DYSTOCIA DUE TO SACRAL TUMOUR

(A Case Report)

by

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The common causes of dystocia are pelvic contraction, and pelvic tumours like fibroid or ovarian cyst. There are many reports wherein the tumours of the foetus, like foetal ascites sacrococcygel tumours, causing dystocia. But the primary benign tumour arising from the sacrum giving rise to dystocia is very rare and not reported in the Indian literature. Hence the following case report is presented.

Case Report

Patient, age 20 years, primigravida was admitted on 20-12-1970 at 6 P.M. with history of labour pains for the last 12 hours. Temperature 98.4°F. Respirations 26/minute, pulse 86/minute, B.P. 120/80 mm of Hg, Hb 8 gm %. Urine was clear and blood group was 'O'. The height of the uterus was 38 weeks vertex was presenting. Head was fixed and foetal heart rate was 136 per minute.

Vaginal examination revealed the cervix to be well effected and dilated to 8 cm. Membranes were intact and the head was high up. A hard bony mass was arising from the middle piece of the sacrum on its anterior aspect which was completely filling the cavity of the pelvis. Pelvis was otherwise roomy. Intrapartum X-ray of the pelvis and the abdomen was taken and it revealed a large tumour 8-10 cm in diameter arising from the middle piece of sacrum which appears to be expanded more towards the cavity and is very clearly defined with amorphous calcification suggestive of osteochondroma. Fig. 1.

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At 10 P.M. lower segment caesarean was performed and a live male baby weighing 2.6 kg was delivered. One bottle of 'O' group blood was given and post/operative course was uneventful and was discharged well on 13th day. Case was shown to Orthopedic Surgeon who advised excision of the tumour after 3 months. So far the patient has not turned up.

Discussion

According to Mudaliar and Menon (1968) the presence of exostosis or other kind of tumours of the pelvic bones are very rare but when such tumours do occur a high degree of dystocia may be caused and are apt to injure the descending head or the uterus. Masani (1969) just mentions tumours and fractures of pelvic bones in the causation of contracted pelvis. Holland, in the Brtish Obstetrics says that osteomata are occasionally found on the symphysis pubis, the sacroiliac synchondrosis and ileopectineal eminence obstructing labour and indenting the foetal skull. The uterus may tear, if it is nipped between the tumour and the foetal head. Large tumours are very rare and are usually malignant. Lichtenstien (1958) in his monograph of bone tumour says that osteochondroma, whether single or multiple, represent a cartilage capped bone growth protruding from the surface of the affected bone. The lesion appears to have its basis essentially in perverted activity of the periosteum which tends to form anamolous foci of metaplastic-cartilage. Although osteo-

chondroma not infrequently spring from the flat bones of the pelvis, ribs, scapula, they are more often encountered in long bones, lower metaphysis of femur and upper metaphysis of tibia size varies from 1 cm to 10 cm. The incidence of chondrosarcoma appears fortunately to be rather low and probably does not exceed 1 to 2% and seems hardly justified on that basis alone in advocating the mandatory surgical removal of all exostosis as a routine preventive measure. On the other hand, one should recommend periodic roentgen examination of exostosis which are not removed in adults to make certain that they have remained quiescent.

Summary and conclusion

1. Case of osteochondroma of the middle piece of sacrum in a primigravida is described.

2. The pathology of osteochondrama described.

3. The mode of management is a regular follow-up or surgical excision.

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