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Conservatively managed puerperal retroperitoneal haematoma

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ABSTRACT

Puerperal haematoma occurs in 1/300 to 1/1500 deliveries. A characteristic presentation of post-delivery collapse with signs of internal haemorrhage and clinically palpable left-sided pelvic mass causing gross hydronephrosis on ipsilateral side was confirmed as a case of retroperitoneal haematoma on ultrasound, which resolved completely on conservative management.

Keywords: puerperal haematoma; retroperitoneal haematoma; post-delivery collapse.

INTRODUCTION

Haematoma may develop following spontaneous or operative delivery as a sequelae to blood vessel injury, as there is a glacier-like movement of the mucous membrane upon the subjacent tissue, the occult bleeding being missed in the absence of overt genital injury; hence, the damage may remain undetected till the patient collapses in the third stage.

The reported incidence of puerperal haematoma is 1/300-1/1500 deliveries.[1] Due to sloughing of the vessel that has sustained prolonged pressure necrosis, haematoma may sometimes reveal later in puerperium.

Retroperitoneal (supralevator or subperitoneal) haematoma that has extended to the base of broad ligament to enter the retroperitoneal space can present abdominally as blood collection lifts the peritoneum. Since it is very difficult to enter the retroperitoneal space, they are managed conservatively.

THE CASE

Mrs. A. Shrestha (IP No. 196167) primigravida was admitted to TUTH on 2nd December 1996 as a case of term pregnancy with breech presentation and grossly hydrocephalic foetus. She had assisted vaginal delivery with Fresh Still Birth (FSB)

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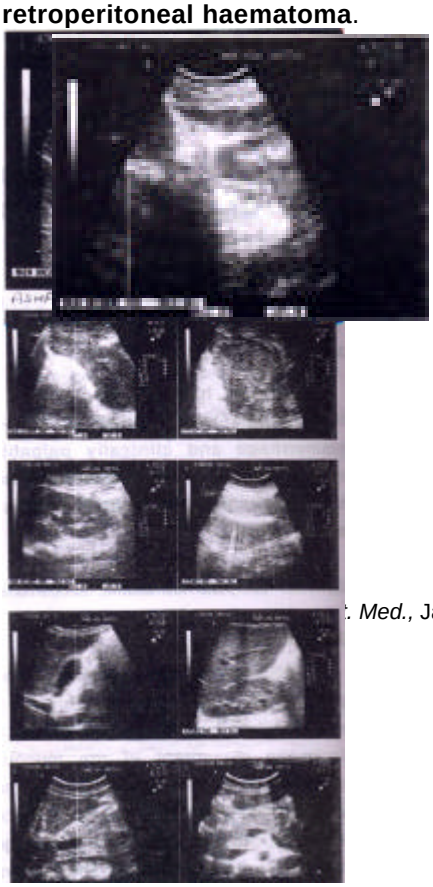
male of birthweight 2.8 kg facilitated by abdominal craniocentesis. Three hours after the procedure, the patient was in shock with no palpable peripheral pulse and blood pressure was unrecordable. General condition improved somewhat after transfusion of 2 units of blood. She was stable for the next 3 days of hospitalisation and was discharged on the 3rd post partum day to be readmitted again after four days due to abdominal pain, vaginal bleeding and fever with chills and rigor.

On examination, she was pale, febrile with low BP 70/40 mm of Hg. Uterus was 20-22 weeks size of pregnancy which was pushed to the right side by a firm mass 6X5 cms on the left side. Bimanual examination revealed shortened vaginal canal and even the introduction of a single finger was impossible.

USG confirmed a mass 8X9 cms on the left side extending up to the left iliac fossa. USG guided aspiration showed frank blood. It was diagnosed as a case of **retroperitoneal haematoma**.



Her Hb which was 7.8 gm% was corrected with transfusion of 2 units of blood. She was febrile (temp. 104^{o} F), TLC was 26,000, high vaginal swab culture sensivity (HVS) revealed klebsiella, urine routine microscopic E. scherichia Coli and stool routine microscopic Giardia. Central venous pressure (CVP) line was kept on 23rd because of severe diarrhoea and very low BP - 70/40 mm of Hg. With the help of suitable antibiotics: CP 20 lacs 4 hourly, ciprofloxacin infusion 12 hourly and metronidazole 500 mg 8 hourly, fever subsided by 29/9/053 i.e. after 14 days of admission and was finally discharged on 8/10/053 after 4 weeks of admission. The reports of three USG readings are as follows:

15/0/053: Echo poor area noted along the plane of left psoas muscle. Left kidney was grossly hydronephrotic. Aspirate from the suspected area thought to be retroperitoneal haematoma contain frank blood.

21/9/053: Uterus bulky with a mass 7X4X7.5 of mixed echogenicity in the pelvis is continuous with parauterine area.

23/9/053: Complete resolution of haematoma. Uterus showed features of endometritis.

DISCUSSION

This patient had post partum collapse following difficult abdominal cephalocentesis for aftercoming hydrocephalic head. Hence, ultrasound-guided procedure would have been safer.[2] Since this was initially missed as a case of retroperitoneal haematoma, one

should suspect this condition whenever there is obstetrical collapse in the absence of visible genital tract bleeding.

The management aspect of puerperal retroperitoneal haematoma is dealt of the time most conservatively as it is difficult to enter the broad ligament with ureters in close proximity. At the most one can drain the collection but blind sutures are avoided.

Chin and colleague (1989)[3] have described angiographic embolization for intractable puerperal haematomas, while Alvarez and coworker (1992)[4] have reviewed the indication of angiographic embolization.

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