



SCAR DEHISCENCE: AN ALARMING CAUSE OF SECONDARY POST-PARTUM HEMORRHAGE-CASE REPORT

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ABSTRACT

Introduction: Cesarean scar dehiscence is a very rare, but grave cause of postpartum hemorrhage (PPH), in which the scar tissue of the previous Cesarean Section (CS) is disrupted and separated. We present a case of a 24 years female, who presented with two episodes of secondary PPH, post cesarean section and on evaluation was found to have uterine scar dehiscence. **Case Summary:** The patient reported to the labour room emergency with complaints of excessive bleeding per vaginum. She had an uneventful antenatal period, and underwent emergency lower segment cesarean section (LSCS) few days ago. Her postoperative period was uneventful and she was discharged on postoperative day (POD) 3 of LSCS. Examination and investigations did not reveal any abnormal finding and the patient was discharged after conservative management. She again reported with the same complaints few days later. In view of second bout of haemorrhage, MRI (magnetic resonance imaging) was done which revealed a focal defect in anterior wall of uterus, at incision site, likely scar dehiscence, which was surgically managed by laparotomy followed by debridement of scar and re-suturing of uterus. The patient was discharged with stable vitals, with no further complaints. **Conclusion:** Cesarean scar dehiscence, although rare, but is a lethal cause of secondary PPH, and it is often overlooked. It has many immediate and long term fatal complications. More case series and case reports are needed to frame uniform guidelines in detecting and early management of such cases.

KEYWORDS : Scar dehiscence, postpartum hemorrhage, lower segment cesarean section

INTRODUCTION

Secondary post-partum hemorrhage (PPH) is defined as any abnormal or excessive bleeding that occurs 24 h after delivery and up to 6 weeks postpartum.[1] Cesarean scar dehiscence is a very rare, but grave cause of secondary PPH, in which the scar tissue of the previous Cesarean Section (CS) is disrupted and separated.[2] Due to increased incidence of cesarean deliveries worldwide, incidence of cesarean scar dehiscence has also increased in the last decade, ranging from 0.2% to 4.3%.[3,4] We present a case of a 24 years female, who presented with two episodes of secondary PPH, post cesarean section and on evaluation was found to have scar dehiscence.

CASE SUMMARY

The patient reported at the Labour room Emergency with complaints of excessive bleeding per vaginum associated with passage of clots. She had an uneventful antenatal period, and underwent emergency lower segment cesarean section (LSCS) 25 days back due to breech presentation. Her postoperative period was uneventful and she was discharged at post operative day (POD) 3. There was no history of foul smelling lochia, fever, local trauma or intercourse at home or any intake of antiplatelet/anticoagulant drugs. On examination, her pulse rate was 102 beats per minute, BP was 100/72mm of Hg and pallor was present. She was afebrile with bilateral clear chest. Her abdomen was soft, non tense, non-tender and suture line was healthy. Local examination showed a fully soaked pad with no foul smelling lochia and per speculum examination showed a healthy looking cervix and vagina with no active bleeding. External os of cervix was closed and the uterus was of 12 weeks size, non-tender. Cervicovaginal exploration was inconclusive and parenteral antibiotics were started. Her hemogram, coagulation profile, liver function and kidney function tests were within normal limits. On Ultrasound, a normal sized uterus was found, and no retained products of conception or any other abnormality was detected. She was discharged after 2 days with stable vitals and no bleeding.

She again reported to the emergency room on her postoperative day 40 of LSCS, with heavy bleeding per vaginum. β -HCG and coagulation profile were normal. In view of second bout of haemorrhage, Magnetic resonance imaging (MRI) (figure 1) was done which revealed a focal

defect in anterior wall of uterus, at incision site, likely scar dehiscence. Laparotomy was done and a scar dehiscence of 4cm was noted. (figure 2 & 3) The scar margins were excised and freshened, followed by suturing of the uterus. The patient recovered smoothly post-operatively and was discharged on POD 3 after laparotomy, with stable vital signs and no vaginal bleeding.

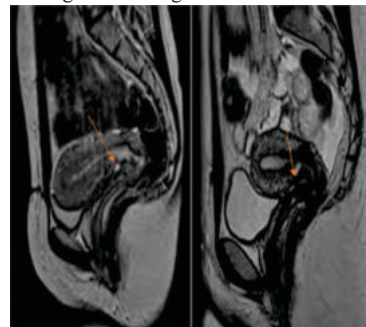


Fig 1: MRI Picture Showing Defect In The Anterior Wall Of Uterus, (orange arrow) Likely Scar Dehiscence.



Fig 2.

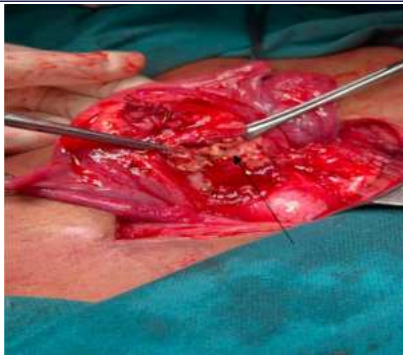


Fig 3.

Fig 2 and Fig 3: Intraoperative pictures showing previous cesarean scar rupture (black arrow).

DISCUSSION

Secondary PPH poses a diagnostic challenge, and its management protocols are not uniform.[6] Hence, clinicians should keep in mind the possibility of scar dehiscence while dealing with secondary PPH in a patient with previous cesarean section. [5, 7] Whenever the clinical and ultrasound findings do not suggest retained placental tissue, further investigations should be carried out. In our case, the diagnosis was missed the first time when the patient presented to us, which caused a delay in diagnosis and additional distress to the patient.

Early diagnosis of scar dehiscence can be made by imaging modality like sonography, which would show fluid collection or haematoma in scar area. Although 3D ultrasound is better, doppler may be used to differentiate between pseudoaneurysm, AV fistula and scar dehiscence. In MRI-T2 weighted image may show a bright fluid filled tract.[8]

The probable risk factors for development of scar dehiscence are nulliparity, diabetes, emergency surgery, infection, incision placed too low in the lower uterine segment. [8,9]

The management depends on the clinical status of the patient. If the vitals of the patient are stable and there is MRI proven partial dehiscence, conservative management by only antibiotics may be sufficient. Surgical management involves conservative surgery by refreshing the edges and resuturing of incision, if the patient desires preservation of uterus, provided the margins are minimally involved, minimal peritoneal involvement, no intraabdominal abscess, abdominal incision is minimally infected, no adnexal involvement and minimal endomyometritis. [10] In the presence of the above complications, hysterectomy should be considered. [10, 11]

Cesarean scar dehiscence is linked with a range of complications. Acutely, these can include hemorrhage, sepsis, peritonitis, and hysterectomy [11,12]. Long-term complications may involve abnormal uterine bleeding, endometritis, chronic pelvic pain, and infertility.[13] Cesarean scar dehiscence also has detrimental effects on subsequent pregnancies like preterm birth, low birth weight, uterine rupture and increased risks of peripartum hysterectomy.[14]

CONCLUSION

Cesarean scar dehiscence, though rare, poses a potentially life-threatening risk of secondary postpartum hemorrhage (PPH) and is frequently underrecognized. It carries significant immediate and long-term fatal complications. In high cesarean section rate countries like India, clinicians must remain vigilant when managing patients with postoperative vaginal bleeding. Increased case series and reports are essential for developing specific management protocols for secondary PPH. Therefore, efforts should be directed towards lowering primary cesarean section rates to mitigate these catastrophic outcomes.

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