

Ruptured uterus in a booked patient

AY Isah, EI Nwobodo, KA Tunau, YT Sununu

Departments of Obstetrics and Gynaecology, Usmanu Danfodiyo University Teaching Hospital, Sokoto, Nigeria

Abstract

Ruptured uterus, a life-threatening obstetric complication, is a rare event among booked patients. We present a case of uterine rupture in a 28-year-old Gravida 2.para 1⁺⁰, 1 alive with previous lower segment Caesarean scar due to neglected obstructed labor from fetal macrosomia. She presented in labor at 40 weeks of gestation after declining the advice for an elective Caesarean section (C/S) and also signed against medical advice to receive care from a traditional birth attendant. She returned 30 hours later with a ruptured uterus. Findings at operation included a macerated stillbirth weighing 4.30 kg and a lower segment transverse scar rupture. Subtotal hysterectomy and peritoneal lavage were performed.

Key words: Booked, rupture, traditional birth attendant, uterus

Date of Acceptance: 14-Feb-2011

Introduction

Ruptured uterus is an obstetric emergency posing a grave danger to both mother and child.^[1] It is one of the obstetric catastrophes which is common in Nigeria and other developing countries.^[2] In developed countries, however, the reverse is the case where it has now almost become non-existent due to a high level of obstetric care.^[2-4] It is one of the leading causes of maternal mortality and morbidity as well as fetal wastage in our environment.^[5-7] The predisposing and precipitating factors to this scourge include previous Caesarean section (C/S) and other surgical incisions on the uterus such as previous hysterotomy and myomectomy.^[1] Others are previous uterine perforation, injudicious use of oxytocin, and obstetric maneuvers such as external cephalic version and difficult forceps delivery.

Various case reports of uterine rupture are in literature including those due to attempt at version^[8-10] and overzealous or massive bolus doses of intravenous oxytocin.^[11] There is, however, paucity of reports of rupture uterus in modern day obstetric practice among booked patients unless among defaulters who resort to attempt at vagina delivery by traditional birth attendants (TBAs). Remote factors responsible for rupture uterus in the developing countries such as ignorance, illiteracy, traditional practices and

beliefs, aversion to abdominal delivery, and non-utilization of available health services^[12] may have been responsible for this misfortune. This case describes a patient with uterine rupture due to persistent belief and encouragement to achieve vaginal delivery by a non-medical practitioner.

Case Report

Mrs. R.I., a 28-year-old booked Gravida 2.para 1⁺⁰, 1 alive, illiterate house wife, was admitted into the Labour Ward on the 2nd February 2007 after having labored at home for 24 hours at 40 weeks of gestation. The membranes had ruptured 12 hours before presentation. She had booked for the pregnancy at 16 weeks and was attending the antenatal care regularly up till 36 weeks. The estimated fetal weight by ultrasound scan at 36 weeks was 4.20 kg. Her first confinement was in the year 2005. She carried the pregnancy to term and received antenatal care in a private hospital. She was delivered of a live male baby by an emergency C/S due to failure to progress in labor due to malposition. The postoperative period was complicated by puerperal sepsis and she was discharged 2 weeks after the surgery. She was the only wife to a petty trader who also

Address for correspondence:

Dr. AY Isah,
Departments of Obstetrics and Gynaecology, Usmanu Danfodiyo
University Teaching Hospital, Sokoto, Nigeria.
E-mail: isahay@yahoo.com

Access this article online

Quick Response Code:



Website: www.njcponline.com

DOI: 10.4103/1119-3077.91766

PMID: 22248960

had no formal education. She was counseled at booking on the likelihood of a repeat C/S. She rejected vehemently in belief that a TBA had assured her of a safe vaginal delivery in the index pregnancy. At 36 weeks of gestation when the fetal weight was estimated to be 4.20 kg, she was again counselled for admission and elective C/S the following week. The patient, however, declined because the TBA had advised otherwise. She was then lost to follow-up until she reported in labor.

On examination, she was in painful distress, anxious, and tachypnoeic. The pulse rate was 110 beats per minute and the blood pressure was 110/70 mmHg. Abdominal examination revealed mild tenderness over the uterine scar and symphysiofundal height corresponded to 42 weeks of cysis. The fetal lie was longitudinal in cephalic presentation and was not engaged. The fetal heart rate was 170/min. Vaginal examination revealed foul smelling liquor amni. The cervix was 5 cm dilated with moderate caput at station 0-2. An assessment of imminent scar rupture was made. The situation was explained and the need for emergency C/S was re-emphasized. She declined and signed against medical advice (SAMA) after telephone conversation with an unknown partner. She returned 30 hours later with features of frank uterine scar rupture. It was then she consented to laparotomy. Immediate resuscitation with intravenous fluid and antibiotics were commenced as preparations were made for urgent laparotomy. She received one unit of blood preoperatively, a unit intraoperative, and another after the surgery. Operative findings were moderate hemoperitoneum and complete scar rupture. A macerated male fetus weighing 4.30 kg was extracted, the uterus was exteriorized after evacuating the hamoperitoneum, and subtotal hysterectomy was performed with peritoneal lavage. Her postoperative period was uneventful and she was discharged on the 8th postoperative day.

