Case Report

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Gravid Uterus in an Anterior Abdominal Wall Hernia and Successful Repair at the Time of Cesarean Section

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Abstract

This is a case report of a pregnant woman with previous 1 cesarean and 1 ectopic exploration whose uterus herniated in an incisional hernia of the anterior abdominal wall at 33 weeks + 6 days of pregnancy. Incarceration of the pregnant uterus in an incisional hernia is a rare but serious obstetric situation1. Treatment is conservative until term followed by delivery and repair of incisional hernia thus resulting in a successful outcome

Keywords: Incisional hernia; Cesarean section; Pregnancy complication.

Introduction

The herniation of a gravid uterus through an incisional hernia site is a rare occurrence.[2] Incisional hernia is a frequent complication of abdominal wall closure and the management of pregnancy with a large incisional hernia with a gravid uterus in its sac is challenging.

Following is a Case report of gravid uterus through an incisional hernia of a midline incision. 33 years old Gravida 3, Para 2, Live 1, Ectopic 1 with previous history 1 ectopic exploration and 1 cesarean section through midline incision was admitted due to lower abdominal pain on & off and ulceration of abdominal skin over incisional hernia at 33 weeks 6 days. She was booked case at government hospital, karaikal. Had her regular checkups until 2nd trimester there. At around 21 weeks she was diagnosed to have small anterior wall defect and referred. Came for 1st antenatal check up at 28 weeks to our hospital,was diagnosed as G3,P1,L1,E1 at 28, weeks with incisional hernia and was managed conservatively at subsequent antenatal visits. General surgeon opinion was obtained and planned for elective cesarean section after 37 completed weeks with incisional hernia repair. Her past obstetric history revealed that she had her ectopic exploration 4 years back and a cesarean section 3 years before because of post dated pregnancy. On both occasions she was operated on through infra umbilical midline vertical incision. There was no history of cesarean section wound infection during the postoperative period in the previous two pregnancies. On examination she was moderately built and nourished, there was mild pallor, her pulse rate was 80 beats per minute and her blood pressure was 120/80 mm Hg.

Abdominal examination revealed Distention of abdomen in central area. Uterus size could not be made out, uterus was felt just underneath with a complete lack of anterior abdominal wall. Fetal heart rate was 144 bpm, Huge defect on the anterior abdominal wall measuring 14*14 cm with the uterus herniating through the defect. Lie and presentation could not be made out. Superficial skin necrosis and Skin ulceration was present. Routine investigations

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were within normal limits. Ultrasound examination showed the uterus herniated in the incisional Hernia of the anterior abdominal wall with the live fetus in cephalic presentation without any gross congenital malformation. Placenta was located in upper uterine segment. She was kept in observation for bed rest with abdominal support. Antiseptic skin ointment was applied over the skin of the anterior abdominal wall. An Elective Cesarean Section was planned AT 37 Completed Weeks and Repair of Incisional Hernia.

Fig. 1: Picture Depicting an Anterior Abdominal Wall Defect with Herniation of Uterus, with Overlying Skin Necrosis and Ulceration.

But on 35 weeks + 4 days, she developed severe pain over her previous scar, on examination she had tachychardia and on per abdomen uterus was irritable, scar tenderness was noticed, FHS 110–140/min. In view of scar tenderness, she was taken up for Emergency LSCS With Incisional Hernia Repair.

Intraoperative Findings Abdomen was opened by elliptical incision. Uterus was visualized just beneath the skin and there was no evidence of the rectus sheath in the vicinity of the incision. Large defect on the anterior abdominal wall was seen. Uterine incision was made over the previous scar and She delivered an alive female baby of weight 2.6 kg with apgar score of 7 and 9 at 1 and 5 minutes respectively. Uterus was closed in layers.

Rectus sheath was mobilized and repaired 'with prolene. Herniorraphy was done. She was given a course of antibiotics. Her postoperative period was uneventful and she went home with a healthy baby weighing 2.45 kg. During her follow up visits she was found to be problem free.

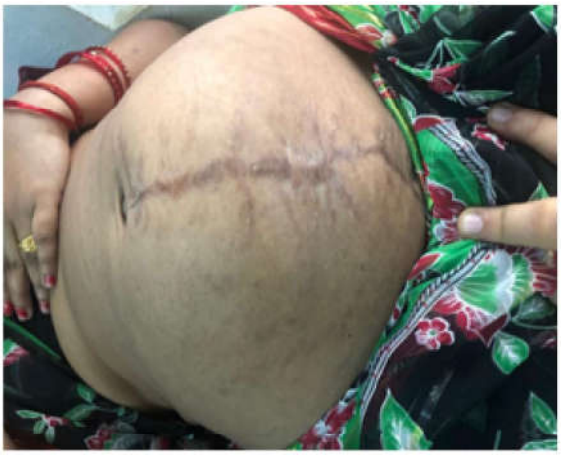

Fig. 2: Post Surgical Picture Depicting the Repaired Incisional Hernia with a Healthy Scar.

Discussion

Herniation of the uterus through an incisional hernia of anterior abdominal wall is very uncommon. Very serious risk to both the mother and the foetus, Full term pregnancy in an incisional hernia of anterior abdominal wall is rarer. Remote complication of a cesarean section could be an incisional hernia due to defective abdominal wall.[1] The complications that have been reported in literature in association with this complication include strangulation, abortion, preterm Labor, accidental hemorrhage, intrauterine fetal death and rupture of lower uterine segment.[3]

Excessive strsetching of the skin may cause ulceration of the skin, as in this case due to friction between the hernia sac and other parts of patient's body.

Management Options

The management of pregnant patient with incisional hernia possess a dilemma as no consensus about the timing of surgical repair or the ideal technique to be used.[4] Dilemma in the management of incisional hernia in pregnancy because no evidence based approach has been described in literature.

- Antepartum hernia repair Herniorrhaphy can be performed during pregnancy if there is evidence of morbid incarceration or the skin is necrosed.
- Postponing herniorraphy until post partum because the enlarged uterus itself and laxity of the abdominal wall may hinder optimal repair.
- Delayed mesh repair at 6-8 weeks postpartum

has been described as an option considering the risk of bleeding and infection.

- Herniorraphy can be performed during the cesarean section. There is debate in type of management also. Few have recommended mesh repair or suture repair. Tension free mesh technique has drastically reduced the recurrence rates when compared to tissue repairs.
- Thus as in our case herniorraphy has been successfully performed as a part of Cesarean section with no increased evidence of wound infection and recurrence.

Conclusion

Management of patient with gravid uterus in incisional hernia needs to be individualized depending on the patient's everyday complaints and the gestational age. Diagnosis is based on the history, examination and ultrasound examination. Conservative management till term is recommended. The enlarged uterus and associated changes in anterior abdominal wall hinder optimal Herniorrhaphy.[5] Awareness of all complicationsand unusual presentation of complications and management can help to achieve successful pregnancy outcome.

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