



Rupture of uterine muscle hematoma following diagnostic amniocentesis at 18 weeks and uterine dehiscence at term

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Objective

We report a patient who experienced uterine rupture with 2500 ml blood loss following the diagnostic amniocentesis at 16 weeks. The same patients had suture dehiscence at the site of hematoma what was revealed during the caesarean section at 37 weeks.

Methods

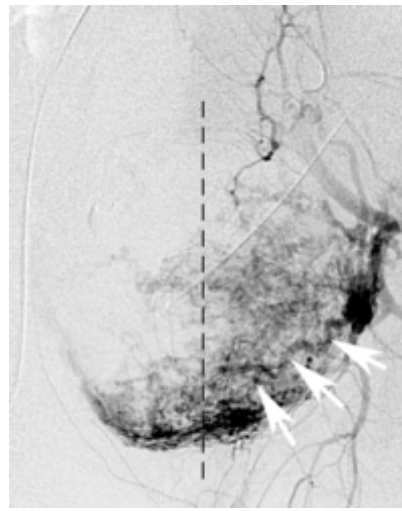
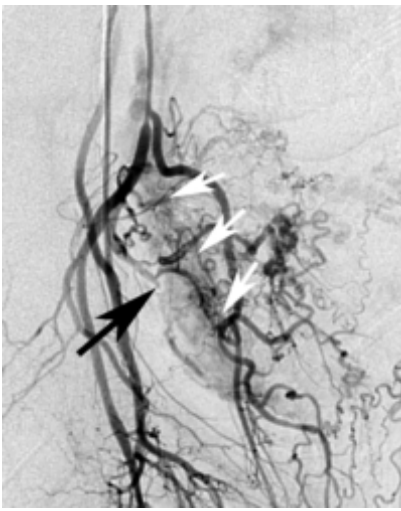
The case was managed at the Pauls Stradins Clinical University Hospital (Riga, Latvia).

Results

A 46-year old, gravida 5, para 1-1-0-0 presented in our hospital at 18+5 with symptoms of acute abdomen. She had undergone diagnostic amniocentesis 10 days prior to the occurrence of symptoms. On examination patient was normotensive (120/80 mmHg) with a heart rate of 82 bpm and a respiratory rate 16 breaths per minute, oxygen saturation 99%. The heart sounds were regular, both lungs were clear on auscultation. Body temperature was normal. On first examination, the abdomen was soft and distended. Abdominal pain was located in left upper quadrant and epigastrium. Peritoneal symptoms were negative. Uterus cervix was closed, thick and posterior. Transabdominal ultrasound showed intrauterine pregnancy with positive fetal cardiac activity. In abdominal cavity free fluid was visualized between liver and left kidney and in left ileo-cecal region. Acute appendicitis was suspected. An emergency upper midline laparotomy under general anesthesia was performed. Upon opening the abdominal cavity, a hematoma was revealed on the right side of uterus – at the site where amniocentesis needle was placed. Incision on hematoma was performed and approximately 1500 mL of dark coloured blood was released. The defect was sutured several times and hemostatic sponge was applied. Right uterine artery was ligated. With suspicion of difficult patient hemostasis vascular embolization was sought. During angiography no active bleeding was visualized and embolization was not performed. Patient was discharged from hospital 10 days after surgery with ongoing pregnancy. At gestational age of 37+6 woman was admitted for planned C-section. A healthy boy was born 3370g, 51 cm, Apgar 8/9. Upon entering the abdominal cavity suture dehiscence was observed in uterine wall (4x4cm) covered only with serosa and surrounded by fibrinous Tachosil remainings and placenta increta revealed during operation. Post operative management was without complications.

Conclusion

Obstetric complications after invasive diagnostic amniocentesis have been reported in extremely rare cases ranging from 0,5-1,2%. Uterine rupture must be ruled out in all pregnant women complaining of acute abdominal pain especially if there is a history of curettage, increased maternal age and multiparity, and amniocentesis in current pregnancy. Excessive suturing on the pregnant uterus above the placental bed might be the cause for placenta increta in this case.



Blood count	On admission (16.05.15 at 12.20)	Pre-operative (16.05.15 at 19.12)	Post-operative (17.05.15 at 12.20)	Reference
Erythrocytes (10 ⁶ /μL)	3.1	2.43	2.92	4.20 – 5.40
Hemoglobin (g/L)	85	67	81	120 – 160
MCV (fL)	86.2	82	84	80-100
MCH (pg)	27	28	28	27-33
Hematocrit (%)	27	20	24	37 – 47
Platelets (10 ³ /μL)	248	200	191	150 – 400
Leukocytes (10 ³ /μL)	9.7	7.9	7.2	4.0 – 10.0
Granulocytes (%)		83.0	77.9	30.0-70.0

Biochemistry	On admission (16.05.15 at 12.20)	Pre-operative (16.05.15 at 19.12)	Post-operative (17.05.15 at 12.20)	Reference
C-reactive protein (mg/L)	7.6	5.2	-	0-5.0
Creatinin (μmol/l)	40	32	34	44-97
Coagulogramm				
APTT (s)	24.7			26.0 – 36.0
INR	0,9			0.8 – 1.2
PT (%)	135.2			70.0 – 120.0
Fibrinogen (g/l)	4.1			1.8 – 3.6