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CENTRAL RUPTURE OF PERINEUM

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ABSTRACT

Central rupture of perineum may be defined as a tear which leaves the posterior commissure and anterior margin of perineum intact, but involves the central portion of perineum causing damage to almost all the muscles and connective tissue of the perineal body and even upto or including the rectum. This lesion is an extremely unusual accident and certainly represents a medical rarity with less than 100 cases reported in the world literature.

KEYWORDS: central rupture of perineum, delivery through perineum, tear repair.

INTRODUCTION

We have all heard about the two usual routes of delivery: vaginal and abdominal. Here we present an extremely uncommon third route of delivery- Delivery through the central perineum rupture!.

CASE REPORT

A 22 year old primipara was referred to our hospital on account of PPH. She had delivered 2 hours back at a PHC. She gave history of labor pains for 4 hours and probably had a quick precipitate delivery through an "abnormal passage" and that she experienced an agonizing tearing pain. The baby was alive 2.5kg female child.

Local examination revealed an extensive perineal laceration reaching just short of the anal margin. Anal mucosa and vaginal interoitus were intact. The tear was rectangular 5×7cm with irregular, serrated and ragged margins. Bridge of skin between the lower margin of interoitus and upper margin of tear was intact and about 4cm broad. Posterior vaginal wall had a defect in the lower third and linear tears extended on both lateral vaginal walls .Cervix and uterus were found intact. External anal sphincters were completely torn.

OPERATIVE PROCEDURE

Under spinal anaesthesia, patient was taken for perineal tear repair. Margins of perineal laceration were trimmed and wound debridement done. Initially the bridge of skin between the tear and vaginal interoitus was incised by a midline incision converting the whole tear into IIIb degree perineal tear. This enabled better visualization of underline structures. After completely understanding the extent of damage and the anatomy, an effort was made to repair the tear and restore the anatomy to near normal. The lacerated muscles of pelvic floor were identified and approximated in midline with Vicryl no 1. Torn fibres of external anal sphincter were repaired in an end to end manner with Vicryl no 1. Posterior vaginal wall was then reconstructed. Vaginal skin closed with interrupted sutures with 2-0 silk. The reformed perineum was long and measured 10cm. Vaginal pack was inserted and removed after 24 hours. Healing was satisfactory, skin sutures removed on day 7 and patient was discharged in good health on day 7 of surgery.

Patient returned for follow up at 1 and 6 months with no complaints. At present our patient is carrying her 2nd pregnancy and is in her second trimester!

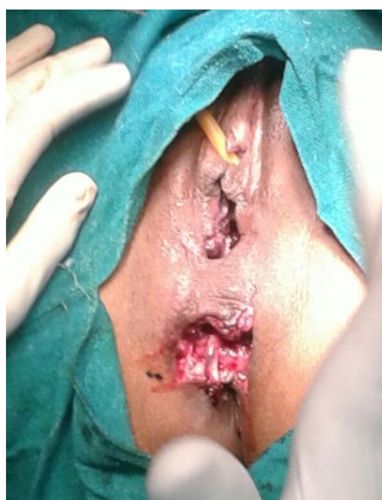

Figure 1- initial picture.

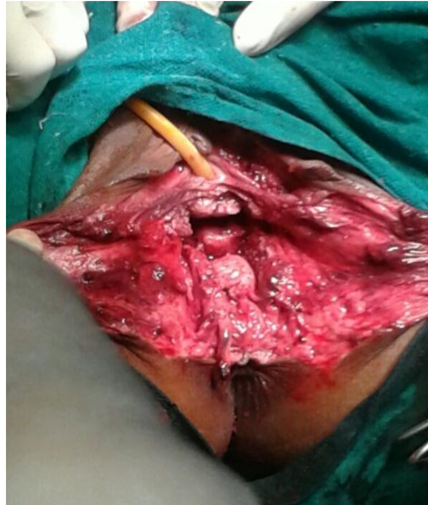

Figure 1a-tear converted to IIIb type tear.

