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Case Report

Ruptured uterus with bladder injury in a scarred uterus: a near miss

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ABSTRACT

Uterine rupture in a previously scarred uterus is a life-threatening obstetric emergency associated with significant maternal and fetal morbidity and mortality. We report a case of a 27-year-old G5P2L1A2 at 36+5 weeks of gestation with two prior caesarean sections who presented with acute abdominal pain, vaginal bleeding, and decreased fetal movements. Clinical findings and USG suggested uterine rupture with intrauterine fetal demise. This case signifies the importance of early diagnosis and referral, prompt surgical intervention by multidisciplinary approach in a tertiary care centre.

Keywords: Uterine rupture, Caesarean section, Peripartum hysterectomy

INTRODUCTION

Uterine rupture is a rare but catastrophic obstetric complication, most commonly associated with previous caesarean delivery. The global incidence is increasing due to rising trends in cesarean section. Women with multiple uterine scars are at significantly higher risk. Additional contributing factors include lack of antenatal care, and delayed referral with obstructed labor.[1,2] Clinical symptoms may vary from subtle symptoms to sudden hemodynamic collapse which highlights early diagnosis and referral to tertiary care with prompt surgical management and multidisciplinary approach adhering to standardised protocols are critical in improving maternal outcome. Associated complications such as massive hemorrhage, fetal demise, and adjacent organ injury (especially bladder rupture) significantly increase maternal morbidity. Timely surgical intervention and adherence to standardized protocols recommended by WHO and RCOG are critical in improving outcomes.[3,4] This case highlights a near-miss obstetric emergency involving uterine rupture with extensive bladder injury requiring peripartum hysterectomy.

CASE REPORT

A 27-year-old unbooked gravida 5 para 2 living 1 abortion 2 (G5P2L1A2) woman at 36 weeks and 5 days of gestation presented to the emergency labour room with complaints of acute abdominal pain since one day, bleeding per vaginum, and decreased fetal movements. The abdominal pain was sudden in onset, continuous, generalized, and progressively increasing in intensity. She also complained of reduced perception of fetal movements for several hours prior to presentation. There was no history of leaking per vaginum, fever, convulsions, trauma, or recent instrumentation.

The patient had received inadequate antenatal care and was referred late to the tertiary care center. Her obstetric history was significant for two previous lower segment caesarean sections and two previous abortions. She also had a past history of eclampsia in a previous pregnancy. There was no available documentation regarding the indication or intraoperative findings of previous caesarean deliveries.

On admission, the patient appeared pale and anxious. She was conscious and oriented to time, place, and person. General physical examination revealed pallor. Her pulse rate was 108 beats per minute and blood pressure was 90/60 mmHg, suggestive of hemodynamic instability and hypovolemic shock. Respiratory rate was 24 cycles per minute. SpO2 was 94% on room air.

On local examination, the abdomen was tense with marked generalized tenderness. Normal uterine contour could not be appreciated. Multiple fetal parts were palpated superficially and easily through the abdominal wall. Fetal heart sounds could not be localized on Doppler examination. Features were highly suggestive of uterine rupture with possible intra-abdominal extrusion of the fetus.

Local examination revealed active bleeding per vaginum. Cervical assessment was deferred in view of suspected rupture uterus and hemodynamic instability.

Emergency investigations were sent simultaneously with resuscitation. Hemogram revealed Hb/ TLC/ Platelet count- 12.4 gm%/ 23.08 cumm/ 91,000 cumm. PT/INR- 11.3/ 1.05. LFT and RFT were within normal range.

Urgent bedside ultrasonography revealed a single intrauterine pregnancy corresponding to 35 weeks and 3 days gestation with absent fetal cardiac activity, suggestive of intrauterine fetal demise. Estimated fetal weight was approximately 2480 g. Placenta was posterior and appeared bulky with suspicion of placental abruption. Amniotic fluid index was adequate.

The patient was immediately shifted for emergency exploratory laparotomy in view of abruptio placentae with IUFD with previous 2 LSCS with hypovolemic shock after written and informed consent with simultaneous resuscitative measures with intravenous fluids, blood products, oxygen support, and preparation for massive transfusion protocol A clinical suspicion of ruptured uterus was kept in mind. Intraoperatively, approximately 2 liters of hemoperitoneum was noted along with a large retroplacental clot weighing around 800 g, confirming placental abruption. A dead male fetus weighing approximately 2.2 kg along with placenta lying in abdominal cavity was delivered.

Further exploration revealed an extensive inverted T-shaped uterine rupture extending from the previous caesarean scar vertically up to the uterine fundus. Associated bladder rupture was also identified, likely secondary to dense adhesions between the bladder and lower uterine segment from previous surgeries.

