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Post caesarean section omental prolapse

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Abstract

The incidence of caesarean section is rising worldwide. Various modifications of the classic procedure which involves the meticulous closure of parietal peritoneum have been introduced. These modifications reduce operating time, postoperative pain and hospital stay. Their effect on long-term complications is yet to be adequately studied. A complication which may have resulted from the non separate closure of parietal peritoneum is presented.

Keywords: Caesarean section, omental prolapse, excision and repair.

Introduction

Caesarean section is a lifesaving operation whose incidence is on the rise worldwide.[1] However it may be associated with complications. Some of these are common while others are rarely seen. Various modifications of the classic procedure which involves the meticulous closure of parietal peritoneum have been introduced.[2] These modifications reduce operating time, postoperative pain and hospital stay.[3] We describe below one of the rarely seen complications of caesarean section.

Case report.

The patient registered for antenatal care at fourteen weeks gestation. She was Para 2+0 with two living children. Both deliveries were by lower segment caesarean section using a vertical midline incision. She was 1.59 meters tall and weighed 107kg (BMI 42.3)Her blood pressure on booking was 120/80mm of Hg. The pregnancy was uneventful. At elective caesarean section under spinal anaesthesia dense adhesions were found covering the lower segment of the uterus. An upper segment caesarean section was done under spinal anaesthesia and a female baby weighing 3.6kg with Apgar score 10 at one and five minutes was delivered. Because of the scar tissue resulting from the two previous caesarean sections the parietal peritoneum could not be isolated for separate closure but was sutured along with the rectus sheath in a continuous non locking fashion using nylon. Subcutaneous tissue was sutured with interrupted plain catgut and skin closure was by interrupted nylon stitches.

Prophylactic antibiotics were given intravenously. Intra and postoperative period was uneventful. The patient was discharged on the fourth postoperative day at her request. Two days later she presented with severe abdominal pain and copious discharge of non-offensive sero-sanguinous fluid from the operation site. Examination revealed a soft abdomen with normal bowel sounds. A soft pink mass about 5cm x 5cm (Fig 1)was found in the upper part of the operation stitch line. It was covered with organised granulation tissue. A diagnosis of omental prolapse was made. One stitch each was removed cephalad and caudal to the mass, all the exudative discharge was expressed and the mass was thoroughly cleaned with normal saline. Under sterile conditions the protruding mass was ligated with chromic catgut and then excised. The rest of the mass was pushed into the peritoneum and the skin

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was repaired with closely placed nylon sutures. Satisfactory closure was observed when the stitches were removed after seven days. Histology confirmed the excised mass to be omentum

Fig 1. Omental Prolapse

Discussion

The herniation of omentum sequel to a caesarean section is rare. After operation spontaneous reperitonisation starts in 2-3 days and complete healing occurs in 5-7 days.[4] While this is occurring the integrity of the closure site is provided by physical closure of the peritoneum. The absence of proper closure because of the presence of adhesions may have predisposed to the herniation. Other contributory factors may have been the early discharge and the patient's obesity. Both may have served to put excessive pressure on the stitch lines creating a defect for herniation. Diagnosis in this case was not difficult but in other cases resort was made to ultrasound for diagnosis[5] while in some cases diagnosis was only made at laparotomy. Treatment in this patient did not involve laparotomy but in other cases laparotomy was inevitable.[3]

Conclusion

In spite of the advantages of non closure of the parietal peritoneum it would appear that this practice is more susceptible to omental prolapse.

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