Original Research Paper

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Gynaecology

A RARE CASE OF PUBIC DIASTASIS FOLLOWING VAGINAL DELIVERY

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ABSTRACT

INTRODUCTION: Parturition induced pelvic instability is a rare condition with incidence of symphyseal rupture after vaginal delivery ranging from 1 in 600 to 1 in 3000 deliveries. We present a case of P3L3 with complaints of heavy blood loss and pain in the pubic region following vaginal delivery.

CASE REPORT: A 26 yr old P3L3 referred from PHC to Tertiary care hospital with complaints of heavy blood loss and pain in pubic area after vaginal delivery. On examination,P/A-uterus well retracted,L/E- Pubic-symphysis separation noted,urethra and clitoris deviated from mid line,detached from pubic-symphsis. Right vaginal wall along with pelvic fascia detached from right ischiopubic ramus.Reconstructive surgery(open reduction and internal fixation)done by approaching pubic symphysis anteriorly.

KEYWORDS : Pubic Symphysial Rupture,reconstructive Surgery.

INTRODUCTION:

Rupture of symphysis pubis during delivery is very uncommon.only a few cases of diastasis have been reported in the literature in women without preceding antepartum symptoms.

Risk factors include elderly primigravida , macrosomia,obstructed labor,bony abnormalities of the pelvis,hyperabduction of thighs, instrumental deliveries.

CASE REPORT:

Mrs R,26 yrs old P3L3 unbooked case referred from yemmiganuru to Government General Hospital,Kurnool with C/O heavy blood loss following delivery ?genital tract trauma(cervical tear). As per history by ASHA ,she had difficult vaginal delivery , fundal pressure given,no usage of instruments, and she delivered an alive female child of wt 3.5 kgs,placenta removed intoto.encountered PPH, which couldn't be controlled by uterotonics and noticed genital tract trauma.An attempt to suture done,couldn't able to secure hemostasis. Pack kept in situ and then referred.

At the time of admission-
c/c,afebrile,dehydrated
pallor++
PR -110bpm
Bp-100/60 mm of Hg
RR-22/min
SpO2-98%with room air
P/A:uterus well retracted
L/E:pack insitu,urine output-adequate,clear
lab investigation revealed Hb-7.2 g%,
blood group –B positive,2 units blood transfusion done

FIGURE-1 photograph showing pubic symphyseal separation.

O/E-mons pubis–edematous.Pubic-symphysis separation noted, severe tenderness was elicited in the pubic symphysis on palpation. . Foleys catheter in-situ.

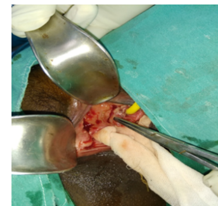
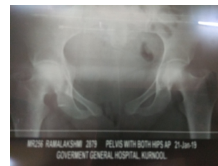


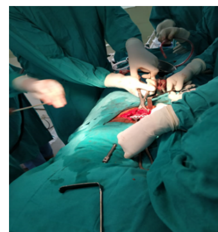
FIGURE-2 photograph showing bladder visible through space of retzius , urethra and clitoris deviated from mid line.

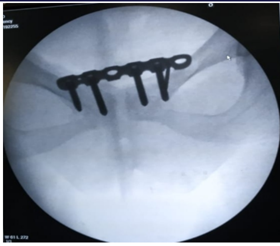
midline,detached from pubic-symphsis. Right vaginal wall along with pelvic fascia detached from right ischiopubic ramus .Anterior wall of the bladder visualised through the separated space of retzius.Cervix appears edematous.Lochia scanty.no foul smell.Left vaginal wall-normal.She was kept on antibiotics,analgesics and adviced for Immobilisation



anteroposterior X-ray of pelvis demonstrating symphsial diastasis measuring 5 cms While performing pelvic compression test ,which is positive,orthopaedicians adviced for pelvic compression belt.

Repeat X-ray was done after 3 weeks,as there is no significant reduction in the diastasis .Reconstructive surgery(Open reduction and internal fixation) was planned and performed. Anterior approach to pubic symphysis done.Symphyseal separation reduced and superior pubic rami plated anteriorly with reconstruction plate.





Intra operative anteroposterior Xray of pelvis following fixation of symphysis pubis using reconstruction plate with screws

- Patient had no urological symptoms and was discharged on post OP day 10 after successful voiding of urine. Follow up after 6 weeks,she reported with normal mobility with no urological symptoms.

- **DISCUSSION:**

Physiological peripartum symphyseal diastasis ranges from 3-7mm which occurs secondary to increased elasticity of pelvic joints induced by an elevation in circulating progesterone and elastin.This condition is usually asymptomatic but sometimes result in pelvic pain,impaired mobility,stress incontinence.

- Treatment of postpartum symphyseal rupture has traditionally been non-operative and conservative.In some cases,reconstructive orthopedic surgery has to be planned if there is no significant reduction and associated urological complaints.
- The management of subsequent pregnancy after plating of pubic symphysis depends on the method of delivery.If a vaginal delivery was anticipated,removal of plate is recommended before the pregnancy to allow pelvic expansion.Because subsequent vaginal delivery may cause recurrence of symphyseal disruption an elective caesarean section is recommended and plate removal is not required.

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