INTESTINAL OBSTRUCTION IN PREGNANCY

(A Case Report)

by

DEBIDAS DUTTA,* D.G.O., M.D., F.I.C.S.

and

S. K. SEAL,** D.G.O., F.R.C.O.G.

Intestinal obstruction is very rare during pregnancy and this condition may elude early diagnosis because the triad of acute intestinal obstruction like pain, vomiting and constipation are mistaken as common disorders of pregnancy itself. The spasmodic or colicky pains may be confused with labour pains, signs like distension and visible peristalsis may be obscured due to the presence of anteriorly placed gravid uterus.

Sevesko and Pisani (1960) reported 6 cases out of 39,231 deliveries in 16 years. Browne *et al* (1963) mentioned only one case in 20 years with just over 24,000 deliveries. Harer (1962) reported an incidence of 1 in 3,600 deliveries and Morris (1965) 1 in 3,161 deliveries. In India, Bhatt (1965) reported 2 cases, Dass *et al* (1968) 7 cases in 8,296 deliveries and Magar *et al* (1976) 2 in 16,728 deliveries.

At Silchar Medical College, there were 10,236 deliveries from April, 1971 to March, 1977 and only 1 case of intestinal obstruction during pregnancy was encountered.

*Assistant Professor of Obstetrics & Gynaecology.

**Professor & Head of the Deptt. of Obstetrics & Gynaecology.

Silchar Medical College, Silchar, Assam.

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CASE REPORT

A 27 years old 4th gravida, whose expected date of delivery was 13-12-76, was admitted as an emergency case on 4-10-76 with history of sudden onset of acute spasmodic pain in abdomen around the umbilicus for about 2 hours. She had 3 spontaneous abortions prior to this pregnancy and a curettage was done once. She was having constipation but there was no history of vomiting. She was put on Duvadilan and Gestanin upto 28 weeks of pregnancy in view of her past history of 3 successive abortions.

The findings on admission were, pulse 82/minute, temperature 36.2°C, respirations 24/minute, blood pressure 138/90 mm. of Mercury, Heart and lungs—N.A.D. Per abdomen, height of uterus was 30 weeks size, vertex, L.O.A. position, not engaged. No painful uterine contractions were felt, F.H.S. 140/minute, regular and clear. There was no muscle guard or rigidity, but there was marked localised tenderness and slight distension over the middle of the fundus of uterus. Pelvic examination revealed long and closed cervix.

Investigations: Hb. 10.5 G%, T.C. 10,000/C. mm., D.L.C. 65%, l 30%, E 4%, m 1%, E.S.R. 80 mm. at the end of first hour, blood group AB, Rh D—positive B.T. 1 min. 15 Sec, C.T. 3 min., 25 Sec, Urine—N.A.D. Provisional diagnosis—Incomplete rupture of uterus (?)

Laparotomy was performed under general anaesthesia within 2 hours of admission which revealed massive adhesions and bands involving loops of small intestines, which were adherent to fundus and anterior surface of body of uterus, loops were dilated proximal to obstructions. All the adhesions and bands were removed with blunt and sharp dissection. There was no sign of rupture of uterus. Besides

routine postoperative care, she was put on Duvadilan injections to avert premature onset of labour. The postoperative period was uneventful and she was discharged on 14th postoperative day. She was again admitted to hospital on 12-11-76 with mild pain in abdomen, which subsided spontaneously within few hours. The possibility of recurrence of intestinal obstruction was ruled out. She was kept in hospital under close observation. Her membranes ruptured spontaneously with the onset of labour pain on 24-11-76. A healthy female baby weighing 2.6 kg. was delivered by low forceps on 25-11-76, 51 days after laparotomy. She was discharged from hospital on 1-12-76.

Discussion

During pregnancy, the gravid uterus occupies much space in peritoneal cavity as term approaches, also there is diminished peristalsis and tendency to constipation, as a result the bands and adhesions which may not produce symptoms in non-pregnant state may cause intestinal obstruction during pregnancy. Intestinal obstructions are commonly seen during third trimester. In 5 patients of Sevesko *et al* (1960), the obstruction occurred during third trimester and the remaining patient had obstruction in 24th week of pregnancy. Three cases of Dass *et al* (1968) had obstruction during 8th to 10th week of pregnancy while 4 cases belonged to 18th to 24th week. Bhatt (1965), encountered intestinal obstructions during 22nd week of pregnancy and 4th puerperal day in 2 cases. Magar *et al* (1976), reported 2 cases during third trimester of pregnancy. The present case also had obstruction in third trimester.

When patient complains of pain, vomiting and constipation during pregnancy, one should bear in mind the possibility of intestinal obstruction particularly when there is previous history of abdominal operation or abdominal tuberculosis. In a doubtful case, X-ray of abdomen in erect posture may be helpful, multiple levels of fluid and gas in small intestines are diagnostic. The symptomatology may also be mistaken as incomplete rupture of the uterus as happened in this case and also with one case of Magar *et al* (1976) and early laparotomy saved the lives of mothers in both cases. The uterus is to be emptied first by caesarean section if the operation to deal with obstructions is found technically difficult due to presence of gravid uterus (Seveske *et al* 1960; Magar *et al* 1976). Foetal mortality is high, varying from 16.6% to 63% as reported by various authors (Seveske *et al* 1960; Morris, 1965; Dass *et al* 1968; Magar *et al* 1976). Maternal mortality is also high, Seveske *et al* (1960) reported 16.6%, Morris (1965) 14%, Dass *et al* (1968) 14% and Bhatt's (1965) both the cases expired. Magar *et al* (1976) had no maternal mortality. In the present case the patient had no vomiting and early laparotomy was done. These factors might have played a great role towards the good outcome.

Summary

One case of intestinal obstruction during 30 weeks of pregnancy is reported. At laparotomy the obstruction was found to be due to bands and adhesions involving the loops of small intestines. The patient had an uneventful recovery and subsequently had a vaginal delivery at 38 weeks of pregnancy. There was no maternal or foetal mortality. The problem in diagnosis of intestinal obstruction during pregnancy is discussed and the early laparotomy is recommended.

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