CASE REPORT

SPONTANEOUS UNSCARRED FUNDAL RUPTURE OF UTERUS AT 16 WEEKS OF PREGNANCY

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ABSTRACT: Most of the cases of rupture of uterus occurs in the third trimester of pregnancy or during labour but here we report a thirty five year old women G₃, P₁₊₁, LCB 10 years back, mode of delivery by LSCS was admitted in MG ward of Malda medical college, West Bengal, India at 16 weeks of pregnancy with complain of acute abdominal pain, vomiting with clinical sign of shock without vaginal bleeding. Haemoperitoneum and dead fetus outside the uterus was discovered by urgent USG of whole abdomen. Emergency laparotomy was carried out and it revealed haemoperitoneum due to spontaneous rupture of uterine fundus through which fetus and placenta were extruded in peritoneal cavity. Though spontaneous fundal rupture is very rare in early second trimester of pregnancy, it should be taken into consideration in the differential diagnosis of acute abdomen during pregnancy specially if there is predisposing factors.

KEY WORDS: Fundal rupture, Haemoperitoneum, Unscarred.

INTRODUCTION: Spontaneous uterine rupture in the second trimester of pregnancy is a very rare event.¹ Usually it is associated with trophoblastic tumor or pathological invasion of placenta through uterine wall, for example placenta increta or percreta. The condition which predispose to invasive placentation include a previous dilatation and curettage for incomplete abortion, endometrial biopsy (where uterus was perforated and myometrium was deeply torn), advanced maternal age, previous endometritis and manual removal of placenta. Uterine malformation associated with pregnancy located in rudimentary horn may cause spontaneous perforation of uterus or rupture of uterus at an early stage of pregnancy.² It may also happen in case of uterus scarred due to previous myomectomy, in previous C/S scar or previous operative laparoscopy.^{3, 4} The commonest site of uterine rupture is in the anterior wall of lower segment. Other sites of rupture are anterior wall of upper segment and lateral wall. Spontaneous rupture of the posterior wall of body of uterus also occur.⁵ Fundal rupture is the rarest. We are reporting the case due to its rarity and to reduce the diagnostic dilemma in acute abdomen in pregnancy.

CASE REPORT: A thirty five years old G₃, P_{1+1(MTP)}, LCB 10 years, mode of delivery by LSCS carrying 16 weeks of pregnancy was admitted in MG ward as a referred case with the complain of acute abdominal pain, vomiting and fainting attack without vaginal bleeding. On through history taking she had a live birth by LSCS 10 years ago and one MTP 8 months before, but no history of trauma to the abdomen, no history of interference or misoprostol intake or hypertension and no history of manual removal of placenta in a case of retained placenta in previous pregnancy. She had an antenatal checkup 10 days ago and USG done 15 days before emergency admission showed single live intrauterine fetus of 13 weeks 3 days maturity with fundo anterior placenta. On examination pulse was 130/min, BP 80/60, pallor ++, tense and tender abdomen. Uterine size could not be

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delineated properly due to obese, tense and tender abdomen. On vaginal examination uterus was bulky, tender, Os-closed, Cx- tubular and firm with motion tenderness, POD was full and tender, no vaginal bleeding. The history and clinical examination raised suspicion of haemoperitoneum. After initial resuscitation with blood and intra venous fluid an urgent USG of whole abdomen was performed which showed haemoperitoneum and fetus without cardiac activity outside uterus. Emergency laparotomy was carried out with the clinical suspicion of lower segment uterine scar rupture or caesarean scar ectopic pregnancy. But surprisingly we saw a transverse rupture of uterine fundus measuring 6 cm x 4 cm (Figure -1) through which fetus and placenta came out. Fetus weighing 200 grams (Figure-2) and placenta extracted from the peritoneal cavity and the site of rupture repaired in two layers with vicryl 1-0. Bilateral tubectomy was done with consent from patient and her husband. Abdomen was closed in layers after proper hemostasis, normal saline wash and after mops and instruments count found correct. Post-operative recovery was uneventful and the patient was discharged on 8th post-operative day.

DISCUSSION: Rupture of pregnant uterus is a serious threat to the mother's life and her unborn child. Most of the cases of rupture of uterus occur due to the dehiscence of previous C/S or myomectomy scar and usually occur in the third trimester or during labour.⁶ The incidence of spontaneous rupture of uterus is 1 in 15000 deliveries and uterine rupture is more likely in a woman of high parity.⁷ Our case was spontaneous fundal rupture in 16 weeks of gestation without any scar in the fundus. Goel et al reported a case of fundal rupture of uterus at 18 weeks of pregnancy in a nulliparous woman.⁸ but our case was third gravida at 16 weeks of gestation.

Spontaneous rupture of uterus may occur due to placenta accrete percreta in multigravida.⁹

It is likely that our case was precipitated by a morbid invasive placenta at the uterine fundus as there was history of MTP 8 months before her emergency admission, though we have no histological proof to confirm our hypothesis.

CONCLUSION: Spontaneous fundal rupture in second trimester is very rare. Though rare should be kept in mind in the differential diagnosis of acute abdomen in case of gravid women specially if there is a predisposing factor.

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FIG.1: FUNDAL RUPTURE (6cm×4cm) OF UTERUS AT 16 WEEKS OF GESTATION

FIG. 2: FETUS WITH PLACENTA (200 gms)

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