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Uterine dehiscence in "unscarred uterus" at 38 weeks gestation: A case report and literature review

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ABSTRACT

Introduction: Rupture or dehiscence of unscarred pregnant uterus is a rare event which can lead to high perinatal and maternal morbidity and mortality. The estimated incidence of a rupture of the unscarred uterus is 1:8,000 to 15,000 deliveries. In most cases it is unpredictable, which makes it difficult to detect based on clinical and physical examination only. **Case Description:** We report a case of uterine dehiscence in a term pregnancy. A 40-year-old Gravida 6 Para 5 Siamese lady at 38 weeks of gestation was admitted for induction of labour for having Gestational Diabetes Mellitus. She received prostaglandin vaginal tablets to ripen the cervix before being transferred to the labour suite for further management. Six hours into labour, she complained of severe abdominal pain in between contractions. The CTG showed fetal bradycardia while cervical dilatation remained at 5 cm. She underwent emergency lower segment cesarean section and a subserosal hematoma was seen on the anterior wall of the uterus extending downwards to lower segment with uterine dehiscence about 3 cm length found underneath. Modified B-Lynch suture was done due to uterine atony. A vigorous baby boy with a weight of 3,100 grams was born. Both mother and baby were discharged well. **Conclusion:** Spontaneous rupture of unscarred uterus should be considered in a labouring patient with non-reassuring fetal heart tracing and severe abdominal pain. It is imperative for close supervision and low threshold for intervention to achieve better outcome when dealing with such cases.

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Improving outcome in pregnancy after MI: A case study

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ABSTRACT

Introduction: Coronary artery disease complicates 0.01% of pregnancies. In this case study, we illustrate the successful management strategy of a pregnancy with a cardiometabolic disorder who conceived after a ST-elevation myocardial infarction (STEMI). **Case Description:** A 41-year-old woman in her third pregnancy was referred to our maternal-fetal-medicine unit at 8 weeks of gestation. She had a history of an acute inferior myocardial infarction (MI) Killip 1 with 70% occlusion of the left anterior descending artery and ectatic vessels, which was successfully thrombolysed 1 year prior. On presentation, she had uncontrolled type 2 diabetes, chronic hypertension on treatment, and was morbidly obese with a BMI of 44 kg/m2. She had 2 previous lower segment caesarean sections and an umbilical hernia repair. A systematic effort involving a multidisciplinary team, both at tertiary and community level, was coordinated from the start, which successfully prevented any cardiac events during pregnancy. She recovered from Covid-19 category 4a at 28 weeks with no cardio-respiratory implications. She went on to have a lower segment caesarean section near term with tubal ligation. Post-operative recovery was uneventful, and she continued to see cardiologists and endocrinologists. **Discussion:** Specific risks such as MI recurrence, pre-eclampsia and low birth weight baby can be minimised through comprehensive antenatal and perinatal plans supported by patient compliance. Our case showed that pregnancy after MI results in good maternal-fetal outcome provided the pre-pregnancy cardiac performance status is good, early multidisciplinary management, patient-centred approach, close antenatal monitoring, adequate delivery preparation and patient compliance.