Clinical Practice Guidelines: Obstetrics/Uterine rupture

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<thead>
<tr>
<th>Date</th>
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<tr>
<td>Purpose</td>
<td>To ensure consistent management of Uterine rupture.</td>
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<td>Scope</td>
<td>Applies to all QAS clinical staff.</td>
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<td>Information security</td>
<td>This document has been security classified using the Queensland Government Information Security Classification Framework (QGISCF) as UNCLASSIFIED and will be managed according to the requirements of the QGISF.</td>
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**Uterine rupture** is defined as a tearing of the uterine wall during pregnancy or birth. Whilst the occurrence of uterine rupture is low, it is one of the most life-threatening obstetric emergencies, with a high rate of both foetal and maternal mortality. Uterine rupture should be suspected if there is:\[1\]

- evidence of maternal shock
- difficulty defining the uterus on palpation
- easily palpable foetal parts

Other than a history of Caesarean section or uterine surgery, risk factors include:\[2,3\]

- trauma
- uterine anomalies
- dystocia
- use of uterotonic drugs (induced labour)
- abnormal placentation
- advanced maternal age
- high birth weight \[1,2,3\]

**Clinical features**

**Clinical presentation can vary from subtle to severe:**

- uterine tenderness
- non-reassuring foetal heart patterns
- loss of intrauterine pressure or cessation of contractions
- abnormal labour or failure to progress
- severe localised abdominal pain
- vaginal bleeding
- maternal hypovolaemic shock

**Risk assessment**

- Nil
Note: Officers are only to perform procedures for which they have received specific training and authorisation by the QAS.