Gravid Uterus In An Incisional Hernia Leading To Burst Abdomen

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Abstract

A case of a gravid uterus in an incisional hernia of a 35-year-old gravida 3 with previous two cesarean sections is presented. The patient developed ulceration of abdominal wall and burst abdomen, which necessitated hernioraphy at 26 weeks gestation. She delivered a 1700 gm female baby by emergency lower segment cesarean section at 34 weeks gestation.

INTRODUCTION

The occurrence of a gravid uterus in an anterior abdominal wall hernia is a rare but hazardous condition. One such case of pregnant uterus in incisional hernia, which led to burst abdomen is discussed. Burst abdomen necessitated antenatal hernioraphy at 26 weeks and subsequently the woman delivered a premature female baby at 34 weeks.

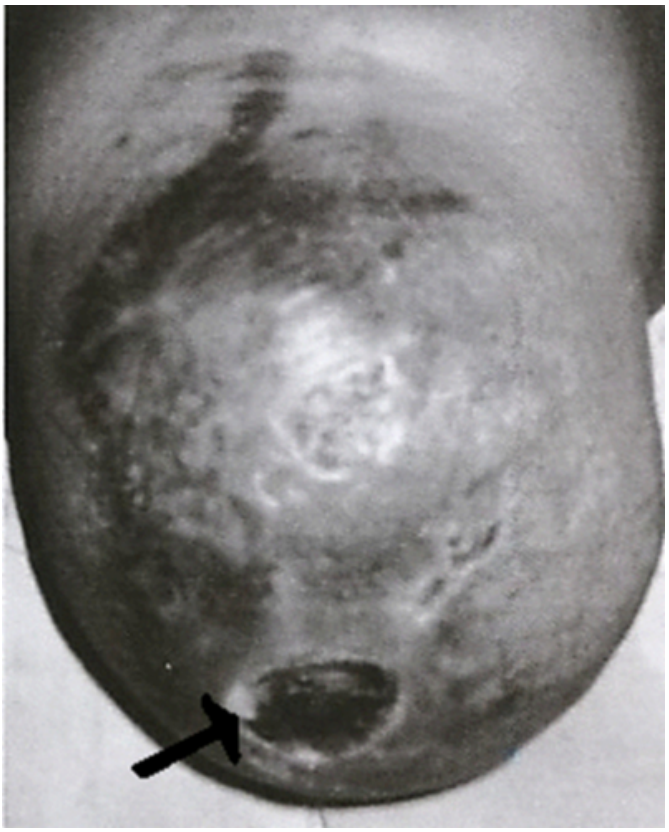
CASE REPORT

Mrs. S 35 years old, gravida 3 with previous two cesarean sections was referred to our antenatal clinic at 24 weeks gestation with incisional hernia containing a gravid uterus. She had a healthy 8-year-old male child from her first cesarean for cephalopelvic disproportion. Her second cesarean was done a year back and baby died on day 20 due to pneumonia. She had wound infection and gaping which healed in about 3 weeks by secondary intention.

In the present pregnancy she presented at 24 weeks with good general condition. There was a broad puckered midline sub umbilical scar. The overlying skin was papery thin with superficial ulceration. The rectus sheath was deficient at this site. The gravid uterus was protruding into the hernial sac. Fetal heart was 148/min. The uterus was reduced intra-abdominally and patient admitted for complete bed rest. Abdominal binder was applied to keep the uterus intra-abdominal. Daily dressing was done with sodium hypochlorite solution (Eusol) and soframycin gauze for healing of the ulcer along with oral amoxicillin and cloxacillin. Her hemogram, serological test for syphilis, urine investigations were all normal. Ultrasonography revealed a single line fetus of 24 weeks gestation with no gross congenital anomalies. The plan was to manage the patient conservatively till fetal maturity. However at 28 week gestation, the patient had a burst abdomen. The thinned out skin had given way and peritoneum was exposed in about a 3 cm area. She was taken up for emergency laparotomy and hernioraphy done with onlay prolene mesh. Tension sutures were applied. Suture removal was done on postoperative day 14. Patient was hospitalized till delivery because there was superficial gaping of the abdominal sutures and wound infection. She was managed with daily dressings and antibiotics. At 34 weeks she complained of acute pain and there was tenderness over whole of abdomen. Fetal heart was 150/minute and uterus irritable. With the doubt of impending scar rupture she was taken for emergency cesarean section. Emergency lower segment section with tubal ligation was done and a 1700g female baby was delivered. Intraoperatively the scar was papery thin. Rectus sheath edges and the redundant portion of mesh were freshened and closure done with non-absorbable suture loop nylon 1/0 with tension sutures also. Postoperative course was uneventful and catheter was removed after 72 hours. The patient was discharged after suture removal on day 14.

Figure 1

Figure 1: Gravid Uterus (▯) seen through incisional hernia



DISCUSSION

Gravid uterus in an incisional hernia is very rarely encountered in obstetric practice ([1],[2]). It is a hazardous condition and needs repair timely before incarceration occurs ([3]). Literature search has shown only five such cases ([1],[2],[3]).

There are no reports of a spontaneous burst of abdominal layers due to gravid uterus protruding in an incisional hernia. Although previously hernioraphy in the antenatal period has been reported due to incarceration, there is no report of emergency hernioraphy due to spontaneous burst abdomen ([2],[4]). In the second trimester the pregnant uterus grows out of the pelvis and the risk of incarceration increases. Incarceration can subsequently lead to abortion, preterm labor, dysfunctional labor and fetal death. Conservative management is preferable by rest and abdominal binders. Hernioraphy is usually planned after delivery as the overstretched abdominal wall may interfere with proper repair and the risk of wound disruption is higher. However incarceration or burst abdomen may necessitate antenatal hernioraphy, as seen in our patient. A large incisional hernia needs antenatal repair only if the risk of incarceration overweighs the risk of continuing pregnancy without repair ([2]). Emphasis should be placed on prevention and repair of such incisional hernia by proper closure of abdominal wound at laparotomy.

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