



Final Results



***Late Dr. Shobha Sharma Paper
and Poster Gold and Silver
Medal Competition Results***

HAPPY GYNECON 2021



***Late Dr. Shobha Sharma Poster Gold
and Silver Medal Results***



Respected Judges

- •Dr. Banumathi
- •Dr. Bharathi Rajshekar
- •Dr. Jayam Kannan
- •Dr. Jyoti Malik
- •Dr. Kiranmai Devineni
- •Dr. Leela Digumarti
- •Dr. Prasanta Naik
- •Dr. Shailja Pinjala
- •Dr. Shanthirani
- •Dr. Subarna Mitra
- •Dr. Sudha Gandhi
- •Dr. Vidya Thobbi

Third Position (40.67 points)

Dr. Himani Punshi

**Heterotopic Pregnancy with Abdominal Ectopic presented
as Lithopedion: A Case Report**

Silver Medal (41 points)

- Dr. Divya Gupta
**A rare case of vaginal sarcoma in pregnancy-A
diagnostic dilemma**

Gold Medal (41.66 Points)

- Dr. Ankika Shrivastava
Continuous Aggressive osseous metaplasia of endometrium (a rare entity and difficult to treat)

HETEROTOPIC PREGNANCY WITH ABDOMINAL ECTOPIC PRESENTED AS LITHOPEDION : A Case Report



Presented by : Dr Himani Punshi
Department of Obstetrics & Gynecology, Pt. Jawahar Lal Nehru Memorial Medical College Raipur(C.G)

Guided by : Dr Jyoti Jaiswal , Dr Smrity Naik , Dr Shweta Dhruw

INTRODUCTION

Abdominal pregnancy is defined as pregnancy anywhere within the peritoneal cavity exclusive of tubal, ovarian or broad ligament with placenta attaching to and deriving blood supply from visceral organs. It can be either primary or secondary(more common)

Secondary abdominal pregnancy refers to pregnancy that originated in the tubes or less commonly the ovaries and reimplant in the peritoneum where the embryo or the foetus continues to grow.

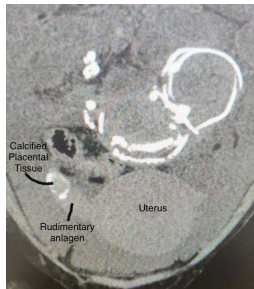
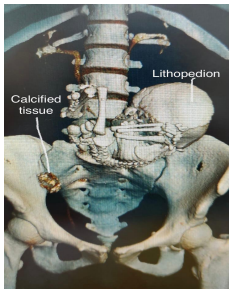
INCIDENCE

Ectopic pregnancy represents about **1-2%** of all pregnancies with **95%** occurring in fallopian tubes.

Abdominal pregnancy just represents **0.9-1.4%** of ectopic pregnancies with estimated incidence of **1:10,000 to 1:30,000(1)**

Maternal mortality is around 7.7 times that of other location of ectopic pregnancy and 90 times that of intrauterine pregnancy(2).

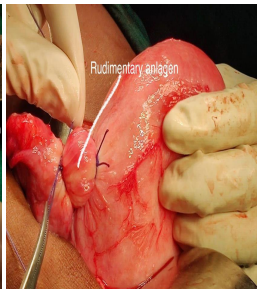
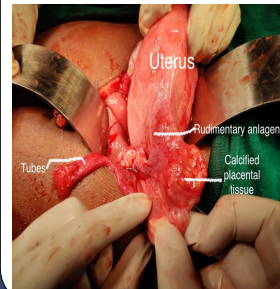
Lithopedion occurs in 1.5- 1.8% of extrauterine pregnancies and 0.00045% of all pregnancies.



CASE REPORT

28 year old P2L1D1 unbooked patient delivered a preterm child 3 days back after which she was unable to pass urine, motion and unable to tolerate oral feeds, presented with complaints of vomiting 7-8 episodes per day and abdominal distention. On examination she was very pale, with abdomen grossly distended. Her urgent hemoglobin was 4.7 gm% and USG suggested gross ascites with abdominal ectopic pregnancy in left lumbar region and lower abdomen. CECT and MRI was done to confirm the diagnosis CT ANGIOGRAPHY revealed vascularity and a calcified fetus of 26 weeks gestation and ruled out mesenteric ischemia.

