NAEGLE'S PELVIS

(A Case Report)

by

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Naegle defined the deformity as a pelvis contracted in one of the oblique diameters with complete ankylosis of the sacroiliac synchondrosis on one side combined with imperfect development of the sacrum and os-innominatum on the same side. Naegle had not observed the deformity in the living body (Thomas, 1941).

The diagnosis is made difficult by the fact that there may be no external deformity or change in gait. Variations in the height of iliac crests and accompanying scoliosis are suggestive findings. The transverse diameter of the inlet is always markedly diminished. The deformity is easy to diagnose on vaginal examination. The lateral pelvic wall on the affected side is easily felt and is found to be nearer to the midline. Curtis in 1937 reported that limping is not common as a presenting symptom. Diagnosis can be confirmed by an antero-posterior X-ray of the pelvis.

Often, the deformity remains unrecognised but the obstetric performance varies from case to case. It is possible to have normal vaginal deliveries (Philips-Wahrsinger 1944), while in others obstructed labour may result in rupture of the uterus (William-1929; Still and Kao 1949).

Torpin and Stabler reported a case of a primipara diagnosed antenatally as a case of cephalopelvic disproportion. On X-Ray the diagnosis of Naegle's pelvis was made and the patient required caesarean section. She had two subsequent caesarean sections with ligation of tubes at the last one. Naegle wrote that unless the pelvis was of large size and the baby small, caesarean section was the best line of treatment. Symphysiotomy has no place in such cases.

Case Report

Mrs. V. F. 19 year old primigravida presented herself on 5-4-71 for routine check-up in the ninth month of her pregnancy. She was due on 18-4-1971. On examination she was 62 inches tall with a span of 65 inches. She weighed 120 lbs. She had right sided scoliosis. Her general condition was good. On local examination fundal height was 14 inches and abdominal girth was 40 inches. The foetus was in vertex one position with the head floating. The foetal heart sounds were one hundred and forty and were regular.

On vaginal examination the sacral promontory was reached easily. The wall on the right side was converging towards the midline. The outlet was narrow with pro-

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minent right ilio-pectineal eminence and right ischial spine. An anteroposterior X-ray of the pelvis was taken (Fig. 1).

Diagnosis of Naegle's pelvis was made and the patient was advised hospitalization for an elective caesarean section. As the patient refused admission due to domestic reasons, was allowed to go home. She came with labour pains on 9-4-1971 and a lower segment caesarean section was performed. During operation the X-ray findings were confirmed. A male baby weighing 3.7 kgm., was delivered. The patient made an uneventful recovery. The X-Ray was repeated on tenth post-operative day and the patient was discharged.

Discussion

Rarity of the diagnosis of this condition is due to wide variations in its clinical manifestations. Cases vary from absolutely normal to ones with bad obstetric history, rupture of the uterus and death. Only routine X-ray pelvimetry in suspected cases of cephalopelvic disproportion can diagnose such cases.

Vaginal delivery is attempted only if the pelvis is larger than normal or the baby is premature. In all other cases caesarean section is the treatment of choice.

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See Fig. on Art Paper III