Case report on spontaneous uterine rupture from placenta accreta in second trimester of pregnancy at a non-tertiary hospital

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BACKGROUND

Uterine rupture following placenta accreta spectrum disorders is an uncommon obstetric condition in the second trimester of pregnancy, but can lead to life-threatening maternal and fetal complications. Previous caesarean section is the dominant risk factor for both abnormal placentation and uterine rupture.

AIMS

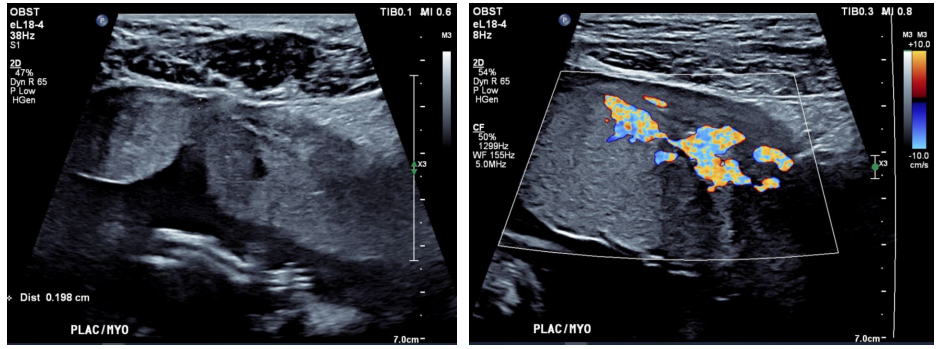
To describe the presentation and management of uterine rupture in the second trimester of pregnancy at a non-tertiary hospital

CASE

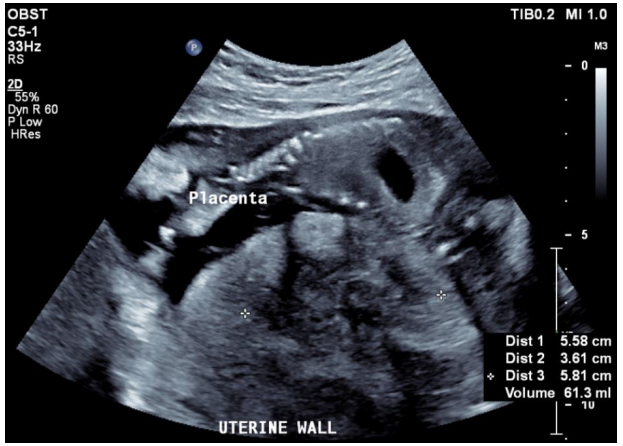
A 25-year-old female at 19 6/7 weeks gestational age presented to the emergency department of Redland Hospital, Queensland. Her presenting compliant was post-coital exacerbation of intermittent generalised abdominal pain without active vaginal bleeding.

Her obstetric history included a previous emergency classical caesarean section and the morphology scan for the current pregnancy showed placenta accreta. She was haemodynamically stable on arrival with no clinical evidence of abdominal peritonism and a fetal heart rate was present.

INVESTIGATIONS



Ultrasound scan at 16 4/7 weeks: Thin myometrium at the lower uterine segment and hypervascularity suggestive of placenta accreta



Ultrasound scan at 19 6/7 weeks: Placental abruption with placenta now posterior and a large heterogenous avascular collection at deep margin

MANAGEMENT

Patient was transferred to a tertiary facility. An emergency laparotomy revealed complete uterine rupture and haemoperitoneum of 3L.

Following intraoperative consultation with Gynaecological Oncology, patient underwent a total hysterectomy and bilateral salpingectomy, and was admitted to the intensive care unit post-operatively.

DISCUSSION

Key learning points

- Placenta accreta-induced uterine rupture should be considered in this uncommon case of insidious onset of abdominal pain in the second trimester of pregnancy
- Early identification and transfer to a tertiary facility with multidisciplinary care is required due to risks of maternal haemorrhage and emergency hysterectomy.

REFERENCES

1. Eshkoli et al., 2013. Placenta accreta: risk factors, perinatal outcomes, and consequences for subsequent births. *Am J Obstet Gynecol*. 208(219): e1-7.