Case Report

Incidental Finding of Uterine Scar Dehiscence at Elective Repeat Caesarean Section at Term

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ABSTRACT

The risk of adverse outcome for the mother and/or baby is high in the setting of uterine rupture and its possibility should be entertained in a pregnant woman with previous uterine surgery and recent onset lower abdominal pain in advanced gestation. In the absence of symptoms, uterine scar dehiscence may occur unnoticed until complications set in. Women with short inter-pregnancy interval, caesarean wound morbidity and classical caesarean section are at increased risk. Each case should be individualised and those at high risk of uterine rupture should be offered appropriate care. We report a case of antepartum scar dehiscence found incidentally at elective repeat caesarean section at term.

Key words: Caesarean section, inter-pregnancy interval, scar dehiscence

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INTRODUCTION

Uterine rupture is an obstetric emergency and should be suspected in a pregnant woman with lower abdominal pain in the background of a previous caesarean section. In the absence of obvious risk factors and clinical signs/symptoms to heighten suspicion, uterine rupture/scar dehiscence may occur unnoticed till complications set in. We report a case of antepartum scar dehiscence found incidentally at repeat elective caesarean section at term.

CASE REPORT

The patient is a 27 year old G4P1+2 (with 2 previous spontaneous complete miscarriages and 1 Caesarean section, none alive). She had a previous emergency caesarean section 5 months before index conception at gestational age of 32 weeks on account of severe preeclampsia with intrauterine growth restriction resulting in an early neonatal death. She had a poorly formed lower uterine segment, and a transversely placed incision was employed at the lower uterine segment. She had an uneventful postoperative period and was discharged home on the sixth postoperative day.

She, however, presented at the booking clinic 8 months later at the gestational age of 13 weeks and had a normal course of antenatal care. In view of the short inter-pregnancy interval of 5 months following the previous caesarean section, bad obstetric history and maternal request, a joint decision was made for an elective caesarean section at 38th week of gestation. At admission, the maternal and foetal conditions were satisfactory with no abdominal pain or scar tenderness, and labour had not set in. She had caesarean section under spinal anaesthetic block with intraoperative finding of clean pelvis with well-formed lower uterine segment bearing a complete scar dehiscence at the upper margin of the lower uterine segment and bulging tense foetal membranes with foetal head closely apposed to the scar margins [Figure 1].

The foetal membranes were ruptured, and a live male baby with Apgar score of 9 at 1 min and 10 at 5 min and birth weight of 3.6 kg was delivered. The third stage was managed actively, and the thinned-out dehisced myometrium was repaired in two layers with Vicryl number 2 suture in interlocking and simple continuous fashion, respectively.

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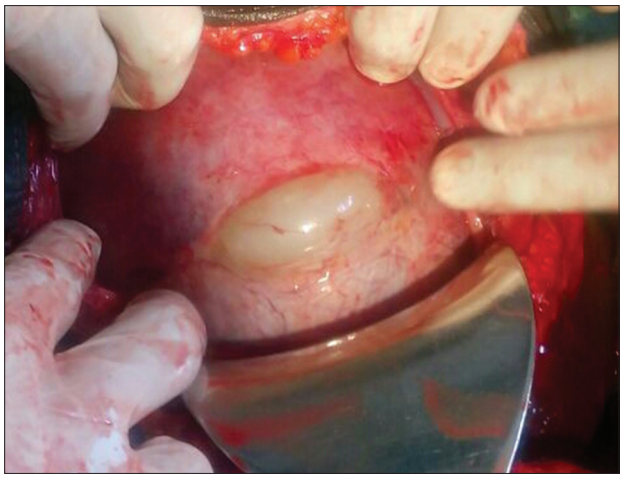

Figure 1: Uterine scar dehiscence with foetal membranes bulging through the gap

She had satisfactory postoperative recovery and was counselled along with the husband on the intraoperative findings and implication on subsequent conception. Contraceptive counselling was offered, and the need for adequate observation of inter-pregnancy interval of up to 3 years was advised. She was seen at the postnatal clinic with the baby in satisfactory condition. She opted for long-acting reversible contraception in the form of progesterone implant.

DISCUSSION

Rupture of the gravid uterus is an obstetric emergency that could result in mortality for the foetus and mother. It often occurs as an intrapartum event with the background of a previous uterine scar, either caesarean or myomectomy.[1,2] The risk of antepartum uterine rupture is higher following classical caesarean section at 2.2% as against 0.5% following single lower segment caesarean section.[3,4]

A previous Caesarean section performed at 32 weeks gestation when the lower uterine segment was not yet properly formed and a short inter-pregnancy interval were the identifiable risk factors for scar dehiscence in this case. She did not have uterine contraction and attempted vaginal delivery or oxytocic use before surgery, which are known predisposing factors to uterine rupture. Similar silent spontaneous uterine rupture was reported by Woo *et al.* in a patient with two classical caesarean section scars.[5]

Antepartum diagnosis of scar dehiscence may be challenging as it is often asymptomatic. There is a global increase in caesarean section rate making previous caesarean section the most common indication for caesarean section.[6-8] With this development of incidental finding or risk of scar dehiscence without prior symptom/sign as in our case, a reduction in the frequency of trial of vaginal birth after caesarean section (VBAC) is being reported.[9] Measures to predict those at increased risk of uterine ruptured are being developed, including ultrasound estimation of thickness of the lower uterine segment.[10] A lower uterine segment thickness cutoff of 3.5 mm has been proposed as safe for VBAC with a varying cutoff from various studies.[10,11] Myometrial thickness measured by transabdominal or transvaginal scan has also been considered.[12] Within the purview of our literature search, there is no conclusive evidence on the role of bed rest and hospitalisation in advanced pregnancy for those at risk of scar dehiscence in pregnancy.

CONCLUSION

This case report points to the possibility of asymptomatic uterine scar dehiscence in pregnancy. While antepartum uterine rupture in the previous single nonclassical caesarean section is uncommon, consideration of the inter-pregnancy interval and gestational age at the previous caesarean section may inform the need to institute surveillance for women at risk.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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