Case Report

Gravid uterus: unusal content of incisional hernia – case report

Agarwal Vimal K[1*], Agrawal Sonal[2]

{[1]Assistant Professor, General Surgery} {[2]Assistant Professor, Obstetrics & Gynecology}
Jhalawar Medical College and Associate Group Of Hospital, Jhalawar, Rajasthan, 326001, INDIA.
Email: drvimal01@gmail.com

Abstract

A 23 year old woman presented in outpatient Department in obst. and gynecology her 3rd pregnancy at 32 weeks of gestation age in labour with an unusual bulge of her lower abdomen. Abdominal bulge was her gravid uterus herniating through anterior abdominal wall. Incisional hernia is though not rare, but potentially serious condition due to its antecedent complications. Initially these hernias may be reducible, but delay in recognition can lead to incarceration and subsequent strangulation of gravid uterus. In this case Caeserean section and bilateral tubal ligation were done with repair of incisional hernia with nonabsorbable suture with uneventful post operative recovery. Even for emergency operations like caesarean section surgical principles must be followed.

Key words: Herniated gravid uterus, incisional hernia, hernia repair, caesarean section.

[*]**Address for Correspondence:**
Dr Vimal Kr Agarwal, B-3, Anand Vihar Colony, Kothi Road, Jhalawar, Rajasthan, PIN 326001, INDIA.
Email: drvimal01@gmail.com

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INTRODUCTION

Incisional hernia of anterior abdominal wall in women is not rare but herniated uterus through an abdominal incisional hernia is uncommon.[1] It is potentially a grave obstetrical situation with serious maternal and fetal risks such as incarceration, strangulation, rupture of lower Uterine Segment (LUS), skin ulceration.[1,2] An incisional hernia usually starts as symptomless partial disruption of deeper layers of laprotomy wound during immediate or early post operative period. In our case report patient is having incisional hernia as a complication of previous caesarean section. When patient became pregnant and pregnancy advanced uterus found itself in the sac of incisional hernia.

CASE REPORT

A 23 year old woman having her 3rd pregnancy presented in emergency at 32 weeks of gestation with labour pains and unusual bulge of her lower abdomen (fig.1). She was an unbooked case. Her obstetric history revealed 1st Cesarean Section by Pfannenstiel incision for cephalopelvic disproportion four years back. Baby died at 3 month of age due to sickness. She had 2nd Cesarean section by vertical incision for obstructed labour two years back. Her 2nd baby also died at 6 months of age. During second caesarean section patient give history of prolonged stay in hospital and fever probably due to surgical site infection.

In this pregnancy she did not had any antenatal checkup. As labour pains started she was referred to tertiary centre from CHC. General physical examination revealed a short stature women poorly nourished with mild degree of pallor. She was afebrile with temperature 37.2^0 C. Cardiopulmonary status was normal with pulse rate 68/min, BP 120/80mmHg and lung fields were clear. Lower abdomen was distended with midline scar of around 25 cm and transverse scar of 15 cm, skin looked thin stretched and shiny. Fundal height was around 32 cm and fetal parts were felt through defect on anterior abdominal wall. Fetal heart sounds were regular. In supine position gravid uterus appeared like football on anterior abdominal wall. Hemogram and urine

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examination were normal. Pelvic Ultrasound revealed uterine fundus and body herniated in incisional hernia and single live fetus of 32 weeks gestationl age in longitudinal lie with severe oligohydroamnios and normal situated placenta. In view of situation she signed consent for emergency lower segment caesarean section and bilateral tubal ligation. Caeserean section was performed by midline vertical incision and alive male child of 2 kg was delivered. Liquor was meconium stained. Baby had apgar score 7 at 1 minute and 9 at 5 minute and did well. Bilateral tubal ligation was also done. Operative findings- uterus was present in hernia sac and size of defect was around 20cm x 15cm (figure 2).

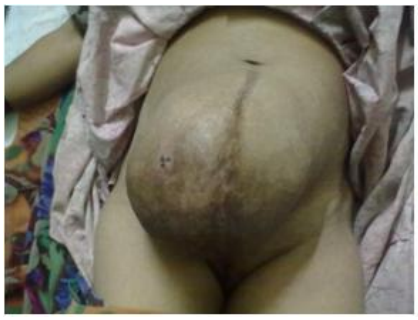

Figure1

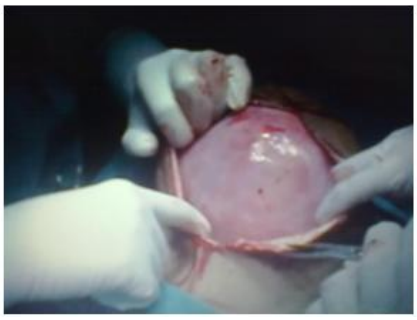

Figure 2

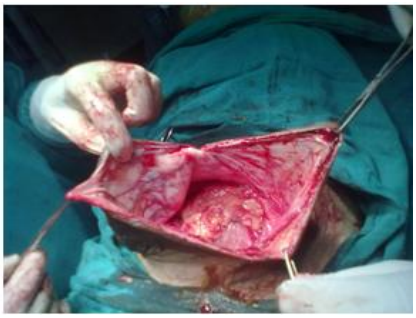

Figure 3

Legend

Figure 1: An Unusual bulge of lower abdomen through incisional hernia containing gravid uterus.
Figure 2: Showing gravid uterus coming out after opening hernia sac.
Figure 3: showing hernia sac after closure of uterus.

