Research Paper Medical Science

A Case of Grossly Mal-Aligned Uterus in A Case of Previous Classical Caesarean Section Discovered on Laparotomy

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ABSTRACT

Classical caesarean section involves incision in the upper segment of uterus. This increases chances of uterine rupture in subsequent pregnancies, it is more or less an obsolete method of caesarean, apart from some rare conditions in which such an incision is indicated viz. densely adherent bladder, mass lesion occupying lower uterine segment.

Any previous laparotomy leads to formation of adhesions. This may result in fixation of the uterus leading to rare pregnancy complications of uterine torsion, incarceration or malposition. At the time of surgery the anatomy is so distorted that the usual site of caesarean entry is not identified or cannot be reached. The anatomy may not be identified until after removal of the fetus and products of conception.

Here we are describing a case of previous caesarean section with dense adhesions which could be identified as a previous "classical caesarean" only after the delivery of fetus and placenta.

KEYWORDS malposition, Caesarean section

INTRODUCION:-

Cesarean section is the commonest obstetric operative procedure worldwide. The incidence of cesarean section is continuously rising giving women frequently an obstetric status of "Previous Cesarean Section". However this makes future obstetric performances and future abdominal explorations risky. The rate of cesarean section in the urban educated population in Chennai is 45% [1]. In medical colleges and teaching hospitals in India the overall rate for cesarean deliveries is 24.4%[2]. In a population based cross sectional study the public, charitable and private sector hospitals had cesarean section rates of 20%, 38%, and 47% respectively [3].

After any laparotomy it is fairly common to develop scar tissue, or adhesions, and cesarean sections are no exception. This scarring and adhesion formation is known to increase the major complications rate from 4.3% to 12.5% depending upon the number of previous cesarean sections [4]. Intraperitoneal adhesions have an incidence of 5.5% to 42.5% [5]. Repeating a caesarean section in subsequent pregnancies is a common mode of delivery [6], and happens variably in 11% to 24% cases of previous one cesarean section [7]. Prior cesarean delivery forms a major indication for repeat cesarean deliveries .[8]The adhesions so formed lead to such a varied per operative findings that surgical approach needs to be individualized.

CASE REPORT:-

A 30 years old unbooked female admitted in the emergency of tertiary care hospital at gestational age of 41 weeks 2 days with pain in abdomen for one day and absent fetal movements for five hours. She had history of previous one caesarean section 2 years back at Kochas, Bihar (indication not known to the patient).She was not booked as an antenatal case in this hospital. Patient had 3 unit blood transfusion during this pregnancy.On general examination ,she was conscious and oriented to time, place and person with mild pallor, normovolumic pulse of 88/min, blood pressure 110/80 mmHg and temperature of 38 degree C. Systemic examination was also normal.

On per abdomen examination, fundal height was 36 weeks with cephalic presentation (4/5) and absent fetal heart rate with good uterine contractions. On per vaginal examination, cervix was almost fully dilated, fully effaced, station was at '0' position, membranes were absent and caput was present. Patient was taken for an emergency caesarean section due to non - descent of the head and development of scar tenderness after proper consent and blood arrangement.

On opening the abdomen, thick band of adhesions were present between the anterolateral and lower part of the uterus, fundus and parietal peritoneum. Uterine anatomy was difficult to delineate. Uterine incision was given after identifying the previous scar which was placed horizontally on lower part of uterus (**figure1)**. Fresh still born baby was delivered. Placenta and membranes were delivered completely. It was after this

that the presence of previous classical scar mimicking lower segment caesarean section scar was identified due to spontaneous correction of the position of the uterus.**(figure2)**. This created an unknowingly inadvertant second classical caesarean scar. Uterine incision was sutured. Hemostasis checked and secured. Abdomen was closed in layers. Postoperative course was uneventful. Patient was discharged on day 5 with proper counselling.

DISCUSSION:-

Fixation of uterus by adhesions is a risk factor for rare pregnancy complications like uterine torsion,sacculations etc. The uterine anatomy can be grossly distorted so much so that usual site of incision can not be reached and identified properly. Entities reportedly associated with uterine malposition, torsion or sacculation include the following - uterine leiomyoma, mullerian abnormalities, pelvic adhesions, large ovarian neoplasms, adhesions due too previous surgery.[9]

In this case, the adhesions due to previous surgery made the longitudinal axis of uterus acutely dextroverted to right lumbar quadrant .When an attempt to trace the round ligament was made in order to delineate the anatomy, fundal area of uterus occupying the right lumbar quadrant, due to dextroversion,gave the impression of unicornuate uterus. This mal-alignment of the uterus is also the cause of non progress of labourinspite of good uterine contractions.

CONCLUSION:-.

Cases with previous surgery with dense adhesions and distorted uterine anatomy requires presence of an experienced surgeon. Previous scars can be misleading at times, therefore anatomy should be delineated by tracing round ligaments whenever possible. Such complications should specially be suspected in cases of previous section performed in remote areas by untrained and unupdated professionals who 'routinely' perform classical caesarean in this era.

FIGURES

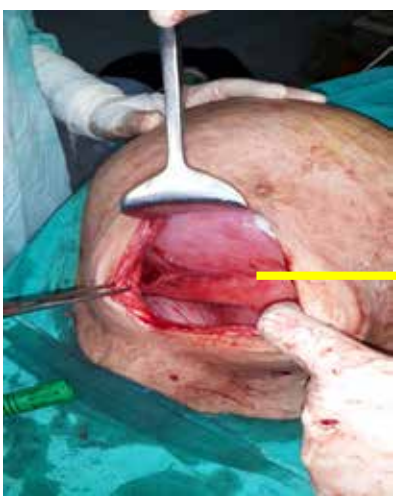
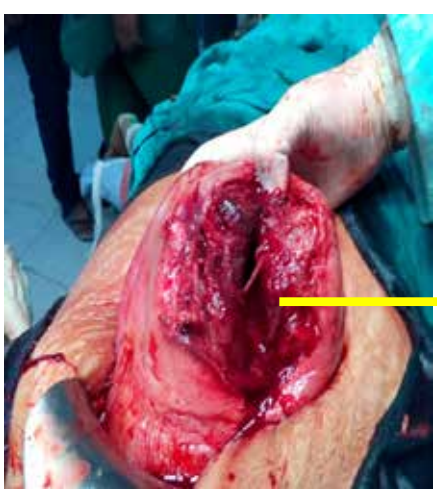


Figure 1

Transverse scar of previous caesarean section



Iatrogenic second classical caesarean section scar

Figure 2

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