CHILDBIRTH THROUGH THE PERINEAL BODY: A CASE REPORT

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INTRODUCTION

Perineal trauma is common and can affect up to 90% of primigravidas. Here we report a fascinating case of perineal trauma resulting from a baby being born through the perineal body making it birth through the perineum literally!

CASE REPORT

Mrs AS was an18 year old primigravida that presented to our labour ward 7 hours after home delivery with complaints of perineal tear.

She had an uneventful pregnancy supervised at a General Hospital (GH). She went into spontaneous labour at 9 months associated with drainage of liquor but no vaginal bleeding. She was seen at the GH by a midwife who performed a vaginal examination and told her she was not yet in labour then asked her to go home and return when the labour pains increased. She went back home and the labour pains persisted and increased gradually to become more severe. However she did not go back to the GH because it was late at night and there was no movement due to the curfew. After 36 hours in labour she started having the urge to bear down, she was assisted by an aunt who encouraged her to continue to bear down. When 4 hours of bearing down failed to deliver the baby, assistance was sought from a birth attendant who was also a cleaner at the labour ward of the GH. She normally attends to deliveries in the community for a token.

The birth attendant reassured her and gave her 2 intramuscular injections (?oxytocin) and asked her to continue bearing down. After another 2 hours of bearing down she delivered the head of the baby spontaneously the rest of the baby was forcefully pulled out by the birth attendant when it failed to deliver on its own. The placenta delivered spontaneously there was no excessive bleeding. The baby was a female neonate of average size that looked pale at birth and had some grunting respiration for a while; it stopped breathing about 1 hour after birth.

After her delivery the birth attendant examined her and said she had a tear which she could not repair so she asked her to go to the GH to get it sutured. She was referred to us by the midwife from the GH because she could not repair the tear.

She denied any history of perineal cut by the birth attendant.

Examination

She was a young lady, anxious not in any obvious distress, afebrile to touch, (Temperature 36.9^{0}C), mildly pale, anicteric no pedal oedema. She was 165cm tall and weighed 56Kg.

Pulse rate 82bpm, Respiratory Rate 20cpm, BP 120/70

Abdomen: No tenderness, uterine size consistent with 18 weeks, it was well contracted.

Vaginal examination: The clitoris, labia majora and minora were normal. There was a ragged tear at the center of the perineal body in direct

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communication with a huge defect in the posterior vaginal wall all the perineal muscles were transected the fourchette was intact (Pictures 1&2).

Rectal examination: The anus was intact, there was weak sphincteric tone, the rectal mucosa was intact with smooth surface and the examining gloved finger was clean.

Impression: Birth through the perineal body with third degree perineal tear (3C).

Treatment: Intravenous infusion and broad spectrum intravenous antibiotics and analgesics were commenced and samples were obtained for investigations. Two units of compatible blood was cross matched. An indwelling Foleys catheter was passed and 150mls of clear urine was drained. Investigation revealed PCV 28%, full blood count, electrolytes, urinalysis and creatinine were normal. She was prepared for examination under anesthesia and perineal repair.

Under spinal anesthesia in lithotomy position cleaning and draping was done exposing only the vulva and perineum. Continuous bladder drainage was maintained.

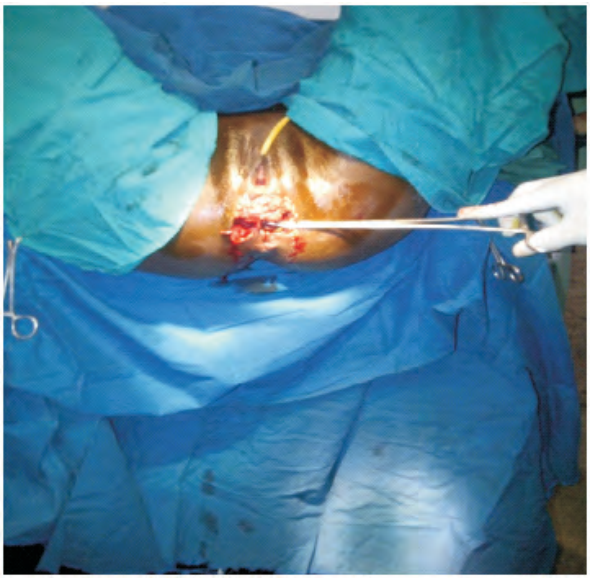
Findings: The intact fourchette was divided to expose the full extent of the tear. There was a tear in the perineal body communicating directly with a huge defect in the posterior vagina; the perineal muscles were all transected exposing the rectum at the lower edge of the tear. The external anal sphincter was also completely severed and retracted to the edges. The cervix, anterior and lateral vaginal walls were intact. (Picture 3).

