

DYSTOCIA DUE TO FOETAL ABDOMINAL ENLARGEMENT

(A Case Report)

by

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Dystocia can be due to abnormalities of passage, passenger or power. The passenger, that is the foetus, may cause dystocia either due to malpresentation, malposition or maldevelopment. Malpresentation or malposition are common causes of dystocia. However, dystocia due to foetal abnormality is quite rare. Here we report a case of dystocia due to persistent cloaca which was markedly distended.

CASE REPORT

Mrs. T.R., 25 years, second gravida was admitted on 20-12-1973 at 1.20 a.m. in Lokmanya Tilak Municipal General Hospital, Sion, Bombay with the complaints of eight months amenorrhoea, labour pains and leaking since previous day morning.

She had one full term normal delivery six years ago, a live female child having no congenital malformation. There was no history of any suspicious drug being taken during pregnancy.

On examination, she was a fairly built woman with average nutrition. She was not anaemic, temperature was normal, Pulse was 92 per minute and blood pressure was 110/70 mm. of mercury. There was no oedema.

On admission, the patient complained of

strong labour pains. Abdominal examination revealed fundal height of 32 weeks, the foetal parts were difficult to palpate, the presenting part, head was deeply engaged. The foetal heart sounds were difficult to locate.

Vaginal examination revealed that the cervix was fully dilated and the head was low on the perineum. Delivery of the head and neck was easy. Attempt was made to deliver the foetus by pulling on the neck but this failed. The labour was obstructed at the level of the shoulders. Vaginal examination showed soft bulging of the anterior abdominal wall of the foetus. The help of portable x-ray was taken and the preparations were done for examination under general anaesthesia and destructive operation.

Under general anaesthesia two fingers could be passed above the chest wall of the foetus. Soft bulge of the anterior abdominal wall was felt and a diagnosis of foetal ascites was made. It was difficult to manoeuvre the evisceration scissors because of the reformed cervix and bulging of the anterior abdominal wall of the foetus. About 1000 ml. of fluid was removed with the aspiration needle through the anterior abdominal wall. As delivery was still not possible, the thorax was perforated with the help of evisceration scissors. The abdomen was approached through the diaphragm. Abdominal viscera were partly evacuated. This reduced the size of the foetal abdomen. The baby was delivered by gentle traction. This was immediately followed by the delivery of the placenta with entire membranes. There was no post-partum haemorrhage or any injury to the cervix, vagina or perineum.

The patient had uneventful puerperium. She was B + or -ve. Her V.D.R.L. was negative

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and blood sugar was normal. She was discharged in good condition on fifth day.

Postmortem Findings

A. External Appearance.

The baby was 2,700 G. in weight and of indeterminate sex. Head and face were normal. Upper extremities were normal. Lower extremities were small but otherwise normal. Thorax was very small. On the right side of the chest, a wound made by the evisceration scissors was seen. (Fig. 1). Abdomen was grossly distended. It showed three cystic swellings, one in the midline in the hypogastrium and two laterally in each iliac fossa. External genital were rudimentary. They were represented by genital tubercle in the midline and genital swelling on its either side. The urethral and anal openings were absent.

B. Internal Anatomy

Heart and lungs were normal. On opening the anterior abdominal wall, a bladder like hollow organ about 10 cm x 6 cm in size came into view in the hypogastric region. By the side of this, there were two other cystic swelling each measuring about 8 cm x 6 cm. (Fig. 2).

Stomach and small intestines were normal. There was only development of the upper half of the large gut. Its lower end was distended and contained faecal material. It was seen communicating with the central cystic swelling.

Kidneys were cystic. Suprarenals were normal. The ureters were dilated. The length of the ureters was 6 cm and width 0.5 cm. Their lower ends were seen opening in the cystic swellings laterally.

A small uterus was identified in the midline on the posterior aspect of the central swelling. Both fallopian tubes were well developed, but ovaries were rudimentary.

Though on external appearance, three cystic swellings looked separate, they were actually communicating with each other. Clear yellow coloured fluid came out on opening these structures.

Embryology

From the fact that both the ureters, lower end of the intestine and the uterus were all opening in the sac, which had a lobulated appearance, the diagnosis of persistent cloaca with nondevelopment of the uro-rectal septum was made. (Fig. 3). The absence of urethral and

anal openings further substantiated our diagnosis.

Histology

Various organs were sent for histopathological study. The microscopic pictures of kidneys, suprarenals, uterus and fallopian tubes were normal. The cut section of the rudimentary ovary showed the typical stroma, but there were no primordial follicles. The cloacal sac showed plain muscle fibres with flattened out inner lining due to overdistention.

Discussion

Distention of the abdomen of the foetus is one of the causes of soft tissue dystocia which is usually diagnosed during labour. This may be due to ascites, distended bladder, persistent cloaca, tumours of kidneys, liver, spleen, testicles or ovaries. Mhatre *et al*, (1967) have reported a case of foetal ascites. Kishore *et al*, (1964) and Chakrabarty (1965) have reported 15 cases of distended bladder, while cases of persistent cloaca are reported by Mehta and Apte (1969) and Sarin and Sharma (1971).

Each of the above conditions is of great pathological interest but the problem for the operator is a distended abdomen preventing expulsion of the child. Radiology can be of great help in diagnosing cases of distended abdomen before delivery. X-ray picture shows distended abdomen straightening of the foetal vertebral column, arms and legs held away from body and splayed out ribs. The diagnosis during labour is made when further progress is arrested after delivery of head and both legs in breech presentation. The diagnosis can only be made with certainty when the whole hand is passed beyond the presenting part under general anaesthesia.

Once the condition is diagnosed, the bulk of the foetus can usually be diminished by withdrawing the fluid by aspi-

ration, if the obstruction is due to ascites or other cystic tumours. If the tumours are large and solid, evisceration can be done either through the abdomen or thorax of the foetus (Munro-Kerr, 1964).

Summary

A rare case of persistent cloaca, which was markedly distended leading to dystocia is presented.

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See Figs. on Art Paper IV