HERNIATION OF A GRAVID UTERUS THROUGH GIANT UMBILICAL HERNIA IN A NIGERIAN: Case Report

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ABSTRACT

A 35 year old grand multigravid lady with herniation gravid uterus at 35 weeks of gestation is presented. She was managed conservatively but went into spontaneous labour. She had emergency caesarean section and umbilical hernia repair with successful outcome for both mother and baby.

Keywords: Grandmultigravida, Herniation, Umbilical hernia.

INTRODUCTION

Umbilical hernia is common among black children but rare in adults. Herniation of gravid uterus through an umbilical defect reaching term is uncommon with few reported cases in the literature. We report a case presenting at 35 weeks of gestation.

A 35 year old unbooked $G_{10}P_{9}+^{0}$ 2 Alive was referred from a primary health facility on account of an abnormal looking pregnant uterus and wound on the umbilicus at 35 weeks of gestation. The umbilicus was said to have swollen and got ulcerated a week prior to presentation. There was associated foul discharge and bleeding from the ulcer with each fetal movement. The ulcer has continued to worsen despite regular dressings from the referral health facility. All her previous pregnancies were unbooked and deliveries were at home. She had umbilical hernia since birth and had never sought for medical attention.

Examination revealed a thin lady not in obvious distress. She was afebrile, moderately pale, anicteric and no pedal oedema. Her blood pressure was 110/80 mmHg and her pulse rate was 110 beats per minute. She had a giant umbilical hernia with ulceration at the summit. The ulcer measures about 10 by 10 cm with sloping edge, covered with purulent discharge and slough. There was associated reddening, oedema and hyperpigmentation of the margins. The rectus abdominus were atrophic and pushed to the sides. The uterus was prolapsed into the umbilical defect and was easily palpable. The uterine size was estimated to be about 36 weeks of gestation with a single fetus in longitudinal lie and in cephalic presentation. The fetal heart tones were present and normal. The cervix was high up that the examining finger could not reach it. An urgent ultrasound scan showed a singleton live fetus at 35 weeks of gestation with anteriorly placed placenta.

An assessment of a grand multipara at 35 weeks of gestation, uterus prolapsed through the umbilicus, umbilical pressure sore, anaemia and sepsis was made.

She was admitted to the antenatal ward for resuscitation, fetal monitoring and investigations. Blood sample was also taken for blood profile, chemical and serological analysis. A wound swab was sent for microscopy, culture and sensitivity. Her packed cell volume was 27%, the platelets and leucocytes count were within normal limit. Her serum electrolytes were also normal. VDRL and retroviral screening were negative. The swab culture however, yielded significant growth of pseudomonas aeroginosa sensitive to ceftriazone among others.

She was placed on heamatinics, daily parenteral ceftriazone and twice daily dressings of the ulcer with eusol and sofratulle. The decision was made to conserve the pregnancy to term and deliver her by elective caesarean section in addition, she was counseled for bilateral tubal ligation which she consented to.

A week after admission she went into spontaneous labour and had emergency caesarean section and bilateral tubal ligation via a longitudinal midline incision on the hernia extending to the lower abdomen. The caesarean section was carried out through a transverse lower segment uterine incision. A live male baby

weighing 2.1 kg with APGAR scores of 8 and 10 in one and five minutes respectively was delivered. Layered closure of the abdomen with excision of redundant skin/ulcer and umbilicoplasty was carried out.

Her postoperative period was uncomplicated. Both mother and baby were discharged a week later and are since lost to follow up.

DISCUSSION

Umbilical hernia is common among children in our environment[1, 2] however umbilical hernia among adults is rare so is protrusion of pregnant uterus through an umbilical defect. [3,4].

Herniation of the gravid uterus is not a common occurrence because it is suggested that as the gravid uterus enlarges, it becomes bigger than the aperture of the hernia and therefore becomes difficult to enter the hernia sac[4, 5]. With repeated pregnancies however, there tend to be divarication of the recti in an already defective anterior abdominal wall the enlarging uterus easily enters the hernia l sac. This hypothesis may explain the situation of this patient. The more common herniation of the gravid uterus through incisional hernias due to compromised healing of the rectus sheath may buttress this point [6,7].

The few reported cases of herniation of gravid uterus in third trimester occur in high parity women[4]and also in other conditions that weakens the integrity of the anterior abdominal wall. [6,8].

