Obstructed Labour due to Chronic Tubercular Osteomyelits

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A 24 year old unbooked primigravida, Mrs. K was admitted in the labour ward of L.N.J.P. Hospital at 38 weeks pregnancy with labour pains of 26 hours duration and leaking per vaginum for 12 hours. There was history of dai interference.

Past History

The patient had swelling of both hipjoints 10 years back which was diagnosed as tubercular osteomyelitis. She was operated on left hip joint followed by irregular antitubercular treatment. Four years ago she developed pus discharging sinuses from right hip joint and had antitubercular treatment for 3 months only.

Examination findings

The general condition of the patient was poor. She was dehydrated and anaemic. She was unable to walk on her own and her legs were crossed over each other. Pulse rate was 120 per minute, B.P. 90/70 mm of Hg and clinically cardiovascular and respiratory systems were normal. The examination of bilateral hip joints showed fixed flexion, adduction and internal rotation deformities with no movement possible. There were 3 to 4 pus discharging sinuses in right groin. A surgical scar was present on lateral aspect of left hip joint. Abdominal examination was difficult due to bilateral fixed hip deformities and kyphosis. Bladder was distended and on catheteristion there was hematuria. Uterus was term size with cephalic presentation. She was getting moderate uterine contractions. Foetal heart sounds were absent. Introitus was difficult to visualise because of her bilateral fixed deformities. With difficulty, one finger vaginal examination was done after lifting both the legs, by an assistant. Cervix was fully dilated with thick cervical lips and membranes were absent. Head was above the brim with caput and third degree moulding. Pelvis was grossly contracted at all levels. A diagnosis of severe degree contracted pelvis with intrauteine death was made.

Investigations

Routine investigations were normal except anaemia. Xray pelvis showed ankylosis of both hip joints with decreased joint space and destruction of articular space suggestive of chronic arthritis. Xray chest showed no active lesion. Mantoux test was positive. Pus culture from groin sinuses showed Kliebsella. Sputum for AFB was negative. ELISA test for M. tuberculosis was positive.

Treatment

Patient's dehydration was corrected and a lower segment caesarean section was performed delivering a stillborn female baby weighing 2 kgs. There were no gross congenital malformations. Technical difficulty was experienced during anaesthesia and surgery due to her fixed spinal and hip deformities. Her postoperative period was uneventful and she was discharged on 10th day on antitubercular treatment.

Hip tuberculosis constitute 0.5 to 0.7 % of all cases of tuberculosis and can cause pelvic contraction. Gross pelvic deformity in this case has resulted in marked decrease in pelvic capacity and foetal loss. Unfortunately our patient came very late and already had obstructed labour and intra uterine death. The doctors attending such patients should caution them that during pregnancy they should have regular antenatal check ups and timely caesarean section whenever indicated.