

Interesting Case

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and Jennifer Farrell

*Clinical History

- ❖ 26 yo Female
- ❖ G2 P1
- ❖ Previous C-Section in Bangladesh
- ❖ LMP : 12/26/2013

*07/22/2014

Fetal Survey Results: Normal
with thickened placenta noted,
patient scheduled for follow
growth exams

F/U Growth Scan on 09/09/14

- ❖ GA by LMP - 36 weeks 5 days
- ❖ HR - 139 bpm
- ❖ Persistent Placentomegaly
- ❖ Improved growth from previous exam with estimated fetal weight in the 81st percentile
- ❖ F/U growth scheduled in 3 weeks to assess placenta and growth
- ❖ Patient told to follow up with OB at regular scheduled time

2D
71%
C 56
P Med
HRes

CEPHALIC

- 0

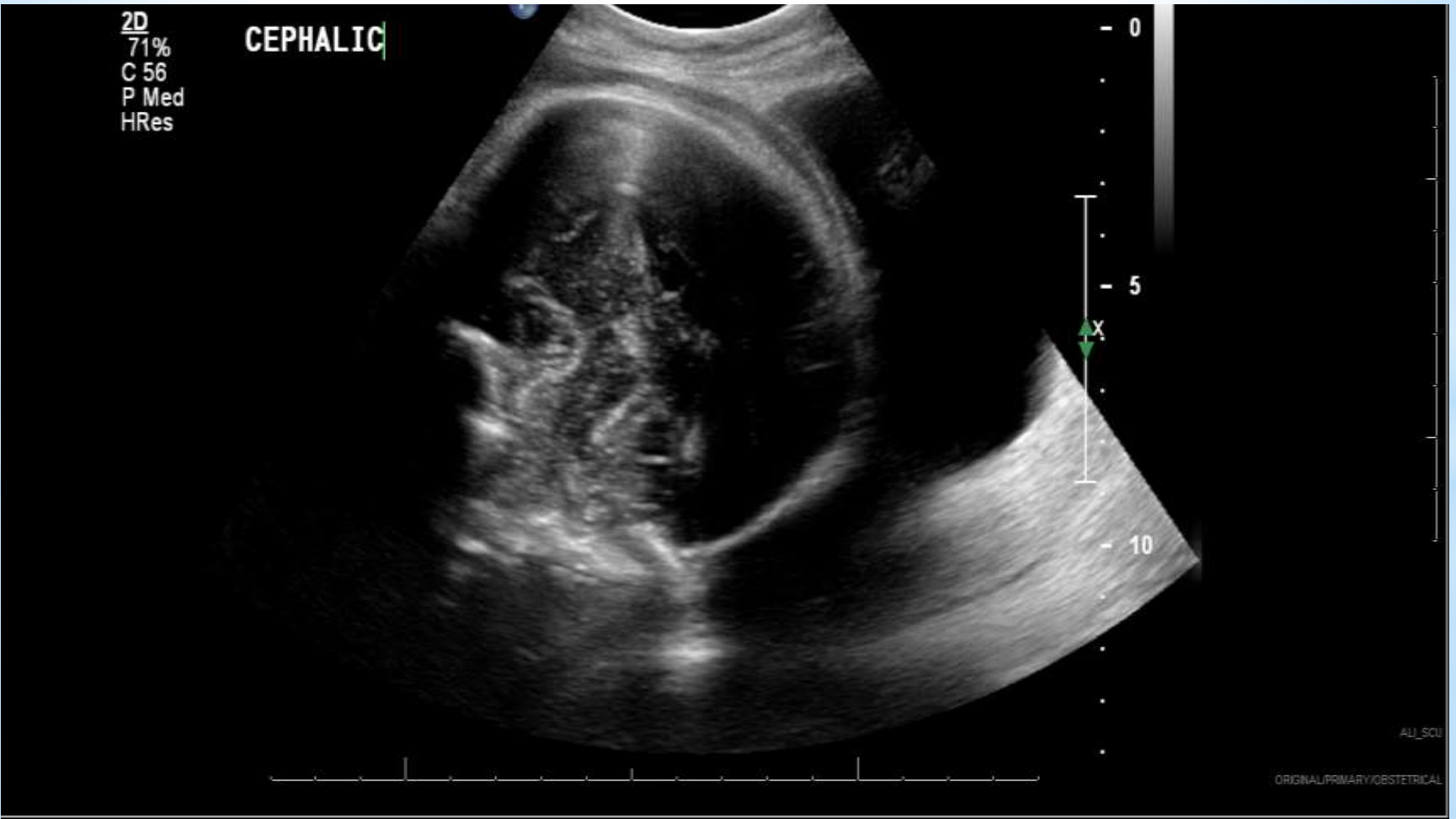
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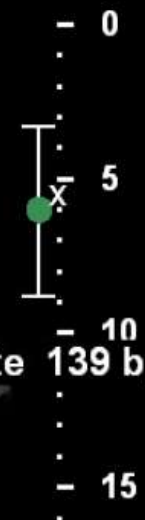
ORIGINAL/PRIMARY/OBSTETRICAL



