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CASE REPORT

A Rare Case of Vaginal Delivery After Uterine Rupture

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Introduction

Rupture of uterus is a serious obstetric complication. Consequences can be more dangerous if it remains undiagnosed. Spontaneous rupture of a scarred uterus is an uncommon event but it is rare for it to be followed by vaginal delivery and to be diagnosed postpartum period is still rare. We report a case of spontaneous uterine rupture which was followed by a vaginal delivery which was diagnosed postpartum. A tender uterus after delivery was the only consistent sign present.

Case

The patient was a 25 year $G_3P_0L_0A_2$, who presented to the casualty with a 28 week pregnancy and pain in the abdomen since a day which was sudden, severe, and was not accompanied by bleeding. There was pallor. The uterus was tense and tender, fundal height was 28 weeks, the fetal heart sound was not audible. Ultrasonography showed a fetus of 27 weeks with absent fetal heart beats, placenta in the upper segment and the presence of a large retro placental clot. There was a cystic structure 6.8 × 5.6 cm in the right adnexa and right ovary was not visualized separately. The coagulation profile was normal and her hemoglobin level was 7.6 g/dl. The diagnosis of abruptio placenta with intrauterine death of fetus was made.

Labour was induced with oxytocin; subsequently artificial rupture of membranes was done. She delivered a still born male baby and the examination of placenta showed a small retroplacental clot. After delivery the pulse rate was 96/min, and the respiratory rate was 38/min. The uterus was tender but was well contracted. Gradually the pulse and respiratory rate increased and abdomen became increasingly tense and tender with an increase in guarding and rigidity. Ultrasound with Doppler showed a simple ovarian cyst with a normal Doppler flow around it. There was gross free fluid in abdominal cavity. On peritoneal tapping blood was obtained.

On laparotomy was a massive hemoperitoneum (~1.5 l). On the right posterior surface of uterus, there was a rent in the body of uterus, which appeared to be at an old scar of a perforation during an earlier dilatation and curettage. The rent was repaired and hemostasis secured (Fig. 1). The cyst was a broad ligament cyst which was excised. The patient had an uneventful postoperative recovery.

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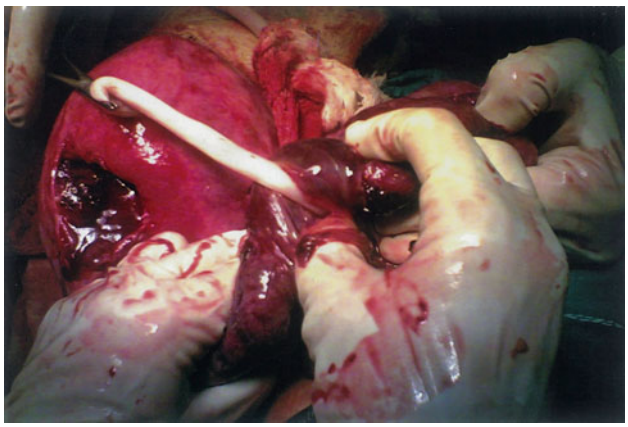

Fig. 1 The picture shows the posterior surface of uterus with repaired uterine scar

Discussion

Uterine rupture is a severe obstetric complication. There are a few reports of vaginal delivery after uterine rupture in previous LSCS [1–3]. The rupture of primigravid uterus is a very rare event and vaginal delivery after it is even more. There have been very few reports of uterine rupture being diagnosed in postpartum [4].

Not all uterine rupture presents with the typical features of abdominal pain, fetal compromise, hypovolemia and vaginal bleeding [5]. In this case the patient had signs and symptoms of hypovolemia with fetal compromise and abdominal pain but there was no vaginal bleeding. It was due to this reason that the diagnosis was missed in the antenatal period also there was a supporting finding of the retroplacental clot on ultrasonography was suggestive of abruptio placenta. Though most probably it was a collection of blood behind ruptured area.

The deteriorating general condition in the absence of any vaginal bleeding suggested strongly towards uterine rupture. The fact that uterus remained tender even after delivery was an important indicator of rupture of the uterus.

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