Sroni Maapana Mahatava in Prasava

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ABSTRACT

The human pelvis has been considered as an evolutionary compromise between birthing and walking upright. The Sroni is a bony structure that can be found in both male and female skeletons. The bony pelvis of adult human exhibits marked sexual dimorphism, The structure of the Sroni is designed to give females the ability to undergo pregnancy and childbirth, while males are able to hold larger and heavier muscles upon their frame. With the onset of puberty, the female pelvis expands; with the onset of menopause, it contracts again. The morphology of the female pelvis is influenced by hormonal changes in puberty and during menopause. As an obstetrician, you will need to have a sound knowledge and understanding of the anatomy of the stree shroni in order to be able to competently assess a woman’s progress in Prasava & pelvic floor plays an important role during Prasava. This involves you being able to identify the relationship between the position and descent of the fetus and the relevant landmarks of her pelvis. Hence, the information in this article will provide a concise introduction of the stree Shroni.

KEYWORDS: Sroni, Prasava, Pelvis, Pelvic Floor, Labour.

INTRODUCTION

Pelvis means a basin. Primarily, the pelvis acts as the main support for the upper part of our body. It transmits our body’s weight to our legs, which enables mobility – walking and running - and flexibility of movements. Pelvis rests upon the lower limbs. The pelvis refers to all the supportive structures that are in pelvis. The female pelvis differs from the male pelvis, being overall broader with a rounded brim that contributes to its specific role in childbirth. The female pelvis is influenced by hormonal changes in puberty and during menopause. With the onset of pregnancy and childbirth, while males are able to hold larger and heavier muscles upon their frame. With the onset of puberty, the female pelvis expands; with the onset of menopause, it contracts again.

Number and Types of bones in Sroni

According to Charaka

2 Sroniphalaka and 1 Bhagasthi.

According to Susrutha

1 Gudasthi (Coccyx), 1 Bhagasthi (pubic bones), 2 Nitambasthi (Hip Bones) and 1 Trikasthi (Sacrum). The bones of Sroni are Kapala (flat) type.

Joints of Sroni

J deterrently, the Sroni is the area below urusandhi & above smaramandira. The measurement of chest of male & waist of female is identical. The chest of female is 18 angulas so is the waist of male. The chest of male is said to be 12 angulas by Acharya Dalhana & 24 angulas by Acharya Chakrapani. The chest of male & waist of females is relatively broader. In tika, Dalhana explained that these measurements are attained after maturity.

Normal Measurement of Sroni

<table>
<thead>
<tr>
<th>Part</th>
<th>Normal Measurement</th>
</tr>
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<tbody>
<tr>
<td>Urasandhi</td>
<td>12 angulas</td>
</tr>
<tr>
<td>Samaramandira</td>
<td>24 angulas</td>
</tr>
</tbody>
</table>

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There are 3 joints of flat bones of Sroni which are tunnasevani (suture) type.

**Sroni Mahatava according to classics**
In the context of mudhagarbha, Susruta had explained the importance of Sroni. While mentioning the causes of mudhagarbha he said even if garbha attains apatya patha (birth passage) in a proper position still it gets obstructed sometimes probably due to abnormal passage which can be constriction of passage at different levels. The abnormalities of passage can lead to dystocia & fetal distress.

**Composition of Pelvis**: In females by pelvis we usually consider bony pelvis which is formed by 4 bones & 4 joints:
- Bones - 1) 2 Hip bones 2) Sacrum 3) Coccyx
- Joints – 2 Sacroiliac joints, Sacrococcygeal joint & Pubic Symphysis

Pelvic cavity is made up of 4 walls: Anterior pelvic wall, Lateral pelvic wall, Posterior pelvic wall and Pelvic floor or Inferior pelvic wall.

The pelvis is divided into
False pelvis: above the pelvic brim and has no obstetric importance.
True pelvis: below the pelvic brim and related to the child -birth.

The true pelvis is important in obstetrics, it is a bony canal formed by the sacrum and coccyx posteriorly and by the ischium and pubis laterally and anteriorly. It is composed of inlet, cavity, and outlet. The true pelvis dimensions are of concern in obstetrics because sometimes these are inadequate to permit passage of the fetus.

Diagram No.-1 (Diameters of Pelvis).
The largest diameter of pelvic outlet = AP diameter.

