A CASE OF RUPTURE OF THE UTERUS WITH UNUSUAL SYMPTOMS

by

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The following is an account of a case where diagnosis of marginal placenta praevia was made but on exploratory laparotomy it turned out to be a case of rupture of the uterus.

CASE HISTORY :

Mrs. Soni B., 8th gravida, aged 30 years, admitted to Shree Sayaji General Hospital, Baroda, from a near-by village on 17-6-56 at 9 p.m., with a history of 9 months' amenorrhoea. She had oedema of feet since 7 days. The patient complained of labour pains since 4 p.m.; she had a bout of profuse bleeding per vaginam at 6 p.m. on 17-6-56. Local village Dai was called to see the patient at her home, who did "Kalla" (vigorous massage of abdomen) and some internal manipulation. Afterwards she was brought by about 9 p.m. to S. S. G. Hospital.

Patient had her first 3 F.T.N.D. in the hospital. Subsequently she had 3 miscarriages, ranging from 4 to 6 months; the last was a premature delivery at 7 months about 2 years back. There was nothing particular in her past illnesses.

On admission to the hospital, she was pale, T. 97°F., P. 84/min., vol. fair, B. P. 90/60, oedema over both feet. All other systems were normal.

Abdominal examination revealed slight uterine obliquity, uterus being about 9 months' size; no tenderness, no rigidity. The head was floating. F.H.S.? The patient was getting pains at intervals of 10 to 15 minutes lasting for 10 to 15 seconds. Fundal height 11.5 inches. Abd. girth 35 inches; urine, albumen present, Hb 40%, R.B.C. 2.8 million, C.I. 0.8. There was very slight amount of vaginal bleeding on admission.

Vaginal examination revealed cervix partially taken up, 2 fingers dilated, bog lines in the posterior fornix. Head at the pelvic brim.

Injection of morphia gr. 1/4 was given and glucose saline infusion started. The patient was kept under observation as a case of marginal placenta praevia.

Patient had a bout of bleeding at 11-15 p.m. P 120 per minute, vol. fair, B.P. 90/60, patient was restless at about 12 midnight. Abdominal examination revealed slight uterine obliquity towards right. Head was entering the pelvic cavity. F.H.S. ? Pains at 10 mts. interval lasting for 15 to 30 seconds. P. 130 per minute, vol. poor, B.P. 80/50, vaginal exam. revealed cervix taken up, and 2 fingers dilated, membranes were flush with the head. Firm elastic tissue felt posteriorly? placental tissue, bogginess in posterior fornix, head felt above the level of ischial spines, sagittal suture in the transverse diameter, posterior parietal presentation. Clinically pelvis did not show any abnormality. Fresh blood was present on examining finger.

Clinically the case was diagnosed as a case of marginal placenta praevia. With the pulse rate going up, and blood pressure falling, increasing restlessness, tongue getting pale and dry and patient anaemic to start with, exploratory laparotomy was done under local anaesthesia at about 1 a.m. on 18-7-56. On opening

the peritoneal cavity, about 1 pint of fresh blood escaped, and a transverse tear of about 3" in the right broad ligament, anterior fold just below the right round ligament extending from the right infundibulo—pelvic ligament to the right cornual region, was detected. One foot was just protruding through the same. The uterine outline seemed normal with foetus inside. It was evident that this was a case of ruptured uterus. The exploration was done from the broad ligament tear and it was noticed that the breech and the lower extremities were protruding through the rent in the right lateral wall of the uterus. The foetus was delivered by grasping the feet through the tear in the broad ligament. The placenta followed immediately through the same rent. After retracting the torn edges of the broad ligament, the rupture of the uterus was noticed in the right lateral side extending from just beneath the cornual end of right fallopian tube to the level of the internal os, involving the right uterine blood vessels and the ascending branch of the uterine artery. The tear was irregular in outline. Broad ligament was torn transversely extending from the right infundibulo-pelvic ligaments to the lower border of the cornual end of the right fallopian tube. All the bleeding vessels were properly secured and ligatured and uterine tear was suturred up. Finally the torn edges of the broad ligament were apposed. Sterilisation was done by modified Pomeroy's method. The operation was started under local anaesthesia and afterwards supplented with general anaesthesia (open ether). During the operation she was given blood transfusion of about 350 cc. and to combat shock she was given inj. Doca and inj. methidrine and later on she was given glucose saline by I.V. drip. After operation was over her B.P. came up to 120/90, P. 90 p/min., vol. good, tongue moist.

The patient recovered completely from shock; she was given all the routine treatment along with antibiotic drugs (combination of streptomycin and penicillin). She started running temperature of about 101°F from the 18th night. She had pain in the chest from 19th afternoon. Respirations were 40/min. shallow, temperature 100°F. There were rales and rhonchi all over the chest. P. 120/min. vol. good B.P. 120/80. Patient ran high temperature and the rapid shallow respirations continued on 21st and 22nd inst. in spite of all the measures adopted. She died on 23rd July 1956.

