Fetus In Bladder – A Rare Sequelae Of Rupture Uterus

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A 25yr old, para 1, unbooked patient with h/o previous caesarean for CPD, presented in the emergency at term with leaking per vaginum and spontaneous cessation of the pains for 8 hrs after being in labor for 16 hrs. There was no associated bleeding per vaginum. On enquiring, there was history of an emergency previous caesarean for CPD requiring hospital stay for one month and resuturing of the abdominal wound.

On examination the patient was conscious, well oriented, dehydrated, pulse-140/min, regular, BP-110/80mmHg and had moderate pallor. She had post polio residual paralysis in her left lower limb. The Cardiovascular and respiratory systems were normal except for tachycardia. Per abdomen, there was an infraumblical median scar. The abdomen was uniformly distended. There was a generalised guarding and tenderness. The uterine height corresponded to 34 weeks, the uterine contour was apparently normal. The presentation was cephalic, uterine contractions and fetal heart sounds were absent. There was an ill-defined globular lump felt above the uterine fundus with a well demarcated groove between the two, the nature of which was not clear on clinical examination. Pelvic examination revealed a fully dilated cervix, absent membranes, vertex at – 2 station, caput & moulding ++ and no liquor. There was mid-pelvic & outlet contraction. On catherisation, 100cc of frank blood was obtained. Clinical diagnosis of obstructed labor with probably ruptured uterus involving the bladder was made and the patient was taken up for a laparotomy.

At laparotomy, there was extreme difficulty in entering the peritoneal cavity due to dense adhesions. The fetus was found lying in a uniform sac with a contracted uterus at the top. Neither utero-vesical fold nor the identity of the sac was made out at this stage.

A vertical incision was made in the anterior wall of the sac and the dead fetus was extracted as breech with placenta and membranes. Visualisation of foley catheter in the sac confirmed it to be the bladder. The uterus was found to be adherent to the posterior wall of the bladder. On separation of the uterus from the bladder by sharp dissection, a T-shaped rupture of the lower segment of the uterus, extending downwards vertically upto the cervix as well as a tear in the posterior wall of the bladder extending from just above the interureteric ridge till about 3cms short of the internal urethral meatus were appreciated. Both ureteric openings were away from the rent. Subtotal hysterectomy with bladder repair was done. Dual bladder drainage with routine care during the post-operative period was given but the patient developed a vesico-vaginal fistula on 11th post-operative day. Bladder drainage was continued for further 3 weeks. Patient was advised repair after 3months. She presented after 10 months for repair which was successfully conducted by abdominal route with the removal of the cervical stump.