RUPTURE OF UTERUS AND BLADDER WITH ESCAPE OF FOETUS INTO THE BLADDER

(A Case Report)

by

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The anatomical proximity of the bladder to the lower segment of the uterus and the cervix makes it susceptible to any sort of injury, specially during pregnancy and labour. In obstructed labour, along with the stretching of the lower segment, stretching, odoema, thinning, and ecchymosis of the bladder is common, but rupture of the bladder is extremely rare. Here we describe a case where not only did the uterus and bladder rupture, but the baby was retained alive in the bladder. The first case of this type reported, was by Devi (1962) and then by Bird (1964) and Gogoi (1968). Rama Murthy reported 2 more cases in 1972. Therefore, in all 9 such cases have been reported in literature.

CASE REPORT

Mrs. S. R. aged 28, Para-III (1st FTND, 2nd LSCS, 2 years back for transverse lie) was transferred from a peripheral hospital on 4-11-1979 as a case of threatened rupture. The total time lapse involved in the transfer was about 2 hours.

ON ADMISSION

The patient was pale, dehydrated, perspiring from her face and had an apprehensive look, i.e. she had all the signs of maternal distress. Hb. was 8 gm.% Pulse 140/min. and BP 100/70. She was conscious, and gave a history of being in labour since 16 hours and having ruptured her membranes 12 hours before. She added that she was getting violent and painful contractions, which had decreased in intensity since the last 3 hours. She did not feel anything giving way, nor could she tell us about foetal movements.

On abdominal examination the usual contour of the uterus was lost. There was a slightly irregular mass about 30 weeks in size which could be felt indistinctly and was considered as the uterus. There was another firm, roundish mass, about 4" x 4", in the right hypochondrium.

On vaginal examination, the vagina was dry and hot, the cervix was 5 cms., loose and hanging, the foetal skull was palpable but high up, membranes were absent and there was a continuous trickle of blood.

On catheterization, only 10-20 cc of fresh blood was obtained. A tentative diagnosis of rupture uterus with a bladder injury was made and the patient was taken for an exploration after resuscitative measures.

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A subumbilical midline incision was made. As the peritoneum was about to be incised, we found that it was stretched, ecchymotic, and had a peculiar dull sheen unlike the peritoneum. Surmising that it could be the bladder, the skin incision was extended 3½" above the umbilicus, and the peritoneal incision was accordingly taken higher up.

On opening the abdomen there was not much of haemorrhage. The upper mass felt on abdominal palpation was actually the uterine fundus and body which was now lying below the liver. A ragged rent in the lower segment could be seen. Only one foetal limb (foot) was visible through another small rent in the lower mass, just above the level of the umbilicus. (Fig. 1). Thinking that this was the stretched lower segment, this rent was extended and surprisingly alive but asphyxiated baby weighing 3 Kg. was removed, and the umbilical cord was traced to the placenta which was lying in the main body of the uterus. To our surprise, the Foley's catheter was found from the place where we had just removed the foetus. It was then surmised that the stretched lower segment scar, along with the stretched base of the bladder must have given way, and the baby expelled into the bladder. After the disturbed anatomy and the extent of damage was surveyed, a decision for subtotal hysterectomy was taken as the unsalvagable uterus had shreded and gangrenous edges, and only a small tag posteriorly (about 2") attached it to the lower segment. The thinned out and irregularly torn remnants of the lower segment and cervix were identified with great difficulty from the vaginal and bladder edges. The base and the dome of the bladder was so badly torn, that it was with utmost difficulty, that the devitalized edges were made out. On the left side the bladder tear was only ½" away from the left ureteric opening and on the right about 1" away. (Fig. 2).

A subtotal hysterectomy was performed, and the now freshened edges of the bladder were meticulously sutured with the help of a urologist in 3 layers with '000' atraumatic intestinal catgut, care being taken of the ureteric openings. There was some difficulty with the peritonization of the cervical stump, as the anterior bruised and torn peritoneal layer, defeated all attempts at identification. A suprapubic cystostomy was done and a Foley's catheter inserted. Simultaneously a Foley's catheter was passed through the urethra. Two corrugated rubber drains were put in either flanks and after a peritoneal lavage the abdomen was closed in layers.

Post-operatively the patient had pyrexia for 4 days and developed diarrhoea on the 6th day. Vaginal examination did not reveal an abscess or pelvic masses. This was treated conservatively with Lomotil and I.V. (Metronidazole). The abdominal drains were removed on the 3rd day, the suprapubic catheter on the 14th day and urethral catheter on the 21st day. The residual urine was 20 cc and no vesicovaginal fistula or stress was revealed on speculum examination. The patient was discharged after 1 month and 10 days on urinary antibiotics, and called for a follow-up. So far she has failed to turn up.

Discussion

A stretched bladder is capacious enough to accept any part of the foetus such as the head or the whole of the foetus. The proximity of the bladder to the lower segment makes it more vulnerable to this type of injury. In our cases both etiological factors viz. a prolonged labour and a previous lower segment scar were responsible. In this hospital, this was the first case, where the whole of the baby was not only retained in the bladder but was found alive.

A case of rupture uterus with rupture bladder with the escape of live foetus into the bladder has been discussed.

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See Figs. on Art Paper I