OBSTRUCTED LABOUR DUE TO LARGE VESICAL CALCULUS

(A Case Report)

by

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The incidence of urinary calculus in females is very low compared to that in males. Kabra *et al* (972) found vesical stones in 10% and renal stones in 20% females. A vesical calculus causing obstruction of labour is rare. Panigrahi (1973) presented a case requiring caesarean section for obstruction by vesical stone. Jacob and Bhargava (1971) reported a case where the obstructing stone could be displaced under anaesthesia to permit a vaginal delivery. Seetha and Ramgopal (1967) reported removal of a stone in 2nd trimester of pregnancy. We present here a case where obstruction caused by a large vesical calculus required delivery by caesarean section.

CASE REPORT

Mrs. N. J. a 20 years old primigravida was admitted at Irwin Group of Hospitals, Jamnagar on 5th January 1976 with H/O 9 months amenorrhoea and labour pains since 2 days.

She gave H/O dysuria off and on since 1 year. On admission pulse 84/M, temperature normal, B.P. 130/90 mm of Hg. No oedema on feet. Abdominal examination showed full term size uterus, position V, 1, foetal head floating and F.H.S. 140/m. occasional uterine contraction.

On vaginal examination cervix 1 cm dilated and partially effaced, membranes intact, pelvis clinically adequate, No C.P.D. No mass was palpated in bladder area.

Investigations: — Hb 10.5 g. Urine-alb-nil. Sug-nil. Patient was kept under observation. On 8th January 1976 she complained of labour pains at 10 p.m. Abdominal findings were same. On vaginal examination cervix was 5 cms dilated, membranes ruptured. A hard mass about 5 cms x 6 cms was palpated in connection with left pelvic wall near the brim. It was very hard and immobile. Exact nature of the mass could not be made out. As vaginal delivery was not possible patient was taken up for caesarean section. Abdomen was opened by Pfannentiel incision and L.S.C.S. was carried out and a living male foetus weighing 2.3 kg. was delivered. After closure of the uterus the pelvis was explored and the mass was found to be a vesical calculus. The urinary bladder was opened extraperitoneally and a large calculus 7.5 cms x 6.5 cms weighing 200 g and with a smooth surface was removed. No other stone was found in the bladder. Bladder was closed in two layers. Uterovesical peritoneum was closed and abdomen was closed in layers. Bladder was drained by an indwelling Malecot's catheter for 10 days. Patient developed urinary tract infection which was treated. Convelescence was otherwise uneventful.

Discussion

A small vesical calculus may not be palpable on abdominal or vaginal examination but a large vesical calculus should normally be palpable on bimanual examination. This may prove difficult during pregnancy, if it is displaced out of pelvis, as must have happened in our case at the

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first examination, especially as the patient was not in active labour. With the onset of labour the stone can get pushed down in the pelvic cavity and cause obstruction. It was then easily palpable. The position and mobility of the stone may vary depending on the stage of labour.

It may be possible to displace a small calculus out of the pelvis to permit a vaginal delivery. But with a mature foetus and a large stone, delivery by caesarean section may be the only safe alternative. However, an attempt to dislodge the stone should be made before resorting to caesarean section.

A large stone, detected during pregnancy, should be removed as it may obstruct labour. In areas where urinary calauli are common, recurrent urinary complaints should alert one to the possibility of a urinary calculus.

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