

## Case Of Grande Multipara With Breech Presentation

### Case Report:

Reg: No. 641A. M.P. Eurasian. Age 39½ years.

Admitted 3.5.1956.

Gravida 13. L.M.P. 26.7.55 E.D.D. 3.5.56.

### Gynaecological History:

Menarche — 13 years.

Menstrual period regular 30 day cycle  
7 days duration of flow.

No dysmenorrhoea. Clots /-. Leucorrhoea /-.

Married at the age of 21 years i.e. 18½ years ago.

### Obstetrical History:

1st child — 17 yrs. ago — N.D. at home (midwife) alive. B.W. 8 lbs. Boy.

2nd child — 15 yrs. ago — N.D. at Home (Midwife). Died 8 yrs. of age from Pneumonia. B.W. 7 lbs. Girl.

3rd child — 14 yrs. ago — N.D. in K.K.M.H. — alive, B.W. 8 lbs. Girl.

4th child — 11 yrs. ago — N.D. at home (midwife) alive, B.W. 7 lbs. Girl.

5th child — 9 yrs. ago — N.D. at home (midwife) alive, B.W. 6 lbs. Girl.

6th child — 7 yrs. ago — N.D. at K.K.M.H. — alive, B.W. 7 lbs. Girl.

7th child — 6 yrs. ago — aborted at 3 mths. after a fall.

8th child — 5 yrs. ago — forceps in K.K. M.H. Died after 1½ yrs. B.W.? (from Pneumonia foll: measles) Girl.

9th child — 4 yrs. ago — Breech in K.K. M.H. — alive, B.W. 6 lbs. Boy.

10th child — 3 yrs. ago — N.D. in K.K.M.H. alive. B.W. 6½ lbs. Boy.

11th child — 2 yrs. ago — Forceps in K.K. M.H. — died after 2 days. B.W. 6 lbs. 2 ozs. Boy.

12th child — 1 yr. ago — N.D. in K.K.M.H. — alive. B.W. 6½ lbs. Boy.

### Present Pregnancy:

This was uneventful apart from slight

weakness of legs and constipation at the 32nd week of gestation.

She came to the Antenatal Clinic regularly for supervision and iron and multivitamins. (6 visits).

Blood-pressure was normal — varying between 110 and 120 systolic and 60 to 70 diastolic.

There was no albuminuria at any time.

Slight oedema of the legs appeared at the 32nd week and persisted until term.

Weight increased from 123 lbs. at the 25th week to 132 lbs. at the 37th week (9 lbs. gain) and dropped 2 lbs. in the next fortnight.

The infant was thought to be presenting by the head.

Labour pains commenced at 11 a.m. 3.5.1956 accompanied by the show. M.R. at 11.20 p.m. 3.5.56. She came to K.K.M.H. at 11.25 p.m. 3.5.56.

### Examination:

General condition — good. B.P. 130/80. Afebrile.

Heart )

Lungs ) no abnormality detected.

### Obstetric Examination:—

Ut. Full-term. Breech R.S.A. at brim. F.H.H. regular 140/min, good vol.

No contraction palpable.

Diagnosis: Grande Multipara with Breech Presentation.

### Vaginal Examination at 4 a.m. 4.5.1956:

Cx. thick. Os 3 fingers dilated. M.R.

Complete Breech R.S.T. in high cavity. No prolapsed cord detected.

Pelvis gynaecoid, and adequate for vaginal delivery.

### Progress of Labour & Delivery.

#### Findings.

4.5.56 4.15 a.m.

Straight X-ray abdomen confirmed Breech presentation.

## Treatment.

— Hrly. F.H. & M.P. chart  
— Inj. Pethidine 100 mgm.  
1.30 p.m. Fair ut. contraction.  
— Inj. Pethidine 100 mgm.  
Vag. Exam. Cx. not effaced. Os 3 fgs.  
M.R. Breech in high cavity.  
—Inj. Penicillin 1 M.U. stat  $\frac{1}{2}$  M.U. b.d.

