

Primary cesarean scar dehiscence: an important yet underreported cause of puerperal sepsis.

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INTRODUCTION

Primary dehiscence of uterine incision is a rare but important cause of puerperal sepsis. The incidence ranges from 0.2 to 1.5% in low transverse uterine incisions. It is characterised by a defect in the uterine incision line after Cesarean section in early postpartum period. Prompt diagnosis with high index of suspicion and timely management can lead to significantly better patient outcomes, reducing the maternal morbidity and mortality.

CASE REPORT

27 year old G2A1 with Dichorionic Diamniotic twin pregnancy with Gestational Diabetes Mellitus with placenta previa underwent preterm emergency LSCS at 30 weeks 6 days i/v/o antepartum hemorrhage. Intraoperative blood loss was 2.2 liters. Intraoperative 2 PCV and 1 FFP were transfused.

On postnatal day 12, patient had persistent lower abdominal pain along with persistent tachycardia with the pulse rate of 112/min which was followed by fever spikes. On examination, uterus was well retracted, abdomen was soft, localized tenderness was present in right iliac fossa. Abdominal wound was healthy. Urine routine showed 63 pus cells which was treated with antibiotics as per the culture sensitivity report. However, due to persistent fever spikes and tachycardia with localized tenderness despite antibiotics, further investigations were carried out involving physician and a general surgeon in the team.

Ultrasound abdomen and pelvis was performed which suggested possible collection in the right iliac fossa with increased echogenicity. CT abdomen and pelvis with contrast showed a loculated collection in the pelvis communicating with the endometrial cavity through defect in the lower part of the uterus likely due to uterine incision dehiscence. Primary uterine scar dehiscence was suspected.

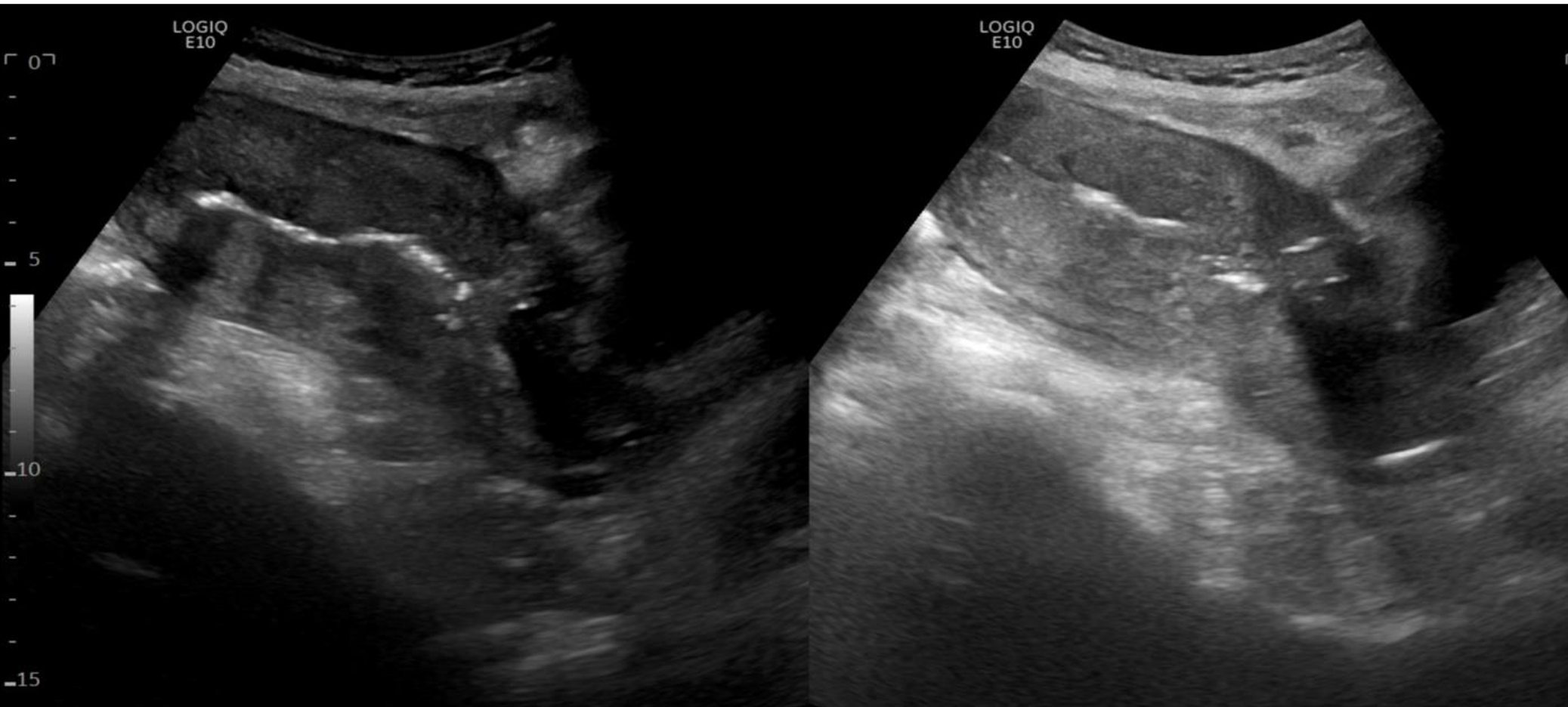
Exploratory laparotomy was performed, partial dehiscence of uterine incision at right uterine angle with fragile edges and pus collection was noted intraoperatively. Patient underwent uterine dehiscence re-suturing with omental graft placement and peritoneal lavage with the placement of intra-abdominal drain. Pus was sent for culture and antibiotics were given as per the sensitivity. Postoperative recovery of the patient was uneventful.