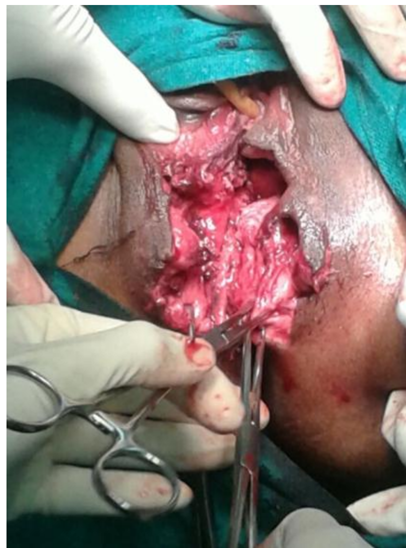

Figure 1b- anal sphincters being repaired.

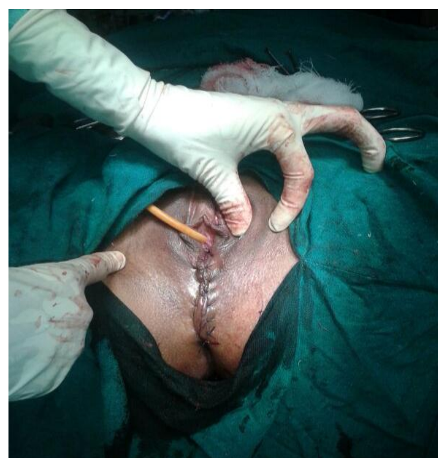

Figure 2-after repair.

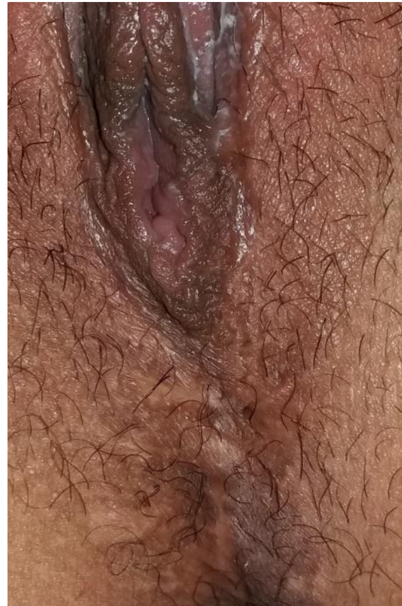

Figure 3-after 1 year.

DISCUSSION

Karlin (in 1927) concluded that central rupture of perineum most commonly occurred between 17-25 years of age, more common in primipara than mutipara and also in those with relatively contracted pelvis and usually precitate labour results in this. Of all the cases that have been reported till date, vertex was the presenting part except in one where it was breech. Baundry in 1894 described a case where the child's hand came out through anus. The hand was replaced and child delivered through vagina. A large hole was found between rectum and vagina on inspection.

CAUSES

Most of the authors believe that patho-anatomic lesions like very high and rigid perineum, vulval edema, condylomas, post-operative or post-inflammatory scars of vulva and vagina, external genital anomalies or bony anomalies, congenital weakness or atrophy of pelvic floor or disproportion between vagina and foetal head could be the cause for central rupture.

A similar case reported earlier revealed that injuries as a sequelae of previous delivery leading to fibrotic ring formation could also result in this.

In our case probably a very high and rigid perineum was the cause. The uterine contraction couldn't overcome the resistance of the long perineum and the head was directed directly downwards. The fetal head instead of travelling along the "acutely forward long curve of

Carris" was delivered through the posterior vaginal wall, the rectovaginal space and finally the perineum!.

COMPLICATION

Anal sphincter lacerations which could result in rectal stricture or incontinence later and permanent rectovaginal fistula are also possible. Haematoma formation in the rectovaginal space is a common occurrence. Haematoma may be massive and may extend upto perirectal space.

CONCLUSION

Central perineal rupture should be repaired meticulously as soon as possible after delivery preferably by an experienced surgeon. A neglected repair will result in future morbidity in form of pelvic floor insufficiency and abnormal scarring of the genital tract.

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