DYSTOCIA DUE TO DISTENDED CLOACA

(A Case Report)

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Distension of the cloaca is a rare foetal abnormality which is usually detected at birth. It is an uncommon cause of enlargement of the foetal abdomen. Labour is often premature so that dystocia is uncommon, but occasionally the size of the abdomen causes obstruction to labour. The present case is an example of the distension of the cloaca in the foetus causing obstruction during labour and leading to occult rupture of the uterus in a multiparous woman.

Case Report

Mrs. A, aged 30 years, a villager, gravida 7 para 6 had delivered spontaneously 6 full term normal infants aided by a "Dai" in her home. She had delivered her last child 4 years ago. During this pregnancy at 28 weeks she went into premature labour. It was a breech labour where the buttocks of the foetus were arrested at the perineum for more than 48 hours. Being attended by a "Dai" for 48 hours in this labour and since there was no further progress in labour the patient was transferred to the hospital as an emergency to the labour room on the evening of 25-2-1973 for further management.

On examination the patient looked toxic, anxious, exhausted and markedly dehydrated. She was anaemic. Her B.P. was 100/70 mmHg. and her pulse was 130/minute. The bladder was distended. About 200 ml. of high coloured urine was drained by catheter.

Obstetrical examination was ambiguous. The exact size and configuration of the uterus was not clear. The abdomen was uniformly tense and markedly distended as compared to the period of gestation. The foetal head was felt superficially in the right hypochondrium and the foetal heart sounds were not heard.

Vaginal examination in labour room was equally deceptive. Vaginal examination under general anaesthesia in the theatre revealed an effaced and fully dilated cervix with breech arrested at the perineum; a soft distended foetal abdomen and a rent in the lower uterine segment on the anterior surface.

A provisional diagnosis of rupture of the uterus and foetal ascitis was made. Hence, laparotomy was undertaken.

Laparotomy Findings

Abdomen was opened by infraumbilical midline incision. There was not even a little free fluid into the peritoneal cavity. It was striking to note that the head and the dis-

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tended abdomen of the foetus were lying in the peritoneal cavity, while the legs of the foetus were seen through the rent in the anterior wall of the uterus. The uterus was well contracted and pushed to the left side. There was no fresh bleeding from the edges of the tear. After extracting a stillborn baby, subtotal hysterectomy was performed. Abdomen was closed after cleaning the peritoneal cavity. Patient was transfused with 1500 ml of blood during operation. The patient was well and afebrile for first 24 hours. She developed dyspnoea and fever on the 2nd postoperative day. She expired 60 hours after operation due to septicaemic shock.

Post-mortem Findings of the Foetus

Apparently the foetus looked macerated and disintegrated. Probably due to manipulation and maceration, the lower extremities were fractured and dislocated at the hip joints. It was a premature stillborn foetus weighing 3 kgs. The bulk of this weight was due to distension of the abdomen. Upper extremeties, head and face were developed normally. Skin was slightly wrinkled. Nails reached upto the ends of the digits. Thorax was comparatively small. Abdominal wall was thin and overstretched due to distension. Its girth at the level of the umbilicus measured 46 Cms (Fig. 1). A distorted penis favoured male sex of this foetus but scrotal markings and testes were absent. A probe through the penis demonstrated no urethral opening. Similarly, anal opening was also absent.

Viscera revealed multiple abnormalities. On opening the anterior abdominal wall longitudinally we came across a hollow organ which was practically occupying most of the abdominal cavity (Fig. 2). The measurements of the hollow organ were 20 cm x 8 cm. About 1500 ml of yellow coloured thin fluid was aspirated out of this hollow organ. On opening the hollow organ mucuous membrane was detected. There was only one horse shoe shaped kidney with two markedly dilated ureters establishing a connection with the hollow organ (Cloaca) at two different sites. Descending colon had a blind connection with cloaca. Stomach was small and tubular. The adrenals were uneven. There was an accessory spleen. The presence of testes was doubtful. There were congenital cysts in the left lung. In the heart there was chordae triloculare (Biventricular) associated with Fallot's tetralogy.

Comments

A septum which is composed of mesoderm, divides the cloaca into two parts; the urogenital sinus ventrally and the anorectal canal dorsally. The septum which is called urerectal septum forms in the angle between the allanto-enteric diverticulum and the caudal end of the hindgut. The bladder develops from the urogenital sinus. The urogenital sinus first undergoes differential dilatation to form from below upwards a pars phallica, a pars pevina, and a vesicourethral canal which is continuous at its apex with the allanto-enteric diverticulum. The anorectal canal forms the whole of the rectum and the upper two-thirds of the adult anal canal. The failure of development of urorectal septum leads to a persistently distended cloaca, and thus the differential dilatation of the urogenital sinus is also prevented.

Dystocia due to distension of the bladder is frequently reported. Kishore *et al*, (1964), and Chakravarty (1965) reported 15 cases of distended bladder with dystocia. Jackson (1963) and Jeffcoate (1931) had also recorded isolated cases of megabladder causing obstruction to the delivery of the foetus. But only 3 cases of distension of cloaca causing obstructed labour are so far reported in the Indian literature; Dhall *et al*, (1967), Mehta and Apte (1969) and Sarin and Sharma (1971). This is the fourth case in the Indian literature.

Usually the abnormality is not suspected until it is found impossible to de-

liver the shoulders in a cephalic presentation. In a breech labour the buttocks are arrested on the perineum and if the foetus cannot be moved after one or both legs are brought down then such abnormality must be kept in mind. The distended uterus not corresponding to the period of gestation attracts attention in such cases. Once the diagnosis is made, the abdomen must be tapped or eviscerated. Laparotomy was mandatory in our case because of the coexisting rupture of the uterus.

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See Figs. on Art Paper IX