Letters to the Editor

Case Report: Successful Maternal and Fetal Outcomes After Uterine Rupture

To The Editor: In our urban, tertiary care university hospital, family physicians take obstetric calls alongside obstetricians, midwives, anesthesiologists, and teams of obstetric and family medicine residents. We present a case that demonstrates how this collaborative, multidisciplinary model provides effective care in obstetric emergencies.

Uterine rupture is a rare but potentially dangerous complication of trial of labor after cesarean, annually affecting 0.2% to 1.0% of cases worldwide.[1]

B.B. was a 33-year-old G3P1011 who presented to the hospital at 41 weeks' gestation for induction of labor. Her obstetric history included a spontaneous abortion at eight weeks in 2006 and a primary cesarean in Ethiopia in 2014 at 41 weeks for failure to progress. Records regarding her previous pregnancies and cesarean operative note were not obtained. Her physical examination was notable for an estimated fetal weight of 3,500 g (7 lb, 11 oz) and previous Pfannenstiel incision. She had received prenatal counseling regarding birth options. She had a previous calculated vaginal birth after cesarean (VBAC) score of 39%; on admission, her adjusted VBAC score was 48%.[2,3]

Her induction was initiated using oxytocin (Pitocin) and a Cook's cervical ripening balloon. Approximately 20 minutes after her cervix was fully dilated and effaced, she developed moderate left-sided lower abdominal pain, and the fetal heart rate became undetectable. Reexamination of the cervix showed loss of fetal station. She was taken to the operating room for an emergent repeat cesarean for suspected uterine rupture.

The patient was given general anesthesia, and a Pfannenstiel incision was made. The fetus was quickly delivered from the abdomen. American Pediatric Gross Assessment Records were 4, 8, and 9 at one, five, and 10 minutes, respectively. The previous hysterotomy scar was noted to be open without additional uterine extensions. Estimated blood loss was 1,400 mL. She remained hemodynamically stable and did not require blood products. The time elapsed from diagnosis to delivery was nine minutes. The patient had an uncomplicated postpartum course and was discharged in stable condition on postoperative day 4.

This case report demonstrates a successful outcome from a complication often associated with significant maternal and fetal morbidity and mortality.[4] Factors that may have increased the risk of uterine rupture include gestational age (41 weeks), unknown uterine incision and repair, and induction of labor.[5,6]

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