Discussion

The case presented above showed the clinical features of placenta praevia, with history of bleeding per vaginam, starting after labour pains, head floating and the feeling of placental tissue by vaginal examination. The patient was kept under observation but after the profuse second bout of bleeding the patient's condition started deteriorating and taking into consideration her general condition, rising pulse rate, falling blood pressure, and pre-existing anaemia, exploratory laparotomy was done. This brought to light the rupture of the uterus.

As there was a partial rent in the broad ligament and the foetus was only partially out in the broad ligament the uterine outline with foetus inside was maintained and the uterine contractions were still present as this ruptured uterus was still trying to throw off the foetus entirely from the uterine cavity. The rupture of the uterus was thus not suspected. This complication must have been of short duration as the patient's condition had not deteriorated severely inspite of such a big rent and the accompanying vaginal bleeding. The pelvis showed no abnormality clinically and there was no bad obstetric history or any vaginal operative interference in

the past and hence the problem arises as to what must have been the cause of rupture of the uterus. It seems probable that the manipulations done per abdomen and per vaginam by the village Dai had brought about this dangerous complication.

On exploratory laparotomy, after extracting the foetus the previously separated placenta followed immediately through the uterine and peritoneal rents. It is very difficult to account for the suggestive feeling of placental tissue posteriorly on vaginal examination. It is possible that the already separated placenta had descended to a certain extent and was accessible by vaginal examination giving us the picture of marginal placenta praevia.

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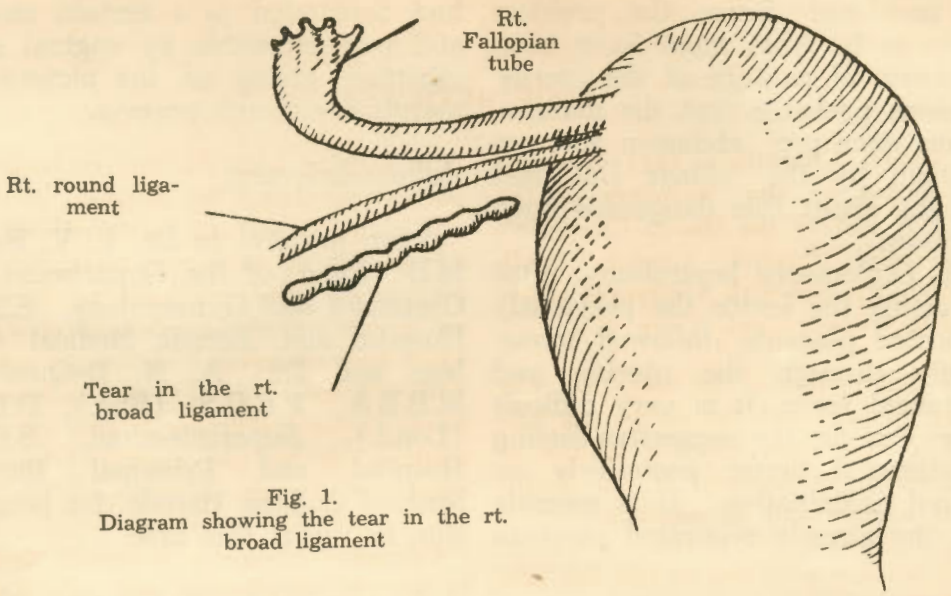

Fig. 1.
Diagram showing the tear in the rt. broad ligament

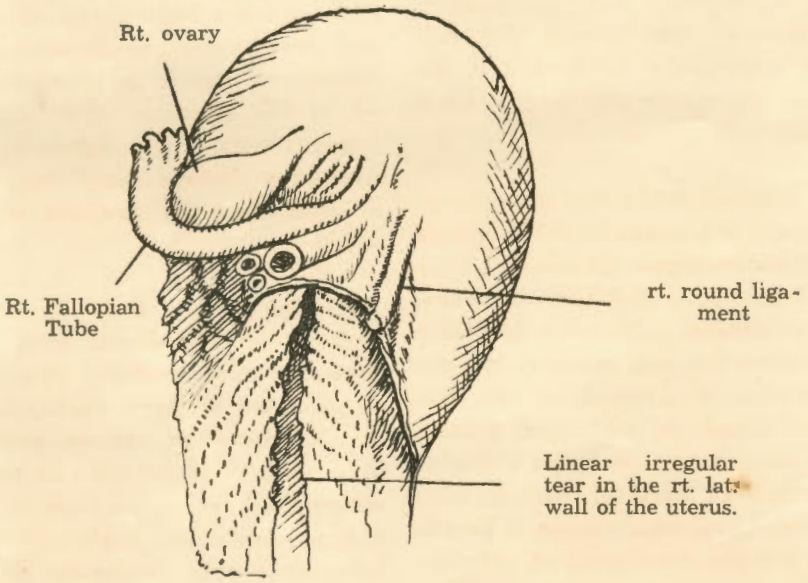

Fig. 2.
Diagram showing the linear irregular tear in the rt. lat. wall of the uterus.