Uterine restoration following fibroid expulsion after uterine artery embolisation using gelfoam

Sir,

We have been using uterine artery embolisation routinely at our centre for the last two years to treat selected symptomatic patients with fibroids. We report a case of a 35-year-old woman who presented with menorrhagia and dysmenorrhoea with a uterus measuring 5.9 cm in diameter, as seen on transabdominal ultrasound and MR imaging. The patient underwent bilateral uterine artery embolisation using a single 5 F Uterine Artery Catheter (Cook, Bloomington, IN, USA) from the right transfemoral route using standard technique. Instead of using polyvinyl alcohol particles we used gel foam particles as detailed in the article by Katsumori et al. Embolisation of both uterine arteries was effected to the point of near occlusion of the uterine arteries and the uterine vascular bed with reflux of contrast into the arch segment and the descending parts of the uterine arteries. Post-embolisation crampy abdominal pain was effectively controlled using intravenous infusion of a combination of pentazocine and midazolam which continued for two days following the procedure.

Following the procedure, the patient’s symptoms of menorrhagia and dysmenorrhoea improved in the first menstrual cycle itself. Three months following the procedure, the patient reported painless evacuation of a fleshy mass per vaginum on the first day of her menstrual period. Ultrasound revealed a 34% decrease in uterine volume and mild left hypochondrial tenderness. Three months following embolisation and is unique because it followed embolisation using gel foam particles, which are very economical and yet highly effective embolisation materials as recently reported.

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References


Persistent hypotension and splenic rupture in a patient with Plasmodium vivax and falciparum coinfection

Sir,

A 28-year-old man was admitted with fever, abdominal pain, vomiting and loose stools of three days’ duration. He was from a region non-endemic for malaria. There was no history either of previous episodes of malarial infection or of travel to an endemic area. On examination, the pulse rate was 106/min and blood pressure was 100/70 mm of Hg. He was febrile (temperature 40°C), and was pale and icteric. His abdominal examination revealed a soft abdomen, with hepatosplenomegaly and mild left hypochondrial tenderness.

Investigations revealed haemoglobin of 5.7 gm/dl, total leucocyte count of 4.9x10^9/L and a platelet count of 23x10^9/L. Thin blood smear revealed Plasmodium vivax rings, schizonts and gametocytes. Gametocyte and ring stages of Plasmodium