Nephrogenic Diabetes Insipidus following Pelvic Organ Prolapse Surgery – A Rare Presentation

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ABSTRACT

Introduction: Nephrogenic Diabetes Inspidus (NDI) is a clinical condition with polyuria and polydipsia. It resulted from insufficient production or end organ resistance to antidiuretic hormone (ADH). There are 2 types of DI i.e. central Diabetes Inspidus and Nephrogenic Diabetes Inspidus (NDI). The incidence of DI is 3 in 100,000 populations. Acquired NDI is the most common cause of NDI. These include kidney or systemic disorder. **Case Presentation:** This is a case report of a 57-year-old lady with pelvic organ prolapse. Her urine output ranges from 2,000 to 2,500 mls/day prior to surgery. Following pelvic organ prolapse surgery, her urine output ranges from 5,000 to 9,000 mls/day. Her urine osmality is low. She was monitored and her deficit was replaced. Her urine output stablilised after 3 days post-surgery. She was discharged 1 week after surgery. **Conclusion:** DI is a rare condition and NDI even rarer. Monitoring fluid post-surgery is important. Adequate correction of electrolyte imbalance is important for patient wellbeing.

Obstructed Hemivagina Ipsilateral Renal Agenesis with infertility – Diagnosis and Management

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ABSTRACT

Case Report: A 33-year-old lady first presented in 2008 with lower abdominal pain and fever, one month after having a laparotomy appendicectomy in Brunei. She attained menarche at 12 and had regular menstrual cycles with minimal dysmenorrhea. She had undergone two laparotomies previously at age 2 for ovarian cyst and subsequently at the age of 17, for a tuboovarian abscess. During her admission in 2008, she underwent a CT scan of her thorax, abdomen and pelvis. The uterus was bulky with haematometra, with multiple loculated pelvic collections, suggestive of a pelvic abscess. Her right kidney was absent. She was given intravenous antibiotics for the PID, to which she responded, therefore, not requiring surgery, which would have been difficult in view of her previous multiple laparotomies. She developed PID in 2012, which resolved with antibiotics and followed up by a consultant at the gynaecology clinic. In 2014, pelvic ultrasound revealed a uterine didelphy, with a hypoechogenic mass below the uterus. At this time, she was seen by a gynaecologist with a special interest in Mullerian Anomalies, who suspected that she had OHVIRA (obstructed hemivagina, ipsilateral renal anomaly with uterine didelphy). Subsequently, MRI confirmed the findings of a transverse vaginal septum obscuring the cervical opening on the right side and a single left kidney. An examination under anaesthesia revealed a bulge at the right lateral vaginal wall with obscured left cervix. The left uterus had a normal endometrial cavity with a single tubal ostium. A small opening was made on the right vagina to relieve the obstructed side. After being married for 2 years and unable to concieve, IUI was attempted but failed. Subsequently, she underwent a vaginal septoplasty, hysteroscopy and a hysterosalphingography (HSG) with an imagine intensifier (II) under general anaesthesia to assess her uterine cavities and tubal patency. HSG is a better option due to the risks involved with a laparoscopy and extensive pelvic adhesions due multiple laparotomies. Post septoplasty, both cervix with normal endometrial cavities were visualized. Bilateral tubal patency was confirmed. **Conclusion:** OHVIRA is a rare Mullerian Anomaly that is often missed as in this case. A high index of suspicion is required to be able to diagnose it correctly.