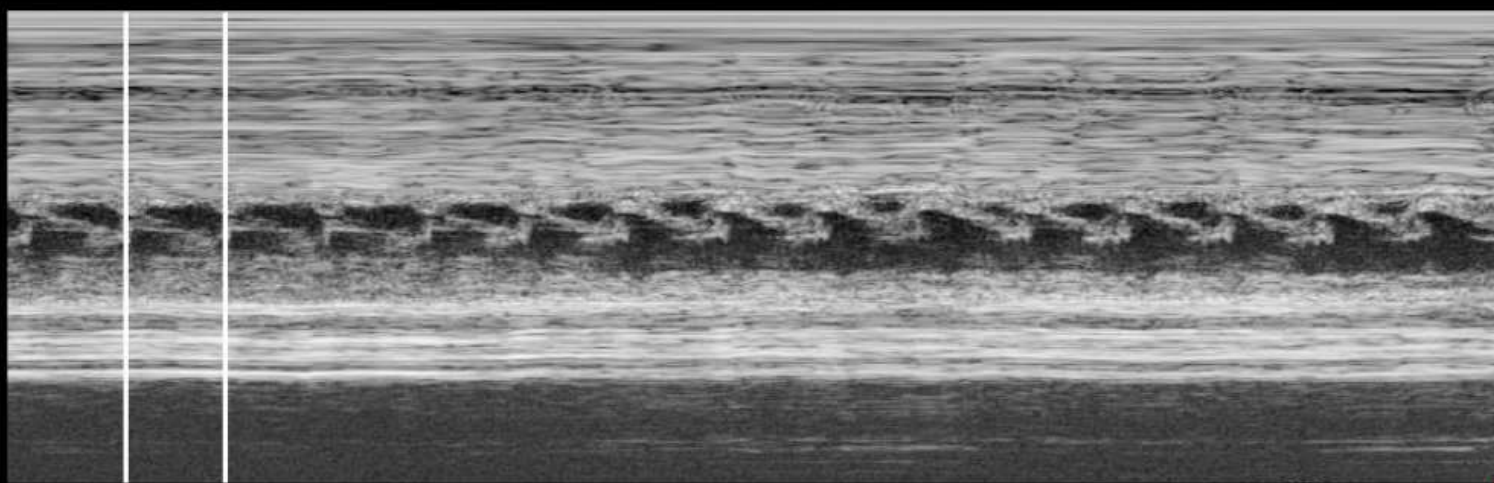
FR 23Hz
RS

M3

2D / MM
74% 84%
C 58
P Med
HRes



Heart Rate 139 bpm



6.6sec



FR 24Hz
RS

M3

2D
66%
C 56
P Med
HRes

P



+ AC 35.58 cm 39w4d

09/15/14 - Followed up with OB :
diagnosed with placenta disorder
and previous C-section affecting
pregnancy

