



## Ruptured uterus presenting as fecal fistula

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### Case report

Mrs. SM, a 30 year old woman with 9 months amenorrhea was admitted on 25<sup>th</sup> March, 2001 at 16.44 hours with the complaints of foul smelling watery vaginal discharge and passage of bone like structures alongwith foul smelling purulent discharge from the abdomen at the site of previous lower segment cesarean section (LSCS) scar for the past 1 week.

She was G<sub>3</sub> P<sub>2+0</sub>. Her first delivery was a full term normal vaginal delivery 12 years back. Her second delivery was a LSCS, conducted in the village, 7 years back. Her third pregnancy was the present pregnancy. She had no antenatal care in this pregnancy. According to her, she was 9 months pregnant but for the past 2 weeks her abdominal fullness had reduced remarkably and there were no fetal movements. There was no abdominal pain or vaginal bleeding.

On examination, she was cachectic with severe pallor. Her pulse rate was 120/minute, pulse regular and blood pressure 100/70 mmHg. Cardiovascular and respiratory systems were normal. On abdominal examination, the uterus was of 28 weeks size. There was a sinus on the anterior abdominal wall at the site of the previous scar through which very foul smelling fecal matter was draining. On vaginal examination, the cervix was flushed with vagina and os was closed.

Investigations: On admission, her Hb was 6 g/dL and leucocyte count normal. Serum sodium was 122 meq/L, serum potassium 4.19 meq/L, and serum chloride 86 meq/L. Ultrasound revealed an enlarged uterus with midline echo and

the fetus crumpled up behind the uterus in the abdominal cavity. Fetal heart beat was absent. A provisional diagnosis of ruptured uterus with fecal fistula was made.

As the patient was severely anemic, she was given two units of blood, and cefotaxime and metronidazole were started parenterally.

She was taken up for laparotomy on 20<sup>th</sup> March, 2001. On opening the abdomen, a ruptured uterus, and macerated fetus and placenta lying outside the uterine cavity were seen. There was bilious and fecal matter inside the peritoneal cavity. There were intestinal adhesions to the anterior abdominal wall which were separated by blunt dissection with a finger. Two sites of intestinal perforation were detected – one 7 cm and another 20 cm from the ileocecal junction. About two feet of ileum was resected and a primary re-anastomosis was done. Subtotal hysterectomy was carried out. Postoperative recovery was uneventful except for a little serous discharge from stitch line for 3 days.

### Discussion

Rupture uterus is the most dreaded complication in obstetric practice and may lead to maternal death if not diagnosed and treated in time. The American College of Obstetricians and Gynecologists reported a 1 to 7% incidence of scar rupture in women with previous lower segment cesarean section <sup>1</sup>.

The cases of ruptured uterus are mostly emergency admissions. Morbidity and mortality are proportional to delay in diagnosis, adequate transport facilities and availability of blood.

Mukherjee and Roychowdhury <sup>2</sup> reviewed 70 cases of ruptured uterus. Scar rupture accounted for 40% (28/70) of their cases. In these 28 cases of scar rupture, they reported 4 maternal deaths (14.3%).

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Kulkarni et al (1998) reviewed 145 cases of ruptured uterus over a period of 10 years. Scar rupture accounted for 18.6% of their cases. The most common complications reported by them are bladder injury, broad ligament hematoma and colporrhexis.

In another review of 117 cases of rupture uterus by Sinha and Roy <sup>4</sup>, scar rupture was found in 26.49% cases. Bladder and broad ligament involvement were found to be the common associations with ruptured uterus. Bowel was involved in only one case where evisceration was attempted.

Our case had a silent rupture of a previous LSCS scar following which the fetal bones perforated the bowel at two sites. This led to fecal fistula discharging fecal matter through the previous subumbilical midline incision. Fetal bones were also

extruded through this site. Formation of fecal fistulas following silent rupture of gravid uterus in a women with previous ceserean section scar is a rare and grave complication accounting for a lot of morbidity and prolonged hospital stay. We could find no report of a similar case in the literature.

#### References

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