CASES SIMULATING RUPTURE OF THE UTERUS

by

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Introduction

Rupture of the gravid uterus is a serious complication. Hence diagnosis of rupture of the uterus is very important. Early diagnosis greatly influences the prognosis of both the mother and the baby. Not very infrequently the diagnosis is missed, specially in silent type of rupture cases. Under the heading of "Occult rupture of the uterus" Ingram *et al* (1952) have discussed the subject. Morrison and Douglass (1945) have also called attention to this quiet rupture where diagnosis is difficult. On the other hand, sometimes cases are met with during pregnancy where diagnosis is provisionally made as rupture of the uterus. The clinical symptoms and signs closely simulate as ruptured uterus, but correct diagnosis is only made subsequently either by laparotomy or post-mortem or by any other clinical means. Seven such cases have been reported here. The material has been collected from Eden Hospital, Medical College and Hospitals, Calcutta.

Case 1

Mrs. S.R.B. aged 35, carrying 32 weeks, 4th gravida was almitted for sudden and severe pain in the abdomen mainly on the right side over the fundus of uterus. On examination, general condition was fair. Pulse/Resp./104/20/ min. B.P. 100/60 mm. Hg. Temp. 100°F. A firm mass was palpable on the right side of the fundus which was extremely tender. There was some rigidity of abdominal muscles and presenting part of the foetus could not be detected, but F.H.S. was present. On vaginal examination, no bleeding detected and os was closed, presenting part was high up. The case was provisionally diagnosed as a case of silent rupture of the uterus and the mass foetal head. Since there was some doubt, X-ray of abdomen was taken and the foetus was noted as presenting by vertex. The patient was kept under observation and was treated with rest, Inj. pethedine hydro. and anti-biotics. After 24 hours there was definite improvement of her condition and temp. became normal. The case was later on diagnosed as **red degeneration of fibroid in the fundus of uterus.**

Case 2

Mrs. D.L.B. aged 40. 7th gravida carrying 32 weeks was admitted with sudden severe pain in abdomen, not simulating labour pain. On admission, patient's general condition was poor. Pallor ++ Pulse/Resp. 124/24 min. Blood pressure 90/60 mm. Hg. Per abdomen uterine contour could not be made out properly. There was extreme tenderness all over abdomen. Foetal parts were easily palpable. Abdominal musculature was very thin. Foetal heart sound was audible but very indistinct. Per vaginum, os closed, and there was slight blood stained discharge. On opening the abdomen there was **partial torsion of pregnant horn of bicornuate uterus.** The non-pregnant horn was size of 14 weeks pregnancy. On opening the uterus retroplacental blood clot was found. Baby was badly asphyxiated and

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premature. Revived but died on 3rd day after birth. No rupture was detected.

Case 3

Mrs, D.D., aged 34, 12th gravida, carrying 34 weeks was admitted with severe pain in abdomen for 2 days. Patient had classical caesarean section 20 years back during her first child birth. After that she had 6 vaginal deliveries, all at full term and 4 abortions. Patient was admitted in a state of collapse. Pulse 150/mm. respiration 30 per minute. Blood pressure 60/? mm. Hg. Extremities cold and clammy. Whole abdomen was distended and was extremely tender. F.H.S. was not audible. On vaginal examination, os was closed and slight serosanguinous discharge was noted. Disruption of previous scar was provisionally diagnosed and the patient was prepared for laparotomy. But before laparotomy could be done patient expired. During post mortem examination uterus found absolutely normal. Site of previous incision was absolutely healthy. There was **volvulous of pelvic colon with gangrene of the part.**

