

Uterine rupture

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

This guideline outlines the risk factors and management of uterine rupture. We have adopted both the RCOG and NICE guidance listed within the assessment and these should be utilised.

This guideline is for use by the following staff groups:

Obstetric doctors and midwives

Lead Clinician(s)

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Approved by <i>Maternity Governance Meeting</i> on:	24 th October 2025
Approved by Medicines Safety Committee on:	N/A
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This is the most current document and should be used until a revised version is in place	

Key amendments to this guideline

Date	Amendment	Approved by:
15 th Nov 2019	No amendments	MGM
25 th Oct 2025	Document review and update in line with national guidance	MGM

Inclusion statement

We recognise that although our policy uses words such as women/woman, not all birthing people or post-natal parents will identify as such. We encourage all staff to be welcoming of the diversity of our local population, be respectful of preferred language, pronouns, and adapt their communication appropriately. All staff should accommodate mothers and parents with individual needs or disabilities, whether they be physical or not visible, and adapt their care to support them with their pregnancy.

Ockenden Maternity Guidelines Assessment

Is there National Guidance Available for this guideline?	Yes
National Guidance used to inform guideline <i>e.g. NICE/RCOG</i>	Birth after Previous Caesarean Birth (Green-top Guideline No. 45) RCOG Recommendations Intrapartum care Guidance NICE
Does the guideline follow National Guidance if available? <i>If no, what rationale has been used.</i>	Yes
If no national guidance available or national guidance not followed, what evidence has been used to inform guideline.	
Ratified at Maternity Guidelines Forum:	24 th October 2025

Please note that the key documents are not designed to be printed, but to be used on-line. This is to ensure that the correct and most up-to-date version is being used. If, in exceptional circumstances, you need to print a copy, please note that the information will only be valid for 24 hours and should be read in conjunction with the key document supporting information and/or Key Document intranet page, which will provide approval and review information.

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Introduction

Uterine rupture is a rare but serious complication of pregnancy and birth. The incidence is 0.05% of all pregnancies. It should be preventable by careful management and is usually, but not invariably, preceded by significant warning signs. Uterine rupture can occur spontaneously in 3rd trimester or following labour or birth. It may be classified as an incomplete or complete rupture.

Risk factors for uterine rupture

- Uterine scar (be aware this is not always a previous Caesarean) - 1/200 (0.5%) for previous LSCS (RCOG, 2022)
- Short pregnancy interval (less than 12 months since previous birth)
- Obstructed labour—particularly in those who have had a previous vaginal birth
- Macrosomic fetus
- Induction of labour using repeated doses of prostaglandins and/or oxytocin. (Mechanical methods of cervical ripening (e.g., Foleys catheter) are associated with lower risk of uterine rupture than prostaglandins. (RCOG GTG 45, 2022))
- Multiple pregnancy
- Polyhydramnios
- Abruption
- Others - trauma, external version, placenta percreta, uterine abnormalities, e.g.: rudimentary horn.

Signs of Uterine Rupture

Maternal

- Uterine scar pain - antenatally or between contractions if in labour
- Acute onset of suprapubic tenderness
- Tachycardia
- Shock
- Severe abdominal pain antenatally
- If in labour: decrease or cessation of contractions
- PV bleeding/bloodstained liquor
- Haematuria
- If a woman has an effective epidural in situ, this can mask the pain experienced in uterine rupture. Breakthrough pain may be a sign of rupture.
- Scar dehiscence may be asymptomatic in up to 48% of women (RCOG GTG)
- It may be harder to detect a rupture in women with an increased BMI.

Fetal

- The fetal heartrate may alter with a uterine rupture. this can be gradual changes leading to a decompensated gradually evolving hypoxia or in a sudden onset, such as a sudden rise in baseline, decelerations that quickly become chemoreceptor decelerations, or it may present as an acute bradycardia.

