DYSTOCIA DUE TO CERVICAL FIBROID

(Report of 2 Cases)

by

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Introduction

A normal labour (eutocia) may be defined as one in which the vertex presents and which is completed in less than twenty-four hours by spontaneous delivery without injury or undue discomfort to the mother. This ideal, the object of every obstetrician can never be obtained in all cases. He has to come across cases of abnormal labour (dystocia) in which timely intervention avoids the dangers to the mother and the foetus. We are reporting two cases of cervical fibroid causing soft tissue dystocia during labour.

Case 1

Mrs. B.K., 28 years, was transferred from a peripheral municipal maternity hospital for 9 months' amenorrhoea and prolonged labour on 25.12.1972. She had three full term normal deliveries. Last delivery was three years ago. There was no history of abortion. Her cycles were regular and normal.

On examination, the patient was of average build and nutrition. There was no pallor. The tongue was dry. The pulse was 100 per minute, blood pressure was 110/70 mm. of Hg. Cardiovascular and respiratory systems revealed no abnormality.

The fundal height was 36 weeks, presentation was cephalic. It was high floating. Foetal heart sounds were 140 per minute and regular.

Vaginal examination showed a firm round mass about 5″ in diameter arising from the posterior lip of the cervix and occupying the whole vagina. The external os was pushed up behind the pubic symphysis. The os was distorted and slit-like. The presenting part was very high. Vaginal delivery seemed impossible and a live healthy male child weighing 3 5 kg. was delivered by lower segment caesarean section. Tubal ligation also was done.

Post-operatively the recovery of the patient was uneventful. The patient was discharged on tenth postoperative day.

When she came for postnatal follow up she was advised to come for myomectomy after three months. When she came for surgery, speculum examination showed that the fibroid had markedly reduced in size. It was now 2½″ in diameter, arising from the posterior lip of the cervix with supravaginal extension. The uterus was retroverted and normal in size.

At the time of vaginal myomectomy, a transverse incision was taken on the posterior lip of the cervix and the fibroid was exposed. There were totally three separate fibroids each measuring about 1½″ in diameter making up the vaginal and supravaginal mass. These were enucleated without opening the peritoneum. Post-operative period was uneventful. Histopathology report confirmed the diagnosis of fibroids

Case 2

Mrs. P.S., 30 years was transferred from a peripheral maternity home for cord prolapse on

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28.5.1973. She gave history of three full-term normal deliveries, out of which only one was alive.

On examination the general condition of the patient was good. Pulse was 72 per minute, blood pressure was 110/80 mm. of Hg.

Abdominal examination revealed a 36 weeks' size uterus which was contracting regularly. The presentation of the foetus was cephalic, high floating and foetal heart sounds could not be heard either with a foetoscope or sonicaid.

Vaginal examination findings were as follows: The cord had prolapsed but the pulsations were absent. The cervix was pushed right behind the pubic symphysis. It was 2 fingers dilated and was thick, fibrous and not taken up. The presenting part was vertex. It was high floating. In the posterior fornix, there was a swelling which was bulging in the vagina. This was firm and absent 4" in diameter. It was obstructing the descent of the presenting part.

Soft tissue dystocia was diagnosed and the patient was taken for caesarean section. On opening the abdomen it was seen that the uterus had undergone marked rotation with the left round ligament presenting in the incision. The uterus was corrected with great difficulty as there was a fibroid about 4" in diameter in the posterior wall of the uterus low down in the lower segment on the right side. The fibroid was impacted.

There was also a tubo-ovarian mass 3" in diameter involving the right fallopian tube and ovary. It showed evidence of inflammation and was adherent to the large bowel posteriorly. The left appendages were normal.

The uterovesical pouch was opened and lower segment caesarean section was done. The baby was stillborn. It was decided to deal with the fibroid and the tubo-ovarian mass at a later date. The patient was treated with antibiotics and the postoperative period was uneventful.

The patient had come for follow up one month later. The tubo-ovarian mass and the fibroid had reduced in size. The fibroid was situated in the supravaginal portion of the cervix. It was about 3" in diameter. She was advised to come later for operation, but she did not turn up.

Discussion

The frequency with which fibroids of the uterus are encountered during pregnancy and labour is most difficult to estimate, because while one author takes record only of tumours of considerable size, another includes every small nodule which he comes across during examination. The frequency of the association is stated to be 0.3 to 0.8 per cent by Munro Kerr and 0.28 per cent by Browne.

Pregnancy having occurred in a uterus with fibroids, the question arises what are the chances of a successful issue with safety to the mother during labour. The effect of fibroids on labour depends entirely upon their size and situation. Situation of the fibroids is of greater importance than the size of the fibroids. The growths which cause difficulty are those situated low in the uterus, especially those of cervical region. Tumours of the body which only dip in the pelvis seldom obstruct labour, even when they are of considerable size, because they are pulled up above the pelvic brim by the enlarging uterus.

When labour is obstructed by a fibroid as in our cases, caesarean section becomes necessary to avoid the complications of obstructed labour. It is unwise to drag the head past the tumour. A pedunculated fibroid can be removed at the time of caesarean section. Myomectomy is contraindicated in the gravid uterus because of the dangers of severe haemorrhage and chances of infection. Greenhill has mentioned a maternal mortality of 20 per cent for this operation. Ideal management of a case of fibroid obstructing labour is a timely caesarean section followed by myomectomy at a later stage.

Summary

Two cases of cervical fibroid obstructing labour are reported. Emphasis has been put on the diagnosis and proper

treatment in time to avoid the complications of obstructed labour.

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