Spontaneous Uterine Rupture

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Article ID: WMC00946
Article Type: Case Report
Article URL: http://www.webmedcentral.com/article_view/946
Subject Categories: SURGERY
Keywords: uterus, perforation, sepsis

How to cite the article: Yasar N, Topaloglu A, Caga T. Spontaneous Uterine Rupture. WebmedCentral SURGERY 2010;1(10):WMC00946

Source(s) of Funding:
No funding is declared

Competing Interests:
No competing interest is declared
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Abstract

Spontaneous uterine rupture is a very uncommon condition. Once ruptured, findings of generalized peritonitis becomes prominent, which may lead to septic shock unless it is treated on time. In our case, we present a 66-year-old woman who was referred to the emergency department in state of septic shock. During laparotomy, intraabdominal pus due to spontaneous rupture of the uterus was explored. After emergent surgery, close follow-up and prompt intervention of the complications enable the survival of the patient.

Case Report(s)

A 66-year-old woman was referred to the emergency department with complaint of cramping abdominal pain over a week and increased by time. She presented a history of hospitalization in this time period, due to subileus in another center and during the investigation, perihepatic and perisplenic free gas, free collection in the Douglas, perihepatic and right paracolic space were identified by abdominal computed tomography and no significant finding was recorded by the colonoscopy. Both examinations were performed one week before her admission to our emergency department. Because her complains increased dramatically, just before her referral, a control ultrasonography was performed and diffuse collection with high density, probably pus, was shown. In her medical background, she had no history of sexually transmitted disease nor application of intrauterine device. She had 8 pregnancies and all of her deliveries were normal vaginal deliveries. On physical examination, the abdomen was distended and tenderness was noted to direct and rebound palpation with guarding in all quadrants but remarkably greater in the lower quadrants. Disorientation, hypotension (90/60 mm/Hg) and subfebrile temperature (37.8 °C) was recorded. Routine hematological and biochemical investigations revealed raised total leucocyte count (14,700/mm³) and decreased hemoglobin (7.2 g/dl) and potassium (2.7 mg/dl) levels. Regarding the findings of acute abdomen, the patient underwent surgery without additional radiological investigation. During the laparotomy, 5 liters of intraabdominal pus was aspirated and no pathological finding was explored but two different perforation sites which were localized on the superior and posterior walls of the uterus. After an effective abdominal washout, total abdominal hysterectomy and bilateral salpingooophorectomy was performed. On the fifth postoperative day, her health status was deteriorated and fever with leucocytosis on complete blood count accompanied. A second computed tomography of thoracoabdominopelvis was taken and abscess formation with a diameter of approximately 10 cm between the stomach and spleen was shown and percutaneous drainage under computed tomography guidance was performed. Subsequently, she recovered from septic shock and discharged from the hospital on the fifteenth postoperative day. Culture of the sample taken perioperatively grew E. Coli. Chronic inflammatory changes in the microscopic cross sections is reported by the pathologic assessment.

Discussion

Pyometra is defined as the accumulation of pus in the uterine cavity resulting from interference with its natural drainage [1-8]. This uncommon condition occurs mainly in postmenopausal and rarely in premenopausal women [1,3,5]. Its reported incidence is 0.5% in gynecologic patients [1]. The cause of this specific pathology is cervical occlusion by benign or malignant tumors or secondary to surgery, radiotherapy or cervicitis. To our knowledge, only 27 cases of spontaneous uterine rupture have been reported in English literature including our case [1]. Purulent vaginal discharge, postmenopausal bleeding and severe lower abdominal pain are the typical findings. However, in patients with perforation, there would be no vaginal discharge [1,3,6]. Once ruptured, findings of generalized peritonitis becomes prominent, which may lead to septic shock unless it is treated on time. In our case, no complaint of vaginal discharge was noted and the patient had already presented the findings of septic shock at her admission.

Conclusion

As in our case, the only life-saving treatment is emergent laparotomy in state of generalized peritonitis.
and septic shock. Usually, hysterectomy is the best choice of procedure after abdominal washout and drainage is performed. Postoperative respiratory insufficiency and intraabdominal abcess formation are the main causes of the mortality. Close follow-up and prompt intervention of the complications enable the survival.
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