Session No. 12—19th April 1956
From Unit "B," Kandang Kerbau Hospital for Women.
Moderator: DR. A. C. SINHA.

A Case Of Obstructed Labour

Case Report:

Reg: No. 1799. S.B.S., Malay (female) — Age 31 years.
Unbooked.
Admitted 28th January, 1956.

Primigravida sent in by a general practitioner on the 28th January, 1956 with the following history:—

(1) Patient in labour for 3 days.

(2) Hair seen at introitus for about 24 hours.

(3) "Pains" poor for the past 24 hours.

(4) Membranes ruptured ? 2 days ago.

O.E.:

G.C. fair. Well covered. Not anaemic. Afebrile. B.P. 122/84. Pulse 90/min.

Heart:)

N.A.D.

Lungs:)

Abdomen:

The guts were very distended. The uterus was very large and tense. It was a vertical lie with the head in the pelvis and foetal heart was not heard. Catheterised 10 ozs. of heavily blood-stained urine.

Vaginal examination: revealed collapsed foetal bones. The os was fully dilated. The liquor amnii was very foul-smelling. The outlet was slightly contracted.

Management:

(1) Injection Penicillin — 1 mega unit — ½ mega unit b.d.

(2) Injection Streptomycin — 1 Gm. — ½ Gm. b.d.

(3) Prepare for Forceps delivery.

Under general anaesthesia, an episiotomy was done and a macerated head was easily delivered by forceps. The shoulders were impacted and bilateral cleidotomy had to be performed. The foetus was so macerated that the head and posterior arm were severed by traction.

Intravenous orcometrine 0.25 mgm. was given as soon as the foetus was out and the placenta was removed manually. Exploration revealed an intact uterus.

The mucosa of the whole vaginal wall was necrotic looking, therefore, a minimal amount of suturing was done and a Foley's catheter left in the bladder.

Her general condition at the end of the operation was fair.

P.O.T.

(1) Catheter to stay in for 10 days.

(2) I.V. drip and Ryle's tube for 24 hours.

(3) I.M. anti-gas gangrene serum 20,000 U. given.

Progress:

1st day: Temperature 101°F otherwise satisfactory.

5th day: Perineal wound broke down — incontininence of faeces. No incontinence of urine.

10th day: Catheter removed — incontinence of urine. Vagina sloughing.

20th day: Vagina clean. Perineum healing by granulation and no more incontinence of faeces. Still dribbling urine.

27th day: Vagina still raw and incontinence of urine persisting. Discharged. Meantime blood for K.T. found to be negative.

Post-natal:

72nd day: G.C. satisfactory. Still having incontinence of urine. Vaginal examination revealed a mass of scar tissue in the vagina extending down to about 1" from the introitus. The cervix could not be identified.

Discussion.

DR. C. S. OON: Presented this case.

DR. A. C. SINHA: Asked if it was possible in the first place to prevent the vaginal stricture by putting in a mould.

PROF. B. H. SHEARES: Defined when forceps should be applied to the foetal head. The definition of two hours for the head on perineum in a primigravida and one hour in a multipara was not in use now. The question now was of length of labour—if the patient was in labour for over 24 hours, then this was a case of dystocia. Other obstetricians lowered the figure 20 hours. As soon as the os was fully dilated forceps was applied

Prophylactic forceps gave better results for both mother and child. It could be applied:—

(a) When the biparietal diameter of the head had passed the sacro-coccygeal platform.

(b) When the head was at the outlet and distending the perineum.

Prophylactic forceps prevented undue stretching of the utero-vesical fascia, cystitis and urinary disturbances, as well as strictures of the urethra. Long pressure of the head in the pelvis and perineum led to interference of the blood supply of the tissues. Wrigley's or De Lee's forceps were used to deliver the head.

DR. A. C. SINHA: Asked after how many hours in labour was the patient said to suffer from uterine inertia?

PROF. B. H. SHEARES: Replied "after 24 hours."

DR. A. C. SINHA: Commented that it was immaterial how long the patient was in the first stage of labour in comparison with the second stage, but once the os was fully dilated the head should be delivered within one hour. The signs of the second stage labour pains should therefore be carefully watched for and clinically assessed.

PROF. B. H. SHEARES: Said that there was no better method to watch the advance of the head than by pelvic palpation.

DR. A. C. SINHA: Mentioned stress incontinence as a complication of prolonged pressure of head in vagina. Many patients did not complain of stress incontinence unless they were asked leading questions. However one should not be too enthusiastic regarding operative treatment for many cases improved with perineal exercises.

There were two types of perinei seen in parturient women—(1) the thick rigid perineum, and (2) the soft distensible perineum. In the latter damage was done by the head to the tissues beneath the mucosa, leading to diastasis of levator ani muscles with ballooning of vagina and later marital difficulties.

PROF. B. H. SHEARES: Said that the reason for the 24-hour limit for dystocia was primarily because the foetus might be in a state of anoxia and secondarily because of the injury to maternal soft tissues.

He further commented on two cases he had of stricture of the vagina in Malay patients. Both were acquired. The first patient was four hours in labour. In order to stimulate labour pains the Malay midwife gave a douche of an astringent lotion. This led to stricture of the vagina. McIndoe's operation was done in this case. Normal marital relations were possible, but the patient did not conceive.

The second patient was in labour for 4 days. She developed a vesico-vaginal fistula with atresia of the vagina. The fistula was repaired and three months later a plastic operation was done using amniotic membrane over the mould. Unfortunately it was found later that the amniotic membrane had sloughed away. Since then the epithelium has grown up the spurious vagina.

Vaginal stricture might be prevented by using an artificial phallus.
