CASE PRESENTATION OF RUPTURE UTERUS

Dr.PREETHI REDDY.

OBG PG 1st year.

- Patient name: xxxxxx
- Age : 25yrs
- Address : Ramannapet,NALGONDA
- Husband's occupation : Auto driver
- Socio economic status :lower class
- Date of admission: 25-12-2013
- Time of admission: 1.30am

A 25yr old patient referred from a private hospital with

- breathlessness
- abdominal distension
- bleeding per vaginum

- H/O PRESENT ILLNESS:
- History obtained from the patient attendants as the patient was not in a condition to give history.
- a)G2P1L1 with approximately 5months of amenorrhea.
- LMP: Not known
- b)visited a private hospital for termination of pregnancy, which was accomplished by vaginal tablets at around 4pm

- At around 6pm they gave h/o regular contractions and intermittent pain abdomen till 12am.
- At around 12 am she had sudden onset of
  - breathlessness.
  - Pain abdomen
  - Bleeding per vaginum
- she was diagnosed to be in hypotension and was referred here.

- MENSTRUAL HISTORY

  Age of menarche – 15yrs

  Duration of menstruation – 3-4 days/30days,regular

- MARITAL HISTORY

  3yrs of married life

  non-consanguinous

  no h/o of usage of oral contraceptive pills

- OBSTETRIC HISTORY: G2P1L1
- 1stPregnancy – concieved spontaneously 1year after marriage
- Emergency LSCS done at term gestation
- Indication-severe oligohydramnios
- Delivered an alive female baby of weight 2.5kg 1 1/2 year back.
- Post-operative period-uneventful.

PRESENT OBSTETRIC HISTORY

2nd pregnancy –she concieved spontaneously 1 1/2yrs after last child birth.

- She was an unbooked case
- No ante-natal checkups

- PAST HISTORY :
- Not a known hypertensive, diabetic.
- no h/o Tuberculosis,Epilepsy,Asthma,Heart diseases,Thyroid disorder
- No h/o Blood transfusion
- h/o one LSCS 11/2yrs back

- FAMILY HISTORY :
- no h/o Hypertension/Diabetes/Epilepsy/Asthma/ Heart diseases/Thyroid disorders

- PERSONAL HISTORY:

  Diet - mixed

  Appetite – normal

  Sleep - adequate

  Bowel and bladder - regular
- DRUG HISTORY : no h/o drug allergies,no h/o intake of any other drug intake.

- GENERAL EXAMINATION:
- Patient is conscious but unable to speak due to severe breathlessness.
- Thin built and poorly nourished
- Pallor + +
- No icterus,cyanosis,clubbing,generalised lymphadenopathy,pedal edema

- Vitals : PR – 134 bpm,
  feeble, low volume
  BP – 80/40 mm of Hg,
  RR – 30cycles/min
  Temp – afebrile

- CVS: S1,S2 heard , no murmurs.
- RESPIRATORY SYSTEM:
  bilateral air entry present
  normal vesicular breath sounds
  no additional sounds.
- CNS: No abnormality detected.

- PER ABDOMINAL EXAMINATION:
- INSPECTION
- - abdomen uniformly distended
  - umbilicus centrally placed
  - skin over abdomen is normal
  - linea nigra present
  - suprapubic transverse scar present
  - no visible pulsations and engorged-veins

- PALPATION –
- Uterine contour couldnot be made out.
- Diffuse tenderness present.
- Fetal parts – palpable superficially
- PERCUSSION –Dull note on percussion present

  shifting dullness present.
- AUSCULTATION – fetal heart sounds not heard.

  bowel sounds absent.

- PER-SPECULUM: Bleeding through os present.
- PER-VAGINUM:

  cervix- soft, posterior

  external and internal os- admitting one finger;

  cervical motion tenderness present.

- SUMMARY:
- G2P1L1 with 5months of amenorrhea,
- 1 previous LSCS 1 1/2 yr back
- With history suggestive of induced abortion
- Features of shock
- Absence of uterine contour
- Superficially palpable fetal parts.

- PROVISIONAL DIAGNOSIS:

G2P1L1 with 20weeks of gestational age with1 previous LSCS with ?Uterine Rupture.

MANAGEMENT

- RESUSCITATION:
- Patient was stabilised by maintaing

  airway
  breathing
  circulation
- Oxygen inhalation
- Two iv lines were secured
- Packed cell transfusion was started

- INVESTIGATIONS:
- EMERGENCY BEDSIDE ULTRASONOGRAPHY OF ABDOMEN AND PELVIS:
- Evidence of free fluid with internal echoes noted in all peritoneal spaces.
- Evidence of fetus with no cardiac activity.
- Placenta could not be visualised.

- COMPLETE BLOOD PICTURE:
- HEMOGLOBIN: 5gm%
- TOTAL COUNT:19,000cells/cubic mm
- NEUTROPHILS:85%.
- PLATELET COUNT:2.3lacs

- PACKED CELL VOLUME : 20%
- BLEEDING TIME:2min
- CLOTTING TIME:3min
- BLOOD GROUP: O-POSITIVE
- CUE: Albumin: Trace
- RBS:106mg/dl
- PT: WNL
- APTT:WNL

