SPONTANEOUS ANNULAR DETACHMENT OF THE CERVIX

by

PUSHPA KAWATHEKAR,* M.S., F.I.C.S.

and

LALIT V. GRAMPUROHIT,** D.G.O

An unduly prolonged labour in a primigravida, at times terminates spontaneously following an annular or partial detachment of the cervix due to the pressure necrosis. The course of events may be as dramatic as cited in the case treated by Chassor Moir, or may be gradual when the patient is being prepared for caesarean section for obvious cervical dystocia as witnessed by Ghosh *et al*, 1973. The following two cases were encountered at one of the Obstetric units of the M. R. Medical College and Govt. General Hospital Gulbarga, during a period of 6 years.

CASE 1

G. 25 years was first seen on 26-8-1973 after 36 hours of labour at the patient's village about 40 miles from Gulbarga. O.H. Married 2 years back, primigravida. M.H.5/30 days regular. L.M.P. 9 months back. Her general condition was good B.P. was 110/80 mm Hg and pulse was 100/mt; she was slightly dehydrated.

Uterus was 36 wks size, contracting and relaxing well every 2-3/mts; head was engaged and foetal heart sounds were absent. She did not know when the membranes had ruptured.

On pelvic examination foetal head was seen at the introitus and the anterior lip of the cervix was covering the head like a band. A gap could be seen between the band and the remaining portion of the cervix. The foetus was pushed out in next few minutes without any manipulation. The baby was a stillborn female weighing 2.6 kg. There was no post-partum haemorhage. Further examination of the cervix revealed a partial detachment of the anterior lip of the cervix which was attached to the remaining cervix by small strands of tissue. The necrosed cervix was removed by cutting the strands. Patient was treated with antibiotics. She made an uneventful recovery.

CASE 2

S. aged 20 years was admitted with the history of labour pains for 40 hours. The membranes had ruptured 30 hours prior to admission to the hospital. O.H. Married 11 months, primigravida. MH 5/30 days regular L.M.P. 9½ months back. Her general condition was fair; B. P. was 120/90 mm Hg; Pulse was 110/mt; she was dehydrated; uterus was of 36 weeks size, head was deeply engaged. Foetal heart sounds were absent. On vaginal examination cervix was thin, 6 cms dilated, and membranes were absent. Caput succedaneum was present and head was at the level of ischial spines. Diagnosis of cervical dystocia was made and while she was being prepared for lower segment caesarean section, she had strong bearing down contractions and expelled a fleshy mass spontaneously (Fig. 1) following which the foetus and the placenta were expelled. The baby was a stillborn male, and weighed 2.8 kg. There was no post partum haemorrhage. Uterus was explored and was found intact. This patient also had an uneventful recovery.

Comments

Most authorities consider annular detachment of the cervix as a rare acci-

*Associate Prof. Obstetrics & Gynaecology, M. R. Medical College and Govt. General Hospital, Gulbarga-585 105.

**Obstetrician and Gynaecologist, Sushruta Maternity and Nursing Home, Gulbarga.

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dent in labour. Greenhill (1965) reports that only 60 authentic cases have been reported so far whereas Brown (1964) quotes a figure of 110 cases. However, Chassor Moir (1964) does not feel it an extreme rarity and says "there are few obstetricians of wide hospital experience who have not on occassions witnessed this occurrence". We could come across only one report by Ghosh and Roy (1973) in a review of the available English literatdre of last 10 years. Our own experience of encountering only 2 cases during a period of 6 years of general hospital as well as private practice, further testifies to the rarity of this condition.

The essential pathology of this condition is failure of the cervix to dilate and subsequent necrosis of the cervix due to prolonged pressure by the foetal head. It is essentially a complication seen in primigravida and inherent structural faults like rigid long cervix (Brown, 1964) and persistent spasm of the lower segment (Lindgreen and Smyth, 1961) are also thought to be contributory factors. In multiparas the failure to dilate may be due to scarring following previous lacerations, cauterisation or cervicitis. Whereas cephalopelvic disproportion is considered as yet another contributory factor by many obstetricians, Jeffcoate and Lister (1952) feel that, the fit of the head to the cervix is never so tight in cephalopelvic disproportion as to cause all round pressure necrosis and detachment of the cervix. In our two cases also cephalopelvic disproportion was practically ruled out as the head was deeply engaged in both the cases.

The clinical features are of prolonged labour and usually the detachment follows strong expulsive contractions and is accompanied with slight bleeding as the vessels are thrombosed. Two types of detachments have been described by Moir (1964) partial or "bucket handle" type and complete or annular.

The maternal mortality was reported to be 15% by Bierer and 4 cases of maternal deaths have been reported by Ingraham and Taylor (1947) in an analysis of 55 cases. These deaths were chiefly due to shock and infection. Maternal death or shock have not been observed by other authors and perhaps this is because of improved intrapartum care and prompt treatment of the cases of cercival dystocia. The foetal prognosis is undoubtedly bad and foetal mortality is reported to be between 29%—45% (Ingram, 1947, and Bieres), Foetal loss is possibly due to prolonged labour rather than to any difficulty in labour.

The prognosis for subsequent deliveries is not bad (Brown 1964) and spontaneous delivery can be anticipated.

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See Fig. on Art Paper IX