OCCULT RUPTURE OF AN INTACT UTERUS DURING PREGNANCY

(A Case Report)

by

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Spontaneous rupture of the intact uterus during pregnancy is exceedingly rare. It usually presents as an acute episode and carries a high maternal and perinatal mortality. But, in still rarer cases the symptoms are minimal and patients seek medical advice even some days and months after the accident. Such cases have been described as "Occult" or "Silent" ruptures. The present case is an example of occult rupture of an intact uterus in a second gravida, diagnosed six days after the accident."

Case Report

Mrs. S., aged 20 years, married female, 2nd gravida who had regular menstrual cycles and had delivered spontaneously a premature stillborn foetus during her first confinement 21 months ago. She had again been pregnant and she was expected to confine on 15-12-1971. At 26 weeks' pregnancy, on 19-9-1971 she experienced acute pain all over the abdomen and slight bleeding per vaginam 4 days later. Her routine activities had been restricted due to pain since the date of the episode and that had forced her to seek medical advice. She consulted a general practitioner who treated her symptomatically with antispasmodics and Imferon injections. Finally she got admitted to our ward on 25-9-1971.

Systemic examination revealed that the patient was markedly anaemic. Her haemoglobin was 3 gm. per cent. Her pulse rate was 110/minute and her B.P. was 130/70 mm Hg.

Per abdomen examination did not reveal the exact configuration and the size of the uterus. There was tenderness all over the abdomen. Foetal parts could be felt superficially, while foetal heart sounds could not be heard. There was dullness in both the flanks to account for the free fluid in the peritoneal cavity.

Per vaginam examination revealed a tubular cervix with os closed. There was slight bleeding on the examining finger. A provisional diagnosis of rupture of the uterus was made and the case was posted for laparotomy. Under spinal anaesthesia with an infraumbilical midline incision, laparotomy was performed.

Laparotomy findings: Peritoneal cavity was full of blood and blood clots. The foetus was floating in the blood in the peritoneal cavity. The placenta was lying in the uterus which had contracted well. There was no fresh bleeding from the edges of the tear. An irregular tear extending from the lower margin of the body of the uterus to the fundus on the anterior wall of the uterus was found. It had extended more to the left side of midline close to the cornual end of the left fallopian tube. Omentum was adherent to the uterus at two points. The omental adhesions were separated. Uterine wound was repaired in 3 layers. The abdomen was closed after

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cleaning the peritoneal cavity. Patient was transfused with 1500 ml of blood during operation. The postoperative period was uneventful.

Follow Up: The patient was discharged on 20th postoperative day. She had come for follow up twice at 6 weeks' intervals and her condition had been satisfactory. A hysterogram at 12 weeks after the operation revealed that the uterine cavity was globular in shape. The patient is being followed up regularly.

Discussion

Initial presentation is the most striking although less surprising feature of this case. In retrospect it would be easy to correlate that the episode of pain corresponded with the beginning of the rupture of the uterus which continued unabated, though clinically the condition of th patient did not change except increasing pallor. Tachycardia, bleeding per vaginam, continuous pain, tenderness and superficial feeling of foetal parts in the abdomen did not receive the attention of the physician to revise his diagnosis in favour of possible rupture of the uterus

There are isolated cases on record where the rupture of an apparently intact uterus during pregnancy has occured following manual removal of the placenta in the previous pregnancy and previous currettage (Rendell 1926; Patel and Parikh, 1960; and Das Gupta 1956). Felmus, Pedowitz and Nassberg (1953) had drawn the same conclusions in a review of 121 cases. Cuthburt (quoted by Narayan Rao, 1964) suggests that sepsis is a more important factor than the actual trauma sustained by the wall of the uterus during the manouvres. The original injury might be quite trivial and may remain unrecognized at the time of operation. A potential weak area develops as a result of trauma and/or sepsis and subsequent healing with fibrous tissue. Where no evidence of previous injury is obtained, the degenerative changes occurring in the uterine wall with increasing age and parity offer another explanation. Mahfouz (1932) contradicted this explanation stating that multiparous labours are six times more common than the primiparous. Individual susceptibility is another offered explanation. Inherent or acquired weakness of uterine musculature as a part of generalized muscle weakness in pregnancy may be a causative factor. The present case is also one in which the cause was not ascertainable

Summary

A case of occult rupture during pregnancy of an intact uterus is reported.

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