

# Letters to the Editor

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## **Perforated uterus - Full term pregnancy**

Sir,

Uterine perforation is still a recognized complication of dilatation and curettage (D&C) which may or may not be discovered at the same time. The prognosis is better if an early diagnosis and treatment is made. If it passes unrecognized or the bowels involved, the prognosis is worse and maternal morbidity and mortality is high.<sup>1</sup> A 32 year old Saudi female, Para 3+2. She had three full term normal pregnancies and uncomplicated vaginal deliveries. Two evacuations of uterus for first trimester abortion. The post operative period was uneventful. No further intervention after D&C was carried out. Booked for antenatal care at 24 weeks pregnancy. All her antenatal screening were within normal limits. She was HbSAg positive. She was seen on 8 occasions. Normal progress was reported. Booking ultrasound scan confirmed normal morphology, compatible with her dates. The placenta was anterior. Admitted at term in spontaneous labor. One and half hours later she gave normal birth of a female infant weighing 3.060 kg. While delivering the placenta, the umbilical cord snapped. On abdominal palpation a dimple in the fundus was noted. A provisional diagnosis of retained placenta with incomplete uterine inversion was made. She was taken to theatre for examination under anesthesia, correction of uterine inversion and manual removal of placenta. The general condition was stable. The vulva and vagina were normal. The attempt to correct the incomplete uterine inversion by hydrostatic method failed. The vagina and uterine cavity failed to be distended and filled up with fluid. On bimanual examination only pieces of placenta were found and were removed manually with no placenta felt. There was no evidence of uterine inversion. A hole in the uterine fundus was felt. The decision was to proceed to laparotomy. On laparotomy the abdomen was filled with blood stained fluid. The placenta was found in the upper abdomen and was removed. The uterus was well contracted. An old 3x4 cm hole was discovered at the uterine fundus through which the placenta must have escaped into the abdominal cavity. The edges were fibrosed, not bleeding with no extension either side. The edges were freshened and the hole was closed in two layers. The patient made a satisfactory recovery and was allowed home on the 6th postoperative day. Perforation of the uterus is complication of uterine curettage. The accidental perforation of the uterus calls for individualized treatment. If it occurs in a small firm uterus, watchful waiting is usually sufficient.

Abdominal surgery is necessary if injury to the bowel or bladder is suspected or if bleeding is excessive and persistent.<sup>1</sup> This patient had asymptomatic perforated uterus following evacuation of uterus for first trimester spontaneous abortion. The perforation passed unrecognized, so no further action was taken. She conceived six months following evacuation of uterus which was perforated and the perforation passed unrecognized. The fibrosed edges of the hole were strong enough to sustain uterine enlargement with pregnancy and save the uterus from rupture. The hole was covered with membranes and not placental tissue. The old uterine perforation was discovered accidentally during manual removal of a retained placenta after normal vaginal delivery.

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## *References*

1. Hodgkinson, CP, Drukker BH. Operative Gynecology In: Danforth DN, Dignam WJ Hendricks CH, Maeck JVS eds. *Obstetrics and Gynaecology*, Philadelphia: Harper & Row; 1982. p. 1247.

## **Breast Cancer - Is there a need for a breast unit?**

Sir,

"Probably there is no other cancer that has changes in the concepts and purpose like breast cancer in this century, and finally, we also must stress once more that breast cancer treatment is extremely surgical treatment. Not a single case can be cured without surgery". This is the opening statement of Professor Umberto Veronesi (Italy), the President of Breast Surgery International, when he presented breast cancer at the Hunterian lecture in the International Surgical Week, Vienna, 1999. Breast cancer is getting the highest level of attention from all medical authorities in the western countries because of its high incidence. In England and Wales, 1 in 12

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**Table 1** - Yearly malignant breast cases compared to benign breast.

| Year      | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 |
|-----------|------|------|------|------|------|------|------|------|------|------|
| Malignant | 26   | 41   | 30   | 39   | 42   | 30   | 44   | 65   | 72   | 48   |
| Benign    | 12   | 24   | 21   | 19   | 21   | 10   | 32   | 31   | 42   | 44   |

