PLACENTA PERCRETA CAUSING RUPTURE OF THE UTERUS

(A Case Report)

by

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Spontaneous rupture of the uterus during pregnancy due to placenta percreta is a rare complication and only very few cases are reported in the literature. Hence the present case of rupture uterus due to placenta percreta is reported.

CASE REPORT

Mrs. A., 40 years, was admitted in J.L.N. Hospital, Ajmer as an emergency case on 4-12-'77 at 7.15 P.M. with 7 months' amenorrhea and acute pain in the abdomen for 24 hours. The pain was servere and constant and was associated with vomiting. In all she had 8 vomits before admission. There was constipation for one day. Her menstrual cycles were regular. She had one full term normal delivery 8 years back.

On general examination she was found to be anaemic and dehydrated, tongue was dry and coated, pulse 120/min., respiration/32/min., B.P. 110/70 mm HG.

The abdomen was distended, tense and tender. The uterine margins were not made out due to distension of the abdomen, exact presentation and position was not made out and the foetal heart sounds were absent.

On vaginal examination, the external os admitted one finger and internal os was closed. The fornices were clear. There was no bleeding.

The diagnosis of pregnancy with intestinal obstruction was made and was treated conservatively. Investigations: Hb. 6 gms., TLC 17000/cumm, DLC P 90%, L 10%. Urine N.A.D.

With the conservative treatment of intestinal obstruction the abdominal distension subsided and general condition did not deteriorate. On 8-12-77 at 8 A.M. abdominal distension subsided and patient had passed motion. On abominal examination it was found that the uterine margins were not made out and the foetal parts were felt superficially and hence the diagnosis of rupture of the uterus was made and laparotomy was decided. The general condition of the patient was good. Laparotomy was done on the same day.

Abdomen was opened by median subumbilical incision. The peritoneal cavity was full of old blood and blood clots. The foetus of 28 weeks in a sac was also lying in the peritoneal cavity and was removed. The uterus was visualised and was enlarged to 20 weeks size. There was a complete tear in the upper uterine segment on the posterior uterine wall up to the fundus. There was a depression in the anterior wall of the uterus (partial inversion) as shown in Fig. 1. The placenta was densely adherent to the anterior and posterior walls of the uterus and no cleavage for separation could be found and hysterectomy was decided. Total abdominal hysterectomy was done. Abdomen was closed in layers after proper hemostasis. One unit of blood was given during operation. General condition was good after operation. Postoperative period was uneventful and she was discharged on 25-12-77.

Gross appearance—The uterus was 20 weeks size and there was a depression in the anterior wall where the placenta was attached causing partial inversion. There was rupture on the posterior wall of the upper segment in the centre. It was 5 cm. long and was extending up to the fundus. The uterine wall at the site of the rupture was thinned out considerably. The placenta was found to be larger and was attached to fundus, anterior and posterior walls and there was no plane of cleavage of placental seperation (Fig. 2).

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Histopathology: Invasion of myometrium by villous tissue and from partial to complete absence of decidua basalis. The histological picture was suggestive of placenta percreta.

Discussion

Spontaneous rupture of the uterus due to placenta percreta is extremely rare. Gordon Miller (1959) reported the incidence to be 7.1% while Shah and Mehta (1973) found it to be 4%. A few individual case records are reported in the literature, (Burke, 1951; Schuyler, 1952; Cuthbert, 1956; Dick and Devilliers, 1972; Choudhary and Mukherji, 1975 and Sehgal *et al*, 1976.

The salient features in the present case were acute pain in abdomen which was associated with vomiting and constipation; as the abdomen was distended the diagnosis of rupture uterus was missed because the patient was not in shock and hence the diagnosis of intestinal obstruction was made and conservative treatment was given. When the abdominal distension subsided then it was found that uterine contour was not made out and hence diagnosis of rupture uterus was made and immediate laparotomy was done.

In the present case, the rupture was on the posterior wall extending upto the fundus, the uterine wall at the site of the rupture was thinned out considerably. The placenta was large, thinned out and occupied most of the uterine cavity. In the management of the placenta percreta hysterectomy is an accepted treatment and was carried out in the present case and also by other authors with favourable results.

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See Figs. on Art Paper V