Case Report: Cervical laceration

An unexpected cause of significant PPH following a lower uterine segment caesarean section

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Background

Postpartum haemorrhage (PPH) is a major cause of mortality and morbidity. While the majority of cases are due to uterine atony, this case highlights the importance of the other three “Ts”, in particular genital trauma. Cervical laceration risk factors include cervical cerclage, induction of labour, precipitous labour, vacuum extraction, nulliparity and episiotomy (1).

Case Report

A 31-year-old G2P0 underwent postdates induction at 40+5/40 on a background of macrosomia and polyhydramnios (AFI 29 and EFW 4.6kg). She progressed and was fully dilated 11hr after commencing a syntocinon infusion and cervical ripening with dinoprostone. A vaginal examination performed 1hr later showed signs of obstructed labour and she proceeded to emergency caesarean section.

Case Report - cont

She underwent a routine lower uterine segment caesarean section and a live female was delivered in good condition. The uterus was routinely closed however found to be atonic. Fundal massage and intravenous oxytocics were given. Closure was routine however she continued to have ongoing vaginal bleeding in theatre in excess of 3000mL despite a contracted uterus.

On examination a 7cm cervical laceration extending to the right vaginal fornix was identified as well as a smaller laceration on the posterior vaginal wall which were repaired. The total EBL was 5000mL she was resuscitated with 2 units packed red blood cells, 3 units fresh frozen plasma and 2500mL of colloids intensive care for observation on a syntocinon infusion.

Discussion

Cervical laceration represents significant morbidity associated with vaginal delivery. Though we do acknowledge the cervical laceration may be a surgical complication, it is possible the cervical laceration occurred prior to caesarean section during first or early in the second stage of labour.

Conclusion

There is limited literature on the mechanisms of cervical laceration and which stage of labour they usually occur. Further insight into this may see changes in our intrapartum management to prevent cervical lacerations in addition to identifying potential risk factors.

References