SURGICAL EMERGENCIES IN OBSTETRICS

by

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Intestinal pathology has the same symptoms and signs in pregnancy as in non-pregnant state. Inspite of this, abdominal and gastrointestinal disorders during pregnancy often seem to immobilise the surgeons. Procrastination to assure a firm diagnosis is the most common mistake, one which frequently leads to even maternal mortality. At no time is the clinical acumen more crucial than in evaluating the pregnant patient with the possible surgical abdomen. It has been amply stated that the obstetrician must think surgically and the surgeon obstetrically. Here we endeavour to present 4 cases of surgical emergencies associated with pregnancy encountered in LTMG Hospital, Sion, Bombay 400 022.

Case 1

Mrs. M.S., 30 year old second gravida, first para was admitted with history of 4 months amenorrhoea with vaginal bleeding for one day and history of vomiting 10-12 times for a day. Past cycles were regular.

On examination, patient looked toxic and dehydrated, pallor +, pulse 120 per min., B.P. 140/90 mm. Hg. On abdominal examination there was distension +, tenderness all over with guarding and rigidity. Peristalsis was absent. There was foul smelling discharge. On vaginal examination, uterus 8 weeks size, fullness in all fornices.

Investigations: Haemoglobin 7 gms.%, W.B.C. 14,200/c.mm. P-60, L-40 ESR 80 mm. Serum electrolytes: Na. 133 mEq/L and K. 2.9 mEq/L. Colpopuncture: Free flow of pus.

Patient was explored, 1000 cc of pus drained. All intra-abdominal organs were covered with flakes of pus, but no other intestinal pathology was discovered. Appendix could not be located. Uterus was bulky and soft. Tubes and ovaries were normal. Abdomen was closed with drains in the flanks. Post-operatively patient was put on ampicillin and garamycin. Inspite of all resuscitative measures patient expired 12 hours after operation. Post-mortem finding showed gangrene of terminal 1/3 of appendix situated in the retrocoecal region. Uterus was enlarged and contained necrotic products of conception.

Case 2

Mrs V.R., 28 year old third gravida, second para, came with amenorrhoea of 2 months and vomiting for termination of pregnancy.

On examination, patient looked imaciated and dehydrated Pulse 100/min., B.P. 100/70 mm. Hg. Systemic examination NAD. Uterus was of 10 weeks size. Fornices were clear. Haemoglobin 10 gms.%.

Patient was poseted for suction evacuation On the day of operation patient was found collapsed after simple enema. She was resuscitated. She complained of pain in abdomen and there was tenderness in hypogastrium. Colpopuncture showed foecal material. Accidental puncture of pelvic colon was suspected. Surgical opinion was taken but no conclusion could be drawn. Meanwhile patient was kept on I.V.

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fluids and antibiotics. After 16 hours patient had all signs of acute abdomen. Patient re-evaluated again by the surgeon and a rectal perforation on the anterior wall was found on examination.

On exploration, there was gangrene of distal half of transverse colon, descending colon, sigmoid and rectum. Whole of gangrenous bowel resected and terminal colostomy performed. Post-operative recovery was uneventful. Termination of pregnancy was carried out two months later by intra-amniotic injection of 20% saline.

Case 3

Mrs. R.P., 30 year old, was transferred from a peripheral hospital for amenorrhoea of 8 months with frequent loose motions, vomiting and pain in abdomen for 6 days. She was fourth gravida and third para.

On examination, dehydration +, vital signs normal. Uterus was 32 weeks, tense, F.H.S. absent. Cervix was 2 fingers, partly taken up. Membranes +. A provisional diagnosis of accidental haemorrhage was made. Patient was treated conservatively with I.V. fluids, enteroquinol and sulfadiazone.

Investigations: Haemoglobin 8 gms.%. Stools NAD. Serum electrolytes: Na 134 mEq/L, K 3.5 mEq/L.