**Pelvic Floor**
- Pelvic floor is formed by pelvic diaphragm which is composed of: 1) Levator ani: Puborectalis, Pubococcygeus and Iliococcygeus 2) Coccygeus (Ischiococcygeus)

**Role of Pelvic Floor during Labor**
- The pelvic floor supports the pelvic viscera, and assist in their functions & important function during 2nd stage of labor. When the head reaches the pelvic floor, the gutter shape of floor tends to cause the fetal head to rotate so that its long axis comes to lie in AP position. The occipital part of the head now moves downwards and forward along the gutter until it lies under the pubic arch.
- As fetal head passes through the lower part of birth canal, the small gap that exists in the anterior part of pelvic diaphragm becomes enormously engaged so that the head may slip into the perineum. Once the fetus has passed through the perineum, the levator ani muscles recoil and take up their previous position.
- Levator ani have an important sphincter action on the anorectal junction & act as sphincter of vagina. Relaxation of levator ani muscle allow urination & defecation to occur.
- Inability of levator ani to relax at the time of delivery is often responsible for delay in second stage of labor. Levator ani muscle often stretch and can be injured during childbirth. Of these, pubococcygeus & puborectalis muscles are more commonly damaged. These injuries may predispose women to greater risk of pelvic organ prolapse and urinary incontinence.
- The Coccygeus muscle draws the coccyx forwards after it has been pushed backwards during parturition or defecation. Coccygeus also supports the pelvic floor against intrabdominal pressure.
- During pregnancy, the pelvic joints & ligaments are relaxed which after delivery again tighten up, so that it returns to its original efficiency. Damage by
laceration during delivery can lead to permanent weakness of pelvic floor.

**Variation in Shapes of Pelvis**

Each type of the pelvises have certain diameters and we have to know the characteristic of each type and its compatibility for vaginal delivery of the fetus:

- **Rachitic Pelvis**: This deformity is caused by rickets (due to Vit D deficiency) Sacrum is rotated so that the sacral promontory projects forward and coccyx tips backward. AP diameter of inlet is therefore narrowed but the outlet is increased. Mode of Delivery is C-section.

- **Naegele’s Pelvis**: It is found very rare & is due to arrested development of one ala of sacrum. It may be Congenital or Acquired. Delivery by C-section is ideal.

- **Scoliotic Pelvis**: Due to scoliosis when lumbar region is involved. In this type of pelvis, the oblique asymmetry results in contraction of one of the oblique diameter. Hence, delivery by C-section is preferred.

- **Kyphotic Pelvis**: It is always secondary to Kyphosis. Subpubic angle is narrow. There is extreme funneling of pelvis. Caesarean delivery is ideal.

- **Robert’s pelvis (Transversely contracted)**: Extremely rare present. There is absence of Ala of both sides of sacrum. Mode of delivery is Caesarean.

**Normal Variants of Pelvis**

- **Gynaecoid** – It is most common type of pelvis & a typical female pelvis with following features: Found in 50% of women. Inlet is rounded & straight pelvic sidewalls with roomy pelvic cavity. The ischial spines are not prominent & there is wide interspinous diameter with good sacral curve. Fetal head engages in transverse or oblique; OA (occipito-anterior) position is common. Labor: easy and complete internal rotation; wide pubic arch reduces perineal tears. Ideal for vaginal delivery.

- **Android** – It is the masculine type of pelvis & having following features: Present in 20% of females. The inlet is Heart shaped (or triangular) - due to prominent sacrum. The pelvis funnels from above downwards (convergent sidewalls). Ischial spines are prominent with sacrum inclining forward. Oblique OP\\ occipito lateral position of fetus is common. Mode of delivery – Difficulty in vaginal delivery with more chances of perineal injuries as there is difficulty in engagement. Limited space at the inlet & progressively lessens down the pelvis, owing to the funneling effect of the side walls, sacrum, and pubic rami. There is restricted space at all levels. Fetal head engages in transverse or oblique in asynclitism, leads to extreme molding. Labor: Deep transverse arrest is common; arrest of descent is common at the mid pelvis, arrest as OP with failed rotation, delivery with difficult forceps, narrow pubic arch leading to major perineal tear. Delivery by C-section is ideal.

