SACCULATION OF THE PREGNANT UTERUS

(A Case Report)

by

(MRS.) P. N. MOHANTY

and

(MRS.) U. BAMBERY

Introduction

Sacculation may arise during any trimester of pregnancy and antenatal diagnosis is extremely difficult. Opinions vary regarding management. Posterior sacculation arising due to fixed retroversion is well recognised but anterior sacculation in the absence of morbid adhesion of placenta is difficult to explain.

Case Report

Mrs. N. S. aged 26 years $G_7P_6A_0$ was admitted at 16 weeks gestation with history of fall from a bicycle. Apart from severe anaemia (Hb-6 gm%), there was no significant finding and after observation and blood transfusion she was discharged to attend Antenatal Clinic regularly. She was admitted as an emergency for severe constant pain all over the abdomen, most marked below the umbilicus, and absence of foetal movements for 24 hours.

There was considerable tenderness below the umbilicus. Foetus was presenting as breech but the head could not be clearly palpaed. Foetal parts were felt superficially. Breech was well above the pelvic brim. F.H.S. was not audible.

It was not considered safe to allow vaginal delivery.

Quadrangular bluish areas were demarcated on its surface by venous sinuses. Foetal limbs were felt inside the sac. The sac was opened and a macerated male foetus extracted. Removal of the foetus exposed a huge, thin-walled amnion-lined space extending almost to the epigastrium. Bowel and omentum were adherent to the surface of this sac. Placenta was attached to its posterior wall and the cavity communicated with the open cervix below. The placenta was very large and morbidly adherent. Patient bled profusely from the cut edges of the sac and went into shock. She was revived by 4 units of blood transfusion and I.V. fluids. In view of her condition hysterectomy was abandoned and the opening in the sac closed by mattress sutures. The adherent placenta was not disturbed

On 18th post operative day she started soakage from the abdominal wound and it became apparent that a utero-parietal fistula had appeared. This was confirmed radiologically. In view of continuous bloody discharge, a decision for exploration and hysterectomy was taken.

At laparotomy the fistula was traced to the uterine cavity. A total hysterectomy was carried out and the patient made an uneventful recovery.

Acknowledgement

We are grateful to the Director, Medical and Health Services, Rourkela Steel Plant, for permission to publish this case report.

From: Ispat General Hospital, Rouerkela.
Accepted for publication on 29-4-86.