SILENT SCAR RUPTURE

(Report of 2 Cases)

by

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and

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Introduction

Rupture of caesarean scar may very rarely occur in subsequent pregnancy without any alarming signs and symptoms.

Two such cases of silent upper uterine scar ruptures in pregnancy are presented.

CASE REPORT

Case 1

Sm. B. B., aged 21 years, a 3rd gravida was admitted on 18-1-78 at 7-40 P.M. for complaints of vague lower abdominal pain It was a case of pregnancy following previous caesarean section.

Past Obstetric History

She had 2 previous pregnancies, one in 1975, and another in 1977. The 1st one was I.U.D. delivered by caesarean section in a nursing home for A.P.H. at 32 weeks. The 2nd one also delivered by L.U.C.S. at term in Eden hospital. She was having this pregnancy during her lactation amenorrhoea. She had no antenatal check up during this pregnancy. She was once admitted in this hospital during this pregnancy earlier from 30-11-78 to 6-12-78 for observation due to? scar tenderness. On admission, the pulse was 128 pm., regular, BP $\frac{116}{90}$ m.m. Hg, uterine contractions present. There was no scar tenderness. Size of the uterus corresponded to 34 weeks pregnancy. Presentation of foetus was vertex, head floating, os-closed., cervix upper part taken up, no 'show'. Foetal heart sounds 144 per minute. Diagnosis-post-caesarean pregnancy with? scar tenderness.

She was kept under observation in the hospital. Her pain subsided to some extent. There was no scar tenderness but the vague discomfort continued and L.U.C.S. was decided upon. On opening the abdomen under G.A. it was found that there was dehiscence of classical scar almost leaving behind the peritoneal coat intact. The peritoneum was incised lingitudinally. A slightly asphyxiated baby was delivered on 19-1-78 after 22 hours of admission. The baby weighed 2.8 Kg. The placenta was found to be anteriorly situated and was adherent to the classical scar (placenta accreta). However, the adherent portion could be separated out with slight difficulty. Classical scar was repaired with ligation of uterine tubes.

Case 2

Mrs. H. K., Muslim, aged 20 years, a 2nd gravida was admitted on 1-5-78 at 1 p.m. for history of fall 10 days ago and blood stained vaginal discharge for 3 days. She was 32 weeks' pregnant and had no antenatal check up during this pregnancy.

Past Obstetric History

She had 1 previous pregnancy before her marriage, which was terminated by hysterotomy in a nursing home. She had temperature for 3 days after the operation. Her general condition was fair, pallor +, anaemia ++ pulse 104 per minute regular, B.P. $\frac{115}{65}$ m.m. Hg.

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Abdomen was soft, elastic, no rigidity, no definite tenderness. Uterus 32 weeks' size, foetal heart sounds not present, foetal parts felt very superficially. Vague tenderness was present all over the abdomen. Foetal presentation could not be elucidated vaginal bleeding was slight. Os was closed. Cervix was tubular.

The patient was admitted and Inj. Morphine was given for sedation. Provisional diagnosis—silent rupture of uterus.

Two hours after admission laparotomy was undertaken. On opening the abdomen by right infraumbilical paramedian incision, the foetus and its sac were found lying in the peritoneal cavity completely outside the uterine cavity, coming out through a full length rupture of the previous hysterotomy scar on the upper segment. Placenta was lying inside the uterine cavity and there was also slight amount of blood stained discharge in the peritoneal cavity. The foetus and the placenta were removed and the uterine scar was repaired carefully as she had no living children. Foetus, was stillborn, macerated and weighed 1.3 Kg. Abdomen was closed in layers. She received 1 bottle of blood and the postoperative period was uneventful. She was discharged on 5-2-78 with an advice to attend antenatal clinic as early as possible during her next pregnancy.

Comments

Two cases of silent uterine rupture are reported. In both the cases the previous scar was in the upper uterine segment and both the ruptures occurred during pregnancy. The incidence of scar rupture after classical section is 6.4% (Donald, 1969). As a general rule rupture occurring during labour affects the lower uterine segment, whereas rupture during pregnancy affects upper uterine segment and in these cases the onset is often fairly silent and insidious, particularly when a previous classical scar gives way (Donald, 1969). In these 2 cases also the ruptures were silent and insidious without evidence of shock, internal haemorrhage or vaginal bleeding. Unfortunately, the insertion of placenta during the 3rd pregnancy was over the scar line. The burrowing action of the villi into what is often an imperfect decidua and the increased vascularity of the area weakened the uterine wall and caused rupture.

In the 2nd case the rupture of a previous hysterotomy incision occurred. The cause of rupture was not known, probably history of fall preceeding the vague pain was responsible. The genital tract infection during the postoperative period after previous hysterotomy probably weakened the scar.

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