FOETUS IN THE BLADDER AFTER RUPTURE OF UTERUS

(A Case Report)

by

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Though the bladder is closely related to the lower uterine segment and the rupture of the lower uterine segment is more common than the upper segment rupture, the incidence of bladder rupture along with the uterine rupture is uncommon. Still uncommon is the escape of the foetus into the bladder. Ramamurthy (1972) found only seven cases in the world literature. He added two cases. Bladder enjoys such protection because of wide range of laxity of its vesico-vaginal fold of peritoneum. The following case of foetus in the bladder following rupture of uterus met in this hospital is reported.

Case Report

Mrs. P.B.R. aged 28 years, second gravida, was admitted to this hospital on 18-10-72 at 8.45 P.M. On enquiry, it was found that she was carrying a full-term pregnancy and was in labour since about 72 hours. She was admitted initially in a district hospital where an attempt was made to deliver her by forceps. After futile attempts, she was sent here for further treatment. In the district hospital, she gave the history of an acute attack of abdominal pain which reportedly subsided after the forceps attempt.

After admission in this hospital, she had two convulsive fits. No history of fits before admission was reported. She did not have any vaginal bleeding. There was retention of urine for 12 hours.

She was married for five years. Her first pregnancy ended in a full-term normal delivery three years back. This time she conceived during her lactational period and therefore exact period of conceptional amenorrhoea could not be ascertained.

She came from a long distance from this central hospital.

On examination at the time of admission, her general condition was not satisfactory. She was conscious. Her blood pressure was high at 170/120 mm Hg., pulse 152 per minute. Anaemia was not marked. Respirations were normal and cyanosis nil. There was no oedema. Systemic examinations revealed no abnormality.

Abdominal examinations revealed two distinct swellings, one lower softer hpto the level of the umbilicus and a smaller upper and harder above the former. Foetal parts could not be felt distinctly. No foetal heart sounds were audible. There was no evidence of free fluid in the peritoneal cavity. Abdomen was not tender.

On vaginal examination, cervix was fully dilated. Head could be felt through the cervix at the level of the brim. Bag of membranes was absent. There was marked caput and moulding over the foetal head. No vaginal bleeding was noted. On catheterisation, two or three ounces of frank blood were drained without any urine.

A pre-operative diagnosis of ruptured uterus with involvement of bladder was made. By the time she was put on the operating table, her condition further went down. Blood pressure came to 80/? with pulse at 144/m. Under general anaesthesia, the abdomen was opened by a midline incision. There was no free blood in the peritoneal cavity. Our attention was immediately drawn to a big haematoma in the lower

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uterine segment. On examination, it was found to be the thin intact ecchymosed utero-vesical fold of peritoneum. It was so thin that it gave way during manipulation. Head of the foetus was found to be jammed in the pelvis and was noted to be lying in the bladder as evidenced by the presence of the rubber catheter by the side of the foetal head. The trunk of the foetus and the placenta were in the upper segment. After removing all these, an exploration revealed a transverse rent in the lower segment, the left end of which was extending towards the upper segment to about two inches in length and the right end descending down about three inches towards the vaginal vault. At the same time a tear of three inches in length transversely in line with the tear in the lower segment was noted on the posterior wall of the bladder. The rubber catheter was now prominently visible on the bed of this bladder injury. A bout of fresh bleeding ensued after the extraction of the foetus deteriorating further the condition of the patient. Anaesthetist cautioned us to hurry. With much difficulty the torn viscera were repaired and peritonised. Abdomen was closed.

She soon showed some improvement after the operation. But again her condition gradually deteriorated from the 3rd postoperative day. There was high pyrexia which could not be controlled. Haematuria persisted. She died on the 5th postoperative day.

Comment

Ours is an infant institute having started since May, 1971. Out of total delivery of 3567 upto the end of November, 1972, five cases of uterine rupture were admitted as emergency. Two cases had tearing off of the vesico-vaginal pouch without bladder injury, one had bladder rupture, and two without involvement of bladder or its pouch.

Pre-operative diagnosis of bladder rupture can often be made from urinary retention and frank haematuria. C. G. Ramamurthy (1972) reported two of his cases where pre-operative diagnosis was suspected from meconium-stained-blood-tinged urine.

Repair of the wounds was considered suitable in this case primarily for her low condition.

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References

1. Ramamurthy, C. G.: J. Obst. & Gynec. India. 22: 567, 1972.