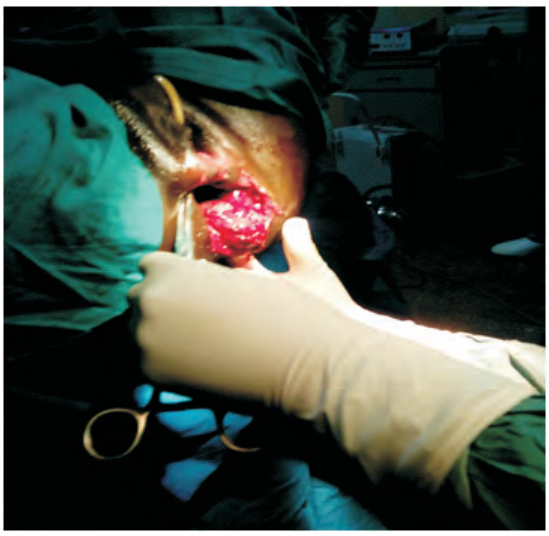
Procedure: The para-rectal fascia was approximated using number 2/0 vicryl suture by taking four interrupted sutures from both sides of the rectum and individually tied in the midline to invert the exposed rectum. The external anal sphincter was identified at the edges of the wound, held with Allis tissue forceps in the midline and sutured by overlapping them using vicryl 1/0. The perineal muscles were approximated by taking deep bites into the belly of the muscles obliterating all dead space and sutured in the midline. The posterior vaginal wall was closed starting about 1cm above the apex of the tear and sutured by continuous sutures using vicryl 2/0. The perineal skin was sutured using 2/0 vicryl by interrupted mattress suture (Picture 4). She had good cosmetic outcome at the end of the procedure rectal examination revealed intact rectum (Picture 5).

Post operatively she was continued on broad spectrum antibiotics and analgesics, multivitamins and Liquid paraffin was added to her treatment. Catheter was maintained for 24 hours. She was placed on low residue diet for 3 days and commenced on sitz bath twice daily from the 1st post op day and anytime she passed stool.

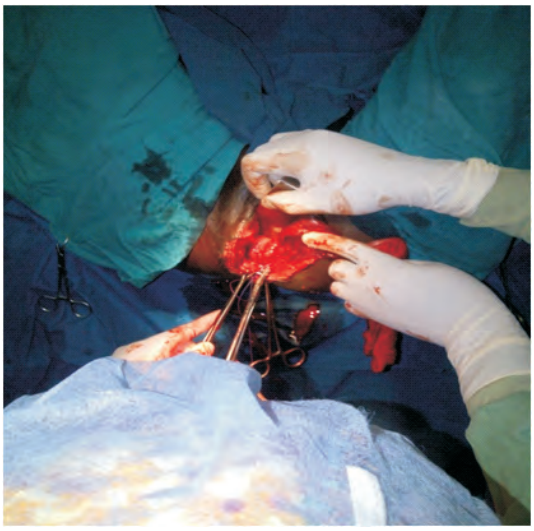
She had flatus and stool incontinence first three days post op. She passed formed stool on 6th post op day. The wound remained clean. On discharge she had no feacal incontinence but experience flatus incontinence. She was discharged home after 8 days and given appointment for 2 weeks. The patient never came back!