Continue NST's twice a week

09/18/2014

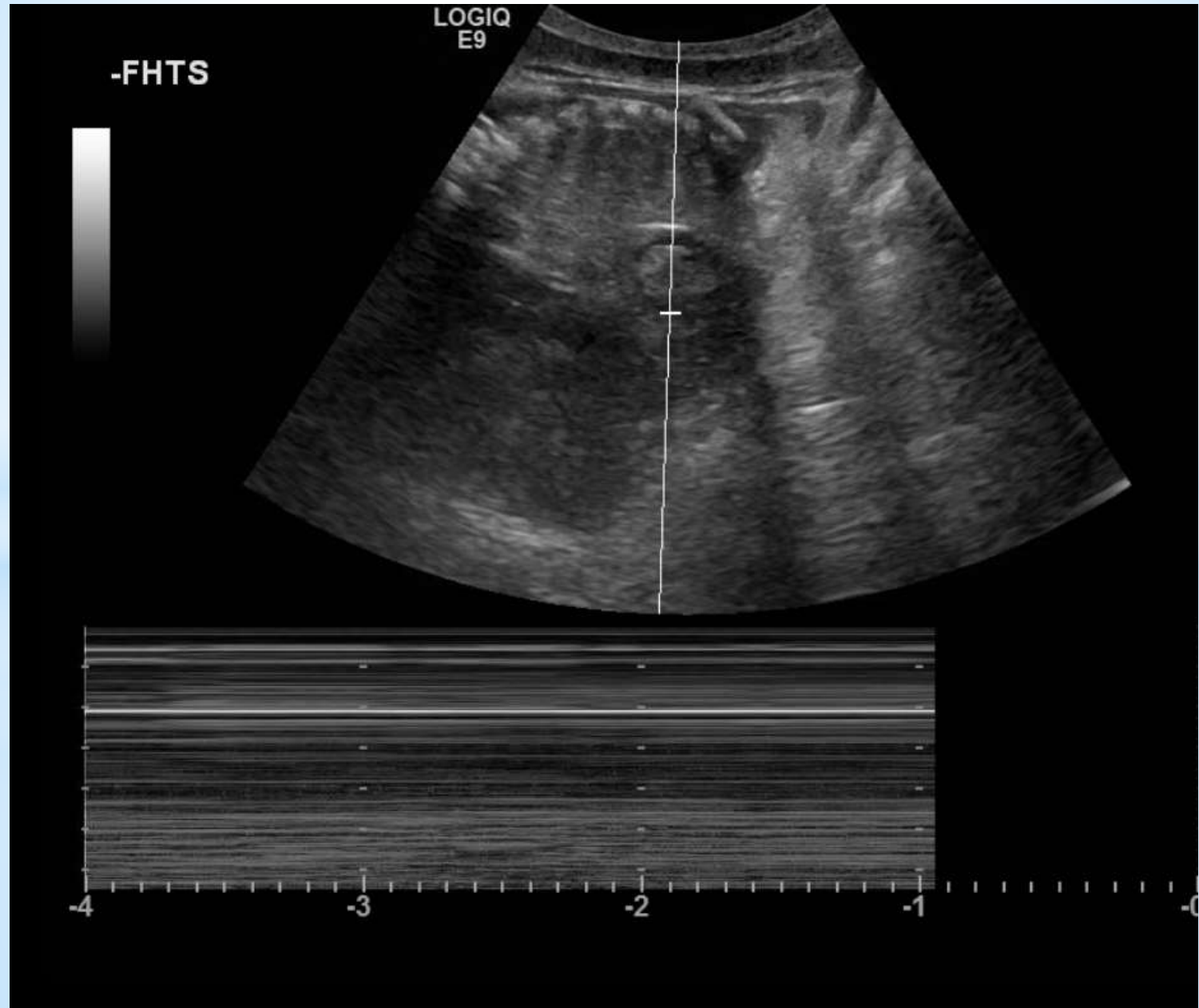
Patient presents for scheduled NST and states she is not feeling movement

No FHT recognized on NST

Ultrasound ordered for further evaluation resulting in -FHT (fetal demise)

GA - 38 weeks 5 days

09/18/2014



09/19/2014

Intrauterine fetal demise confirmed

Elected TOLAC (trial of labor after cesarean) with known risk of uterine rupture of 3%

