UTERINE RUPTURE FOLLOWING A MOTORCYCLE ACCIDENT AT N'DJAMENA (CHAD). A CASE REPORT.

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ABSTRACT

Rupture of a gravid uterus is a rare complication of motorcycle accident. We report the case of a 33-year old woman, gravida 6, referred as a case of uterine rupture with intrauterine fetal death at 36 weeks gestation, following a motorcycle accident. Emergency laparotomy revealed an anterior - lateral uterine rupture on the right side about 11 cm which involved the ipsilateral uterine artery. A conservative surgical treatment was employed. Splenectomy was also performed.

KEYWORDS : Uterine rupture - Pregnancy - Abdominal trauma - Road traffic accident.

INTRODUCTION

Uterine rupture is defined as a solution of non-surgical continuity of the uterus[1]. It became exceptional in the industrialized countries[2]. In Africa to the south of the Sahara; it constitutes a major obstetric problem. Its frequency is in order of 0.6% in Central African Republic[3], 1.01% in Enugu (Nigeria)[4], 1.15% in Bamako (Mali)[5] and 2.33 % in Niger republic[6]. Uterine rupture still remains one of the obstetrician's essential preoccupations. The main reported aetiologies are[7,8]: foeto-pelvic disproportion, dystocic presentations and the inappropriate use of the oxytocin. Among these aetiologies trauma is a cause in less than 1% [9]. We report a case of uterine rupture by direct abdominal trauma during a road accident in N'djamena (Chad).

CASE REPORT

Mrs. B.A. 33 years, 6th pregnancies, 5th deliveries with 5 living children (in her first marriage), was referred to our hospital in March 25, 2014 at 2 P.M by a peripheral health center for suspicion of uterine rupture post road accident. The pregnancy was dated to 36 weeks gestation based on an early ultrasound scan at 10 weeks of gestation.

The accident occurred two hours before presentation. The patient was a passenger on a motorcycle which collided with another motorcycle during a rush hour. Her abdomen knocked the handlebar of the motorcycle. She was first transported to a center of heath situated close to the place of accident.

Then she was evacuated to the maternity of the Mother and Child Hospital for better treatment. Pregnancy has been uneventful; she has made 5 prenatal consultations (of which the last was 2 days prior to the accident). All previous childbirths were normal and the patient has never been operated. On admission, she complained of generalized abdominal pain. She was conscious. The general examination revealed a general stage kept with pale conjunctivae mucous, an arterial tension of 80/60 Hg mm, a radial pulse of 120/minute and a temperature of 37.3°C.

The obstetric examination especially noted a painful abdomen in her whole mostly in sub umbilical area and to the left upper quadrant. It's difficult to delimit the uterus,

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but we noticed a sensation of fetus under skin and the absence of the fœtal's heart during auscultation. On vaginal examination, the vulva was clean and the cervix was anterior, soft and closed.

The rest of the clinical exam didn't note any other anomaly. An assessment of uterine rupture was made and the patient was prepared for laparotomy. Finding at the laparotomy revealed hemoperitoneum of 1500 ml and an intra-abdominal fetus with its placenta (weight = 2850g, feminine sex, born death, size = 49 cm, cranial Perimeter = 33 cm, thoracic Perimeter = 28 cm). After the extraction of the fetus an anterior - lateral uterine rupture in the right side reaching the vascular pedicle of about 11 cm of length was observed. A hysteroraphy was performed.

The exploration of the abdominal cavity discovered a lesion of the spleen about 3cm situated on the anterior face. The visceral surgeon conducted a splenectomia. The abdomen has been closed on a drain (blade of Delbet) put in place in the right parieto-colic gutter. The blood loss was compensated intra operatively by transfusion of 4 units packed red blood cells type (O +). The postoperative course was simple with discharge at the 7th postoperative day. In order to prevent pregnancy, contraceptive method based of progesterone (implanon[R]) was used during follow up.

DISCUSSION

Uterine rupture that occurs following violent trauma on healthy uterus seat typically affects the anterior face or the uterine bottom. These lesions are often associated with placental detachment. The consequences are more on the mother than for the fetus [9-11]. Most uterine rupture following road accidents occur at term [12] as seen in the index case.

The diagnosis of uterine rupture is usually clinical and straightforward as in the case presented. This obvious diagnosis found in our case is imputed on the one hand to the clinical stage and on the other hand to the circumstances of intervening. The uterine trauma followed by abdominal pains and the hemodynamic stage at the presentation are all in favor of uterine rupture.

At laparotomy the option are either conservative or radica1[12]. Our approach was conservative like those reported by earlier authors[12, 13]. The lack of tubal ligation in this case can be explained by social reasons. In Chad, to perform tubal ligation we need before a written consent. The second reason is related to the family's situation of our patient. She never gave birth with her new husband.

Maternal prognosis depends more on the extent of the lesions and the speed of the treatment. The quick treatment appears like a factor reducing blood loss and limiting its impact on the maternal hemodynamic stage. The spleen rupture found in our case was a factor that exacerbated the blood loss.

The high fetal mortality associated with uterine rupture has been reported in the literature[14-16]. However, according to Dao[12] the fetal lethality is not directly related to the severity of the accident, but result from the complications related to placenta' detachment.

CONCLUSION

Uterine rupture in pregnancy is a rare phenomenon. The diagnosis is often obvious and straightforward. Resuscitation and laparatomy should go in tandem. In per operative period the search for associated visceral lesion is always necessary. Beyond contraceptive treatment aimed to prevent pregnancy, the obstetrical prognosis is compromised. Then caesarean section should be indicated for future delivery. ■

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