LABOUR COMPLICATED BY HYDATID CYSTS

(A Case Report)

by

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Introduction

Hydatid disease is not uncommon in India but hydatid cyst of genital tract is a rare occurrance comprising of about 3% of all cases of hydatidosis (Parikh and Parikh, 1966). Pelvic hydatid cysts are usually secondary to primary viscero-abdominal lesion. Review of literature shows that obstructed labour is only rarely caused by hydatid cysts and pre-operative diagnosis is usually difficult.

CASE REPORT

Mrs. N., 1 year old primigravida, Hindu, was admitted on 6-7-1979 with 9 months pregnancy and labour pains for 4 hours. On examination general condition was fair, not anaemic, pulse, 72/min. regular, BP 110/60 mm.Hg. and minimal oedemafeet was present. Systemic examination was normal.

On abdominal examination uterus was full term with longitudinal lie and cephalic presentation, head was free, mild uterine contractions were present and fetal heart rate was 140/min., regular. An irregular swelling of about 5 cm x 5 cm sibe could be palpated on right side about 5 cm above the symphysis pubis. This swelling was firm, mobile and non-tender and was thought to be a subserous fibroid.

On pelvic examination, cervix was pushed hind pubic symphysis os admitting one finger, membranes were present, head was presenting high up. In the posterior fornix a soft irregular mass about 15 cm x 10 cm in size was felt. The mass was non-tender, immobile and was bulging through posterior fornix below the level of head.

A clinical diagnosis of pregnancy with? multiple fibroids or pregnancy with? ovarian cyst with a small subserous fibroid was made. As the pelvic mass was preventing the descent of head into the pelvic cavity, caesarean section was decided. Abdomen was opened by a sub-umbilical right paramedian incision. On opening parietal peritoneum, a whitish cyst about 5 cm x 5 cm in size was seen close to incision attached to peritoneum. Another cyst about 4 cm x 4 cm was seen lateral to the above cyst, also attached to the parietal peritoneum. Lower segment caesarean section was done and an alive female baby was delivered. After closing uterine incision, abdomen and pelvis was explored. A cyst about 12 cm x 12 cm in size was seen in the broad ligament on right side with infundibulopelvic ligament stretched over it. Another cyst about 10 cm x 10 cm was felt impacted in the pouch of Douglas. On palpating liver, slight scarring and irregularity was felt in the right lobe.

A diagnosis of multiple hydatid cysts was made, the cyst near the incision line was excised carefully and sent for histopathology examination. As minimal surgery is advocated during caesarean, no further attempt was made to remove pelvic cysts. Abdomen was closed in layers. Patient had an uneventful post-operative period and went home in satisfactory condition on 14-7-1979. She has been asked to

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report 6 months later for re-evaluation and removal of pelvic masses.

Detailed questioning of patient later on did not reveal any positive social, occupational or family history suggestive of hydatid disease. She had no symptoms in the past of primary echinococcosis. Histopathology of the removed cyst confirmed the diagnosis of hydatid disease.

Discussion

The diagnosis of pelvic hydatid disease in pregnancy is usually made durlng or after laparotomy. Few cases reported in literature were diagnosed pre-operatively. In 1902, Franta reviewed literature and reported 36 cases of hydatid cyst causing dystocia ln labour and another 22 cases where operative removal of cyst was done in pregnancy. Following this extensive review, Embrey (1938) reported 2 cases wifh tumour in the pouch of Douglas causing obstructed labour. One of them had had one peritoneal cyst removed at fifth month of pregnancy. He quoted 4 more cases of hydatid cysts complicatlng pregnancy, reported earlier in the literature. A few reports of hydatid cyst causing obstructed labour have also come from India. Devi (1955) reported a case where obstruction was thought to be due to fibroid uterus. Caesarean section was done and the cyst was removed after puerperium. Parikh and Parikh (1966) reported 2 more cases diagnosed during caesarean section. Narayan Rao *et al* (1965) reported an unsual presentation of hydatid cysts in 2 cases. Both cases had fatal epileptiform convulsions and diagnosis was confirmed post mortem. Several cases have been reported in non-pregnant patients, laparotomy deciding the diagnosis in cases being opened as fibroids or ovarian tumours. The case reported here had multiple hydatid cysts with no suggestive history. The patient presented early in labour thus caesarean section was done before dystocia could occur. The parietal cysts were quite deceptive, being confused with subserious fibroids pre-operatively. Since the pelvlc and parietal hydatid cysts are known to be manifestations of secondary echinococcosis, the primary in this case might have been in liver, whlch had ruptured asymptomatically and healed by scarring.

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