SPONTANEOUS RUPTURE OF AN INTACT UTERUS AT 24 WEEKS OF PREGNANCY

(A Case Report)

by

KH. TOMBA SINGH,* M.B.,B.S., (Cal.), M.D.
S. SANGEETA DEVI,** M.B.,B.S. (Gau)
and
S. K. BHATTACHARYYA,*** F.R.C.O.G., F.I.C.S.

Spontaneous rupture of an intact uterus during pregnancy is a rare and unexpected accident while rupture of the uterus during labour is not so uncommon. Spontaneous rupture usually occurs due to yielding of previous scar on the uterus due to caesarean section. Previous rupture, myomectomy, surgery for inversion of the uterus, thinned uterine wall from previous manual removal of placenta, and/or following curettage operations.

Here is a case in whom uterine rupture occurred spontaneously at 24 weeks of pregnancy.

CASE REPORT

Patient R.D. 30 years Hindu female attended Gynaecological emergency on 30-6-79 at 10 a.m. with complaints of pain in the lower abdomen of 3 days and severe pain with vomiting since the morning following 5 months amenorrhoea. There was no history of trauma or interference of pregnancy. She attained menarche at the age of 14 years and her previous menstrual cycles were normal but they became irregular after the last child birth. Patient was not sure of her last menstrual period. She had 4 full term normal deliveries at home, last child being 5 years of age. She underwent dilatation and curettage operation in the District Hospital about 1 year back for irregular menstruation Just after the operation she was on intravenous drip for 48 hours and was discharged on the 5th day with an advice not to have further pregnancy because of her weak womb which may rupture any time if she conceives. She was advised for tubectomy but she refused the operation. Her personal and family history were not significant.

ON EXAMINATION

Patient was moderately anaemic and dehydrated but fully concious with pulse rate of 108 per minute, respiration 20 per minute and blood pressure of 80/?. Temperature was 36°C. Cardiovascular and respiratory systems were normal. There was no cyanosis and no oedema feet.

ABDOMINAL EXAMINATION

Abdomen was distended. There was tenderness all over the abdomen and slight guarding of lower abdomen more on the right side. Liver and spleen were not palpable and renal angles were free. Bowel sounds were absent and there was positive shifting dullness. Uterus was of 24 weeks size, normal contour, foetal parts were palpable but foetal heart sounds were not audible. There was no tenderness on the uterus.

VAGINAL EXAMINATION:

On speculum examination, cervix was healthy, long, os was closed. There was no tear, no injury and no bleeding.

**Assistant Professor.*
***Assistant Surgeon.*
****Professor and Head of Deptt. of Obstetrics and Gynaecology.*
*Regional Medical College, Imphal, Manipur-*795 004.

Accepted for publication on 15-4-80.

On vaginal examination, cervix long, os closed, presenting part was high up and fornices were free. There was no bleeding.

Patient was resuscitated for urgent laparotomy. General surgeon was consulted to exclude any acute surgical condition, but except for the diagnosis of internal bleeding no definite conclusion was drawn. Abdomen was opened by right paramedian incision under nitrous oxide and oxygen anaesthesia. Peritoneal cavity was full of blood clots. There was rupture of the uterus on the posterior wall about two inches from the midline and one and half inches below the fundus on the left side. There was a longitudinal slit of about three-fourth inch long with irregular margins. Oozing was still present from the wound, The tubes and ovaries were completely normal. Anterior hysterotomy was done and a foetus with placenta weighing 1.6 kg. was removed. There was no old clot in the uterine cavity. Digital palpation revealed relatively diminished thicknes of the uterine wall at the site of rupture. The rupture site was repaired by through and through stitches using 1/0 chromic catgut. The uterus was closed in two layers. Bilateral tubectomy was done by modified Pomeroy's technique. The abdomen was closed in layers. Patient received two units of O Rh positive blood during and after the operation, Immediate post-operative blood pressure was 120/90 mm of Hg. She had an uneventful post operative recovery and was discharged on the 12th day.

Discussion

Rupture of an intact uterus during 2nd trimester has been reported rarely. Presence of a weak scar was the commonest predisposing factor of rupture uterus during pregnancy.

Felmus *et al* (1953) after reviewing the literature has reported 121 cases including 5 cases of their own, Sitaratna (1975) has also added one fundal rupture during 2nd trimester. The possible cause of spontaneous rupture of the uterus in mid-pregnancy here was uterine perforation following vigorous curettage of the uterus during previous dilatation and curettage operation done about one year back which was treated conservatively. The findings on laparotomy at the site of rupture also confirmed the previous trauma to the uterus.

Comments

Dilatation and curettage being the commonest gynaecological operation, care should be taken during every step of this procedure. The conservative treatment of uterine perforation during D & C or D & E operation for non-sterilized patients requires a second look. The possibility of uterine rupture should be kept in mind when there is intraperitoneal haemorrhage in a pregnant patient with a previous history of uterine injury and infection especially so in a multipara.

Acknowledgements

Thanks are due to Dr. V. Hoping, M.S., Assistant Professor of Surgery, R.M.C. for his help in the management of the case and also to Medical Superintendent and Principal, Regional Medical College and Hospital for allowing us to use the hospital records and to publish this case report.

References

1. Felmus, L. B., Pedowitz, P. and Nassberg, S.: Obstet. Gynec. Surv. 8: 155 1953.
2. Sitaratna, A.: J. Obstet. Gynec. India. 25: 705, 1975.