

TOTAL HEMOSTASIS HYSTERECTOMY ON SCARRED UTERUS AFTER VAGINAL DELIVERY CAUSING TWO UTERINE RUPTURES: A CASE REPORT***Khalid Lghamour, Najia Zraidi, Amina Lakhdar, Aicha Kharbach and Aziz Baidada**

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Article Received on 06/06/2022

Article Revised on 27/06/2022

Article Accepted on 17/07/2022

ABSTRACT

We report the case of a patient who has a scarred uterus, who gave birth twice by vaginal delivery after caesarean section, and who has just given birth also by vaginal delivery with suction cup the current pregnancy, with as a result a delivery hemorrhage and two uterine ruptures. total hemostasis hysterectomy was the only recourse for maternal rescue .

KEYWORDS: total hemostasis hysterectomy; uterine rupture; scarred uterus.**INTRODUCTION**

The vaginal delivery of a patient with a scarred uterus sometimes exposes her to the risk of dehiscence or uterine rupture of the old scar. When the diagnosis of uterine rupture after vaginal delivery is retained by the clique signs and uterine revision, an exploratory laparotomy should be started urgently. When uterine ruptures are irreparable or when the maternal prognosis is compromised, total hemostasis hysterectomy is the ultimate course for maternal rescue.

CASE REPORT

Patient 32 years old, history of scarred uterus, gravida 4, para 4, the first pregnancy ended with a caesarean section for over term 14 years ago, the second pregnancy delivered by vaginal route 9 years ago, the third pregnancy delivered by vaginal route 5 years ago, the fourth is the current pregnancy with a gestational age at term according to the date of the last menstruation.

The patient gave birth to a live female infant at the local hospital of Tifelt, 40 km from our maternity hospital, with a birth weight of 3650 grams. After delivery, the patient presented a delivery hemorrhage, she was put in condition and was referred in time with her baby in our formation.

On arrival, the patient was conscious and hemodynamically stable with Blood pressure=14/9. Gynaecological examination found a false safety globe with reddish genital bleeding of moderate severity.

An examination under valves was done, there were no tears of the uterine cervix. A uterine revision was performed which found two uterine ruptures, one located at the level of the old uterine scar, and the other on the posterior right side of the uterus.

An exploratory laparotomy was performed which confirmed the presence of two uterine ruptures with injury to the right psoas muscle and respect for the iliac vessels.

It was decided to perform a total hemostasis hysterectomy for maternal salvage which was performed under general anesthesia. The lesion of the right psoas muscle was sutured, hemostasis was assured, and the hysterectomy specimen was sent for anatomopathological study.

Histopathology confirmed total hysterectomy with no histological signs of malignancy.

The postoperative course was without particularities, the result obtained was good.