Six hours later patient collapsed and was given mephentin drip and blood transfusion. Accidental haemorrhage was suspected. As patient did not progress A.R.M. with 2.5 unit pitocin started. Patient did not respond to pitocin drip for 12 hours, hence taken up for caesarean section.

On exploration, 14 feet of small intestine was gangrenous. Caesarean section and resection anastomosis of intestine performed. The baby was still born and was weighing 1.9 Kg. Post-operatively patient was put on garamycin and ampicillin. On fourth post-operative day blood fibrinogen level was 100 mg.%, platelet count 30,000 and she expired on the same day.

Case 4

Mrs. G.R. 20 year old, third gravida, second para came with history of amenorrhoea of 7 months with colicky pain in abdomen and vomiting for 2 days.

On examination, pulse 100/min. B.P. 130/80 mm. Hg. Pallor +, there was signs of peritonitis, uterus was 28 weeks, F.H.S. +.

Investigations: Haemoglobin 8 gms.+, TC 12,000/cmm P-70, L-30. Electrolytes within normal limits. Plain x-ray abdomen showed distended loops of intestines in left flank with multiple fluid levels in upper abdomen.

On exploration, there was gangrenous loop of intestine 1½ feet in length and 3 feet away from duodeno-jejunal flexture. There was a twist in in the mesentry in the anti-clock wise direction of 360°, multiple adhesions and enlarged lymph nodes were present. Resection anastomosis was done. Patient was put on antibiotics, Inj. Duvadilan, and I.V. fluids. Patient made an uneventful recovery and delivered at full term a healthy baby weighing 2.8 Kg.

Discussion

Incidence of appendicits in pregnancy quoted by Sankari (1968) is 0.05%. Hoffmen and Sazuki (1949) found it to be 0.1%.

In first trimester, the area of maximum tenderness is at McBurney's point. But in later months due to the displacement of appendix by growing uterus, it is more often generalised. Walling off of peritonitis during pregnancy is hampered because the omentum is denied access to the appendicular area by the pregnant uterus. High levels of circulating adrenal corticosteroids during pregnancy may also favour the spread of inflammatory process. There is marked deterioration in prognosis of mother and foetus if operation is not performed within 24 hours.

Mesentric Vascular Occlusion

Svesko and Pisani (1960) have quoted the incidence of intestinal pathology as 1.5 in 10,000 deliveries.

Vascular occlusion may be arterial or venous but seldom differentiated clinically. The classical triad of symptoms are abdominal pain, rectal bleeding or diarrhoea and extreme collapse as seen in

case 3. Unfortunately, these symptoms occur only in irreversible stages. Treatment is always surgical. Resection should be performed removing six inches of intestine on either side of line of demarcation.

Volvulus

It is an infrequent complication during pregnancy. Harer and Harer (1961) have found 112 cases reported in literature, of which more than 50% had past history of abdominal surgery. Dass *et al* (1968) and Bhatt (1955) have reported 4 and 2 cases respectively in second trimester. Our case had volvulus during 3rd trimester and plenty of adhesions were found on exploration. Signs and symptoms develop when torsion is beyond 180°. It commonly occurs during 4th and 5th months of pregnancy, 8-9 months of pregnancy and at the time of delivery and puerperium.

As mortality is 60-70%, pregnancy and a viable child should be overlooked early pregnancy. If pregnancy is done advanced, caesarean section and intestinal pathology is dealt with.

Nausea, vomiting, constipation and vague abdominal cramps in first half of pregnancy tend to mask the symptoms and in many instances may fatally delay the diagnosis. In later half of pregnancy, the diagnosis of toxaemia, abruptio placentae, rupture uterus and even hysteria may be made.

Summary

All our cases were reviewed in time by surgeons. Maternal mortality in surgical emergencies is commonly found to be about 25-55% with a foetal mortality of 50-75%.

In conclusion the policy of earlier operations for relatively benign symptoms if adopted few patients may be operated needlessly. This is a small price to pay compared to the tragedy following procrastrination (Douglas).

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