Careful management is very important due to the serious complications that are associated with the condition. Gravid uterus Herniation is associated with potentially serious complications. [5, 6, 9,10]. Our patient presented with ulceration of the overlying skin that bleeds with fetal movements.

The management poses serious challenges especially when complications such as mechanical strangulation, obstruction, incarceration or ulceration occur. There is no standard management format and therefore management of such rare cases has to be individualized based on the knowledge of changes in pregnancy, fetal development and parturition. A conservative approach using abdominal binders and manual reduction during the antenatal period and labour has been described with varying success [5, 8]. Antenatal surgical correction of the hernia has also been described with some success[6]. This approach is however associated with significant risk to the pregnancy as well as added risk of anaesthesia [6]. In addition the gravid uterus may hinder successful repair. The occurrence of life threatening complication at term or near term warrants emergency caesarean section to save both baby and mother, however if this occurred early in pregnancy, then repair of the hernia with continuation of the pregnancy is an alternative choice. This patient went into preterm labour probably triggered by the umbilical ulceration and local sepsis and therefore had a successful emergency delivery.

Caesarean section in such a case may be complex because of dextro –rotation of the uterus. The lower uterine segment incision may wrongly be placed with grave consequences. An experienced surgeon should undertake such procedure in order to avoid untoward injuries [6].

Pregnancy and multiparity is common among females in our environment. This is coupled with serious challenges in antenatal care and labour supervision. In consideration of these, an early elective repair of umbilical hernia in the young female is advocated to prevent potential complications during pregnancy.

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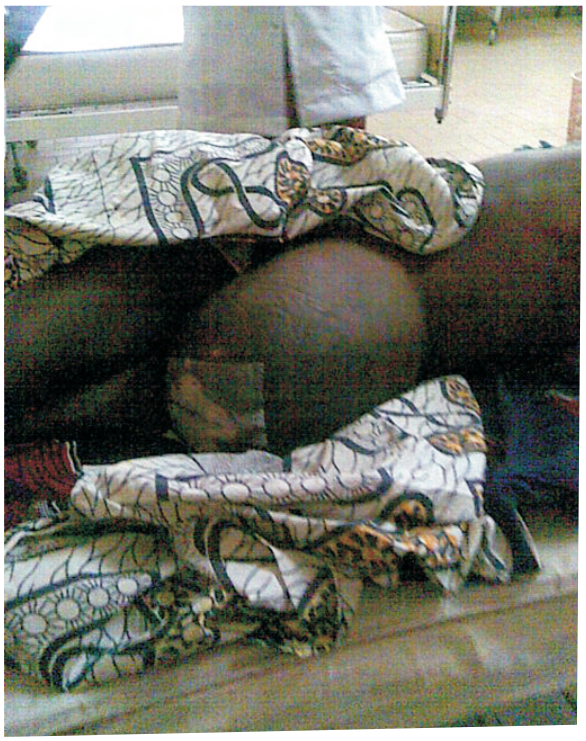
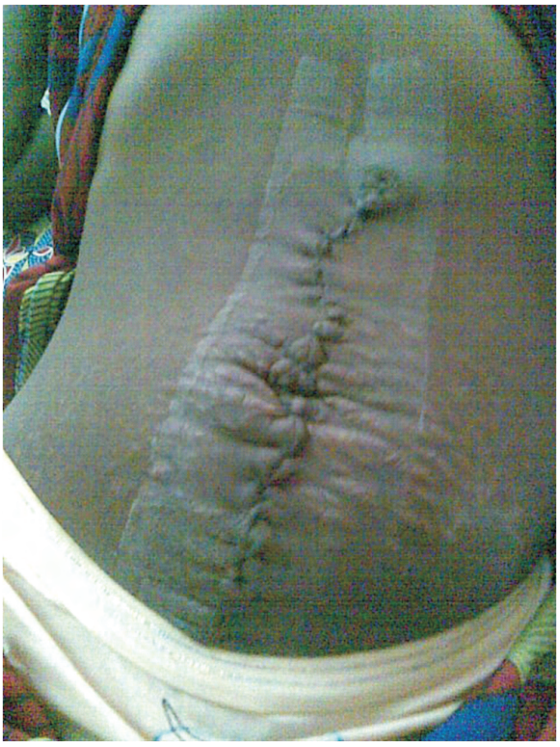


PIX 1 BEFORE SURGERY



PIX 2 AFTER SURGERY