

Unusual Presentations of Uterine Rupture: A Case Series

Alesandra R. Rau, MD¹, Cortney M. Eakin, MD², Anjali Y. Hari³, MD, M. Elena Rhoads, MD PhD², and Griselda A. Reyes, MD²

¹Department of Obstetrics and Gynecology, University of California – Irvine, School of Medicine, Orange, CA.

²Department of Obstetrics and Gynecology, Division of OB/GYN Hospitalists, University of California – Irvine Health, Orange, CA.

³Department of Obstetrics and Gynecology, Division of Gynecologic Oncology, University of California – Irvine Health, Orange, CA.

Introduction

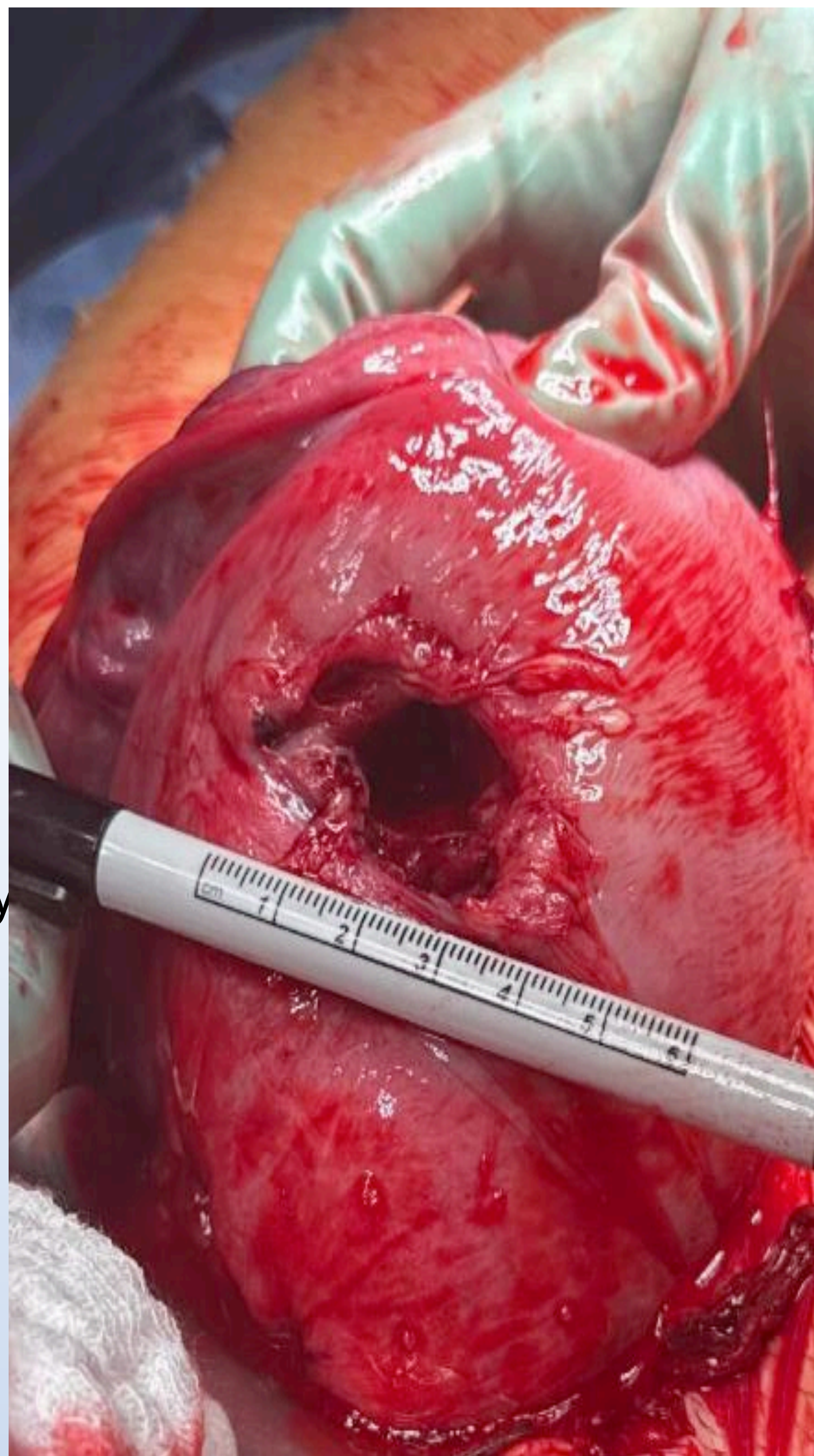
Uterine rupture is an uncommon, but serious intrapartum complication. It is most often seen in patients with a prior low-transverse cesarean delivery undergoing a trial of labor (TOLAC). In our experience, not all ruptures present in patients with clear risk factors or with the classic signs and symptoms described in medical literature. Because the incidence of these unusual presentations is rare, there is limited literature available.

