CARCINOMA RECTUM CAUSING OBSTRUCTED LABOUR

(A Case Report)

by

S. Bhan,* M.D.

R. Madan,** M.D., D.G.O.

and

G. Dhar,*** F.R.C.S., D.R.C.O.G.

Rectal carcinoma with pregnancy, although a rarity, presents the problem of early diagnosis, as most of its signs and symptoms may mimic those of a normal pregnancy and it is one of the most difficult problems to ascertain which of the patients have serious intestinal organic lesions.

About 155 cases of rectal carcinoma with pregnancy have been reported (O'Leary *et al*, 1967). The true incidence of carcinoma with pregnancy is difficult to determine. It is about 1 in 100,000 pregnancies (Woolf, 1965). McLean *et al* (1955) found 1 case in 50,000 pregnancies.

CASE REPORT

H.B., 22 year old woman was admitted as a case of full term pregnancy with labour pains of 48 hours' duration. She was Gravida 2, para I with the previous obstetric history of full term stillbirth due to delayed labour about 1 year back.

On examination patient was very anaemic, oedema was ++, B.P. 110/70 mm Hg. Height of fundus 36 weeks, LOT, Vertex was free and F.H.S. 150/min. Uterine contractions were mild to moderate.

On vaginal examination-cervix was about 2/5th dilated, thick, membranes were absent and caput ++. The posterior fornix was obliterated by a very hard mass extending upto the middle 2/3rd of posterior vaginal wall. The growth was fixed but vaginal mucosa was free.

On, rectal examination—a big growth was felt in the rectum about 5 cm from anal verge, involving whole circumference of rectum. The upper limit of the growth could not be reached. It was fixed and in the centre there was small lumen which admitted tip of a finger.

Provisional diagnosis of carcinoma rectum causing cervical dystocia and obstructed labour was made.

Investigations: Hb-5 gm%. Urine Exam. NAD.

On interrogating this patient about the past history pertaining to carcinoma rectum she admitted of having bleeding P.R., constipation off and on and pain in the lower abdomen for 2 years. The symptoms had aggrevated in this pregnancy for which she had consulted a physician specialist who had given her the symptomatic treatment. Patient never had a proper antenatal check-up.

Treatment: Patient was transfused with blood and L.S.C.S. was performed after 24 hours. An alive male baby was delivered. At operation, ascitis was present, para-aortic glands were palpable but there were no obvious secondaries in the Liver. Postoperative period was uneventful but she was transfused with 2 units of blood. On 11th postoperative day proctoscopy was done and rectal biopsy was taken which showed adenocarcinoma rectum. The final diagnosis of carcinoma rectum stage IV (inoperable) was made.

Follow up: The growth was spreading very fast and within 2 weeks it had involved the lower 1/3rd of the posterior vaginal wall as well. Patient never complained of any symptom per-

**Assistant Professor.*

***Gynaecologist.*

****Professor and Head of the Dept., Govt. Medical College, Srinagar.*

Accepted for publication on 27-11-75.

taining to malignancy and was discharged 2 weeks after operation with the advice to continue the treatment on the surgical side, which she never did. Two months after the operation, patient was last seen in the Gynaecological O.P.D. when she complained of bleeding P.V., severe pain in the back and the lower limbs. Vaginal examination could not be done as vagina was full of growth which was bleeding. Patient was admitted on surgical side, palliative treatment was given and went home. She was never seen again and is presumed to be dead.

Comments

The cases of rectal carcinoma with pregnancy have been reported for more than a century now. The earlier reports were those of Cruveilhier (1835), Mackenzie (1860), Greenbalgh (1866), Harman (1878) and Kattenbach (1879) with 100% material mortality. There was no maternal mortality in the cases of Jordan (1894), Riddett (1897), Holzapfel (1899) and Baldy (1901). Most of the case reports published have been single cases (Marcus *et al*, 1957; Hendleman and Mestel, 1958; and Banerji, 1965); however, Warren (1957) reported on 9 patients, Hesseltine and Loth (1956) on 4, Beston and Golden (1961) on 5 cases and O'Leary *et al* (1967) reported on 17 patients.

