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Evisceration of Gravid Uterus in Anterior Abdominal Wall Defect with Scar Rupture: A Case Report

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Abstract : *A case of evisceration of gravid uterus in anterior abdominal wall defect with scar rupture. The pregnancy was further complicated by intra uterine fetal demise. The management of the case is discussed.*
Keywords: *evisceration of gravid uterus, anterior abdominal wall defect, scar rupture, caesarean section, caesarean hysterectomy.*

I. Introduction

The incidence of scar rupture in post caesarean pregnancy is 0.5%. Incidence of anterior abdominal wall defect is rare and accounts to 3.1%. Evisceration of gravid uterus in anterior abdominal wall defect is rare and with scar rupture is the rarest complication but serious condition due to potentially severe maternal and fetal risk. We have come across one such case where there was evisceration of gravid uterus in anterior abdominal wall defect. This was further complicated by uterine scar rupture and omental protrusion through the necrosed skin and intra uterine fetal demise.

II. Case report

A 22 yr old $G_2P_1L_1$ with 36 weeks gestational age with post-caesarean pregnancy was referred to the emergency department of our hospital on 10.09.2012 at 11.50 pm in view of post-caesarean pregnancy with anterior abdominal wall defect with decreased fetal movements and giving away sensation .

The patient had not perceived any fetal movements since morning. Also she noticed omental evisceration through the lower part of the anterior wall defect while defecation. There was no history of pain abdomen or bleeding per vaginum or haematuria. Her obstetric history was significant. She had an emergency caesarean section during first pregnancy for obstructed labour, at a private hospital, in a rural area, 15 months ago. She had post-op wound infection which was treated conservatively and subsided. In present pregnancy during 5^{th} month of gestation she noticed an anterior abdominal wall protrusion. She consulted the doctor and they advised repair during caesarean section.

She was of average build and nutrition. At admission, clinically, she was anaemic, afebrile, had tachycardia and a blood pressure of 110/70 mm of Hg. Abdominal examination revealed a lower abdominal mass with a previously stretched subumbilical midline scar. There was discharge of serosanguinous fluid and protrusion of omentum through the lower part of the mass (Fig 1). Skin over the abdomen was pigmented with multiple ulcerations and areas of necrosis. Exact uterine contour could not be made out. Fetal parts were felt easily. No tenderness, guarding or rigidity. On auscultation, fetal heart sounds were absent. Per vaginal examination revealed cervix to be uneffaced with closed os. Routine investigations were within normal limits.

Emergency bedside ultrasound revealed – incisional hernial sac with uterus to one side and fetus floating in intact gestational sac to another side. FHS were absent. Provisional diagnosis is evisceration of gravid uterus in anterior abdominal wall defect with uterine scar rupture .

Emergency laparotomy was done with the help of general surgeon. Fetus with intact amniotic cavity and placenta was found in the hernial sac. Uterus with full length unhealthy scar rupture in the lower uterine segment was found towards one side (Fig 2). Single dead fetus, Fch with 2.25 kg weight, with cord thrice around the neck was removed (Fig 3). Bilateral broad ligament hematoma were present. Hysterectomy was done. Eviscerated omentum was excised. Unhealthy redundant hernial sac was excised and anatomical repair of hernia was done. Abdominal drain was removed on 3^{rd} post-op day. Suture removal was done on 10^{th} post-op day and the wound was healthy. On follow up 2 weeks later, wound was healthy and healed well.

III. Discussion

The incidence of anterior abdominal wall defect following the caesarean section accounts for 3.1% [1, 2]. Incidence of incisional hernia is influenced by midline vertical incision, the need for additional operative procedures, post-operative abdominal distension, intraabdominal sepsis, wound infection, wound dehiscence and abdominal incision of previous caesarean section healing with secondary intention [2]. Herniation of gravid uterus through an incisional hernia of the anterior abdominal wall is a rare condition because, in most instances, by the time the uterus is large enough to reach the fascial defect on the abdominal wall, it is also too large to

protrude through the hernia [3]. Approximately ten cases of gravid uterus in incisional hernia and five cases of gravid uterus in umbilical hernia have been reported in the world literature [4], with clinical presentations ranging from asymptomatic, to uterine incarceration, with or without strangulation , to uterine evisceration [4,5]. Potential complications include spontaneous abortion, preterm labour, accidental haemorrhage, intrauterine growth restriction, intrauterine fetal demise and rupture of lower uterine segment [3]. Considering the global increase in caesarean rates, an increase in incisional complications might be anticipated in the following years. The management of a pregnant patient with incisional hernia poses a dilemma as there is no consensus in the current literature regarding the ideal management approach. Each case should be individualised. If uncomplicated, a conservative approach until term followed by delivery and herniorraphy is a good option [4].

IV. Figures

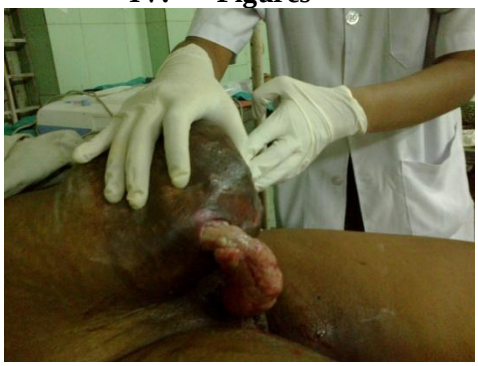

Fig1. Omental prolapse in anterior abdominal wall defect.

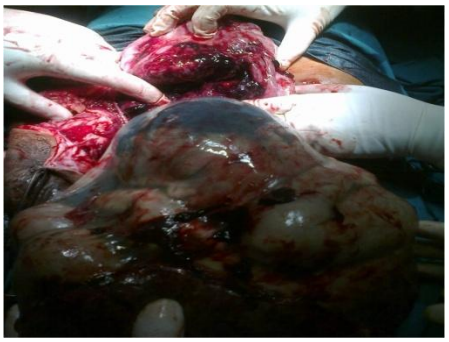

Fig2.evisceration of intact sac with scar rupture

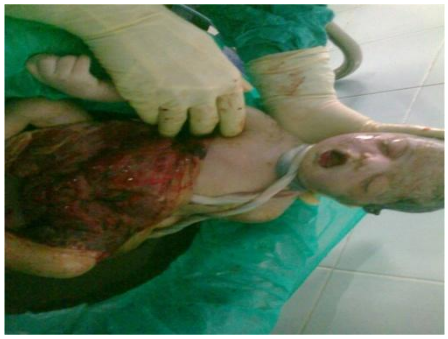

Fig3.cord loop around the neck

V. Conclusion

Inter pregnancy interval after caesarean section must be maintained for atleast 2 years to prevent scar rupture. Heavy strenuous work must be avoided during post op period for 3 to 4 months to prevent anterior abdominal wall defects.

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