5.5.56 5.45 a.m. Fair pains, F.H. & M.P. steady. P.V. Os 4 fgs. dilated. Breech in mid-cavity.

— Inj. Pethidine 100 mgm.  
1. p.m. Poor ut. contractions.  
— Urine C/S. — Alb. nil.  
F.H. steady.

— Acetone trace Chlorides 8 gms.  
— I/V Calcium Gluconate 10% cc.  
— I/V Vit. B. 100 mgm.  
— 1/V Dextrose drip 5% 1 pint.

5.30 p.m. Pains still poor — once in  $\frac{1}{2}$  hr.

5.5.56 10.10 p.m. Cx. fully dilated. Assisted breech delivery done. Live female infant 6 lbs. 2 ozs. delivered. Cried spontaneously. Placenta normally expelled after 5 mins. Total labour 3 days 11 10/60 hrs.

Lying-in-period has been afebrile. Baby is breast fed. General condition of mother and baby is satisfactory.

## Discussion:

DR. Y. SALMON: Presented the case.

DR. C. S. OON: Commented on the complications of Grande Multipara. She defined a grande multipara as one who has had 8 or more pregnancies although some writers include para 5 and above. The incidence of grande multipara is about 12.6%. (Dangerous multipara "is thought to be a better term for several reasons e.g. repeated strain on the cardio-vascular system, osteoporosis from repeated pregnancies and lactation, increased incidence of twin pregnancy (three times more common), accidental haemorrhage, malpresentation, prolapse cord, uterine inertia and postpartum haemorrhage. She also showed that the maternal mortality rate increased directly with parity.

DR. A. C. SINHA: Supported the terminology of "Dangerous Multipara." He said it was a definite clinical entity and deaths in these patients were not solely the re-

sults of bad obstetrics in the hands of younger doctors. Maternal mortality increased directly not only with parity, but also with the age of the mother.

PROF. B. H. SHEARES: Said that Leyland Robertson was the first man to draw attention to this condition. In 1930 he produced figures to show that in women with eight children and over the mortality rate was three times higher than in primigravidae.

Calcium depletion in successive pregnancies has an effect on the mother's pelvis leading to difficult labour. He also blamed loss of muscle tone as a cause of abnormal presentations.

In 1933 Peckham produced figures from the John Hopkins' Hospital. 22,727 consecutive deliveries were analysed. The mortality rate in women with eight children and over was  $2\frac{1}{2}$  times higher than in primigravidae.

In 1934 Bethel Solomons in Rotunda coined the term "Dangerous Multipara."

Yerushalmy of New York found that out of 255,000 consecutive deliveries there were 1,250 deaths. Women with eight children and over had a mortality rate of 63.8 per ten thousand deliveries; primigravidae had a rate of 23.4 per ten thousand deliveries.

Kandang Kerbau Hospital figures were:

(1952-1954)

	per 1,000 deliveries
Primigravidae - - -	2.26 death
Para 2-7 - - -	2.15 "
Para 8 and over - - -	6.87 "

There was a high incidence of rupture of the uterus, antepartum and postpartum haemorrhage, and occult disproportion. Calcium deficiency in poor patients played an important part in the causation of occult disproportion.

DR. J. M. LEWIS: Asked if iron, multi-vitamins and calcium given in the antenatal period helped in reducing the hazards in grand multipara.

DR. A. C. SINHA: Replied in the affirmative. The various factors which went to make a grande multipara a "Dangerous Multipara" were—

- (1) Laxity of skin and muscles leading to loss of tone, malpresentation and finally rupture of uterus.

