MIDTRIMESTER RUPTURE OF UTERUS DUE TO PLACENTA PERCRETA

by

COL. (MRS) NIRMAL AHUJA,* M.B.B.S., M.D.

Abstract

Two cases of rupture uterus in midtrimester due to placenta percreta are reported. Both these cases were treated in Dehradun at an interval of 6 years and belong to hilly tribes. One was a case of twin pregnancy of 24 weeks duration with one placenta normally implanted and the other caused fundal rupture of the uterus. Second case was a woman with 20 weeks pregnancy. Both cases survived after an emergency hysterectomy.

Introduction

Cutherbert (1956) reported a case of 43 years old 2nd gravida with rupture of uterus due to placenta percreta at 20 weeks gestation. Sitaratna (1975) reported a case of fundal rupture of the uterus in second trimester of pregnancy possibly because of placenta percreta, as histopathological examination was not done to confirm the diagnosis.

Compared to placenta accreta, placenta percreta is very rare. Miller studied 14 cases of placenta accreta and found only one of placenta percreta. Out of 622 cases reported by Fox there were 57 cases of placenta percreta.

CASE REPORTS

Case 1:

Mrs. P.B. aged 34 years, 7th gravida was admitted on 26-12-69 at 7.30 p.m. with pain in the abdomen since last 3 days after an amenorrhoea of 6 months. Pain started on the left side and spread to the whole of abdomen and was progressively increasing in intensity. There was no history of vaginal bleeding. Throughout the present pregnancy she had been having vague abdominal pain and felt her abdomen was bigger than expected at 6 months gestation. There was no history of curettage in the past.

Menstrual History: 4-5/30 days regular flow normal. Last menstrual period—6 months back.

Obstetric History: Had 6 full term normal home deliveries. Last child birth was 3 years back. No history of manual removal of placenta. No history of puerperal sepsis.

Examination: Thin, ill looking patient who was groaning with pain. Pulse 118/min B.P. 104/70 Temp. 98°F. Heart and lungs normal.

There was generalised fullness of the abdomen, more marked on the left side. The Contour of the uterus and its size are illustrated in Fig. 1. There was marked tenderness and guarding of the abdomen. Foetal parts could not be defined. Foetal heart sounds could not be heard. Bowel sounds were present. There was no free fluid in the abdomen.

Cervix was in axis of vagina, external os was closed. There was no fullness in the fornices. There was no blood on the examining finger.

Investigations: Hb 8.5 gms% TLC 18000/cmm Poly 80%, lympho 20%. Urine NAD, X-ray abdomen showed foetal parts of a single foetus. A provisional diagnosis of rupture uterus or torsion of an ovarian cyst with pregnancy was made and a laparotomy was performed.

There was free blood in the peritoneal cavity and a few clots of blood were seen over the fundus on the left side of the uterus, but exact source of the bleeding could not be defined as the uterus on the left side was extending upto the level of costal margin. To visualise the source of haemorrhage hysterectomy was done

*Associate Professor.
Obstetrics and Gynaecology, A.F.M.C. Poona.

Accepted for publication on 20-7-79.

and two foetuses (a male and a female) extracted. One placenta was normally implanted and could be removed without any difficulty, whereas the second placenta was firmly adherent was seen eroding through the uterine wall on the left side of the fundus. Subtotal hysterectomy was done. She made an uneventful post-operative recovery.

Figure 2 shows the irregular fundus of uterus due to erosion of placenta through the muscle of the uterus, hysterotomy incision and the foetuses placed side by side. Histopathological examination confirmed the erosion of placental villi into the myometrium Figure 3.

Case 2:

Mrs. A.S. 32 years old 5th gravida was admitted on 22-3-75 with vaginal bleeding and pain in the abdomen for 10 days after an amenorrhoea of 5 months. To start with pain in the abdomen was mild but became acute 4 days later when it spread to the whole of the abdomen. Menstrual History: 4-5/30 regular, flow normal. Last menstrual period 5 months back.

Obstetric History: 3 full term normal hospital deliveries and 1 caesarean section for transverse lie 4 years back. Patient had postoperative pyrexia for 7 days due to abdominal wound infection.

Examination: Patient looked ill and restless. Pulse 112/min, B.P. 100/60, Temperature 101°F. on abdominal examination there was generalised distension of the abdomen with fullness in the flanks. Abdominal wall did not move well with respiration. There was a midline subumbilical puckered scar. There was marked tenderness and guarding of the abdomen. An ill defined mass could be felt on external ballotment. Free fluid was present in the peritoneal cavity.

Cervix was pointing backwards, external os was closed. Uterus was anteverted but exact size could not be defined because of tenderness.

Investigations:. Hb 7 gm%, TLC 9800/cmm, P 70% L 28% M2%. Urine NAD. A provisional diagnosis of rupture uterus was made.

Laparotomy revealed about 2000 ml of free blood in the peritoneal cavity. A foetus of nearly 20 weeks size was seen floating in the pool of blood. There was an irregular rupture of the uterus involving whole of the fundus, with part of the placenta and membranes protruding through it. Part of the placenta was deeply adherent to the uterine wall and could not be removed. The previous classical caesarean scar was free. A subtotal hysterectomy was performed. Postoperative period was uneventful.

Fundal rupture with membranes, part of the placenta and foetus are shown in Fig. 4. Histopathological examination of the area where placenta was pathologically adherent revealed muscular erosion by the villi which is shown in Fig. 5.

Discussion

These two cases reported were in their late thirties and were of high parity as has been observed by others. In one of these cases there was no contributory factor for morbid placental adhesion, though in the second case there was history of previous caesarean and post operative infection. Pain was the main presenting complaint. In the first case she had discomfort throughout the pregnancy; whereas in the second case pain was associated with the onset of rupture. As reported by others the rupture occurred at the fundus in both the cases. As the general condition of both these patients was poor, a subtotal hysterectomy was resorted to and they made an uneventful recovery.

References

1. Cutherbert, K. J. R.: J. Obstet. Gynec. Brit. Emp. 63: 243, 1956.
2. Fox, H.: Obstet. Gynec. Survey. 27: 475, 1972.
3. Pettit, M. and Mitchell, N.: Am. J. Obstet. Gynec. 58: 1201, 1949.
4. Sitaratna, A.: J. Obstet. Gynec. India. 25: 705, 1975.

See Figs. on Art Paper II-III