REPORT OF 2 CASES OF "OBSTRUCTED LABOUR" FOLLOWING CERVICOPEXY OPERATION

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and

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"Obstructed labour following the operations of cervicopexy is very rare. On reviewing the available literature on the subject, we have not come across a single case of obstructed labour which could be attributed to the operation. In this article, we are reporting two cases of obstructed labour following cervicopexy operations, and the follow-up of other cases during labour.

Case 1

Mrs. A. S. aged 20 years was admitted on 11-5-68 at Nair hospital with the complaints of secondary sterility and dyspareunia. The patient had previously one abortion of 3 months. Her menstrual cycles were regular.

Cervicopexy was done for second degree prolapse at this hospital in July 1966. The patient had a recurrence of the prolapse within 3 months of the operation.

On examination, there was second degree prolapse without any cystocele or rectocele. The uterus was of normal size.

Since the patient had a recurrence of the prolapse even after cervicopexy operation, it was decided to use Merselene tape to support the uterus. The abdomen was opened through a Pffenensteil incision after excising the previous scar. There were plenty of adhesions. The bladder was very high (because of previous advancement). The bladder was pushed down with great difficulty. The centre of the Merselene tape was fixed on the anterior surface of the cervix, as low as possible by linen sutures. The ends of the Merselene tape were brought out extraperitoneally and fixed to the undersurface of the anterior rectus sheath. The postoperative period was uneventful. Three months later there was no recurrence of the prolapse.

The patient was readmitted on 3-1-70 with the history of 9 months amenorrhoea, bleeding per vaginum and 2nd degree prolapse. The uterus was 36 weeks' size, presentation was V_1 and the foetal head was floating. F.H.S. were normal.

Per speculum examination showed that the cervix was coming out upto the introitus. There was no bleeding and the patient was not in labour. There was no C.P.D. clinically. The patient was given head low position. Prolapse of the cervix was reduced and a glycerine acriflavine pack was put into the vagina.

On 15-1-70 from 8.55 p.m., the patient started labour pains. Per abdomen—V_1 floating. F.H.S. regular. Per vaginum the cervix was 3 fingers dilated, taken up, membranes were present. The presenting part was vertex and the biparietal diameter was above the brim but the head could be made to enter the pelvis easily. There was no C.P.D. clinically. The patient was given pethidine 100 mg. intramuscularly and was observed.

Vaginal examination was repeated on 16-1-70 at 8.30 a.m. The findings were the same. The patient was getting strong pains.

At 10 a.m. the patient was re-examined. There was distention and stretching of the lower segment. The head was still floating. F.H.S. were regular. Vaginal examination showed the same degree of cervical dilata-

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tion. Since there was no progress for 12 hours, in spite of strong uterine contractions and because the patient had already undergone two previous operations, and there was stretching of the lower segment, the patient was taken up for caesarean section.

Caesarean section was done under general anaesthesia. The abdomen was opened through a midline infraumbilical incision. There were many adhesions. The lower segment was not well formed. There was marked distention of the lower segment above the level of the fixation of the Merselene tape. The portion of the lower segment below the fixation of the strips was not stretched. There were areas of haemorrhages, above the areas were the strips were fixed, and these areas were very much thinned out. The head was obstructed at this level. There were many adhesions in the region of the lower segment and it was very difficult to push the bladder down, and hence, classical caesarean section was done. The baby was extracted by breech, the baby's neck was caught by the constriction in the uterus at the level of the fixation of Merselene tape. The head was delivered slowly and with great difficulty. Baby cried well and weighed 2.6 kg. During the extraction the classical scar extended down as an irregular tear. The classical caesarean section scar was sutured in the routine way. The irregular tear was also sutured in 2 layers. The adhesions were removed. Perfect haemostasis was achieved and the abdomen was closed in layers.

The postoperative period was uneventful. The patient was discharged on the 10th day.

Postnatal check-up after one month showed no prolapse and follow-up examination after one year also showed no prolapse.

