

# A desperate destructive procedure by a laywoman with disastrous consequences – An unusual case

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## Abstract

## INTRODUCTION

Uterine rupture, a dramatic obstetric emergency occurs more commonly in the underdeveloped countries, where it is still a significant problem (1). It is a major cause of maternal mortality in many Asian and African countries. Uterine rupture in developed countries usually presents in a manner, which is quite different from that often seen in less developed region of world (2). The most common cause of uterine rupture in the developed world is the previous caesarean scar. In contrast injudicious use of oxytocin and obstructed labour are the most common cause in the developing countries (3). Other known risk factors include a history of myomectomy, cephalopelvic disproportion, fetal malpresentation, breech version, operative delivery, trauma, grand multiparity, prostaglandin induction for abortion and electromyolysis (4). With improvement in obstetrical care, stormy obstetrical emergencies have become very rare and seldom destructive operations are required. However, in Uttarakhand, a hilly region the population is sparse and living in far flung areas where, medical facilities are inaccessible. Therefore, desperate obstetrical emergencies managed by unskilled dais (indigenous untrained midwives) and relations are frequently encountered in this tertiary care hospital. We report one such case here.

## CASE REPORT

A 28 year old P<sub>3</sub>L<sub>2</sub> was brought as an emergency case on 3rd May 2008 in profound shock with complaints of something coming out per vaginum. A history of delivery of a stillborn male child, conducted by a dai at home 30 hrs prior to admission was extracted from the relatives.

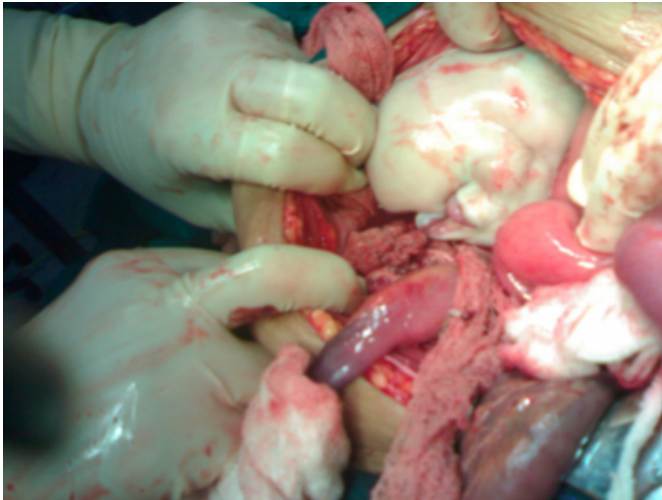
On examination, general condition was poor with pulse rate 112/minute regular and thready, cold extremities, blood pressure 100/60 mm/Hg and pallor. Copious amount of

sweating was present, but no pedal edema was observed. On clinical systemic examination, no abnormality was detected. Per abdomen examination revealed that abdomen was distended more in right lumbar, umbilical and hypogastric regions with guarding present. Fundus of uterus was at the level of umbilicus, firm, mobile side to side and tender. Ascitic fluid was present. Bowel sounds were absent. On local examination approximately 10 inch long gangrenous foul smelling loops of small intestine were seen lying outside the vulva which was repositioned back. Slight bleeding per vaginum was present. No cord or placenta was palpable. Because of poor condition of the patient, further examination was postponed for operating room (O.T.). A diagnosis of rupture uterus with prolapsed gangrenous bowel loops with shock was made. Routine laboratory investigations were normal except hemoglobin which was 9.2gm/dl and serum total bilirubin was 1.8 mg/dl.

The patient was resuscitated with I.V. fluids, blood and blood components, broad spectrum IV antibiotics and shifted to the O.T. for emergency laparotomy. Under general anesthesia (G.A.) abdomen was opened by midline vertical incision, foul smelling discharge came out along with blood and blood clots. It was observed that uterus had ruptured anteriorly over lower segment and ragged irregular margins with massive bleeding and clots were present. Two gangrenous loops of small intestine devoid of mesentery, entering into the cervix were present (one about 50 cm long, 10 cm proximal to ileo-caecal junction and second was 1.5 m from duodenal-jejunal junction). Gut loops were gently pulled through cervix and pushed up from vagina. Anterior vaginal wall behind the bladder was devitalized, though no obvious bladder injury was present. On further exploration, a decapitated head; swollen and edematous was lying in right hypochondrium while some hairs were lying free and others were adhered to bowel loops. (Fig1.)

**Figure 1**

Fig 1. Decapitated head lying freely in the peritoneal cavity along with gangrenous loop of gut .



Emergency subtotal hysterectomy was done and decapitated head was removed with the help of sponge holding forceps. (Fig2). Wide resection of small intestine at two places with end to end anastomosis with ileostomy was done. Hairs were removed as much as possible and peritoneal lavage was done. A wide bore drain was put in the pelvis on the left side and abdomen was closed in layers with tension sutures using no. 1 prolene. Subsequent vaginal exploration was done and paraurethral tears were repaired. No cervical or vaginal tear were present. The patient was managed with heavy dose of antibiotics, blood, and 4 units fresh frozen plasma along with elective ventilatory support. The patient was weaned from the ventilator after 24 hours. Post operative period was uneventful with ileostomy draining well. Indwelling catheter was removed after 3 weeks and patient was discharged in satisfactory condition.

**Figure 2**

Fig 2: Decapitated head being removed



## DISCUSSION

Due to lack of medical facilities and trained medical personnel, illiteracy, poor transportation and telecommunication, large numbers of patients are at the mercy of untrained dais or lay relations. On close questioning, during recovery period, patient's relatives informed that during labour when breech presentation was diagnosed, the relatives were faced with no alternative but to decapitated the head with sickle. In order to remove the decapitated head, they probably ruptured the uterus thereby pushing the head into the abdomen. With repeated attempts, in order to remove the placenta, the coils of intestine were brought out.

Recommendations to improve maternal survival in hilly areas include extending the maternal & child health programme, organizing the subsidiary and primary health centers with the early referral systems for high risk and problematic cases to subdivisional and district hospital, well-equipped referral hospital, round the clock obstetric services at referral hospitals, training of traditional birth attendants (TBAs), and equipping them with delivery kits (5). Regular antenatal care, hospital deliveries and vigilance during labour with quick referral to a well-equipped center will reduce the incidence of such mishaps (6). It is said that there is no role of destructive operations in modern obstetrics however in developing country like India where medical facilities are not up to the mark in remote areas; the training of postgraduates in the art of destructive operations should be continued.

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