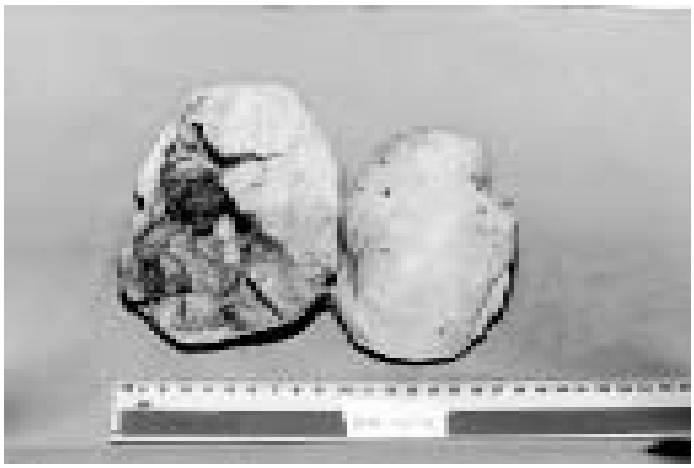

Figure 1. The tumor showing smooth external surface and variegated cut surface.

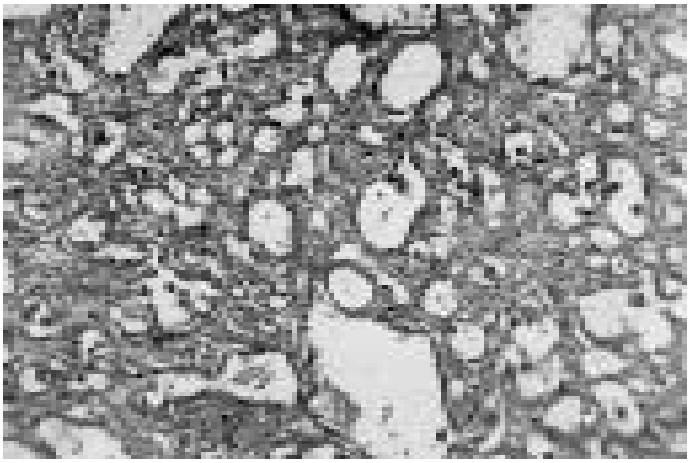

Figure 1. Microphotograph showing loose reticular pattern and rounded papillary processes with central capillary covered by a single layer of anaplastic cpithelium with insignificant stroma.

level. After 2 cycles of chemotherapy given with an interval of 3 weeks, α-fetoprotein level came down to 1.06ng/mL. On 21st November, 2003 further chemotherapy was denied by the patient due to financial problem. On the 14th July, 2004, she came to the outpatient with acute pain and lump in the abdomen.

The tumor recurrence necessitated a laparotomy at which a large intraperitonial, friable, hemorrhagic mass adherent to the parietes and the surrounding omentum was found in the left hypochondrium. The uterus and left sided tube and ovary were unremarkable. There was no ascitis.The mass was removed

Histopathology of the excised mass showed deposits of yolk sac tumor in the peritoneum with large areas of hemorrhage and necrosis. Serum α-fetoprotein level was high. X-ray chest and sonography of the whole abdomen gave normal findings. Chemotherapy was started again but she expired on 20th August, 2004.

Discussion

Endodermal sinus tumor of the ovary is a neoplasm of young adults. The serum α-fetoprotein level is invariably high. Clinical stage is the most important prognostic factor. Serial estimation of serum α-fetoprotein is useful in monitoring the tumor course[1].

Association of endodermal sinus tumor of the ovary with pregnancy is a rare event. Review of the literature revealed that combination chemotherapy during pregnancy had a successful outcome for mother and fetus[2]. Tumor reductive surgery strongly affects the prognosis[3].

Unfortunately our patient came in labor and delivered a preterm fetus before the diagnosis of ovarian tumor was made.

References :

1. Rosai J. In : Ackerman's Surgical Pathology 9th edn. Harcourt Brace and Company Asia Pte Ltd. 1997;1496-7.
2. Malone JM, Gershenson DM, Creasy RK et al. Endodermal sinus tumor of ovary associated with pregnancy. Obstet Gynecol 1986 (suppl 3) :86s-89s.
3. Nawa A, Obata N, Kikkawa F et al. Prognostic factors of patients with yolk sac tumors of the ovary. Am J Obstet Gynaecol 2001; 184: 1182-8.

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Spontaneous splenic rupture in pregnancy - a rare entity

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Key words: spontaneous splenic rupture, pregnancy, hemoperitoneum

Introduction

Spontaneous splenic rupture in pregnancy is rare and occurs most commonly in third trimester or puerperium[1]. Several case reports have been published since the first case report in 1803 [2]. This entity is of great importance since it carries a very high rate of maternal and fetal mortality if the possibility is not suspected. We present a rare case of spontaneous rupture of spleen in third trimester of pregnancy, the only one seen over last 10 years in our institution.

