

RUPTURE UTERUS DUE TO EWINGS SARCOMA PUBIC BONE

(A Case Report)

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Tumours of various kinds may arise from the walls of the false or true pelvis and so obstruct its cavity as to render labour impossible. Fibromas, osteomas, chondromas, carcinomas and sarcomas of the pelvis have been described, chondromas are the most common variety (Eastman, 1980).

Ewing's called the lesion "diffuse endothelioma" or Endothelial myeloma of bone. These names were based on the idea that tumour was derived from vasoformative tissue and that the tumour cells were, in the broadest sense, angio-endothelial cells. The Ewing sarcoma is a specific primary malignant tumour of bone which Ewing singled out in the early 1920's as a clinico-pathologic entity. The interesting point in presenting the case is its rarity and that too with pregnancy, leading to rupture uterus.

CASE REPORT

Mrs. K. 20 years aged was admitted in J.L.N. Hospital, Ajmer on 27-10-79 with a history of amenorrhoea 9 months, labour pains since 5

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a.m. on 26-10-79 and loss of foetal movements about 12 hours. The patient was handled by 'dias' at home.

Menstrual history: Menarche was at 12 years. Her past menstrual cycles were regular and her date of last menstrual period was about 9 months back, but exact date is not known. Obstetrical history: She had two full term normal home deliveries conducted by 'dias', last delivery was 3 years back.

Past history: History of fall 5 months back, since than she noticed pain in right lower limb and difficulty in walking.

General physical examination: Patient is a short statured, poorly built and nourished and moderately anaemic.

Pulse: 120/minutes feeble, low in volume
B.P. 100/60 mm Hg.

Respiration: 30/minute and laboured.

Nothing abnormal detected.

Investigations:

Hb. 9 gm%, TLC 8800/cu mm: Poly — 88%
Lymphos 10% E—2%. Bleeding time and clotting time—Normal, Urine—NAD. Blood Urea 43.3 mg% Sodium + 131 mg%, K 3.1 mg%, Urine culture Sterile. Vaginal swab culture. Klebsilla grown on culture sensitive to Gerramycin. Widal test +ve, E.C.G.—Sinus Tachycardia.

X-ray Pelvis (Fig. 1): A soft tissue swelling around right pubic bone is seen. There is onion peel appearance, periosteum cortex is moth eaten.

There is geographical destruction of pubic rami with surrounding sclerosis suggesting Ewing's sarcoma (Fig. 2). Microphotograph

shows compact broad sheet of small polyhedral cells of uniform morphology, with round dark nuclei separated by pale ill-defined cytoplasm. The tumour cells show peritheliomatous orientation around blood vessels, of poorly developed fibrovascular stromas. Areas of cells degeneration and necrosis are also present.

Abdominal examination: Uterine contour distorted uterus not acting, foetal parts. Superficial, head felt in right lumbar region and the foetal heart sound was absent. There was rigidity and tenderness in suprapubic region.

Per vaginal examination. Catheterization was done and clear urine drained. There was firm, diffuse, painless swelling of right labia majors and bulging in the right pelvic wall.

Cervix pushed behind symphysis pubis admitting one finger presenting part receded upwards.

Pelvic assessment: Sacral promontory touched with difficulty, right pelvic wall convergent due to swelling, left side wall average both the ischial spines prominent and out let was adequate.

Diagonal conjugate—10.1 cm, TCO-10 cm Bleeding per vaginum was present and exploratory laparotomy was decided.

Laparotomy

Abdomen opened up by sub-umbilical mid-line incision under general anaesthesia. There was free blood in the peritoneal cavity with placenta and membrane. Uterus was well contracted, there was transverse old rupture in lower uterine segment. The lower margin of rupture uterus was densely adherent to bladder. There was infected bilateral broad ligament haematoma. The swelling which was felt per vaginum was separated from the right side broad ligament haematoma. Caesarean hysterectomy done. Intestines were matted with pussy flakes. Abdomen closed in layers after proper haemostasis. Patient stood operation well.

Postoperative period: She had peritonitis, treated conservatively. On 14th post operative day she had burst abdomen. Resuturing was done on same day. She complained of continuous pain in the local swelling, which was radiating to right lower limb. On local examination it was found that the swelling increased in size involving vagina and bladder anteriorly. The swelling was variable in consistency, soft

to spongy and tender. X-ray pelvis was suggestive of osteomyelitis with abscess formation. Therefore, under general anaesthesia, the swelling was incised, but alongwith 2 cc pus necrotic material was obtained and that was sent for histopathological examination.

Histopathological examination revealed Ewings Sarcoma:

Patient was referred to Bikaner, Medical College and Hospital for radiotherapy as it was not available in this institution. Patient did not turn up for followup.

Discussion

It is not a very common lesion as already said, indeed it is much rare than osteogenic sarcoma (Jafee, 1968; Boyed, 1948). This is the first case report in this hospital, as a rupture uterus due to Ewing's sarcoma. There are many factors causing rupture uterus but bony tumours are rare causes of rupture uterus (Eastman, 1980).

The patients usually are between the age of 5 to 20 years (Boyed, 1948 and Jafee, 1968). Common site is inornate bone as described by Jafee (1968) There is often a history of trauma, followed shortly by pain, at first intermittent but later on continuous pain, fever and appearance of swelling (Boyd, 1948; Jafee, 1968). All these clinical features were present in our case. Sometimes, clinical features are suggestive of osteomyelitis, a disease for which this condition is some times mistaken both by the clinicians and pathologist (Boyed, 1948). In the start we too thought it to be a case of osteomyelitis. On palpation these tumours are large, soft friable and spongy at places. It was spreading medially in vagina and anteriorly towards bladder. Same described by Jafee (1968). Most of these patients run a slight rise in fever 101°F , with leukocytosis, anaemia and increased E.S.R. (Jafee, 1968; Boyed, 1948). When the

swelling is incised, a soft necrotic cellular material is obtained which can easily, be mistaken for pus (Boyed, 1948). Same happened with us on incising the tumour. The roentgen ray picture shows diffuse involvement of the greater part of the bone. There is a combination of bone formation and bone destruction. The new bone on the surface may present a laminated appearance like the layers of an onion (Fig. 1), but the diagnosis is always confirmed by histology (Boyed, 1948; Jafee, 1968), by its specific finding described in (Fig. 2).

Treatment described by Jafee (1968) and Boyed (1958) is best radiotherapy.

So we also referred the case for radiotherapy. Prognosis is always fatal (Jafee, 1958; Boyed, 1948). Survival rate is 3 years from the time of the local clinical complain (Jafee, 1968).

References

1. Boyed, W.: Text book of pathology, Ed. VII, 1961 Philadelphia, Lea and Febiger, pp. 1259.
2. Jack, A., Pritchard, Paul, C. and Macdonald: Williams Obstetrics Edition XVI, 1960, Printed reunited state of America pp. 714.
3. Jafee (Henry): Tumours and tumours condition of the bones and joints, Ed. November 1968 Philadelphia Lea and Febiger, pp. 350.

See Figs. on Art Paper IV