

A rare presentation of post hysterectomy retroperitoneal haematoma

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Post-hysterectomy adynamic ileus, which improved after spontaneous resolution of peri renal retroperitoneal haematoma, is reported.

Introduction

Retroperitoneal haematoma occurring after an abdominal hysterectomy is a rare post operative complication, which presented in our case with gross abdominal distension due to ascitis induced by peritoneal irritation from the escaping red blood corpuscles RBC resulting into adynamic ileus. The hematoma showing spontaneous resolution on conservative management is thus reported.

Case

A 52 year old lady presenting with amenorrhea and pelvic pain for 4 months with grossly enlarged uterine size reaching nearly up to the xiphisternum was diagnosed as molar pregnancy. She was hypertension with Blood pressure recordings of 190/ 120 mm of Hg and was noticed develop dyspnoea, so an emergency total abdominal hysterectomy with with bilateral salphingo-oophorectomy was done for mole in situ (*Fig. 1*) as her other parameter such as Liver Function Test was normal. Intraoperative Blood transfusion was not required as blood loss was not excessive.

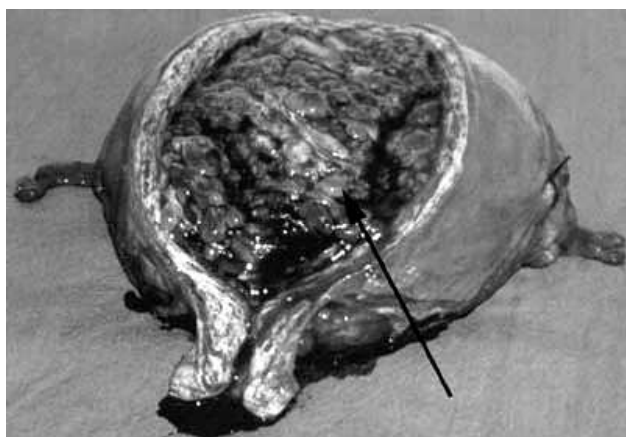


Fig. 1 Hysterectomy specimen of the mole.

Two days later she looked pale and after two units of blood transfusion was found to develop jaundice (serum bilirubin 50 mmol/L), bilateral pitting leg edema and huge abdominal distension with gross ascitis.

X ray abdomen showed jejunal distension and gas in large Bowels although the bowel sounds were heard.

USG demonstrated fluid collection and fibrinous exudates separating the ascitic fluid into multicystic areas however CT scan (*fig 2 and 3*) in addition to gross ascitic fluid depicted, right sided retroperitoneal haematoma reaching almost up to the kidney which was seen displacing the right ureter to such an extent that both the ureters were noted to lye at different planes. While both the kidneys and ureters were well visualized normally and presumed to be functioning well. To relieve her from dyspnoea a drainage tube was kept under fluoroscopic guidance and 700cc of slightly hemorrhagic ascitic fluid was drained.

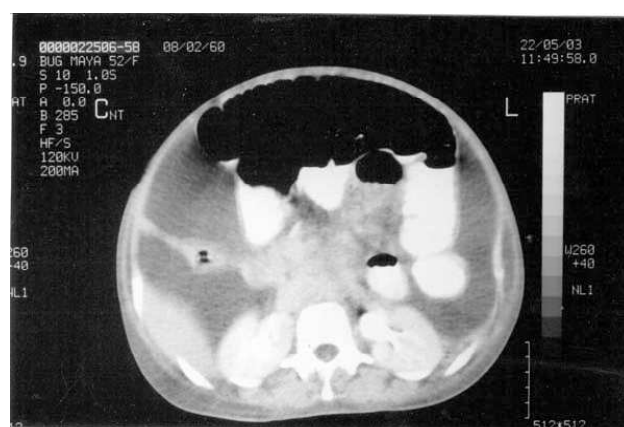


Fig. 2 CT scan showing ascites and gaseous distension of bowel loops.

As discomfort increased with no improvement on pain, re-laparotomy was done on the 10th postoperative day. This allowed drainage of slightly blood tinged 1.5 L of ascitic

post hysterectomy retroperitoneal haematoma



Fig. 3 CT scan showing retroperitoneal hematoma displacing the right ureter anteriorly. Right ureter is prominent compared to left side.

fluid. The intestines were bloated but there were no features of obstruction. A large 18 x 20 x 6-7 cm retroperitoneal haematoma was noted in the abdomino-pelvic wall on the right side, which was left undisturbed. Abdomen was closed leaving in a drain after peritoneal lavage.

This woman had unrecordable BP during operation and remained so for 4 hours post operation for which she was maintained on dopamine along with ventilatory supports and cared in the intensive care unit ICU. Extubation was done on 3rd day. Albumin 50 ml was infused for hypoalbuminaemia and 5 pints of blood were also transfused for post operative anaemia (Hemoglobin 6 gm %) and also to improve the gross oedema of legs. The abdominal distension was observed to improve after 7th post operative day (laparotomy) when she tolerated oral liquid diet. Wound was cleaned; the drains abdominal and tension suture were appropriately removed accordingly.

