International Clinical and Medical Case Reports Journal
Case Report (ISSN: 2832-5788)

Case Report: Catastrophic Uterine Rupture in a Twin Pregnancy at 32+5 weeks

Shahdab*, Olufunke OSO

Peterborough City Hospital

Citation: *Shahdab, Olufunke OSO. Case Report: Catastrophic Uterine Rupture in a Twin Pregnancy at 32+5 weeks. Int Clinc Med Case Rep Jour. 2025;4(9):1-3.*

Received Date: 22 August 2025**; Accepted Date:** 16 September 2025**; Published Date:** 19 September 2025

***Corresponding author:** Shahdab, Peterborough City Hospital

ABSTRACT/BACKGROUND

Uterine rupture is a life-threatening obstetric complication associated with significant maternal and perinatal morbidity and mortality. Maternal mortality remains a major concern worldwide and continues to be high in most of sub-Saharan Africa [1]. Women with a previous classical uterine incision are at greater risk of rupture compared with those who have undergone low transverse cesarean section [1].

Clinical signs may include abdominal pain, non-reassuring fetal heart patterns, and loss of fetal station, most commonly arising from a uterine scar defect after cesarean delivery [2]. Additional risk factors include a history of uterine surgery (e.g., myomectomy), shortened inter-delivery interval, gestational age greater than 40 weeks, and fetal macrosomia (>4000 g) [2].

During pregnancy, physiologic changes can obscure the diagnosis of acute abdomen. Symptoms such as nausea, vomiting, and abdominal discomfort may overlap with normal pregnancy complaints, making it challenging to differentiate from severe intra-abdominal pathology [3]. Furthermore, fever may not always be present, and clinical examination alone may not be sufficient for diagnosis [3].

We present a case of catastrophic uterine rupture in a woman with a twin pregnancy and a history of previous cesarean sections.

CASE PRESENTATION

A 32+5 weeks' gestation woman, gravida 4 para 3, presented with worsening intermittent abdominal pain since morning. Her obstetric history included one spontaneous vaginal delivery and two previous lower segment cesarean sections. She was carrying monochorionic diamniotic (MCDA) twins. Her BMI was 30.1, and her blood group was A Rh-negative.

Antenatal ultrasound at 31+6 weeks revealed discordant twin growth: Twin 1 at the 12.9th centile (normal range) and Twin 2 severely growth-restricted at the 3.6th centile. At presentation, her Modified Obstetric Early Warning Score (MOEWS) was 0.

On examination, palpable uterine activity was noted, with relaxation between contractions but generalized uterine tenderness. There was no localized scar tenderness. Speculum examination showed a long, multiparous cervix, and Actim Partus test was negative. Cardiotocography (CTG) demonstrated non-reassuring features for both twins.

The patient became acutely distressed, pale, and sweaty. Bedside ultrasound revealed severe fetal bradycardia with flickering cardiac activity only.

An emergency **Category 1 cesarean section** was performed via the previous Pfannenstiel incision. On entering the abdomen, a massive hemoperitoneum was observed, and both fetuses were found floating freely within the peritoneal cavity. Twin 1 was delivered as an antepartum stillbirth, weighing 1440 g. Twin 2 was delivered in poor condition with severe metabolic acidosis (cord arterial pH 6.90) and low Apgar scores.

A catastrophic **midline uterine rupture** was identified, extending the full length of the uterus caudally toward, but not involving, the bladder. The defect was repaired in three layers. Estimated blood loss was 5.7 L, requiring intraoperative transfusion of three units of packed red blood cells.

The mother survived, though her postoperative recovery was complicated by paralytic ileus, leading to prolonged hospital stay.

DISCUSSION

Most patients with uterine rupture present with severe abdominal pain and non-reassuring fetal status [2]. However, the presentation may be atypical and mimic other obstetric emergencies such as placental abruption or intrauterine infection. Timely recognition is crucial, as delay significantly increases maternal and neonatal morbidity and mortality.

Although uterine rupture is more common in scarred uteri, it can also occur in unscarred uteri, where diagnosis is often delayed [3]. The major risk factor remains a previous cesarean section. In this case, the history of two prior cesarean deliveries placed the patient at increased risk.

Maternal mortality remains a global health priority. The Millennium Development Goal (MDG 5) aimed to reduce maternal deaths, and although progress has been made, accelerated efforts are required to achieve the Sustainable Development Goal (SDG) target for 2030 [1]. Uterine rupture, often resulting in massive hemorrhage, is a preventable cause of maternal mortality, particularly in resource-limited settings.

This case highlights the importance of maintaining a high index of suspicion for uterine rupture in any pregnant woman presenting with abdominal pain, regardless of gravidity or parity.

CONCLUSIONS

- Uterine rupture remains a life-threatening obstetric emergency with catastrophic outcomes.
- A previous cesarean section scar is the most significant risk factor, but rupture should also be considered in primigravid patients.
- Clinical symptoms can be nonspecific, requiring vigilance and rapid decision-making to optimize maternal and fetal outcomes.

- Improved surveillance, timely surgical intervention, and access to blood transfusion are essential to reduce maternal and neonatal mortality.

REFERENCES

1. Egbe TO, Halle-Ekane GE, Tchente CN, Nyemb JE, Belley-Priso E. Management of uterine rupture: a case report and review of the literature. BMC Res Notes. 2016.
2. Halassy SD, Eastwood J, Prezzato J. Uterine rupture in a gravid, unscarred uterus: case report. Case Rep Womens Health. 2019;24:e00154.
3. Posthumus L, Donker ME. Uterine rupture in a primigravid patient, an uncommon but severe obstetrical event: a case report. J Med Case Rep. 2017;11:339.