- (2) Skeletal changes such as osteomalacia and arthritis giving rise to disproportion.
- (3) Trauma, e.g. from previous myomectomy, L.S.C.S., previous deliveries, etc., thus predisposing patient to other obstetrical hazards such as uterine rupture. An unattended cervical laceration might be the cause of a cervical dystocia in later deliveries.
- (4) With advancing age degenerative diseases made their appearance such as diabetes mellitus, degenerative diseases of the cardiovascular system, etc.
- (5) Nutritional factors which influenced uterine action.
- (6) Larger babies in subsequent pregnancies.

DR. T. W. RODDIE: In answer to a question said that there was a high parity in Northern Island where the religion was predominantly Roman Catholic. He wondered if the mortality from multi-parity would be reduced if there was more adequate supervision for the grande multipara viz, good experienced obstetricians, enough money and enough good food. But

then, the problem might not arise, as people having good food were usually subfertile. The high death rate for over eight para here might be explained by the fact that some patients, having had normal deliveries at home, tended to stay at home until some catastrophe forced them to come to hospital and then it was too late.

DR. T. K. CHONG: Mentioned that in the etiology of rupture of the uterus Jeffcoate noted that the primigravid uterus reacted to disproportion by increased tone while the multigravid uterus ruptured. Furthermore, in a multipara the pelvis showed mild degree of osteomalacia, accounting for difficult labour.

PROF. B. H. SHEARES: Said that if the woman was given the right nutrition and care then the condition of grande multipara would not cause any worry.

DR. A. C. SINHA: Commented that the problem here was of the young grande multipara and therefore the hazards were not as great as compared with the old grand multipara.

PROF. B. H. SHEARES: Thought that the term "Dangerous Multipara" was best for these cases because it put us on our guard for possible complications.

## Two Cases Of Carcinoma Of The Cervix Treated By Radical Surgery

### Case Report:

#### CASE I

NAME: Heng Ah Mui

AGE: 50

PARITY: 8

#### SYMPTOMS:

- (1) White sero-mucous odourless discharge P.V. for 3½ years.
- (2) Backache for 1½ yrs.

SIGNS: P.V. Cervix ulcerated and bleeds on touching Uterus RV. RF. mobile. Some thickening in the right vaginal fornix.

P.R. — No rectal involvement present.

#### CLINICAL STAGE ONE

#### BIOPSY RESULT:

"Bits of tissue showing infiltration with irregular groups of squamous cells. Also marked inflammatory

changes. Diagnosis: Squamous cell. Carcinoma (spindle cell type).

#### CYSTOSCOPY ETC:

"Bladder appears normal. Catheter failed to pass in the right. Retrograde pyelogram shows normal filling of left renal pelvis and calces."

#### LABORATORY INVESTIGATION:

Hb = 83%

TW = 5000

Blood urea—26 mgm. %.

#### RADIUM:

Not given.

#### OPERATION:

Radical Wertheim's.

#### CASE II.

Mrs. A. Gomez.

Age: 38.

Party: 4.

White odourless discharge P.V. which was watery at first later became mucoid for 6 months duration. P.V. Friable growth involving the cervix only. Uterus RV. RF. mobile.

## CLINICAL STAGE ONE

### BIOPSY RESULT:

"The tissue is markedly infiltrated with cancer cells with irregular growth. Marked inflammatory changes also seen. Diagnosis: Squamous cell carcinoma (spindle cell type).

### CYSTOSCOPY:

"Congestion around the left ureteric orifice. There seems to be a block in the left-ureter about 2 cm. from the orifice."

### LABORATORY INVESTIGATION:

Hb = 98%

TW = 10,200

### RADIUM

26.3.56 — 110 mgm. inserted for 22 hours. Total 2420 mgm—hours.

### OPERATION:

Radical Wertheim's.

## Discussion:

DR. N. N. LING: Presented these cases.

DR. T. K. CHONG: Commented on the treatment of carcinoma cervix.

The treatment of carcinoma of the cervix may be by:—

1. Surgery.
2. Radiotherapy.
3. Radiotherapy and surgery combined.
4. Palliation.

Today universal agreement on the choice of therapeutic methods has no means been reached, for each method has its own proponents.

