OBSTRUCTED LABOUR BY DISTENDED URINARY BLADDER

(Case Report)

by

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It is very unusual to find a distended bladder causing obstructed labour. Of course, it is common to observe distended bladder abdominally during labour, associated with uterine inertia and prolonged labour. Vesical calculi and other soft tissue tumours of the bladder are known to cause dystocia. As a normal mechanism of labour the bladder is pushed up during the second stage of labour to make room for the foetal descent. The degree to which a distended bladder may cause obstructed labour has not been satisfactorily evaluated nor reported in the literature. Recently a similar case report (Chaubal *et al* 1966) was published.

Case Report

Mrs. S. M., aged 22 years, para 2, gravida 2, was admitted to the Obstetric ward for confinement on 6-1-67. She was in advanced labour since a day previous to admission. She had retention of urine for few hours before hospitalisation. Her pregnancy was full-term. Her previous labour was normal about two years ago. She did not have previous urinary trouble.

Uterus was of full-term size, having moderate uterine contractions. The foetus was presenting by vertex in LOA position. The head seemed to be of normal size and was found to be unengaged. It was slightly pushed to the left lateral side of the brim. Foetal heart sounds were regular at the rate of 148 per minute. A soft cystic mass was palpated per abdomen in the right lower lateral quadrant of the abdomen. This was felt quite separate and superficial from the uterine mass. Percussion note was dull. No tenderness was present.

Before doing a vaginal examination, an attempt was made to pass a rubber catheter into the bladder. This could not be done. The catheter met an obstruction in the urethra. Head was too high up to compress the urethra. No force was used for fear of causing injury to the urethra.

On vaginal examination, the cervix was found to be two fingers dilated and almost effaced. Membranes were intact, Cervix was pushed to the left lateral side by a soft, tense cystic swelling (3″ x 4″) bulging into the vagina from the right antero-lateral fornix. Head was felt to be in close contact to the cystic mass.

Diagnosis of an ovarian cyst causing obstructed labour was made. A decision was made to do a caesarean section.

In the operation theatre, the patient was put under general anaesthesia. Another attempt was made to pass a catheter into the bladder. It failed again. A lower segment caesarean section was done. On opening the abdomen, to our great surprise, the lump was found to be the distended bladder. The ovaries and the tubes were normal.

After taking out the baby, another attempt to pass a catheter into the bladder failed initially, but succeeded after repeated and forceful attempts. The lump disappeared.

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Comments

The abdominal lump was rightly thought to be the distended bladder, though it was placed very much laterally. But the tense cystic vaginal swelling was never in our mind, even remotely, to be the distended bladder. Features were very similar to an ovarian cyst, particularly of the dermoid variety. Bladder was not known, in general, to cause such dystocia. Wolfson reported an interesting case of bladder diverticulum. Due to some difficulty, we could not do the post-delivery cystoscopic examination on our patient. Hence possibility of this condition could not be excluded. Simple catheterisation of the bladder would have settled the issue, had it not been so difficult to pass the catheter. We could not account for this difficulty. Crabtree described marked oedema of the base and the anterior wall of the bladder after doing the post-delivery cystoscopic examination. But here the foetal head was found to be completely free from the urethra and was unengaged at the time of admission into the hospital. In an experimental study, Kantor *et al*, in 1949, distended the bladder by some radio-opaque substance during labour and noted its relation to the head and the pelvis at different stages of labour. His results were as follows.

"1. Prior to engagement of the head a large portion of the bladder retained its pelvic position. During this phase, the distended organ did obstruct descent.

2. At the time of engagement, a moderate portion of the bladder was in the pelvis. When distended, it did interfere with the normal progress and occasionally the presenting part remained disengaged.

3. When the presenting part was deep in the pelvis, the bladder was mostly abdominal with only a small pelvic portion. If the pelvic portion was ample and the foetus small, a large tongue of the bladder was noted."

With this idea, a possible explanation can be put forward thus:

That the head was engaged initially at the onset of labour and caused oedema of the base of the bladder. Bladder was then distended. Its pelvic portion which was retained in the pelvis disengaged the head and caused obstruction to labour.

In conclusion, a full bladder should always be in mind as a cause of soft tissue dystocia.

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References

1. Chaubal, S. D., et al: J. Obst. & Gynec. India. **16**: 611, 1966.
2. Crabtree, E. G.: Urological Diseases of Preg., 1942.
3. Kantor, I. Herman, et al: Am. J. Obst. & Gynec. **58**: 2, 1949.
4. Wolfson, W. L.: J. Obst. & Gynec. Brit. Emp. **32**: 577, 1925.