Initial uterine conservation measures were attempted. The uterine rent was repaired in three layers and uterotonics were administered. However, persistent torrential bleeding continued despite bilateral uterine artery ligation and internal iliac artery ligation. As hemostasis could not be achieved and maternal condition continued to deteriorate, a decision for emergency life-saving peripartum hysterectomy was taken.

Bladder repair was subsequently performed in layers by Urosurgery team and a drain was placed in the pouch of Douglas. The patient received 4 units PRBC, 4 units RDP, 4 units FFP intraoperatively and was started on ionotropic support. Patient received ICU care for 72 hours, broad spectrum antibiotics and 1-unit PRBC and 3 units FFP transfusion in post operative period

The patient was discharged on request on post operative day 7 with Hb of 7.5 gm/dl on oral elemental Iron 100 mg twice daily and high protein diet. She was called back of post operative day 14 for catheter and suture removal. Patient recovered well.

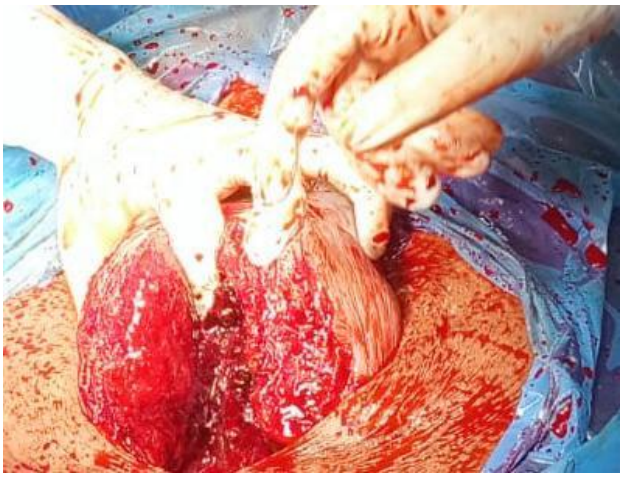

Figure 1: Intra operative finding suggestive of ruptured uterus

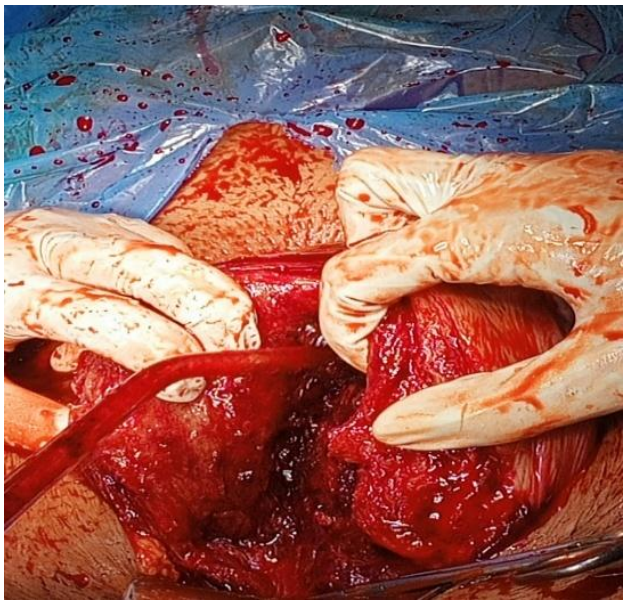

Figure 2: Intra operative finding suggestive of ruptured uterus

DISCUSSION

Uterine rupture is strongly associated with previous caesarean delivery, particularly when multiple scars are present.[1,2,5] In this case, the patient had two prior LSCS and inadequate antenatal surveillance both major contributors. The classical triad of pain, bleeding, and fetal distress/death was evident. The presence of easily palpable fetal parts and absent fetal heart sounds strongly indicated complete rupture.[2]

Bladder injury is a recognized complication due to adhesions between the bladder and lower uterine segment in scarred uteri. Its presence significantly increases operative difficulty, blood loss, and maternal morbidity.[5,6]

Massive obstetric hemorrhage remains one of the leading causes of maternal mortality worldwide. WHO and RCOG guidelines recommend early recognition, aggressive fluid resuscitation, stepwise devascularization, and timely hysterectomy when conservative measures fail.[3,4]

In this case, conservative surgical measures failed and an early decision for hysterectomy proved life-saving. This qualifies as an obstetric near-miss event, where timely multidisciplinary intervention involving obstetricians, anesthesiologists, ICU care, and transfusion services ensured maternal survival.[3,4]

CONCLUSION

Catastrophic uterine rupture with bladder injury represents a severe obstetric emergency. Early diagnosis, prompt surgical intervention, and adherence to hemorrhage management protocols are critical for improving maternal outcomes. Strengthening antenatal care and ensuring timely referral can help prevent such life-threatening complications.

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