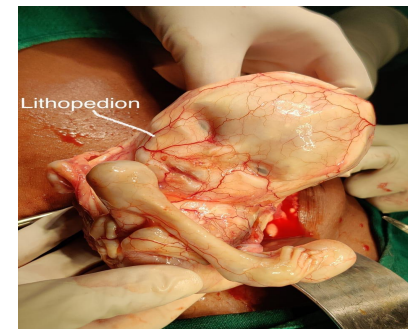
Exploratory laparotomy revealed calcified fetus (**lithopedion**) present in the lower abdomen. Small calcified mass of 3*3 cm, might be remnants of placental tissue was found attached to the external surface of a small muscular mass of 2cm attached to right sided tube and ovary which must be rudimentary anlagen on the right side of uterus. Based on history & above finding it was an undiagnosed case of **Heterotopic pregnancy**.(Secondary abdominal ectopic. She was discharged on 8th day of post op recovery in good condition.



DISCUSSION

Most cases of abdominal ectopic pregnancy do not survive. Pregnancies with some vascular attachment to the uterus seem to be associated with a higher chance of fetal survival. The mainstay of management for abdominal pregnancy is surgery. Removal of the ectopic pregnancy mass could cause intractable hemorrhage and/or organ injury because of deep trophoblastic invasion into the surrounding tissue. However, leaving the placental tissue is associated with large number of post op morbidity and mortality. In our case whole of the calcified tissue which may be placental tissue along with rudimentary horn was removed and haemostasis was achieved. An abdominal pregnancy is often associated with fetal deformities such as facial and cranial asymmetry, joint and limb deformity.

Lithopedion (stone baby) develops when an abdominal pregnancy remains undiagnosed for more than 3 months, without autolysis and gets **calcified**. It usually presents with features of acute abdomen and obstruction.



CONCLUSION

Rapid initial assessment with high index of suspicion, ultrasound imaging and MRI remains a great aid in prompt diagnosis of abdominal ectopic and its vascularity.

Prompt delivery of the fetus, control of hemorrhage and decision of placenta removal are great challenges. A multidisciplinary approach is needed for successful management of such patients and to reduce maternal mortality and morbidity.

This case was unique as abdominal ectopic pregnancy is a very rare phenomena and the peculiarity of this case is its presentation as a post natal case with heterotopic pregnancy (delivered vaginally) with secondary abdominal ectopic of 26 weeks gestation .The ectopic fetus developed as a hard calcified mass (lithopedion) with features of acute abdomen.

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2. (Yasumoto K, Sato Y,Ueda Y, et al. Expectant management for abdominal pregnancy (2017))
3. Rahman MS, Al Suleiman SA, Rahman J, Al-Sibai MH. Advanced abdominal pregnancy- observation in 10 cases. *Obstetrics Gynecol.* 1982;59:366–372. [PubMed] [Google Scholar]
4. C.A stevens. Malformations and deformity in abdominal pregnancy.

A RARE CASE OF HUGE 6.5 kg DERMOID CYST ARISING FROM MESENTERY: A CASE REPORT

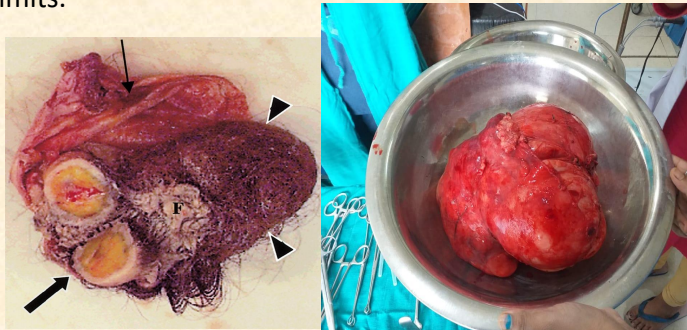
DR KRITIKA VERMA, DR RUCHI GUPTA, DR PRATIBHA LAMBODARI, DR ANJUM KHAN, DR NEELAM SINGH, PT. JNM MEDICAL COLLEGE, RAIPUR

INTRODUCTION-

- The incidence of dermoid ovarian cyst is 15-20%³ of all ovarian neoplasm, which is a common entity.
- Mesenteric cyst is one of the very rare entities with incidence of 1 in 2,00,000 & mesenteric dermoid cyst are even rarer entity amongst all of the mesenteric cysts with incidence of 1:1,00,000³
- Both mesenteric cyst and mesenteric dermoid cyst have good prognosis².
- Here, we report a rare abdominal tumor which was initially diagnosed clinically as an ovarian dermoid cyst but finally operative and histology revealed mesenteric dermoid cyst.

CASE REPORT-

- A 36-year-old, multipara presented with abdomino-pelvic mass gradually increasing in size since 1 year with recent onset of abdominal pain. She had normal menstrual cycles and normal bowel and bladder habits.
- Physical examination revealed abdomino-pelvic mass of 26cm*20cm size, globular, non tender, variegated surface, mobile, cystic to solid in consistency.
- Tumor markers- AFP, β -HCG, CA-125- all within normal limits.



