

# A Rare Case of Retroperitoneal Haematoma Complicating Pregnancy

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## Abstract

Nontraumatic retroperitoneal haemorrhage is uncommon in pregnancy and the diagnosis is often difficult due to gravid uterus. The high mortality rate associated with this condition is correlated to the rapidity of haematoma formation. This case is presented here due to its rarity and fatal outcome as symptoms from a retroperitoneal haematoma are usually not impressive until the sudden onset of hypotension or shock.

## Introduction

Idiopathic retroperitoneal haematoma is a rare condition which affects apparently histologically normal retroperitoneal blood vessels and is characterized by sudden onset of bleeding from splanchnic vessels into the retroperitoneal space. It is an acute, life threatening condition most dangerous in pregnancy due to diagnostic difficulty as the haematoma is masked by the gravid uterus.

## Case Report

Mrs. Shabana 28 yrs. old housewife G<sub>3</sub>P<sub>2</sub>L<sub>2</sub> with 35.4 wks. of pregnancy with previous LSCS with complete placenta previa was admitted for elective caesarean section at 37 wks. of gestation. She was asymptomatic on admission with no history of any major medical or surgical illness. She had first full term normal delivery and second full term caesarean section.

On admission vital parameters were within normal limits and no abnormality detected on systemic examination.

Abdominal examination – Midline vertical scar of previous caesarean section. Uterus corresponded to 36 weeks of gestation. Foetal heart sounds were 142/min. and regular. Routine ANC investigations were within normal limits. Colour Doppler revealed 35

weeks of pregnancy with complete placenta previa with evidence of placenta accreta on the anterior wall. The period of two days was uneventful. On day 3 of admission at 7.30 AM. She had severe breathlessness and epigastric pain. She was markedly pale, feeble peripheral pulsation with systolic blood pressure of 80 mm Hg. Abdomen was distended with tympanic note especially over epigastric region. Uterine contour was maintained and uterus was relaxed. Foetal heart sounds were absent. P/S examination no e/o bleeding or leaking. Emergency investigations – coagulation profile deranged. ABG – severe acidosis. Urgent USG was advised. Since patient was gasping intubated immediately and resuscitative measures started. Nasopharyngeal suction had copious frothy material. Blood transfusions started. Differential diagnosis which we thought were pulmonary embolism or amniotic embolism. In spite of resuscitative measures the pt. couldn't be revived and was declared dead at 8.45 a.m. (within one hour of presentation). Post mortem revealed a huge left sided retroperitoneal haematoma weighing around 1.2 Kg. (2.5 litres) in the pelvis extending from mesenteric base left pararenal space and paracolic gutter behind rectum. Gravid uterus with intact scar and adherent placenta. No retro placental clot.

## Discussion

The incidence of retroperitoneal haematoma complicating pregnancy is not known. Till now only 33 cases have been reported in literature and mortality rate is very high. Idiopathic retroperitoneal haematoma was first described by Barber in

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1909 who labelled it as “Abdominal Apoplexy”.<sup>1</sup>

In the majority of the cases the cause can be identified and may be due to trauma, ruptured aneurysm, ileopsoas muscle bleeding,<sup>2</sup> spontaneous rupture of a renal angiomyolipoma<sup>3</sup> or anticoagulant therapy. Specific causes from obstetric point of view are trauma (blunt/penetrating), inadequate haemostasis at the time of caesarean or rupture of scar during a trial of labour. However there are cases in which no definite pathology can be found as was the case with our patient. Patients usually present with abdominal pain, nausea and vomiting. Examinations reveals signs of hypovolaemic shock, ileus and tender mass in the abdomen and flanks.<sup>5</sup> CT scan is the principal method of diagnosis. It helps in establishing the site, size and the possible underline cause. Management depends upon the stability of the patient and size of haematoma. If haematoma is small it can be observed with arteriography and injection thrombin. Unstable patients require immediate laparotomy with evacuation of haematoma and ligation of bleeding point and/or ligation

of hypogastric vessels on both sides. Percutaneous transcatheter embolisation wherever facilities are available is also an option. The only way to avoid a fatal event is to know and think about this rare but important complication that may occur during pregnancy or after delivery.

#### References

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#### POLYCLINICS IN LONDON

The essence of the reform was to replace a polyclinic model with general (i.e., family) practitioners, as in the UK. Now, we are watching with interest the same process in reverse: general-practice surgeries in London are to be replaced with a network of polyclinics, as proposed in A framework for action, led by Ara Darzi. The reaction to the proposal was somewhat negative because of, among other things, the view that polyclinics had been discredited in Soviet Russia. Fedanova, provided us with the results of a recent audit, which showed that 96% of patients see a district doctor *without* appointment on the day of their choosing. Patients might have to wait, but 88% will have been seen within an hour. Specialists will see their referrals within 10 days. 95% of chest radiographs are done on the day they are requested. Complex investigations are usually completed within 10 days.

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