Case 1: The Spontaneous

28yo G4P1112 at 31w1d presented via EMS with acute onset abdominal pain, nausea and vomiting at home.
Pregnancy c/b uterine didelphys, prior classical cesarean delivery

Physical Exam:
Maternal vital signs: within normal limits
General: pale, diaphoretic
Abdomen: gravid, diffusely tender, + rebound, guarding
SVE: 3/50/H
FHT: Cat I - 130 baseline, mod variability,
- accels, - decels
Toco: low amplitude irritability

Maternal: discharged on POD#3
- Uterine defect repaired primarily
- QBL 1100mL, 2u pRBC intraoperatively
Neonatal: admitted to NICU
APGAR's 7/8, weight: 1805g.
arterial cord gas 7.32/47/21/-2.
- Discharged at CGA 39w2d

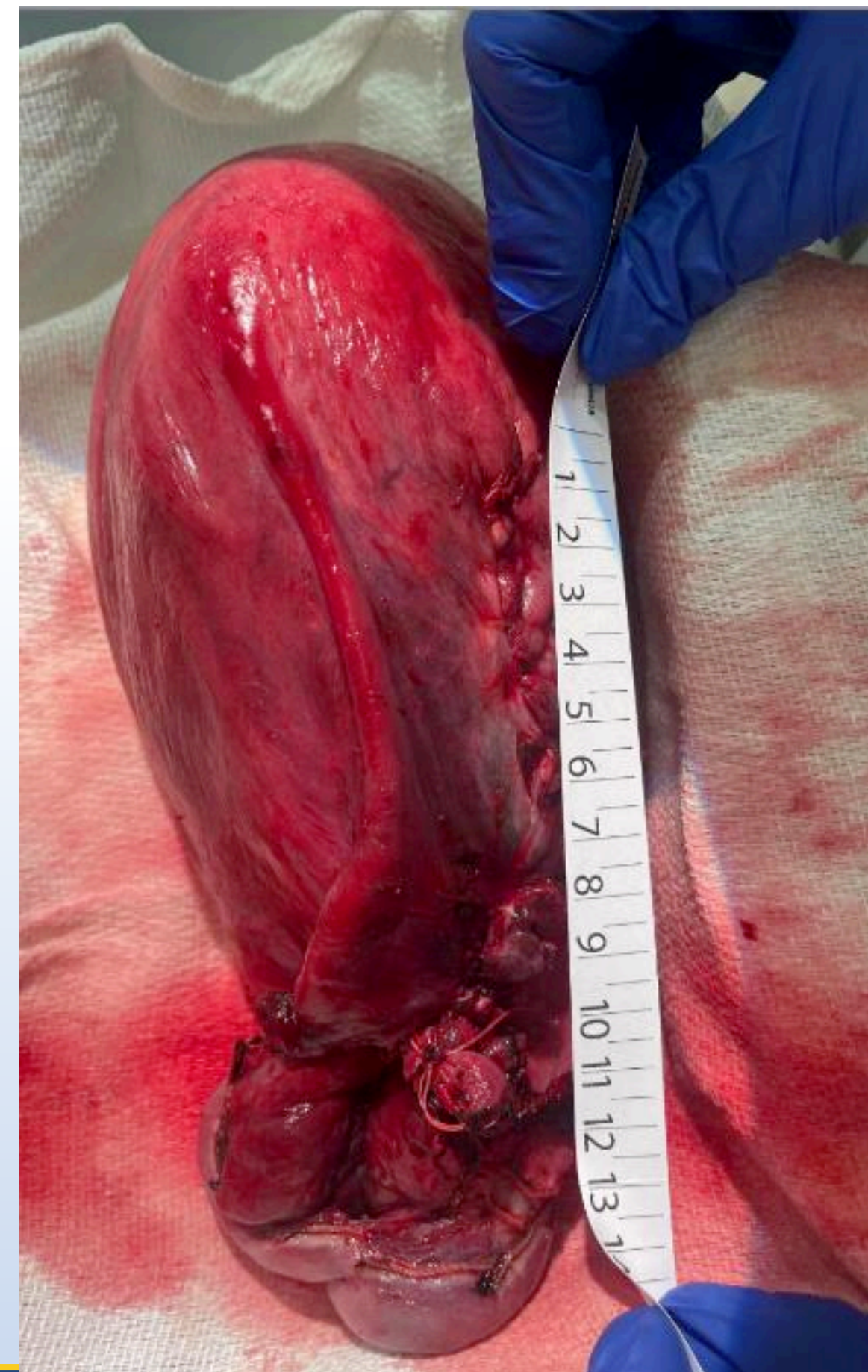


Case 2: The Secretly Scarred

42yo G6P2032 at 38w0d admitted for induction of labor for fetal growth restriction.

Physical exam:
9.5/100/0, FHT Cat II with recurrent variable decelerations, minimal variability followed by bradycardia with nadir to 60's.
Subjective: patient complained of pain and "feeling off". diaphoretic and pale, maintained normal HR and BP with SpO2 dropping into low 90's

Maternal: to SICU, extubated.
- QBL: 3990 mL; 4u pRBC, 1u PLT, 6u FFP, 1 cryoprecipitate.
- POD#5: discharged to home
Neonatal: to NICU
APGARs 1/3, weight 2735g, venous cord gas 6.86 /125/21/-15.
- Therapeutic hypothermia for HIE
- DOL#9: discharged without evidence of neurologic deficit



Case 3: The Scary

30yo G1P0 at 37w4d diagnosed with intrauterine fetal demise during routine office OB visit.

Moderate vaginal bleeding, BP 80/49, symptomatic hypotension with tachycardia - 160's.
SVE: profound loss of fetal station from C/C/+2 to C/C/-1

Maternal: to SICU, required continued vasopressor support, artificial airway maintained.
- QBL: 3530mL. 5 pRBC, 8u FFP, 1u PLT, 1u cryoprecipitate and 1u albumin.
- POD#0: Pressors weaned
- POD#1: Extubated
- POD#5: Discharged home



