Session No. 2—26th January 1956.

From Unit "B," Kandang Kerbau Hospital for Women

Moderator: DR. A. C. SINHA

(a) Two Cases Of Twin Pregnancy

Case Report:

Case No. 1

Reg: No. 997—K.G.—Chinese—Age 43 years —Gravida 10 — Admitted 16.1.56.

Previous Obstetric history:—

1. 9 full term single pregnancies.
2. All were delivered normally at home.
3. No history of toxaemia of pregnancy in any of them, although she experienced morning sickness for the first two months during each of the pregnancies.

Previous Medical history:—

Nil of note.

Family history of twins:—

1. Maternal side — nil.
2. Paternal side — 1 set of identical twins, daughters of the elder brother of her husband.

Present history:—

She was referred here from the Maternal and Child Welfare Centre, Thomson Road, for an X-ray. P.D. ? Twins. ? Hydramnios. Symptoms:

(1) Swelling of legs—1½ months.

(2) Slight headache and giddiness 3 days.

B.O.R., P.U. — no change.
L.M.P. = 15.4.55
E.D.D. = 22.1.56
M.P. regular, 30 days cycle, each lasting 2-3 days.

Clinical Examination:

General: Thin, slightly anaemic. Bad teeth — gold teeth + + B.P. = 130/90.
Heart — AB. at left 5th intercostal space 3½" from M.S.L., no thrill, no bruits.
Lungs — clear.
Pitting oedema of ankles.

Obsteric:

Abdomen large: Height of Fundus 20" Girth = 40"
and tense making palpation for foetal parts and presentation difficult; foetal heart sound not located.

Laboratory tests:

TR = 2.8 millions.
Hb = 54% (7.8G)
Catheterised specimen of urine — albumin +; E.C. 2-3; P.C. 6-7; RBC occasional.

Radiological finding:

A straight AP of abdomen was done. Report—"Twin pregnancy."

Management and treatment:

1. Rest in bed.
2. Low salt and high protein diet.
3. Injection Imferon 2 c.c. stat and 4 c.c. daily for 5 days.
4. Casilan one oz. t.d.s.

Progress note:

i. Very co-operative patient; she has been free from headache and giddiness since admission.

ii. Oedema of ankles has disappeared although her weight has remained the same i.e. 9 st. 6 lb.

iii B.P. normal — 120/80.

iv. Urinary albumin — nil v. TR = 3½ million, Hb = 59%.

Case No. 1 (B)

Reg. No. 373 — W.S.C. — Ch. — Age 39 years — Gravida 3 — Admitted on 6.1.56.

Previous Obstetrical history:

(1) First child, F.T., Toxaemia, Forceps to shorten 2nd stage; about 2 hours in labour, birth weight about 4 lbs., delivered in China.

(2) Second child, F.T., Toxaemia, Forceps to shorten 2nd stage, about 2-3 hours in labour, 8 lbs. at birth, delivered in China.

Previous Medical history:
Nothing relevant.

Family history of twins:
(1) Maternal — none.
(2) Paternal — none.

Present history:
Seen at the A.N. Clinic on 6.1.56 and was admitted for treatment of Toxaemia of pregnancy.

Symptoms:
(1) Headache and giddiness off and on.
(2) Swelling of legs since the 7th month. B.O.R. no change in micturition habits.

L.M.P. = 7.4.55
E.D.D. = 14.1.56
M.P. very irregular, varying from 24 to 37 days each lasting 5 to 6 days.

Clinical Examination:
General:
Thin, not anaemic.
Bad teeth — ceries +, gold-capped +.
Raw red tongue with angular stomatitis;
B.P. = 150/90.
Heart and lungs — clinically clear.
Oedema of anterior abdominal wall and legs up to the knees.

Obstetrical:
Abdomen — i height of fundus = 19½"
ii girth = 40"
L.O.A. Head engaged, F.H.N.H.
Liquor +

Diagnosis:
Hydramnios with toxaemia.

Laboratory Tests:
TR = 3.03 million
Hb = 59%
Blood urea = 25 mgm. %.
Cath. specimen of urine:
Albumin +; E.C. 4-5; P.C. 8-10.
Granular casts few

Radiological finding:
Straight AP of abdomen to exclude foetal abnormality.

Report: "Twin pregnancy."

Management and Treatment:
1. Rest in bed.
2. Low salt and high protein diet.
3. Diamox Tab. 1 o.m.
4. Largactil Tab. 50 mgm. t.d.s.
5. Injection Imferon 4 c.c. daily.
6. Injection Plexan 4 c.c. daily.