1. **SURGERY:** Improvement in anaesthesia, surgical technique and pre- and post-operative cure has justified surgeons such as Meigs (1954), Brunschwig (1953) and others in choosing surgery as the method of treatment.

Some believe that carcinoma in situ is definitely an indication for operation. But pathologists and gynaecologists at Hamburg in 1955 agreed that radical operation should not be routinely performed for many women

in the younger age group may be harmed more by the hysterectomy than is compensated by the protection given.

The Wertheim operation is usually only done in Stage I and II cases. Surgery has been advocated as being superior because it claims to be able to remove lymphatic metastases, whereas direct proof that lymphatic metastases can be destroyed by deep X-rays is still equivocal. Surgery is also indicated for cases co-existing with large fibroids, ovarian cysts, pyosalpingses, a contracted vaginal vault and radium resistant cases. Roughly, the 5-year cure rate is 50% for cases with no gland-involvement. With gland involvement the cure-rate drops to about 1/6th. Besides immediate post-operative complications, late complications, such as bladder fistulae, rectovaginal and particularly ureterovaginal fistulae have yet to be considered.

Schauta's radical hystero-vaginectomy has only been popular in the Continent. The greatest objection to this operation is that the glands are not removed.

**PELVIC EXENTERATION:** Brunschwig devised this operation in the hope of effecting an occasional cure to quite a number of seemingly hopeless cases or at least to relieve the extremely distressing conditions of an untreated case, but the mortality is about 20%.

2. **RADIOTHERAPY:** Radiotherapy has its advocate especially Koltmeir at the Radiumhemmet. The results are as good if not better than surgery. Many techniques have been devised, of which the best known are the Stockholm, Paris and Manchester techniques.

Koltmeir says the evolution of the treatment is progressing along the following lines at the Radiumhemmet:

1. A careful examination including cystoscopy, urography and sometimes phlebography.
2. Usually, a fractionated intracavity radium treatment is given as the first step of the irradiation. Treatment is indi-

dualised in regard to the degree of infection, the gross anatomic type of the tumour, its spread to paracervical or paravaginal tissue and the area of the obturator fossa. Due regard is paid to the dosage distribution both from the intra-uterine and the vaginal radium.

3. Roentgen therapy to the parametrium and the pelvic wall is given in all cases and in selected cases also to the paravaginal tissue through perineal fields.
4. Radio-active colloidal gold is injected into the parametrium in selected cases of suspicious lymph node metastases.
5. Additional treatment with telecobalt is applied in selected cases of cancer of the cervix with pelvic lymph node metastasis as far as these can be diagnosed by phlebography, urography and clinical examination.

There are still certain drawbacks to radiotherapy e.g.

1. There is no ready way of assessing radiosensitivity as yet.
  2. It is as yet not possible to determine with any certainty, the results of radiotherapy to the lymph nodes.
3. **RADIOTHERAPY AND SURGERY COMBINED:** Irradiation and surgery should be regarded as supplementary to each other. At the Radiumhemmet, in patients with poor radiation response, a combined treatment of intracavitary radium, interstitial radioactive colloidal gold and hysterectomy has been suggested as the treatment of choice. Wertheim's hysterectomy can also be carried out 4 weeks after a course of X-rays of a reduced dosage and routine post-operative irradiation may also prove of value.

Lymphadenectomy after irradiation is supposed to improve the 5-year cure rate by about 10%.

#### 4. PALLIATIVE TREATMENT:

In the more advanced stages of the disease, continuous nursing is a

necessity to make the patient as comfortable as possible. Aspirin, Veganin, Physeptone, Morphine and Largactil are only a small portion of the many pharmaceutical means of relieving pain. Surgical measures of alleviating pain consist of:

1. Intraspinal injection of alcohol.
2. Induction of caudal anaesthesia with proctocaine.
3. Cordotomy and even leucotomy. Colonic transplantation of the ureters in cases of vesico-vaginal fistula or colostomy for recto-vaginal fistula will bring relief from distressing conditions.

