

Uterine Rupture guideline

Guideline information

Guideline number: 642

Classification: Clinical

Supersedes: Version 2

Local Safety Standard for Invasive Procedures (LOCSSIP) reference: N/A

National Safety Standards for Invasive Procedures (NatSSIPs) standards: N/A

Version number: Version 3

Date of Equality Impact Assessment: 16/03/2026

Approval information

Approved by: Maternity Written Document Group

Date of approval: 30/04/2026

Date made active: 18.05.2026

Review date: 30.04.2029

Summary of document:

Uterine rupture is rare but a life-threatening occurrence with an occurrence of 0.02%. Early recognition with prompt action is paramount and can reduce maternal and neonatal morbidity and mortality

Scope:

This guideline is to support the health care professionals providing care to women who at may be at an increased risk of, or experience, a uterine rupture The guidance below uses the term 'woman' (pronouns she or her) to describe individuals whose sex assigned at birth was female, whether they identify as female, male or non-binary. It is important to acknowledge it is not only people who identify as women for whom it is necessary to access women's health and reproductive services. Therefore, this should include people who do not identify themselves as women but who are pregnant or have recently given birth. Obstetric and Midwifery services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex that they were assigned at birth.

To be read in conjunction with:

[755 - All Wales Guideline: Prevention and Management of Postpartum Haemorrhage](#) -opens in new tab

Patient information:

Owning group: Maternity Guideline, Audit and Research Group 30/04/2026

Executive Director job title: Chief Operating Officer

Reviews and updates:

Version 1. 14/09/2017

Version 2. 18/06/2021

Version 3 30/04/2026

Keywords

Uterus rupture

Glossary of terms

CTG – Cardiotocography

FBC – full blood count

G&S – group and save

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Scope

This guideline is to support the health care professionals providing care to women who at may be at an increased risk of, or experience, a uterine rupture

Introduction

Uterine rupture is rare but a life-threatening occurrence. Early Recognition with prompt action are paramount and can reduce maternal and neonatal morbidity and mortality. The longer it takes to diagnose and respond to a uterine rupture the more likely it is that the baby and/or the placenta can be pushed through the uterine wall and into the mother's abdominal cavity with can result in serious complications, such as maternal haemorrhage, haemorrhagic shock, the need for peripartum hysterectomy and fetal neurological complications e.g. hypoxic ischaemic encephalopathy, permanent brain injury and even death.

It mostly happens in a scarred uterus The risk of scar rupture after one caesarean section is one in 200 women with spontaneous births; however, this increases two- to three-fold with induction and augmentation of labour

The incidence of uterine rupture is 0.2 per 1000 (0.02%) maternities overall. 1 This incidence is increased in women who have had a previous caesarean section; 5 per 1,000 (0.5%) with a planned vaginal birth, and 2 per 1,000 (0.2%) with a planned caesarean. Two or more caesarean deliveries, an interval of less than 12 months since their caesarean delivery, induction of labour and the use of oxytocin all increase the odds of rupture. Rupture of an unscarred uterus is rare (0.5-2.0 per 10000 births) and unexpected, and diagnosis may therefore be delayed

Definition

Uterine rupture "separation of the entire thickness of the uterine wall, with extrusion of fetal parts and intra-amniotic contents into the peritoneal cavity".

Uterine dehiscence "a disruption of the uterine muscle with intact serosa, and the placenta and fetus remain within uterine cavity. Usually asymptomatic".

The difference in the definition is often academic, and suspected cases should be treated as "rupture" unless proven otherwise.

Risk Factors

A uterine rupture typically occurs during early labour but may already develop during late pregnancy

During Pregnancy	During Labour	Post Delivery
<p>Previous <u>classical</u> caesarean birth</p> <ul style="list-style-type: none"> • Previous hysterotomy (very rare) • Previous myomectomy <ul style="list-style-type: none"> • Previous uterine rupture • Placenta accreta • Motor vehicle accidents • Müllerian anomalies of uterus • Hysteroscopic metroplasty • Difficult curettage for miscarriage <p>Rare causes described in primigravida women</p> <ul style="list-style-type: none"> • Ehler-Danlos syndrome • Chronic steroid use • Use of cocaine 	<p>Previous caesarean birth</p> <ul style="list-style-type: none"> • Previous myomectomy • Grand multiparity • Malpresentation: unrecognised brow, face and shoulder presentation • Unrecognised cephalopelvic disproportion • Multiple Pregnancy • Obstructed labour • Prostaglandin and oxytocin augmentation in women with high parity and previous caesarean section • Use of high doses of misoprostol in parous women • Instrumental delivery (injudicious use of Keillands forceps) • Assisted breech deliveries <p>Rare causes</p> <ul style="list-style-type: none"> • Tumours obstructing the birth canal • Deep infiltrating endometriosis • Pelvic deformity 	<ul style="list-style-type: none"> • Precipitate labour • Manual removal of placenta • Uterine manipulation (intrauterine balloon) • Placenta accreta

Providing care during labour and birth for any women with known risk factors for rupturing uterus.