Discussion

This case is reported because of the conflict between belief and orthodox practice. The first delivery was by emergency C/S that was complicated by puerperal sepsis. She was lucky not to have secondary infertility and conceived within 2 years after her first delivery. She booked early and had the benefit of antenatal care but subsequently had a ruptured uterus requiring hysterectomy, due to ill advice and mismanagement by the unskilled attendant. Cases of ruptured uterus due to mismanagement by TBA, in-experienced midwives abound in the literature, but the prevalence among booked patients may appear to be low as in the case presented. A case of ruptured uterus in an unbooked primigravida following excessive fundal pressure was recently reported in our unit,^[8] and cases due to overzealous oxytocin infusion^[11] and attempted external cephalic version have been reported from other parts of the country.^[9,10] Previous uterine curettage, myomectomy

with breach in the endometrial cavity, and difficult forceps/vacuum delivery have been identified as etiological factors for uterine rupture in some nulliparous patients.^[13] A previous C/S was the determining factor in this patient. We could not, however, determine with certainty the extent of attempt at relieving the obstruction by the attending unskilled practitioner between the time of SAMA and re-admission.

Prompt re-admission without prejudice and adequate resuscitative efforts contributed to the survival of this patient. The case underscores the need for proper education of TBAs in propagating the benefits of proper use of obstetric facilities with early referral. If TBAs comply with this, their role in reducing maternal mortality and morbidity cannot be overemphasized. This case also illustrates the urgent need to look into the power of authorities to enforce the right of unborn child in cases where it becomes difficult to obtain consent for medical procedures. It also highlights the fact that practitioners should look beyond the immediate confine of the patient when consent is becoming difficult as there may be likely external forces mitigating against it. This baby may have been salvaged if there was no interference from her traditional supervisor. It is important that the TBAs be incorporated in the campaign to reduce maternal mortality and morbidity in our environment.

References

- Ojwang SB, Bennum MM, Musila S. Uterine rupture due to road traffic accident. *East Afr Med J* 1978;35:14-5.
- Robert AO, Ekele BA. Rupture uterus: Halting the scourge. *Trop J Obstet Gynaecol* 2002;19:1-3.
- Faleyimu BL, Makinde OO, Ogunniyi SO. Rupture of Gravid Uterus in Ile-Ife, Nigeria. *Trop Doct* 1990;20:188-9.
- Konje JC, Odukoya OA, Ladipo OA. Rupture uterus in Ibadan, A twelve year review. *Int J Gynecol Obstet* 1990;32:207-13.
- Ekele BA, Audu LR, Muyibi S. Uterine rupture in Sokoto, Northern Nigeria... are we winning? *Afr J Med Sci* 2000;29:191-3.
- Ghatak DP. Rupture of the uterus: A review of 146 cases. *Trop J Obstet Gynecol* 1989;3:41-4.
- Audu LR, Ekele BA. A ten year review of maternal mortality in Sokoto, Northern Nigeria. *West Afr J Med* 2002;21:74-6.
- Nnadi D, Nwobodo E, Ukwu A, Airede L. Uterine rupture in a primigravida: A case report. *Sahel Med J* 2006;9:71-3.
- Ibekwe PC. Rupture uterus in a primigravida: A case report. *Trop J Obstet Gynaecol* 2002;19:47-8.
- Umezurike CC, Feyi-Waboso PA. Rupture uterus in a primigravida, Secondary to abdominal manipulation by a traditional birth attendance: A case report. *Trop J Obstet Gynaecol* 2005;22:83-4.
- Orji EO, Dayo AA, Malomo OO. Rupture of the pregnant uterus in an unbooked Primigravida: A case report. *Trop J Obstet Gynaecol* 2002;19:49-50.
- Harrison KA. Poverty, Deprivation and Maternal health – The 1995 William Meredith Fletcher Shaw Memorial Lecture. In: Studd J, editor. *The yearbook of the RCOG*, London: RCOG Press; 1996.p. 33-44.
- Ola RE, Olamijilo JA. Rupture of the uterus at the Lagos University Teaching Hospital, Lagos, Nigeria. *West Afr J Med* 1998; 17:188-93.

How to cite this article: Isah AY, Nwobodo EI, Tunau KA, Sununu YT. Ruptured uterus in a booked patient. *Niger J Clin Pract* 2011;14:499-500.

Source of Support: Nil, **Conflict of Interest:** None declared.