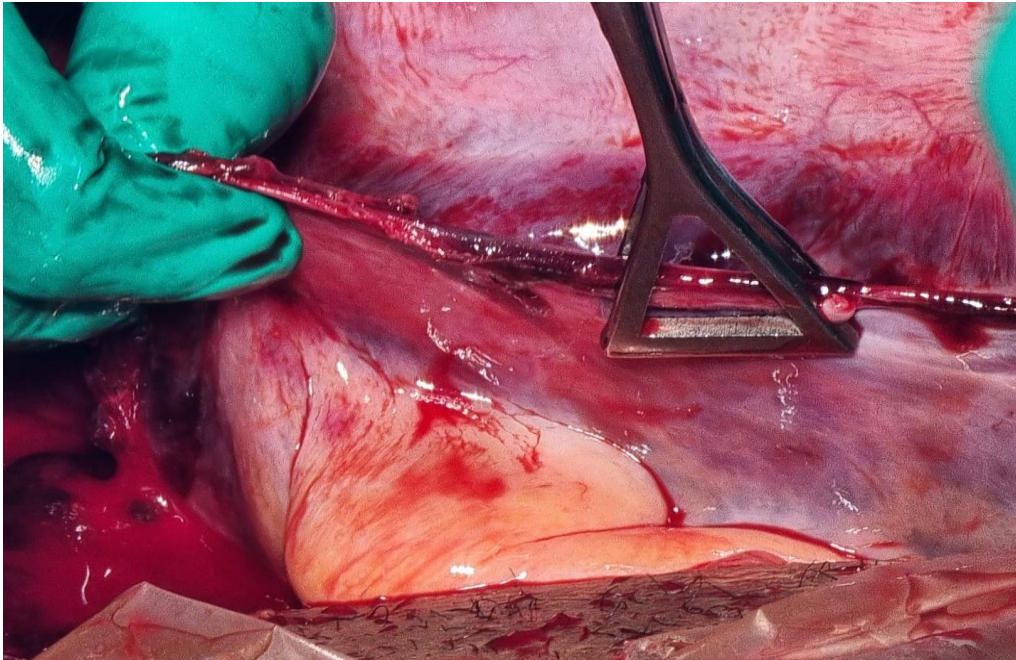
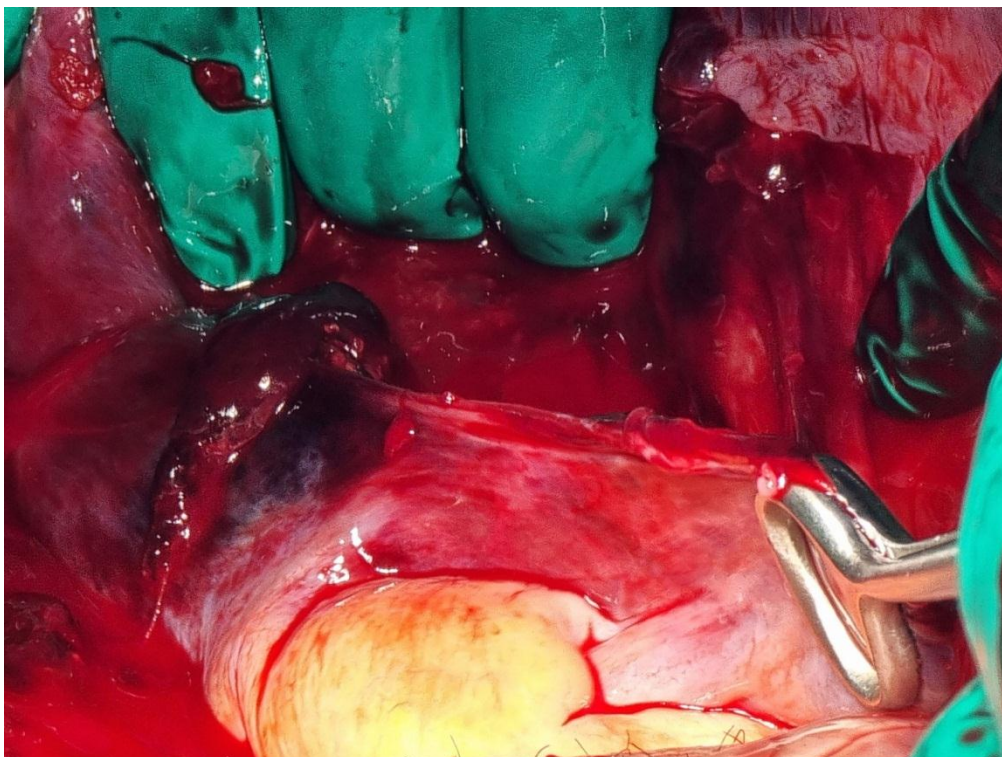


Figure 1: exploratory laparotomy.



