Early Mid-Trimester LSCS Scar Rupture

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A 35 year old Mrs. P. (G4 P1 L1 MTP2), Nurse by occupation with 3-4 months amenorrhea, was brought to St. Georges Hospital, Mumbai on 21st March 1997 with H/O one episode of giddiness & Vomitting at 8.00 am while on duty. There was no H/O bleeding per vaginum or loss of consciousness.

Her LMP was in December 1996, the date was not known. She was married since 3 yrs. H/O one fullterm lower segment caesarean section, for CPD in private hospital in Mumbai 2½ Yrs back and delivered male baby which is alive and well. There was no H/O fever or wound infection. During second and third pregnancy she underwent medical termination of pregnancy around 8 weeks of gestation, 2 yrs and 1 yr back respectively.

On examination patient was conscious with extreme pallor, Pulse 100/min, low volume and B.P. 80/50 mm of Hg. Her Abdomen was distended, with tenderness & guarding present. Bowel sounds were absent. On deep palpation uterus was just palpable at pubic symphysis. Per Speculum & per vaginal examination revealed marked tenderness with no vaginal bleeding. Cervix was displaced upwards towards right. Large soft mass felt in the posterior fornix. The exact size was difficult to assess. Ultrasonography revealed intra-uterine gestation and suspicious findings of uterine rupture with free fluid in abdomen. U.S.G. Guided tapping confirmed the haemoperitoneum and exploratory laparotomy was carried out immediately with consent for SOS hysterectomy.

On opening the abdomen, haemoperitoneum was detected (>1000 ml Bl). Uterus was about 14 16 wks size. There was rupture of half of previous scar through which maternal surface of placenta was protruding. The rupture involved the left wall of uterus, severely damaging the left uterine arteries. There was active bleeding from the rupture site. Fetus with intact sac was still within the uterine cavity. Placenta and fetus removed and subtotal hysterectomy was performed.

Total blood loss was approximately two litres which was replaced by intra and post operative blood transfusions. Post operative period was uneventful.

Patient came for follow up on 01/04/1997 with no complaints.

Rupture of lower segment caesarean section during early antenatal period is an unusual finding in this case. Lower segment caesarean scar rarely if ever ruptures before onset of labour. Placental implantation over the previous scar and also the possibility of silent uterine trauma during previous two M.T.P's appeared to be contributory factors for early rupture of the scar.