AICOG 2025
Mumbai
67th All India Congress of Obstetrics & Gynaecology
FOGSI celebrates 75 years – Diamond Jubliee
8-12 January, 2025 | JIO World Convention Centre

Poster Number: EP 274
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A RARE CASE REPORT OF SUCCESSFUL PREGNANCY OUTCOME IN A PATIENT OF BLADDER EXSTROPHY

INTRODUCTION

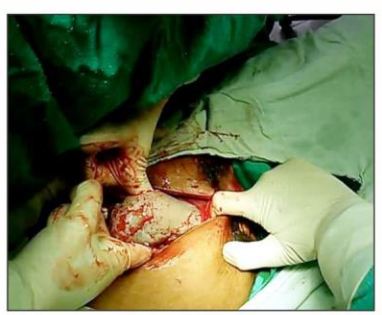
- Exstrophy of the bladder is part of a spectrum of anomalies involving urinary tract, genital tract, musculoskeletal system, and sometimes intestinal tract.
- Lower anterior abdominal wall and anterior wall of bladder are absent.
- Posterior bladder wall and Ureteric orifices are exposed. Bladder neck and urethra are poorly defined. Pubic symphysis is widely separated.
- The incidence is 1 in 10,000 and 1 in 50,000 live births with a male to female ratio of 2.3 : 1.

CASE REPORT

- A 26 years old G2P0+1L0 antenatal woman presented with amenorrhea 9 months with marital life of 3 years B/D-NA B/U-39 WKS 1D and was in labour. She was referred from periphery for transverse lie. She had h/o continuous dribbling of urine since childhood, for which she had multiple visits to hospital for surgical intervention, but due to poor follow up she could not get the surgery done. There was no history of burning micturition. There was no significant medical, surgical, personal or family history. She had antenatal visits and course of her pregnancy had been uneventful.
- On abdominal examination, umbilicus was absent, pubic bones were separated, posterior base of bladder with ureteric openings was seen, continuous dribbling of urine was coming from the ureteric orifices and the anterior bladder wall was absent.
- On obstetrical examination, uterus was term 32 weeks size with fetus in breech presentation with reassuring fetal heart rate, with adequate uterine contractions.
- On local examination no differentiation between the labia majora and minora could be made and no urethral meatus was seen. Both vaginal and anal opening were shifted anteriorly.
- On per vaginal examination cervix was fully dilated and fully effaced. Presenting part was footling breech. Immediate caesarean section was planned in presence of surgeons team under spinal anesthesia.

THE CAESAREAN

- A vertical incision given on abdomen 4-5 cms above bladder, skin and subcutaneous tissue was opened. There was neither rectus sheath nor rectus muscle. There was no parietal peritoneum and no vesicouterine fold of peritoneum. Lower uterine segment was well formed and a nick was given on Lower uterine segment. Baby delivered by breech presentation. Uterus closed in 2 layers, subcutaneous tissue and skin closed, hemostasis achieved She delivered a healthy but growth restricted male child weighing 2.2kg.



DISCUSSION

- Our patient had an uneventful pregnancy course, except malpresentation and IUGR.
- In a largest cohort study conducted in University College London Hospitals, antenatal complications like malpresentation, preterm labor, preeclampsia, eclampsia were seen. Genital prolapse was seen in more than 50% cases of antenatal bladder extrophy.
- Acute urinary complications like intractable urinary infection and urinary retention may need catheterisation. Urinary infections are more common in twins.
- Intraoperative and postoperative complications like transection of ureter, PPH, genital prolapse and fistula were seen.

FERTILITY & OBSTETRIC OUTCOME

Fertility outcome in patients with bladder extrophy trying to conceive			
Outcome Conception Investigated for infertility	Within 1 yr 4 (21%)	Delayed 15 (79%) Endometriosis-4 Tubal Obstruction-3 Unilateral oophorectomy-3 PCOS-2 Unknown-3	Fertility treatment 5 (26%)IVF-4 (successful in only 1 case) Ovulation induction-1

CONCLUSION

- Patients of BE commonly have recurrent UTI and urinary tract obstruction for which every Booking visit should include a renal ultrasound, creatinine, glomerular filtration rate, and urine culture, and these tests should be repeated every 6 weeks in the second and third trimesters.
- They also reported to have an association with preeclampsia for which the patient should regular blood pressure monitoring and dipstick testing.
- These patients can have a successful pregnancy outcome with a meticulous planning and Elective cesarean mostly planned in the majority of cases at 37 weeks with urology team. Vaginal delivery should only be considered when the pregnancy is uncomplicated and a senior obstetrician and urologist should be available for emergency delivery.

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