Dystocia Caused By Chronic Fecal Impaction

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Dysfunctional labor resulting from fecal impaction is a rare occurrence.[1-4] All of the previously published cases resulted in vaginal delivery after disimpaction. We report the first case of obstruction of labor secondary to massive chronic fecal impaction and megacolon that required Cesarean section.

Case Report

The patient, a 19-year-old gravida 2 para 1, was admitted to our hospital on 31 October 1990. By history of last menstrual period she was 42 weeks' gestational age. She complained of the onset of labor pain 3 hours before admission to the hospital. The patient's prenatal care consisted of two prenatal visits to an outlying health department. Her medical history revealed chronic constipation since early childhood, requiring multiple hospitalizations, yet the patient and her family were unaware of a specific diagnosis or of any recommendations for definitive treatment. Chronic constipation and fecal incontinence had persisted into adulthood. It was reported that numerous physicians had attempted to perform pelvic examinations and Papanicolaou smears but had been unable to do so because of her abnormal colon. The prenatal history also noted that the patient had been hospitalized in psychiatric hospitals, but again a specific diagnosis was not known. Review of the prenatal social history showed that she had at times been homeless during her pregnancy. She had smoked one pack of cigarettes per day during her pregnancy but denied use of alcohol or recreational drugs. The above history was confirmed by family members present at the time of hospitalization. They also reported that the patient had a profound fear of physicians, which was confirmed by our observations.

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The patient was a poorly nourished, but well developed, gravid woman who was anxious and uncooperative and was in early labor. Her temperature was 37°C (98.6°F), pulse rate 92 beats per minute, respirations 22/min, blood pressure 142/80 mmHg. On abdominal examination the fundal height was 36 cm with the vertex in the left iliac fossa. Fetal heart tones, with a rate of 130 to 140 beats per minute, were monitored externally. Uterine contractions were palpated and monitored externally every 3 minutes. The patient was extremely uncooperative during pelvic examination. The external genitalia appeared normal. Digital examination of the vagina revealed that the cervix could not be palpated. A large mass in the rectum could be palpated through the posterior vagina. The presenting part of the fetus could not be felt. There was anal incontinence of soft stool, and hard stool could be palpated on rectal digital examination.

Consultation was obtained with a senior obstetric faculty member and a general surgeon. It was believed the patient had chronic megacolon of undetermined cause, that she was in early labor, and that fecal impaction was preventing descent of the fetus and possibly dilatation of the cervix.

Epidural anesthesia and disimpaction were offered to the patient, which she adamantly refused. After discussing the risk, Cesarean section followed by disimpaction under general anesthesia was offered to the patient, to which the patient was agreeable.

At Cesarean section the uterus was deviated to the left and twisted over a massive colon that measured at least 12 cm in diameter and was filled with mushy material believed to be feces. This dilatation of the colon extended from the rectum to the splenic flexure. The cervix rested well above the inlet to the pelvis. The baby was delivered without incident with Apgar scores of 7 and 8 at 1 and 5 minutes, respectively. After closure of the uterus the abdomen was explored, revealing a dilated colon, which extended from the rectum to the splenic flexure; estimated diameter was 20 cm. After closure of the abdomen

the patient underwent disimpaction of a huge amount of stool.

Postoperatively, the patient developed a fever and after appropriate cultures was treated with antibiotics. On the 3rd postoperative day the patient refused further treatment and left the hospital against medical advice. She did not return for follow-up care.

Discussion

Rambo[1] was first to report dystocia resulting from fecal impaction in this century; however, he described a case reported in 1886 in which the patient, a multipara with a rectovaginal fistula, gave birth vaginally after removal of "an impacted mass of feces as large as a child's head."[p 812] Rambo's patient had a fecal impaction that completely blocked the pelvis, and the cervix could not be felt. The presenting head was in the left iliac fossa. Vaginal delivery was accomplished after removal of 1780 g of feces.

Etzel, et al.[2] reported a patient, gravida 2, para 1, who had "neglected prenatal care because she had a fear of physicians." The woman had been in labor with rupture of the membranes for 3 days. A pathologic retraction ring was present in the uterus and uterine rupture was feared. The authors stated that "when all attempts to obtain cooperation from the patient had failed, compulsory methods were utilized" to accomplish disimpaction. A stillborn infant in breech position was delivered vaginally.

Grasby and Higgins[3] reported a 19-year-old primigravida who presented with almost continuous uterine contractions and a mass palpated through the posterior vaginal wall. Rectal examination confirmed impacted feces the size of a fetal head. The fecal mass was disimpacted under general anesthesia and a cyanosed infant was delivered vaginally.

Holt and Hendricks[4] reported a case of fecal impaction secondary to ingestion of clay, in which enemas resulted in removal of 1200 grams of hard feces with progress of labor and subsequent vaginal delivery. A psychiatrist who saw their patient in consultation noted that she was "hostile, somewhat retarded and possibly schizophrenic." Holt and Hendricks suggested that Rambo's patient, who had "the lower bowel filled with putty-like fecal material," had also ingested clay.

With our patient, there was no opportunity to attempt disimpaction of the fecal mass because of the patient's refusal and rejection of regional anesthesia. Disimpaction under general anesthesia, then allowing recovery with subsequent continuation of labor, was also considered. The patient, however, also refused this option, and there was uncertainty that disimpaction would be successful enough to allow descent, thus possibly subjecting the patient to a second general anesthetic. Upon exploring the abdomen after Cesarean section, it was thought that even if disimpaction had been attempted, there could not have been successful reduction of the mass to accomplish vaginal delivery.

Common features in the case reports of fecal impaction dystocias include elevation of the presenting part and obstruction of descent, difficulty in reaching the cervix on vaginal examination, a mass palpable through the posterior vagina, psychiatric history, fear of physicians, lack of patient cooperation, and possibly clay ingestion. Vaginal delivery may be possible if evacuation of the impaction is accomplished.

References

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