RUPTURE OF THE UTERUS AND THE URINARY BLADDER WITH ESCAPE OF FOETAL HEAD INTO THE BLADDER

(A Case Report)

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The urinary bladder, because of its close anatomical proximity to the uterus, may be lacerated in cases of rupture of the lower uterine segment. In extreme cases even the foetal parts have been known to escape through the laceration into the cavity of the urinary bladder. The first such case was reported by Devi (1962) and followed later by Bird (1964), Gogoi (1968) and Shah (1970).

Case Report

Mrs. J, 35 years old resident of a village about 50 miles away from Ajmer, was admitted on 4.12.70 at 6.30 A.M. in Jawaharlal Nehru Zanana Hospital Ajmer, as an emergency case. The patient gave a history of a full term normal home delivery of the first twin foetus at 3 P.M. on 3.12.70 Immediately after that there was prolapse of a hand of the second twin foetus. She was brought to the hospital after the attending village dai had failed in her manipulations.

She had four full term normal deliveries, all living. Last delivery was four years ago. On examination the general condition of the patient was poor. She looked very anaemic, the temperature was 98.4°C, pulse rate 120 per minute low in volume and tension and blood pressure was 100/60 mm Hg. The uterus was enlarged to nearly 32 weeks of pregnancy. The contour of the uterus merged imperceptibly with a rounded prominent swelling in the suprapubic region which was tense and tender. Underneath this swelling the foetal head could be felt superficially. On catheterisation 5 ounces of frank blood came out. A tentative diagnosis of ruptured uterus with the foetal head lying superficially in the suprapubic region was made and the patient was immediately prepared for laparotomy.

Operation Notes

On opening the abdomen under general anaesthesia, the peritoneal cavity revealed no free blood. Infront of the lower part of the contracted uterus a bluish coloured swelling was present extraperitoneally. On palpation through the thin wall of this swelling, the foetal head could be felt. The swelling was bulging high up, being covered by the uterovesical fold of peritoneum. Incomplete rupture of lower uterine segment was suspected. A transverse incision was made in the uterovesical pouch of peritoneum. A transverse nick was made in the wall of the lower swelling through which the foetal head became visible. The incision was then extended. A full term dead male foetus was extracted through it, followed by the two placentae and the membranes. The catheter now came in view and in closer examination the urine could be seen spurting from the two ureteric orifices. The interior of the bladder was enormously stretched with very thin bruised and necrosed musculature. Exploration of the bladder interior through the incision revealed a T shaped rent in the posterior wall of the bladder, the horizontal bar of T passing just above the two ureteric orifices and the central limb going towards the urethra. This

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was communicating with the uterine cavity through a transverse rent involving the anterior wall of the lower uterine segment which was found necrotic, gangrenous and badly bruised. It was through this rent that the foetal head had made its way into the bladder. The two rents could be repaired with much difficulty, especially the rent in the bladder, where the ureteric orifices were in very close proximity of the rent. The incision in the bladder wall was then repaired. Hysterectomy could not be done for fear of injury to the ureteric orifices as they were very close to the ruptured lower uterine segment. Sterilisation was done by Pomeroy's method and abdomen closed in layers, leaving a drainage tube inside.

The condition of the patient remained very low throughout the operation. A Foley's catheter was left in the bladder for continuous drainage. For the next 72 hours of the post operative period blood pressure was maintained with blood transfusion, I.V. glucose drip with noradrenaline and cortisone therapy. Blood pressure was stabilised at 100 mm. Hg. to 110 mm. Hg. systolic. On the 7th post operative day the abdominal wound gaped in the middle portion and through it urine started coming, wetting the dressing. There was dribbling of urine from the vagina also. The abdominal wound was gradually healing and the leakage of urine through it had much decreased. The dribbling of urine through vagina, however, was still persisting when she was taken home by her relatives on 22.1.71 in spite of the persuasion to the contrary.

Summary and Comments

A case of rupture of the lower segment of the uterus involving the posterior wall of the urinary bladder with the foetal head escaping into the bladder is reported.

In countries where medical aid is advanced, rupture of the uterus is a rarity. In less developed countries neglected or badly handled cases of malpresentation such as shoulder presentation, cephalopelvic disproportion, hydrocephalus and injudicious use of oxytocic drugs lead to rupture of the uterus and varying degree of injury to the bladder. Due to transport difficulties the patient often arrives very late with obstetric shock.

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References

1. Bird, G. C.: J. Obst. & Gynec. Brit. Cwlth. **66**: 967, 1964.
2. Devi, N. S.: J. Obst. & Cynec. Brit. Cwlth **69**: 1407, 1962.
3. Gogoi, M. P.: J. Obst. & Gynec. India. **18**: 130, 1968.
4. Shah, Y. V.: J. Obst. & Gynec. India. **20**: 666, 1970