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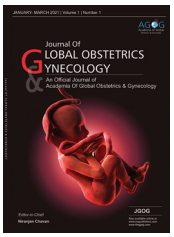
Case Report



Trapped in the Scar: A Rare Case of Fetal Head Impaction in Previous Scar of a Second Trimester Abortion

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ABSTRACT

Second-trimester abortions, especially in women with a history of cesarean delivery, carry a heightened risk of complications. One rare but serious complication is the impaction of the fetal head into a previous cesarean scar, a condition that may mimic uterine rupture or incomplete abortion and poses significant diagnostic and management challenges. We report a case of a 32-year-old multiparous woman with a prior lower segment cesarean section who underwent induced abortion at 14 weeks for intrauterine fetal demise. Following Foley's catheter induction, the patient expelled only partially. Ultrasound revealed a retained fetal head impacted within the anterior lower uterine segment at the site of the previous cesarean scar. Surgical intervention through laparotomy confirmed fetal head entrapment in a dehiscent scar. The fetus was extracted, and uterine repair was performed without complications. An impacted fetal head in a cesarean scar during a second-trimester abortion is a rare but potentially life-threatening complication. Early recognition and timely surgical management are essential to prevent morbidity. A detailed obstetric history and vigilant monitoring can significantly reduce risk in high-risk patients.

Key words: Second trimester abortion, Previous caesarean scar, Intrauterine fetal demise

INTRODUCTION

Second-trimester induced abortions can occasionally lead to rare yet serious complications, particularly in individuals with a prior history of uterine surgery like cesarean section. One such uncommon event is the impaction of the fetal head within a previous cesarean scar, a condition that may clinically resemble incomplete abortion or uterine rupture, thereby complicating diagnosis and management.

With the increasing rate of cesarean sections globally, complications related to uterine scars are becoming more frequent. Abnormal placental attachment, thinning or partial opening of the scar, and difficulty in fetal expulsion can contribute to fetal head impaction – often unexpectedly – during termination procedures.

Timely identification of this complication is essential to minimize maternal risk, safeguard future fertility, and avert uterine rupture. This report discusses a rare clinical scenario of fetal head impaction in a cesarean scar during a second-trimester medical abortion, emphasizing the critical role of clinical awareness, imaging support, and prompt surgical intervention in such high-risk cases.

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CASE REPORT

A 32-year-old female, G2P1L1 with a previous 1 Lower Segment Cesarean Section with 14 weeks of gestation, came to the emergency ward of our hospital with an ultrasonography suggestive of intrauterine fetal demise. The patient is registered at a tertiary care hospital and has 2 previous antenatal care visits. She had complaints of per vaginum spotting on and off for 2 days and generalized abdominal pain for 2 days. The patient has a history of pregnancy-induced hypertension in a previous pregnancy, but is not on any antihypertensives at present. The patient is a known case of hypothyroidism currently on T. Thyronorm 100 mcg for 2 years. The patient has no other major medical or surgical illness. No history of previous blood transfusions, drug allergy.

All routine investigations were sent, blood type and cross was done, and intravenous (IV) antibiotics were given along with tetanus toxoid. A high-risk consent and consent for a Foley's catheter induction were taken, and the patient was induced with a Foley's catheter. The Foley's bulb was expelled after 12 h with

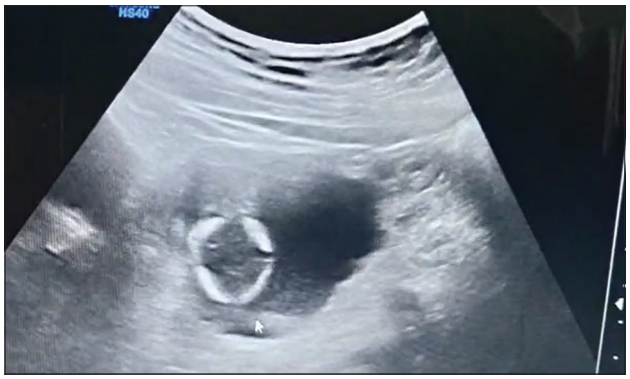

Figure 1: Ultrasound showing an impacted fetal head

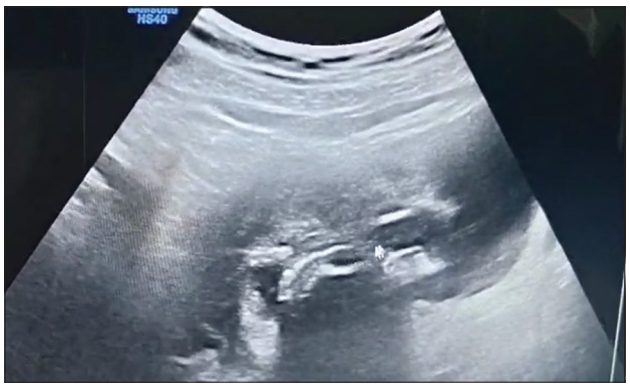

Figure 2: Ultrasound showing impacted fetal spine

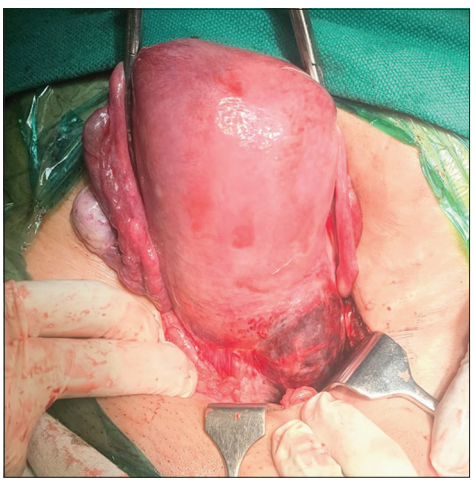

Figure 3: Impacted fetal parts in scar sealed by hematoma

increasing traction. The patient expelled a macerated fetus in an incomplete and piecemeal fashion. With fetal parts delivered separately. Post-procedure ultrasonography was done to look for retained products of conception.

