NEGLECTED CASE OF RUPTURED UTERUS

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INTRODUCTION

Rupture of the uterus is a grave obstetric complication that is associated with high maternal and perinatal mortality. It may be complete which involve the entire uterine wall or incomplete, when a cover of viseral peritoneum or broad ligament is left over the uterus. It often involves scarred uterus, secondary to previous caesarean delivery[1]. The rise in cesarean section rate has increased the number of women exposed to the risk of complication. However unrelieved obstructed labour due to macrosomic or abnormal fetus remains the major cause of uterine rupture, usually occurring in grand multiparous patients[2]. A maternal and fetal outcome usually with an unscarred uterus is worse than in those with a previous uterine scar[3].

CASE REPORT

A 32 years old woman having no alive issue presented in her third pregnancy. She was unsure of date and her complaints were full term pregnancy with on and off leaking for 14 days, labor pains that remained for 7-8 days followed by loss of fetal movement for last 3 days and high grade fever for last 2 days. Pregnancy was confirmed by signs and symptoms. She had no antenatal check up, no investigation and no medication. Fourteen days back she started having vaginal leaking. Traditional birth attendant was called at home, but there was no history of any injection or IV fluid given by the birth attendant. Labor pains started after 3 days of leaking, contractions were moderate in intensity according to the patient. Labor pains remained for 7 to 8 days. Then there was loss of fetal movement and labor pains 4 days before admission. She had a constant generalized abdominal pain. She developed fever which was not associated with rigors, chills, nausea, vomiting or diarrhoea. There was no history of vaginal bleeding. Her first and second pregnancies were also complicated by prolonged labor and the outcome was fresh stillbirth. Patient was toxic looking at the time of examination, had labored breathing and was dehydrated. Her pulse was 110 beats per minute, temperature was 102^0F and respiration 58 per minute. Abdominal examination showed fundal height of 34 week, longitudinal lie with cephalic presentation, generalized tenderness all over abdomen. Fetal parts were easily palpable. Vaginal examination showed fully dilated cervix, vertex presenting, moderate caput and no bleeding or leaking. Clinical diagnosis of ruptured uterus was made. Patient was investigated, she was having neutrophil count of 92%, bed side coagulation time was 8 minute, PT, APTT were deranged and oxygen saturation was 93%. Patient was managed by giving oxygen, IV fluids and prepared for exploratory laparotomy. On opening peritoneal cavity, foul smelling, pus mixed blood about 1-1.5 liters drained out. Fetus and placenta were in peritoneal cavity. Fetus was extracted out as cephalic, skin of fetus was peeling off and it was 3 kg female baby with no gross anomaly. The uterus was ruptured in the lower segment extending more toward the right side with irregular and necrosed margins. There was a collection of pus along with blood on the right angle of uterus. These operating findings were suggestive of rupture of more than 24 to 48 hours. Uterus was repaired with great difficulty due to fragile irregular edges especially on its right angle. Hemostasis was secured and abdominal cavity was washed with normal saline. Post operatively the patient was kept on triple regimen antibiotics and high protein diet. Hower fever did not settle and her antibiotics were changed according to culture and sensitivity of blood. Stitches were removed on 10^{th} post operative day and she was discharged on 11^{th} post operative day with counselling regarding future pregnancies and hospital delivery.

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DISCUSSION

Rupture of pregnant uterus is a catastrophic obstetrical complication, being one of the most common causes of maternal mortality and morbidity in developing countries. Though scarred uterus secondary to previous caesarean delivery is one of the commonly recognized risk factors for rupture of uterus, other risk factors are prolonged / obstructed labor, grand multiparity, macrosomic / hydrocephalic fetus, trauma, injudicious use of uterotonic drugs, labor dystocia, intrauterine manipulations such as internal podalic version and breech extraction, mishandling by trained / untrained TBA, malpresentations and instrumental delivery[4].

The frequency of rupture uterus in developing countries is about 1 in 700 deliveries. In these settings essential obstetric care is lacking due to illiteracy and ignorance. The majority of the population living in rural areas has limited access to essential obstetric care, therefore the frequency of life threatening obstetric complications including rupture of uterus is higher in these nations[5]. Prolonged obstructed labor is another important risk factor for uterine rupture. This is mostly due to macrosomic, malformation and malpresentation of fetus. Violent uterine contraction against obstruction often leads to uterine rupture. The higher frequency of rupture has been observed in multiparous women in studies from developing countries. Whether the ruptured side should be repaired or hysterectomy performed would depend on various factors and should be individualized. In a woman desirous of further fertility, it would be justifiable to repair if her general condition permits, but in the majority of cases especially in a multipara or a diseased uterus, a timely and quick hysterectomy along with cardiovascular resuscitation would help in avoiding a potential mortality.

In our case we repaired the uterus as the patient was stable vitally, was not bleeding heavily and she had no alive issue. Many women die during resuscitation or during surgery[6]. This highlights another loop-hole on the provision of maternity services in the developing world and measure to ensure timely transportation to the tertiary care facility should help reduce this delay.

CONCLUSION

Neglected cases of obstructed labour are still seen in our country due to poor maternity services. There should be a higher degree of suspicion of ruptured uterus in such cases and emergency laparotomy should done as we did in our case. We repaired the uterus as she had no alive issue, otherwise removal of infected and damaged uterus is the best option.

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