Anatomical hernia repair (suture repair) was also conducted with polypropylene suture 1-0 after delivery of child. Redundant skin and subcutaneous tissue was excised. Abdominal binder was also provided for post operative period. Patient made uneventful postoperative recovery and was discharged on 12th postoperative day after stitch removal. She was reviewed in postnatal clinic after 6 weeks, both patient and baby did well. There was no evidence of recurrence of incisional hernia.

DISCUSSION

The incidence of anterior abdominal wall incisional hernia varies below 5% - 15%, while caesarean section account for 3.1%.[3,4,5] A literature search revealed only 15 reported case of incisional hernia containing gravid uterus as content worldwide.[2,6,7,8] The presence of gravid uterus in an anterior wall incisional hernia can pose a serious obstetric situation which requires emergency reduction. Herniated gravid uterus may cause ulceration on anterior abdominal wall, preterm labour, IUGR, accidental haemorrhage, strangulation, intrauterine death, rupture of lower uterine segment, postpartum haemorrhage, dysfunctional labour, caesarean hysterectomy and even death.[4,5,9,10,11] The predisposing factors include midline or T shaped incision, infection and malnutrition along with poor surgical technique, presence of postoperative distension, intra abdominal abscess. As far as our case has been concerned the patient was was having T shaped laparotomy scar with lower socioeconomic strata and malnourished. Incisional hernia is a frequent complication of abdominal wall closure with a reported incidence of 5% - 15% following vertical midline incision at one year follow up. In our case there was weak scar of 2nd caesarean section due to obstructed labour. Though herniorraphy can be performed during pregnancy but if there is necrosis of skin or risk of incarceration it is usually postponed till delivery as the enlarged uterus may interfere with healing. In our case patient reported in labour pains so hernia repair was done along with caesarean section with non absorbable suture. Little has been reported about the fate of abdominal wall subjected to future pregnancies following repair of ventral hernias. However our patient consented for bilateral tubal ligation because this was her 3rd caesarean section and she did not want to undergo anymore psychosocial trauma of pregnancy. A well placed incision may require less traction for exposure, undergo less tension after closure and produce less separation of layers. In general transverse abdominal incisions have fewer disruption than vertical ones.[5,12]

CONCLUSION

Management of pregnant patients with uterus lying in incisional hernia needs to be individualized depending on severity of complications and gestational age at presentation. Conservative management until term is recommended, and herniorraphy should be postponed until delivery, as antenatal repair is not possible during antenatal period because of gravid uterus. But if strangulation of uterus occurs at near term, emergency

laprotomy caesarean delivery followed by repair of hernia may be the best option. In emergency operations including caesarean section surgical principles should not be violated.

REFERENCES

1. Sahu L, Bupathy A. Evisceration of pregnant uterus through incisional hernia site. J Obstet Gynaecol Res. 2006;32:338-340.
2. Malhotra M, Sharma JB, Wadhwa L, Arora R. Successful pregnancy outcome of cesarean section in a case of gravid uterus growing in incisional hernia of anterior abdominal wall. Indian J Med Science 2003; 57:501-503.
3. O Dwyer PJ, Courtney CA. Factors involved in abdominal wall closure and subsequent incisional hernia. Surgeon.2003;1:17-22.
4. Rao Radha S, Shankaregowda HS. A case of herniated gravid uterus through a laparotomy scar. Indian J Med Sci.2006;60:154-157.
5. Adesunkami AR, Faleyinmu B. Incidence and aetiological factor of incisional hernia in a post caesarian operation in a Nigerian hospital. J Obstet Gynaecol.2003;23:258-260.
6. Saha PK, Rohilla M, Dahiwal LK, Gupta I. Herniation of gravid uterus: Report of 2 cases and Review Literature. Medscape General Medicine 2006;8:14.
7. Banerjee N, Deka D, Sinha A, Prasad R, Takkar D. Gravid uterus in incisional hernia. J Obstet Gynacol Res 2001;27:77-79.
8. Nagpal M, Kaur S. Herniated pregnant uterus with bleeding from previous abdominal scar. J Obstet Gynaecol India 2003;53:283.
9. Dare O, Lawal OO. Experience with 29 case of female ventral incisional hernia in Ile Ife, Nigeria Int J Gynaecol Obstet. 1991;36:29-32.
10. Fullman PM. An incisional hernia containing an incarcerated twin pregnant uterus. Am J Obstet Gyecol. 1971;111:308-309.
11. Dare FO, Makinde OO, Lawal OO. Gravid uterus in an anterior abdominal wall hernia of a Nigerian woman. Int J Gynaecol Obstet. 1990;32:377-379.
12. Duncan JL, Rogers K. Umblical and Epigastric Hernia Surgery. 1991;97:2326-2329.

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