DR. A. C. SINHA: Said that the greatest advance in therapy of carcinoma of the cervix was that we had a choice of radiation, surgery or a combination of both. He then discussed the anatomy of the lymph nodes draining the cervix and went on to the surgical aspects of therapy today. He gave the history of the operation for carcinoma of the cervix as it was done today.

- (1) Original Wertheim's was just panhysterectomy without dissection of the lymphatic tissues.
- (2) Extended Wertheim's (Bonney) included lymphadenectomy up to the bifurcation of common iliac vessels.
- (3) Extended radical hysterectomy (Meigs) took lymphadenectomy still further on to include those along the common iliac vessels.
- (4) Extended radical hysterovaginitomy where part or whole of the vagina was also excised.
- (5) Pelvic exenteration.

Coming to details he said that he had seldom stripped the ureter for more than 2½ c.m. although he had seen it done for 6 c.m. and more, where interference of the blood supply might have resulted in disaster.

He said that he had operated on fifty cases of carcinoma of the cervix to date, and out of these two died of haemorrhage post-operatively.

**PROF. B. H. SHEARES:** Said that in the volume of literature on carcinoma of cervix there was a lack of standardization of treatment. Unless we could find the specific cure for cancer, surgery and radiation were but make-shift treatment.

In the last ten years surgery had come into prominence as a line of treatment because adjuvants mainly blood transfusion, good anaesthesia and antibiotics made the operation safer for the patient. However, when one compared the results of radiation and surgery one came to the conclusion that radiation was the better treatment.

Surgical enthusiasts said that in involvement of lymph nodes by cancer cells, irradiation did not affect the cancer cells in the lymph nodes, but expert radiotherapists claimed that it was possible to do so and that it was not possible to remove all the affected nodes by surgery.

In stage O carcinoma many surgeons and patients preferred hysterectomy to irradiation because the latter needed a careful follow-up.

As regards the histological grading of the tumor some said it was difficult to differentiate between radio resistant and radio-sensitive cases, and therefore they depended more on clinical staging of the tumour.

If a patient was examined 6 to 8 weeks after irradiation and mitotic cancer cells were found, then the case was labelled "as radio-resistant."

**DR. A. C. SINHA:** Discussed the technique of the Wertheim operation. He preferred to start with the dissection of the aortic glands which is in keeping with

the principals of cancer surgery c.f. Wilfred Shaw who advised commencing with the hysterectomy. Bleeding was the greatest bugbear in his experience; the danger zones were dissecting glands around inferior vena cava and obturator fossa. If excision of tissue upto the common iliac vessels was contemplated a high skin incision, at least 2" above umbilicus, was necessary. Excision of vagina down to the mid-third was difficult and might require leaving in a pack to control oozing. Finally the danger to the ureter was a constant fear.

**PROF. B. H. SHEARES:** Said he found that removal of the lymph nodes on the external iliac vessels could cause difficult bleeding as they were usually adherent to the vessels. This did not necessarily mean that they contained metastases. Blunt dissection was possible at the upper end but lower down in the pelvis it was not feasible.

**DR. SINHA:** Said that ligation of the internal iliac artery has been recommended in the textbooks as a routine to minimise bleeding, but in his experience this has not proved helpful.

**DR. J. LEWIS:** Asked if androgen therapy had been tried in cases of carcinoma cervix.

**DR. A. C. SINHA:** Replied that it had been tried in advance cases—with equivocal results.

**DR. S. M. GOON:** Asked about bilateral adrenalectomy?

**PROF. B. H. SHEARES:** Replied that radical surgery with bilateral adrenalectomy had been tried but the results had not yet appeared in publication.