Case report

A 27 years old $G_3P_1L_1A_1$ was admitted at 8 months amenorrhea with

complaints of sudden onset of acute abdominal pain. Pain was associated with nausea, vomiting and syncopal attacks. It was also referred to the left shoulder tip. There was no preceding history of trauma or vaginal bleeding. She had reported to a level II hospital in a state of shock where she was resuscitated and was referred to our tertiary care teaching institution as a case of abruptio placenta.

On general physical examination she was anxious but well oriented. Pallor was moderate with mild circulatory decompensation (pulse rate of 120 per minute and blood pressure of 110/80 of mmHg). On abdominal examination the uterus was of 30 weeks size and fetal heart sounds were clearly heard. There was tenderness all over the abdomen with maximum intensity in left lumbar region. Clinical evidence of free fluid was present. On vaginal examination the os was closed and no vaginal bleeding was noted. Obstetric sonography revealed a single live fetus of 30 weeks gestation with large amount of free fluid in the abdomen. Abdominal paracentesis revealed hemoperitoneum. Emergency laparotomy was done and approximately 3 L of fresh and clotted blood was removed. Source of bleeding was found to be approximately 3x3 cm defect in splenic capsule with active bleeding from the ruptured site. Splenectomy was done by a surgical colleague. The uterus was found to be intact. Liver was palpated and found to be normal. The patient received 4 units of blood transfusion during surgery. Postoperative period was uneventful. Patient received intramuscularly injection proluton depot and two doses of injection decadron 12mg, 12 hours apart along with antibiotics.

Histopathologic examination of the spleen revealed normal parenchyma, capsule and vasculature. The patient was discharged on the 10th postoperative day. Her pregnancy continued uneventfully till term. She had a term vaginal delivery of a live healthy baby conducted by a midwife at home.

Discussion

Rupture of the spleen can occur with any degree of trauma to a normal spleen or minimal trauma to a diseased spleen. But spontaneous rupture in pregnancy is rare. Splenic rupture is spontaneous only if it is not associated with a history of antecedent trauma, any systemic disease, or any gross pathology detected at the time of exploration. Etiological factors that have been suggested are (i) physiological splenic enlargement and increased blood volume in normal pregnancy along with trauma of parturition and (ii) congenital factors like a short splenic pedicle or a deeply recessed location of spleen contributing to rupture by compression by the diaphragm during coughing, sneezing or vomiting [3]. These seem to be the only plausible explanations in this case.

Khaled et al [4] have reported two cases of postpartum splenic rupture and have speculated forceful traction with undue force with instruments during cesarean section and insertion of abdominal packs as theoretic causes of splenic rupture.

Our patient had symptoms similar to those seen in patients with splenic rupture such as severe abdominal pain localized to left upper quadrant, shoulder tip pain, distension and rigidity of the abdomen, and eventually shock.

Other commonly encountered obstetric emergencies that present with similar symptoms are uterine rupture, antepartum hemorrhage due to placental abruption, intraabdominal bleeding, and injury to viscus. These cause significant difficulty in early diagnosis of splenic rupture. In our case the diagnosis of splenic rupture was not considered before laparotomy. But the need for emergency operative management was well understood since sonography showed intraperitoneal hemorrhage. Ultrasound proves to be an important diagnostic tool for such patients.

Management is operative in majority of such cases where significant hemoperitoneum is present. Conservative approach is followed in only those patients with hemodynamic stability and absence of peritoneal signs. Splenic rupture is a surgical emergency that requires immediate diagnosis and urgent management. Delay in diagnosis can be fatal. The reported maternal mortality of splenic rupture is 0-45% and there is a 47-82%[1,5] risk of fetal death. Thus a differential diagnosis of spontaneous splenic rupture should be kept in mind in pregnant women with acute abdominal pain and distention with or without vaginal bleeding, and a comprehensive evaluation of the entire abdomen done.

References

1. McCormick GM, Young DB. Spontaneous rupture of the spleen. A fatal complication of pregnancy. Am J Forensic Med Pathol 1995; 16:132-4.
2. Sparkman RS. Rupture of the spleen in pregnancy: report of two cases and review of the literature. Am J Obstet Gynecol 1958;76: 587-98.
3. Orloff MJ, Peskin GW. Spontaneous rupture of the normal spleen: A surgical enigma. Int Abst Surg 1958;106:1-5.
4. Khaled S, Nagi A, Usta I et al. Postpartum splenic rupture. Obstet Gynecol 2003;102 (5 Pt 2): 1207-10.
5. Denehy T, McGrath EW, Breen JL. Splenic torsion and rupture in pregnancy. Obstet Gynecol Surv 1988; 43: 123-31.

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An interesting case of gastroschisis

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Key words: gastroschisis, abdominal wall defect, silo procedure

Introduction

Gastroschisis is evisceration of the intestine through the defect in fetal abdominal wall located lateral to normal umbilical cord. It is a sporadic abnormality found in 1:4000 to 1:10000 births[1]. We are presenting an interesting case of gastroschisis.

Case report

A 23 year old primigravida married for 7 years, came for antenatal registration with 7 months amenorrhea. There was no significant positive