- CECT (abdomen and pelvis)- suggested a 14.4*21*23.1 cm heterogeneous lesion arising from pelvis showing fatty attenuation and multiple areas of dense calcification, suggestive of teratoma.

Patient was managed



surgically after necessary pre-operative investigations.

Laparotomy findings revealed a huge solid mesenteric mass of 22*20cm size weighing 6.5 kg. Small bowel & both ovaries were adhered & was separated from mass by fine dissection. Postoperative period was uneventful.



HISTOPATHOLOGICAL

examination showed mature cartilage, osteoid formation, fibro-adipose connective tissue, focal lymphoid aggregates, congested blood vessels and focal mature neuronal component and no immature elements seen, confirming dermoid cyst.

DISCUSSION-

- ✓ Dermoid cyst, also called mature cystic teratoma are most common primary ovarian neoplasm.
- ✓ Mostly found in 20-40 years.
- ✓ These tumors originate from totipotent germ cells.
- ✓ They are very slow growing, with an average growth rate of 1.8 mm/year in premenopausal women¹.
- ✓ They are bilateral in 10% cases .
- ✓ Rarely malignant 1.7% of all cases. Squamous cell carcinoma is common^{1,2}.
- ✓ Recurrence is found in 3-4% cases¹.
- ✓ Mesenteric dermoid cyst are rare intra-abdominal tumor found most commonly in ileum (60%) next is ascending colon(40%)³.
- ✓ However, if a mesenteric cyst locates within the pelvic cavity, as in this case, it may be misdiagnosed as an ovarian cyst.
- ✓ Various sonographic features suggestive of dermoid cyst, include echogenic calcification in a cystic mass, cyst with fat fluid level, hyperechogenic lines and dots².
- ✓ It can be treated by laparoscopy or laparotomy surgeries¹.
- ✓ A conservative surgical approach is required in young patients with the aim to preserve ovarian function.¹
- ✓ Mostly asymptomatic but may present with complications such as torsion(15%), rupture, spillage, peritonitis, squamous cell carcinoma, recurrence. ¹

References-

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3. Chandrasekhar Sharanappa Neeralagi1, KR Surag2 Yogesh kumar3 Mesenteric Teratoma in ElderlyFemale, 10.7860/JCDR/2017/23549.9268.

CONTINUOUS AGGRESSIVE OSSEOUS METAPLASIA OF ENDOMETRIUM: A RARE CLINICAL ENTITY

INTRODUCTION: Osseous metaplasia of endometrium results from the transformation of non osseous connective tissue into mature bone. Nearly 80 cases have been reported. In most cases ossification occurred after abortions. The most common presentation is infertility.

CASE REPORT

A 31 year old female P0L0A2 married for 7 years presented with history of secondary infertility for 5 years. She had history of two induced abortions each at around 2 to 2.5 months of gestation around 6 years back.

On Gynaecological examination uterus and ovaries were normal. Her menstrual cycles were at regular interval and with normal flow.

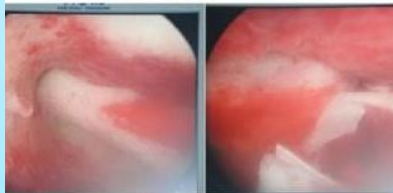
MANAGEMENT:

ULTRASOUND: Hyperechoic calcifications reported inside endometrial cavity.

HYSTEROSCOPY: Hysteroscopy was performed with 30 degree hysteroscope with normal saline as Distending media.

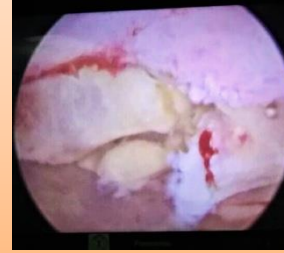
In 1st Hysteroscopic sitting Multiple coral white coloured bony tissues were removed which were embedded in the uterine cavity

→ Patient was kept in follow up and repeat ultrasound still showed calcification. So repeat hysteroscopy was performed in which endometrial cavity was filled with multiple flat bones so again removal of bones were done.



