

IDIOPATHIC FOETAL ASCITES

(A Case Report)

by

A. H. MHATRE,* M.B.B.S., D.G.O.

C. M. GAREHGRAT,* M.B.B.S., D.G.O.

D. D. SATHE,** M.D., F.C.P.S.

and

S. D. PANDYA,*** M.B.B.S., D.G.O.

Obstetricians quite often come across cases of foetal dystocia. However, dystocia due to foetal ascites is comparatively rare. Here we report a case which we had at our hospital.

Case Report

A VI gravida, aged 30 years, was admitted to the hospital at 40th week of pregnancy for labour pains on 21st December 1966. She had attended our ante-natal clinic from the 30th week of pregnancy and no abnormality was detected during ante-natal check-up. There was no history of any foetal anomaly in her previous pregnancies or in her family.

Blood K.T. was negative, she was AB RH positive, haemoglobin was 8.8 g% and urine did not show presence of sugar or albumin. Blood sugar was 85 mg.%

On admission, the uterus was 36 weeks' size, presenting part was vertex I. Foetal heart sounds were 140/mt., regular. There was no hydramnios. Blood pressure was 134/94 mm. Hg., pulse 72/mt., regular and there was no oedema.

*Gynec. Registrars.

**Part-time Obstetrician & Gynaecologist.

***Casualty Medical Officer.

L. T. Municipal General Hospital and Medical College, Bombay.

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The membranes ruptured spontaneously. The cervix was then 3/4 dilated and taken up. Labour progressed well. The first stage lasted for 8 hours. The head was delivered with occiput anterior without any difficulty and there was no delay in birth of shoulders. Both the arms were brought down. No further progress was then possible, despite fundal pressure and arm traction.

The hand was passed along the ventral aspect of foetus. The foetal abdomen was found to be grossly distended but soft. A probable diagnosis of foetal ascites was made and immediately plain x-ray of abdomen was taken, which confirmed the diagnosis. Delivery could not be effected. The umbilical cord which was out, stopped pulsating.

An attempt was made to perforate the foetal abdomen by scissors, after introducing the left hand in the vagina and going right upto the foetal abdomen. The scissors were guided along it. But as scissors started slipping away from the foetal abdomen and due to fear of injury to the maternal soft parts, no more attempts were made with them. Then Drew Smythe catheter was passed into the vagina by the same technique. The foetal abdomen was perforated near the epigastric region by a sharp jerk. Straw coloured fluid which escaped from the abdomen was collected, and measured 610 ml. The body of the foetus then came out without any difficulty.

The placenta was expressed. The patient was given injection methergin intramuscularly soon after the completion of labour. The uterus and vagina were explored. No injury to the maternal tissues was detected; third stage blood loss was minimal.

The placenta weighed 680 gms. and showed no abnormality. The puerperium was uneventful. Patient was discharged 5 days after delivery.

The foetus weighed 2300 grms, female, and showed no external abnormalities, except the distended abdomen. The anus was patent. The height was 48 cms. and abdominal girth (after injecting the same amount of fluid) was 41 cms. (Fig. 1)

The abdomen was opened, but showed no abnormalities except for the presence of ascites.

Discussion

Undue size of the foetus may be general or confined to certain parts of the body, such as head, neck, shoulder, thorax, abdomen or pelvis. Such enlargement, either general or local, is expected to cause obstruction to the normal process of labour.

Distension of the foetal abdomen from idiopathic ascites, distended bladder, tumours of the spleen, liver, testicles (undescended), ovaries, kidneys and umbilical hernia, are relatively speaking great rarities and each of these conditions is of great pathological interest.

Different authors have recorded different causes for enlargement of foetal abdomen.

Barr and MacVicar (1956) have reported a case of idiopathic foetal ascites, while Bode mentioned a case in which a retroperitoneal teratoma was the cause of abdominal distension. D. W. Beacham and W. D. Beacham (1952) and Jeffcoate have also

recorded a case causing dystocia due to megabladder.

In cases of cranial presentation, usually the head comes out through the maternal pelvis easily along with shoulders, but if shoulders do not descend then there may be a little more difficulty in appreciating the cause of dystocia.

The unusual distension of mother's abdomen may attract the attention. Usually the hand has to be passed into the uterus beyond shoulders and thorax before a diagnosis can be made.

In breech presentation, one or both legs can be brought down but the further progress becomes impossible.

Usually most of the conditions encountered are cystic and, therefore, the bulk of the child can be sufficiently reduced on withdrawing the fluid by tapping the foetal abdomen.

In cephalic presentation dystocia due to foetal ascites is usually discovered following the delivery of the head and shoulders when further progress is arrested (Shaw and Mariott-1949), Beacham and Beacham (1952). But Puig Y. Roig (1948) said that such a condition can be diagnosed with great certainty before labour by radiography.

The x-ray picture of foetus with distended abdomen shows the ribs splayed out and legs, arms held away from the body.

Management

If the size of the abdomen is the cause of obstruction, the life of foetus should not be considered.

Paracentesis of abdomen is necessary in most of the cases as the conditions encountered are mostly cystic.

Simpson's perforator was found to be the answer by Barr and Mac Vicar, while Mayo's scissors were used by Beacham and Beacham. DeLee and Greenhill (1947), suggested resection of several foetal ribs and sternum followed by perforation of the diaphragm to evacuate the abdominal contents.

In our case we used Drew Smythe catheter and found it very useful in tapping the ascites.

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Figs. on Art Paper VI