women will develop the disease during their life time.<sup>1</sup> In the USA the probability of a woman developing breast cancer in 1996 was estimated to be 1 in 8.<sup>2</sup> In May 1999, the Ministry Of Health-National Cancer Registry has published a book named the Cancer Incidence Report in Saudi Arabia.<sup>3</sup> In this book the Kingdom is divided into 13 administrative regions to ensure a comprehensive collection of data. Offices have been established to collect data of cancer patients in all regions of the Kingdom in the period between January 1994 and December 1996. The results related to breast cancer are as follows: -Total cases 1430 = 19.1% of all cancer in females (thyroid follows - 8.8%); - It is number one cancer in the Kingdom (liver cancer 1216 cases - 7.4%); - Mean age at diagnosis was 48.3 years; - Diagnosis of In situ carcinoma was almost none, and infiltrating ductal carcinoma was diagnosed in 76.1%. Referring to the computer of the hospital, total number of patients admitted and treated for breast disease each year have been collected and then plotted on charts. Two ways of collecting data have been used in a trial to avoid research bias. The first was to look at the total number in a period of time randomly selected (January 1987 to January 1997). The second was to look at the number of patients presenting each year in a period of time randomly selected also (from January 1990 to January 2000). The number presenting each month in 1998 is compared with the number presenting each month at St. Thomas hospital to give an idea about its significance. The aim is to prove or disapprove the theory that an increasing number of breast disease patients are managed by the hospital, especially breast cancer patients.

The first method, from January 87 to January 97 (9 year period), 431 patients have been admitted and treated for breast carcinoma. With simple calculations the mean number of patients per year is approximately 48 (431/9) patients. If we calculate the mean of cancer cases per year in the Kingdom from the national cancer registry it will be (1430/3 =

477). We conclude from this that Armed Forces Hospital manages about 10% of breast cancer cases in the whole Kingdom.

The second method, there is a clear increase in the number of breast cancer patients from 1990 (26 patients) to an average of 38 patients per year in the following 6 years. However, there is a sharp rise in the year 1997 (65 cases) and the year 1998 (72 cases), then the number declines back towards the average in 1999 (48 patients). From the chart, the total numbers of benign and malignant cases are also increasing and clearly more malignant cases are admitted and treated compared to benign cases. St Thomas hospital is located in the center of London; it has a specialized breast unit with a specialized breast surgeon that with his team run a breast clinic. This clinic provides the triple assessment service (clinical examination, radiographic studies and fine needle aspiration cytological examination), at the end of the clinic the patient has the result and the proper later management plan of her complaint, all in one day. As a referral center according to their computerized statistics they have managed 130 patients with variable stages of breast cancer during the period 01/01/1999 to 31/03/2000 (15 months) or an average of 9 patients per month. In our hospital, which is not a referral center for breast cancer, and in 1998 (72 patients) we had an average of 6 patients per month. If we take in consideration the higher population of London and the documented higher incidence of breast cancer in the western countries, and 9 cases of breast cancer are presented to a referral center for breast cancer, the average seen in the Military Hospital of Riyadh could not be ignored (6 cases per month in 1998). Certainly, the incidence of breast carcinoma is increasing in the Kingdom, and the Military Hospital in Riyadh is receiving increasing number of patients each year to the extent approaching a specialized breast center. It is a fact that a delay in diagnosing and commencing definite management is associated with advancing of the disease and consequently poorer results of any appropriate treatment. The delay is more likely if

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non-specialized persons are dealing with breast pathology.<sup>4</sup> Also much of the concern has to be thought of if this delay can transform a curable disease to only a controllable disease. Lately, several factors have heightened skepticism about the benefits of screening. First, screening can harm individuals, particularly via the adverse effects of false-positive and false-negative results. Secondly, not all persons whom might be affected reach to screening centers. Thirdly, the major issue of cost-effectiveness of screening in health care.<sup>6</sup> It is also a fact that setting a screening program will not be cost effective, since the incidence of breast carcinoma in the Kingdom in general is not of warning level. In my opinion, setting a breast unit that provides the triple assessment service and commencing definite treatment within days, combined with easy booking for worried patients, can hit the target of earlier detection and treatment of the disease by a specialized multi disciplinary team, and in addition keeping clear records of patients that can help to re-

direct the management policy if needed and also follow families with probable genetic predisposition for breast cancer.<sup>8</sup>

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### References

1. Man CV. Bailey and Loves Short Practice of Surgery. 2nd ed. London: Chapman & Hall; 1995. p. 553.
2. Shwartz. Principles of Surgery. 7th ed. Singapore: McGraw-Hill; 1999; 1: 544.
3. Cancer Incidence Report. Saudi Arabia: Ministry of Health; 1994-1996.
4. Keddie N. Medico-Legal problems in breast surgery. MDU Council. Journal of the Medical Defence Union 1993; 3.
5. Time for evidence-based screening. Journal of the Royal Society of Medicine 1998; 91: 7.