GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Management of Ruptured Uterus

Specialty:	Obstetrics
Date Approved:	October 2025
Approved by:	Intrapartum Forum
Date for Review:	July 2030

RUPTURED UTERUS - MANAGEMENT

Ruptured Uterus is an obstetric emergency which can occur in any woman, but is more common in multiparous women and those women who have had a previous LSCS who may / may not have an induced labour.

Risk Factors

- High Parity
- Obstructed Labour
- Injudicious use of Oxytocin
- Instrumental birth – rotational forceps
- Uterine manipulation – internal podalic version, manual removal of placenta
- Uterine scar, uterine perforation, hysterotomy
- Previous caesarean section – a classical scar may rupture prior to labour
- Use of prostaglandins for Induction of labour – especially previous LSCS
- Placenta accrete

Classical Presentation

- Onset of continuous severe pain
- Cessation of Contractions
- Vaginal bleeding
- Abnormal CTG
- Blood Stained liquor
- Haematuria
- Loss of station of the presenting part
- Clinical signs of shock due to concealed haemorrhage

Suspect ruptured uterus if there IS: -

- Sudden sharp shooting abdominal pain followed by cessation of uterine contractions or breakthrough pain despite previously effective epidural block
- Vaginal bleeding which can be mild

- Tenderness over the lower abdomen with alteration of the position / station of the presenting part – easily palpable fetal parts per abdomen
- Evidence of fetal distress, maternal shock and collapse can follow quickly

Close observation of labouring women having a trial of labour following LSCS must be ensured. If augmentation of labour is commenced there must be close monitoring, and any deviation reported to medical staff.

Management of RUPTURED UTERUS

1. Emergency bleep '2222' and state 'obstetric emergency' and 'neonatal resuscitation team' on labour ward
2. Inform Labour ward Coordinator
3. Staff required: -
    a. Obstetric Registrar
    b. Anaesthetist
    c. Theatre team
    d. Obstetric SHO
    e. Obstetric and Anaesthetic Consultant
    f. Neonatologist
4. left lateral tilt
5. 100% oxygen
6. Intravenous access secured with 2 large bore cannula
7. Bloods taken for FBC, U&E's, coag study, ROTEM, Venous blood gas Group and X match – minimum 4 units
8. Inform Blood Bank of the emergency and the possible need for more blood
9. Prepare for a laparotomy – using Main theatre staff if required
10. Continuous monitoring of the mother's vital signs and continuous fetal monitoring until laparotomy
11. Check Resuscitaire Equipment and inform NNU
12. Ensure that a relative/partner is informed of condition.
13. Prepare the woman for theatre:- including where possible, consent
14. Transfer woman to Theatre
15. Delay should not occur to await arrival of a Consultant Obstetrician
16. Ensure that documentation is contemporaneous – using a scribe to record events.

Uterine scar dehiscence can be repaired, especially if not extended.

A badly torn uterus can be preserved provided adequate haemostasis is achieved

Hysterectomy, usually sub-total should be carried out without delay if :-

- Extensive uterine tears
- Uncontrolled haemorrhage

Post - op

- Ensure thromboprophylaxis, antibiotics and adequate analgesia
- Complete an electronic datix Form
- Following recovery ensure that the woman and her partner are debriefed
- If women have had a hysterectomy advice regarding cervical smears should be given -**essentially if had a subtotal they should continue to have cervical screening**.
- Advice regarding contraception should include subsequent sterilization, which in extensive tears to the uterus, would be recommended.

A postnatal appointment will be made for the woman to attend the named consultant clinic, where assurances can be made that the woman has understood the circumstances surrounding birth, future pregnancies and appropriate contraception.

Maternity Services

Checklist for Clinical Guidelines being Submitted for Approval by Quality & Safety Group

Title of Guideline:	Management of Ruptured Uterus
Name(s) of Author:	Intrapartum Forum
Chair of Group or Committee supporting submission:	Madhuchandra Dey/Quality and Safety Forum
Issue / Version No:	3
Next Review / Guideline Expiry:	October 2030
Details of persons included in consultation process:	Intrapartum Forum
Brief outline giving reasons for document being submitted for ratification	To update existing policy
Name of Pharmacist (mandatory if drugs involved):	Not applicable
Please list any policies/guidelines this document will supercede:	Management of ruptured Uterus 2020
Keywords linked to document:	Uterus, Ruptured
Date approved by Directorate Quality & Safety Group:	n/a
File Name: Used to locate where file is stores on hard drive	

* To be completed by Author and submitted with document for ratification to Clinical Governance Facilitator


Call for help (2222)
Senior midwives, senior obstetricians, senior anaesthetist and senior neonatology team
Immediate resuscitation
• IV access, full blood count, cross-match four units, clotting and IV fluids if clinically indicated
• Continuous electronic fetal monitoring on transfer to theatre and until commencement of caesarean birth
Expedite birth
• Ensure appropriate senior obstetric, anaesthetic and neonatologist presence
• Perform immediate caesarean birth
• Ensure prompt neonatal resuscitation
• Assess extent of uterine injury
• Determine whether to repair or perform hysterectomy
• Give antibiotics and uterotonics
Post-operative care
• Maternal critical care
• Aim to keep mother and baby together and provide support with feeding and caring for baby (if possible and appropriate)
• Ensure adequate analgesia
• Thromboprophylaxis
• Documentation
• Debrief the woman, partner and clinical team
• Complete clinical incident report