Rupture of the Uterus:

Treatment by suturing the tear

by Johan A.M. Thambu
MBBS (Malaya), MRCOG (Lond), AM
Pakar Peribidanan dan Sakitpuan,
Rumah Sakit Bersalin,
Kuala Lumpur.

IN RECENT YEARS, interest has been focused on the conservative treatment of uterine rupture (Menon 1954; Swami and Patel 1960). Seth (1968) described his experiences of repair of the uterine rupture without carrying out sterilisation.

Materials

The study covers all cases admitted to the Department of Obstetrics and Gynaecology, Rumah Sakit Umum Kuantan for the period January 1968 to December 1969. All the cases of ruptured uterus were referrals from the outlying rural areas to the nearest District Hospital and from there to Rumah Sakit Umum Kuantan.

TABLE I
Methods of Treatment of cases of ruptured uterus, G.H. Kuantan

	Year 1968	Year 1969
Treatment	No. of cases	No. of cases
Hysterectomy	3	1
Suturing and sterilisation	1	3

Case Report

The first case in this report is described below so as to illustrate the problem and the method of treatment.

A 30-year-old Malay woman Gravida 7, Para 3, stillbirth 3, was referred to a district hospital from a remote village. She had been looked after by an untrained kampong bidan and since there was no progress in labour, the kampong bidan carried out 'urut' (Malay term for massage). Subsequent to this, the patient became restless and developed severe abdominal pain. The relatives then took her to the nearest district hospital, where she was diagnosed as a case of obstructed labour and immediately referred to Rumah Sakit Umum Kuantan on 22nd January 1968.

On admission to hospital, her condition was poor and clinical examination showed a shocked patient with a tense abdomen. Foetal parts were easily felt inspite of the tense abdomen. A diagnosis of rupture of the uterus was made, the patient was resuscitated, and an emergency laparatomy was carried out under general anaesthesia. The findings at laparatomy were, a dead foetus weighing 7lbs. 2 ozs. lying free in the peritoneal cavity. The uterus showed a large circular irregular tear in the lower segment extending laterally to the posterior surface. The uterus above the tear was only held on to the lower segment by a 2" broad posterior band. A decision was made to repair the tear. The ragged, traumatised edges of the tear were excised and the repair carried out in two layers.

Bilateral tubal ligation was carried out. Her post-operative period was uneventful apart from pyrexia which responded to antibiotics. She was discharged and sent home on the 13th post-operative day. She was followed up in the gynaecology clinic for over a

period of one year. She had no complaints. Her menstrual cycle was normal.

Discussion:

Rupture of the uterus is a rare condition but doctors in the rural areas would occasionally meet such cases. The patient is always an unbooked case with no previous obstetric care and the delivery managed by an untrained midwife or bomoh. A common aetiological factor in the causation of the rupture has been the practice of 'urut' or massaging the uterus in labour.

'Urut'

This is a common procedure carried out by the untrained midwife for a number of obstetrical and gynaecological problems. Sambhi (1968) described his experiences about the bomoh's abdomen. Urut or massaging the abdomen has been practiced to induce bleeding in cases of delayed period; to induce abortion; to induce labour and to hasten labour. It is a safe procedure in the gynaecological or postnatal patients where urut, in combination with the application of special oil, followed by abdominal binders with cloth, helps the patients to get their muscle tone back and reduce the incidence of genital prolapse. But urut carried out in late pregnancy or in labour in an attempt to deliver a patient is a dangerous procedure. The prolonged labour may be due to an obstructed labour and pressing the fundus with extreme violence would rupture the uterus (Ferguson & Peid 1958, Trivedi, Patel and Swami 1968).

In view of this widespread practice of urut in the rural areas, rupture of the uterus could occur in a young patient. Traditional obstetric practice has always stressed that the treatment of rupture of the uterus is hysterectomy. I feel that because of the special socio-economic-cultural factors, conservative surgery (i.e. resuturing the tear with or without sterilisation) has a special place in the management of these cases. The special factors which would influence the decision is as follows.

1. **Age** – The patients are usually young and reproductive and child-bearing is very important to these young rural mothers.
2. **Menstruation** – To the rural Malay women, menstruation is an important part of her life. With hysterectomy, this function is lost and the patient feels that she is not a complete woman. Post-hysterectomy patients always complain that they are not well and feel unhappy that the 'dirty' blood is not flowing out monthly. In spite of detailed explanation regarding the physiology of menstruation, these patients feel that to be healthy, menstruation must occur at monthly intervals.
3. **Poor general condition** – By the time the cases of ruptured uterus are referred to hospital, the condition of the patient is very poor. Inspite of active resuscitation, these patients present a grave risk for any major operative procedure like hysterectomy. In such cases, simple resuturing, followed by sterilisation, is the safest procedure.

Conclusion

In young rural women presenting with a ruptured uterus, simple resuturing of the rupture has a place in the treatment.

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References

1. Ferguson R.K. and Reid D.E. (1958) *Amer. J. Obstet. Gynaec* 76, 172.
2. Swami N.B. and Patel T.V. (1960) *J. Obstet. Gynae. India* 11.63.
3. Sambhi J.S. (1968) *Far East. Med. J* Vol. 11 347.
4. Sheath S.S. (1968) *J. Obstet. Gynaec. Brit.* (Wltn. Vol. 75 pp 55 – 58).
5. Williams – Hunt P.D.R. (1952) Malayan Aborigines Govt. Press, Kuala Lumpur.
6. Trivedi RR. Patel KC and Swami N.B. *J. Obstet. Gynae. Brit.* (Wltn. Vol. 75 pp 51-55).