

"A Study of Rupture Uterus Maternal and Foetal Outcome"

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I. Introduction

By definition uterine rupture means breach in the continuity of the uterine wall beyond 28 weeks of gestation. If it occurs before 28 weeks it is said to be perforation. In True or complete rupture, uterine cavity communicates with peritoneal cavity and is associated with bleeding into peritoneal cavity involving the uterine vessels. In occult or incomplete rupture, uterine cavity and peritoneal cavity doesn't communicate and is separated by visceral peritoneum or broad ligament, may be associated with large amount of bleeding concealed within layers of broad ligament. In silent rupture or scar dehiscence peritoneum is intact and fetal parts can be seen through membranes it is also called as windows, not associated much blood loss. Uterine rupture is a **life-threatening** event for mother and baby & is a potentially **catastrophic** event during childbirth. Uterine rupture typically occurs during the active labour, but can occur even in late pregnancy. Uterine rupture is a major obstetric hazard. In India it still accounts for 5-10 % of all maternal deaths. The perinatal mortality ranges from 80 to 95 %.

Aims and objectives:

To determine the

1. Incidence
2. Etiology
3. Risk factors
4. Complications
5. Feto-maternal outcome

II. Materials And Methods

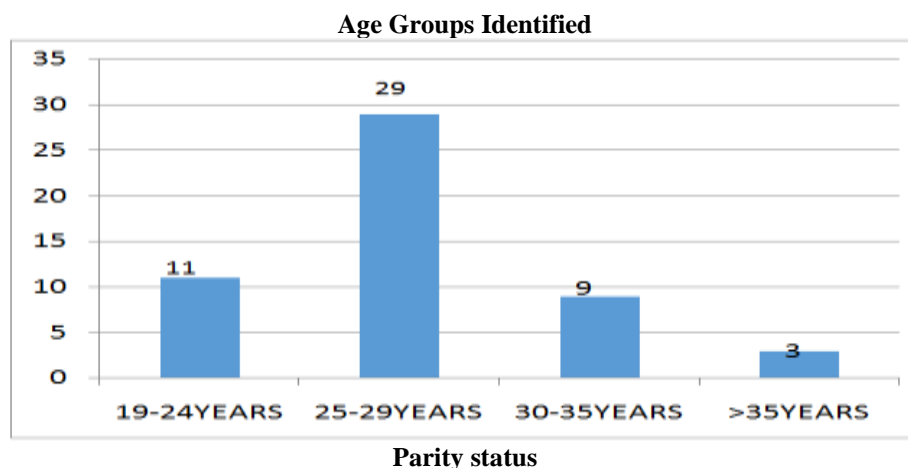
It's a 5 years retrospective study of 52 cases of rupture uterus in women during the period of JAN'2010 – DEC'2014. at RIMS Kadapa.

