PROLAPSE OF THE FOETAL INTESTINES

(A Case Report)

by

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Exomphalos or omphalocele is a rare condition. Nelson gives an incidence of 1 in 5,000 births. Rupture of the omphalocele with prolapse of the foetal intestines is still rare. Munro Kerr and Moir presented in their 6th edition of Operative Obstetrics, the picture of one case (F. J. Browne's unit) of a ruptured exomphalos with the foetal gut and the liver protruding from the mother's vulva. There were two cases of exomphalos out of 12,256 births at the Medical College Hospital, Nagpur, during the years 1952-1959. The following case is reported for the several interesting features it presents.

Cast History. Mrs. V, aged 25 years, gravida 2 para 1, was admited at 4-35 a.m. with history of 9 months' amenorrhoea and having been in labour for the last 6 hours. The patient stated that the pains were unduly strong from the beginning and she noticed something suddenly coming out of the vagina with one strong pain. The medical officer on duty could not make out the presentation and position of the foetus, could not hear the foetal heart, found coils of gangrenous intestines protruding out of the vulva and thought the case to be a case of ruptured uterus. However, on careful examination it was found that the general condition of the patient was good, pulse 90 per minute, with good volume and tension, and B.P. 130/90. Heart and lungs revealed nothing abnormal.

Abdominal Examination. The uterine contour could be made out definitely. The uterus was tense but not tender. Occasional contractions of the uterus were felt. Presentation and position of the foetus could not be made out on palpation. Foetal heart was absent.

Vaginal Examination. The cervix was fully dilated. Shoulder was presenting at the brim. Head was felt high up in the right iliac fossa. Position of the foetus was right dorsoposterior. The intestines could be traced to the abdominal wall of the foetus. Liquor was thick and meconium-stained. A diognosis of transverse presentation with prolapse of the foetal intestines was made.

Under general anaesthesia the above findings were confirmed. Internal podalic version was done and the baby was extracted. Head was quite big and hyprocephalic. However as the skull bones were collapsed it could be delivered very easily. There was brisk bleeding after the delivery of the foetus and as such placenta was removed manually and the uterine cavity was explored. No rent was palpable in the uterine wall. The uterus contracted with 0.5 mgs. of i.m. ergometrine and the bleeding was controlled. Puerperium was uneventful and the patient was discharged on 7-6-1958.

Description of Baby. The baby was a female, weighed 7 pounds and presented the following features. The skin was showing signs of maceration. The head was hydrocephalic though the skull bones were collapsible. On the right side there was cleft lip with cleft palate. The chest

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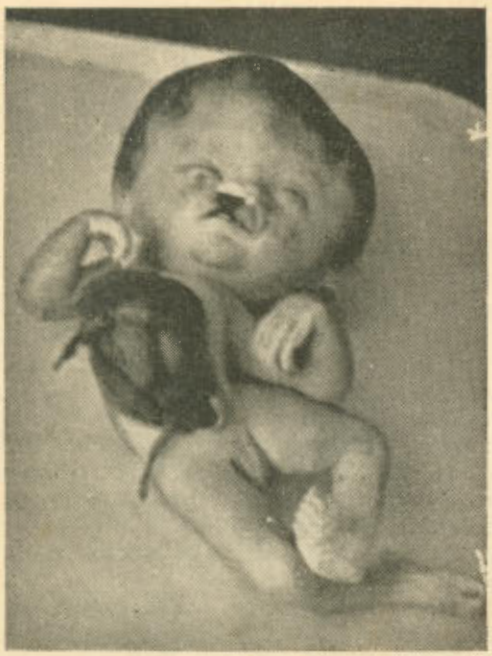

Fig. 1

wall on the right side was deficient and not developed. Greater portion of the anterior abdominal wall was absent. The amnion was torn through leaving exposed the small and the large intestines. The umbilical cord was completely absent. On the left side there was talipes eqiono-varus. There was an extra finger to the left hand attached to the little finger.

Comment

The diagnosis of an exomphalos is usually made after the birth of the baby. During labour the condition is often mistaken for a prolapse of the umbilical cord. If the cord pulsates there is no likelihood of any mistake being made. The umbilical cord can be distinguished from the prolapsed intestines by the fact, that with a piece of bowel (foetal or maternal) the mesenteric attachment can always be defined, whereas the umbilical cord is free.

If the intestines are prolapsed outside the vulval outlet the doubt occurs whether they are foetal or maternal. The foetal intestines with the meconium inside resembles the gangrenous intestines of the mother, which may prolapse through a rent after the uterus ruptures. In the case quoted by Munro Kerr and Moir "the student examining the patient during labour inadvertently ruptured as he thought, the amniotic sac. Immediately loops of intestines protruded from the vulva. The consternation of the watching accoucheurs was somewhat allayed when the liver appeared and the correct diagnosis was made." In this particular case the medical officer on duty thought it to be a case of ruptured uterus with prolapse of the gangrenous intestines of the mother. The history of the patient that with one strong pain something came out of the vulva, with a tense abdomen rendering it impossible to make out the presentation and position of the foetus, with the intestines protruding outside the vulva may certainly make one to think of rupture of the uterus. However in all such cases, a proper history, with the correct assessment of the condition of the patient, with presence or absence of signs of prolonged and obstructed labour and the size of the intestines, will differentiate, whether they are foetal or maternal intestines. It was obvious that the transverse presentation was the cause of the easy prolapse of the foetal intestines outside the vulval outlet.

The interest in this case is further enhanced by the presence of multiple congental abnormalities in the foetus. It is said, exomphalos is asso-

ciated with other congenital malformations. But it is definitely unusual to find so many in one and the same foetus. The hydrocephalus was the cause of shoulder presentation in this case. As the foetus showed signs of maceration, intrauterine death of the foetus must have occurred before the onset of labour, which naturally facilitated an easy extraction of an hydrocephalic head because of the collapse of the skull bones.

Summary

A case of ruptured exomphalos with prolapsed foetal intestines and other multiple congenital malformations of the foetus associated with an abnormal (transverse) presentation is reported.

References

1. Mudalier A. L.: Clinical Obstetrics; 2nd edition.
2. Munro Kerr and Moir: Operative Obstetrics; 6th edition.
3. Nelson: Text Book of Paediatrics.

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