First Trimester Uterine Rupture, a Rare but Life-Threatening Event: A Case Report

Nafiseh Saghafi, MD; Asieh Maleki, MD; Sedigheh Ayati, MD; Laya Shirinzadeh, MD

Department of Obstetrics and Gynecology, Ghaem Hospital, Faculty of Medicine, Mashhad University of Medical Sciences, Mashhad, Iran

Correspondence: Asieh Maleki, Department of Obstetrics and Gynecology, Ghaem Hospital, Ahmad Abad Street, Postal code: 91766-99199, Mashhad, Iran
Tel/Fax: +98 51 38012477
Email: malekiaa@mums.ac.ir

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Abstract
Uterine rupture often occurs in the third trimester of pregnancy or during labor. Its occurrence in early pregnancy and in the absence of any predisposing factors is very rare. Untimely diagnosis and a low index of suspicion could be life-threatening. Here we report the case of a 29-year-old woman with a history of two previous cesarean sections. An ultrasound report revealed a dead fetus in the abdominal cavity at 14 weeks into the abdominal cavity due to a rupture at the site of the previous cesarean scar. Awareness of probable diagnosis of uterine rupture in a pregnant woman with abdominal pain could be important for timely diagnosis and proper management.


Keywords ● Uterine rupture ● Pregnancy Trimester, First ● Cesarean section

Introduction
Rupture of the pregnant uterus is one of the most important causes of obstetric hemorrhage. It is classified as complete or partial separation of the uterine layers and can be a life-threatening event for both mother and fetus, especially in complete form. The incidence of uterine rupture is 1 in 4,800 deliveries in developed countries and the rupture of an unscarred uterus is a few as 1 in 10,000-15,000 birth. The greatest risk factor for either form of rupture is a prior cesarean delivery or other myometrial surgical incision. Other risk factors include grand multiparity, trauma, malpresentation, obstructed labor, misuse of uterotonic drugs, particularly for sequential labor induction. Uterine rupture rarely occurs in an unscarred pregnant uterus. The probability of a rupture is higher when a combination of several risk factors is present. Most uterine rupture occur in the third trimester at the onset of the contractions and mainly in a previously scarred uterus. Uterine rupture in the first trimester of pregnancy or even in the early second trimester is very rare. Considering the rarity of uterine rupture in the first trimester of pregnancy, we present a rare case of uterine rupture at 14 weeks of gestation in a 29-year-old woman with a history of two prior cesarean sections.

Case Report
A 29-year-old woman (gravida 3, para 2, live 2), with a history of two previous cesarean sections (both were lower segment CS), was admitted to Ghaem University Teaching Hospital (Mashhad, Iran) in November 2017. She complained of moderate abdominal pain and vaginal bleeding during the previous 10 days. Her
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The patient was unable to seek proper medical consultation due to the history of an irregular menstrual cycle and lack of financial means. She only took a urine pregnancy test. Two days prior to admission, she underwent a sonogram and the report revealed a 24 mm endometrial lining and an 82×37 mm heterogeneous mass in the left adnexa, probably associated with a perforated gestational sac. An 8 cm long dead fetus corresponding to 14 weeks of gestational age, laterally positioned at the side of the heterogeneous mass was reported. The patient was about 12 weeks pregnant and placental tissue was present with multiple organized blood clots surrounding the lower segment of the anterior wall of the uterus and bladder. After removal of the placental tissue and clots, a tear of approximately 3 cm in length at the site of the previous cesarean scar was exposed; no active bleeding was noted (figure 2). The uterus was examined for residual placental tissue and the remaining tissue was removed. A macerated fetus was found in the left lateral paracolic gutter of the abdominal cavity (figure 3). Both salpinx and ovary were normal. The presence of a rupture at the site of the previous cesarean scar and almost empty uterus led to a change of diagnosis from abdominal ectopic pregnancy to uterine rupture. There was no abnormal placental adhesion or bleeding, which ruled out the diagnosis of cesarean scar pregnancy. The uterus was closed in two layers of 1-0 vicryl sutures. Subsequently, the abdominal cavity was washed with 2-liter warm saline and the walls were closed in the anatomical plane. There was no medical indication for a blood transfusion nor post-operative complications. Hematinic was prescribed and the patient was discharged 2 days after the surgery. At 6-month follow-up, no specific problems were noted. Written informed consent was obtained from the patient for the publication of this case report.

