SPONTANEOUS RUPTURE OF UTERUS IN 3RD TRIMESTER OF PREGNANCY

by

R. N. BHOWMICK*

Spontaneous rupture in late pregnancy is not uncommon. Apart from classical wounds in uterus like upper segment caesarean section, hysterotomy and myomectomy with opening of endometrium, deep cervical tear, vigorous curettage, undiagnosed perforation of uterus, manual removal of placenta with injury to myometrium are the possible etiological factors. Rare causes are thinned out posterior wall of uterus due to ventrifixation of uterus and direct trauma to uterus by fall and blows. Leaving aside situation of placenta in the clasical scar of the uterus, placenta percreta has come into perview in recent literature since 1900 as a rare cause of spontaneous rupture. Placenta percreta, though uncommon, when associated with rupture of uterus posses a very urgent and fatal Obstetric catastrophae unless diagnosed promptly and tackled energetically.

CASE REPORT

I. Mrs. S. M. aged 36, 8th Gravida, with 6 living issues and one abortion, was admitted early morning on 21-2-76 in Sadar Hospital, Purulia, with history of amenorrhoea for 9 months, pain in abdomen for 6 days, rise of temperature, and loss of foetal movement for 6 days. She was treated by private local doctor in thana, with saline and sedative for 5 valuable days without relief of symptoms and ultimately referred to District Hospital. History of curettage of incomplete abortion in a Primary Health Centre could be elicited. Patient was conscious and having constant pain in abdomen. Her pulse was 132/min. B.P. 110/70 and temperature 102°F. Uterus was 34 weeks size. distension was marked and tenderness was also marked.

Intestinal sounds were sluggish. Outline of uterus could not be demarcated. Foetal parts were felt clearly in the right side but whole outline of foetus could not be made out due to tenderness and muscle guarding. There was no foetal movement and no foetal heart sound. Cervix was patulous and partly tubular. There was no active bleeding but foul smelling, coloured discharge was present.

With provisional diagnosis of spontaneous rupture laparotomy was performed with midline sub-umbilical incision on the same day. There was foul smelling and altered blood in the peritoneal cavity with putrification. Whole of the foetus and placenta were in the peritoneal cavity. Foetus was macerated and decomposed. There was rupture in the fundus of uterus with eversion of the edges. Uterus was well retracted and deviated to left side and was found behind the foetus. No evience of old perforation or unusual thinning could be seen in the fundus. Quick subtotal hysterectomy was done giving two bottles of blood and abdomen closed with difficulty due to distension. Patient died however, 4 hours after operation due to septicemia and shock.

II. Mrs. M.S. aged 30 years, 5th Gravida with 1 living issue was admitted in N.B. Medical College Hospital, Siliguri on 17-1-81 at 4 p.m. with history of amenorrhoea for 8 months, pain in abdomen and loss of foetal movement for 3 days. She was referred from Islampur Sub-Divisional Hospital of adjoining district where she was treated with fluid and sedative for shock. Obstetrical history showed 1 living issue out of 4 term pregnancies. In her first

*Assistant Professor. Department of Obstetrics and Gynaecology, N.B. Medical College and Hospital, Sushrutanagar: Darjeeling.

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labour a destructive operation with manual removal of placenta was performed. In 2nd and 4th pregnancies she had still-births at term.

On examination, patient was found to be anaemic, B.P. 130/80, pulse 120/min., and uterus 32 weeks size. There was distension of abdomen. No uterine outline could be ascertained due to tenderness. Foetus could be felt very clearly just under the skin. Cervix was found to be tubular with os closed. There was slight vaginal bleeding. Her shock deepened after admission. No immediate blood could be transfused due to shortage of 'B' Group RHO Negative Blood.

Laparotomy was performed at 8 p.m. Peritonium was found to be oedematous. Abdominal cavity was filled with free blood. Foetus was lying transversely and was of about 32 weeks size. Retracted uterus was lying behind the foetus. There was rupture in the fundus of the uterus more on the right side, placenta was found attached to the fundus more on left side. morbidly adherent with muscle coat with echymosis of serous coat. Attempt at separation could only lead to copious bleeding without effect. Quick subtotal hysterectomy was done as general condition was low. Patient received one bottle of RHO negative blood later. She had an uneventful recovery and was discharged on 10th post operative day.

Discussion

In both the cases there was history of uterine trauma in the form of curettage and manual removal of placenta. As no old perforation could be seen in the first case, grande multiparity with thinning of fundus and possible hyalinization of uterus could be the etiological factor. Manual removal of placenta and history of infection following destructive operation might be the cause for placenta percreta in the second case.

Summary

Two cases of spontaneous rupture of uterus at 36 weeks and 32 weeks of pregnancy in multipara are reported. Both had fundal rupture presented at 5 and 3 days after incident. In the first case cause of rupture was obscure, in the 2nd it was placenta percreta.