PELVIC HYDATID CYST CAUSING DYSTOCIA

by

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Introduction

From time immemorial tumours of the genital tract are known to cause dystocia, but those of other origins like pelvic kidney, enlarged spleen or even a hydatid cyst are rare causes. From developed countries, in the early part of this century about 2 dozen cases have been reported wherein hydatid cyst was the aetiological factor for dystocia (Franta 1902, Embrey 1938). But persuing the Indian Literature in Obstetrics only 2 cases have been reported of pelvic hydatid cysts causing obstructed labour. (Devi 1955, Parikh 1966). Recently, in the maternity Department of the Bellary Medical College a case of rupture uterus due to neglected shoulder presentation was encountered. The prime cause for the malpresentation being a pelvic hydatid cyst snugly fitting the sacral curve extending upto the pelvic brim. Because of the rarity of this entity it is detailed here.

Case Report

Patient N., aged 30 years was brought in the late hours of the evening on 19-1-1973 in a moribund state. She had ruptured her membranes 2 days back and presented as a text book picture of neglected shoulder presentation.

Obstetric History

Her previous 3 deliveries were uneventful, last delivery being a year ago. Her first 2 children were alive, but she had lost her last one because of small pox. She did not know the date of her last menstrual period.

General Examination: The patient was in a dehydrated state with signs of maternal keto-acidosis.

Local Examination: Instead of the uterine contour there were two separate masses. The foetal parts were superficial and foetal heart sounds were not audible. Immediate laparotomy was performed as diagnosis of rupture uterus was made. The findings proved interesting. The tonically retracted uterus was pushed to the right side. On incising the papery uterovesical layer a macerated male foetus was removed. The ruptured site was unusual as the tear in the lower uterine segment had extended into the left broad ligament into the vault very near the left ureter. A fibrotic mass was found impacted in the pouch of Douglas extending upto the pelvic brim. Total hysterectomy was performed followed by ennucleation of the fibrotic mass. During operation 2 units of blood were given.

Postoperative period was uneventful except that there was slight icterus on the 1st day, which later disappeared. Casoni's test on 2 separate occasions was negative. Blood smear did not show eosinophilia. As the wound was septic resuturing was done 15 days later. Patient was discharged on 22-3-1973 after a complete recovery.

Macroscopic Appearance of the Cyst: It measured 10 × 5 cms. The outer layer was 2 mm thick and resembled the white of a hard boiled egg.

Cut Section: The edges curved inwards exposing the thin transparent inner germinal layer. From this nearly 100-120 daughter cysts rolled out along with a clear colourless hydatid fluid. There were a few grand daughter cysts as well (Fig. 1).

Microscopic Examination: The ectocyst

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had a laminated hyaline membrane. The granular germinal layer was distinct with the presence of brood capsules and scattered dead scolisis.

Discussion

The portal of entry is the alimentary tract of man, the infecting agent being the egg in the dog's faeces. The chief sites where the adult embryo lodges are the liver and lungs (primary and secondary filters). Later the eggs may enter the systemic circulation and therefore hydatid cyst may form in almost any site in the human. Kaulgud (1972) from the Surgical wards of our Hospital has confirmed 30 cases for the past 5 years and has added 5 more (personal communication). He found that the primary site was the liver in 20 cases and noted abnormal sites like breast, axilla and thigh. He did come across single case of hydatid cyst in the pouch of Douglas. Interestingly enough the female to male ratio was 1.7:1, the commonest age group being the 3rd and 4th decades, Roy (1970) has noticed that of his 60 cases in 5 years from 4 teaching hospitals, such rare sites suggested high infestation rate. It is pertinent to mention here that in comparison to Roy's 60 cases, Kaulgud observed 35 cases in 5 years from only one teaching Hospital. This proves that high incidence of hydatid disease seems to be a regional peculiarity in Bellary along with the nearby Rayalaseema area of Andhra Pradesh. The incidence of hydatid disease throughout India is as on an average about 27 new cases each year (Roy 1970). Of these only 2 to 3% of cases of hydatidosis are of the genital tract (Parikh 1966). Only about dozen cases have been noticed in gynaecological practice which were inadvertently diagnosed as fibromyoma wherein the hydatid cyst was in the uterus. (Sarojini 1962; Parikh 1960 and Joshi *et al* 1966). Extrauterine sites like pouch of Douglas, broad ligament, uterovesical peritoneum and ovaries have also been reported (Chandra and Singh 1964). All these cases were invariably mistaken for ovarian cysts or chronic inflammatory masses in the adnexae. The disease remains latent and hence symptomless. They may cause dysmenorrhoea, dysuria or bladder neck obstruction. Chatterjee (1970) emphasized that its presence is detected either at autopsy or when it causes pressure effects or more so when it ruptures or suppurates. The final diagnosis in every single case was made only at laparotomy.

Regarding obstetrics, pelvic hydatid cysts causing obstructed labour have been reported by Devi (1955) and Parikh (1966) from India. This rare phenomena may be silent or may rupture during pregnancy causing anaphylactic shock (Guz 1950). In this particular case the hydatid cyst had not ruptured either during pregnancy or labour nor even while ennucleating it. But, it is definite that it has been the cause for diverting the lie of the foetus since it was occupying the region of the pelvic brim.

The transverse lie was not recognised in pregnancy and hence neglected during labour, eventually leading to uterine rupture. If the patient had come early in labour this catastrophe could have been averted by detecting the cystic mass in the pouch of Douglas and precautionary measures taken to do an elective caesarean section presuming that the cyst was an ovarian tumour causing obstruction. Although the occurrence of hydatid cysts is rare, its presence must be kept in mind while dealing with cystic masses in the pouch of Douglas. The author was lucky enough in performing a neat enucleation, little realising that if the cyst had rup-

tured it would have led to a train of unhappy events.

Conclusion

An interesting case of rupture uterus due to neglected shoulder presentation is presented here as the prime cause for the malpresentation was a hydatid cyst impacted in the pouch of Douglas. This aetiological factor was noted only at laparotomy and was not diagnosed earlier as the patient had come as an emergency case.

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See Fig. on Art Paper VII