

DYSTOCIA DUE TO TRUE FOETAL ASCITES

by

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Introduction

Distension of foetal abdomen has been reported many times as an important cause of dystocia (Dayal *et al* 1962; Sharma 1960). The possibility has been described as early as 17th century and from time to time cases of dystocia have been reported as a result of foetal abdominal enlargement, due to various causes. These are generally termed as "Foetal Ascites" as the actual anomaly in the foetus is known only after the autopsy on new born (Mehta and Pandya 1964). The patient comes to the hospital generally late in advanced labour foetus invariably dead and intected. A fatal case of this type is reported with review of the literature.

CASE REPORT

A. K. a 32 years old second gravida, was brought to the Military Hospital, Pathankot on 9.4.1974, from interior of Himachal Pradesh. The woman was in labour for more than 24 hours following 6 months' amenorrhoea. Her abdomen was distended much beyond term and she was seen at various stages by village 'Dai', a general practitioner and civil dispensaries and was sent to this hospital with a provisional diagnosis of internal Haemorrhage.

On admission the woman was severely dehydrated, general condition was poor, pulse 130/mt, respirations 30/mt, B.P. 106/80 mm Hg., eyes sunken, tongue dry and coated, mouth having fetid smell.

The abdomen was distended. Uterus was more

than 36 weeks' size. It was tense and tender. Foetal parts were not palpable. FHS were not audible. There was no evidence of free fluid in the peritoneal cavity.

The external genitalia were swollen and oedematous and were smeared with foul smelling greasy material. Cervix was fully dilated, membranes were absent. A small soft, cystic foetal head was felt above the level of ischial spines. No cranial bones were palpable. Foul smelling discharge was present. There was no bleeding.

Plain X-Ray of abdomen showed a large area of translucency with very small shadow of foetal head of about 24 weeks. No limbs or thoracic cage was seen.

A diagnosis of monster causing dystocia was made and laparotomy was planned after correcting the dehydration and electrolyte balance.

Operative findings

The abdomen was opened by a median incision extending from 2 inches above the umbilicus to symphysis pubics. Uterine fundus was found at the level of xipisternum. The uterus was opened by a classical incision. The uterine cavity was occupied by the body of the foetus with a very thin cyst like abdominal wall. The dead foetus could not be removed until about 2000 ml. of fluid were aspirated from the foetal abdomen. The fluid was watery and clear. Placenta and membranes were removed and there was no postpartum haemorrhage. Uterus contracted readily and was closed in layers. Abdomen was closed in layers. The post-operative period was stormy and patient developed peritonitis, which required second laparotomy and drainage. The patient died on 6th day due to septicaemia.

The foetal abdomen was opened and another 2500 ml fluid was removed. The viscera were all normal anatomically. No apparent cause of ascites could be found. The skull was soft and

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pliable and scalp ecchymosed probably due to repeated examinations.

Discussion

The diagnosis of foetal ascites is generally made late in labour. Mhatre, *et al* (1967) have described X-Ray features of this type of case as ribs spread out and legs and arms held away. Mehta and Apte (1969) have given five characteristics in X-Ray. (1) Outstretched limbs, (2) Absence of foetal hallow, (3) Straight vertebral column, (4) Bell shaped thorax, (5) Presence of telipes. These are no doubt important criteria but are variable according to the amount of fluid in foetal abdomen. X-Ray is a useful aid in diagnosis in a negative way by ruling out locked twins. Otherwise, it may be difficult to diagnose by X-Ray a hydramnios from foetal ascites.

These babies may present as breech or as vertex. If they come as breech the diagnosis and management vaginally may be a simple process by tapping and extraction (Dhall and Dhall, 1967). In cephalic presentation, the labour may be arrested at any level. Head high up as in the present case, at neck and shoulder, or with limbs delivered out with head.

The treatment is destructive embryotomy, and may be done vaginally when diagnosis is certain, or by abdominal route. Sometimes, as in present case the neck is so thin and friable that the head

starts tearing away while extracting. Patel (1966) has reported actual tearing of the neck so also in the present case. The amount of fluid in the foetal abdomen varies greatly from as little as 610 ml. (Mhatre *et al*, 1967) to 5,000 ml. (Patel *et al*, 1966) and 4,500 ml. as in present case. Multiple congenital malformations have been noted in the foetus.

Summary

1. A case of dystocia due to foetal ascites is reported.
2. Diagnosis and management of such a case is discussed.

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See Fig. on Art Paper X