Ultrasonography suggestive of ? Uterine scar dehiscence likely at the previous scar site with expulsion of the amniotic sac with a partially macerated fetus in the uterovesical pouch (Figures 1 and 2).

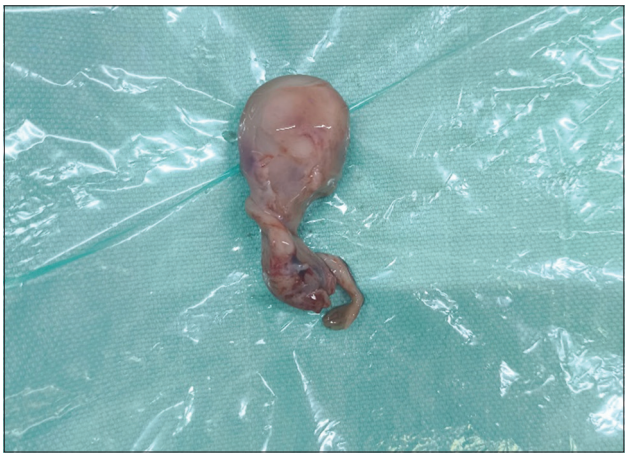

Figure 4: Fetal part retrieved

After giving their well-informed, written, and valid consent, the patient was taken up for emergency exploratory laparotomy.

Intraoperative findings

A 2 cm × 2 cm-sized mass seen at the left end of the uterine scar is sealed off by a hematoma (Figures 3 and 4).

Operative steps – the uterovesical fold of the peritoneum is dissected, and the bladder is pushed down. Serosa over the mass separated. Fetal parts and blood clots were evacuated.

A defect of size was 3 cm × 2 cm residual in the scar. Gentle curettage of the cavity was done, and the defect was closed with Vicryl 2–0 in a continuous interlocking manner. Hemostasis checked and confirmed. The patient tolerated the procedure and anesthesia well. The patient was discharged after 5 days of IV antibiotics and check dress.

DISCUSSION

Fetal head impaction within a previous cesarean scar during a second-trimester abortion is an extremely rare but clinically significant complication. The rising incidence of cesarean deliveries globally has been paralleled by an increase in the prevalence of abnormal placentation and other scar-related complications in subsequent pregnancies or terminations.[1] In the present case, the fetal head became impacted within the niche of a previous lower uterine segment scar, complicating the process of abortion and necessitating surgical intervention.

Second-trimester abortions are associated with a higher risk of complications compared to first-trimester terminations. In women with a prior cesarean section, the risk of abnormal implantation and structural alterations in the uterine wall must be considered during pre-abortion planning.[2] The scar niche, or cesarean scar defect, is a known entity that can result in incomplete healing of the myometrium, creating a potential site for fetal impaction or adherence during uterine evacuation.[3]

In this patient, the presence of a prior cesarean section likely predisposed her to this rare complication. The fetal head, being

the most rigid part of the fetus, can become lodged within the weakened scar tissue, particularly if there is premature rupture of membranes or if misoprostol-induced contractions cause uneven expulsion forces. This situation can mimic incomplete abortion or, in more severe cases, even uterine rupture.[4]

Ultrasound plays a critical role in detecting retained products of conception; however, in such rare cases, the diagnosis may not be apparent until surgical evacuation is undertaken. Hysteroscopy and ultrasound-guided evacuation may help in identifying abnormal fetal positioning or scar defects.[5] In this case, piecemeal expulsion and failure of the fetal head to deliver prompted surgical exploration, revealing the impacted head in the scar.

Management requires a multidisciplinary approach involving obstetricians, radiologists, and anesthetists. Gentle surgical removal with careful uterine repair, if necessary, is key to preventing further trauma to the uterine wall. A long-term follow-up is essential, especially if future fertility is desired, and patients should be counseled on the potential risks in subsequent pregnancies, including scar ectopic pregnancies and uterine rupture.[6]

This case underscores the importance of heightened vigilance in women with prior cesarean deliveries undergoing second-trimester terminations. Individualized counseling, imaging, and surgical preparedness can mitigate maternal morbidity in such scenarios.

CONCLUSION

Impaction of the fetal head in a previous cesarean scar during second trimester abortion is a rare but significant complication that requires prompt recognition and skilled surgical management. This case highlights the importance of careful pre-procedural assessment in women with uterine scars, the need for preparedness for intraoperative challenges, and the value of a multidisciplinary approach to ensure optimal maternal outcomes. Vigilance and individualized management strategies can help prevent morbidity and improve safety in similar scenarios.

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