RUPTURE IN A SUPPOSED LOWER SEGMENT CAESAREAN SECTION SCAR

BY

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Owing to the increasing popularity of the lower segment operation, rupture of a Caesarean scar during a subsequent natural labour is becoming a rare accident. The following case is reported in order to show that the possibility of rupture should always be considered, even when the scar is believed to be in the lower segment.

Case History

Previous Operation.—The patient was a para-1 aged 35. No accurate notes of the former operation could be obtained. It was performed at a R.A.F. hospital, and personal contact with the medical officer who performed it was impossible, as he is now abroad. The abdominal scar extended from the umbilicus to the suprapubic region in the midline. So far as could be ascertained from the hospital, a "lower segment" Caesarean section had been performed on Feb. 18, 1939, for an extended breech presentation with a small pelvis. Version having failed, the patient was delivered before the onset of labour of a living child weighing 5 lb. 4 oz., and she made a good recovery.

Second Pregnancy.—This was uneventful throughout. She had been warned early in the pregnancy, in view of her previous operation, that it would be necessary for her to be delivered in hospital according to the usual custom. During the last few weeks of her pregnancy she was kept under close observation for signs of overstretched of the uterine scar, but nothing abnormal was apparent. At 35 weeks the vertex was presenting and the head was well engaged in the pelvis with the occiput anterior. Although the promontory could be felt at a little over 4 inches, disproportion appeared to be negligible. At her last attendance at the antenatal clinic the uterine scar seemed satisfactory. The afterbirth was delivered before the onset of labour of a living child weighing 9 lb. 7 oz., and she made a good recovery.

Onset and Progress of Labour.—Labour began naturally on the expected date, and the patient was admitted to the Maternity Unit of the National Hospital for Nervous Diseases, London, at 4 p.m., on 7 October 1943. Observations were made at the Midwife's Home, and at 6.30 p.m. the patient was transferred to the hospital. At 7 a.m. on the following day the membranes were intact, the head was engaged in the I.O.A. position, and there was nothing to indicate that the course of labour would be abnormal. At 11.30 a.m. of the same day the patient was transferred to the Obstetric Unit, and delivery of the baby was considered. The patient had had 150 g of senna and 12 c.m. of oxygen, and the scar extended along the midline incision free blood and liquor were encountered. The arm and shoulder of the foetus presented through an irregular laceration, which appeared to extend from below on the right side of the lower uterine segment to a point higher up on the left side, and from 9 to 12 cm. long in the anterior wall, and 11 by 7 cm. in the posterior wall, and by the breech. After a short period of asphyxia it recovered and cried almost at once. After separation and removal of the placenta and membranes it could be seen that the rupture extended well up into the body of the uterus close to the origin of the round ligament on the left side. The edges of the wound were badly lacerated, friable, and infiltrated with blood-clot. There was also considerable haemorrhage between the layers of the broad ligament on the left side. A subtotal hysterectomy, with conservation of the ovaries, was therefore performed, and the abdomen closed. Immediately after the operation the patient's condition was fairly good. Her pulse was 120. A blood clot and haemorrhage had occurred, and the hysterectomy and 500 c.m. was given rapidly, followed by a further 500 c.m. by slow drip on her return to the ward. Three hours after the operation her pulse was 96 and her general condition much improved. The pus in the abdomen was allowed to drain, and the old Caesarean scar is faintly seen as a contracted area of myometrium with a few tags of omentum adherent to it. The rupture and scar pass obliquely across the anterior wall from the right side at a point 9 cm. below the uterine attachment of the right ovarian ligament to the left side at a point 1.5 cm. below the left ovarian ligament. The scar is therefore in the body of the uterus and not in the lower segment. The microscopic sections made across the scar showed a scar is seen as an area of fibrosis, with contraction, in the myometrium. There is continuity of muscle fibres through the scar.

Discussion

Commenting upon the few cases of rupture of a lower segment scar that have been reported, Marshall states: "Though less than a surgical hazard, all of the cases of incision was not wholly confined to the lower segment, and that it was the corporal part which subsequently ruptured." Although he was referring chiefly to the vertical incision, this criticism might well be applied to the case reported above. In fact, it is clearly shown by the pathological report that the incision was placed entirely in the body of the uterus, although it was evidently intended to be in the lower segment.

The oblique direction is not easily explained. Whether the incision was intended to be vertical, or whether this was the result of an asymmetrical curve upwards in a transverse incision, it is impossible to say. The patient was not in labour at the first operation, and it is possible that the development of the lower segment was defective or that it was difficult to define. Nevertheless it emphasizes once more the importance of a really low transverse incision.

Certain conclusions may be drawn from this case with regard to previous Caesarean operations in general: (1) That full notes of a previous Caesarean operation should always be obtained if possible. (2) That the abdominal scar is not necessarily a true indication of the nature of the uterine scar. (3) That great vigilance is necessary in all cases previously operated on by Caesarean section, particularly after a series of natural labours, which must take place in a hospital. (4) That definite signs of overstretching of the scar usually precede the

Treatment of Skin.—(1) Do not use any prophylactic treatment which is shown to cause undue areas of skin to the skin being suspected by early skin changes. The value of B.A.L. at this stage is considerable. (2) Remove hair from affected area with clippers. (3) Clean the part with bland antiseptic. (4) Leave blisters intact when possible. (5) Remove redundant skin only if it is unavoidable. (6) Apply a sterile oily dressing. (7) Sulphonamides can be used to counteract infection if no systemic effects are present. (8) Any form of coagulant treatment is contraindicated. (9) Never change a dressing unless it is absolutely necessary. (10) After the first few days each case must be treated on its merits, keeping in mind the actual clinical manifestations rather than their origin. (11) The exudate from mustard gas and lewisite lesions is innocuous. (12) In serious cases, it is essential to keep the blood so that appropriate action can be taken to counteract any adverse effects.

A list of those appointed by the E.M.S. to assist in the treatment of gas casualties will be found in the E.M.S. Instruction No. 283 (revised June 1, 1943).

I should like to express my gratitude for the help received from Dr. Stopford Taylor on the treatment of skin, Mr. T. J. Phillips on the treatment of eyes, and Mr. Pollitt on the treatment of burns. The Ministry of Supply, the Medical Services, the Passive Air Defence, and the Ministry of Supply have also given me much valuable information.
MEIGS'S SYNDROME

HYDROTHORAX AND ASCITES IN ASSOCIATION WITH FIBROMA OF THE OVARY

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Pleural effusion and ascites may be found in association with cardiac, renal, or hepatic disease, and in the absence of any such clearly defined clinical syndrome are commonly attributed to carcinoma of the ovary. However, we wish to report a case of simple fibroma of the ovary occurring in association with pleural effusion and ascites, a combination of symptoms which has never been recorded in the literature. Such a case was reported by Prof. Baird of Aberdeen, and from the evidence we have obtained, we believe that the occurrence of such symptoms is due to the presence of a fibroma of the ovary.

Pleural effusion is a common occurrence in cases of peritonitis, and ascites may be found in association with pleurisy. In some cases, the ascites is caused by the presence of a fibroma of the ovary. In such cases, the ascites is often accompanied by pleural effusion, and the two conditions may be present simultaneously.

It is well known that pleural effusion may be caused by the presence of a fibroma of the ovary. In such cases, the effusion is usually small, and is usually due to the presence of a small fibroma of the ovary. In some cases, however, the effusion may be large, and may be due to the presence of a large fibroma of the ovary.

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