REFERENCES

Garg R, Agrawal R, Goel G. Puerperal Sepsis with Uterine Scar Dehiscence after Cesarean Section: A Rare Complication. J South Asian Feder Obst Gynae 2018;10(Suppl 2):435-437.

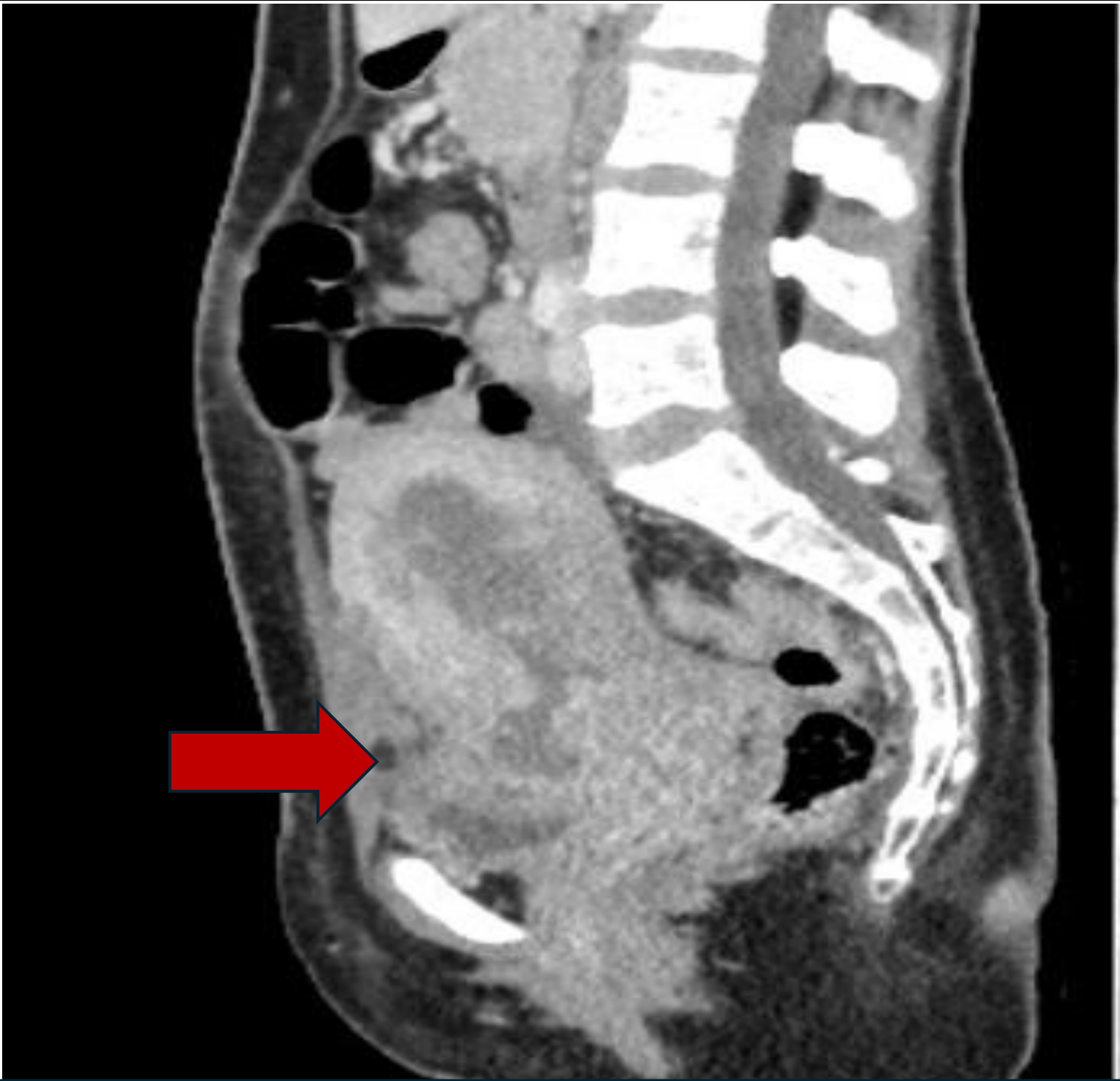
USG ABDOMEN AND PELVIS

USG showed echogenic foci in the endometrial cavity and bulky uterus showing postpartum status.



C.E.C.T. SCAN OF ABDOMEN AND PELVIS

Peripherally enhancing loculated collection the pelvis communicating with the endometrial cavity through the defect in the lower part of uterus suggesting dehiscence at incision site.



DISCUSSION

We report a case of successful management of a case of puerperal sepsis due to primary uterine incision dehiscence leading to formation of localized pelvic abscess, communicating with the uterine cavity. Risk factors for primary uterine incision dehiscence can be patient related factors as well as surgical technique/material. Patient related factors are Diabetes Mellitus, low BMI, malnutrition, anaemia, high-risk for emergency surgery such as placenta previa. Improper surgical technique for uterine closure or suture material could also be the contributing factors. Patho-physiology of the condition is understood as formation of a serous collection or hematoma within the uterine incision line getting infected secondary to endometritis leads to necrosis of myometrial tissues subsequently leading to dehiscence of uterine incision and formation of Intra abdominal abscess. Management depends on clinical presentation, hemodynamic stability of the patient and Imaging results. Options for management are conservative and Surgical. Surgical management can be repair of the defect with conservation of uterus which can be done by either laparoscopy or laparotomy. Certain cases may require obstetric hysterectomy. Our patient had multiple risk factors such as low BMI, GDM, anaemia, multifetal gestation, placenta previa, preterm emergency LSCS with PPH with h/o recurrent urogenital infections in antenatal period. High index of suspicion led to early diagnosis and prompt treatment resulting in favourable outcome with conservation of uterus.

CONCLUSION

Primary uterine incision dehiscence is rare but important cause of puerperal sepsis. Timely diagnosis and treatment is the key to successful management. High index of suspicion is important in recognising this complication as a cause of puerperal sepsis. Uterine conservation with drainage of abscess and repair of the defect is possible under broad spectrum antibiotic cover, in timely diagnosed cases thus reducing patient morbidity and mortality.