Progress Note:
(1) Toxaemia has shown very slight response to therapy: except for the absence of symptoms of headache and giddiness, and a slight loss in weight from 9 st. 8 lbs. to 9 st. 3 lbs; the B.P. and urinary albumin have remained the same.
(2) There is improvement in the blood picture, TR = 3.8 million, Hb. 3.8 million, HRfl mfmb mf mbfm = 75% (10.9G).

Discussion:

DR. N. N. LING: Presented the cases.

DR. A. C. SINHA: Discussed the two conditions superfoetation and superfecundation.

He said the incidence of twin pregnancies was given as 80 per 1000 deliveries. He next discussed the obstetric complications of twin pregnancy.

DR. C. S. OON: Did not think that the incidence of foetal abnormality in twin pregnancy was more than in normal pregnancy.

DR. S. T. JAMES: Mentioned anaemia as a further complication of twin pregnancy. He wished to know whether placenta praevia occurred more frequently in twin pregnancy than in a single pregnancy.

DR. A. C. SINHA: Did not think so.

DR. J. W. F. LUMSDEN: Asked whether in the etiology of twinning, unfavourable environment e.g. anaemia might favour division of the ovum to form twins, etc.

DR. A. C. SINHA: Agreed that some deficiency state, not necessarily anaemia might favour the development of multiple pregnancies.

DR. T. K. CHONG: Stated that in labour, twin pregnancies were often complicated

by Uterine Inertia. After delivery of the first baby, the second baby was not usually born until the membranes were artificially ruptured.

PROF. B. H. SHEARES: Said that the second baby should be born within 10 minutes of the first. If this did not occur, it was necessary to rupture the membranes of the second baby. Should there be any further delay, then delivery should be effected by forceps in vertex presentations and extraction in breech presentations. The second baby was usually smaller than the first.

DR. C. S. OON: Agreed with Professor Sheares that interference in the case of the second twin was indicated in about 5-10 minutes after delivery of the first twin but she did not agree to breech extraction.

DR. A. C. SINHA: Brought in the complication of locking of twins. This was a grave condition and generally occurred in the second stage.

DR. S. T. JAMES: Said he had not seen a case of Locked twins in Singapore but he recalled a case in London where the locking was of the chin-to-chin type, the first baby presenting by the breech and the second as a vertex. The first baby had to be decapitated, but the second was born alive.

PROF. B. H. SHEARES: Said that a head-to-head impaction in labour was called "collision of twins." He had seen 2 cases of locked twins.

DR. S. T. JAMES: Warned that in multiple pregnancies, one had to be wary in the administration of intravenous Ergometrine prior to the delivery of the placenta. Often a twin pregnancy was not diagnosed and if Ergometrine was given with the birth of the anterior shoulder of the first baby, then a real danger existed.

(b) A Case Of Hydatidiform Mole With Doubtful Malignant Change

Case Report:

Reg. No. 108B — F.B. — Age 20 years — Married 1 year.
No history of abortion
1 living child—6 mths. old.
Patient was admitted as an emergency case on 13th January 1956 at 12.45 a.m. with a history of sudden profuse vaginal bleeding with clots.

Previous Obstetric History:
The first child was normally delivered at a private clinic six months ago. Child artifically fed.

History of the present complaint:
She was first seen at 1.45 p.m. on 13th December, 1955 at the Gynaec. O.P.D. (Ref: 3191 B — OPD No. B/9170/55) with a history of:
3 months — amenorrhoea (L.M.P. 10.9.55)
1 month — nausea and vomiting.
1 week — slight vaginal bleeding after a fall on her buttocks.

Examination:
13.12.1955: General condition good. No signs of any recent injuries seen over body. B.P. 140/70. On palpation the uterus was found to be enlarged to the size of 26 weeks pregnancy. No foetal parts were felt and no foetal heart sounds were heard.

Vaginal Examination:
Slight brown discharge P.V.
Cervix soft. Internal os closed.
No internal ballottment detected.

X-ray abdomen: No foetal parts seen.

Diagnosis: Tydatidiform Mole.

Management and Treatment:
13.12.25: Cunningham's treatment started. Part of the mole was evacuated in the night.
14.12.55: D. &. C. by Dr. Chong under mole removed and sent for biopsy.

Biopsy Report No. B. 4280/55:
Necrotic endometrial tissue with oedematous villi, fairly large with necrotic cells seen. No evidence of malignancy.

Diagnosis: Hydatidiform Mole.
11.12.55: Patient was discharged as satisfactory and referred to the Follow-up Clinic at the O.P.D.

Follow-up:
5.1.56: General condition satisfactory. Very slightly brown discharge on pad. Uterus bulky. Appendages not enlarged Toad's test positive.

13.1.56: 12.45 a.m.
Re-admitted into hospital in the night (Ref: Reg. No. 108B) with a history of sudden profuse vaginal bleeding with clots.

