A-015

Neonatal uterovaginal prolapse: A rare case report

Yogeeta Gunasagran, Ana Vetriana Abdul Wahab

Department of Obstetrics and Gynaecology, Hospital Wanita dan Kanak-Kanak Sabah, Kota Kinabalu, Sabah

ABSTRACT

Introduction: Congenital neonatal uterovaginal prolapse is rare. It is mostly associated with spinal cord defects but can occur without it. We report a case referred to us at day 1 of life for an uterovaginal prolapse. **Case Description:** Baby M was 3.1 kg at birth with an uneventful delivery. On examination, there was a sacral dimple and a fleshy edematous mass likely representing an uterovaginal prolapse that was 3 cm beyond the introitus. There were no abnormalities detected on the ultrasound abdomen and spine. We inserted a vaginal plug layered with Premarin cream. The end was then tied off with a silk suture to aid with easier removal of the vaginal plug. We placed a gauze at the vaginal to secure the vaginal plug. An indwelling urinary catheter was inserted, and a pressure garment was applied over the diaper and baby was placed in Trendelenburg position. **Discussion:** Management of cases such as this varies. Amongst them were application of hypertonic saline packs that were applied to the prolapse followed by partial labial fusion with interrupted sutures, insertion of a vaginal pessary using rubber nipples or rolled penrose drains, digital reduction and placing a Foleys catheter in the vagina. There have been two reported cases of invasive surgical techniques following failure of conservative management with Foley's catheter. We successfully managed to reduce the prolapse using a vaginal plug that we kept in place for 6 days. Trial of non-invasive methods should always precede other more invasive methods in managing the prolapse.

A-016

Synchronous ovarian adenocarcinoma and squamous cell carcinoma of cervix: A rare case report

Logeswary Nadarajan[1], Lee Saw Joo[2], Zalina Nusee[1]

[1]Department of Obstetrics & Gynaecology, IIUM@SASMEC, Kuantan, [2]Departments of Obstetrics & Gynaecology, Hospital Raja Permaisuri Bainun, Ipoh

ABSTRACT

Introduction: Synchronous tumours of gynaecological malignancies occur rarely and mostly represented by synchronous ovarian and endometrial cancer. Synchronous malignancies of cervix and ovary are rare with poor prognosis. Low stage and low grade synchronous tumours must be distinguished from metastatic tumours for accurate management. **Case Description:** A 63-year-old was diagnosed with synchronous squamous cell carcinoma of cervix and high grade serous carcinoma of ovary. Clinical presentation, investigation and intraoperative findings were atypical. Patient presented with postmenopausal bleeding and mass per abdomen. Pipelle sampling revealed squamous cell carcinoma of cervix. Examination under anaesthesia noted endocervical growth measuring 3 x 4 cm with endoluminal extension into the endometrial cavity. CT imaging showed left ovarian mass measuring 10.0 x 11.7 cm. Uterine corpus involvement in this case mislead us to the initial diagnosis of ovarian metastasis in cervical cancer. **Discussion:** Our initial diagnosis of ovarian metastasis from cervical carcinoma was supported by a study that concluded that uterine corpus involvement was an independent risk factors for ovarian metastasis. Transtubal implantation has been postulated as a mechanism of spread. The presence of an endometrial lesion that eventually turned out to be benign endometrial polyp which originally could had been a carcinomatous serous endometrial polyp prior to initiation of chemotherapy. Unfortunately, the endometrial lesion was not sampled prior to neoadjuvant treatment and this had been the learning point. It is crucial to focus on the differential diagnosis between primary and metastatic tumours during the diagnostic process as the management and prognosis of each entity differ.