Ruptured Uterus in Pregnancy: A Case Report

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INTRODUCTION

Uterine rupture in pregnancy is rare and often presents with a high incidence of fetal and maternal morbidity. There are many factors that increase the risk of uterine rupture. But, the overall incidence is low, reporting 1 in 1146 pregnancies that are about 0.087%.¹ Due to the non-specific signs and symptoms of uterine rupture which makes the diagnosis difficult and sometimes delays the treatment, which leads to increased maternal and fetal mortality and morbidity.² Hence, still uterine rupture in pregnancy is considered to be of much feared event for medical practitioners. Uterine rupture can be defined as a full thickness disruption of the uterine wall involves the overlying visceral peritoneum. It can either occur in unscarred uterus or uterus with previous scar.³ It is associated with clinically significant uterine bleeding, fetal distress, protrusion or expulsion of fetus or placenta into the abdominal cavity. It may require uterine repair or hysterectomy or caesarean section. The most common risk factors for uterine rupture are congenital uterine anomalies, multiparity, previous uterine myomectomy, fetal macrosomia, labor induction, instrumentation and trauma.

CASE REPORT

A 32-years-old female patient, gravida para live, and abortion with history of 4 months of amenorrhea got admitted with severe epigastric pain. She was referred for severe pallor and hypotension. She had a previous history of induced abortion for which dilatation and curettage were done 9 years ago, and 2 years later she had lower segment caesarean section done and the baby is 7 years old. She had undergone appendicectomy 3 years ago. On clinical examination patient was conscious, no pedal edema, pulse was thready, blood pressure (BP) 70/30 mm of Hg. On abdomen examination - Uterus was 18-20 weeks size, there was severe tenderness and distension was present. Fetal heart was not heard. Per vaginum findings - Cervix was closed, slight bleeding was noted. As the patient was hemodynamically unstable, was resuscitated and immediate transfusion was given, after which her BP was 90/70. Ultrasound abdomen showed possibility of rupture of right cornual or interstitial pregnancy with massive hemoperitoneum. Routine investigations were done. Emergency laparotomy was done immediately, the uterus was 16 week size, an intact gestational sac was found protruding through rent in the right side of the fundus (Figure 1). Both tubes and ovaries were normal. About 3 L of blood and plenty of clots amounting to 1 L of blood evacuated from the abdominal cavity. Total abdominal hysterectomy was done with in-situ fetus in the amniotic sac (Figure 2). Four units of packed cell were given. The coagulation profile was done routinely and was found to be normal. Post-operative period was uneventful. Patient was doing well and discharged home. She came for review.

DISCUSSION

Spontaneous rupture in mid-trimester is very rare especially when there is no history of attempted termination of pregnancy. The site of rupture is at fundus, not at the
in our case. The other option is conservative surgery wherein repair of the rent is done when the fertility is to be preserved.\(^7\) But, it has higher maternal risk. The other procedures like rent uterine repair, uterine packing, methotrexate therapy, hypogastric artery ligation, stepwise devascularization and bilateral uterine artery embolization are done.\(^8\) The adjuvant options like uterine artery embolization in placenta percreta remains controversial.\(^9,10\) Since no clear evidence suggesting optimal treatment plan for patients with placenta percreta, sometimes uterine artery embolization followed by delayed hysterectomy is done to decrease the enormous blood loss from the invasive placenta.\(^11\)

**CONCLUSION**

Uterine rupture is rare, but pose worst obstetric complications and henceforth efforts to reduce morbidity and mortality from uterine rupture should be focused on reducing primary caesarean section rates and optimizing care for women with previous caesarean section and also one has to be very careful and keep the possibility of placenta percreta in mind. Ultrasound and color Doppler study for the diagnosis of the site of placentation along with maternal serum alpha fetoprotein in doubtful cases seems to be necessary for early diagnosis and conservative treatment.

**REFERENCES**

10. Alanis M, Hurst BS, Marshburn PB, Matthews ML. Conservative management of placenta increta with selective arterial embolization.
