



## Destructive operations in obstetrics

Unduly prolonged obstructed labor with the fetus jammed in the pelvic cavity beyond any hope of spontaneous delivery is not seen in the developed countries today. But such a situation is prevalent in the developing countries across the continents. It plagues thousands of women every year and accounts for 8% of maternal deaths in developing countries<sup>1</sup>. In India 70% of our population lives in rural areas with barely any modern obstetric facilities. Antenatal care is mostly not available or not availed of for various reasons. Home deliveries with untrained female attendant is almost a norm. In India 50% deliveries lack skilled or trained assistance. When labor gets obstructed due to contracted pelvic and fetal malformation or malpresentation the parturient, as an inevitable last recourse, is taken to the nearest primary health center (PHC) which is often quiet a distance away requiring time consuming arduous journey. The arriving parturient often merits the description of a woman in neglected obstructed labor with a dead fetus and distressed mother with dehydration, advanced infection and a uterus desperately trying to surmount the obstruction. The PHCs, more often than naught, lack necessary skilled obstetric and anesthetic services, and adequate surgical and ancillary facilities like blood transfusion to deal with the ordeal of the suffering parturient who just needs a simple craniotomy or cleidotomy or a difficult decapitation or evisceration or a prompt cesarean section with all its morbidity. Unable to offer these life saving procedures the woman is sent on another ordeal of a long and difficult journey, consuming very precious time, to reach a tertiary health care center usually attached to a medical college. Cesarean delivery is often resorted to as an easier way out in preference to destructive operations, often for want of training and skill in conducting these rewarding procedures.

Arora et al<sup>2</sup> from a medical college hospital Pondicherry reported in 1999, 33 destructive operations performed between 1981 and 1991 – 27 craniotomies, two decapitations, three eviscerations and one cleidotomy. In three cases the procedure failed needing cesarean section. Indications for craniotomy were hydrocephalus (52%), obstructed labor (19%), arrested after coming head (7%), cord prolapse (5%), persistent mentotransverse (4%), and placental abruption (4%). There were two maternal deaths one from postpartum

hemorrhage and one from severe postoperative shock after cesarean section. Six percent had vaginal lacerations and 3% urinary or wound infections. They state that their 0.094% incidence of obstructed labor was lower than 0.24 to 0.283% reported from other Indian hospitals. They found that women were referred late from the PHCs and emphasised the need to train the PHC doctors in performing craniotomy, decapitation and evisceration. In 2001 Biswas et al<sup>3</sup> from Kolkata, reported a 1.17% (141 in 12,034 deliveries over a year) incidence of obstructed labor – 0.29% or 36 with dead fetus. 44.4% underwent craniotomy and 55% evisceration. Cephalopelvic disproportion was the commonest cause of obstruction. There was one traumatic rupture of the uterus but no maternal death.

In 2005 Singhal et al<sup>4</sup>, from a medical college hospital in Haryana, reported 51 destructive operations done for obstructed labor with dead fetus over a 7 year period. Of these 68.62% women had craniotomies, 19.60% had decapitation, 7.84% had evisceration and 3.92% had cleidotomy. Cephalopelvic disproportion was the commonest indication. Two fetuses were grossly malformed, 49.05% weighed between 3 and 4 kg, and 9.43% were macrosomic. 49.09% women developed complications like atonic postpartum hemorrhage, vaginal and perineal tears, puerperal sepsis, and urinary infection. There was no maternal death. The authors rightly conclude that destructive operation is a good option even today. Adhikari et al<sup>5</sup> from a Medical College hospital in Kolkata report in 2005 a 0.56% incidence of obstructed labor (245/43906 deliveries) from January 1993 to December 1998. 63.27% or 155 were delivered by cesarean section and 36.73% or 90 had destructive operations - 67 craniotomies (60 for cephalopelvic disproportion, four for hydrocephalus and three for arrested after coming head), 21 decapitations and two eviscerations.

Of the 94 (38.37%) women with dead fetus eight were delivered by cesarean section. In all 12 cesarean babies died within 30 minutes of birth. Five mothers died after craniotomy, not because of craniotomy but due to complications of eclampsia. 7.09 (11/158) had complications after cesarean rectus - wound infection, urinary infection, and hematoma in the broad ligament or rectus sheath.

Amongst the 90 destructive operations there were two vesicoaginal and two rectovaginal fistulas, and 15 genital tears - a complication rate of 21.11% (19/90). The authors advocate an individualized approach to obstructed labor.

Gupta and Chitra <sup>6</sup> from a Medical College hospital in Delhi compared 56 destructive operations for women arriving late in obstructed labor with a dead fetus done between 1985 and 1991 with 27 cesarean sections done in 1989 and 1990 for similar indications. They found that destructive operations had no maternal death, few complications, and short hospital stay while cesarean section had one maternal death, long hospital stay, need for blood transfusion, and more complications. They rightly concluded that destructive operations not only have a place in developing countries but when feasible are safer than cesarean deliveries. Reports from Africa project a similar picture, quoting the incidence of obstructed labor as 1.27% (207/16221)<sup>7</sup>, 0.96% (380/39456)<sup>8</sup> and 4.7% (527/11299)<sup>9</sup>.

Although obstructed labor is banished from the western world where the destructive operations are obsolete and not needed, in developing countries like India obstructed labor with dead fetus and severe infection is a sad reality, and destructive operations are an essential part of obstetric practice and cannot be wished away. In many situations they should be a preferred option to cesarean delivery which needs much better facilities and greater morbidity. There is a great need for training PHC doctors in performing destructive operations and in judging situations where these are apt. This can best be done by deputing a competent person from a teaching

hospital to a PHC for 6-12 months. Incidentally, this deputed person will also improve the overall obstetric skill of the PHC doctor and the obstetric services offered at the PHC.

#### References

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