RUPTURE UTERUS DUE TO OVARIAN CYST

(A Case Report)

by

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Rupture of the uterus is one of the most serious obstetric complications and in our country its incidence is high as compared to that in advanced countries. During the last 5 years (1974-1978), 48 cases of uterine rupture, mostly coming from outside, were treated in Eden hospital, among 42,940 deliveries—an incidence of 1 in 895. Incidently, during the same period, 48 cases of pregnancy with ovarian tumour or fibroid uterus were treated in this hospital, an incidence of 1 in 895. An interesting case of rupture uterus due to obstruction by an ovarian cyst is reported here.

Case Report:

Sm. S.R.J., aged 21 years, P1 + 0, was admitted on 15-3-79 at 3-45 A.M. for labour pain since 8 A.M. 14-3-79 and severe agonising pain since 12 noon which subsided at 4 P.M. She was unbooked and the E.D.D. was on 7-3-79.

She was referred to this hospital from a subdivisional hospital, 100 miles away as a case of "labour with acute abdomen". Earlier she attended a health centre nearby. She had a normal full term home delivery 2½ years back, female, alive.

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On examination: Nutrition—poor, pallor +, dehydration +. Pulse 120 per minute, B.P.—110/80 mm. of Hg. Heart Lungs—NAD. Per abdomen—uterus was of term size, outline irregular, generalised tenderness all over abdomen, foetal parts felt superficially, F.H.S.—absent. Per vagina, vulval oedema ++, os—fully dilated, membranes—absent, Caput ++, Vertex—R.O.P. Pelvis—adequate, liquor—bloodstained, Hb—9 gm%, Urine—albumin, sugar—nil.

Management:

She was resuscitated with I.V. fluid, Penicillin and Streptomycin started and requisition for blood was sent. Laparotomy was done at 6-45 A.M. The abdomen was full of blood, the foetus, placenta and cord were found completely extruded outside the uterus. The retracted uterus revealed a complete left lateral tear of the lower segment including cervix (Figure —. While placing the first pair of clamps for hysterectomy on right side, to our surprise an ovarian cyst (" x 4") was found impacted in the pouch of Douglas. Total hysterectomy with right sided ovariotomy and salpingectomy was done. Female still born baby weighed 3000 gms. She was given 2 bottles of blood postoperatively. Macroscopically it was a simple serous cyst.

Initial post-operative period was uneventful but she started having pyrexia with rigor (101°-104°F) from 8th day. Antibiotics were changed by Septran and then Mandelamine was added. Investigation on 26-3-79 showed blood T.C. 16000/cumm. Poly—80%, lympho—21%, mono—1%, Eosino-3%. Thick film—no malaria parasite. Urine culture—Pseudomona. Vaginal swab—coliform bacilli. Internal exami-

nation revealed a hard mass 2" x 2" behind upper third of vagina. Ampicillin Chloramphenicol combination along with Sterodin and Suganril controlled the temperature and reduced the mass considerably. She was discharged on 9-4-79 in good condition. Follow up—on 25-4-79—she was in good condition. The pelvic mass was absent.

Discussion

The possibility of uterine rupture due to obstruction by an ovarian tumour or subserous pedunculated fibroid is there, but the incidence is very rare. This case was diagnosed too late only at laparotomy. As the abdominal features were obvious for rupture uterus, adequate care was not taken to find out the cause of floating head or rupture uterus.

Unfortunately, this patient had no antenatal care and came to us when the benign cyst had already done its final mischief. Herein lies the importance of an internal examination on first antenatal visit or on second visit after gaining confidence of the patient so that appropriate measures can be taken at right moment if any pelvic tumour is detected.

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See Figs. on Art Paper I