Figure 1: Trans-Abdominal ultrasound shows empty uterus, mild collection and fetus without heartbeat in the left lateral paracolic gutter of the abdominal cavity corresponding to 13 weeks of gestational age (white arrow) and a heterogeneous mass in the left adnexa (yellow arrow).

Figure 2: Laparotomy revealed a tear of about 3 cm at the site of previous cesarean scar in a 14-week pregnant uterus; shown by suction head.
Discussion

A rare case of uterine rupture at 14 weeks of gestation is reported in which, based on ultrasound reports, the primary diagnosis was extra-uterine pregnancy. However, upon laparotomy, a tear of approximately 3 cm in length was observed at the site of the previous cesarean scar with no active bleeding. A dead fetus was found in the abdominal cavity; confirming the diagnosis of a ruptured uterus.

Uterine rupture accounts for 14% of all hemorrhage-related maternal mortality. Most often, uterine rupture occurs in the third trimester.

Table 1: Uterine rupture in the gestational age less than 20 weeks

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Age (years)</th>
<th>Gestation (week)</th>
<th>Gravida/Para/abortion</th>
<th>Initial presentation</th>
<th>Risk factor</th>
<th>Rupture site</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbas5</td>
<td>2018</td>
<td>24</td>
<td>10</td>
<td>3/2</td>
<td>Acute abdominal pain and shock</td>
<td>Two previous scars</td>
<td>Fundus and posterior wall</td>
<td>Primary repair</td>
</tr>
<tr>
<td>Surve7</td>
<td>2017</td>
<td>25</td>
<td>10</td>
<td>3/1/ab1</td>
<td>Acute abdominal pain and shock</td>
<td>Previous scar</td>
<td>Previous scar</td>
<td>Primary repair</td>
</tr>
<tr>
<td>Mirandaa9</td>
<td>2017</td>
<td>32</td>
<td>13</td>
<td>3/2</td>
<td>Acute abdominal pain</td>
<td>Previous scar and short pregnancy interval</td>
<td>Previous scar</td>
<td>Primary repair</td>
</tr>
<tr>
<td>Bandarian8</td>
<td>2015</td>
<td>30</td>
<td>11</td>
<td>4/2/ab1</td>
<td>Acute abdominal pain and shock</td>
<td>Two Previous scars, D&amp;C</td>
<td>Previous scar</td>
<td>Primary repair</td>
</tr>
<tr>
<td>Ho4</td>
<td>2017</td>
<td>33</td>
<td>17</td>
<td>2/0/ab1</td>
<td>Lower abdominal pain and abdominal distention</td>
<td>Placenta accreta</td>
<td>Fundus</td>
<td>Primary repair</td>
</tr>
<tr>
<td>Vaezi11</td>
<td>2017</td>
<td>34</td>
<td>12</td>
<td>2/1</td>
<td>Acute abdominal pain</td>
<td>Without</td>
<td>Fundus</td>
<td>Primary repair</td>
</tr>
<tr>
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<td>34</td>
<td>15</td>
<td>3/1</td>
<td>Acute abdominal pain</td>
<td>Without</td>
<td>Fundus</td>
<td>Primary repair</td>
</tr>
<tr>
<td>Sun5</td>
<td>2012</td>
<td>31</td>
<td>17</td>
<td>3/2</td>
<td>Acute abdominal pain and shock</td>
<td>Without</td>
<td>Fundus</td>
<td>Primary repair</td>
</tr>
<tr>
<td>Sunanda13</td>
<td>2014</td>
<td>31</td>
<td>17</td>
<td>2/ab1</td>
<td>Acute abdominal pain</td>
<td>Bicornuate uterus</td>
<td>Right horn of fundus</td>
<td>Primary repair</td>
</tr>
<tr>
<td>Faroog9</td>
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<td>27</td>
<td>17</td>
<td>4/2/ab1</td>
<td>Acute abdominal pain</td>
<td>Twin/placenta percreta</td>
<td>None</td>
<td>Total hysterectomy</td>
</tr>
<tr>
<td>Porcu14</td>
<td>2003</td>
<td>28</td>
<td>12</td>
<td>1/0</td>
<td>Acute abdominal pain</td>
<td>DES</td>
<td>None</td>
<td>None</td>
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<tr>
<td>Arbab15</td>
<td>1996</td>
<td>25</td>
<td>8</td>
<td>Ab2/p2</td>
<td>Severe hemorrhagic shock</td>
<td>Bilateral salpingectomy/ left cornual resection</td>
<td>Vertical rupture of Fundus</td>
<td>Primary repair</td>
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<td>1996</td>
<td>34</td>
<td>13</td>
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<td>Acute abdominal pain and shock</td>
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<td>Primary repair</td>
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</tr>
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<td>The present case</td>
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<td>29</td>
<td>14</td>
<td>3/2</td>
<td>Abdominal pain</td>
<td>Previous scar</td>
<td>Previous scar</td>
<td>Primary repair</td>
</tr>
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</table>
of pregnancy, during labor, or mainly in a previously scarred uterus. Its occurrence in early pregnancy is very rare even in the presence of predisposing risk factors. At term and near-term pregnant women, especially in the setting of a trial of labor after prior cesarean delivery, careful and close monitoring of both mother and fetus can help in its timely diagnosis. Abnormal labor progress, abnormal abdominal pain, vaginal bleeding, loss of station of presenting part, maternal tachycardia, and fetal bradycardia are indicative factors for detecting uterine rupture. However, in early pregnancy, especially without the presence of any predisposing risk factors, the diagnosis may occur with latency or may never be detected; leading to life-threatening complications. Furthermore, signs and symptoms of uterine rupture in the early trimester are non-specific. Although the presence of previous uterine scar has been described as the main cause of uterine rupture, some recent studies have reported abnormal placentation (accrrete, increta, and percreta) as the most common underlying etiology even in early pregnancy. As shown in table 1, a review of 15 cases of uterine rupture in the first trimester of pregnancy showed that the most common causes were placenta percreta (4 cases). Considering a worldwide increase in the cesarean delivery rate, such an outcome was anticipated.