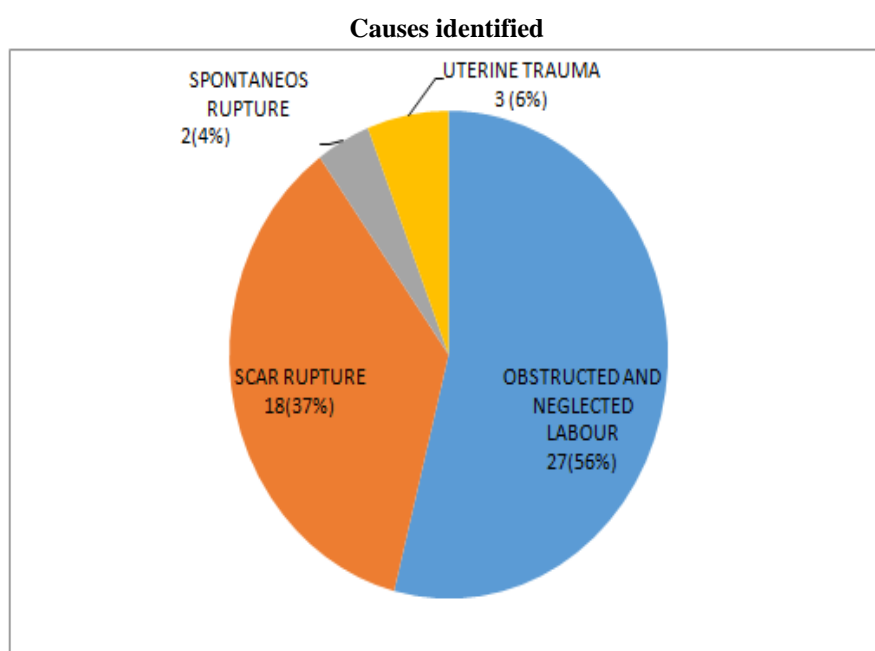
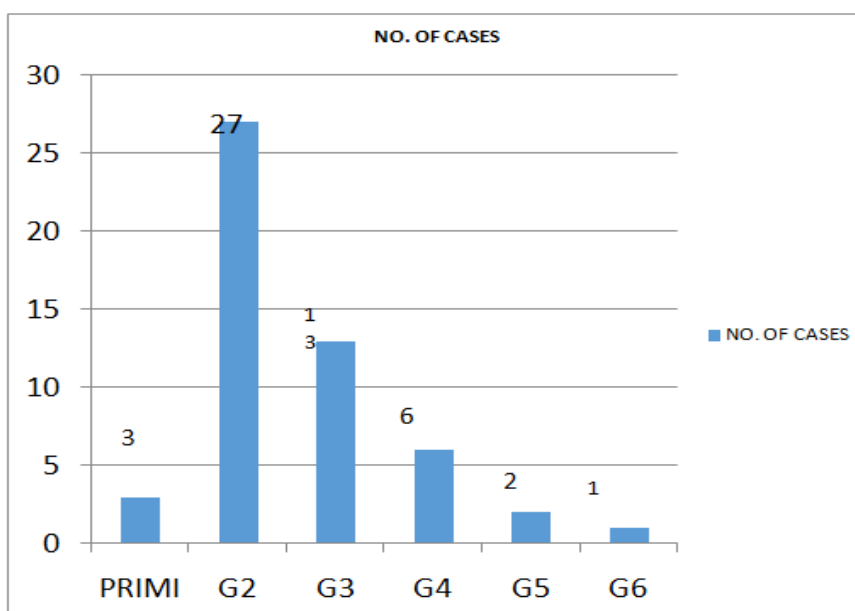
Study variables are –

1. Age Groups & parity
2. Incidence
3. Socio - demographic characteristics of patients
4. Causes
5. Management options,
6. Feto - maternal outcome (morbidity & mortality)

III. Results And Analysis

Among 32,400 deliveries during the period of 5 years (Jan'2010 – Dec'2014 at RIMS- kadapa, A.P., India.) 52 women had uterine rupture during this period. Present study incidence is **1.6 in 1000**

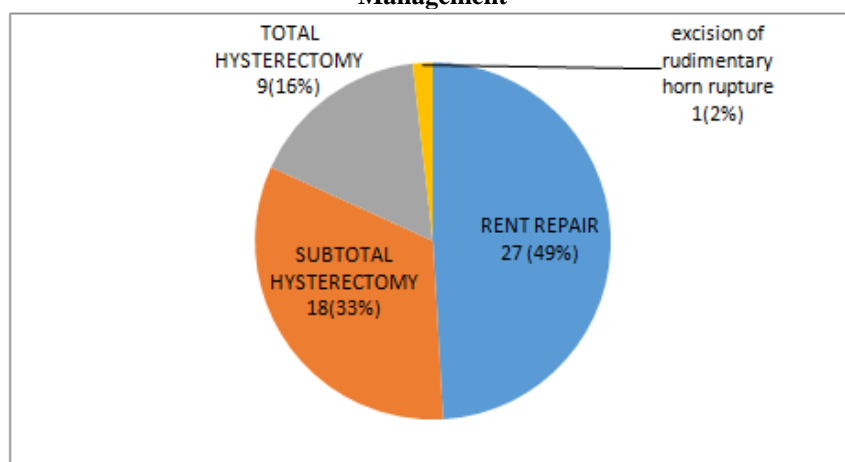




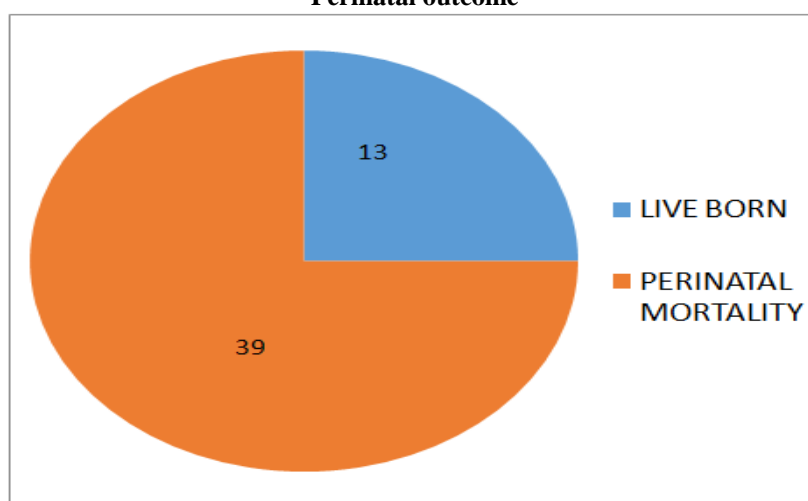
Risk factors identified for rupture uterus

