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Silent uterine rupture of scarred uterus--an unusual presentation as amniocele

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CASE REPORT

SILENT UTERINE RUPTURE OF SCARRED UTERUS —AN UNUSUAL PRESENTATION AS AMNIOCELE

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Obstetricians should be aware of the possibility of silent rupture of scarred uterus. Ultrasound has an important role in the diagnosis of silent uterine rupture. A case of silent uterine rupture with foetal demise, that remained undiagnosed for many weeks, is described.

Keywords: Silent uterine rupture, scar dehiscence, scarred uterus

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INTRODUCTION

Uterine rupture is an uncommon but potentially fatal complication of pregnancy. The difficulty in diagnosis and management arises in cases of chronic and silent uterine rupture. Silent ruptures have also been reported after D&E and hysteroscopic procedures.[1,2] Normal cardiotocographs (CTG) can be obtained in silent uterine rupture hence it is not a useful tool in the diagnosis.[3] We present a case of silent uterine rupture with amniocele that remained misdiagnosed as large ovarian cyst for many weeks.

CASE REPORT

A 27-year-old woman from a remote rural area of Balochistan came to outpatient clinic at our secondary care hospital for the first time. She was gravida 2, para 1, with a history of caesarean section followed by neonatal death two years back. She presented at 29+ weeks gestation with decreased foetal movements and an ultrasound report, showing single active foetus of about 29+ weeks, with transverse lie, and posterior low lying placenta reaching os. The scan also suggested a large ovarian cyst of 18×12 Cm size with smooth wall, lying in left flank. The patient was referred to tertiary care hospital for potential need of NICU services, where she presented three weeks later. Ultrasound at that time showed a single nonviable baby of about 32 weeks gestation with no liquor around, a band extending from the upper segment of uterus up to the cervix, and a large cystic space. The woman came back to us and was scheduled for elective caesarean section due to transverse lie with previous scar. The following morning, she presented with labour pains. On opening abdomen at emergency caesarean section, there was no haemoperitoneum, and about 4 Cm dehiscence was found in the centre of previous scar. Amniotic sac had completely herniated through the rent forming an amniocele that was lying in peritoneal cavity in left flank with loops of cord floating in it. The baby was lying in uterus in transverse position. Uterus was normal in shape and the cavity had no band. A 2.6 Kg macerated male baby with no apparent anomaly, was delivered. Uterus was repaired. The woman was discharged on second postoperative day in satisfactory condition.

DISCUSSION

The 'silent' rupture of uterus is encountered when the patient is asymptomatic and rupture or rent in the uterus is discovered incidentally on ultrasound or at surgery. Risk factors are previous scar or other surgeries upon uterus, induction of labour by prostaglandins and augmentation of labour by oxytocin in a multiparous woman.[1,2] The dilemma in diagnosis arises when uterine rupture remains asymptomatic or presents with non-specific symptoms, e.g., vague abdominal pain or discomfort for many weeks. There is difficulty in diagnosis due to lack of resources, expertise and ultrasound skills. CTG is not a useful tool in the diagnosis of silent uterine rupture.[3] In our case, at the time the woman sought medical advice at 29+ weeks, she already had rent in the uterus with an amniocele, interpreted as ovarian cyst on ultrasound. During subsequent three weeks, all of the amniotic had fluid shifted in this amniocele resulting in decreased foetal movement and ultimately foetal demise. In the following ultrasound there was no liquor around the baby and the image of uterine band was apparently the lower uterine wall that lied between the uterine cavity and the amniocele.

A case similar to this is reported where a lady presented at 29 weeks with abdominal pain for several weeks and ultrasound revealed foetal parts outside the uterine cavity.[4] Two other cases are reported where they conservatively managed prenatal uterine rupture, diagnosed first at 17 and 19 weeks respectively on ultrasound.[5,6] Silent rupture can occur in previous scars as well as in unscarred uterus.[7,8] These ruptures remain silent for days and weeks. Another case is reported where two large 5 Cm and 10 Cm complete ruptures were incidentally discovered on third postnatal day during tubal ligation.[9] An unusual presentation of prenatal silent rupture is reported as anhydramnios and lung

hypoplasia at 31 weeks. Further investigation revealed foetal leg protruding through uterine wall.[10]

CONCLUSION

High index of suspicion should arise for uterine rupture in cases of previous scar or procedures upon uterus, when they present with unusual features and suspicious ultrasonography findings like bands, cysts and unexplained anhydramnios. Ultrasonography has an important role in diagnosing silent and old ruptures. Every effort should be made to seek expertise to define uterine wall integrity and rule out amniocele or herniation of amniotic sac in suspicious cases.

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