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CASE REPORT

A RARE CASE OF SPONTANEOUS POSTPARTUM MULTIPLE BLADDER PERFORATIONS

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ABSTRACT: A 22 years old female presented with ascites five months after delivery. She had repeated attacks in the past and had been treated conservatively elsewhere. On examination she was poorly nourished, with tachypnoea, tachycardia and gross ascites. Raised blood urea and serum creatinine. Had raised urea and creatinine level more than 3 times the serum level in the ascitic fluid. With a provisional diagnosis of intraperitonial bladder rupture she was subjected to CT cystogram - showed rent in the posterior left lateral wall of bladder with urinary ascites. Cystoscopy showed multiple perforations with multiple sacculations and trabuclations. Laparotomy done, perforation closed and abdominal toileting done with SPC placement. Postoperative recovery was good. Follow-up cystogram at two months was normal.

KEYWORDS: Spontaneous bladder perforation, post-partum.

INTRODUCTION: Isolated intraperitoneal bladder rupture leading to ascites following prolonged labour and vaginal delivery is an extremely rare entity. This case is being reported for its unusual presentation and being one among the very few cases reported in literature.

CASE: A 22 year old female patient presented with history of abdominal distention and on and off fever since 5 months. She had undergone full term vaginal delivery after prolonged labour 5 months back (Primigravida) elsewhere. Patient was not catheterized before delivery. She noticed abdominal distension and pain abdomen- 3 days following delivery which decreased following catheterization. Patient had recurrent episodes of abdominal distention following catheter removal and was treated with repeated catheterization and antibiotics. Patient was diagnosed as a case of tubercular abdomen-started on ATT in a district general hospital. Patient had no history of voiding disturbances, no history of trauma and her menstrual cycles were normal. On examination patient had tachycardia, tachypnoea. Per abdomen examination: there was tense distention, engorged veins, free fluid+++, Bowel sounds -normal. Per rectal examination-normal, Anal tone – normal.

INVESTIGATIONS: Hb%-9gm/dl. Urine analysis-WBC cells–plenty. Urine culture and sensitivity–sterile. Urine AFBX 3 days- negative.

Blood	Ascitic Fluid
Urea: 98mg/dl.	153mg/dl.
Creatinine: 2.8mg/dl.	10.1 mg/dl.

Ultrasound Abdomen: Thickened bladder wall. Multiple internal echoes- cystitis. Gross ascites.

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CT–Cystogram: Suggestive of rent in the postero-lateral wall of urinary bladder on the left side. Urinary ascites. Cystoscopy-Perforation in the bladder in the posterior wall and dome of the bladder. Mucosa- pale and unhealthy. Severe trabeculations with sacculations. Rt. ureteric and Lt. ureteric orifice- normal.

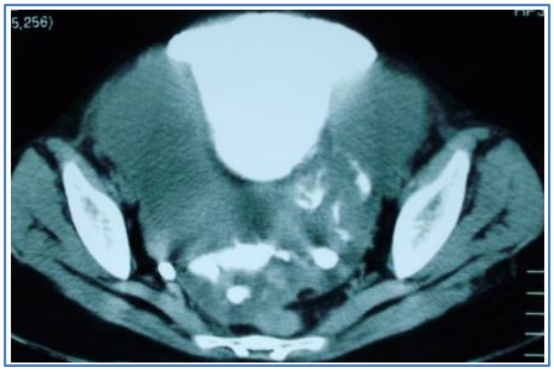

Fig. 1: CT-Cystogram showing rent in wall of urinary bladder and extravasation of urine into the peritoneum

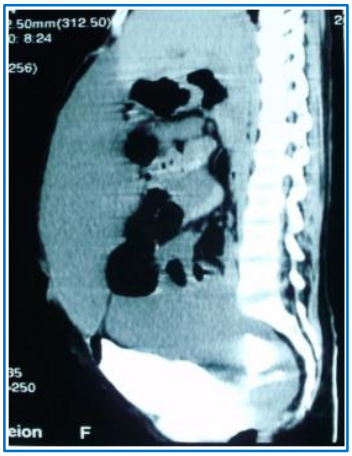

Fig. 2: CT-Cystogram showing rent in posterolateral wall of urinary bladder

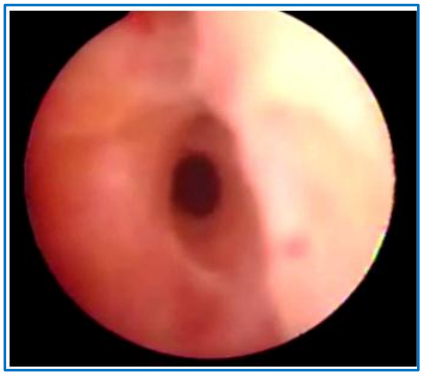

Fig. 3: Cystoscopy: Perforation in the bladder in the posterior wall of the bladder. Mucosa- pale and unhealthy

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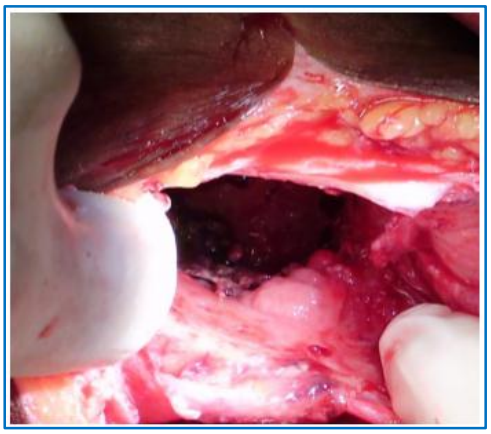

Fig. 4: Intra-Op: Perforation in poster lateral wall noted

Intra Op: Exploratory laparotomy and closure of posterior wall perforation done. Peritoneal lavage given. Biopsy taken from the bladder wall. Bladder catheterized.

Post-op recovery was uneventful. Ascites subsided. Catheter removed on 14th post-op day. Post-op cystogram was normal.

Histopathology: Non- specific inflammation. No evidence of tuberculosis/ malignancy.

DISCUSSION: Spontaneous Rupture of Bladder and extravasation of urine in the peritoneum without evidence of trauma is rare.[1] Postpartum patients who have had episiotomy or perineal repair frequently experience voiding difficulties which may lead to urinary retention.[2] Retention may not be recognized since these patients pass small amounts of urine frequently.[2] Postpartum bladder rupture due to urinary retention should be ruled out if there is a history of abdominal pain, oliguria, and elevated serum creatinine.[3] Diagnosis is confirmed by CT-Cystogram. Treatment is by emergency exploratory laparotomy, peritoneal lavage, closure of perforation and prolonged catheter drainage. Early diagnosis and prompt surgical treatment decreases the morbidity and mortality associated with this condition.

CONCLUSION: Bladder perforation following vaginal delivery is very rare. Multiple bladder perforations in the post-partal period is not reported in the literature. It is important to be aware of this condition in order to diagnose and treat the condition correctly. This case is being presented for its unusual and unique presentation.

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