University Hospitals Plymouth NHS Trust

MATERNITY GUIDELINES

Ruptured Uterus

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1. Predisposing Factors

- Previous caesarean section, especially classical incision.
- Injudicious use of oxytocin / prostaglandins administered to women with a previous caesarean scar
- Obstructed labour
- Grand multiparity
- Previous instrumentation of the uterus
- Rare- External Cephalic Version, placenta percreta, uterine abnormalities
- Myomectomy

2. Clinical Assessment

The woman may present with the following:

- Severe prolonged fetal distress is often associated with uterine scar separation during labour (Neale, 1996).
- Reduction / cessation of uterine contractions
- Lower abdominal pain and tenderness in the supra-pubic area due to scar separation, although this is not diagnostic of uterine rupture.
- Pain breaking through epidural anaesthesia.

- Tonic contractions and the appearance of Bandl's retraction ring abdominally may occur if the uterus ruptures as a result of an obstructed labour.
- Blood loss may be visible at the vagina although this is often concealed (Farmer et al, 1991).
- Maternal tachycardia.
- Maternal shock.

3. Management

Immediate action will include:

- **Summon** immediate senior help by triggering an obstetrician emergency on 2222 this will include consultant obstetrician request a consultant anaesthetist
- **Establish** a peripheral intravenous line
- **Record** all vital signs
- **Prepare for immediate laparotomy/ LSCS if still in labour**
- **Group and save with rapid transport to laboratory by hand**
- **Cross match blood according to clinical need**
- **Repair of uterus:** Depends on the size and nature of the rupture
- **Hysterectomy:** May need 2 experienced obstetricians. Should be vigilant about ureters - consider post-operative renal ultrasound or IVU.
- **Datix incident**

4. Record keeping

It is expected that every episode of care be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals as per Hospital Trust Policy. This is in keeping with standards set by professional colleges, i.e. NMC and RCOG.
All entries must have the **date and time** together with **signature and printed name.**

Monitoring and Audit

Auditable standards:
Please refer to audit tool, location: 'Maternity on cl2-file11', Guidelines

Reports to:

Clinical Effectiveness Committee – responsible for action plan and implementation of recommendations from audit

Clinical Governance & Risk Management Committee

Frequency of audit:
Annual

Responsible person:
Labour ward clinician

Cross references

Antenatal Guideline 31 - Maternity Hand Held Notes, Hospital Records and Record Keeping

Antenatal Guideline 44 – Guideline Development within the Maternity Services

References

Al-Zirqi I, Stray-Pedersen B, Forsén L, Vangen S. **Uterine rupture after previous caesarean section.** BJOG 2010; DOI: 10.1111/j.1471-0528.2010.02533.x.

Grady, K., Howell C., Cox C., (2009) **MOET course manual, second edition** RCOG press.

Gardeil F., Daly S., Turner M.J. (1994) **Uterine rupture in pregnancy reviewed**. European Journal of Obstetrics and Gynaecology and Reproductive Biology. 56(2):107-110.

Maresh M., Neales. K. (1994) **High dependency care of the obstetric patient**. in James D.K., Steer P., Gonik B. eds. High risk Pregnancy. Saunders 1235-1257.

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