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Case Report

Mid Trimester Uterine Rupture in an Unscarred Uterus

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Abstract
Uterine rupture is a serious obstetric complication mainly seen in third trimester of pregnancy in previously scarred uterus. Second trimester uterine rupture in an unscarred uterus is very rare. We are presenting a case of uterine rupture at 26weeks of gestation in a31 years old multigravidae with previous three normal deliveries after being induced with misopostol for abortion
Keywords: *Uterine Rupture, Pregnancy, Hemoperitoneum.*

Introduction

Uterine rupture is an obstetric emergency significantly associated with high fetal as well as maternal morbidity and mortality. Advanced maternal age, multiparity, placenta increta, macrosomia, shoulder dystocia and medical termination of pregnancy are some other important contributing factors to this condition. The overall incidence of rupture uterus in unscarred uterus and scarred uterus varies from 0.7 and 5.1 per 10,000 deliveries respectively [1].Consequences of uterine rupture depend on the time between diagnosis of uterine rupture and delivery and can be divided to fetal and maternal. Fetal consequences are admission to neonatal intensive care unit, fetal hypoxia or anoxia, and neonatal death. Maternal consequences are hemorrhage, hypovolemic shock, bladder injury, need for hysterectomy, and a maternal death.[2]

Case Report

Mrs X, 31 years old female $G_4p_3L_3$ at 26 weeks of gestation with previous three vaginal deliveries presented to us with severe pain abdomen in casualty. There was no history of bleeding per vaginum or discharge per vaginum. Patient gave history of induction with misoprostol in a peripheral centre for mid trimester termination of pregnancy. On examination-pulse-110/min, B.P.-90/60mmhg, moderate pallor was seen. On per abdomen examination abdomen was tense, guarding was present and fundal height could not be made out. Per vaginal examination revealed long tubular cervix, uneffaced. Ultrasound showed mild free fluid in abdomen, no cardiac activity seen. Investigations showed Hb-8gm/dl, other reports within normal limits. Patient was taken up emergency laparotomy. 1000cc of hemoperitoneum was seen, fresh still borne female fetus weighing 680gms was seen in lying in abdomen. A rent of 8-10 cm was seen in lateral wall of uterus (figure.1) Hysterectomy was done

as rent could not be repaired and there was continuous bleeding from rupture site.

Two units of packed cells were transfused post operatively. Patient was discharged in a satisfactory condition on day 9.

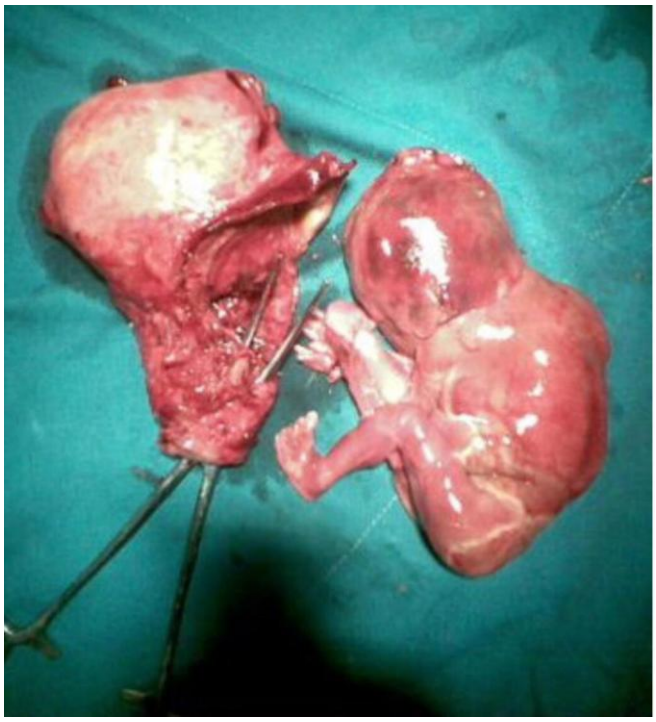

Figure 1 Postoperative specimen showing rent in lateral wall of uterus along with fetus.

Discussion

Although a scar on the uterus is a major risk factor for uterine rupture, high parity is a major risk factor in unscarred uterus. The incidence of rupture of unscarred uterus is found to be 1:17,000-20,000 deliveries.[3] The causes seen in the reported cases are external injuries, induction of labor, multiparity, cephalo-pelvic disproportion, adherent placenta, fundal pressure, abruption of placenta, cocaine abuse, history of intrauterine intervention causing perforation.[3] Other risk factors for unscarred uterine rupture include, uterine anomalies, obstetric maneuvers, malpresentations, excessive uterine expressions, curettage, injudicious use of oxytocin, uterine diverticula, chronic corticosteroid use, whereas some have no obvious cause.[4]

Whatever be the cause of uterine rupture, scarred or unscarred uterus, it remains a life-threatening situation, which may cause severe postpartum hemorrhage resulting in hysterectomy and, at times, maternal mortality.[5] Total hysterectomy is the operative procedure of choice; repair is possible in some cases.[6] In our case, repair was contemplated but not done, as her condition was poor and continuous bleeding at rupture site.

Conclusion

Unscarred uterine rupture, especially in early pregnancy is a rare and catastrophic event,

Uterine rupture should be first ruled out in all pregnant women presenting with acute abdominal pain irrespective of gestational age. Search for non-gynaecological causes in such clinical presentations can delay crucial obstetric surgical intervention that can lead to loss of obstetric function, morbidity and mortality

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