DYSTOCIA AND RUPTURE OF UTERUS DUE TO FOETAL ASCITES

(A Case Report)

by

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Dystocia can be due to abnormalities of passage, foetus or uterine pains. Dystocia resulting from malformed foetus is a rare occurence. During the past 2 decades, the facilities at hand have been considerably enhanced to assess the pelvis at all levels and to determine cephalopelvic disproportion. Abnormal uterine action can be diagnosed and managed easily.

Occasionally an obstetrician is confused because of a malformed foetus. The difficulty is not experienced till the malformed foetus brings the progress of labour to a standstill. This dystocia can result from hydrocephalus, tumours of the neck, ascitis, etc. This paper presents an interesting case where foetal ascitis brought about obstructed labour and resulted in rupture of uterus.

CASE REPORT

Mrs. J., aged 32 years was admitted on 27-7-75 at 5.30 a.m. as an emergency case with a history of 9 months' amenorrhoea and labour pains. She was transferred from a primary Health Centre, with history of delivery of head and both hands at 3 p.m. on previous day and no progress since then inspite of good uterine contractions. She had 7 F.T.N.D. of which 5 were alive and healthy and 2 died in childhood. Last delivery was 2 years ago.

On examination the patient looked toxic, anxious, exhausted and dehydrated. She was anaemic and her haemoglobin was 6 gms%. Her blood pressure was 110/80 mm Hg and her pulse was 110/minute. The bladder was distended. About 250 ml. of clear urine was drained by catheter. Other systems were normal.

On abdominal examination, the abdomen was markedly distended. The foetal parts were felt superficially. The uterine contractions were absent and foetal heart sounds were not heard. The abdomen was very tense and tender.

The head and both hands were outside the vulva. Plain X-ray of abdomen was taken, which did not reveal anything. A gentle vaginal examination was done and thorax was felt in the vagina.

A diagnosis of ruptured uterus with some gross congenital malformation obstructing labour was made and a laparotomy was decided upon. The head and both arms were cut off just to, prevent the injury and spread of infection.

Under general anaesthesia the abdomen was opened through a left paramedian incision. The rest of the foetus lying outside in the abdominal cavity could be extracted easily by breech. The placenta was also lying free in the peritoneal cavity. There were about 800 cc of old blood clots in the peritoneal cavity. The uterus was well contracted and pushed to the left side. There was no fresh bleeding from the edges of the tear. There wes a spiral tear in the right lateral corner of the uterus extending from the lower uterine segment to the vagina. After performing a subtotal hysterectomy the rent in the lower uterine segment and upper vagina was sutured with continuous catgut stiches. Abdomen was closed after cleaning the peritoneal cavity. Two bottles of blood were transfused during the operation. The condition of the patient was very low during the operation but improved afterwards. She was febrile for 5-6 days and also developed V.V.F. She was discharged on the 10th postoperation day with the advice to come after 3 months for the V.V.F. repair.

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Post-mortem findings of the foetus

The foetus was female and macerated. It was a fully mature stillborn foetus weighing 4.5 Kgs. The bulk of this weight was due to distension of the abdomen. Head, face, extremeties were developed normally. Nails reached upto the ends of the digits. Thorax was comparatively small. Abdominal wall was thin and overstreched due to distension. Its girth at the level of the umbilieus measured 54 cms. and on dissection was found to have foetal ascitis. Other organs were normal. Histopathology examination showed meconium peritonitis with changes in intestine.

Discussion

Usually the abnormality is not suspected until it is found impossible to deliver the shoulders in a cephalic presentation. In a breech labour the buttocks are arrested on the perineum and if the foetus cannot be pulled then such abnormality must be kept in mind, though shoulder dystocia, constriction ring and short cord are to be excluded. Once the diagnosis is made, the abdomen must be tapped or eviscerated. Laparotomy was mandatory in our case because of co-existing rupture of the uterus. This foetal ascitis was not recognised during pregnancy or early in labour, eventually leading to uterine rupture. If the patient had come early in labour this catastrophe could have been arrested by detecting ascitis and managing the case vaginally.

Summary

An interesting case of rupture due to foetal ascitis is presented here. This grand multiparous patient was in labour with head outside the vulva for about 22 hours. The etiological factor was noted only at laparotomy which was mandatory because of the co-existing rupture of the uterus.

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