The bones were sent for **Histopathological examination** after 2nd hysteroscopy and the reports were suggestive of **trabeculae of immature bones consistent with fetal bones.**

A 3rd hysteroscopy was performed after 2 months because of intrauterine calcification in ultrasound. This time the cavity was filled with **flat bones with sharp edges and were thicker** than earlier. So gentle removal of few bones were done so as to avoid injury to the uterine cavity. In spite of 3 hysteroscopic sittings the bony tissues could not be removed completely and **it was observed the more the removal of bones were done the more the bones get formed inside the endometrial cavity**



DISCUSSION

Ossification of endometrium is a rare clinical entity. The scientific literature proposes several different explanations which can be summarised in two broad categories:

1. Persistence of embryonic tissues that keep developing after curettage or the appearance of bone tissue as a result of **chronic inflammation** derived from remaining non bony necrotized embryonic tissue.
2. Induction of process of osteogenesis by one's own embryonal cells, provoking osseous differentiation of hypothetical pleuripotential endometrial cells.

Fetal bones might also serve as a source of calcium for ossification but it is possible only for abortions occurring in 2nd trimester.

Osseous metaplasia gets deeply embedded in the uterine mucosa and present the same contraceptive effect as intrauterine contraceptive device.

Endometrial ossification may result in secondary infertility, menstrual irregularities, pain and dysmenorrhoea.

Ultrasound plays an important role showing hyperechoic lesions and is suggestive of osseous tissue and confirmation is done by hysteroscopy.

The literature supports that hysteroscopy can be used as both diagnostic and therapeutic tool.



Recent ultrasound of patient after 3rd hysteroscopy showing calcified lesion.

CONCLUSION:

The present case is different from other cases reported in the literature because of its recurrence and aggressive nature, as a result of which it remained uncured. Surrogacy is the best available option that can be suggested to the patient. The patient will be kept in follow up and in future hysterectomy might be performed.

A rare case of vaginal sarcoma in pregnancy - A diagnostic dilemma

Department of Obstetrics and Gynaecology, Pt JNM Medical College, Raipur, Chhattisgarh, India

Dr.Divya Gupta, Dr. Avinashi Kujur, Dr.A.Daharwal, Dr. Minu Keshkar, Dr.Suma Velgin Ekka, Dr.Archana Roy

INTRODUCTION-

Vaginal sarcoma is an exceedingly rare diagnosis constituting 2-3% of malignant neoplasms in female genital tract¹. Among variety of histological types, vaginal sarcoma represents only a fraction (3.1%)². The **aetiology** is currently unknown and unrelated to pregnancy. DES exposure, HPV infection, family history, cervical cancer may be the cause in some women. Still, influence of pregnancy on initiation, promotion and development of sarcoma is unclear. Mortality rates are high depending on the stage of disease at the time of diagnosis. Management involves multidisciplinary approach considering maternal welfare as well as foetal life.

CASE REPORT-

A 20 year old primigravida with 31 weeks pregnancy presented with lower abdominal pain and on & off urinary retention from 1 month, for which she was showing at peripheral centre. She was catheterised and referred to DR. BRAMH Raipur. P/A-32weeks, cephalic, head floating, liquor clinically adequate, expected fetal weight 1.2-1.4kg, FHR+ at left spinoumbilical line. P/S- A huge mass in lower third of left lateral vaginal wall, extending posteriorly which was occupying whole of vagina. Which was mimicking a cervical fibroid. Copious pus discharge from vagina present. P/V- Same firm, tender mass of about 10x10 cm with regular margin was felt which was extending posteriorly however the origin could not be traced, as it didn't seem to arise from uterus or cervix. Her vitals were stable and baseline antenatal investigations were within normal limits. She was given intravenous antibiotics, tocolysis, steroid coverage and magnesium sulphate for neuroprotection of fetus.

No significant medical or family history.

After 3 days of admission she was taken for emergency LSCS in view of Pre-PRM, by which she delivered a male baby of 1.3kg with APGAR 5, 8. Intraoperatively no mass felt arising from uterus or cervix but a diffuse mass was palpated in pouch of Douglas extending into left pelvic wall, whose lower margins could not be reached.

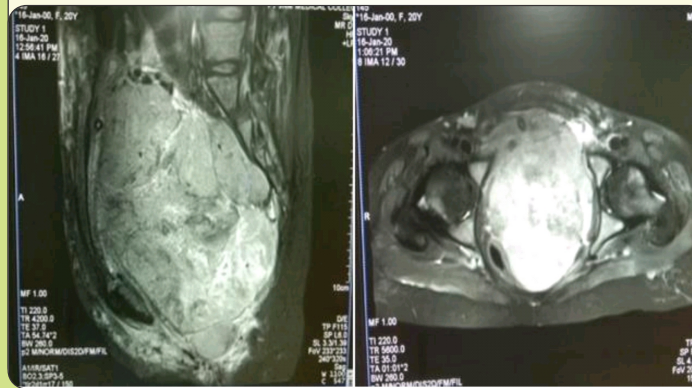
Biopsy from vaginal mass was sent twice for pathological examination but reports were inconclusive, after the conclusive report of sarcoma is obtained she was planned for immunohistochemistry and chemotherapy but meanwhile she sadly

USG-

Large fairly defined lesion with multiple internal hypoechoic area of size 14x13x11cc noted in pelvic region arising from cervix extending upto vagina showing peripheral vascularity suggestive of cervical fibroids with hematometra.

