DELIVERY OF PLACENTA BEFORE THE FOETUS: AN UNUSUAL PRESENTATION OF RUPTURED UTERUS

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Abstract
An unusual case of ruptured uterus characterized by spontaneous delivery of the placenta while the foetus is retained in the abdomen is presented. The management and prevention of ruptured uterus in Sub-Saharan Africa is discussed.

Key words: Delivery of placenta, ruptured uterus

Introduction
In many parts of Sub-Saharan Africa, ruptured uterus still poses serious threat to both maternal and foetal wellbeing. Ruptured uterus is one of the principal causes of maternal mortality in developing countries accounting for about 5-18% of maternal deaths and corresponding perinatal mortality of 30-95%. The sad news about rupture uterus in our environment as rightly observe by Ekele and Roberts is that most of the factors associated with the condition over three decades ago are still largely with us today such as illiteracy/poverty, traditional practices, high parity, lack of antenatal care and unsupervised deliveries. In the developed world however, ruptured uterus occurs as an occasional obstetric mishap frequently following complications of oxytocic labour induction or augmentation, failed trial of scar or trauma such as road traffic accident.

Most patients with ruptured uterus in this environment present with vaginal bleeding with or without hypovolaemic shock, haemoperitoneum, peritonitis and extrusion of the foetus and placenta into the peritoneal cavity. Some are admitted in moribund states with death before delivery. Rarely is the presentation characterized by expulsion of the placenta per vaginum while the foetus remained in the abdomen.

Case report
A 25 year old unbooked G5 Para (4 alive) Housewife presented at our labour unit on the 29th April 2001 with history of lower abdominal pains for 12 hours and vaginal bleeding for four hours duration at term. She went into spontaneous labour at home and after barely eight hours in labour, developed sudden severe and persistent abdominal pains with associated vaginal bleeding estimated to be about one litre. There was no history of bleeding from other orifices. She claimed that her antenatal period was uneventful. All her four previous deliveries were unsupervised but normal, and her last confinement was three years ago. She was not known with any chronic medical disease.

Clinical examination revealed an anxious young lady who was moderately pale and dehydrated but anicteric and afebrile (T=36.7°C). She was moderately dyspnoeic (respiratory rate=30) but with clear lung fields. Her pulse rate was 120 beats per min with a blood pressure of 100/70mmHg and normal precordium. Abdominal examination revealed marked tenderness over the lower abdomen. The fundal height was consistent with 34 weeks gestation and the lie of the foetus noted to be transverse. There were no palpable uterine contractions and the fetal heart tones were not heard. There was no demonstrable intra peritoneal fluid collection. Vaginal examination revealed the placenta wholly in the vagina which was easily delivered. The cervix was about eight centimetres dilated and the presenting part was shoulder.

An impression of suspected incomplete uterine rupture was made. Resuscitation was promptly commenced with intravenous normal saline, blood transfusion and antibiotics. She was catheterised and size 18 naso-gastric tube passed for drainage. The packed cell volume on admission was 22%. She was counselled for laparotomy under general anaesthesia. Operative findings included an incomplete (i.e. intact visceral peritoneum) reverse uterine rupture wholly in the lower segment measuring about 10cm. A fresh female stillborn (weight=2.8kg) lying transversely and partially extruded from the uterus. She had repair and bilateral tubal ligation. The postoperative course was smooth. She received two units of blood postoperatively and packed cell volume on the 4th postoperative day was 32%. She was
allowed home on the 8th postoperative day to be followed-up in the gynaecologic/family planning clinic.

Discussion

Ruptured uterus is a common event in developing countries with an incidence rate of 1:100 - 400 deliveries documented for Sub-Saharan Africa \(^1,4,6\) as against 1: 4000-6000 deliveries in resource rich areas of the world. \(^1,9\) In many series reported from Africa, primary uterine rupture from obstructed labour due to cephalo-pelvic disproportion and malpresentation among grandmultiparous patients are commonly encountered. \(^1,3,4,6,12,13\) Our patient was Para\(^4\) and developed primary uterine rupture from mechanical dystocia due to transverse lie. The uniqueness of this case was the spontaneous delivery of the placenta via the vagina. As stated by Lawson, \(^12\) the spontaneous delivery of the placenta in the presence of dystocia is ruptured uterus until proved otherwise. The mode of presentation of this case clearly illustrates this. It is probable that there was also some degree of placenta praevia which thus facilitated exit of the placenta.

Controversies still exist concerning the optimal surgical technique in the treatment of uterine rupture; repair with or without tubal sterilization or hysterectomy. Reports from Africa \(^13,14\) favoured simple repair with bilateral tubal ligation. In our centre repair with tubal sterilization is the rule not only because of fewer postoperative morbidities when compared to hysterectomy\(^13\) but also due to strong cultural inhibition to the latter.

Prevention of obstructed labour remains the key to the elimination of uterine rupture in our environment. This mainly involves improvement of the socio-economic condition of the people, adequate antenatal and intrapartum supervision and utilisation of family planning services.

References