

DESTRUCTIVE OPERATIONS IN PRESENT-DAY OBSTETRIC PRACTICE

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Introduction

Destructive operations in present-day obstetric practice are not that destructive as they are seldom performed on normally formed living foetus as in the past. One may dislike these operations, but one cannot avoid these in developing countries as the incidence of obstructed or neglected labour is still high because of lack of total antenatal care. In India, perhaps less than 20% of deliveries receive skilled attention and more than 80% of the population live in the villages, where obstetric care is still meagre (Upadhyaya, 1975).

Materials and Methods

This study comprises of 75 cases of destructive operations, done in Eden Hospital, Calcutta, during the period of January, 1976 to 20th August, 1979, among 30,276 deliveries, an incidence of 0.24%. Only 5 cases were booked and the rest unbooked.

The types of operations were, (i) Craniotomy in 45 cases. (ii) Evisceration in 25 cases. (iii) Decapitation in 2 and (iv) Spondylotomy in 3 cases. The incidence of destructive operations for each year of study was more or less similar.

Results

It was significant to find that a good number of the patients were young, 25.33% being aged between 15-20 and 33.33% between 21-25 years (Table I).

It was curious to find that 30.66% of the cases (Table II) were primigravidae and 24% second gravidae. The usual belief that malpresentations are common in multiparas is not always true.

Prolonged labour (Table III) with dead baby was major indication of craniotomy. It was performed on 1 living baby as there was gross intrauterine sepsis and in 3 cases of hydrocephalus. The malpresentations include occipitoposterior-4, face-2, brow-2 and breech-1.

The miscellaneous group includes failed forceps-2, accidental haemorrhage-1, cord prolapse-1, compound presentation-1 and post C.S.-1. The cases of failed forceps came from outside. For shoulder presentation with dead baby, the choice was evis-

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TABLE I
Age

Operation	No. of cases	15-20 yrs.	21-25 yrs.	25-30 yrs.	31-35 yrs.	36-40 yrs.
Craniotomy	45	12 (26.66%)	13 (28.88%)	12 (26.66%)	7 (15.55%)	1 (2.22%)
Evisceration	25	6 (24%)	10 (40%)	4 (16%)	4 (16%)	1 (4%)
Decapitation	2	1 (50%)	—	1 (50%)	—	—
Spondylotomy	3	—	2 (66.66%)	1 (33.33%)	—	—
Total	75	19 (25.33%)	25 (33.33%)	18 (24%)	11 (14.66%)	2 (2.66%)

TABLE II
Parity

Operation	No. of cases	P ₀₊₀	P ₁₊₀	P ₂₊₀	P ₃₋₄	P ₅₋₆	P ₇₋₈
Craniotomy	45	18 (40%)	12 (26.66%)	5 (11.11%)	4 (8.88%)	2 (4.44%)	4 (8.88%)
Evisceration	25	4 (16%)	5 (20%)	8 (32%)	6 (24%)	2 (8%)	—
Decapitation	2	—	—	1 (50%)	1 (50%)	—	—
Spondylotomy	3	1 (33.33%)	1 (33.33%)	1 (33.33%)	—	—	—
Total	75	23 (30.66%)	18 (24%)	15 (20%)	11 (14.66%)	4 (5.33%)	4 (5.33%)

TABLE III
Indications

Craniotomy (45)	Evisceration & Decapitation (25 + 2)	Spondylotomy (3)
Contracted pelvis	4 Shoulder presentation	6 Breech—
Malpresentation	9 Shoulder with hand prolapse	16 with Hydrocephalus
Prolonged labour	15 Shoulder with hand and cord Prolapse	4 with big Baby &
Hydrocephalus	6 Hydrops foetalis	1 arrest of after
PET & eclampsia	5	coming head
Miscellaneous	6	2
		1

TABLE IV
Duration of Labour at the Time of Operation

Operation	No. of cases	12-24 hrs.	25-36 hrs.	37-48 hrs.	Over 48 hrs.
Craniotomy	45	12 (26.66%)	15 (33.33%)	10 (22.22%)	8 (17.77%)
Evisceration	25	9 (36%)	12 (48%)	2 (8%)	2 (8%)
Decapitation	2	—	2 (100%)	—	—
Spondylotomy	3	2 (66.66%)	1 (33.33%)	—	—
Total	75	23 (30.66%)	30 (40%)	12 (16%)	10 (13.33%)

ceration. Overall, 71 babies were dead at the time of operation. The period of gestation was below 35 weeks in 5 cases 35-37 weeks in 23, 38-40 weeks in 42 and over 40 weeks in 5. Table IV shows the duration of labour.