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- Any CTG changes during a trial of VBAC especially changes with sudden onset, uterine rupture should be considered as a cause of these changes and escalation should be prompt
- Retraction of the presenting part (moves up out of the pelvis)
- Fetal parts may become more easily palpable

Management

- If suspected antenatally in the community arrange 'critical obstetric emergency which is life threatening' ambulance transfer to Delivery Suite with paramedic
- If suspected while in the hospital:
 - Stop oxytocin if in progress
 - Initiate Obstetric and Neonatal 2222
 - Alert obstetric, anaesthetic and paediatric teams, haematologist & theatre team
 - Out of hours, the on-call Consultant obstetrician must be contacted to attend delivery suite
 - Resuscitate patient using ABC approach
 - airway
 - oxygen
 - left lateral
- IV access large bore cannula x 2 – crossmatch 4 units blood urgently. FBC & clotting screen.
- Fluid replacement – stabilise BP
- Establish fetal condition by continuous monitoring – deliver when mother stable and analgesia is effective (type of analgesia to be decided with timing in mind)
- Prepare theatre for 'crash' laparotomy ± hysterectomy (up to 33% risk following uterine rupture), or repair of the uterus
- Document time to decision to birth interval. Target is <30 minutes when rupture is suspected. (NICE NG 235, 2024)
- Scribe should be allocated so that times and events can be recorded accurately.
- Follow [Postpartum Haemorrhage \(PPH\) including Massive Obstetric Haemorrhage \(Management Of\)](#)
- Patient and birth partners should be kept informed throughout.

Sometimes less acute presentations are diagnosed after a vaginal birth. Manage individually with direction from the consultant on-call. Initial conservative management may be appropriate in a stable patient.

It is not the practice in this unit to routinely examine the lower segment by vaginal examination following a successful vaginal birth after a previous caesarean section.

A Datix incident report should be submitted immediately following the event.

Women with a uterine scar (either previous uterine surgery or caesarean)

Antenatal management including documented plans for birth and induction involving a documented discussion with an experienced obstetrician (ideally a consultant but at least registrar).

Attentive intrapartum fetal and maternal surveillance in a setting where the baby can be delivered within 30 minutes.

Involvement of an experienced obstetrician in intrapartum decisions.

Information about relevant symptoms to be reported to those caring for them in labour.

If a uterine rupture has occurred, vaginal birth should not be encouraged in any subsequent pregnancies. If preference is for a vaginal birth, thorough counselling from early pregnancy should take place with a consultant obstetrician, and a consultant midwife if appropriate. All discussions in pregnancy should be clearly documented on the Badgernet record.

Post Birth Information for woman

The urgency around the event of uterine rupture can be traumatic, and it is important for the woman and her birthing partners to be given the opportunity to ask questions and raise any concerns they have before they are discharged home. This discussion should also include implications and choices for future pregnancies. This should take place prior to discharge from postnatal ward. A discharge letter should be completed. (Consultant)

Mental wellbeing support should be discussed.

Provide information and written documentation on uterine rupture, future pregnancy planning and recommend early consultant-led review in next pregnancy. (RCOG GTG 45, 2015)

References

- Royal College of Obstetricians and Gynaecologists (RCOG). (2015). *Birth after previous caesarean birth (Green-top Guideline No. 45)*. [online] Available at: <https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/birth-after-previous-caesarean-birth-green-top-guideline-no-45/>
- National Institute for Health and Care Excellence (NICE). (2023). *Intrapartum care: care of healthy women and their babies during labour (NICE guideline NG235)*. [online] Available at: <https://www.nice.org.uk/guidance/ng235/chapter/Recommendations>

Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: <i>(Responsible for also ensuring actions are developed to address any areas of non-compliance)</i>	Frequency of reporting:
	WHAT?	HOW?	WHEN?	WHO?	WHERE?	WHEN?
	Uterine rupture occurrence and management	Datix	Adhoc	Governance team	M&N/QSRM	Adhoc

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Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Maternity Governance Meeting
Maternity Guidelines Committee

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Maternity Quality Governance Meeting