Ruptured Uterus in a Primigravida, Secondary to Abdominal Manipulation by a Traditional Birth Attendant: A Case Report

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Abstract
Rupture of the gravid uterus is a life threatening obstetric complication which is a rare event in the primigravida. We present a case of uterine rupture in a 34 year-old unbooked primigravida. She presented in labour post-term to a traditional birth attendant who carried out an abdominal manipulation to correct a suspected oblique lie. Soon afterward she developed severe epigastric pain and breathlessness and was referred to our center. Findings at operation included a live female baby weighing 2.9kg and 6 cm transverse posterio-fundal rupture. Repair of the uterine rupture was done without bilateral tubal ligation.

Key Words: Uterus, Rupture, TBA, Manipulation [Trop J Obstet Gynaecol, 2005, 22: 83-84]

Introduction

Rupture of the uterus is an obstetric catastrophe which is common in Nigeria and other developing countries[1,3,4]. The converse is the case in developed countries of the world where uterine rupture is a rarity due to adequate level of obstetric care [1,3,4]. It is one of the leading causes of maternal morbidity and mortality and fetal wastage in our environment [1,3,4,5,6].

The reported incidence of ruptured uterus in Nigeria varies from hospital to hospital with a range of between 1 in 93-500 deliveries [1,2,3,4,5,7]. These figures are similar to those reported from other developing countries.[6] In contrast, the incidence is between 1 in 1500 2500 deliveries in the developed world [8,11]. The factors responsible for the high incidence of ruptured uterus in our environment include prolonged obstructed labour, injudicious use of oxytocics; multiparity, rupture of a previous caesarean section scar, operative vaginal deliveries and trauma [1,2,3,4,5,7]. The remote factors responsible for ruptured uterus in the developing world include poverty, ignorance, illiteracy, traditional practices, aversion to abdominal delivery and non-utilization of available health services. [1,4,14]. We present a case of uterine rupture in primigravida due to abdominal manipulation by an untrained, illiterate, traditional birth attendant (TBA), which was managed in Nigerian Christian Hospital Aba, Nigeria.

Case Report

Mrs. C.J, a 34 year old unbooked primigravida presented in our center on 29th of April, 2002 with a history of severe epigastric pain and breathlessness. She went into spontaneous labour in the 43rd week of gestation and reported to a traditional birth attendant. The lie was said to have been oblique and the TBA carried out an abdominal manipulation to correct the lie which resulted in the above -mentioned symptoms.

On presentation she was anxious, dehydrated and distressed with pain. Her pulse rate was 88 beats per minute and her blood pressure was 120/60 mmHg. The respiratory rate was 24 cycles per minute. Abdominal examination revealed epigastric and bilateral hypochondrial tenderness and single fetus in longitudinal lie and cephalic presentation with a regular fetal heart rate of 134 beats per minute. Vaginal examination showed a fully effaced cervix with 4cm dilatation, absent fetal membranes and meconuim stained liquor. A clinical diagnosis of abruptio placenta with a live fetus was made to rule out ruptured uterus. Immediate resuscitation with intravenous fluids, analgesics and antibiotics was commenced as preparation was made for urgent exploratory laparotomy. Four units of blood were ordered but were not made available because the patient was a Jehovah's Witness.

Operative findings include, live female fetus weighing 2.9kg and a 6cm transverse posterio fundal rupture. She had repair of the uterine rupture without bilateral tubal ligation. The post-operative period was uneventful. She was counseled on the nature of her problem and was advised to book early in her subsequent pregnancies. She was also counseled on the need for her to be delivered by elective caesarean section in her subsequent pregnancies. She was also given a card detailing what was observed and done at surgery, and recommendation for subsequent pregnancies.

Discussion

The cause of uterine rupture in this case was trauma from abdominal manipulation to correct abnormal lie by

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a traditional birth attendant. The force used for this procedure must have been excessive. While external cephalic version at term by a trained personnel certainly has a place in modern obstetric practice [12,13], its use cannot be justified in a woman with prolonged pregnancy and history of liquor drainage, [12]. Moreover, with the right indication, it should be done by one with relevant skill and knowledge in the right environment. Uterine repair without bilateral tubal ligation was done for this patient because of her age, parity, the simple nature of her rupture and the need to preserve her reproductive function.

Moreover, in view of the high premium placed on child bearing and the high infant mortality in most developing countries, a strong case should be made for conservation of child bearing capacity,[9]. She was however counseled on the need for antenatal care and elective caesarean section as the patients with uterine rupture are least likely to return for obstetric care in the next pregnancy and labour.

Ruptured uterus is associated with high maternal and perinatal mortality.[1,2,3,4,5,7]. The fetus survived in this case because the rupture involved a relatively avascular portion of the uterus.

Prevention of this disaster requires availability and utilization of good antenatal and delivery care services, judicious use of oxytocics, careful selection of cases for trial of caesarean section scar, close labour monitoring, avoidance of difficult manipulative vaginal births, effective contraception, health education, female education and overall improvement in the socio-economic status of women [3,4,14].

References:

1. Roberts AO, Ekele BA. Ruptured Uterus: Halting the Scourge. Trop J Obstet Gynaecol, 2002: 19(1): 1-3
2. Iloabachie GC, Agwu S. The increasing incidence and declining mortality of ruptured uterus in Enugu. *J Obstet Gynecology*, 1990; 10: 306-311.
3. Faleyimu BL, Makinde OO, Ogunniyi SO. Rupture of Gravid Uterus in Ile-Ife, Nigeria. *Tropical Doctor*, 1990; 20(4):188-189.
4. Konje JC, Odukoya OA, Ladipo OA. Ruptured Uterus in Ibadan A Twelve year review. *Int J. Gynecol Obstet*, 1990; 32: 207-213.
5. Ghatak DP. Rupture of the uterus: A review of 146 cases. *Trop. Obstet Gynaecol*, 1990; 8(2): 41-44.
6. Phillys JA. Ruptured Uterus in Mulanje CCAP Hospital 1974-1982. *Tropical Doctor*, 1990; 20(4): 175-176.
7. Amata AO. Anaesthetic and intensive care management of rupture of the gravid uterus: A review of 50 cases. *Tropical Doctor*, 1988; 28(4): 214-217.
8. Ibekwe PC. Ruptured uterus in a primigravida: Case report. *Trop J Obstet Gynaecol*, 2002; 19(1): 47-48.
9. Ayangade O: Rupture of the uterus: 10 year review. *Trop J Obstet Gynaecol*, 1990; 8: 25-27.
10. Orji EO, Dayo AA, Malomo OO: Rupture of the pregnant uterus in an unbooked primigravida: a case report. *Trop J Obstet Gynaecol*, 2002; 19(1): 49-50.
11. Beazley JM: Maternal injuries. In: Whitfield CR (Ed), *Dewhurst's textbook of Obstetrics and Gynaecology for postgraduates*. Blackwell Science Ltd, London (5th Edition) 1995: 421-423.
12. Burr R.W., Johanson R.B.: Breech Presentation: Is external cephalic version worthwhile? In: Studd J. (Ed), *Progress in Obstetrics and Gynaecology*. Churchill livingstone London 1988; 12: 87-9.
13. Thornton J.G. External cephalic version: Is it still justified in developing countries: *Tropical Doctor*, 1985; 15(4):173-174.
14. Harrison K.A: Poverty, Deprivation and Maternal health-The 1995 William Meredith Fletcher Shaw Memorial Lecture. In: Studd J. (Ed), the *Yearbook of the RCOG*, RCOG Press London 1996: 33-44.