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Original Research Paper

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A STUDY ON OBSTRUCTED LABOUR-STILL A LIFE THREATENING CATASTROPHE IN MODERN OBSTETRICS

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ABSTRACT

Background : Approximately 8% of all the maternal deaths in developing countries are due to obstructed labour.Neglected Obstructed Labour is a major cause of both maternal and neonatal morbidity and mortality . The incidence of Obstructed Labour is 4.6% of all live births globally.Obstructed Labour is common in developing countries , it accounts for 11.4% of maternal deaths in the eastern part of India.

Methods: Two year retrospective study (October 2019- September 2021). All the mothers who were admitted in Labour room with signs and symptoms of obstructed Labour were included in the study.

Results: Out of the 15064 deliveries ,38 cases of obstructed Labour studied, most common cause for obstructed labour was Cephalo Pelvic Disproportion(65%).

Conclusion: Management of obstructed labour is mainly about its prevention in the antenatal and intrapartum period.A balanced decision about best method of relieving obstruction with least hazard to the mother and fetus improves fetomaternal outcome.

KEYWORDS : Obstructed Labour , Maternal Death , Neonatal Morbidity

INTRODUCTION

Obstructed Labour is considered when the presenting part of the fetus cannot progress in to the birth canal inspite of strong Uterine Contractions due to mechanical Obstruction.

There is usually a mismatch between fetal size, or more accurately, the size of the presenting part of the fetus,and the mother's pelvis. It usually develops when women is left uncared for in labour and there is some maternal or fetal cause for the obstruction.

Some Malpresentations, especially a brow or a shoulder presentation , will also cause Obstruction.The Obstruction can only be alleviated by an operative delivery: cesarean section, instrumental delivery (forceps or vaccum extraction) or symphysiotomy.

Obstructed labour ranked 41st in GBD 1990, representing 0.5% of the burden of all conditions and 22% of all maternal conditions.Diagnosis of Obstructed Labour is made when the duration of labour is prolonged , a labouring mother became unable to support herself with signs of maternal exhausion like dehydration , rapid pulse,raised temperature and increased respiratory rate,edematous,drawn-up bladder, Bandl's ring, edema of the vulva,fetal distress, large caput and excessive moulding, distended bowel loops, absence of liquor with foul smelling meconium.

Everyday in 2017, approximately 810 women died from preventable causes related to pregnancy and child birth.Between 2000 and 2017, the maternal mortality ratio dropped by about 38% world wide. 94% of all maternal deaths occur in low and lower middle-income countries.Skilled care before ,during and after childbirth can save the lives of women and new borns.More than 70% of all maternal deaths is due to five major complications: haemorrhage,infection,unsafe abortion, hypertensive disorders of pregnancy and obstructed labour.

The Risk factors include age less than 17 years , Grand multigravidae,height less than 145 cm ,previous cesarean section, still births and previous prolonged Labour. Community Risk factors include poor antenatal care ,poor intrapartum monitoring,custom of early marriage , lack of transport and communication and delay in referral to higher level of care for cesarean sections.

Maternal Complications like Uterine Rupture, Postpartum Haemorrhage,puerperal sepsis, Genito urinary Fistulae and fetal outcomes like birth asphyxia,still birth ,neonatal jaundice, intra cranial Haemorrhage.Complications resulting from Obsructed Labour can be avoided if a woman in obstructed Labour is identified early and appropriate action is taken .

MATERIALS AND METHODS

The two year retrospective study was conducted at the Department of Obstetrics and Gynaecology , GGH , Kadapa.(OCT 2019- SEP 2021)

The total number of births during this period was 15064 and the total number of Women with Obstructed Labour was 38 cases .All the mothers who were admitted in Labour room with signs and symptoms of obstructed Labour were included in the study.

RESULTS

Table -1 :age Distribution

Age	Number of cases	%
18-20	10	26
21-25	17	44
26-30	4	10
>30	7	18

- In the current study the majority of the cases of Obstructed Labour belongs to age group of 21-25(44%).

Table-2 :parity Distribution

Parity	Number of cases	%
Primi	21	55
Second Gravida	8	21
MultiGravida	9	23

- The incidence of Obstructed Labour is more in primi Gravida .In Present study 55 % of patients were Primi Gravida.

Table-3 :booking Status

Booking Status	No of cases	%
Booked	10	26
Unbooked	28	73

- Majority of the cases were unbooked in this study (73%).

Table-4 : Management

Management	Number of cases	%
LSCS	32	84.22
Instrumental delivery	5	13.15
Laparotomy	1	2.63

- Most common mode of delivery was LSCS (84.22%). 13.15% had Instrumental Delivery .

Table-5:outcome

Perinatal Outcome	No of case	%
Live	33	86
Still Birth	1	2
IUD	1	2
Poor APGAR	3	7

- In my study live birth was 86% , still birth and IUD seen in 2%, 2% respectively. 7 % had poor APGAR Scores.

Table-6 : Complications

Rupture Uterus	1	2
Abdominal Distension	5	13
Wound Infections	4	10

The complications in my study were abdominal distension 13% , wound infections 10%, rupture Uterus 2%.

Table -7 :causes

Causes	No of Cases	%
CPD	25	65
Contracted Pelvis	5	13
OccipitoPosterior	2	5
Deep Transverse Arrest	1	2
Face Presentation	2	5
Hydrocephalus	1	2
Compound Presentation	2	5

Cephalopelvic Disporoportion was the major cause of Obstructed Labour (65%) in my study.

DISCUSSION

The incidence of obstructed Labour was 0.25% during the study period which is in accordance with the study done by Adhikari et al 2004 where the incidence was 0.56% .According to Shimelis fantu et al 2009 , the incidence was 12.2 % where as study by Daffallah et al 2003 from Sudan, it was 1.27%.The incidence is decreasing due to improvement in antenatal and intranatal care.

In my study the majority of the cases belongs to the age group of 21-25 years and 55% were primi gravida, 73% were unbooked cases .

In obstructed Labour there is no place for wait and watch policy.In my study most of the cases 84% were terminated by LSCS.According to Adhikari et al 2004 63.27% had LSCS . Konji et al 82% Ozumba and Uchegbu from eastern Nigeria did Caesarean section in 85%.

Cephalo Pelvic Disproportion was the major cause of Obstructed Labour (65%) in my study which is in accordance with study done by Shimelis fantu et al 2009(67.6%).In my study live birth was 86% , still birth and IUD seen in 2% , 2% respectively. 7 % had poor APGAR Scores.The complications in my study were abdominal distension 13%, wound infections 10%, rupture Uterus 2%.

There is no maternal mortality in my study. According to Adhikari et al , maternal mortality was 2.04% where as in study by Datta and Pal , Sahu and Sinha it was 11.4% and 4.3 % respectively.

CONCLUSION

Low socioeconomic status,illiteracy, inadequate antenatal care services and poor referral system are the factors that results in obstructed labour.The decreasing trend in incidence is probably a reflection of improvement in antenatal care and institutional deliveries.Universal good obstetric care and continous vigilance, use of partograph and timely intervention can prevent obstructed labour and virtual disapperance of obstructed labour.Management of obstructed labour is mainly about its prevention in the antenatal and intrapartum period. A balanced decision about best method of relieving obstruction with least hazard to the mother and fetus improves fetomaternal outcome.

"We have a secret in our culture and it's not that birth is painful .It's that Women are strong."

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