OBSTRUCTED LABOUR DUE TO OEDEMATOUS CERVICAL LIP.

(A Case Report)

by

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Introduction

It is difficult to predict the course of a complicated labour and it is equally difficult to predict about the labour which is apparently progressing well—as delay or obstruction can occur at any level which the foetus has to cross. This case is presented in view of scarcity of such reports in the literature.

CASE REPORT

Mrs. N., aged 24 years, brought from a village and admitted in the hospital on 19-10-70 at 10.30 A.M. with the history of labour pains since last 12-13 hours which had become quite strong since 6-7 hours and since that time a mass was protruding out of the vulva with every uterine contraction. She was handled by a Dai at home and had never attended the hospital previous to this.

Obstetric History

She was a 3rd para, 2 full term normal home deliveries, last delivery—3 years ago. No history of any abortion. She had a history of uterine prolapse since last delivery 3 years ago.

On Examination

She was anaemic and exhausted with dry tongue and pulse rate of 110 per minute. Blood pressure 100/70 m.m. of Hg. Temp. 99°F. Per abdomen—Uterus was 34 weeks' size. V 1, floating F.H.S. good about 120 per minute. Bladder was full and as the patient could not pass urine herself, catheterisation was done and about 200 c.c. of clear urine was found. Vaginal examination revealed a rounded mass about 5"/5" protruding out of the vulva (Fig. 1) which on examination was found to be the oedematous anterior lip of the cervix. The posterior lip was very much thinned out and was felt with difficulty. Membranes were absent. There was a large caput over the head, a good portion of which was still above the ischial spines (floating). There was foul-smelling meconium stained vaginal discharge.

Considering the condition of the mother, cervix and signs of foetal distress together with the high position of the foetal head, quick delivery by cesarean section was thought of, but meanwhile the patient had a strong uterine contraction and expelled a healthy female child weighing 2.5 K.G. There was some delay in expelling the last portion of the placenta (Fig. 1) but otherwise the immediate post delivery period and puerperium was uneventful.

Subsequent examination of the patient on the third day after delivery showed that the oedema of the cervical lip had disppeared except that the cervix (ext. os) was descending down upto the vulva on straining; there was no other abnormality.

Discussion

Obstruction or delay in labour due to cervical causes, either an organic lesion or functional rigidity is a well known factor requiring operative interference, which if not done timely may result in loss of foetus and serious injuries to the parturient canal. Cervical dystocia is diagnosed when the cervix dilates partially and then further dilatation does not occur in spite of good uterine contractions. In some cases there is some de-

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monstrable organic rigidity due to fibrosis a previous operation or some growth. Functional or idiopathic rigidity of the cervix is common in primiparas, not necessarily elderly primiparas, where there is delay in the dilatation of the cervix. Tardy dilatation due to abnormality of uterine action is not to be considered as functional rigidity. It is only when cervical dilatation is arrested in presence of good uterine action, functional rigidity is diagnosed. In Randall (1964) series there were 12 cases in 3200 deliveries.

Acute oedema of the anterior lip of the cervix due to the pressure of the presenting part on the symphysis pubis can occur in late pregnancy, more so if there is associated prolapse. Premature bearing down efforts in the first stage are likely to cause oedema of the cervix. Munro Kerr has described a case where oedema was so much that the whole oedematous cervical lip was protruding out of the vulva and was of the size of an orange. The patient was in late pregnancy and the oedema subsided with rest and the patient later delivered normally.

Another important factor in these cases is that no special treatment for the oedema is needed, it always subsides itself after delivery.

Summary

A case report of cervical dystocia in which eventually normal delivery occurred is presented.

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References

1. Munro Kerr: Operative Obstetrics, ed. 7, London, 1964, Bailliere, Tindall and Cox, p. 392.
2. Randall: Cited in Munro Kerr's Operative Obstetrics, ed. 7, London, 1964, Bailliere, Tindoll & Cox, p. 386.

See Fig. on Art Paper V