Picture 1&2: Perineal body rupture with communication into vagina and intact fourchette





Picture 3: Showing transected perineal muscles with rectum exposed at the lower edge



Picture 4: Repair of perineal skin

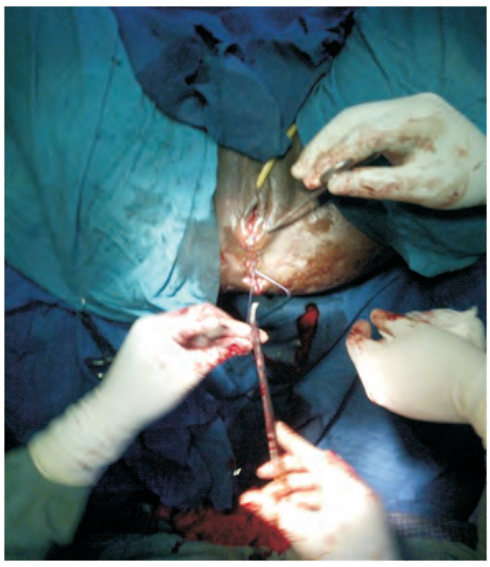
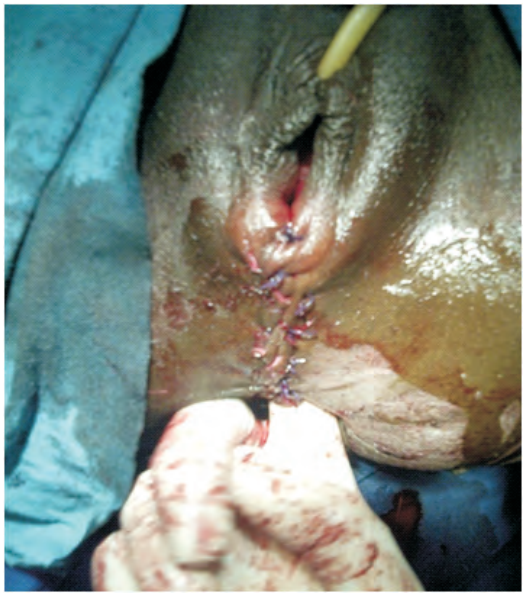


Figure 6: Rectal examination at the end of the procedure.



DISCUSSION

The examination findings of rupture of the perineal body communicating directly with a tear in the lower third of the posterior vaginal wall and the intact fourchette, indicates the baby must have been born passing through the posterior vaginal wall and recto-vaginal pouch tearing the perineal muscles and perineal skin, to emerge out through the center of the perineal body by-passing the normal vaginal orifice. Thus making this *birth through the perineum*!

Although this phenomenon is rare, similar incidence of transperineal birth has been reported twice, One in a woman with infant delivered in the direct Occipito Posterior Position (OPP)[2] and the other of a perineal birth that was averted by pushing the baby's head towards the entroitus with fingers through the perineal body tear. The baby was eventually delivered vertex but with similar damage to the perineum as seen in this case[3].

Mrs AS most likely had persistent OPP which led to the prolonged first and second stages of labour, with the sensation to bear down lasting several hours. In persistent OPP with bearing down, the baby's head

is pushed against the perineum much more than when the occiput is anterior this leads to the early sensation to bear down. OPP is associated with increased risk of perineal trauma and likely hood of instrumental vaginal delivery or CS[1]. In this case despite the long duration of labour, there was no difficulty in passing urine and catheterization on admission was easy and revealed clear urine. The anterior vaginal wall was also normal thus the prolonged labour is unlikely from mechanical obstruction from cephalo pelvic disproportion.

In an attempt to explain what led to this type of perineal tear, possibly the combination of factors from the persistent OPP, the long hours of labour and prolonged bearing down efforts combined with the forceful contractions from the effect of the bolus oxytocin and relaxing effect of progesterone on the perineum in labour all combined to somewhat lead to profound weakness in the perineal body which made it susceptible to rupture. Additionally the liquor had already drained early in labour so there was no lubrication and prolonged pressure of the baby's head on the perineum in second stage could lead to ischeamia making the tissues friable.

Although the patient denied any form of cut to the perineum and there was no sign on examination, TBA's in northern Nigeria occasionally give a cut in the vagina called *gishiri* cut which is often used to relieve obstructed labour and other ailments.[4]

Mrs. AS was fortunate to survive such an ordeal however she did not return for follow up but who can blame her! She had full ANC, presented herself to the hospital in labour but at the end she went through such a traumatic experience, lost her baby and will probably live with long term debilitating complications like perineal pain, dsypareunia, genital prolapse, tear in subsequent deliveries due to less compliant perinuem from scarring and if neglected again possibly VVF and RVF. The question is will she be confident enough to present herself to the hospital in her next pregnancy?

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