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Cervical Conglutination: A Case Report

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Abstract

Conglutination is one of the rarest disorders encountered during labor. Reported by few authors over the centuries, its diagnosis and management are fraught with pitfalls in terms of the experience of the health-care team and the likely complications of vaginal delivery. We report on a case received at the university clinics in Kinshasa, Democratic Republic of the Congo, where we successfully delivered vaginally. Discussions are not clear-cut as to the preferred route of delivery in cases of external cervical conglutination, but in our context where society is pronatalist and women are unwilling to undergo caesarean section, every intervention [to be] performed should consider the impact of such intervention on the woman's obstetrical future and the vaginal route should be preferred whenever reasonably possible.

Keywords

Cervical Conglutination, Cervical Achalasia, External Cervical Os

1. Introduction

Conglutination, also known as "achalasia of the external cervical os" in some reference manuals, is a primary condition met within primipara and multipara during labor in which the cervical canal becomes effaced or obliterated, but the external os remains closed and, at times, difficult to locate [1]. It is one of the rarest labor disorders, probably due to a mismatch between dilation and effacement [2]. Several authors have written about it, but the literature on the subject is still very limited. Already, towards the middle of the last century, there had been only twenty-eight articles for almost a century, the majority of which consisted of case reports, as reported by Carter and quoted by Waterman in 1947 [1]. It is worth thinking about it when in doubt, especially when evaluating patients with strong contractions and full effacement with intact amniotic mem-

brane which gives an abnormal amniotic membrane feeling in cervical examination [2].

In inexperienced hands, an attempt at rupture fetal membranes might lead to serious haemorrhage following due to a trauma to the uterus itself because the cervix is not dilated even though it felt so [3].

Careful assessment reveals an aperture and a small nipple-like ledge on what is considered as the membranes. Skilled practitioners can diagnose cervical conglutination and indicate, as a matter of urgency, a caesarean section [2] or opt for a conservative attitude, taking into account the risks involved [4].

Any obstetrician who suspects a case of conglutination should share this experience with other colleagues and assistants, with a view to understanding the mode of onset of conglutination, but above all its clinical features [2]; in fact, conglutination is a pathology rarely described in everyday practice.

In our training, we have experience of around 4 cases, yet not reported. However, it was on the strength of this experience that the diagnosis was finally made and helped for better management, as we shall discuss after the presentation of the case.

2. Case Presentation

We present a case of cervical conglutination in a twenty-eight-year-old primigravida transferred for best management of cervical atresia. She consulted for regular lower back pains for twenty-four hours.

Her medical history is not particular without use of abrasive solutions (like potassium permanganate sitz baths frequently used in our social circle) for intimate care.

She does not know the date of her last menstrual period, and she attended six prenatal consultations which were unparticular. She had performed 2 ultrasounds, the last of which showed an active singleton pregnancy of thirty-five weeks and one day and a short cervix with dehiscent endocervix.

Her examination essentially reported a good general condition yet she had fever forty-eight hours ago; fundal height of twenty-seven centimetres and regular uterine contractions. Vaginal fornix was not well delimited with central aperture on an unclearly perceived cervix.

All those features led us to think about premature labor and fibrosed cervix. So an unfructuous tocolysis was done.

After reviews by obstetric consultants, the diagnosis of cervical conglutination was made, and the decision was made for vaginal route following an attempt of desobstruction which was performed with Kocher clamps to dilate the cervix by spreading the forceps jaws apart, then digital pressure till six centimeters dilation. Membranes were intact and we had a fixed cephalic presentation.

She delivered two hours later to a female newborn, with an Apgar score of 6-7-8 and weighing 2100 g. The newborn was admitted in neonatal ICU for perinatal asphyxia. The mother presented a cervical hemorrhage on cervical wounds.

Wounds were repared and a transfusion was indicated. She was discharged 5 days later.

The newborn suffered an early neonatal death on the second day of birth as she presented a respiratory distress, though she had progressed well initially and even started feeding.

3. Discussion

This was a case of cervical conglutination where the team's experience enabled us to make an early diagnosis and make a decision about the route of delivery.

In the literature, practices differ from one author to another. In view of the clinical situation presented by cervical conglutination and its diagnosis, which often occurs after prolonged labor, some authors consider that it is more appropriate to perform an emergency cesarean section [2].

However, most authors regard treatment as simple and effective in the majority of cases. They recommend the application of digital pressure at the site of the external os which yields after a minute or two. The os then rapidly dilates and delivery is uneventful. In cases where the os is not identifiable, a small incision may be required (in our case, we determined that using a clamp was more appropriate then making a risky incision) and although it is possible for such an incision to lead to extensive tearing, the occurrence of this complication is not reported in the literature. There is a place for Caesarean section in this type of case when labor has been greatly prolonged or when there is a good chance of extensive genital tearing and severe bleeding as might occur if the cervical tissue was relatively thick [4].

Caesarean section is an option depending on the duration of labor [before diagnosis] and the experience of the team. Also, cases of conglutination of the internal os should not be unnoticed, as they may be more prone to complications, such as uterine rupture, and lead to cataclysmic haemorrhage, often with intrapartum death. Bird and Morgan have reported cases which illustrate this point [5] [6].

Our case had a favorable maternal outcome, but we believe that the adverse neonatal outcome may have been due to neonatal infection, which would explain the rapid deterioration of the newborn, despite his being born in good condition and thriving well in the first twenty four hours of birth.

If the patient returned in her next pregnancy, she would be assessed for recurrence as some cases of recurrence are reported by some authors in the literature [1].

4. Conclusion

Cervical conglutination remains a rare pathology. Practitioner who receives this case is first confronted with the diagnostic difficulty, and then the choice of delivery route will have to take into account all the factors involved, the particular social context, as well as the obstetrical outcome. What's more, as the diagnosis

is not easy and the signs are not obvious, a meticulous examination is absolutely essential, despite the urgency of the situation. Awareness of the possibility of vaginal delivery can be helpful for the team managing the case.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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