Case 4

Mrs. S. M. aged 36, 15th gravida carrying 36 weeks was admitted for pain in abdomen for 3 days which became intense since evening following an attack of severe cough and fever for 3 days. No labour pains started yet. Previous obstetric history, 8 full term deliveries and 6 abortions. On admission, patient's general condition as poor, pulse 130 per minute, respiration 26 per minute blood pressure 130/90 mm. Hg. Temp. 100°F. Patient was very pale and looked exhausted. Per abdomen, uterus 30 weeks' size, a separate mars felt at the left 30 weeks' size, a separate mass felt at the left corner of the uterus which was extremely tender. Foetus was presenting by vertex which was very high up, floating. Foetal heart sound was aulible. There was extreme tenderness all over abdomen. On vaginal examination, cervix tubular, and os was closed. No vaginal bleeding was present. Since the patient was 15th gravida provisional diagnosis was silent rupture of uterus and laparotomy decided. On opening the anterior sheath of rectus oedema of the surrounding tissue noted and beneath the sheath collection of blood clots was detected which extended below the muscles and was pushed into the abdominal cavity by rupturing the parietal layer of peritoneum. Rectus muscles on both sides but more on the left, were fragmented by oedema and collection of blood clots. Diag nosis of **rectus sheath haematona was made; uterus found normal.**

Case 5

Mrs. D.D. aged 19, primgravida carrying 39 weeks, was admitted with history of prolonged labour for 4 days. Patient was admitted in a state of collapse. Pulse was almost imperceptable. Blood pressure 60/? mm. Hg. There was sudden cessation of labour pains. Per abdomen, the feel of the uterus was hard, the contour could not be made out due to distention of this intestines. Foetal heart sound was absent. Cervix was almost fully dilated and head was low down.

Rupture of uterus was suspected, but since the patient as a young primigravida with head low down, and a dead foetus with severe infection was present, craniotomy was performed after taking the patient in O.T. and keeping every thing ready for laparotomy. But after delivery, exploration of uterus did not detect any rupture. Patient was treated conservatively with fluids, antibiotics and was discharged on 10th day, in good condition.

Case 6:

Mrs. R. M. aged 35, 8th gravida, carrying 32 weeks admitted for pain in abdomen for about 24 hours and slight vaginal bleeding for 8 hours. Patient was admitted in a state of shock. Pulse was almost imperceptible, oedema +, blood — pressure could not be recorded. Uterus 32 weeks' size, extremely tender and tense. The outline could not be properly made out. Foetal heart sound was absent and vaginal bleeding was present. Urine examination showed presence of moderate amount of albumin. Provisional diagnosis was rupture of uterus since the patient was a grande multi. Patient expired within an hour of admission. On postmortem examination, **uterus found intact but it was typically couvelaire uterus.** Huge retroplacental haematoma was detected.

Case 7:

Mrs. J.B. aged 35, 6th gravida carrying full term was admitted for severe pain in abdomen and prolonged labour (for 30 hours). She was given some injections outside (? pitocin) after which the abdominal pain increased. Patient was admitted in collapsed condition. Pulse 156/minute, respiration 35/minute. Blood pressure B.P. 80/40 mm. Hg. Temperature subnormal, extremities cold. Per abdomen uterus was tense and extremely tender. F.H.S. nil Guts distended. Per vaginum os 3 fingers dilated. Shoulder was presenting offensive pus like discharge was seen coming per vaginum. Rupture of uterus was suspected since the patient was grande multi, with transverse lie, and there was history of injection of pitocin given outside for prolonged labour. After resuscitation laparotomy was performed. No rupture was detected. Uterus found filled with pus after delivery of the foetus. Hysterectomy was done. Patient expired on 3rd post-operative day.

Conclusion

Seven cases simulating rupture of the uterus have been reported here. The clinical symptoms and signs of these cases closely simulated rupture of uterus. The danger of diagnosing these cases as rupture was unnecessary laparotomy. In case of red degeneration of fibroid or pyometra laparotomy is not usually desirable. Conservative treatment with other ancilliary measures will usually help in these cases. Since rupture of uterus is very serious complication, for diagnosing these cases one must be rupture minded, but before laparotomy, the possibility of those conditions reported here, should be kept in mind to avoid unnecessary laparotomy and with this the unnecessary risk to the patients.

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References

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