Rectal carcinoma in pregnancy can occur in any age group and parity. The youngest patient reported is of 19 years (O'Leargy *et al*, 1967). Most of the lesions are discovered after the complaint pertaining to gastro-intestinal tract and common error in missing the diagnosis is to attribute these symptoms to the commonly encountered conditions associated with pregnancy as the complaints of nausea, vomiting, abdominal pain, constipation, diarrhoea and bleeding P.R. due to haemorrhoids are frequently seen in a pregnant woman. It is necessary that the persistant symptoms should require studies like digital examination, sigmoidoscopy, stool examination for blood and barium examination. The latter should be employed when the cancer is seriously suspected without any regard to the hazards of the foetal exposure to irradiation.

The surgical treatment of the cases diagnosed during pregnancy should be based on the same lines as in the uncomplicated cases with pregnancy, except that when the diagnosis is made during the last few weeks of pregnancy, the operative treatment should be delayed until after delivery.

The obstetric management of the patient is to be well planned. Although vaginal delivery can be planned, usually L.S.C.S. is performed after 32 weeks of pregnancy, as it is certain, it obviates the possibility of dystocia, it removes the probable risk of embolic metastases precipitated by pressure of the foetal head over the growth and it permits of inspection of the peritoneal cavity, for operability of the growth. Vaginal delivery is contra-indicated in presence of the anterior rectal wall carcinoma because haemorrhage may ensue or labour may become obstructed.

Survival is related to the stage and grade of the tumour. Generally pregnancy has no adverse effect on the course of the carcinoma rectum, nor is cancer injurious to the pregnancy.

Summary

A case report of carcinoma rectum causing cervical dystocia and obstructed labour is presented. The summary of the literature reveals that significant and persistant change in bowel habits or symptoms should alert the medical attendant to the possibility of cancer of the colon.

Acknowledgements

We are thankful to Dr. S. N. Ahmad Shah, Principal, Government Medical

College, Srinagar for permitting us to publish the hospital record.

References

1. Baldy, J.: (1901) cited by Reference 15.
2. Banerji, B.: J. Obst. & Gynec. India, 15: 191, 1965.
3. Beston, J. R., Jr. and Golden, M. L.: Am. J. Obst. & Gynec. 81: 718, 1961.
4. Cruveilhier, J. J. (1835): cited by Reference 17.
5. Greenhalgh, R.: Lancet. 2: 203, 1866.
6. Hendleman, L. and Mestil, A. L.: Obst. & Gynec. 11: 119, 1958.
7. Herman, G. E. (1878): cited by Reference 17.
8. Hessiltine, H. C. and Loth, M. E.: Western J. Surg. 64: 529, 1956.
9. Holzapfel, K. (1899) cited by Reference 17.
10. Jordan, F. H. (1894) cited by Reference 17.
11. Kaltenbach, R. (1879) cited by Reference 15.
12. Mackenzie, F. W. (1860) cited by Reference 17.
13. Marcus, M. B., Cibley, L. J. and Brandt, M. L.: Am. J. Obst. & Gynec. 73: 1337, 1957.
14. McLean, D. W., Arminski, T. C. and Bradley, G. T.: Am. J. Surg. 90: 816, 1955.
15. O'Leary, J. A., Pratt, J. A. and Symmonds, R. E.: Obst. & Gynec. 30: 6, 862, 1967.
16. Riddett, A. J.: Lancet. 2: 600, 1897.
17. Warren, R. P.: Brit. J. Surg. 45: 61, 1957.
18. Woolf, R. B.: Gastrointestinal complications of Pregnancy" in Obstetrics and Gynaecology Guide (Vol. I). Commerce Clearing House, Inc., Chicago, 1965.