1. Sociodemographic factors :
 - Low levels of literacy,
 - Marriage at an early age,
 - Socioeconomic deprivation,
 - Desire for large family,
 - Low prevalence of contraceptive use
 - Ineffective performance of MCH services
2. Prior lower segment caesarean section
3. Multi gravida with prolonged or obstructed labour
4. Low lying or abnormal placentation
5. Iatrogenic

Management



Perinatal outcome



Maternal outcome

Blood transfusions	Blood transfusions	All case
No complications		27 cases
Bladder repair		5 cases
Pelvic abscess		1
VVF		1
URTI		1
PUERPERIAL DEPRESSION		1
THROMBO EMBOLISM		1
WOUND INFECTION		1
MATERNAL MORTALITY		2

IV. Discussion

Among 32,400 deliveries ,52 women had uterine rupture during this period . Present study incidence is 1.6 in 1000.Its comparative to other studies of asian countries.(1:1100 in nepal) ,Kumarietal (2003)1.4:1000.It is more than the incidence of developed countries & less than the incidence of underdeveloped countries. In our study there were 2 maternal deaths. This low maternal mortality could be attributed to early presentation, availability of blood transfusion, and round the clock services of competent anesthetist and obstetrician enabling prompt management. Perinatal mortality was 75%. Babies of only those women who presented at early stages of rupture, can hope for survival.The decision to perform uterine repair or hysterectomy in cases of uterine rupture is influenced by the parity, number of living children, extent of uterine rupture, condition of the tissues, and the general condition of the patient. Repair of the uterine rupture is a logical approach and should be performed in women with scar rupture, and in those with a linear tear.

V. Conclusion

Rupture uterus is the indirect index of the obstetrical care. The most frequent cause in rural areas being obstructed and neglected labour resulting in high perinatal, maternal mortality and morbidity, this is followed by scar rupture.

To reduce this high incidence of rupture uterus effective MCH services to be exercised at all the levels of health care delivery system in developing countries like India to maintain the safe- motherhood

References

- [1] Guise J-M, McDonagh MS, Osterweil P, Nygren P, Chan B, Helfand M. Systematic review of the incidence and consequences of uterine rupture in women with previous caesarean section. *BMJ* 2004;329: 1–7.
- [2] Wen SW, Rusen ID, Walker M, et al. Comparison of maternal mortality and morbidity between trial of labor and elective cesarean section among women with previous cesarean delivery. *Am J ObstetGynecol* 2004;19: 1263–1269.
- [3] Dodd J, Crowther C. Vaginal birth after caesarean versus elective repeat caesarean for women with a single prior caesarean birth: a systematic review of the literature. *Aust NZ J ObstetGynaecol* 2004;44: 387–391.
- [4] Cox ML. Contracted pelvis in Nigeria. *J ObstetGynaecol Br Emp* 1963;70: 487–494.
- [5] Fisk NM, Shweni PM. Labor outcome of juvenile primiparae in a population with a high incidence of contracted pelvis. *Int J GynaecolObstet* 1989;28: 5–7.
- [6] Neilson JP, Lavender T, Quenby S, Wray S. Obstructed labour. *Br Med Bull* 2003;67: 191–204.
- [7] Topuz S. Spontaneous uterine rupture at an unusual site due to placenta percreta in a 21 week twin pregnancy with previous cesarean section. *ClinExpObstetGynecol* 2004;31: 239–241.
- [8] Rajaram P, Agarwal A, Swain S. Determinants of maternal mortality: a hospital based study from South India. *Indian J Matern Child Health* 1995;6(1):7–10.
- [9] Moodley J, Pattinson R. *Saving Mothers. Second Report on Confidential Enquiries into Maternal Deaths in South Africa, 1999–2001, 1999.*
- [10] Pattinson RC, Moodley J. Confidential enquiry into maternal deaths in South Africa. In: MacLean AB, Neilson JP, editors. *Maternal Morbidity and Mortality*. London, UK: RCOG Press, 2002: 34–54.