

A Case Report on Silent Scar Dehiscence in a Patient with Previous Transverse Cesarean Section

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Abstract

Introduction: Cesarean section is the delivery of an infant (live or dead) through an abdominal incision after the period of viability. An incomplete uterine rupture, also referred to as uterine dehiscence, is defined as a clinically occult and incomplete disruption that does not lead to any serious neonatal or maternal consequences.

Case report: This is a case report of a pregnant women with previous 1 cesarean section, with silent scar dehiscence found accidental on repeat cesarean section, and its successful management during the procedure.

Conclusion: Uterine scar dehiscence when detected early can be prevented from progressing further to scar rupture. Prompt decision making and skilled surgical repair may aid in reducing the incidence of such complications.

Keywords: Incomplete uterine rupture; Silent Scar dehiscence; Cesarean section.

Introduction

Cesarean section is the delivery of an infant (live or dead) through an abdominal incision after the period of viability. "Once a cesarean, always a cesarean" was a popular belief, partly because the operation was mainly indicated for cephalopelvic disproportion in the past, but that is not the scenario now, because of successful VBAC. Under favorable circumstances a repeat cesarean section may not be necessary. Nevertheless a previous cesarean section certainly casts a shadow over

upcoming pregnancies, there by increasing the risk of cesarean section. Delivery by Cesarean section is associated with increased risk of maternal and perinatal morbidity in the upcoming pregnancies, which includes uterine rupture, whose risk raises according to the number of previous Cesarean sections. An incomplete uterine rupture, also referred to as uterine dehiscence, is defined as a clinically occult and incomplete disruption that does not lead to any serious neonatal or maternal consequences. It is often incidentally discovered at the time of Cesarean section. Following is a case report of a patient with a 3 year old uterine scar-silent dehiscence.

Case Report

36 year old Gravida 2, para 1, live 1, patient at gestational age of 38 weeks plus 3 days was admitted in Vinayaka Missions Medical college karaikal in the department of obstetrics and gynecology, planned for an elective Cesarean section in view of previous LSCS. The previous LSCS was done in the town government hospital in view of oligohydramnios with fetal distress, with no history of cesarean section wound infection or other complications during the post operative period.

She was a booked and immunized patient at Vinayaka Missions Medical College, who conceived spontaneously, with all 3 trimesters uneventful, with normal antenatal hematological picture.

On Examination: She was moderately built and nourished with a pulse rate of 86 beats per minute, with blood pressure of 130/90 mmhg. Abdominal examination revealed a longitudinally distended abdomen with linea niagra and striae gravidarum, umbilicus everted and flanks full, with a suprapubic transverse scar healed by primary intention with no visible pulsations or dilated veins.

On Palpation: the uterus corresponded to term and relaxed, with a single live fetus in longitudinal lie in cephalic presentation, with regular fetal heart rate of 142 beats per minute on auscultation, with no signs and symptoms of scar tenderness.

P/V Findings: Cervix posterior, uneffaced, os closed, presenting part vertex at brim (high up), no show. Decision of Cesarean section was made in view of previous LSCS with patient not willing for VBAC.

Intra-Operative Findings: Abdomen opened in layers by pfannensteil incision. Peritoneum entered. Uterus with scar dehiscence was noted, through which amniotic sac was seen bulging, which was ruptured and delivered an alive boy baby by vertex of birth weight 3.03 kg with APGAR 8/10, 9/10. Placenta was delivered along with membranes in-toto. Uterus was closed in layers. Bilateral tubes were identified and sterilization was done by modified Pomeroy's technique. Hemostasis secured.

Post operatively patient was given a course of antibiotics and was discharged on post op day 8 with a healthy baby. She was seen in the OPD after 2 weeks for follow up and was in good condition.



Fig. 1: Uterus showing intact peritoneum only at site of previous transverse cesarean section.



Fig. 2: Lower uterine segment post delivery of the fetus.

Discussion

The incidence of Cesarean section is rising in most parts of the world and is being performed with increasing impunity largely due to antibiotics, improved anesthesia and availability of blood transfusion. A number of complications have been associated with Cesarean sections, early complications like hematoma, infection, wound dehiscence, thrombus formation and Late complications includes placenta accreta, peritoneal adhesions, infertility and myometrial thinning with uterine rupture.

Uterine ruptured is classified as complete and incomplete:

- **Complete:** when all 3 layers of uterine wall are separated.
- **Incomplete:** also referred to as Uterine Dehiscence is when the uterine muscle is separated but visceral peritoneum is intact.

The risk of rupture is more with classical type when compared with that of transverse incisions. Uterine scar dehiscence is a rare complication of LSCS with incidence ranging from 6.6% to 69%. Scar dehiscence depends upon a number of factors like prior uterine incision type, number of prior Cesarean incisions, residual myometrial thickness, inter-delivery interval and factors hindering previous incision healing. An event of uterine rupture is life threatening to both the mother and baby. Symptoms of rupture may be initially quiet. Once a woman is in labour, she may experience abdominal pain and vaginal bleeding, at the point in which it would be difficult to distinguish from normal labour. Concomitant symptoms of imminent uterine rupture include maternal tachycardia, vaginal bleeding, abdominal pain or tenderness, suprapubic bulge, scar tenderness, non-reassuring fetal heart rate and recession of

fetal head. In this case, these signs were absent and incomplete scar dehiscence was an accidental finding. Cesarean section always includes the risk residual myometrial thinning, and its repair can be challenging. Although the fetus can be delivered carefully, the LUS wound can extend transversely or downward leading to damage of the bladder and other adjacent structures. Obstetricians should take great care to avoid such complications.

Conclusion

Uterine scar dehiscence when detected early can be prevented from progressing further to scar rupture which is a grave complication. Uterine scar dehiscence can be detected by its imminent signs and symptoms, but may go unnoticed as the patient progresses to term, even in the presence of advanced Feto-Maternal monitoring techniques. Prompt decision making and skilled surgical repair may aid in reducing the incidence of such complications.

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