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SPONTANEOUS SEPARATION OF THE UTERINE CERVIX DURING LABOR,(U)
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By

Ryszard Hipp, Zenon Marcinowski, Danuta Skiba

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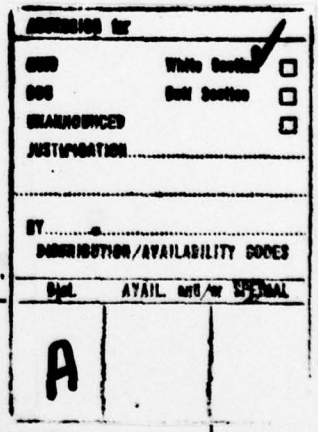

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SPONTANEOUS SEPARATION OF THE UTERINE CERVIX DURING LABOR

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The uterine cervix intractability at the time of labor can bring about its cracking. The collagenous fiber disposition, vasculature as well as directions of the acting forces cause the neck radial cracking (3,8). It happens very often that, as the result of lasting head pressure, circulation disturbances and secondary necrosis, a part of the front lips undergoes separation. An unusually rare complication, when the ostium is intractable, is a circuitous separation of the uterus distal part which arises as a dense ring (3,8). Most presently described cases relate to the uterine cervix separation during late miscarriages and premature deliveries (3) when the uterine cervix is not prepared for the dilatation to the same extent as during the labor at term (1,6,9). The reason for the above-mentioned complication is constitutional factors, the others think it is connected with a mechanical injury. One of the reasons for the uterine cervix separation is assumed to be its constriction due to extensive scarring after the electrocoagulation (5), although it is assumed that where there existed ostium dilatation disturbances during the labor after the electrocoagulation applied, deformation and scars following these shocks were so extensive that it was impossible to get rid of them by means of the electrocoagulation(7) despite the fact the electrocoagulation itself does not influence negatively the course of the labor following it (2). Describing the longitudinal cracking of the neck, the attention is being drawn to the circulation disturbances in the small pelvis (4) and the possibility of the bedsore in the area of the vagina because of long lasting pressure of the head (10).

Case 1. The patient by the name of T. M., at the age of 20, at her first delivery was admitted to the hospital on the 17th of August, 1969 at her 42nd week of pregnancy at the 2nd hour of the 1st period of the labor with the retained amniotic waters. The longitudinal location of the fetus head was confirmed. The patient did not experience miscarriages, during the pregnancy she suffered the burning leucorrhea. At the 17th hour on her arrival in the Department, the ostium dilation was a finger size and the amniotic waters were retained. Under the above-mentioned conditions with a weak delivery function a drop intransnous infusion of the 5 unit solution of the Syntocinon (Sandoz) preparation in 500 ml of the 5% glucose was initiated. This infusion laster 6 hours, during further 4 hours the labor function was moderately intensive, the head was fixed and the ostium dilated at three fingers. Not very disciplined parturient patient kept pushing despite the prohibition when dilatation is not complete. At the 29th hour of the 1st period of delivery the uterus convulsions took place every 4 or 5 minutes, the ostium was dilated at 4 fingers, the amniotic waters remained retained. 30 minutes after that the germinal veside went into burst, the head was in the pelvic isthmus and the sagittal suture ran obliquely in the dimension close to the simple one, the dilatation was complete (this evaluation was done on the basis of the test through the rectum). Ten minutes later after the perineum incision an alive fetus, (female) weighting 3200 g and whose length was 53 cm and head perimeter was 34 cm, came into being. Ten minutes after the delivery the entire placenta was born in a natural way and insignificant bleeding from the vagina took place. The annular origination about 15 cm in length was langing out of the vagina and connected with the front lip.

Tests in the speculum confirmed non-complete separation of the neck at the level of the internal orifice (orificium internum uteri) (the neck was connected with the uterus only through the band of the pencil thickness at the top of the front lip) as well as cracking of the vagina at the phornix level. The patient was in good condition, bleeding was moderate, the uterus was contracted.

Because of the impossibility to secure the neck separation through the vagina and to prevent bleeding into the abdominal cavity, the decision was to open the abdominal cavity. The uterus injuries or the uterus separation from the fornixes was not confirmed. On the left side of the side parametrium there were small ecchynoses. The neck was completely removed without appendages. The vagina cracked walls in the fornix area were sown. From the segments taken from the fornix separation edge and uterine cervix stem there is an evidence of the presence of small unnatural inflamatory infiltrations. The neck was congested. The postoperation process was without any complecations. On the 11th day after her stay in the hospital, the patient was released.

Case 2. The patient by the name of T.L., in the age of 35 who gave birth lots of times was brought to the hospital on the 20th of October, 1969 in her 38th week of pregnancy at the 9th hour of the 1st period of delivery with the retained amniotic waters. The longitudinal location of the fetus head was confirmed. During 9 years she delivered without no complications. She did not experience miscarriages. Three years before that she had the electrocoagulation of the disk of the vaginal part because of the vagina erosion. Because of the impossibility to determine the dilatation by means of examining of the rectum, after 2 hour stay in the Department an internal examination had to be carried out and this examination confirmed that the vaginal part had undergone atrophy, the neck had been thin and plane and the head had been located in the intoitus. The examination in the speculum confirmed that the ostium was the small point which was the source of obtaining a small amount of the flowing blood. Within the distance of 1 cm from the vagina fornixes one noted circuitous surface cracking of the uterine cervix around the ostium (from 6 till 9 o'clock A.M. and from the noon till 3 P.M.). In relation with the above-mentioned the cesarean section was performed, the fetus was delivered alive and his weight was 3750 g (male). During the

section, the integrity of fornixes, parametria and the Douglas sinus were examined on the side of the abdominal cavity and no connections between the vaginal fornixes and abdominal cavity were found. On the side of the vagina the ostium was dilated by the Hegar dilators. During the dilatation the uterine cervix was cracking radially on both sides. The mucous membrane of fornixes and uterine cervix crackings were provided with individual sutures through the vagina. The postoperational condition was without any complications, on the llthe day after the childbirth the patient was released from the hospital.

In the first case the intractability of the ostium of the uterine cervix could be caused by an inflamatory condition in the cervical canal of the uterus. It seems that when the fetus head is not fixed and the ostium is intractable and as a result of pushing by not very disciplined patient, the neck pressure and secondary iscaemia can arise as consequences. The above-mentioned in its turn caused the uterine cervix cracking at the level of the rear fornix. The head pressure caused circuitous separation of the non-dilating further neck, and the fetus was born under the neck which was separated and pushed aside under the pubic bone. In the second case, non-dilatation of th ostium, which is contracted because of scars which are the result of inflamatory conditions and the electrocoagulation performed, is accountable for the neck stretching under the head pressure and for the cracking in the place of the slightest resistance. The cesarean section prevented the complete separation of the uterine cervix.

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Summary

A case is presented where spontaneous separation of the uterine cervix from the corpus occured (on the level of the fornices) in the course of spontaneous delivery. In this case natural forces delivery of a liveborn child occured and in consequence hysterectomy was obligatory through laparotomy.

Another case presents threatened separation of a unyielding vaginal portio — after passed electrocoagulation of the cervix. In the latter case, early detection of imminent complication forced to perform cesarean delivery.

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