J. Nep. Med. Ass. (1970) 8, 31 *Case report*

BLADDER STONE DYSTOCIA

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Primary vesico lithiasis is considered a Socio-economic disease found more commonly in developing countries where the stone may often first begin in childhood. (Lowsley et al 1944) However, even in endemic areas, it is rare for the size of a calculus to interfere with delivery in adult life. Some textbooks, devoted to obstetrics and gynaecology in the tropics, omit mention of this possible complicaiton. One of us, (M.W.A.) in a life-time of maternity practice on this sub-continent had never encountered a previous case.

Sarma, (1960) of Madras, referred to an 1875 monograph by Hugenberger which described 23 cases, and added one of his own. His case was of a 25 year old, gravid 3, para 2, patient who was successfully delivered of a 6 lb. 5 oz. viable baby with Milne-Murry forceps and a generous episiotomy despite a large "typical laminated phosphate ovoid calculus" demonstrated radiologically in the post-partum period. The patient "politely and firmly" declined cystolithotomy. With her next pregnancy, she was admitted in labour and an antepartum vaginal cystolithotomy performed.

Earlier Neer (1919) referred to 46 cases collected in 1907 and added a report of a 30 year old para 2 patient. She volunteered a history of renal calculus five years previously. Under anaesthesia the calculus was displaced and forceps delivery achieved. Two months post-partum, a six ounce, 2 3/4 inch greatest diameter calculus was removed by suprapubic cystolithotomy.

Our patient (S. S.—014774) was a 25 year old primigravida who was aware of her bladder calculus for six years but had neglected treatment because of cost and distance from a hospital. She enjoyed an uneventful pregnancy, but labour was prolonged for eight days. Foetal activity ceased after the fourth day, and a stillborn vertex presentation was delivered with the combined strenuous efforts of two village midwives.

She presented at Shanta Bhawan Hospital two months post-partum with a vesico-vaginal fistula, and a readily palpable mobile hard pelvic mass on vaginal examination. X-Ray established the diagnosis. Vaginal cystolithotomy was performed, followed in a

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week's time by vesico-vaginal fistula (v. v. f.) repair. The calculus was pear-shaped, with a tan coloured granular surface. It measured 6 cms. in its long axis, and 4. 1 cms. at its greatest diameter (11. 7 cms. circumference). It weighed 28 grams. Analysis (through the courtesy of Vancouver General Hospital) identified calcium, magnesium and ammonium phosphates and urates. The phosphate salts were probably precipitated in the alkaline urine of a remote cystitis. (Butt 1956)

COMMENT

The rarity of a bladder calculus producing dystocia is the justification for adding this case to the literature. Its modest size does not contend with record challenging giants which may reach 1816 grams. (Campbell 1957) Its interest lies in the differential diagnosis, which includes cervical fiboid and pelvie exostoses, and management

In labour the anterior vaginal wall with its vesical calculus may be pinched between the baby's head and pubic arch. If neglected, as in our case, gangrene may develop with .v v. f. formation. If the patient presents already in labour the alternatives are vaginal cystolithotomy (Sarma's definitive management), manoeuvre the calculus out of the way (as in Neer's case), or circumvent it by Caesarian Section with elective post-partum supra-pubic cystolithotomy. The stage of labour, foetal factors and operative facilities will combine to determine the choice of treatment in the individual case.

References

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