Medical Memoranda

Impregnation and Delivery per Rectum: an Obstetrical Freak

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In underdeveloped countries vesicovaginal and rectovaginal fistulae are commonly seen, almost always the result of difficult deliveries after prolonged labour at home for several days, and are often associated with severe perineal damage. The following case is an extremely unusual one.

CASE REPORT

PAST HISTORY

A married woman aged 18 was referred to Muhimbili Hospital on 22 February 1962 from up country for incontinence of urine and faeces which followed a delivery in her village two years previously, when she had a stillbirth after an obstructed labour of six days.

On her admission the following findings were noted: the urethra ended blindly after $\frac{1}{2}$ in. (1.3 cm.); vesicovaginal fistula and rectovaginal fistula—the bladder communicated with the vagina and rectum, forming one continuous cavity; the anterior and posterior vaginal walls were completely missing, with extensive scarring involving rectum, vagina, and bladder, with adhesions to pubic bones; the rectum and introitus vaginae were separated by only a skin flap—the remains of the perineal body; the sphincter ani was completely torn; the cervix was identified embedded in scar tissue posteriorly, with corpus uteri palpable above it; and the uterus was noted to be somewhat small.

Transverse colostomy was performed, followed by repair of the third-degree tear. Closure of the rectovaginal fistula was attempted, leaving a hole in the rectovaginal wall on account of lack of available tissue.

For the same reason vaginal repair of the vesicovaginal fistula proved impossible; therefore it was decided to leave the vesicorectal fistula and attempt to channel the urine from the bladder into the rectum and to close the lowermost portion of the vagina so as to render the patient dry. Accordingly, two flaps from the anterior and posterior walls of the vagina which formed the inferior margins of the vesicovaginal and rectovaginal fistula were dissected, and these were inverted and sutured just above the introitus vaginae. The raw surfaces of these flaps were covered with a skin flap taken from the right labium minor. By this procedure the urine was made to drain from the bladder remains directly into the rectum, thus forming an artificial channel.

Postoperative progress was uneventful, and the patient was continent of urine and faeces. After the colostomy was closed she was discharged, and advised to return after one year for further plastic operations.

PRESENT HISTORY

The patient was referred back to Muhimbili Hospital on 14 March 1966 with the following history: the periods had continued to be normal (2–3/28 cycle) up to three months previously, when they stopped completely. She first attended a local hospital on 9 March on account of abdominal pain and swelling. The pain at first was intermittent, lasting for a few days, later becoming acute, and she was unable to evacuate urine. An abdominal swelling was noted, arising out of the pelvis. A suprapubic puncture was attempted, but as no urine was withdrawn she was referred to a near-by hospital (Shinyanga Hospital), where the suprapubic puncture was repeated and offensive blood-stained fluid was obtained. She was referred to Muhimbili Hospital.

On admission the patient was somewhat anaemic, and her general condition was fair. She was obviously in pain. Examination showed a suprapubic swelling the size of an 18-weeks pregnancy. This was tender, and sinuses were present, draining pus, at the site of the previous punctures. Breasts were active. B.P. was 120/80. Blood examination showed Hb 6.6 g./100 ml. (57%) and a W.B.C. of 15,000/cu. mm. Examination of rectum showed necrotic cord presenting.

She admitted having had intercourse per rectum and thought she was pregnant, as she had felt movements one month before, but these had stopped.

Radiological Examination.—An 18-weeks foetus with Spalding's sign was present. The lateral view showed the foetus to be lying far anteriorly overlapped by gas shadows, and the uterine outline could not be identified. The appearances were suggestive of an extrauterine dead foetus.

Examination under anaesthesia was carried out on 16 March with the following findings: the urethra ended blindly after $\frac{1}{2}$ in. (1.3 cm.); no introitus vaginae was present. Rectal examination revealed a vesicorectal fistula admitting one and a half fingers about 1 in. (2.5 cm.) above the sphincter. Foetal parts were present, and these were felt to be in the bladder.

Next day evacuation of the foetus was carried out. After enlarging the vesicorectal fistula by splitting longitudinally in the middle, a macerated foetus was extracted via the rectovesical fistula through the rectum (see Illustration), and the placenta followed. Both the crown-to-rump length of 150 mm. and the radiological appearance of the foetus suggested foetal maturity of about 18 weeks.

Arm presenting through the anus. Note scar tissue in vagina.

Postextraction.—Examination showed a vesicovaginal cavity the size of a fist, and on the anterior rectal wall appeared the uterus, os dilated, admitting three fingers. The uterine wall was $\frac{1}{2}$ in. (1.3 cm.) thick and rigid, forming a bell-like cavity. Bleeding from the uterus did not occur after extraction. There was some blood-stained discharge per rectum for five days after extraction, otherwise the course was uneventful. On 6 April the sphincter ani was functioning normally, and the patient was continent of urine and faeces.

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