A CASE OF SPONTANEOUS RUPTURE OF THE UTERUS

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Introduction

A true spontaneous rupture of the uterus during pregnancy is exceedingly rare. In these cases there is no known damage to the uterus due to perforation, manual removal of placenta, deep cervical tear or vigorous curettage. Spontaneous rupture during pregnancy is usually in the upper segment as is reported in the literature.

We are reporting a rare case of spontaneous rupture of the uterus in the 34th week of gestation where there was a vertical midline rupture on the posterior wall of the uterus extending from the fundus upto the lower uterine segment.

CASE REPORT

Patient, Mrs. A., 22 years old, a booked second gravida with 8½ months amenorrhoea was brought to this hospital on 2nd March, 1976 with sudden acute pain in the abdomen of 32 hours duration. The pain started when she went to pass motion. Since then she also had recurrent fainting attacks whenever she tried to sit up. She had not been able to pass urine since this episode. Her menstrual cycles were normal, occurring once in 30 days and lasting for 4-5 days. Her last normal menstrual period was on 12.7.75 and due date was 19.7.76. She had delivered a macerated stillborn baby about 1 year ago at home in the 9th month of pregnancy after an easy labour.

On Examination

Patient was conscious with marked pallor and with a pulse rate of 140/min. The systolic blood pressure was 70 mm of Hg. and diastolic reading could not be recorded. Heart and lungs were clinically normal.

Abdominal Examination

There was generalised distension and tenderness over the abdomen. The bowel sounds were absent. The contour of the uterus and foetal parts could not be clearly made out. Foetal heart was absent.

Vaginal Examination

On catheterisation no urine was drawn. Cervix was hanging loose. The external os was patulous and internal os admitted tip of finger. The presenting part could not be felt. Dark coloured blood was present on the examining finger.

A provisional diagnosis of spontaneous rupture of the uterus was made.

Investigations

Hb. 2 gms%; X-ray abdomen showed vertex presenting high up.

Immediate laparotomy was decided upon. She was given 2 units of blood preoperatively and her systolic blood pressure reading came upto 90 mm. of Hg.

The findings on opening the abdomen were as follows:

The peritoneal cavity was found to be filled with fresh and clotted blood. The placenta came into view. The baby was still within the uterine cavity and was extracted as breech after removal of the placenta. After cleaning the abdominal cavity it was found that there

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was a longitudinal rupture on the posterior surface of the uterus in the midline starting just below the fundus and extending upto the lower segment. The ragged edges of the ruptured uterine wall were freshened, stiched in three layers and a Pomeroy sterilization was done. One unit of blood was given during the operation. The patient made an uneventful recovery. Histopathology of the tissue from the uterine wall at the site of rupture showed fragments of congested oedematous muscle bundles. An occasional fragment was lined by blood clot in which chorionic villi and decidual tissue was seen. No obvious etiological factor for rupture of the uterus could be found.

Discussion

In the present case the patient had attended the antenatal clinic on two occasions. On admission the history of sudden acute abdominal pain with attacks of syncope and obvious collapse with marked pallor and difficulty in outlining the uterus and foetal parts suggested the presence of internal bleeding probably dut to rupture of the uterus.

The common causes of spontaneous rupture of the intact uterus in pregnancy have been attributed to multiparity (Felmus *et al* 1953), rudimentary horn of a bicornuate uterus (Pedowitz and Pewell 1958), placenta accreta (Carsten 1964) or previous obstetric trauma like manual removal of placenta (Sitaratna 1975).

The site of rupture in the present case, a posterior midline rent extending from just below the fundus upto the lower uterine segment closely corresponds to the case reported by Walvekar *et al* (1975). Placentation over the site of rupture, however, did not explain the rupture as histological evidence showed no abnormal penetration of muscle by the chorionic Villi. It is more likely that such midline ruptures are due to inherent weakness of the musculature at the site of fusion of the two Mullerian Ducts during development.

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