Meanwhile the histology revealed invasive mole. Urinary HCG were negative in three consecutive weeks. Repeat CT was normal.

Discussion

Postoperative abdominal distension, unlikely due to aggressive infections or obstructions is usually seen to respond to the conservative management in due course of time, which in this case, failed to do so until the ascitis was abdominally drained.

We were reluctant to reopen this case in the first place, as there were insufficient evidences regarding vault hematoma (internal pelvic examination was normal) or formation of dense band of adhesion that could supposedly have been a contributory cause of abdominal distension. Further more the doubts regarding the likely diagnosis of bowel

obstruction were being ruled out by the visualization of normal peristalsis of the bowels in the USG. At this particular point CT scan was considered an alternate option, as the patient was too frail to be able to stand for the Erect X ray of the abdomen that probably could have best demonstrated fluid level if present, which is a feature of obstruction. However the culprit after CT Scan was known to be a Flank or peri renal retroperitoneal haematoma zone 2 (other Types are centromedial Zone 1 and pelvic Zone 3) which does not need to be explored until there is acute expansions of hematoma as evidenced by contrast studies of kidneys showing non visualization of either kidney or extravasation of the contrast.

Here laparotomy was done, not to explore the hematoma but to ensure what might have been the other possible causes of the ascites, apart from hypoalbuminaemia, which was duly treated.

Even the cause of ascitis was later attributed to be due to hypoalbuminaemia and retroperitoneal haematomas^{1,2}. It has been suggested that the transudation of RBC from the hematoma across the peritoneal membrane and the intraperitoneal blood thus collected is sufficient enough to produce peritoneal irritation thereby provoking ascitis, which unfortunately was massive in this case.

Going back through the operative notes in our case that mentioned the slippage of the right ovarian pedicle realized that the retroperitoneal hematoma must have been due to minor venous leak that was triggered by hypertension or vasculitidis which unexplored found it's way to ultimate resolution.

We waited for spontaneous resolution of this huge retroperitoneal haematoma with the firm belief that abdominal distension would soon diminish with the subsidence of the haematoma and so was the response.

Retroperitoneal hematoma is often a fear to the Endoscopic Surgeon and as it is equally with the Urologist, however only fewer complications from gynecological surgery has been brought forward.³⁻⁶

Our case despite of the extensive retroperitoneal haematoma advancing up to the kidney survived although associated with severe jaundice, gross leg oedema, ascitis, abdominal distension and ileus. While there are scaring reports of obstetric deaths from retroperitoneal haematoma and except for one case that followed bleeding from missed uterine angle at caesarean, rest were from spontaneous rupture of aneurism of renal, splenic, iliac and inferior epigastric veins. Among all of them, one of the death was quiet unsuspected as it occurred after the vaginal delivery where the postpartum blood loss noted was only 50 ml (Why do mothers die? Confidential enquiry to maternal deaths.) At times extension of retroperitoneal hematoma up to the kidney has been cited under incomplete uterine rupture.⁷

Conclusion

Retroperitoneal haematoma, an unforeseen post operative complications presenting with ascitis and adynamic ileus may be awaited for spontaneous regression in some cases like ours.

References

1. Myerscough. Maternal injuries. In: Munro Kerr's Operative Obstetrics. Tenth Edition. New Delhi. AITBS publishers. 1992. 441-467.
2. Dina El Mowafi. Michael P Diamond. Adhesion and obstruction after gynaecological surgery. In: J Studd eds. Progress in obstetrics and Gynecology, 14th edition. . Edinburgh. Churchill Livingstone. 2000. 413-427.
Zweigel D, Thiele H, Schworm HD. Injuries of the large vessels caused by laparoscopy. *Zentralbl Gynakol.* 1987;**109**:673-8.
3. Querleu D, Dargent D, Ansquer Y, Leblanc E, Narducci F. Extraperitoneal endosurgical aortic and common iliac dissection in the staging of bulky or advanced cervical carcinomas. *Cancer* 2000; **88**:1883-91.
4. Lev-Gur M, Patel S, Greston WM, McGill F. Pararenal hematoma as a complication of vaginal hysterectomy. A case report. *Reprod Med* 1987;**32** :68-71.
5. Brown CF, Mashini IS, Turner WA, Gallup DG. Retroperitoneal hematoma: an unusual complication of cold knife conization of the cervix. *Obstet Gynecol* 1986;**68**: 66S-67S.
6. Weinberg MS, Quigg R, Krane RL. Retroperitoneal bleeding: hidden culprit of acute renal failure. *Urology* 1983; **21** :291-4.
7. Cederqvist LL, Birnbaum SJ Rupture of the uterus after midtrimester prostaglandin abortion. *J Reprod Med.* 1980; **25**:136-8.