

CENTRAL RUPTURE OF PERINEUM

(A Case Report)

by

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Central rupture of perineum is defined as a tear which leaves the posterior commissure and the anterior margin of the perineum intact, but involves the central portion of the perineum even upto or including the rectum. It is also referred to as 4th degree perineal laceration. It is a rare, but serious obstetric injury and not more than 100 cases have been reported. (Jovanovic and Jovanovic, 1972).

CASE REPORT

SB., 25 years old primipara was admitted on 3.11.1973, about one hour after delivery at home. Labour pains started at 6.30 P.M. on 3.11.1973. The pains were strong and frequent and she had a quick and unassisted precipitate delivery at 10.30 P.M. when she was in the toilet. She described that the baby and placenta were delivered through "abnormal passage." The baby was alive, and weighed 2300 g.

She had a central perineal laceration. (Figure 1) The tear was irregularly rectangular in shape and about 3 cm. broad and 7 cm long. The margins of the laceration were fresh, irregular, serrated and blood-stained. The laceration was located posteriorly with its posterior margin extending just upto the external anal sphincter. The anal mucosa was intact. The skin over the anterior portion of the perineum was intact. The distance from the posterior com-

missure to the anterior edge of the laceration was 4 cm. The vaginal introitus was intact. Vagina admitted two fingers. The posterior vaginal wall was badly lacerated and the lacerations were extending laterally on both sides. The rectovaginal space was markedly traumatised and there was a haematoma in the rectovaginal space. The cervix and uterus were intact. The bony pelvis was normal. Rectal examination showed that the anal and rectal mucosa were uninjured, although the external anal sphincter was lacerated.

Operative procedure: The repair of the central perineal rupture was undertaken under general anaesthesia. The margins of the perineal laceration were trimmed and wound debridement was done. The bridge of tissue connecting the vaginal introitus and the upper margin of the laceration was incised by a midline incision. This ensured better exposure of the posterior vaginal wall and muscles of the pelvic floor, enabling adequate repair of the tissues in layers. The lacerated muscles of the pelvic floor were identified and approximated in the midline. The posterior vaginal wall was reconstructed. The skin was approximated with black silk. The reformed perineum was long and measured 10 cm. The vagina was plugged with a flavine gauze roll, which was removed 10 hours after the operation. The wound healed well and the patient was discharged on the 12th post-operative day.

Discussion

Karlin (1927) in his review of the cases of central rupture of perineum concluded that the injury was more frequent between 17 and 25 years of age; more common in primiparas; more frequently seen with precipitate labour; and in all cases, the foetus presented by vertex, except in

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one case in which the breech was presenting. The present case illustrates all the above features. According to Jovanovic and Jovanovic (1972) the babies delivered through the central rupture of perineum were alive in only 8 cases, and the present case is the ninth one in which a living baby was delivered through central rupture of perineum.

Precipitate labour has been considered as the most frequent cause of central perineal rupture, although other factors such as excessive softness of the perineal body, rigid vaginal introitus, unusually long perineum, firm fibrotic ring in the lower third of vagina, and previous obstetric injury to the vagina may also result in central perineal rupture. Jovanovic and Jovanovic have enlisted the other probable etiological factors which may result in this type of rare obstetric injury. In the present case, precipitate labour and long perineum were responsible for the central rupture of perineum. It is postulated that the foetal head was driven down fast due to the strong and frequent uterine contractions of precipitate labour. Since the perineum was long, the force of such contractions were directed directly downwards over the peri-

neum. Hence the fetal head instead of travelling along the curve of Carus, was delivered through the posterior vaginal wall, rectovaginal space and the perineum. Delivery of foetus through the rectum and anus is only a further exaggeration of this process.

Central perineal rupture should be repaired as soon after delivery as is possible, although it may be advisable to wait until suitable operating conditions are available or until the patient's condition permits. The tear must be meticulously sutured, because a neglected or inadequately treated central rupture of perineum will cause insufficiency of the pelvic floor resulting in urinary and gas incontinence.

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References

1. Jovanovic, D. and Jovanovic, L. A.: *Obst. & Gynec.*, 40: 594, 1972.
2. Karlin (1972): quoted by Jovanovic and Jovanovic.

See Fig. on Art Paper VI