RUPTURE OF UTERUS AND BLADDER WITH FOETUS ESCAPING INTO THE BLADDER

by

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A Case Report

A booked patient Mrs. P. gravida 2, para 1 was admitted with labour pains and rupture of membranes of more than 16 hours duration She was complaining of inability to pass urine. Labour pains stopped one hour before admission. There was vaginal bleeding. She was handled by a Dai at home.

Past Significant History

She had delivered a still born baby 2 years back after forceps delivery. Following forceps delivery she had developed rectovaginal and urethrovaginal fistula which was successfully repaired after delivery. She had regular check-up in present pregnancy and was advised admission at 36 weeks of gestation, but the patient never came till she went into labour at home.

Clinical Findings on Admission

The patient was restless, dehydrated, pale, Pulse was 120/minute. BP 100/70 mm. Hg. Hb. 8 gms. Chest and lungs were clear. On abdominal examination there was an unduly prominent mass in lower abdomen extending upto umblicus, which gave an impression of tense distended bladder. There was another firm mass situated high up in right hypochondrium. Foetal parts could not be made out as the usual contour of full term pregnant uterus was absent. Foetal heart was absent. Vaginal examination was done in the theatre. Vulva and vagina was congested, oedematous, bleeding was present. Catheterization was attempted but failed, anterior vaginal wall was torn badly leaving external urinary meatus intact. Presenting part was high up, anterior lip of cervix drawn up and posterior lip of cervix oedematous hanging loose.

At laparotomy uterus was well contracted, empty, lying in right hypochondrium, beneath the liver. Bladder was stretched over the fetus. (Fig. 1). Placenta was lying in pouch of Douglas. Around 1000 ccs. of free blood was lying in peritoneal cavity. Foetus was delivered by breech. Further exploration revealed, posterior wall of bladder was torn vertically. Lower segment of the uterus was torn into pieces along with anterior vaginal wall. Patient's condition became critical on the table. Systolic blood pressure of 50 mm Hg. was recorded with thready pulse. Blood loss was around 2500 cc. Total abdominal hysterectomy with repair of anterior vaginal wall and posterior wall of the bladder was done, after ureteric and suprapubic catheterization. Five units of blood were given on the table. Extubation was done 5 hours after completion of the operation. Post operative period was uneventful. Patient was discharged after 3 weeks. She had vesicovaginal fistula which was repaired after 9 months in Christian Medical College Hospital, Vellore.

From: Christian Medical College Hospital, Vellore.

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See Fig. on Art Paper VII