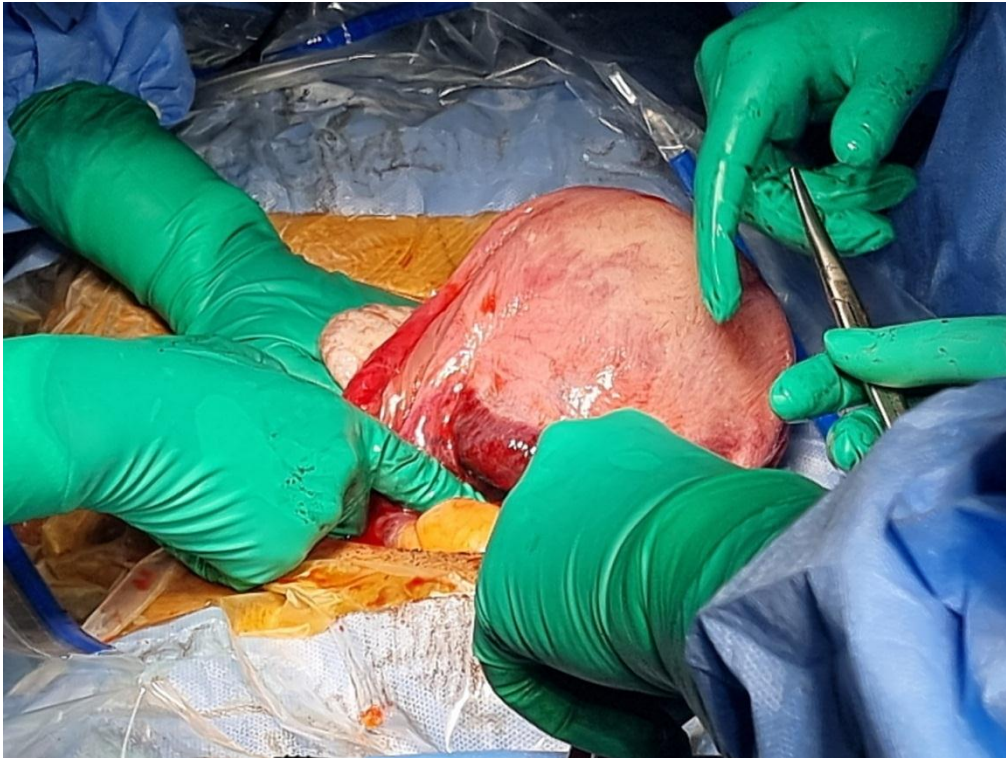


Figure 2: Uterine rupture of the old cesarean scar.





Figure 3: Uterine rupture on the right posterior surface.

