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BLADDER INJURY IN ASSOCIATION WITH UTERINE RUPTURE IN A GRANDMULTIPARA: A CASE REPORT

Gynecology

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ABSTRACT

Uterine rupture in pregnancy is a rare event and frequently results in maternal and/or fetal compromise. The susceptibility of a normal, unscarred uterus to rupture is less. As against the equal distribution of uterine rupture in case of scarred uterus during labour and the antepartum period, in a normal unscarred uterus the percentage of uterine rupture increases markedly during labour as compared to the antepartum period.

Though, increased rate of abortion, higher incidence of anaemia, higher twin pregnancy rates and malpresentations along with minor ailments like haemorrhoids and varicose veins have been found to be well associated and commonly seen with grand multiparity, the incidence of uterine rupture specially in association with bladder rupture has not been reported so commonly. We report a case of bladder injury associated with uterine rupture in a grand multipara female.

KEYWORDS

Grandmultipara, Uterine rupture, Bladder injury

INTRODUCTION

Uterine rupture is a catastrophic event during childbirth in which the integrity of the uterine wall is breached. There is full thickness separation of uterine wall in a complete rupture with expulsion of fetus and/or placental tissue into the abdominal cavity whereas in an incomplete rupture, the overlying serosa or peritoneum is spared. Grandmultiparity, malpresentations, breech extraction, neglected labour, oxytocin infusion and uterine instrumentation constitute the

predisposing factors for uterine rupture(1). Ever since Solomans in 1934 drew attention to what he called 'the dangerous multipara', grand multiparity has been recognized as a clinical entity in its own right. Rupture of the uterus is more common in a scarred uterus as compared to an unscarred one(2).This obstetric mishap is closely associated with fetal & maternal mortality as well as maternal morbidities such as bladder rupture, vesicovaginal fistula and rectovaginal fistula and psychological trauma. Even if the mother is saved from such a grave accident in her obstetric history, the above mentioned morbid conditions which occur as a sequelae of bladder injury have a marked adverse effect on the quality of life of the lady.

CASE REPORT

A 35 year old female presented to us with complains of amenorrhoea since 9 months and labour pains since 1 day with sudden cessation of pains since 2-3 hours. Patient was a sixth gravid with 5 live issues, all being full term normal uneventful deliveries at home. On admission, patient was in shock with 90 systolic blood pressure and weak thready peripheral pulse. Per abdomen examination revealed a uterus of 28-30 weeks size with loss of uterine contour. Fetal parts were felt with ease. Fetal heart sounds could not be localised clinically and on local examination of the perineum a dry and cyanosed hand of the fetus was seen coming out of the introitus. Laparotomy was performed and fetus along with placenta were found lying in the peritoneal cavity. A midline lower segment uterine rupture was present extending upto the cervix and involving the bladder. Subtotal hysterectomy was performed and bladder was repaired in two layers. Post operatively urethral catheter was kept in situ for 14 day. Patient was discharged from the hospital in satisfactory condition.

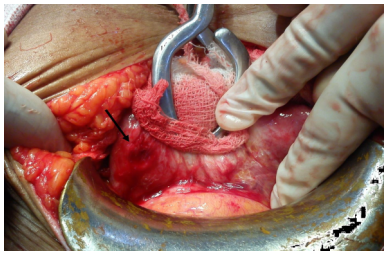

Figure 1-Image showing Rupture Bladder

DISCUSSION

Uterine rupture constitutes one of the most important causes of bladder injury in emergency obstetrics. In uterine rupture cases the common clinical signs of concomitant bladder injury are gross haematuria and meconium stained urine. Other rare presentations like vernixuria, urinary incontinence induced by vesicouterine fistulas, fever and urinary tract infections have also been noted. In vaginal birth after caesarean, bladder rupture has been reported(3),however bladder injury and uterine rupture can occur anytime during labour. Injury to bladder in association with uterine rupture after a normal spontaneous vaginal delivery at home has also been reported(4).

Unlike in the developed world where oxytocin stimulation and scarred uterus are the major causes, fetopelvic disproportion causing obstructed labour is the major cause of uterine rupture in developing countries(5). Poor maternal care, improper birth spacing, ignorance of pregnant women about the danger signs,

poor road network and inadequacy of skilled birth attendants in health facilities are some of the predisposing factors for increase in grave complications as mentioned in the present case.

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