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SPONTANEOUS UTERINE RUPTURE AT MID TRIMESTER

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Abstract : Spontaneous rupture of unscarred gravid uterus is a rare occurrence and that occurring in midtrimester is very rare. Rupture of gravid uterus is a surgical emergency. We hereby report a case of multiparous woman G4P3L3 with spontaneous rupture of gravid uterus in mid trimester which was managed in our hospital. Patient presented with breathlessness and abdominal distension. There was no past history of uterine curettage or surgery on uterus. After ultrasonogram, uterine rupture was diagnosed for which emergency laparotomy was done. There was a rent in the fundus and right cornua of the uterus with the amniotic sac lying in the peritoneal cavity. Subtotal hysterectomy was done and the patient recovered well.

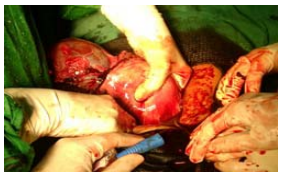
Keyword : Uterine rupture, multigravida, laparotomy, subtotal hysterectomy

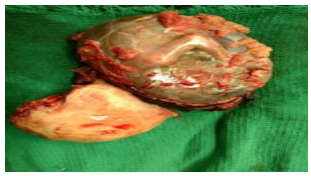
INTRODUCTION:

Spontaneous uterine rupture during midpregnancy is very rare and it occurs more likely in women of high parity. The weakening of the uterine wall results from fibrosis following bruising, stretching or tearing of the uterine muscles in previous labour. The reported incidence of spontaneous uterine rupture is about 1 in 15000 deliveries. We report a case of spontaneous uterine rupture that occurred at 20 weeks of gestation.

CASE REPORT:

A 30 years old multipara, G4P3L3 presented with 5 months of amenorrhoea with complaints of breathlessness and mild abdominal pain, has been referred as a case of severe anaemia complicating pregnancy. Obstetric History: She had three previous full term vaginal delivery at nearby primary health centre and all children are healthy at 6, 3, 1½ years respectively. There was no previous abortions with instrumentation, any surgeries on uterus like myomectomy in the past. There was no history of trauma, or fall over abdomen. There is no history of termination of pregnancy. On admission patient was anaemic, mildly tachypnoeic, PR-108/min, BP-90/60 mmHg. Abdomen was mildly distended, bowel sounds was present. Uterine contour was not well defined and was tender on palpation. Vaginal examination revealed closed internal os and there was no bleeding. Investigation showed Haemoglobin-6.5 gms%, Blood group-B+ve, Renal and Liver function tests, bleeding and clotting time were within normal limits. Sonography revealed evidence of gestational sac lying in the peritoneal cavity corresponding to 20 weeks of gestation, fetal cardiac activity was absent, rent was noted in the fundus of uterus with hemoperitoneum. Emergency laparotomy was planned immediately for the indication of rupture uterus. There was hemoperitoneum with the fetus in the sac lying in the peritoneal cavity. There was a rent in the fundus extending to the right cornua. Laprotomy was proceeded with subtotal hysterectomy. Adequate compatible blood transfusions was given. Postoperative period was uneventful. Patient recovered well.





DISCUSSION:

Uterine rupture is a potentially life threatening complication in both the mother and the fetus. It occurs in 0.11% of all pregnancies in developing countries and 0.012% in developed countries. Uterine rupture is a catastrophic tearing open of the uterus into the abdominal cavity. Scarred uterus is most susceptible and unscarred uterus is least susceptible to rupture. The predisposing factors of rupture in unscarred uterus are grandmulti, neglected labour, breech extraction, uterine instrumentation, congenital uterine anomaly. Grand multiparity is a important risk factor where the uterine wall weakness results from fibrosis following bruising, stretching or tearing of the uterine muscles in previous labour1. In congenital uterine anomaly, wall of the abnormal uterus tend to become abnormally thin as pregnancy advances and the thickness can be inconsistent over different aspects of myometrium. Pregnancy that implant in rudimentary horn has high risk of rupture. Onset of uterine rupture is often marked by sudden fetal bradycardia and treatment requires quick surgical attention of good neonatal and

maternal outcomes. Labour is usually, but not always is associated with uterine rupture. One third of ruptures in patients with a previous classic uterine incision occur before onset of labour. Mid trimester uterine rupture is very rare2, indeed in a apparently uninjured or unscarred uterus to give way during pregnancy3. Misuse of oxytocin carries significant risk of rupture especially during vaginal delivery after caesarean section4, when given at high infusion rate5,6. With more potent uterine stimulants like PGE1, PGF2, uterine rupture occurs in approximately 2.5% of women after their use. Maternal death is a rare complication of rupture, though it is more common in ruptures occurring outside of a hospital and in women with an unscarred uterus. Overall, uterine rupture accounts for approximately 5% of all maternal deaths each year. Multiparity with extreme weakness of uterine wall caused by repeated childbirth could be a possible cause of uterine rupture in this case. Prompt diagnosis, immediate surgery, availability of large amount of blood have greatly improved the prognosis.

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