Incarcerated Gravid Uterus in an Incisional Hernia

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ABSTRACT

Incisional hernia of the anterior abdominal wall is common but gravid uterus herniating into the sac is rare. Even rarer is the gravid uterus getting incarcerated in the hernia sac. The authors present an interesting obstetric challenge wherein a 30 year old pregnant lady reported to their antenatal clinic with an unusual bulge in the lower abdomen at the 7th month of pregnancy. This was found to be an incarcerated gravid uterus. It was further complicated by the presence of a trophic ulcer on the skin overlying the uterus. Very few such cases have been reported in literature and each one is a study in itself. The authors would like to share their experience in successfully managing the condition with the assistance of information from the internet and colleagues from across the globe. They will also identify the lessons learnt from this experience.

Keywords: Delivery, Gravid, Hernia, Incarcerated, Incisional, Ulcer, Uterus

INTRODUCTION

It has been frequently reinforced during medical discussions and teaching sessions that the eyes do not see what the mind does not know. It is perhaps equally important to realize that when eyes do see something that a mind does not know, it is time to search and interact with minds that do know. When the lady who is the focus of this case study walked into the antenatal clinic, the resident doctor was completely bewildered as to what the abdominal “lump” was that was found on clinical examination. The lady had a history of amenorrhoea and fetal heart sounds could be heard on auscultation. The question the doctor asked is: “Is this an abdominal pregnancy?” That is a pregnancy that is outside the uterus. A search on the internet not only helped us to establish a diagnosis it also enabled us predict complications and manage the patient. We feel we owe it to our colleagues to share our experience with them.

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Why did we write it up:

1. Incarceration of gravid uterus is a rare complication of an incisional hernia but can be diagnosed easily if one is aware.
2. There are predictable but preventable complications so it is important to add to the information and case reports available in published literature.
3. There are no established management guidelines for such rare conditions; however, reported cases form a good database for taking treatment decisions.
4. With a rising rate of caesarean deliveries the world over, we may come across this condition more often, especially in the resource poor settings with prevalent malnutrition and high wound infection rates.

CASE DETAILS

A thirty year old lady presented to antenatal clinic of our hospital in the seventh month of her pregnancy. She complained of discomfort in her lower abdomen and was concerned about the peculiar pendulous shape of her abdomen which had developed during the previous two weeks. She could perceive fetal movements well. There was no associated vaginal discharge and she had no symptoms of urinary or bowel conditions.

The lady belonged to the lower socio-economic class and came from a nearby village in central India. She had not received antenatal care anywhere except for the tetanus booster vaccination and iron supplementation tablets provided by the health care worker of her village. (The local health care workers in villages include the Auxiliary Nurse Midwives (ANM) in addition to a woman from the village community called the ‘Anganwadi’ worker. They pay home visits to pregnant women for distribution of iron tablets and for tetanus immunization.)

This was her fifth pregnancy. She had had two normal vaginal deliveries 12 and 9 years prior to this pregnancy. She subsequently had a term delivery by caesarean section about eight years ago. Sadly the child died soon after birth. There were no health records and the patient could not tell us the reason for the caesarean delivery or the cause of neonatal death. Postoperatively, she developed skin wound infection that was managed conservatively. In the following months she became aware of an abnormal bulge (the incisional hernia) in the lower abdomen but did not seek medical help. She went on to have an uneventful pregnancy and normal vaginal delivery (Vaginal Birth After Caesarean or VBAC) about 6 years ago. So she had three living children.

Following the last delivery, she got concerned about the persistent abdominal bulge. She underwent a surgery for repair of incisional hernia about 5 years ago at another centre but it failed and she noticed recurrence of hernia within three months of repair. She did not follow up at that centre or elsewhere for hernia recurrence.

On examination, the patient was thin with an average frame. She looked pale and the general physical examination was suggestive of malnutrition. Her skin was dry and wrinkled, her hair was thin and lustreless and her nails were pale and brittle. Her vital signs of temperature, pulse, respiration and blood pressure were normal. The systemic examination was essentially within normal limits. On her abdomen, there was a full length incisional hernia of the infra-umbilical midline vertical scar. The hernia sac contained the 28 week size gravid uterus that appeared like a pendulous mass of the lower abdomen reaching almost up to mid thighs on standing (Figure 1). It was irreducible (incarcerated) even when the patient was supine; however, there were no features suggestive of strangulation. The abdominal wall and skin over it was thin and stretched with ischemic changes in the most dependent portion. Two ulcers, each approximately 2cm.x2cm, with necrotic debris were present over this area (Figure 2). The uterus was relaxed, the fetal parts were easily palpable and fetal heart sounds were normal and regular.

Except for mild anaemia (Hemoglobin: 10.5g/dL), the baseline routine blood investigations were within normal limits. The initial
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