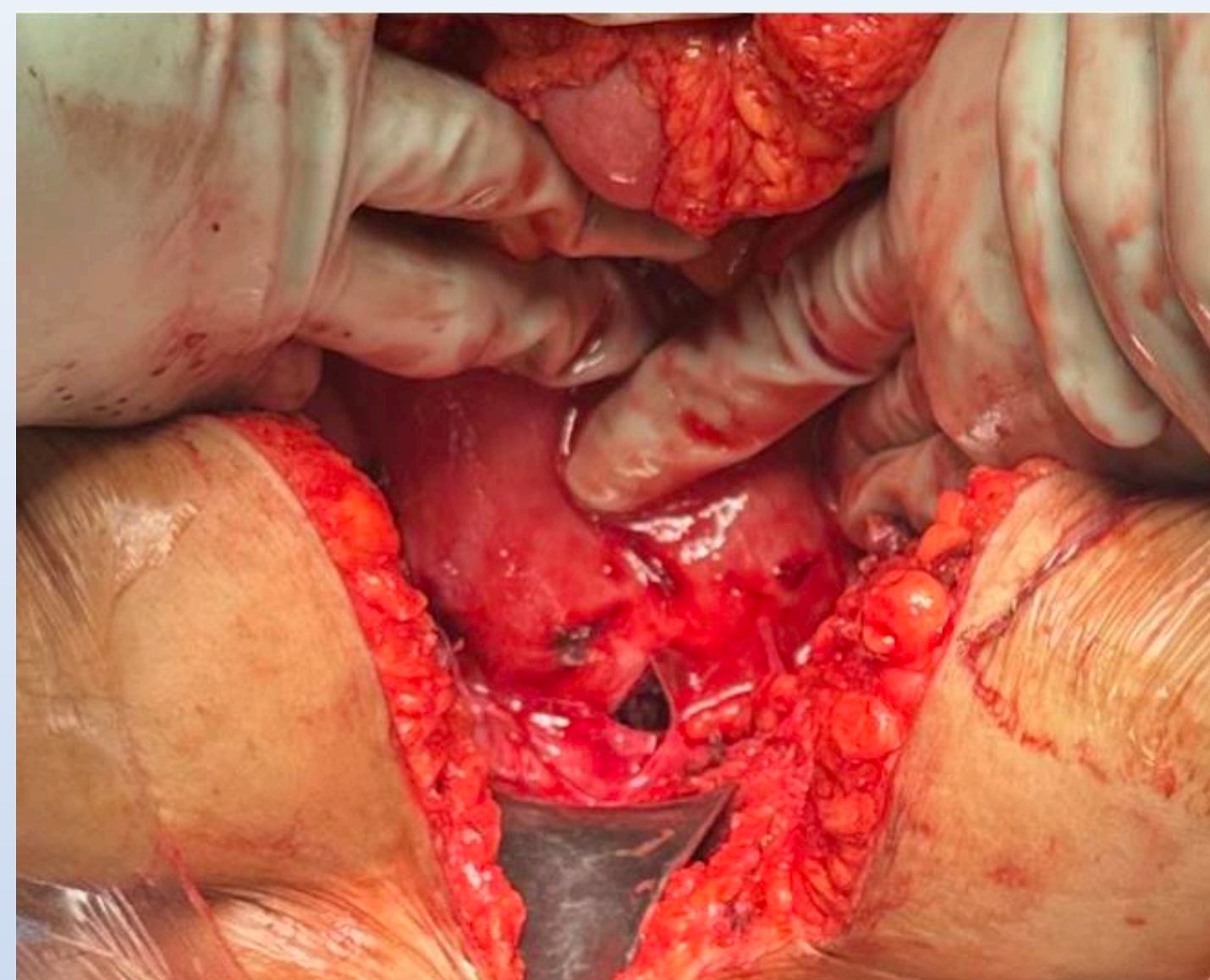
Case 4: The Silent

41yo G5P3013 p/w previable PPROM and underwent induction termination at 19w

Pregnancy c/b 2 prior cesarean deliveries

Physical exam:
Delivery room QBL 560mL
Placenta removed piecemeal
Defect palpated in lower uterine segment on bimanual exam
Exploratory laparotomy confirmed uterine rupture

Maternal: uncomplicated post-op course
- EBL 1260 mL
- Surgical pathology: confirmed PAS, grade 1
- POD#3: discharged home



Conclusion

Beyond the prompt recognition and surgical management received, these cases highlight the importance of a high index of clinical concern and laparotomy when suspicious. Obstetricians are tasked with developing a high-fidelity, multidisciplinary teams and creating a culture of safety for junior and interdisciplinary colleagues. Excellent interdisciplinary management of these patients allowed prompt recognition and efficient management.