

Case Report

UTERINE FUNDAL RUPTURE IN AN UNSCARRED UTERUS IN A GRAND MULTIGRAVIDA: A CASE REPORT

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ABSTRACT

Rupture of unscarred uterus is rare with incidence being 1:15000 pregnancies. Potential life threatening event to mother and fetus cases have reported following fundal pressure during labour. We report a case of spontaneous rupture of uterus during labour. A 38 year old grav 9 para 7, living 6 abortion 1 a coolie worker at term an unbooked case till date presented with sudden onset pain abdomen since past 3 hours. On arrival, she was tachycardiac, hypotension was present. Uterine rupture was diagnosed by palpation of fundus uterus, fetal extremities with the absence of fetal heart immediate exploratory laparotomy was done and rupture of fundus with dead fetus noted intra-op peripartum hysterectomy was done, post operative period was uneventful, there was no pph, Rh negative blood was arranged, Hysterectomy done as she was grand multi.

Keywords: Uterine Fundal Rupture

INTRODUCTION

Spontaneous uterine rupture is a rare but serious life-threatening obstetrical emergency. Previous cesarean section is the most important predisposing factor for this catastrophic event and it is usually reported during labor in patients with scarred uterus. Besides cesarean section, inappropriate prostaglandin and oxytocin usage, previous instrumental abortion, vacuum extraction delivery, and vigorous fundal pressure are the other risk factors for uterine rupture [Cunningham *et al.*, 2014; Turner, 2014]. Uterine rupture in an unscarred uterus is rare, with an estimated occurrence of one in 10000 to 15000 deliveries [Cunningham *et al.*, 2014]. These cases are usually diagnosed intrapartum or shortly after delivery and managed with immediate repair of the usually encountered full-thickness rupture site or subtotal hysterectomy.

CASE

A 38 year old grav 9 para 7, living 6 abortion 1 a coolie worker at term an unbooked case till date presented with sudden onset pain abdomen since past 3 hours. The patient unaware that she is pregnant reported with h/o 9 months of amenorrhea and pain abdomen since 3 hours which was acute in onset and was progressive in nature. On examination: Patient was found conscious and oriented but tachypneic and Pale (clinically 6g%), Pulse 108/min low volume, Blood pressure: 88/56mm of hg. Cardiovascular system-S1 S2 heard tachycardia present, Respiratory system normal vesicular breath sounds heard, no added sounds, tachypnea present. Per abdomen- tense tender, fetal parts superficially felt, uterine contour not made out properly, fetal heart sounds not heard. On per vagina examination cervix was 3cm dilated, 2cm long, bleeding present, presenting part not felt, abdominal paracentesis was done, frank blood obtained (suggestive of haemoperitonium).

Intra Operative Finding: Abdomen was opened with infra umbilical vertical incision. Fetal head was found in the abdomen cavity just below incision, haemoperitonium of about 1 litre with clots was present, complete rupture of uterus at fundal region extending to anterior wall. Dead male baby of weight 3kg extracted and proceeded with peripartum hysterectomy.

Post Operatively: 2 unit packed cells and 3 unit FFP transfusion done. I.V antibiotics given for 7 days. Post operative period was uneventful, patient discharged on 10th day after removing sutures.

Case Report



Figure 1: Fetal Head in Abdominal Cavity



Figure 2: Placenta is attached posteriorly in fundus



Figure 3: Complete rupture in fundal region extending anterior wall

DISCUSSION

Uterine rupture is one of the most important obstetric emergencies, threatening the lives of both mother and fetus. There are two types of rupture: 1) complete, where the whole thickness of the uterine wall is involved, usually occurring in an unscarred uterus; and 2) incomplete, where the visceral peritoneum remains intact, as seen in scar dehiscence [Cunningham *et al.*, 2014].

The most common presentation is intrapartum, but rupture can be diagnosed ante- or postpartum. Intrapartum events are usually detected after a sudden increase in maternal pulse rate and a decrease in blood pressure together with vaginal bleeding and abdominal pain followed by fetal bradycardia [Carlin and Alfirovic, 2006]. However, in the postpartum period, a clinical diagnosis is difficult and a high index of suspicion is essential. Risk factors for uterine rupture include obstructed labor, grand multiparity, cephalo pelvic disproportion, placenta percreta, induction of labor in a woman with a previously scarred uterus, uterine anomalies, inappropriate prostaglandin and oxytocin usage, previous instrumental abortion, vacuum extraction and forceps delivery, vigorous fundal pressure, and intrauterine manipulations [Cunningham *et al.*, 2014; Turner, 2014 and Pan *et al.*, 2002], accidental causes like blunt trauma and motor cycle accident [Turner, 2014; Sisay *et al.*, 1997].

Langton *et al.*, 1(997) reported a case of spontaneous uterine rupture that occurred in a nonlabouring uterus of a primigravida with no previous risk factors at 32 weeks and a tear extending into two-thirds of the uterine wall with small actively bleeding vessels was identified during laparotomy. The patient in our case was a grandmultiparous woman at term.

Hruska *et al.*, (2006) reported a uterine rupture patient who presented to the outpatient on 4th postpartum day of an uncomplicated vaginal delivery involving low dose oxytocin stimulation and underwent a total abdominal hysterectomy due to a defect in the left lower uterine wall [Hruska *et al.*, 2006].

Case Report

In our case grand multi para presented with spontaneous rupture without the knowledge of she being pregnant or e/o labor pains. multiparity advanced age, lack of awareness about contraception are predisposing factors

CONCLUSION

Spontaneous rupture of the unscarred uterus during labor is rare. Risk factors include weakness of the uterine muscle and the application of fundal pressure. Early detection and immediate surgical intervention are the mainstays of management.

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