SPONTANEOUS RUPTURE OF THE UTERUS

(2 Case Reports)

by

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The diagnosis of rupture of the uterus is by no means always an easy one, especially when the onset is insidious and when all the classical signs and symptoms of rupture are not present. This is especially true when the accident occurs before the onset of labour.

Although rupture of the uterus of all types have been reviewed in literature time and again, there is the small, unusual and high risk group of patients, where rupture occurs spontaneously, before the onset of labour and without any apparent cause. Probably, hereafter such cases will be increasingly encountered due to the liberal use of Medical Termination of pregnancies.

Case 1

Mrs. S., 32 years old, an unbooked case gravida 4, para 3 was admitted at 7.00 A.M. on 5-10-1978 with 9 months' amenorrhoea and mild abdominal pain since the previous day. She had a bout of vaginal bleeding 12 hours previously after which pains subsided. She developed severe abdominal pain 4 hours prior to admission.

Her menstrual cycles were regular. She could not recall her LMP. She had 3 previous full term natural deliveries and her last child birth was 2 years ago. On examination, patient was conscious, cold and clammy with marked pallor and pulse rate more 132/mt. B.P. was 60 mm. Hg. systolic Cardiovascular and respiratory systems were clinically normal.

Abdominal Examination: There was generalised distension and tenderness of the abdomen. Uterine contour was not made out; foetal parts were felt superficially and foetal heart was absent; 100 C.C. of clear urine was catheterised. Vaginal Examination: Cervix: was uneffaced, Os admitted 2 fingers; presenting part was very high up and could not be made out.

A diagnosis of rupture uterus was made and after initial resussitative measures, laparotomy was done. The peritoneal cavity was filled with free blood, with the foetus and placenta lying free in the peritoneal cavity.

The site of rupture was on the posterior uterine wall, extending from the fundus, just posterior to the left Utero-tubal junction, downwards upto lower uterine segment. The cervix and vagina were intact.

Total hysterectomy with left salpingo-oophorectomy was done. Gross examination of placenta and uterus were unremarkable.

Histopathology showed destruction of myometrium along with vasodilatation and interstitial haemorrhage in the region of the rupture. Patient was discharged on the 12th postoperative day.

CASE: 2

Mrs. M, 25 years, gravida 2, Para 0, an unbooked case was admitted on 31-1-1979 at 11.30 P.M. with 8 months' amenorrhoea and vague abdominal pain for one day, accompanied by vomiting since the onset of pain.

Her menstrual cycles were regular and she could not remember her LMP. Her first preg-

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nancy ended in an abortion at the fourth month following which a curettage was done.

General Examination: Patient was very restless, pale, cold and clammy. Her pulse rate was more than 140/mt. and B.P. was 70/50 m.m. Hg. Her central nervous and respiratory systems were clinically normal.

Abdominal Examination: The abdomen was distended. Uterine contour was not clear. Foetal parts were felt superficially and foetal heart was not heard. Flanks were dull on percussion.

Vaginal Examination: The cervix was effaced and Os. was closed. 250 C.C. of clear urine was catheterised. Hb. 40% Urine: Alb: Nil. A provisional diagnosis of rupture uterus was made and 2 bottles of blood were transfused before doing laparotomy. The peritoneal cavity was filled with blood and clots. The foetus and placenta were in the peritoneal cavity. The rent in the uterus was irregular, situated in the posterior uterine wall. Subtotal hysterectomy was done. Half an hour after surgery, patient expired.

Discussion

Among the factors that predispose the uterus to rupture, the most common is the presence of a scar, particularly the one from previous caesarean section. The other predisposing factors which cause "apparent thinning and fibrosis of the myometrium" (Felmus, 1953) and therefore predispose to rupture of the unscarred uterus are previous curettage and obstetrical trauma (Sitaratna, 1975), infections and trophoblastic invasion of the myometrium.

Voogd (1956) has stated that 'ruputure occurring during labour usually involve the lower uterine segment and those prior to onset of labour are usually corporal'.

In the above reported cases, while the etiology in the first case was not known, the curettage following the abortion might have caused the damage in the form of weakened myometrium and hence the rupture in the second case.

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