Case Report

Spontaneous rupture of uterus in primigravida

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Abstract

Primigravida, Married since 1yr. No history of hypertension, diabetes mellitus, bronchial asthma. There was no previous surgery. On examination patients general condition was good. Pulse was 110 beats per minute. Her blood pressure was 120/80 mm of mercury. Respiratory rate was 16 per minute. On CVS examination S1 S2 were normal. On RS examination chest was clear. On per abdomen examination. Fundal height of uterus was 34 to 36 weeks Cephalic presentation with fetal head fixed. 2 to 3 Contractions was present lasting for 15 to 20 seconds in 10 min. Tenderness was present. Fetal heart sound was 140 beats per minute regular. Per speculum and per vaginal examination was not donepatient was posted for emergency lower segment caesarean section and was found to have upper segment uterine rupture, which was sutured after delivering the baby. Both mother and baby were stable post operatively.
Keywords: ruptured uterus, upper segment, primigravida.

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INTRODUCTION

Ruptured uterus is a catastrophic obstetric complication. It is an unexpected, relatively uncommon occurrence in general obstetric population which must be diagnosed and treated (Leung *et al*;1993(;Phelan *et al*,1998).The commonest risk factor for rupture uterus is previous caeserian section in scarred uterus and cephalopelvic disproportion in unscarred uterus (Chen *et al*,1995) Incidence of rupture in primigravida with unscarred uterus is 0.03 to 0.08%.It is extremely rare in unscarred uterus with mortality rate ranging between 1 to 13% and perinatal mortality between 74 to 94%.

CASE REPORT

Mrs XY aged 25yrs was admitted in Bharati hospital on 23/3/15 with complaints of : Pain in abdomen since 4 hrs**.** Bleeding per vaginum since 2hrs**.** There was no history of leaking per vaginum of decreased fetal movement. Menstrual history. Lmp was not known to the patient but according to first trimester sonography she as 39 weeks of gestation.

Obstetric history: Primigravida, Married since 1yr.

No history of hypertention, diabetis mellitus, bronchial asthma. There was no previous surgery. On examination patients general condition was good. Pulse was 110 beats per minute. Her blood presssure was 120/80 mm of mercury. Respiratory rate was 16 per minute. On CVS EXAMINATION S1 S2 WERE NORMAL. On RS examination chest was clear. On per abdomen examination. Fundal height of uterus was 34 to 36 weeks Cephalic presentation with fetal head fixed. 2 to 3 Contrations was present lasting for 15 to 20 seconds in 10 min. Tenderness was present. Fetal heart sound was 140 beats per minute regular. Per speculum and per vaginum examination was not done.

INVESTIGATION ON ADMISSION

Haemoglobin 12.6 gm %. Tlc count 14,300/cumm. platelet count 2,45. Random blood sugar 73mg/dl. HIV non reactive. HbsAg negative. BLOOD GROUP A+VE. Ultrasonography. 1st trimester: Sliuf with gestational age of 12Weeks 4 Days. 3rd Trimester: Sliuf of 30 Weeks 2 Daysin Cephalic Presentation, AFI-10.5Cm, Placenta–Anterior Wall With Its lower Edge About 4cm Away From Internal OS. Immediately patient was taken for caeserian section. Intraoperatively there was upper segment uterine rupture measuring aroung 4*4 cm with placenta coming out through it. There was no

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haemoperitoneum. Immediately baby was delivered vertex through uppersegment rent, baby cried immediately after birth. it was male baby weighing 2.1 kg. Placenta and membranes delivered completely.

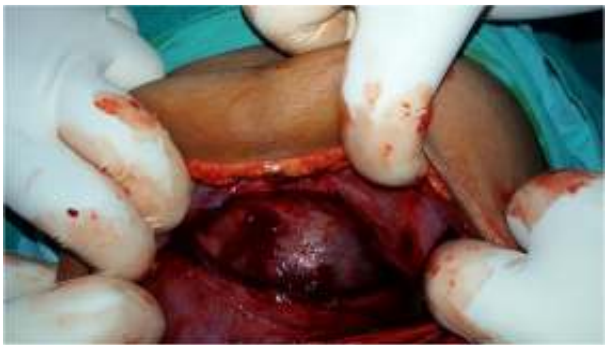

Figure 1

Upper segment uterine rupture was sutured by vicryl no 1 in 2 layers. haemostatis was achieved. Abdomen closed in layers. Post operatively patient was stable her general condition was fair, her pulse was 82 / min, bp was 110/80 mm of hg, abdominal girth was maintained and urine output was clear. Patient recovered well. There was no other complication intraoperatively or post operatively. Patient was discharged after 10 days.

DISCUSSION

Uterine rupture is tearing of the uterine wall during pregnancy or delivery (WHO, 2005). It is one of the life threating obstetric emergency with significant effect on reproductive function of women. There are several risk factors for rupture of uterus like multiparity (Neilson *et al*; 2003), uterogenic drugs, placenta percreta (Topuz, 2004), intrauterine manipulations such as internal podalic version, cephalopelvic disproportion, forceful uterine contractions, malposition, malpresentation, multiple pregnancy, perforation of uterus during MTP, obstructed labor. Instrumental delivery, scarred uterus following operations like caeserian section, myomectomy, utriculoplasty. Impaired collagen synthesis have also been implicated either secondary to chronic steroid use or known collagen synthesiss disturbance uch as Ehlers Danlos disease which causes ruptured uterus. This patient had no previos intrauterine instrumentation or surgeries on uterus. warning signs og rupture uterus during pregnancy include:

1. Frequent and strong uterine contractions occuring more than 5 times in every 10 min or each lasting for 60 to 90 sec.
2. Bandl's ring formation.
3. Tenderness in lower uterine segment.
4. Vaginal bleeding.(Yap *et al* ;2001)

Following signs appeared after rupture of uterus: tachycardia occurs, other signs are tender swollen abdomen, bladder may also be obstructed, easily palpaple fetal parts, absent fetal heart sounds. The damage to uterus is sometimes beyond repair and hystrectomy is required to save patients life. Following signs appeared after rupture of uterus: tachycardia occurs, other signs are tender swollen abdomen, bladder may also be obstructed, easily palpaple fetal parts, absent fetal heart sounds. The damage to uterus is sometimes beyond repair and hystrectomy is required to save patients life. The author Oxum in his study divides uterine rupture into several groups:

1. A silent or quiet presents without initial dramatic signs and symptoms often only in rise in maternal heart rate pallor or slight vaginal bleeding.
2. A violent rupture is apparently almost immediately characterized by sharp pain following a hard uterine contractions, presenting part is no longer in pelvic rim and fetal heart rate absent. signs of shock appear suddenly.(Oxum; 1986).
3. Uterine rupture with delayed diagnosis is a condition that is not evident until patient is in a process of gradual deterioration.

CONCLUSION

We report this case to highlight the fact that although rupture uterus is very rare complication in primigravida, it can occur and it should be diagnosed and treated promptly and it should be included in differential diagnosis of shock during labour regardless of parity.

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