Ruptured Uterus in a Primigravida: Case Report

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Abstract

A case of ruptured uterus in a 30 year-old primigravida is presented. The patient went into labour at term and reported to a local maternity where it was discovered that the fetus had a breech presentation. The attending midwife decided to attempt an external cephalic version. Soon afterward, the patient developed generalized abdominal pains, dizziness and fainting attacks. Prompt referral, immediate resuscitation and urgent laparotomy saved the patient although it meant the end of her reproductive career.

Key Words: Uterus, Rupture, Haemorrhage, Primigravida. [Trop J Obstet Gynaecol, 2002, 19: 47-48]

Introduction

Rupture of the uterus is a serious emergency, posing a grave danger to both mother and child [1]. In the developed countries where there are adequate and excellent facilities for obstetric care, rupture of the uterus is a rare event [2,3]. In developing countries with poor facilities, high parity, cephalopelvic disproportion and an increasing incidence of previous uterine scars (caesarean section and myomectomy), this is a fairly common catastrophe [4,5,6]. The incidence of ruptured uterus at the University of Nigeria Teaching Hospital, Enugu, Nigeria was 1:500 deliveries in 1990 [4] and 1:188 deliveries in 1999 [7] showing a rising incidence. This, when compared with an incidence of 1:2500 deliveries [8] in developed countries, is unacceptably high. Ignorance, illiteracy and lack of formal education militating against acceptance of formal antenatal care, inadequate antenatal care and supervision in labour and injudicious manipulation by untrained attendants contribute to the high incidence [9,10]. Secondly, the deplorably poor socio-economic status of our people, coupled with the high cost of medical treatment in public and private health institutions, contribute to scare patients away from hospital, especially those that need specialist attention the most. This report describes a case of uterine rupture in a primigravid patient, caused by the inexperience of the attending midwife.

Case Report

Mrs. O. S., a 30 year-old primigravid, illiterate housewife, was referred from a community maternity centre on the 26th of April 1999 with a history of sudden onset generalized abdominal pains, dizziness and fainting attacks. She was a clinic defaulter but claimed that her antenatal care at the maternity centre was uneventful. She went into spontaneous labour at 40 weeks' gestation and reported to the maternity centre. The presentation was breech and the inexperienced attending nurse tried an external cephalic version but failed. Soon afterward, the patient experienced sharp abdominal pains, with dizziness and fainting attacks. She was then referred. She had a 5-year period of infertility before this pregnancy.

She was quite pale on examination, with tachypnoea, tachycardia and a blood pressure of 90/60 mmHg. Abdominal examination revealed diffuse tenderness, easily palpable fetal parts and absent fetal heart sounds. Abdominal tap yielded non-clotting blood. Immediate resuscitation with intravenous fluids and antibiotics were commended as preparation was made for an urgent laparotomy. She had two units of blood transfused before surgery, one unit intra-operatively and another unit after surgery. Operative findings included a ragged posterior wall uterine rupture, extending from the fundus to the cervix, a dead fetus lying freely in the peritoneal cavity which also contained two litres of blood. She had repair of the rupture and bilateral tubal ligation. Her postoperative recovery was uneventful.

Discussion

This case is reported because of its pathetic nature. Here is a woman who suffered infertility for five years, succeeded in achieving a viable pregnancy and ended up with uterine rupture, fresh stillbirth and bilateral tubal ligation, all due to the carelessness of the inexperienced attending nurse. This case is one out of thousands that occur daily in developing countries.

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Some controversy still exists among obstetricians as to the operative procedure of choice for ruptured uterus[6,11], but unarguably what is done is dictated by what the surgeon see at laparotomy[13]. Bilateral tubal ligation, as was done for this patient, was almost unavoidable as the rupture was quite extensive and terribly ragged. Although meticulous repair was carried out, there was serious doubt concerning the ability of that uterus to carry another pregnancy.

It has been clearly shown that uterine rupture contributes significantly to the high maternal and perinatal mortality seen in most developing countries [14,15]. This patient would have succumbed if not for aggressive resuscitation and prompt intervention. Most cases are preventable as evidenced in the one reported. The need for antenatal care and hospital confinement should be emphasized to the population through health education. Improvement in the educational and socio-economic status of our women are all important as they will be more aware when to seek medical attention.

Lastly, when trained midwives who have a clear knowledge of when they must send patients to hospitals are placed in every village, when postgraduate experience in obstetrics is given to all doctors who are likely to care for pregnant women, and when each region has a highly efficient, well-staffed central hospital, this rising trend of uterine rupture will abruptly drop and deaths from this grave obstetric emergency will cease.

References

1. Ojwang SBO, Bennum MM, Musila S. Uterine rupture due to road traffic accident. *East Afr Med J.* 1978; 35:14 - 15
2. Donald, I. *Practical Obstetric Problems.* 4th ed. London, Lloyd Luke, 1969 Pp 722.
3. Wright EA. Rupture of the gravid uterus at the University College Ibadan, Nigeria: A review of 134 Cases. Trop J Obstet Gynaecol, 1984; 4: 47-50.
4. Iloabachie GC. Agwu S. The increasing incidence and declining mortality of ruptured uterus in Enugu. *Obstet Gynecol.* 1990: 10: 306–311.
5. Megafu U. Factors Influencing Maternal Survival in ruptured uterus. *Int J Gynecol Obstet,* 1985: 23: 475–480.
6. Makinde OO, Akinyemi SA. Review of Ruptured Pregnant Uterus. *Trop J Obstet Gynaecol,* 1990; 8: 52–54.
7. Ibekwe PC. Ruptured Uterus at the University of Nigeria Teaching Hospital, Enugu Nigeria: A 5 year review. Obstetric Long Commentary for the Part 11 (Final) Examination, FWACS, October 1999.
8. Beazley JM. Maternal injuries and complications. In: Whitfield C.R (ed) *Dewhurst's Textbook of Obstetrics and Gynaecology for Postgraduates* 4th Edition. Blackwell Scientific Publications Oxford, 1986 pp 417–426.
9. Walton SM. Uterine Rupture in Kenya: A guide to prevention and early diagnosis. *East Afr Med J,* 1978; 55: 9-13.
10. Harrison KA. Maternal mortality: a sharper focus on a major issue of our time. *Trop J Obstet Gynaecol,* 1988, SE1: 1-13.
11. Onwudiegwu U, Okonofua FE. Comparison between subtotal and total emergency obstetric hysterectomies. *Orient J Med,* 1993; 5: 122-124.
12. Lawson JB. Sequelae of obstructed labour. In Lawson JB, Stewart DB (eds) *Obstetrics & Gynaecology in the Tropics and Developing Countries*. London, Edward Arnold. 1967; Pp 203-210.
13. Chukwudebelu WO, Ozumba BC. Maternal mortality at the University of Nigeria Teaching Hospital, Enugu: a 10-year survey. *Trop J Obstet Gynaecol,* 1988, SE1: 23-26.
14. Briggs ND. Maternal deaths in the booked and unbooked patients: University of Port Harcourt Teaching Hospital experience, *Trop J Obstet Gynaecol,* 1988; SE1: 26-29.