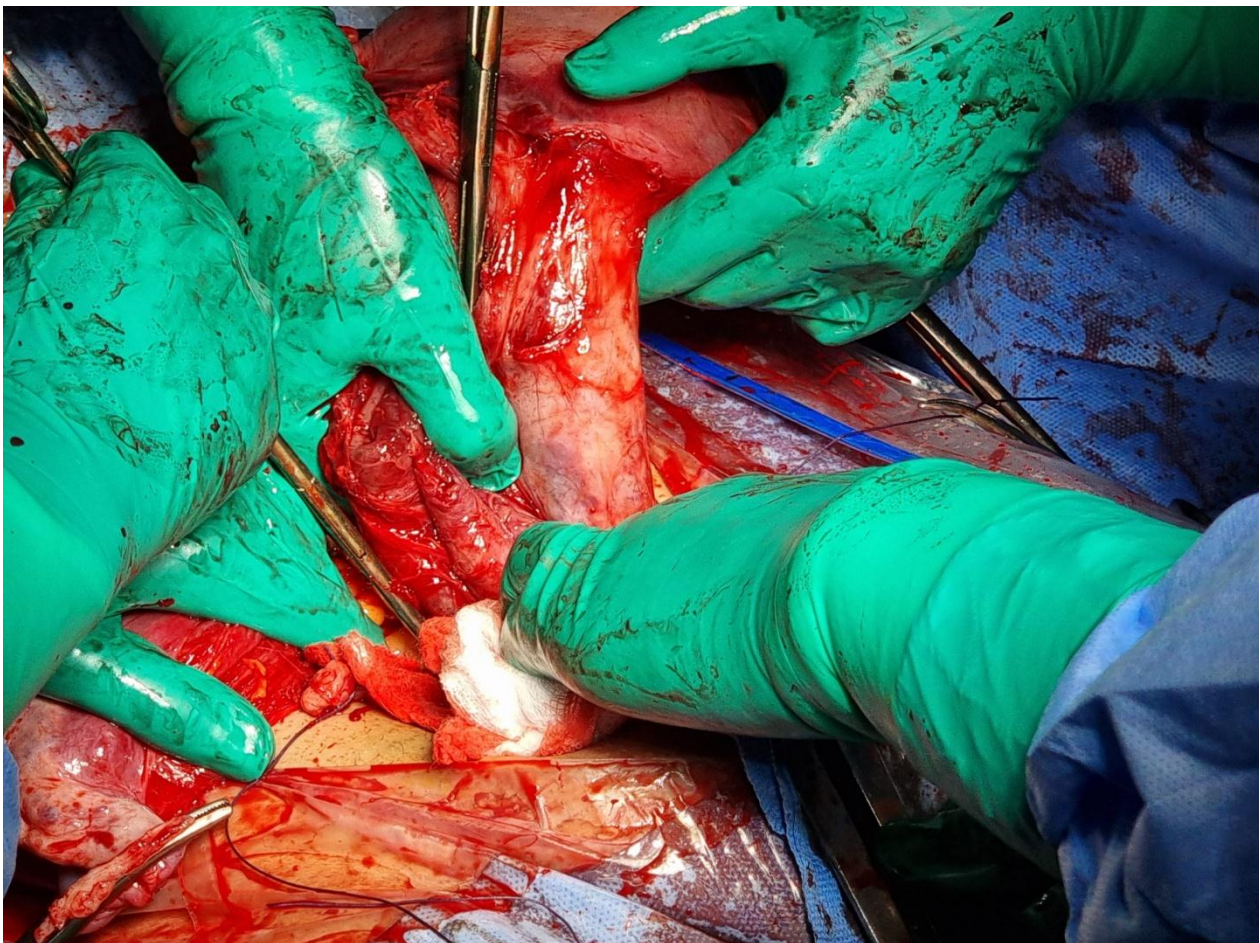


Figure 4: the decision to perform a total hemostasis hysterectomy.

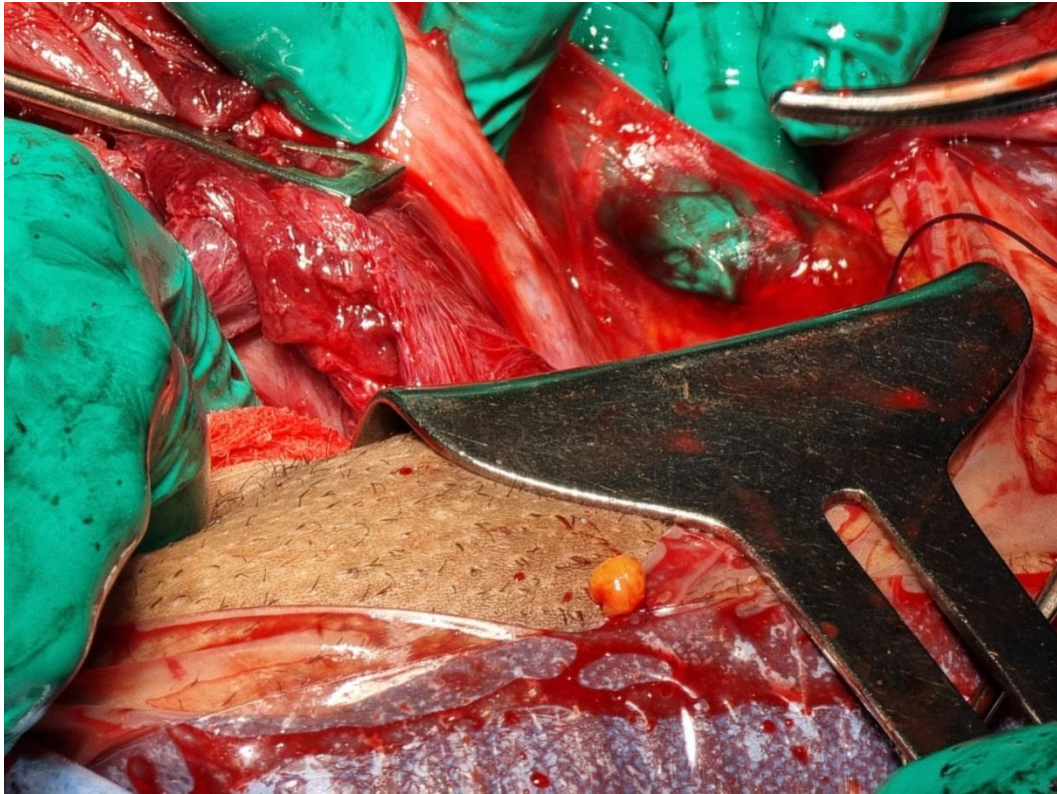


Figure 5: the different stages of hysterectomy.

