# A CASE OF MULTIPLE CONGENITAL ABNORMALITIES

by

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In 1937, Malpas gave the incidence of congenital malformations as 2.1% of total births. Anencephaly hydrocephaly, spina bifida, either separate or combined abnormalities account for about half the cases Penrose (1939). Severe congenital malformations accounted for 15% of perinatel deaths in Egland, Scotland and Wales in March, 1958 (Claireaux 1961). The cause may be genetic, or environmental or combined. Deformities due to defective genes sometimes run in families. Drinkwater (1910) reported some bony abnormality in a family. Grunberg in 1944 found abnormalities of rodnets as hydrocephalus, congenital deafness, polydactylism, brachydactylism, cleft palate etc., due to mutation of gene cells. Environment affects the development most. Larson and Sterkey (1960) reported a case of a patient receiving antidiabetic drugs during pregnancy who gave birth to a malformed child at 8 months. Sobel gives the malformation rate by Insulin coma Therapy to be 35.3%. Meltzer (1956) reported talipes-equinovarus by the use of aminopteroglutamic acid in order to induce abortion. Workoney *et al* order to induce abortion. The terrotogenic effect of cortisone is yet to be confirmed. Leyssac tried cortisone in 212 pregnancies out of which only 5 resulted in a malformed child, i.e. 2.3%.

**Case Report**

Case No. 517/1970, Mrs. S. B., house wife, aged 24 years, was admitted for confinement on 5-5-1970 at 4 A.M. Her complaints were amenorrhoea for 9 months and pain for one day. O/H. One female baby, 2 years old, normal delivery.

Present History—during the 2nd month of pregnancy, she had two injections of oestroprogyn for diagnosis and then took homeopathic medicines for inducing abortion. There was no history of any malformed child, on any side of the parents.

Blood pressure 120/88, pulse 80/min., Temp 98.4°F. Other systems were also clinically normal.

On abdominal examination, uterus was full term size with vertek presentation and L.O.A. position. Foetal heart sounds were audible on left side. Head was fixed.

On pelvic examination, os was taken up and 2 fingers dilated. Pelvis seemed adequate. A soap water enema was given and pethidine 100 mg was injected at 4.30 A.M. At 3 P.M. full dilatation occurred. Mediolateral episiotomy was done but even then the head was not progressing well. In spite of strong uterine contractions and slight pressure per abdomen, head was recoiling back. Another pelvic examination was done. Head seemed to be larger but perforation could not be decided due to patient's unwillingness. Episiotomy was extended laterally and head was delivered with the help of one blade of forceps. Then shoulders were obstructed. Due to the hydrocephalic head, other abnormalities were also suspected. As there was no chance of survival of child, morphia 1/4 gr. was injected at 4 P.M. for obtaining good relaxation. The whole right hand was introduced into the vagina and cavity explored. A fleshy mass could be felt. Then with the help of left hand on abdomen, the head was rotated towards symphysis pubis, and pushing it towards perineum, anterior shoulder was taken out; subsequently the posterior shoulder and the whole body was

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delivered at 6.45 P.M. There were multiple abnormalities in the child. Bilateral vaginal and right sided cervical tear occurred which were repaired with episiotomy wound. Placenta came out spontaneously. There was no postpartum haemorrhage. Post natal period was uneventful due to the use of antibiotics.

*Discussion*

The abnormalities found, are not accounted for, except that hormones used during early pregnancy for the test might have produced the malformation of sexual organs. In the case recorded by Bretnol, the patient had arrhenoblastoma during pregnancy, the hormones secreted by which not only effected the patient, but also developed hermophroditism in foetus.

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*References*

1. Bette, H.: Miunchen, Med. Wchnschr. **99**: 1246, 1957.
2. Brentnall, C. P.: J. Obst. & Gynec. Brit. Emp. **52**: 235-240, 1945.
3. Clarireaux, A. E.: Brit. M. J. **1**: 1313, 1961.
4. Curtis, G. W. et al.: Arch. Path. **59**: 667-690, 1955.
5. Drinkwater, H.: Proc. R. Soc. Med. **10**: 60, 1917.
6. Gruneberg, G.: Proc. R. Soc. Med. **37**: 125, 1944.
7. Larsson, Y. and Sterky, G.: Lancet. **2**: 1424-1426, 1960.
8. Leyssac, P. P.: Ugeskrift for Laeger. **121**: 33-39, 1959.
9. Malpas, P.: J. Obst. & Gynec. Brit. Emp. **44**: 434, 1937.
10. Meltzer, H. G.: H. G. J.A.M.A. **161**: 1253, 1956.
11. Murphy, M. L.: Congenital Malformations pp. 78-114, 1960.
12. Murphy, D. P.: Am. J. Obst. & Gynec. **18**: 179, 1929.
13. Penrose, L. S.: J. Ment. Sci. **85**: 1141, 1939.
14. Sobel, D.: Ame. Arch. Gen. Psychiat. **2**: 606-611, 1960.
15. Warkany, J. et al: J. Dis. Child. **97**: 36-43, 1959.
16. Wilkins, L. et al.: J. Clin. Endocrinol. **18**: 559-585, 1958.
17. Wilkins, L.: J.A.M.A. **172**: 118-122, 1960.

*The case report would have been more interesting had it been possible for the author to get a post mortem report.*

*See Fig. on Art Paper X*