An unusual case of placenta abruption complicated with ruptured uterus: case report

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Citation

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Abstract

Presentation of abruption of placenta and ruptured uterus is extremely rare, there were only a few cases described in the past. A 40 year-old woman, gravida 7 para 6 presented with features of placenta abruption with fetal demise, where she was allowed to labour while anticipating vaginal delivery. Unfortunately during the course of labour she was suspected to have ruptured uterus, and laparotomy was performed. Findings were hemoperitoneum, Couvelaire uterus with bilateral uterine rupture involving uterine vessels. A dead fetus was delivered followed by supracervical hysterectomy. She recovered without major complications. Careful monitoring of this patient was the only thing which allowed us to discover this unusual presentation.

INTRODUCTION

Concurrent presentation of abruption of placenta and ruptured uterus is extremely rare, there were only few cases described in the past [1,2]. Both conditions are considered as obstetrical emergence and their diagnosis can easily be made through clinical presentation [3]. Presentation of both conditions in the same patient can result in delay in providing appropriate treatment if not recognized early.

CASE REPORT

A 40 year-old woman, gravid 7 para 6 was admitted due to labour pains, cessation of fetal movements and vaginal bleeding at gestational age of 38 weeks. She had previously normal vaginal births. She was not known to have hypertension in her previous pregnancies. Her physical examination revealed Bp of 140/90 mmHg, edema of lower limbs, fundus was equivalent to 36/40 weeks, uterus was tender and woody hard, there were palpable contractions, and cephalic presentation. Bed side ultrasound scan showed fundal placenta and fetal heart couldn't be demonstrated.

Pelvic-vaginal examination: perineum was stained with blood/clots; cervix was 6 cm dilated membranes intact, meconium stained liquor noted after artificial rupture of membranes was performed. Urine for protein was 3+ and her initial hemoglobin was 11.2 g/dl. Impression was pre-eclampsia / fetal demise / abruptio placenta. She was catheterized, cross matched and given intravenous fluid. Labour was allowed to proceed.

Fours hours later, she became very unstable, severely anaemic, Bp 80/60 mmHg, tachycardic, fundal height noted to have increased, the whole abdomen became tense, and cervix was 9 cm, no active vaginal bleeding. In view of the above findings, uterine rupture was suspected.Decision was made to take this patient to theatre for laparotomy. Findings were hemoperitoneum of 3 litres, partial bilaterally uterine rupture, involving uterine vessels, fetus in cephalic presentation still in-utero. Uterus appeared to be extavasated with blood, bladder was not involved. A dead fetus weighing 3 Kg was delivered through ruptured site. The already detached placenta was also delivered with retro-placenta clots seen. Supra cervical hysterectomy was performed. She received about four units of blood and five litres of normal Saline & Ringer's Lactate in the operating theatre. Post-operative progress was uncomplicated; she was discharged on day 14.

COMMENT

This patient presented with features very suggestive of placenta abruption, but in the course of her labour she spontaneously ruptured her uterus. Initially diagnosis for placenta abruption was straight forward vaginal bleeding, uterine tenderness and also several studies have demonstrated a link between hypertension and placenta abruption [3,4].

Deteriorating condition of the patient, reduced vaginal bleeding and generalized abdominal pain with rebound tenderness was sufficient to lead us to diagnosis of uterine

rupture [3]. Management of ruptured uterus and placenta abruption is different; hence distinguishing between the two conditions is important. Management of abruptio placenta with fetal demise includes immediate delivery, preferably by vaginal birth [3,4]. Abdominal delivery is indicated when vagina delivery is unachievable or when bleeding is so severe that the patients condition is deteriorating very fast [3,4]. However in case of uterine rupture, immediate laparotomy is the only option [3].

Uterine rupture in this case may have been explained by high parity [1]. However there usually is a precipitating factor like obstruction or use of oxytocin, which was not apparent in this case. Whether Couvelaire uterus or abruption placenta has any impact on integrity of the uterine myometrium remains unclear [1,2].

CONCLUSION

The lesson learnt from this case, it is important to respond to every new symptom during management of abruption placenta and this is only possible with careful monitoring even in limited resource centres.

References

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