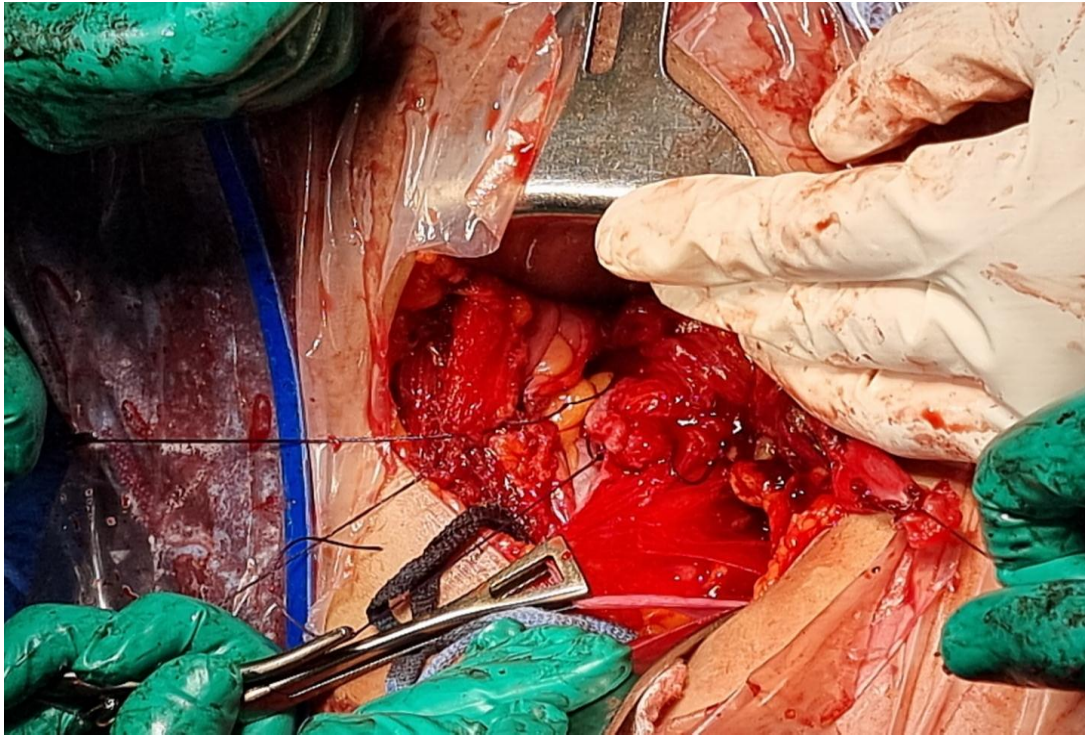


Figure 6: the end of the hysterectomy.