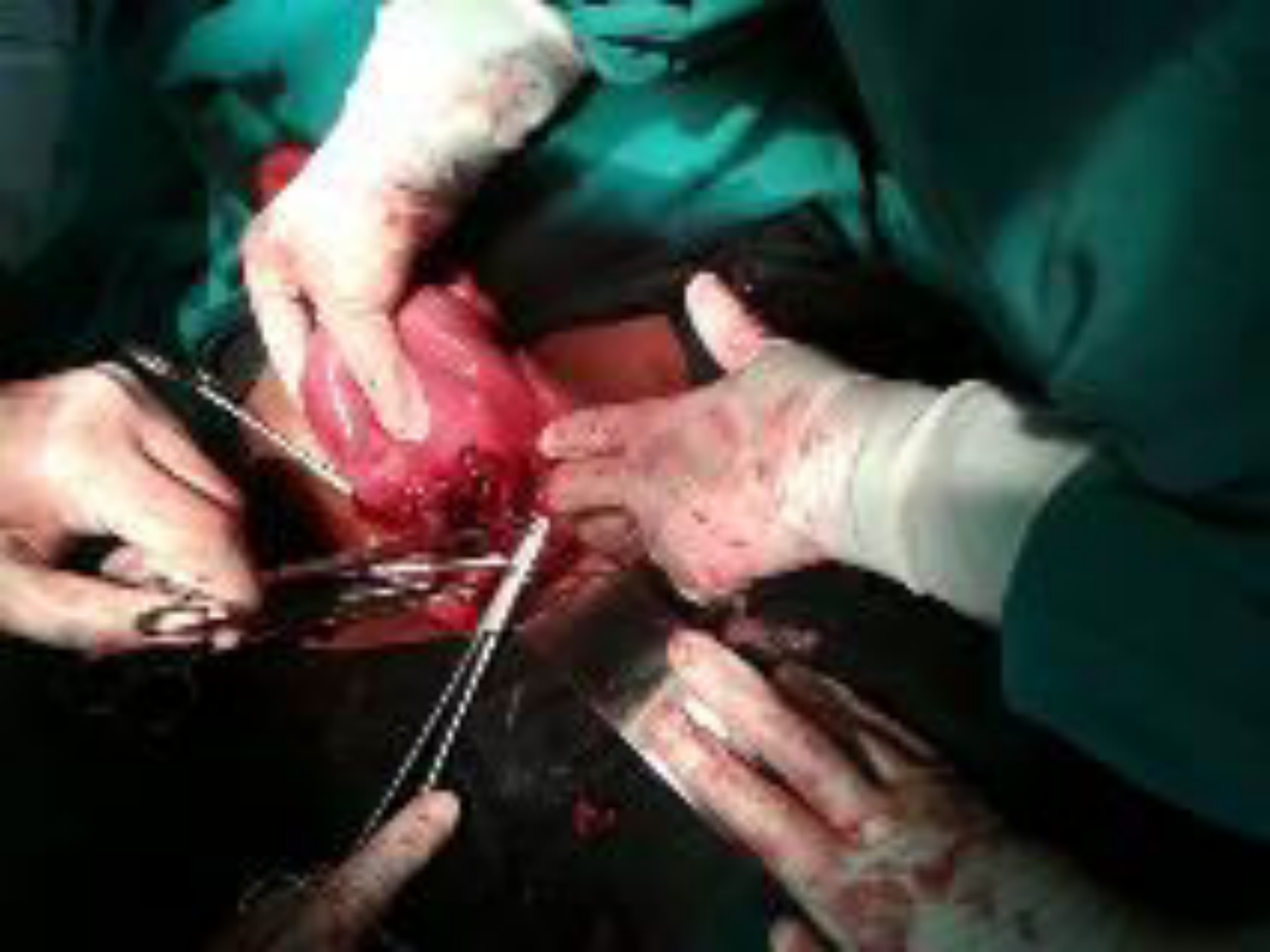
Contd...

- RENAL FUNCTION TEST : WNL
- LIVER FUNCTION TEST: WNL
- HIV: NON REACTIVE.
- HBSAg:NON REACTIVE
- VDRL:NONREACTIVE

- Patient was posted for EMERGENCY LAPROTOMY.
- Emergency pre-anaesthetic checkup was done by anaesthetists.
- Patient was induced with general anaesthesia.

- INTRA OPERATIVE FINDINGS: Abdomen opened by sub-umbilical midline incision.
- Hemoperitoneum of about 2500ml of blood drained,blood clots of approximately 1000ml were removed.
- Dead female fetus of weight 500gms seen in the abdominal cavity.
- Placenta got separated and seen in the abdominal cavity.

- Rupture of anterior wall of the uterus seen through out the previous scar length.
- Fetus and placenta removed.
- Uterus closed in 2 layers with catgut no 1, hemostasis secured.
- Abdomen closed in layers.



- 4units of packed cells and 2 units of FFP transfused intra-operatively.
- Urine output 400ml and clear at the end of the procedure.
- Patient was extubated and she was conscious , co-operative and oriented.

- FINAL DIAGNOSIS:

  G2P1L1 with complete lower segment scar rupture with IUD in haemorrahagic shock.

- PROCEDURE:

  Emergency exploratory laporotomy with repair of scar rupture.

- Post operative treatment:
- Nil by mouth
- Intravenous fluids @ urineoutput + 75ml
- 2units of packed cells transfused.
- Inj.piperacillin and tazobactumtaz 4.5g iv BD
- Inj gentamycin 80 mg iv BD
- Inj metranidazole100ml iv TID
- Inj. Ranitidine 50mg iv BD
- Inj tramadol 50mg iv BD.

- Post operatively patient was hemodynamically stable

  Temp: normal

  PR: 100bpm/min regular in rhythm
  normal in volume

  BP:90/60mm of Hg

  R.S:Bilateral air entry present

  Normal vesicular breath sounds

  C.V.S: S1,S2 present, no murmur

- Post-operative period was uneventful.
- Suture removal was done on POD-7
- Repeat Hb: 10.6g%
- Patient was discharged on POD-8.
- Condition of the patient satisfactory at the time of discharge.

- FOLLOW UP:
  Patient came for follow up after 15days to gynaec OPD
- She had no complaints.
- Wound – healthy.

THANK YOU