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Correspondence

Response to Correspondence "Asymptomatic uterine rupture detected at cesarean section: Some different viewpoints"

Dear Editor,

We appreciate the opportunity to address the comments and concerns raised by Dr. Matsubara about our previous report [1]. We agree with his comments and would like to reply to his questions.

To answer his first question, she did not complain of uterine contractions and was not at risk of preterm birth. Thus, Matsubara's hypothesis that the presence/absence of uterine contractions may affect rupture extension might be reasonable. In addition, the smooth muscle tissue around the rupture had become hardened granulation tissue. This might be one of the reasons preventing the progression of the rupture.

The second question was whether the rupture was covered by the intestine/mesentery/omentum. The rupture was actually covered only partially by the right fallopian tube, mesosalpinx, and partial omentum. Matsubara's concept of "masked uterine rupture" is that the rupture is tightly covered by other abdominal tissues [2]; therefore, our case did not completely match his concept. However, our case's partial adhesion might have prevented the enlargement of the rupture to some extent.

To answer his final question, we always tend to check the fundus and the back of the uterus by extracting the uterus from the abdominal cavity. However, as Dr. Matsubara mentioned, it is sometimes difficult to check the fundus due to severe adhesion around the uterus. If these conditions were exhibited in the present case, we could not have detected the rupture, and perhaps, the cesarean section would have been finished without repairing the rupture. If the repair is not performed, some patients with the condition may remain asymptomatic and the rupture may spontaneously close. However, other patients suffer from several complications. Generally, because of the reflux of menstrual blood from the rupture hole into the abdominal cavity, symptoms including dysmenorrhea, chronic pelvic pain, postmenstrual spotting, and prolonged menstrual bleeding may develop. Furthermore, this blood accumulation may cause deterioration of uterine mucus quality, block the passage of spermatozoa, or inhibit the implantation of fertilized eggs, inducing secondary infertility [3,4].

We thank Dr. Matsubara for his interest in our case report. As previous reports mentioned, asymptomatic uterine ruptures actually exist [1,5]. Among them, there might be cases with masked uterine rupture, as Matsubara mentioned. Hence, obstetricians should pay attention to the potential risk of this condition.

Conflicts of interest

The authors declare no conflict of interest.

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