DYSTOCIA DUE TO DISTENDED CLOACA

(A Case Report)

by

SRIMANTA KUMAR PAL,* M.B.B.S., D.G.O., M.S. (Cal.)

and

S. K. GUPTA,** M.D., D.C.P., F.R.C. Path. (Eng.)

Distension of foetal abdomen is an important cause of soft tissue dystocia. The usual causes of such distension are ascites, distended bladder, tumours of kidneys, liver and spleen.

In the present communication a rare foetal anomaly of 'persistent cloaca' is described which gave rise to obstructed labour.

CASE REPORT

Mrs. M. B., aged 20 years, second gravida 36 weeks' pregnant was admitted in our hospital on 19-11-78. She was referred from a nearby P.H.C. after in labour for 30 hours. She had one term delivery 3 years back. She had no antenatal check up in the current pregnancy.

General examination revealed clinical features of prolonged labour and obstetric exhaustion.

Abdominal Examination

There was undue enlargement of abdomen. Uterine contractions were present. Uterus was tense and hence foetal parts were difficult to locate. Foetal heart sounds were absent.

Vaginal Examination

The external genitalia was swollen and oedematous due to repeated internal examinations. Foetal head was outside the vulva and the anterior shoulder was lying free beneath the symphysis pubis. Attempts to deliver the abdomen by pulling on the neck and hooking around the axillae failed.

Etiological diagnosis of obstruction remained uncertain at this stage. She was resuscitated with Inj. Pethidine and glucose drip. Tetracycline was administered parenterally. One hour later, patient was anaesthetized and two fingers were passed along the chest wall of foetus while assistant was retracting the foetal head on the other side. Soft bulge of anterior abdominal wall was felt and diagnosis of foetal ascites was made. The abdomen was perforated with a perforator with difficulty. About two pints of meconium stained fluid came out. This was quickly followed by the birth of the baby. Inj. methergin was given intravenously and placenta was removed by controlled cord traction. Routine exploration of uterus was made. Liquor amni could not be measured but appeared normal in quantity.

The postpartum period was uneventful. Her postprandial blood sugar on 4th postpartum day was 90 mg. per cent and V.D.R.L. test was negative. She was discharged on 6th postpartum day.

Description of Foetus

(A) External appearance

The fresh stillborn male baby weighed 2.5 kg. The crown-rump, crown-heel and circumference of chest measured 25 cm., 38 cm. and 31 cm. respectively. The circumference of collapsed abdomen at the level of umbilicus was 41 cm. (Fig. 1). Abdominal skin was thin and overstretched.

Head, face and upper extremities were normal. Thorax was rather small. External urethral and anal openings were absent.

*Gynaecologist, Basirhat Hospital, West Bengal.

**Reader, Department of Pathology, Medical College, Calcutta.

(B) Internal anatomy (Pertinent findings):

(i) The most part of the abdomen was occupied by a hollow organ which measured 25 cm x 12 cm x 12 cm. Both the ureters opened separately into this organ and so also the lower part of the large gut. Histologically, this showed characteristic fibromuscular wall (Fig. 2). The internal urethral opening was absent and urethra was atretic.

(ii) Kidneys and adrenals were normally situated but both the ureters showed marked hydrouretic changes.

(iii) Macroscopic and microscopic examination of other organs including placenta failed to reveal any other abnormality.

Discussion

Enlargement of foetal abdomen can occasionally be diagnosed by radiology (Mehta and Apte, 1969). But more frequently the diagnosis is made when there has been unexplained arrest in the progress of labour after birth of the head in cephalic presentation or after birth of one or either feet in breech presentation. Other conditions which can give rise to similar 'surprise dystocia' are contraction ring, short cord, impacted anterior shoulder or conjoined twin (Pal *et al*, 1977). Faced with such circumstances one has to pass the hand into the uterus beyond the shoulders and thorax so that an exact diagnosis can be made with certainty.

Whatever may be the etiologic background, the treatment of obstructed labour due to enlarged foetal abdomen is destructive operation. Aspiration needle, long scissors or a perforator can be used for this purpose depending on the space available in a given case. But caesarean section will be safer in cases where obstruction is caused by a foetal tumour which is quite large and solid in nature. In the present case, however, a sharp stroke by a perforator succeeded in draining the accumulated fluid. Abdomen collapsed and subsequent birth of the baby was easy.

Summary

A case of dystocia due to persistent cloaca with undue enlargement of foetal abdomen is presented. Diagnosis and management of such a case is discussed.

Acknowledgement

We are thankful to Dr. S. R .Ghosh, Superintendent, Basirhat Hospital, for kindly allowing us to publish this case.

References

1. Mehta, L. and Apte, V.: J. Obstet. Gynec. India. **19**: 748, 1969.
2. Pal, S., Sarkar, S. and Chaudhuri, S. K.: J. Obstet. Gynec. India. **27**: 454, 1977.

See Figs. on Art Paper VII