CENTRAL RUPTURE OF THE PERINEUM

(A Case Report)

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An unusual case of central rupture of the perineum was seen and treated at Ludhiana Maternity Hospital, and because of its interesting clinical features, is presented.

CASE REPORT

Patient L. W. aged 26 years was admitted on September 13th, 1978. On admission the general condition of the patient was poor and she was bleeding from a perineal tear. The history showed that the patient, a full term primigravida, started getting labour pains around midnight of September 12. She was alone at home with her mother and a midwife was called in. At about 5.30 A.M. on September 13th, she was getting strong labour pains and delivered a healthy male baby. The midwife observed to her horror, that the baby had delivered through a tear in the perineum in the region of the anal opening and that the introitus was in tact (Fig. 1). The placenta also was delivered through this tear and not normally through the vaginal opening. There was severe postpartum haemorrhage. The midwife tried to stop this bleeding with a piece of cloth and rushed the patient to hospital. On admission the patient was exanguinated, in poor condition and still bleeding from the perineal tear. Her pulse was 142 per minute, B.P. 90/70 mm. of Hg and E.C.G. showed sinus techycardia. Locally, there was an irregular tear in the perineum near the midpoint, leaving a bridge of tissue across the lower part of the vagina in front (Fig. 2). The metal dilator (Fig. 2) showed the direction the baby took while being delivered head first.

As both spinal and general anaesthesia were considered dangerous, 1% Novocaine was used as local anaeshesia. The fourchettee, skin and tissue over the metal dilator (Fig. 2) was incised so as to convert it into a single wound, and it was now easier to see the extent of damage done. There were deep tears going upward on both sides of the vagina. The perineal body was completely torn and the levator ani muscles were lacerated and laid bare. Luckily the rectum was intact. Fine catgut sutures were put starting from the uppermost margins of the vaginal tears and continued downward to the perineum. This controlled a lot of bleeding. The perineum was then reformed in layers and the skin was stitched with cotton thread. One unit of blood was given. On completion of the operation the general condition of the patient considerably improved. Fifteen days later, except for a small raw area in the region of the anus (Fig. 3) the wound had healed. On 10-10-1978, patient was discharged cured. Three months later in January, 1979, patient was seen again and she was in perfect health with no complaints.

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Comments

This sort of rupture is rarely seen. Munro Kerr has described this type of injury. He believes it may be the result of excessive softness of the perineal body. It may also be result of a long perineum or an unsually rigid condition of the introitus. Haemorrhage is the real problem and delay might have cost the patient her life. It is easier to repair if the bridge of tissue is divided, as was done in this case. The parts are then approximated as in a third degree tear. Anaesthesia can also be a problem and satisfactory result was obtained in this case with local anaesthesia.

Conclusion

A case of Central rupture of the perineum is presented.

References

1. Munro Kerr's operative obstetrics Eighth Edition. The English language book Society and Ballieve Tindall P. 876.

See Fig. on Art Paper III