Case 2

Mrs. S. F. aged 22 years was admitted on 9-11-70 with the history of 9 months' amenorrhoea and leaking membranes. She gave the history of cervicopexy done 3 years ago for nulliparous prolapse. She had 2 abortions of 4 months and 3 months prior to the operation. Menstrual cycles were regular.

On abdominal examination there was a scar of the previous operation. The uterus was 36 weeks' size, V_3 floating and F.H.S. were regular.

On vaginal examination the cervix was 2 fingers dilated, thick and not taken up. The membranes were intact. There was no C.P.D. clinically. The patients was put at complete rest and was given injection of penicillin and streptomycin six hourly, since she had leaking, which stopped in 48 hours. The patient was kept in the ward since she was near term.

On 19-11-70 at 7.00 a.m. the patient started labour pains per abdomen, V_1 engaged F.H.S.—were regular. Per vaginal examination, the cervix was 2 fingers dilated, thinned out, and partly taken up. The membranes were bulging. Since there was no C.P.D. clinically, vaginal delivery was decided upon. The patient was observed carefully.

At 10 a.m. (within 2 hours) the patient complained of severe pain, therefore she was re-examined.

Abdominal examination revealed that the shape of the uterus was irregular, the lower segment was stretched and Bandel's ring was palpable at the level of the umbilicus. F.H.S. were regular.

Vaginal examination revealed the same findings as before. Since abdominal findings were suggestive of obstructed labour, the patient was taken up for caesarean section (at 10.45 a.m.).

Caesarean section was done under general anaesthesia. The abdomen was opened through a midline infraumbilical incision. The lower segment was stretched and very much thinned out. Even the strips of the rectus sheath were stretched. The bladder was high up. Utero-vesical pouch of the peritoneum was opened and the bladder was pushed down. The bladder could be pushed down easily. The lower segment was incised transversly above the level of the fixation of the strips, and the baby was extracted by vertex. The extraction was easy. The lower segment was sutured in 2 layers. The uterovesical pouch of the peritoneum was closed and the abdomen closed in layers. Baby weighed 2.7 kg.

Post operative recovery was uneventful. On follow up examination, there was no recurrence of the prolapse.

Discussion

Cervicopexy operations were done on 31 cases of second degree prolapse, in young patients, without any cystocele or rectocele.

Out of 31 cases, 7 patients conceived after the operation. Four patients delivered normally without any difficulty. They had no complication during the pregnancy, labour or puerperium. There was no recurrence of prolapse following the delivery. This shows that normal delivery is possible following cervicopexy and unless there is an obstetrical indication, or if the labour does not progress satisfactorily, such patients do not need caesarean section.

Normal vaginal delivery following cervicopexy has been recommended by the previous authors also. In Purandare's series (1966), nineteen patients had conceived after cervicopexy operations and had in all 25 conceptions. Incidence of abnormal deliveries was not higher than normal. Only 2 caesarean sections were done, one for C.P.D. and the other for cord prolapse.

Purandare (1966) and Baxi (1969) have mentioned that there may be difficulty in performing caesarean section due to the adhesions and also because of the advancement of the bladder. Purandare further states that during caesarean section particular attention must be paid to the bladder which has been advanced otherwise it is liable to injury and the lower segment incision should be above the level of the fixation of the strips so that the repair is not disturbed.

On follow-up examination, there was no recurrence of prolapse in both the cases, showing that caesarean section had not disturbed the attachment of the strips.

Summary

1. Two cases of obstructed labour following cervicopexy have been reported, and discussed in detail. The above cases show that "Obstructed labour" can occur after cervicopexy operation, and therefore, such cases should be carefully observed during labour and all such patients should be warned to have hospital delivery.

2. Cervicopexy was done on 31 cases. Seven patients conceived after the operation, four delivered normally, one patient had 2 abortions, and 2 patients had obstructed labour and they required caesarean section.

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