Labor induced- fetal head seen in birth canal

Began normally - Contractions noted

During labor contractions cease and patient has upper abdominal pain

-Palpable fetal parts with fetal head maternal right

-Abdomen very tender to the touch

Ultrasound ordered for further evaluation of possible uterine rupture

09/19/2014



LOGIQ
E9

SAG LT

35

-35
cm/s

0	CHI	
-	Frq	4.0
-	Gn	41
-	D	14.0
-	AO%	95
-		
	CF	
-	Frq	2.5
-	Gn	14.0
5	L/A	1/3
-	PRF	2.3
-	WF	401
-	S/P	5/10
-	AO%	95

M

10

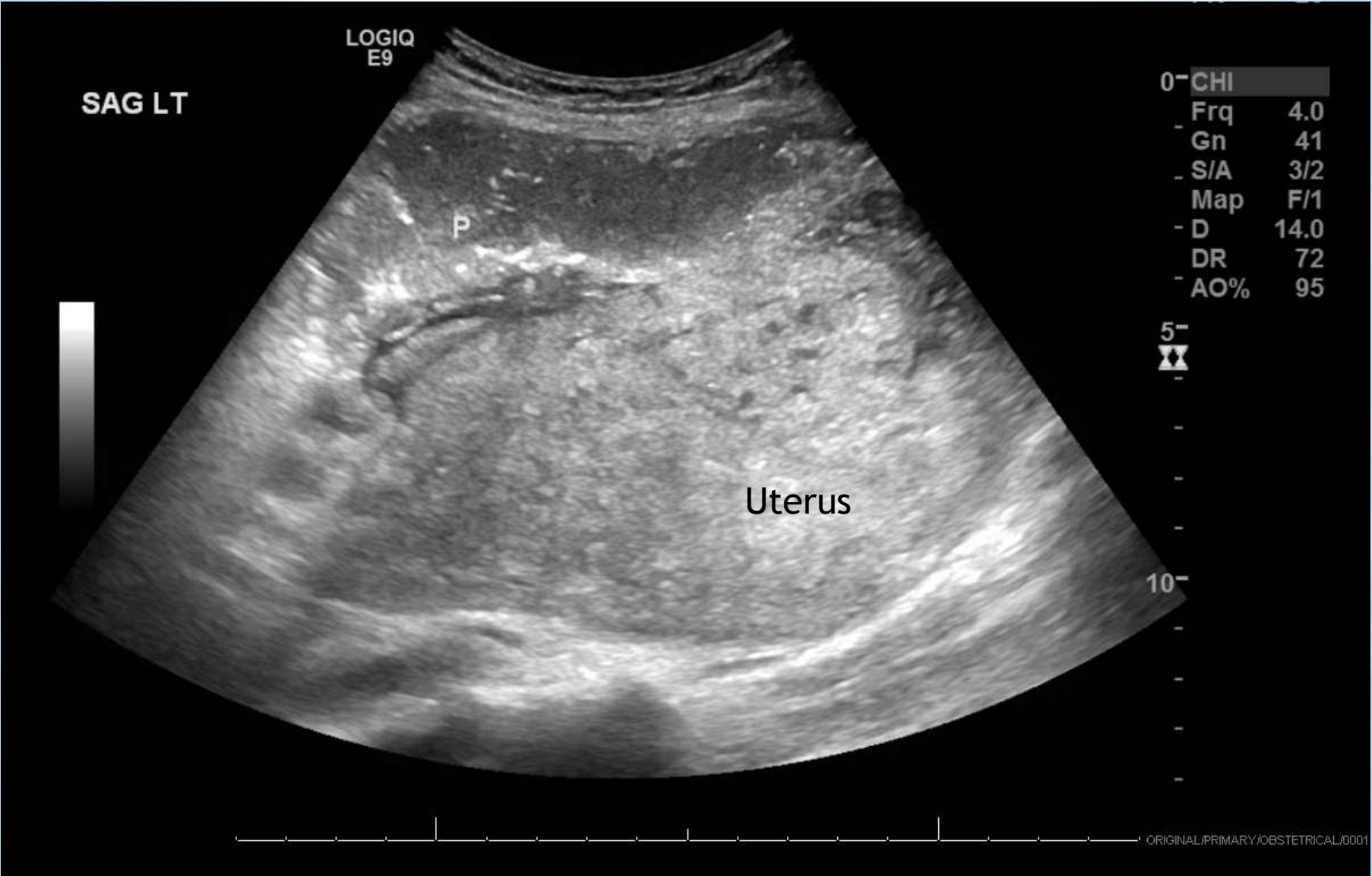
LOGIQ
E9

TRV IS

0-	CHI	
-	Frq	4.0
-	Gn	41
-	D	14.0
-	AO%	95
-		
	PDI	
-	Frq	2.5
-	Gn	12.0
5-	L/A	1/3
-	PRF	2.3
	WF	328
-	S/P	5/12
-	AO%	95

M

10-



LOGIQ
E9

SAG LT

0- CHI
- Frq 4.0
- Gn 41
- S/A 3/2
- Map F/1
- D 14.0
- DR 72
- AO% 95

5-
X

10-

09/19/14

FR 20

LOGIQ
E9

TRV

0-CHI
- Frq 4.0
- Gn 41
- S/A 3/2
- Map F/1
- D 14.0
- DR 72
- AO% 95

H

5-
XX
-

PLAC

UT

10-
-
-
-
-



Ultrasound Findings :

Findings consistent with uterine rupture with intrauterine contents (placenta and fetus) within the abdominal cavity, outside the uterus

Summary :

Clinically :

-pre c-section patient was dilating and fetal head was seen in birth canal, patient was experiencing labor pains

-Labor pains stopped and fetal head was no longer seen in birth canal

C-section performed

-**rupture** occurred along the previous classical C-section scar defect - 12 cm in length

-pus with necrotic tissue were found along the edges of the rupture in the uterine cavity and along pelvic peritoneal surfaces

-Fetus and placenta removed from peritoneal cavity

-Tight true knot in umbilical cord noted with obstruction of blood supply which caused fetal demise pre-rupture

-Uterus extracted, cleared of clot and necrotic tissue and returned to the abdomen, patient survived