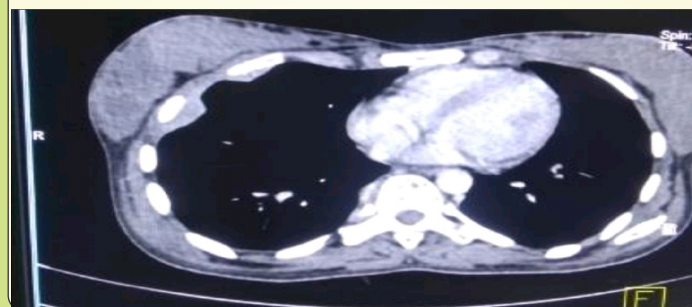
MRI finding-

A hyperintense soft tissue mass 12.3x11x15.7 cc in abdominopelvic cavity. A large leiomyoma with multifocal degeneration characteristics of malignant transformation. Multiple enlarged lymphnodes in bilateral inguinal and iliac region. Metastasis noted in bone marrow of pelvis and bilateral femur.



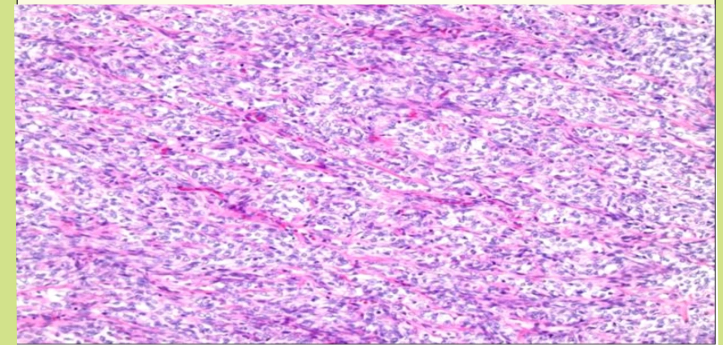
CT CHEST-

shows lung, pleural and bony metastasis.



PATHOLOGICAL FINDING (Biopsy) -

Cluster of malignant cells with clear cytoplasm and hyperchromatic nuclei, separated by delicate fibrous septa suggestive of sarcoma.



DISCUSSION & CONCLUSION-

Pregnancy includes many hormonal, molecular, anatomic transformation in genital tract. Overlapping of these changes with cancerous changes makes diagnosis challenging. Sarcoma runs very fast course the patient was referred to us at a very late stage when metastasis had already occurred. Study suggests that early detection and operative intervention before metastasis has occurred gives good maternal outcome³. Hence timely detection by proper history taking, examination, radiological finding, biopsy and other modalities such as immuno histochemistry is paramount.

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3. George Zarkavelis, Dimitrios Petrakis, George Fotopoulos, Sotirios Mitrou, Nicholas Pavlidis, Bone and soft tissue sarcomas during pregnancy: A narrative review of the literature, Journal of Advanced Research, Volume 7, Issue 4, 2016, Pages 581-587.




***Late Dr. Shobha Sharma Paper Gold
and Silver Medal Results***



Respected Judges

- Dr. Jayam Kannan
- Dr. B. S. Jodha
- Dr. B. SHANTHIRANI
- Dr. Bharathi Rajshekar
- Dr. Charmila Ayyavoo
- Dr. Chinmayee Ratha
- Dr. M. Banumathy
- Dr. Manisha Agarwal
- Dr. Sailaja Pinjala
- Dr. Sudha Gandhi
- Dr. Vidya Thobbi



*Third
Position
(42.34
Points)*

Dr. Varsha Somdeve

A case report-Atypical presentation of choriocarcinoma following two consecutive dilation and curettage.



*Silver Medal
(42.67 Points)*

Dr. Farhat Jahan Khan

Sickle cell disease with twin gestation with hypertensive disorder of pregnancy with recurrent crisis and immune hemolysis; A diagnostic and management Enigma

Gold Medal (44.34 Points)

- **Roma Jethani**

Metastatic pelvic masses with unknown primary- A diagnostic dilemma

- **Sanjita Pal**

Point of care blood clotting test and its correlation with fibrinogen level: Potential in goal directed transfusion in postpartum hemorrhage