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Megarectum in pregnancy: A case of vaginal penetration failure during coitus

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ABSTRACT

Introduction: Megarectum refers to extreme dilation of the rectum as a result of underlying nerve supply abnormalities or muscle dysfunction. We report a rare case of megarectum diagnosed during early pregnancy presenting with failure of vaginal penetration during coitus. **Case Description:** A 23-year-old lady in her first pregnancy at 11 weeks gestation presented with failure of vaginal penetration during coitus. Since 1 month prior, sexual intercourse was not possible and attempted coitus had resulted in severe pain. There was no history of abdominal pain or per-vaginal bleed. She did notice a change in bowel habit where only a small amount of constipated stool was passed out during defecation. Clinical examination revealed an indentable 18 weeks size mass over the suprapubic area and another firm mass at the left iliac fossa region. Patient refused vaginal and rectal examination due to fear of pain. Imaging studies revealed gross dilatation of a faecal-loaded rectosigmoid colon measuring 19.2 cm x 8.4 cm, causing elongation of vagina and displacement of a bulky uterus superiorly to the left iliac fossa. A collapsed empty gestational sac measuring 3.16 cm was seen, suggestive of missed miscarriage. She subsequently progressed to spontaneous complete miscarriage. At the time this report is written, the patient has yet to agree on any surgery or rectal biopsy. **Discussion:** We wish to highlight this rare case and discuss the impact, outcome and management of megarectum in different clinical scenarios during pregnancy.

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Obstetrical dilemma – Pregnancy after myocardial infarction: Safe or unsafe?

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ABSTRACT

Introduction: Although there has been growing evidence in managing cardiac events in pregnancy, management of pregnancies following an acute coronary event is lacking. **Case Description:** We report a case of a 35-year-old who suffered a myocardial infarct (MI) five months following her delivery. Her antenatal care was relatively straightforward, apart from hypertension and obesity. She defaulted treatment subsequently and presented with hypertensive crisis and chest pain. She suffered total occlusion over right coronary and left anterior descending artery and her ejection fraction was 30%. Stents were placed and she was started on dual antiplatelet therapy, ACE-inhibitors, beta blockers and statins, which she took for a year. She was not referred for contraception/pre-pregnancy counselling. Patient then defaulted treatment and conceived again 14 months after her cardiac event. She was then managed by a multidisciplinary team and remained asymptomatic with aspirin and beta blockers. As repeated echo showed good ejection fraction, an elective date for vaginal delivery was planned at 37 weeks. **Discussion:** This case illustrates the ambiguity of managing pregnant women with history of MI. There is lack of literature in recommendations on safe inter-delivery space, management, and prognostic differences with involvement of single / multiple vessel disease and different revascularization interventions, such as coronary artery bypass graft surgery versus percutaneous coronary intervention. This case also highlights the importance of following up women post-coronary events. More research is required to identify additional obstetric risk factors that contribute to lifetime cardiovascular risks. Pregnancy after a myocardial infarct in patients who are asymptomatic with preserved ejection fraction appears to be safe. However, more evidence-based recommendations are needed to develop guidelines in managing these women.