



CASE REPORT OF RUPTURE UTERUS

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ABSTRACT

Uterine rupture is one of the major obstetric complication that endanger the life of fetus an mother. When it is spontaneous, it occurs most often during labor in a context of scarred uterus. Uterine rupture during pregnancy is a rare situation. The diagnosis is not always obvious and morbidity and maternal and fetal mortality is still high. We report a case of rupture uterus in a neglected labour with fetal congenital anomaly.

Key words: Uterine rupture, Obstetric complication.

INTRODUCTION

Uterine rupture is a public health problem in developing countries. Uterine rupture occurs in 1 : 200 to 1 : 3000 deliveries, depending upon standard of obstetric care and the population dealt with. Complete rupture involves the entire uterine wall and results in a direct connection between the peritoneal space and the uterine cavity. In India it still accounts for 5-10 % of all maternal deaths. The perinatal mortality ranges from 80 to 95 %. There are several risk factors associated with rupture of uterus, but the most common is a previous Cesarean section. Rupture of an unscarred uterus is a rare event. An early diagnosis and prompt treatment of the condition is the most important factor in the maternal and perinatal outcome. Here we report a case of unscarred rupture uterus.

CASE REPORT

A 25 year old patient with G3P2A0L2 with 9 months of pregnancy with breech presentation referred to our set up from primary health centre as a case of partially delivered baby and difficulty in head delivery. Retrograde History taken, H/0 9 months of amenorrhea, delivered partially at PHC by Breech presentation with difficulty in head delivery and referred to our Hospital. Her last menstrual period was 28/11/2013 according to that it was a

fullterm pregnancy. Her obstetric history she was 3rd gravida patient with previous 2 normal delivery. On general examination Pulse: 110/min, BP: 100/70 mm Hg, Temp: Normal, Respiratory rate: 16/min, Pallor was present. On systemic examination: Per Abdomen: Uterus 26 week size exact part cannot be made out Fetal parts felt exactly below skin. Per vulval: Fetus outside upto Shoulder. Head inside (Large Head) Per Vaginal: Cervix fully dilated Cervix fully effaced large head felt. On ultrasound examination: BPD: 126 mm suggestive of Hydrocephalus. Placenta: seen surrounding head region. Wall surrounding placenta is not seen s/o thinned out or rupture. There is a linear hypoechoic area noted at Fundus p/o Rupture uterus. Mild free fluid is noted in peritoneal cavity with moving internal echoes p/o hemoperitoneum. Decision for Exploratory Laprotomy taken. Exploratory laprotomy followed by Subtotal Obstetrics hystrectomy was done under General anesthesia.

Per operative findings suggestive

Hemoperitoneum was present. Baby was out of uterus (Head out due to ruptured uterus). Cephalocentersis done and baby delivered out vaginally. Placenta and membranes delivered out completely.

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Complete uterine rupture at lower segment of about 8 cm was present, which was extending on left side in Broad ligament. Hematoma was present at broad ligament on left side. Hemoperitoneum was drained out. Subtotal Obstetric hysterectomy was done. Left sided internal iliac artery was ligated to achieve hemostasis. Intraperitoneal drain was kept. Exploration was done from below, which suggest Cervix was torn downwards extended upto Upper Vagin. Lateral vaginal wall tear sutured. Total 4 units of PCV 4 units of FFP and 4 units of PRC were given. Injectable higher antibiotics were given. Stitch removal was done on 8th post-operative day and patient was discharge.

DISCUSSION

Ruptured uterus still remains one of the serious obstetric complications. Lack of health information, illiteracy, poor antenatal care, poverty, home delivery by traditional birth attendants and delay in referrals all contributes to uterine rupture. Prevalence of uterine rupture is 0.83%. This study was similar to study done by Malik HS. However the incidence is higher in a study done by Alam et al, who had a figure of 1.14%. Studies conducted in developing countries gives strong evidence that uterine rupture is a major health problem in developing countries, with the rate higher in rural areas. The studies also revealed that socioeconomic condition along with poor health services play a major role in determining the incidence of rupture [1-8].

Rupture uterus can either occur in women with (1) a native, unscarred uterus or (2) a uterus with a surgical scar from previous surgery. Uterine rupture occurs when a full-thickness disruption of the uterine wall that also involves the overlying visceral peritoneum (uterine serosa) is present. By definition, it is associated with the following: Clinically significant uterine bleeding Fetal distress Protrusion or expulsion of the fetus and/or placenta into the abdominal cavity Need for prompt cesarean

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delivery Uterine repair or hysterectomy. Surgical intervention after uterine rupture in less than 10-37 minutes is essential to minimize the risk of permanent perinatal injury to the fetus.

However, delivery within this time cannot always prevent severe hypoxia and metabolic acidosis in the fetus or serious neonatal consequences. The most consistent early indicator of uterine rupture is the onset of a prolonged, persistent, and profound fetal bradycardia. Other signs and symptoms of uterine rupture, such as abdominal pain, abnormal progress in labor, and vaginal bleeding, are less consistent and less valuable than bradycardia in establishing the appropriate diagnosis.

Maternal mortality ranged between 1% and 13%, and perinatal mortality between 74% and 92%. Reduction of the prevalence of rupture of unscarred uterus requires the following: reduction of unwanted pregnancies, particularly for women of high parity; accessibility of obstetric services including caesarean section for obstructed labour; where conventional caesarean section facilities are not accessible, innovative solutions such as symphysiotomy or caesarean section with local analgesia should be considered; and guidelines to ensure that misoprostol for labour induction is used in safe dosages.

CONCLUSION

Uterine rupture occurring on an unscarred uterus is sometimes an unpredictable event. It is associated with very bad maternal and fetal prognosis. Usually it occurs during labour.

Our case report shows that unskilled trial of labour in hydrocephalus fetus with breech presentation in multiparous women is a risk factor for uterine rupture. So, proper antenatal care, to screen high risk pregnancies like congenital anomalies of fetus, abnormal presentation, obstructed labour and timely refer to higher center can decrease maternal and perinatal morbidity and mortality.