O/E: General condition good.
Temp. 98.4° F. Pulse 84. p.m., B.P. 106/58.
Heart/Lungs. — N.A.D.
Abdomen soft, no mass palpable.

Vaginal Examination:
Clots ++ in vagina.
Uterus slightly bulky. AV. AF. mobile. Cs 1 finger dilated. Ovaries clinically not enlarged.
2.00 p.m. **Diagnostic Curettage done** — Dr. Chong.

Found: Uterine cavity 1" + and on curetting a small amount of necrotic-looking tissues and clot was removed for biopsy.

Biopsy Report No. B 170/56:
Necrotic endometrial tissue and necrotic villi with large blood clots seen. In Section (1) oedematous villi with marked cellularity. Syncytial and Langhan's cells seen.

Diagnosis: Tydatidiform Mole with malignant changes.

Follow-up:
14.1.56: X-ray chest — clear.
Toad's test: Undiluted urine — positive.

Dilution — 1 in 50 — negative.

DR. R. LOH: Presented the case.

DR. A. C. SINHA: Commented on the histology of Hydatidiform Mole and the maternal decidua, stressing on the natural properties of the trophoblast e.g. that of invasion, proliferation and destruction.

PROF. B. H. SHEARES: In discussing the pathology of Mole, stressed the fact that 10% of all pregnancies ended in abortion, and that 2/3 of these blighted ova showed evidence of hydropic change in the villi.

Three important points had to be considered in this case, viz:

(a) Clinical history.
(b) Histological picture of the mole.
(c) Gonadotrophin assays.

It was Virchow, who first called a Mole a "myxomatous degeneration of the villous stroma," Later Zondek noted an increased excretion of gonadotrophins in the urine and serum of these cases.

Four types of moles have been described:—

(1) Benign hydatidiform mole.
(2) Chorio-adenoma destruens.
(3) Chorio-carcinoma.
(4) Syncytial endometritis.

In Hydatidiform mole no malignant change was seen. On the other hand, in chorio-carcinoma there was absence of villous pattern, and a tendency to invasion of the blood vessels and decidua by the trophoblast. It was important to note that it was the villus which was the stabilising factor and prevented spread to the uterine wall.

DR. A. C. SINHA: Said that the clinical difference between Chorio-adenoma destruens and Chorio-carcinoma was that the former killed by intraperitoneal haemorrhage and the latter by metastases.

PROF. B. H. SHEARES: Wished to know how the case under discussion should be classified. A predominance of Langhan's cells and mitoses would suggest malignancy. Was it a case of Chorio-carcinoma or was it just that the uterus had not been completely evacuated during the first D. & C. He favoured the latter.

However the slide showed clumps of cells which appeared to be Langhan's in type.

As regards treatment of Hydatidiform Mole, he said the present trend was veering towards hysterotomy, as only then could the uterus be completely evacuated; furthermore, it was not possible to say that a mole was malignant unless the uterus was opened.

DR. A. C. SINHA: Said that not many cases of malignant mole diagnosed histologically died of intraperitoneal haemorrhage, and in quite a few of these cases the patient was cured and went on to further pregnancies.

DR. T. K. CHONG: Said a few words about the treatment of this case. Since the patient was so young, he thought conservative treatment was indicated with a follow-up every 2 weeks, checking on vaginal bleeding and the Toad's test. Incidentally. he mentioned another case

of Hydatidiform Mole seen recently in a woman 40 years of age, who had had 4 children. The uterus was evacuated by D. & C., and the bilateral ovarian cysts present at the time of evacuation disappeared in 2 months time.

PROF. B. H. SHEARES: Indicated that the treatment in the second case should have been hysterectomy.

DR. J. W. F. LUMSDEN: Was of the opinion that the follow-up of a case of Mole to see if malignancy occurred, was only of academic value, because once chorion-carcinoma was diagnosed, the condition was fatal.

DR. A. C. SINHA: Said that there appeared to be a higher incidence of Hydatidiform Moles in Eastern countries.

PROF. B. H. SHEARES: Agreed with Dr. Sinha and said that he would put the figure at 60 moles a year admitted into K. K. Hospital

DR. A. C. SINHA: In summing up the management of this case, said it was necessary for the uterus to be curetted again 4-6 weeks' time and the urinary Toad test done to exclude Chorio-carcinoma. He wished to know how long after a normal pregnancy did the Toad test become negative.

DR. J. W. F. LUMSDEN: Said after 1 week.

PROF. B. H. SHEARES: Said after 4 days.
DR. S. T. JAMES: In closing commented that it was important to note that the urine Toad test might be negative in some cases of Chorio-carcinoma.
