

Non traumatic early rupture of previous caesarean scar - A case report

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Abstract

Uterine rupture is one of the most feared obstetric complications affecting the pregnant woman and fetus. Most of the cases have various risk factors and mainly occur during the second or third trimester. However, spontaneous uterine rupture during the first trimester is extremely rare. We experienced a case of spontaneous uterine rupture in a 41-yr-old multiparous woman with. The initial impression was a hemoperitoneum of an unknown origin with normal early pregnancy. Intensive surgical method would be needed for accurate diagnosis and immediate management in bad situation by hemoperitoneum even though a patient was early pregnancy.

Keywords: caesarean scar.

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INTRODUCTION

Uterine rupture is one of the most dangerous obstetric situations, carrying an increased risk of maternal and perinatal morbidity and mortality.^{1,2} Uterine rupture during gestation is mainly found during the second or third trimester in the women whose past history includes Cesarean delivery.^{1,3} Spontaneous uterine rupture of unknown cause during the early pregnancy is extremely rare. Few researchers have reported spontaneous uterine rupture without underlying causes during the first trimester. We report a case in which a multiparous woman showed hemoperitoneum by spontaneous uterine rupture in early pregnancy.

CASE REPORT

A 41 yr old female 2nd gravida previous lscs with 14 weeks pregnancy was admitted in our emergency room

with an unusual presentation of chest pain, sweating and vomiting. Patient was asymptomatic 2 hours back when she suddenly developed the above complaints. Patient had undergone in vitro fertilization and conceived a triplet pregnancy, and she underwent embryoreduction of one baby 10 days back. Patient was admitted in the ICU urgent lab investigations were sent. Patient developed backache and pain in abdomen a few hours post admission, her USG was performed, which revealed massive hemorrhage gravid uterus with twin pregnancy of 15-16 weeks with IUD of both twins. Third fetus not seen? masserated, possibility of uterine rupture or ovarian cyst rupture. Her HB was 6.4% TLC 27,100 and platelet 4,38,000. Her emergency exploratory laparotomy was conducted after securing adequate blood. On opening the abdomen, rupture of uterus was present at left side of previous LSCS scar, there was irregular rupture, hemoperitoneum was present, clots – 750gms. Trichorionic triamniotic triplet pregnancy was present. 1st baby intact with sac was seen coming out of the rupture site. 2nd n 3rd baby delivered out with sac and placenta intact removed. Right side multiple cyst was present, largest of 4-3cms. Uterus was sutured in double layer. Hemostasis achieved and abdomen closed. Patient was kept in intensive care unit post operatively for 2 days. Post operative period was uneventful and necessary blood was given .on discharge her HB was 11.2 gm% and suture removed on 7th day and discharged on 8th day.

Early recognition and treatment of such cases is very important as it is a life saving measure.

DISCUSSION

According to the several information about uterine rupture obtained from the literature, most of the cases had various risk factors.⁴ It is evident that the single most important factor in determining the risk of uterine rupture is whether the uterus has a previous scar or not.¹ The past injuries such as Caesarean delivery, hysteroscopic resection of uterine septum, myomectomy, and cornual resection are considered to be the causes of uterine rupture⁵. It is reported that spontaneous rupture of unscarred uterus occurs in 1 in 15,000⁶. It may occur in a patient who has high parity⁷, placenta increta or percreta, adenomyosis, abortion with instrumentation, manipulation during delivery, induced delivery by misoprostol⁸, vigorous fundal pressure during delivery, cocaine abuse⁹ and idiopathic cause⁶. Most of the above listed causes shows that uterine rupture is mainly occur before or during labor after the second trimester. Also some researchers reported on the uterine rupture observed in women who were not pregnant^{10,11}. However, spontaneous uterine rupture during the first trimester like our case, is extremely rare. Only a few cases were found in the literature. In the case reported by Biljan *et al.*¹², uncomplicated evacuation of the uterus for suspected retained products of pregnancy was performed following second delivery. And the previous abortion cannot be considered to induce uterine rupture because the patient had normal spontaneous vaginal delivery at term for the third trimester. In our case report, however, the patient did not have the history about of the curettage of the uterus. So the cause of the rupture was not clear. Uterine rupture is usually a serious and potentially catastrophic event because of massive uterine bleeding. Early surgical intervention is the key to successful treatment of uterine rupture⁴. In this situation, hemoperitoneum can be regarded as nonobstetric cause or immediate management can be delayed, because spontaneous uterine rupture in early pregnancy having gestational sac is very uncommon¹³. Conclusively, intensive surgical method would be needed for accurate diagnosis and immediate treatment when a patient was in bad situation by hemoperitoneum in early pregnancy.

CONCLUSION

Uterine inversion is an obstetric complication that, due to its gravity, requires a rapid diagnosis and immediate

clinical action. Its low incidence leads to scarce experience in solving this kind of situation. Regardless of the treatment, vaginal or surgical approach, the best prognosis occurs in situations when the diagnosis and maneuvers for uterine reversal are made early. The authors concluded that there are no predictive factors known for uterine inversion because of its rarity, only risk factors. Therefore, it is essential to keep in mind this diagnosis in all cases of postpartum hemorrhage, and be updated about the medical therapy and surgical techniques required to solve this type of complication.

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