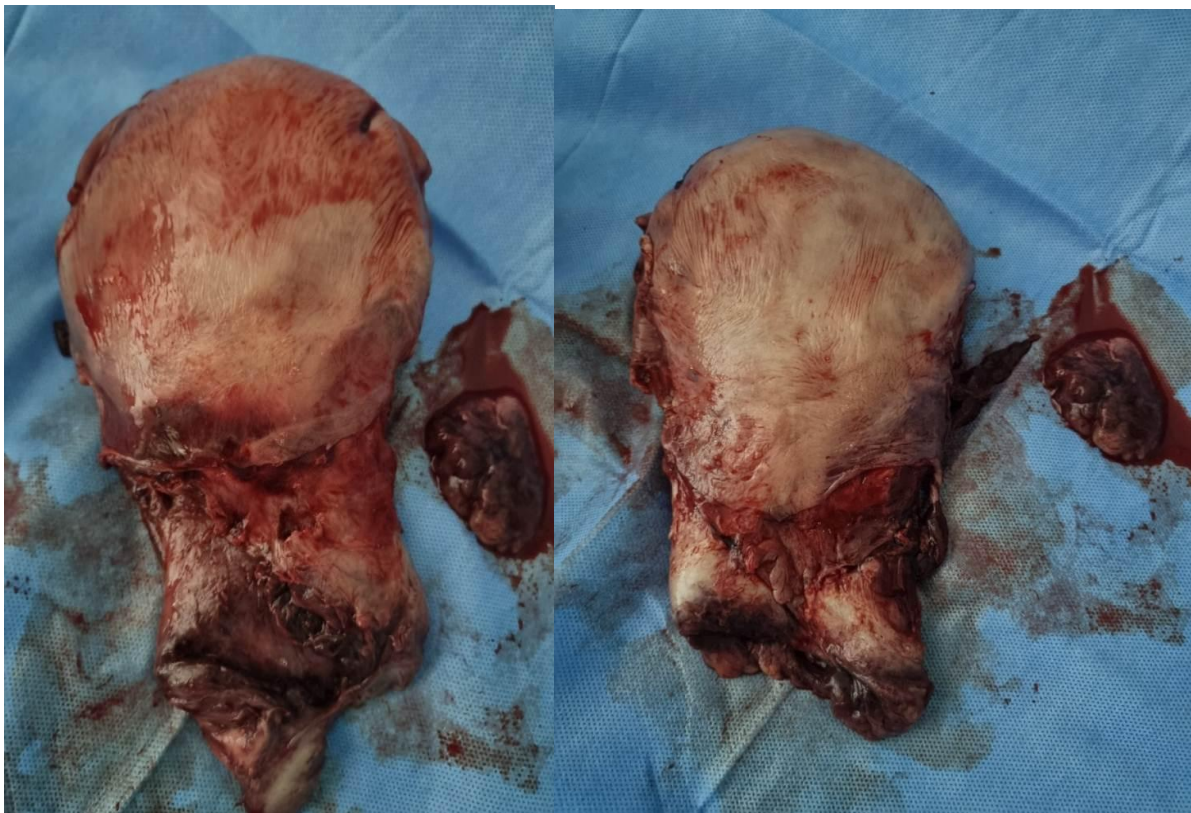


Figure 7: the total hysterectomy operative part.

DISCUSSION

The scarred uterus is a risk factor for fetal and maternal morbidity in subsequent pregnancies, regardless of the route of delivery. The main cause of scarred uterus is a history of caesarean delivery by caesarean section.

Uterine rupture is a very rare event but is one of the most serious obstetric complications.

It is a cause of perinatal as well as maternal mortality and the most commonly feared acute complication of delivery in the presence of a scarred uterus.

In the general population, the incidence of uterine rupture has been estimated at 5 to 6/10,000.^[1,2] or approximately one in 1700 parturients in a national prospective study conducted in the Netherlands in 2004-2005.^[2]

Scarred uterus is the main risk factor for uterine rupture in these countries. Thus, at least 90% of ruptures occur in a scarred uterus.^[2,3,4]

Currently, in developed countries, the majority of uterine ruptures occur during labor in patients with a history of cesarean section.^[5]

In the United States, the aphorism "once a cesarean, always" influenced obstetrical practice until the 1980s. Subsequently, the National Institute of Health^[6] encouraged vaginal delivery after caesarean section in order to reduce maternal morbidity following a second cesarean section, on the one hand, and to reduce the cesarean section rate on the other hand.

Uterine rupture on a segmental cesarean section scarred (transverse or vertical) is the most common situation.

Total hemostasis hysterectomy is an interannexal hysterectomy. It can be performed in the immediate aftermath of a cesarean section or be indicated after vaginal delivery.

After a vaginal delivery, the usual incision is transverse suprapubic.

The initial steps of the total hysterectomy are: ligation and section of the round and utero-ovarian ligaments, ligation and section of the uterine arteries.

The frequency of hysterectomies is extremely variable, ranging from 0.2 to 5/1000 births^[7, 8, 9] and tends to increase in parallel with the rate of caesarean section.^[10, 11] In a recent review of the literature, uterine rupture constitutes 12% of the indications for hemostasis hysterectomy.^[7]

The rate of haemostasis hysterectomies varies in the literature between 5.6% and 26.6% in the case of complete uterine rupture.^[12,13]

Guise *et al.* estimate that 3.4 women out of 10,000 choosing labor will undergo a hemostasis hysterectomy.^[14]

The indications for hemostasis hysterectomy are failure of conservative treatment, major uterine damage, particularly in the case of uterine rupture, as in our case.^[15,16]

CONCLUSION

Total hemostasis hysterectomy is the last resort for maternal rescue in case of delivery hemorrhage due to

uterine rupture in a scarred uterus following vaginal delivery when the uterine lesions are multiple and irreparable or when the maternal prognosis is at risk.

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