Two Unusual Complications of Umbilical Hernia in Pregnancy

Among the tribes of the Plateau region of Northern Nigeria umbilical hernias are very common, and many regard the protruding umbilicus as a thing of beauty. Some even proudly adopt the name "Mai cibi"—the possessor of an umbilicus. Despite the frequency of umbilical hernias, intestinal complications are very rare. This is perhaps due to the magnitude of the hernias and the wideness of their necks. The following complications in association with pregnancy are worthy of record.

CASE 1. EXTRAUTERINE PREGNANCY LEADING TO BREECH PRESENTATION IN UMBILICAL HERNIA

On March 20, 1955, a Tera woman from Zambuk was admitted to hospital complaining of a severe abdominal pain which had lasted some days. She said that several similar attacks had occurred during the past few months. She claimed to have had three months' amenorrhoea, but that on the previous day there had been slight vaginal bleeding. Too much reliance, however, cannot be placed on these details, for we have found that the primitive Nigerian peasant often gives a very inaccurate history.

The patient was extremely ill; there was some abdominal distension and pallor of the mucous membranes. The feature, however, which attracted immediate attention was the umbilical swelling. This was about the size of a tennis ball and was covered with stretched shiny skin. It was tender, firm in consistency, and irreducible. On abdominal palpation there was a firm mass extending from the pubis to the umbilicus.

A tentative diagnosis of ectopic rupture was made, although this did not appear to explain the umbilical swelling. Under spinal anaesthesia the abdomen was opened by a midline incision and the lower mass was found to be blood clot covered with a shiny membrane. Firmly wedged in the umbilical hernia was a foetus presenting as a breech. This was in a fresh condition and when removed measured 8½ in. (22 cm.) from crown to heel—that is, 4–5 months' gestation.

The left Fallopian tube was swollen and dark but otherwise normal. The right tube was completely destroyed. There were numerous adhesions between the omentum and the lower abdominal mass.

The foetus was extracted, the right tube excised, and as much as possible of the blood clot and placenta removed, although the exact limits of the latter were difficult to define. There was little fresh bleeding, and the abdomen was closed with no attempt to deal with the hernia.

Post-operatively she developed severe shock and was given polyvidone ("plasmosan") and intravenous saline, as blood was not available. Her haemoglobin level, however, was extremely low and she died 16 hours later.

CASE 2. HUGE IRREDUCIBLE UMBILICAL HERNIA CONTAINING FULL-TERM GRAVID UTERUS

On November 17, 1958, a Birom woman from Forum was referred to the antenatal clinic by one of our district midwives. She was a para-11, aged about 40, and was 38 weeks pregnant. All her children had been born alive, although only two were living. Such a mortality in infancy and childhood is not uncommon among the Plateau tribes, largely as a result of malaria, dysentery, malnutrition, and aspiration pneumonia from forced feeding with water. She said that her more recent labours had been "more difficult" than the earlier ones. An umbilical hernia had been present since birth and had gradually grown larger.

On examination there was a large umbilical hernia (see photograph). This was irreducible and the sac appeared to

be completely occupied with the gravid uterus. When the patient stood upright the fundus of the uterus was at a lower level than the symphysis pubis. Per vaginam the cervix could not be reached. The uterus was thus almost completely upside down and it was acting as a lever with the lower edge of the hernial orifice as the fulcrum. The lower the fundus descended the greater the tendency for the cervix to be pulled up and the vaginal walls to be stretched. There was a considerable degree of hydramnios and the foetus was very mobile.

In view of the past history it was felt that there was a reasonable chance of spontaneous delivery, provided that the uterus could be held in a fairly normal anatomical position.

On November 28 she went into labour; her record is as follows. 6.25 a.m.: midwife reports strong contractions. Position ?R.O.P. 7.15 a.m.: head free, just above the symphysis. An attempt was made to elevate the hernia by passing woven bandage slings over the shoulders; this was only partially successful. 12.35 p.m.: patient's condition good; membranes intact; cervix now palpable and dilated three fingerbreadths. 4.15 p.m.: contractions much weaker; head still free; membranes intact; dilated 3–4 fingerbreadths.

In view of the weakening contractions and high head it was decided to do a caesarean section under local anaesthesia. The patient requested sterilization at the same operation.

5 p.m.: infiltration of ½% procaine into the tissues around the neck of the hernia, down the midline to the symphysis pubis and laterally into the sheaths of the widely divaricated recti. 5.30 p.m.: when the local field-block anaesthesia was almost complete the membranes ruptured with the loss of a large volume of liquor. Within a few minutes a living male child—weight 6 lb. 15½ oz. (3,160 g.)—was delivered spontaneously as an R.O.A. The placenta followed within 30 seconds and there was very little loss of blood.

Although we do not treat the simple umbilical hernia, this one demanded surgical intervention. A primitive peasant woman such as this, however, would be unlikely to return for further treatment when once she was discharged. Thus as the area of operation was already anaesthetized and the patient's condition good, we decided to proceed immediately with a Mayo-type repair. The tubes were ligated and cut before the peritoneum was closed, anaesthesia being reinforced with open "trilene" during the intraperitoneal procedures.

The patient made an uneventful recovery and was discharged three weeks later. When seen 18 months later the hernial scar was sound, and mother and child were in good health.

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The blanket which passes round the abdomen shows the lower limit of hernial neck. The level of the fundus can be gauged from that of the hand.