- **Anthropoid** – It resembles with pelvis of anthropoid ape. Present in - 25% of women. Pelvic inlet is long oval. AP diameter > transverse diameter. Long & narrow sacrum. Straight pelvic sidewalls. Fetal head can engage in OA or OP, flexion can be delayed. Labor: More chances of face to pubis delivery. Prognosis is good.

- **Platypelloid** – Also known as Flat pelvis. Following features are present in this type of pelvis: Uncommon in both sexes - 5% of women. Pelvic inlet appears slightly flattened. Transverse diameter is greater than AP diameter. Sacral promontory pushed forwards. Mode of delivery - Fetal head engages in transverse diameter with marked asynclitism. - once engagement occurred then no difficulty in vaginal delivery. C-section is better option. Prognosis: Poor, CPD, delay at inlet.

![Diagram no.-2 (Pelvic Variations and its Abnormality)](https://www.wjpmr.com)

**Diagram no.-2 (Pelvic Variations and its Abnormality)**

**CPD** - In this condition, the capacity of pelvis is inadequate to allow the fetus to enter the birth canal.

- Causes – Small pelvis & Non gynaecoid pelvis.
- Degree of disproportion and contracted pelvis
  - Severe – Obstetric conjugate < 7.5cm.
  - Borderline – Obstetric conjugate between 9.5 & 10cm & AP & transverse diameter of inlet are reduced.

- Labor in contracted pelvis
  - Minor degrees do not create much problems.
✓ In case of moderate & severe
  • Induction of labor
  • Elective caesarean at term
  • Trial Labour.

Effects of contracted pelvis on pregnancy and labor

✓ Pregnancy
  • Incarceration of retroverted uterus in flat pelvis
  • Abdomen is more pendulous in multigravida
  • More chances of malpresentation
  • More chances of unstable lie.

✓ Labor
  • Chances of PROM
  • Chances of cord prolapse increases
  • Slow Cervical dilatation
  • Prolonged or Obstructed labor
  • Increased risk of operative interference.

DISCUSSION

✓ The Stree Sroni is well adapted for the process of prasava (childbirth). In addition, it contains, supports & protects the pelvic viscera. Pregnancy & childbirth appear to be associated with an increased risk of developing pelvic floor disorders.

✓ Acharya Sushruta emphasizes on the knowledge of anatomy of body. One should have a good knowledge of anatomy of body, then only he should go for any treatment or surgical procedure.

✓ शरीर स्नातक व दुस्तराय: स्यादविकाशर: ! (सु, शा-४ /९१).

✓ In classics also, it is mentioned in the reference of mudha garbha, that sometimes after complete formation(maturity), the fetus is not able to come out even after reaching its passage (pelvis & vagina). The Sroni vikara which are responsible for mudha garbha can be considered as pelvic inlet contraction & pelvic outlet contraction. A sound knowledge and understanding of the anatomy and the knowledge of the Stree Sroni is necessary to assess a woman’s progress in prasava.

✓ The knowledge of shape and capacity of female pelvis can reduce maternal & fetal mortality & morbidity. Thus the pelvic floor is a sophisticated anatomical and functional unit, with a complex interaction of multiple structures. It needs further practical research to strengthen the concept.

CONCLUSION

The pelvis is the bony canal through which the fetus has to pass during childbirth. The human female pelvis undergoes adaptations that are of obstetric importance. These adaptations develop chiefly in childhood, puberty & pregnancy. It is therefore of great importance to determine the diameters of this canal and therefore the childbearing capacity of the mother. Childbirth is an important event in a woman's life. Vaginal childbirth is the most common mode of delivery and it has been associated with increased incidence of pelvic floor disorders later in life. Understanding the importance of the pelvic floor during childbirth is helpful to prevent childbirth-related injury and improving pelvic floor function in the future. The various dimensions of the pelvis are therefore particularly significant in the context of childbirth and the successful passage of the fetus through the bony pelvis. The Gynaecoid is considered as the most common type of female pelvis. The size and shape of the bony pelvis can affect the ease or difficulty of delivery. A narrow pelvis gives more difficulty than a broader one, by obstructing the descent of the fetus. Certain landmarks in the anatomy of the pelvis are commonly used to estimate the descent of the baby during labor. The muscles of the pelvic floor support all the abdominal and pelvic organs from below – that is why it’s called a floor.

REFERENCES