SPONTANEOUS UTERINE RUPTURE IN AN UNSCARRED PRIMIGRAVIDA: DIAGNOSTIC CHALLENGES UNDER EPIDURAL ANALGESIA

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Background

- Rare but life-threatening obstetric emergency
- Typical risk factor: prior uterine surgery
- Other risk factors
  - ➢ Uterine abnormalities
  - ➢ Overdistension
  - ➢ Uterotonic medications
  - ➢ Connective tissue disorder
- Epidural analgesia may mask pain → delayed diagnosis
- Rare in primigravid, unscarred uterus

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The Case

Labor Course

36-year-old primigravida at 40w2d

- Uncomplicated obstetric history with resolved placenta previa
- Induction of labor
- Epidural analgesia
- Prolonged labor → forceps-assisted delivery

Clinical Deterioration

- Post third-degree laceration repair → persisted bleeding
  - Tranexamic acid
  - Methylergonovine
  - Misoprostol
  - JADA

Diagnosis

- Ultrasound
  - Intraabdominal free fluid
  - Extrauterine JADA balloon

Operative Findings

- 12-cm posterior uterine rupture
- Hysterectomy with partial vaginectomy
- Massive transfusion protocol
  - 23 pRBC
  - 20 FFP
  - 6 Platelets
  - 7 cryoprecipitate
- 12 liters blood loss

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Why this case matters

- Uterine rupture can **occur without prior uterine surgery**
- Epidural can mask classic symptoms → **delayed diagnosis**
- Maintain high vigilance in unstable patients
- **Ultrasound can aid diagnosis**
- Hemodynamic instability out of proportion to visible bleeding was a key clue for further investigation