DYSTOCIA DUE TO FOETAL ASCITES

(A Case Report)

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Distension of the abdomen of the foetus from ascites, distended bladder and tumours of spleen, liver, testicles (undescended), ovaries, kidneys, are generally speaking great rarities and are rare causes of obstructed labour.

The foetal abnormality is usually discovered following delivery of the head and shoulders when further progress is arrested. It would appear, however, that the diagnosis can be made before labour with considerable certainty, by radiography. Puig Y. Roig (1948) reported one case of foetal ascites thus diagnosed and three cases suspected which were all confirmed at delivery.

The problem for the obstetrician is the same, no matter what the condition may be, viz. — a distended abdomen preventing expulsion of the child.

If the presentation is cranial, the diagnosis is simple, because the thorax of the child would pass through the maternal pelvis easily; when however the shoulders also do not descend, there is little more difficulty in appreciating the cause of dystocia. In that case, the obstetrician has to pass the hand into the uterus beyond the shoulders and thorax before a diagnosis can be made. Should the child present by breech, one or both legs can be brought down, but further delivery is impossible (Chassar Moir). In cases of distension of the foetal abdomen the bulk of the child can usually be sufficiently diminished by withdrawing the fluid by an aspirator, as most of the conditions encountered are cystic.

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Case Report

J.G., a fifth gravida, aged 31 years, was admitted as an emergency case to the hospital on 6th February 1964, with the history of 9 months' amenorrhoea and labour pains since about 8 hours. She did not attend any ante-natal clinic. Her previous obstetrical history was normal. No history of any congenital deformity in the previous children was available. Her last delivery was 3 years back.

On admission, the patient complained of very strong pains for the last 4 hours but with no progress, and hence she sought admission to the hospital. The uterus was of full-term size, the foetal parts were difficult to palpate, the presenting part—head—was floating. The foetal heart sounds were absent.

The membranes ruptured spontaneously

and vaginal examination revealed a compound presentation of vertex, hands and a loop of the umbilical cord; the cervix was fully dilated. There were no pulsations in the cord. The head was in the occipito-posterior position at the level of the ischial spines. The size of the head and the fingers of the hands were smaller than the average and hence suspicion of twins arose. The hands were pushed above the head but with each pain there was a tendency for them to come down.

After 2 hours the pains were becoming weaker and the mother showed signs of exhaustion. The head could be seen at the vulva during contractions but with relaxation the head was seen to recede completely inside the vulva. To assist the delivery, traction was given to the head which got severed from the body easily. Further delivery of the foetus was decided to be done under anaesthesia but within a few minutes she got strong pains and a tense, cystic, blackish part was seen presenting through the vulva, but receding with relaxation. On vaginal examination, it was thought to be the bulging membranes covering the head of a possible second foetus. It could be ruptured with the fingers and on rupture, there was a forcible gush of clear fluid, about 6-7 pints. On further examination through the artificial opening no head was palpable but coils of intestines were felt. A diagnosis of foetal ascites was made at this stage only. Slight traction was then given on the hands which had again prolapsed and the foetus was delivered. The baby was macerated. Placenta was delivered spontaneously. There was a moderate amount of post-partum haemorrhage which was controlled with inj. Ergometrine 0.5 mg. given intravenously.

The puerperium was uneventful and the patient was discharged on the 6th post-partum day.

The baby was 5 lbs. in weight (excluding the ascitic fluid). It had a grossly distended abdomen the walls of which were irregular in their consistency and there were two dark pigmented areas—one just above the umbilicus—which was ruptured—and the other on the right side. The abdominal viscera were normal macroscopically. The umbilical cord was attached on the left and upper part of the abdomen. The thorax was only 1 inch in length. Rudimentary genitals were seen and a probe could be passed through a small urethral opening. The legs and the arms were small. Talipes equino-varus was present and the arms were lying in the extended position. The placenta looked to be larger in size than normal (10″ x 10″) for this foetus. It showed no macroscopic abnormality except for the friability.

Unfortunately the relatives refused post-mortem examination; and we could not take the weight of the placenta nor could we do any histopathological study.

Kahn test in the mother was negative. Her blood group was '0' Rh positive. Fasting blood sugar was 95 mg.%; sugar was absent in the urine and a trace of albumin was found. These investigations were performed on the second day of the delivery.

Discussion

In the case under report, the foetal abdomen was very tense and its appearance seen on separation of the vulva was like that of a foetal head covered by a bulging membrane. It was ruptured thinking it to be the membranes of the second baby of suspected twins in labour. The accidental rupture at once diminished the bulk, which was the cause of the obstruction and the foetus could then be delivered easily.

De Lee and Greenhill suggest that in the cases with head presentation, after the head is delivered and the distended trunk does not come down, several ribs and the sternum should be resected with heavy scissors and the lungs and the heart removed, the diaphragm punctured and the abdominal contents evacuated. This may be necessary only in solid tumours of the abdomen.

As the size of the abdomen of the patient was of average full-term size,

it did not make us suspect any abnormality. It was a surprise case of dystocia and that too due to a rare cause like foetal ascites.

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References

1. Barr, James S. and Viccar, Mac: J. Obst. & Gynec. Brit. Emp. **63:** 890, 1956.
2. Chassar, Moir: Munro Kerr's Operative Obstetrics ed. 6, London, 1956, Bailliere, Tindall & Cox, p. 248.
3. De Lee: Greenhill Text-book of Practical Obstetrics ed. 11, Philadelphia & London, 1955, W. B. Saunders & Co., p. 648.
4. Puig. Y. Roig Med: Espan. **19:** 117, 1948.

Fig. 1.
Foetus with abdomen distended with an amount of fluid equivalant to that drained.

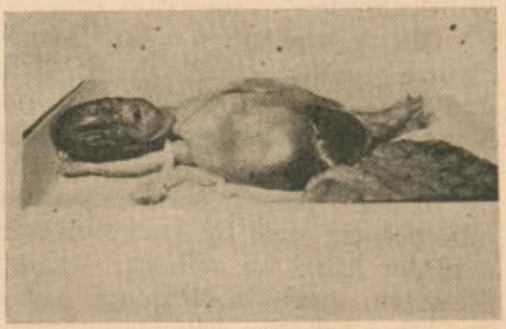

Fig. 2.
Foetus with the severed head placed in position.