IMPACTED DERMOID CYST IN THE POUCH OF DOUGLAS CAUSING OBSTRUCTED LABOUR

(A Case Report)

by

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Pregnancy associated with an ovarian tumour is undoubtedly a rare occurrence. Ovarian cyst, impacted in the pouch of Douglas causing obstructed labour is still more rare. This communication presents a case which came from rural area with obstructed labour caused by an impacted ovarian cyst in the pouch of Douglas, which was histopathologically proved to be a dermoid cyst.

Case Report

Mrs. S.S., 36 years of Sundarban area, a 3rd gravida carrying full term pregnancy was admitted to Nilratan Sircar Medical College Hospital on 22-3-1981 with pain abdomen for last 27 hours and rupture of membranes for last 23 hours. Patient was initially at home where dai has failed to confine her and she had been sent to Jainagar Health Centre from where she was referred to this hospital. She had previous 2 full term normal deliveries at home. Babies were said to be of average weight. Both of them are living (12 years, 7 years). During her present pregnancy she had only occasional pain and abdominal discomfort. On eliciting past history it was known that she used to feel heaviness in the lower abdomen for 1½ years before this pregnancy.

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General Examination

Her tongue was dehydrated, Pulse—120/min., Blood pressure—130/90 mm. of Hg., Temperature—99°F, she was little restless and was sweating.

Uterus was full term. There was a suprapubic swelling firm in consistency reaching upto the level of umbilicus which appeared to be stretched and distended lower segment. Upper segment was tonically contracted and demarcated from lower segment by an oblique groove. Presentation was vertex which was just fixed. F.H.S. was present and position was right occipito transverse.

Os was 6 cm. dilated. Cervix was oedematous and three fourth taken up. Membranes were absent. Vertex was just above the level of ischial spines with a caput projecting in the form of a wedge through the os. A fullness was felt through the posterior fornix which was tense cystic in feel, but whether it was uterine or extra uterine could not be elicited properly because of restlessness of the mother and also because of the fact that its upper limit could not be palpated abdominally for the gravid uterus lying in front.

Management

Patient was rapidly resuscitated and then prepared for lower segment caesarean section.

When abdomen was opened some amount of free fluid was found inside the abdominal cavity. Lower segment was found to be stretched, distended and thinned out. There was a groove at the junction of upper and lower uterine segment. Bladder was dragged up

oedematous and distended. Incision on the uterus was made at the upper part of the lower uterine segment. There was compound presentation i.e. vertex in right occipito transverse position with anterior parietal presentation along with one footling (right). Baby, being smeared with few ml dirty thick foul-smelling meconium, was delivered which was grossly asphyxiated and resuscitated with difficulty. Lower segment was repaired and haemostasis was carefully secured.

A cystic mass was found impacted in the pouch of Douglas in between the posterior surface of lower uterine segment and anterior surface of sacrum. The mass was delivered out of abdomen and found to be ovarian cyst of left side. There was no twist of the cyst. Right fallopian tube and ovary were found to be healthy. Ovariotomy on left side and partial salpingectomy on both the sides were done. Histologically, it was proved to be a dermoid cyst.

Post operatively mother suffered from slight abdominal distension and stitch abscess which were adequately treated. Baby was 2 kg. 900 gms. in weight and was doing well under the care of a paediatrician.

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