OBSTRUCTED LABOUR DUE TO FOETAL ABDOMINAL DISTENSION

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Dystocia due to foetal abnormalities is quite often encountered in our day to day practice. However, dystocia due to distended cloaca is comparatively rare. Here we report a case of dystocia due to persistent cloaca admitted in our hospital.

Case Report:

Mrs. I. B. 25 years, second gravida, was admitted on 16-3-70 at 7.50 P.M. in Associated Group of Hospitals, Bikaner, with the complaints of 7½ months' amenorrhoea, and sudden passage of water per vaginam, while getting up from sitting position at home. It was soon followed by delivery of the head of the foetus. After about an hour of struggle at home the patient was brought to the hospital.

Patient had normal menstrual history, her menstrual cycle was of 25 to 30 days, flow was moderate lasting for 4 to 5 days. Last menstrual period was on 2-8-1969.

The patient had one full term normal delivery 3 years ago, a live female child having no congenital malformation. The patient was not under the care of a doctor during this pregnancy.

On examination she was a fairly built woman. She was anaemic, temperature was normal. There was no albumin or sugar in urine.

Abdominal examination revealed fundal height of 34 weeks, uterus was tense, not acting, and foetal parts were not clearly made out. On local examination, the head with loops of cord and both hands of foetus were lying outside the vulva. Internal examination revealed a taken up cervix, with 3/5th dilatation of os, and chest wall could be reached. Attempt was made to deliver the foetus by pulling on the neck, but this failed, so delivery under general anaesthesia was decided upon.

Under general anaesthesia finger could be pushed up above the chest wall, where soft bulging of the anterior abdominal wall was felt, and a diagnosis of foetal ascites was made. Abdomen was perforated by Simpson's perforator in the right, hypochondrium; about 1600 ml. of clear fluid drained out. The foetus could then be delivered easily, which was followed by the delivery of the placenta with entire membranes. There was no postpartum haemorrhage or injury to the cervix, vagina or perineum.

The patient had uneventful lying in period in the hospital, V.D.R.L. was done; it was negative. She was discharged in good condition on eighth day.

Postmortem Findings:

It was a premature foetus, weighing 3 lbs. 6 ozs. Head and face were normal. Hair were present on the head. Skin was slightly wrinkled. Nails reached upto the ends of the digits; upper extremities were normal, stretched out. Lower extremities were small but otherwise normal. Thorax was very small. Heart and lungs were normal.

Abdominal wall was thin because of overstretching due to distended abdomen. Girth of abdomen at the umbilicus was 40 cms. The umblical cord was attached to the abdominal wall with a broad base (Fig. 1). In the right hypochondrium a wound which

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was made by a perforater was present. These was no evidence of external genitalia. The anal and urethral openings were absent.

On opening the anteiror abdominal wall longitudinally a bladder like hollow organ-occupying almost whole of abdominal cavity came into view (Fig. 2). The maximum length of the hollow organ was 16 cm., width 6 cms. The thickness of its wall was about 6 mms. On opening the hollow organ mucous membrane was seen and it contained a yellowish thin fluid. A rent suggestive of having been made by the perforator was seen over its anterior wall high up near its upper border. Kidneys and suprarenal glands were normal. The ureters were markedly dilated. The length of ureters was 10 cms. and width .8 cms. At the junction of ureters and cloaca there was a pin-point depression through which a probe could not be passed. Stomach and small intestines were normal. Lower end of large gut was distended and contained faecal matter. It merged with the cloaca blindly.

Both ovaries were lying on anterior wall of cloaca. Small Fallopian tubes were also seen (Fig. 3).

The pelvic bones were small, compressed and flattened.

Discussion

Undue size of foetus may be due to abnormal size of the foetus as a whole, or localized enlargement of certain parts of body e.g. head, neck, thorax, abdomen or pelvis. Dystocia due to abdominal enlargement is rare. Idiopathic foetal ascites, distended bladder, distended per- cloaca, tumours of kidneys, liver, sistent cloaca, umblical spleen, testicles and ovaries and hernia are rare but important causes of dystocia.

Barr & Mac Vicar (1956) and Mahatre *et al* (1967) reported cases of idiopathic foetal ascites. Kishore *et al* (1964), and Chakrabarty (1965) reported 15 cases of distended bladder. Jeffcoate had also recorded a case of megabladder causing dystocia, but only two cases of distended cloaca (Dhall *et al* 1967 and Mehta and Apte 1969) are so far reported.

In this foetus there was a persistent distended cloaca because uro-rectal septum did not develop. There was no external urethral opening. Anus was also absent due to developmental anomaly in cloacal membranes.

In this case head came out through maternal pelvis easily with hands and loops of cord. The distended uterus not corresponding to the period of gestation attracted attention but the diagnosis could only be made under anaesthesia, when whole hand was passed beyond thorax, and foetal abdomen was found grossly distended but soft. According to Shaw and Maricott (1949), and Beacham & Beacham (1952) the diagnosis of foetal ascites can only be made when further progress is arrested after delivery of head and shoulders. Radiography can be of great help in diagnosis before delivery (Puig Y. Roig 1948).

X-ray picture of foetus with distended abdomen shows straightening of foetal vertebral column, arms and legs held away from body, splayed out ribs and other abnormalities like talipes.

Management

Once the condition is diagnosed, paracentesis of abdomen should be done. In cephalic presentation it has to be done through thorax and diaphragm if abdomen is not reached.

Barr & Mac Vicar found Simpson's perforator as an ideal instrument and Beacham and Beacham, De Lee & Greenhill (1947) used Mayo's scissors. Mhatre *et al* found Drew Smythe catheter suitable in their case.

In our case we used Simpson's perforator for tapping.

Summary

A rare case of distended cloaca leading to dystocia is presented. Multiple other abnormalities were also present.

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See Figs. on Art Paper XIV