There is not always an underlying medical cause for uterine rupture. It seems that in these cases, which often occur in early pregnancies, the fundus is the most common site of rupture. This is while in term and near-term pregnancies, most uterine ruptures occur at the site of previous cesarean section scar. A previous study reported 8 cases of uterine rupture in unscarred uteri at a gestational age of below 20 weeks. In all those cases, the fundus was the rupture site. Multiparity was suggested as the main predisposing factor in most cases. However, since the cases involved second or third pregnancies, it seems that there was no underlying medical cause. Other causes of uterine rupture are congenital uterine abnormalities (e.g., bicornuate uterus and uterine septum) and diethylstilbestrol exposure. In another study, past medical history of procedures performed on the uterus, such as bilateral salpingectomy or cornual resection, was reported as the main risk factor.

In most reported cases of uterine rupture in early pregnancy, patients were presented with acute abdominal pain and shock. This might be due to untimely diagnosis or, in most cases, the involvement of the fundus. However, in our case, the patient was stable and showed no sign of hemoperitoneum, which could have been due to the small size of the rupture and hemostasis with clot formation. It seems that despite the difficulty of detecting uterine rupture in early pregnancy, most ruptures can be repaired. The majority of the reviewed studies indicated two main causes of uterine rupture, namely abnormal placenta invasion and previous cesarean scar. This, combined with an increasing rate of cesarean sections worldwide, highlights the need for a high degree of clinical suspicion in early diagnosis of uterine rupture.

Conclusion

Awareness of probable diagnosis of uterine rupture in pregnant women with abdominal pain is important for timely diagnosis and proper management; even in the early gestational age of pregnancies and in the absence of known risk factors.

Conflict of Interest: None declared.

Reference

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