The operation was done after proper resuscitative measures with I.V. fluids and suitable antibiotic coverage. All the operations were performed under G.A., mostly open ether. In 1 case of evisceration, the baby had to be ultimately brought out by internal podalic version.

Complications: Table V shows that ope-

TABLE V
Showing operative complications

Complication	Number
Episiotomy wound extension	5
Cervical Tear	2
Retained placenta	3
Uterine atony & shock	7
Rupture uterus	1

TABLE VI
Showing Maternal Morbidity

Complication	Number
Puerperal Pyrexia	15
Urinary tract infection	10
Parametritis, Septicaemia	1
Intra uterine sepsis	4
Episiotomy wound gaping	6
V.V.F.	1

rative complications. There was bilateral cervical tear in 2 cases and rupture uterus in 1 following craniotomy which ended in subtotal hysterectomy. Ten cases required blood transfusion. In majority of cases continuous bladder drainage was kept.

Morbidity and Mortality

One unbooked case aged 24 years, developed V.V.F. 7 days after craniotomy. She was in labour for 51 hours. The V.V.F. was successfully repaired on

30-1-1978. One mother died 25 days after craniotomy. She was an unbooked primigravida in labour for 26 hours. She was discharged after 10 days but had to be re-admitted after 7 days with extensive parametritis and died of septicaemia.

Discussion

Ideally a situation that calls for destructive operation should not develop in modern obstetrics but as shown in this study, we cannot avoid it. In Western countries, except in foetal abnormality, it is reserved for the cases which have passed unrecognised resulting in obstructed labour with dead foetus (Dewhurst, 1976). Such conditions should not occur if cases are properly supervised. Even in these cases, section is considered safer and less traumatic (Moir, 1956; Dewhurst, 1976).

In our country, it is not unusual to find a case of obstructed labour coming from far away, often with a neglected shoulder presentation, lower segment overstretched and baby dead (Upadhyaya, 1975). Such a case taxes one's clinical judgement. Before any attempt to deliver the baby one must resuscitate her adequately with IV, fluid to correct acidosis, electrolyte imbalance and to forestall shock. This is an essential part of the treatment. As regards section versus destructive operation, every effort must be made to avoid the former in developing peoples (Dewhurst, 1976) unless there is gross C.P.D., or threatened rupture. Because, many of our patients are young, 25.33% being age 15-20 and 33.33%, 21-25 years (Table I). Further, 30.66% were primigravidae and 24%, second gravidae (Table II) many of them having no living issue. Caesarean Section will limit their obstetric career. Secondly, most of them live in an area where antenatal care is unknown. Even if

advised, they will not attend the health centre to respect the wishes of elders and try their obstetric performance in the home, some of them ending in rupture uterus. Thirdly, in late cases, handled outside by untrained personnel-infection, peritonitis and septicaemia following laparotomy remain a major cause of mortality in our hospitals. 56% of this series were in labour over 24 hours and 13.33% over 48 hours. In western countries, they say, that infection is no problem because of potent antibiotics. But here, gross infection due to overcrowding and resistant strains organisms, are frequent and the facility for culture and sensitivity very much limited. So antibiotics are not always the solution and vaginal delivery in our experience gives better result. All these are not to undermine the scope of caesarean section and assessment of the case is very important. If there is any suspicion of threatened rupture or the true conjugate is below 7.5 cm, section should be the choice. In this hospital, section was done in more than 10% cases of transverse lie with dead baby (Modak *et al*, 1979). In grossly infected cases, caesarean hysterectomy may be done (Chatterjee, 1979).

In Western practice, decapitation is rarely used (Dewhurst, 1976). We are in favour of evisceration as it is done under direct vision and so less traumatic. Considering the type of cases, the operative complications and morbidity (Table V, VI) in this study were not high and the maternal mortality was 1.33%. In pre-antibiotic days maternal Mortality in U.K. hospitals, was 7.2-15.6% (Moir, 1956).

Lastly as the cases are not many now-a-days about 1 in 400 deliveries in this study, one may not attain enough ex-

perience in these operations. Caesarean section would be then safer.

Summary

1. This study is based on 75 cases of destructive operations, done in Eden Hospital, Calcutta, in 4 years (1976-79) among 30,276 deliveries, an incidence of 0.24%. Of them there were 45 craniotomy, 25 evisceration, 2 decapitation and 3 spondylotomy.
2. 58.66% were aged between 15-25 years and 30.66% were primigravidae. Prolonged and obstructed labour with malpresentations and dead baby were the major indications.
3. One case sustained rupture uterus, I, V. V. F. following craniotomy and 7 had P.P.H. with shock. The maternal mortality was 1.33%.
4. The place of destructive operation has been discussed with a brief review of the literature.

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