for the high divorce rate of 84% as the husbands had despaired that their wives would ever get cured and resume their normal reproductive function again.

The high failure rate and increased complications occured because the vesico-vaginal fistulae in combined fistulae are normal massive with a lot of scarring and fixity to the pelvic bones as they are the results of exceptionally severe prolonged and obstructed labour (12, 1) as shown in the 88% of the massive fistulae in this study. As in a combined fistulae the recto-vaginal fistulae is repaired only after successful repair of vesical-vaginal 45% of the patients had to remain with their colostomies for over 1 year due to failure to close the vesico-vaginal fistulae. 92% of these patients had had more than one repair so that the increased scarring and fixity to the bony pelvis which were associated with vaginal stenosis made the chances of future success very low (2, 12, 13). In 1/3 of the patients with massive fistulae, the urethrae were destroyed also and only 2 patients among them were subsequently cured after repeated operations.

The remaining had very little hope of getting cured (12).

The catheters were blocked in 15% of the repairs and among the patients with blocked catheters the failure rate was 75%. Continuous catheter drainage for 6 weeks despite the breaking down of the repair was however, not instituted as recommended by Lawson (1975) presumably because all the urine was pouring out from the massive fistula. The catheters were blocked at night and they were discovered 12 hours later. The urine output after repair of vesico-vaginal fistula should be about 100 mls per hour (2, 12) and if hourly monitoring of urine output was done the blocked catheters could have been detected early.

Reaction haemmorrhage and secondary haemmorrhage occured in 1 patient each. In the former the repair broke down whereas in the latter the repair was successful. In Matis (1982) series there were 4 cases with 1 death. There were no cases of ureteric occlusion in this study as these are common in massive defects (2, 12) and in Mati's series (1982) there were 7 cases. Severe stress incontinence in which the patients were just as wet as before the operation occurred in 3 patients. This complication is common after repairing massive fistula and juxta urethral fistula (2, 12, 13).

All the patients with secondary amenorrhoea resumed their periods within 6 months after repair and other series showed similar results (2, 13) and likewise the excoriation associated with vesico-vaginal fistulae healed in all patients after successful repairs as reported also by Massawe (13). Bladder calculi were observed in 4 patients all of whom had had more than 1 repair with chromic catgut. This is a common finding after repeated repairs with chromic catgut and sometimes occurs due to stagnation of urine in bladder recess (2, 12, 13). After removal of stones 4 weeks must elapse before attempting to repair again (12) and 50% of the patients were subsequently cured.

The 2 patients with combined fistulae due to advanced cervical malignancy were both elderly and in poor general condition with uraemia and therefore they could not stand any palliative treatment.

The occurrence of combined fistulae in developing countries will continue to be a problem causing considerable morbidity and distress to young women most of whom delivered still births and have little hope of conceiving again as an appreciable number of deliveries still occur at home in developing countries. In Tanzania 60% or more of the deliveries still occurred at home (14, 15, 17) whereas in Ghana 75% (16). Most of these deliveries occur under

traditional birth attendants who have little knowledge about midwifery and therefore cannot predict or detect abnormal labour. As cephalopelvic disproportion is common among African primigravida (1, 3, 6, 9,12, 13) such patients are often mismanaged in the villages and the end results are very high perinatal morbality which is sometimes associated with difficult combined fistulae such as those which have been described in this study. A vicions cycle is then started among those with difficult combined fistulae as such patients have little hope of getting completely cured and even if they get cured the chances of conceiving are low and their husbands abandon them and hence the patients are left miserable throughout their lives.

In developing countries as resources for adequate qualified personnel and equipment to deal with urogenital fistulae are often very limited, prevention has been advocated as the only means at present to combat this problem (6, 9, 10, 12). The coverage of antenatal clinics should be increased and at the antenatal clinics, short primigravidae and those with deformities or large babies should be advised to go to health centre early in labour with a view to referring them to district hospital as soon as complications arise.

Other patients should also be encouraged to deliver in hospital under supervision. During the intrapartum period proper use of the partogram should be made so that all those with abnormal labours are referred as early as possible to the district hospitals.

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