In women with recognised risk factors for ruptured uterus:

- Labour should not be prolonged.
- Bloods should be sent for FBC and G&S at the onset of active labour. Confirm whether suitable for electronic issue.
- Assessment for IV access should be made and if no concerns about IV access it may be delayed till such time where fetal or maternal concerns are raised.
- Continuous Electronic Fetal Monitoring (CEFM) of the fetal heart should be recommended.
- Augmentation of labour with Oxytocin should be discussed with the consultant and be in adherence with the Health board guideline.

Signs and Symptoms of Uterine Rupture

Symptoms of a rupture may be initially quite subtle, and pain is a generally a poor indicator of scar rupture; however, constant pain and severe pain being elicited by palpation over the scar site should arouse suspicion

Premonitory signs prior to rupture

- Maternal restlessness, constant pain in the lower part of the uterus; persistent scar pain between contractions. In the presence of an epidural and the woman is complaining of breakthrough pain then this would warrant a senior obstetric review.
- Maternal tachycardia

Signs of Rupture

- CTG abnormalities (present in 55-87% of uterine ruptures): sudden and persistent bradycardia most common
- Fetal parts difficult to palpate
- Bandl's ring is described as a late warning sign of impending rupture. Bandl's ring usually appears before uterine rupture when it occurs secondary to obstructed labour

Following Rupture

- Woman may describe a sudden feeling of something giving way
- Sudden sharp/ severe shooting abdominal pain or referred pain followed by cessation or slowing down of contractions or breakthrough pain despite previously effective epidural block
- Peritoneal irritation (shoulder tip pain or chest pain, resulting from blood irritating the diaphragm)

On clinical examination

- Loss of uterine contour
- Two swellings i.e. fetus lying in the abdominal cavity, and contracted and retracted uterus
- Fetal parts easily palpable
- Bulging under the pubic bone (baby's head has protruded outside of the uterine scar)
- Haematuria
- Vaginal bleeding may occur but is not a cardinal symptom, as it may be modest despite major intraabdominal haemorrhage.
- Maternal shock (rising pulse/falling BP /sweating/poor peripheral perfusion) and collapse

****continuous pain + abnormal CTG – think uterine rupture***

Postpartum

In postpartum women, occult (silent or incomplete) is uterine rupture that occurred without the classic signs of pain or bleeding during birth. It is then characterized by pain and persistent vaginal bleeding despite use of uterotonic agents. Haematuria may occur if the rupture extends into the bladder

It is important that the clinicians involved have a situational awareness, considering the whole clinical picture along with the Mother's appearance and behaviour.

Management

- Summon immediate help including senior/ consultant involvement and Anaesthetist on call. Ring 2222 for emergency. On call consultant to be informed and attend.
- Immediate resuscitation (ABC). IV access x 2 (use 2 size 14-16 G),
- Stop Oxytocin infusion if in use
- IV access and if not suitable for electronic issue request X match 2 units of blood.
- Airway + oxygenation
- Volume replacement.
- Prepare for theatre for emergency caesarean or instrumental birth.
- Plan for emergency caesarean section / exploratory laparotomy
 - Repair of the uterus is possible in the majority of women
 - Haemorrhage from extension of the rupture into the broad ligament or extensive damage to the uterus will likely require hysterectomy –
- Correct any blood loss.
- Catheterise and apply hourly urinometer.
If rupture is discovered at the time of manual exploration following delivery of the placenta and the woman is bleeding, immediately escalate to consultant.
- If not bleeding, discuss with on call consultant as laparotomy may not be required.
- Patient and relatives must be made aware pre-operatively of the possibility of PPH and hysterectomy and this should be reflected in the consent form.
- Anticipate compromised baby. Call for experienced paediatrician to attend birth.

Laparotomy

- Risk of MOH and fetal demise
- Class of CB/ laparotomy and the maximum time limit between "decision to birth" should be clearly stated.
- Consider midline laparotomy (in case of shock, foetal parts easily felt (i.e. suspected complete rupture)
- If anatomy not clear, especially if "extension of the rupture into the broad ligament /broad ligament haematoma or extensive damage to the uterus" please do not apply blind sutures. Alternatively, please apply compression of the bleeding until senior help arrives

The Clinician responsible for carrying out the repair should complete full and accurate documentation including the identification of rupture, consent, procedure, and the repair.

Post Operative / Post Natal Care

- A plan of care for the immediate post-natal period should be clearly documented by the operating obstetrician.

- Thromboprophylaxis and IV antibiotics
- Complete a clinical incident form (Datix)
- Following recovery ensure that the woman and her partner have opportunity to see a senior obstetrician for debrief before going home.
- The woman and her partner should also be given an opportunity to have a further consultation after discharge from hospital.
- An 8–12-week postnatal appointment must be made for the woman to attend the named consultant clinic. It is imperative to ensure that the woman has understood the circumstances surrounding birth and receives advice regarding future pregnancy interval following ruptured uterus which recommends a minimum inter-delivery interval of 18 to 24 months from the time of the repair until the next conception (ACOG). Advice regarding future mode and timing of birth and appropriate contraception should be given as appropriate.

References

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[Roles and responsibilities of a consultant | RCOG](#)

ACOG. Interpregnancy Care. January 2019

[Interpregnancy Care | ACOG](#)

NG207 [Inducing labour](#) – opens in new tab

[Outcome of subsequent pregnancies post uterine rupture in previous delivery: A case series, a review, and recommendations for appropriate management](#) December 2022.