HOEMOPERITONEUM IN PREGNANCY

by

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The following case seems sufficiently interesting to be recorded.

Mrs. B. K., aged 23 years, was first seen on 17-11-61 for a routine antenatal check up. Her last menstrual period occurred on the 14th of September, 1961.

General health was satisfactory. B.P. 120/80 mm. of mercury. Pulse rate 82 per minute. Upper limit of the uterus was 1" above the symphysis pubis, cervix soft, uterus uniformly enlarged and soft.

Obstetric history. Para 3 + 0. All normal full-time. The last child-birth was about 2 years ago.

At about noon of 18-11-61, the patient complained of vaginal bleeding with pain in lower abdomen. A slow vaginal ooze continued till about 4 p.m. when she had acute pain in the lower abdomen with a gush of vaginal bleeding and the patient was rushed to a nursing home.

An examination at 6-30 p.m. the same evening revealed the following:

The patient was in acute distress, moderately anaemic, pulse rate 120 per minute, B.P. 140/80 mm. of mercury.

Abdomen tender below the umbilicus, uterus was tender, enlarged, its upper margin being about 4½" above the symphysis pubis, i.e. there was an enlargement of about 3½" since she was examined first about 24 hours previously. Cervix was closed, there was a slow trickle of blood vaginally.

An immediate laparotomy was decided because of the clinical condition of the patient, sudden enlargement of the uterus with pain and tenderness, with a closed cervix.

The first finding on opening the abdomen was the presence of fresh dark blood in the peritoneal cavity amounting to about 6 oz. Uterus was unformly enlarged, of normal colour and consistency, without any evidence of sub-peritoneal haemorrhage or ecchymosis anywhere. Ovaries and fallopian tubes were normal. The fimbriated end of the left fallopian tube was found to be moist with liquid blood. This was mopped away when blood was seen coming out of the left tube again, especially on milking the tube. Both surfaces of the uterus were uninjured. Spleen and other abdominal viscera on examination did not suggest any abnormality.

A low incision was made on the uterus which was full of blood clots. The placenta was attached to the anterior wall rather to the left side, and behind it were two blood clots of about ½" x ½" in size. There was no palpable dilatation of the medial end of the left fallopian tube or any suggestion of cornual dilatation on any side. The foetus was of the size of about 12 weeks. Blood clots and products of conception were removed and uterus closed.

Before closing the abdomen, ovaries, tubes, both surfaces of the uterus, broad ligaments and abdominal viscera were again examined. There was no further collection of blood.

Post-operative period was uneventful. There was no rise of temperature and abdominal wound healed by first intention.

Discussion

Presence of free blood in the abdominal cavity naturally raises suspicion of injury to different structures or of ectopic gestation. Repeated examinations failed to reveal any evidence of injury. There was no haematoma of the corpus luteum in either ovary. The other possibilities which can be taken into consideration seem to be: (1) Early toxaemia, causing retroplacental haemorrhage

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which ploughed through the uterine muscle and caused intra-peritoneal haemorrhage. This appears to be unlikely, as the uterine surface looked absolutely healthy. Of course, no histological section of the uterine muscle and placenta was done but operative findings were very much against this diagnosis. (2) Gestation in the left fallopian tube which aborted through the abdominal ostium. The points against it are: (a) There was no evidence in the fallopian tube, peritoneal cavity or in the collected blood, of any product of conception or of a mass suggestive of tubal mole. The tube appeared healthy and normal.

(b) It may be argued that there may be practically no evidence in the fallopian tubes excepting histological examination when the ovum or mole is completely extruded from the tube. Assuming that a tubal pregnancy coexisted in this particular case, it has to be accepted that the uterine pregnancy was of 12 weeks' duration (corroborated by foetal size). A tubal pregnancy of corresponding duration must have left some macroscopic evidence in or around the tube or in the peritoneal cavity. There may not be any evidence if the tubal pregnancy occurred at a later date, after the uterine pregnancy, i.e. a case of superfoetation, which is much too rare to be taken into consideration.

(3) Rupture of a vein in the broad ligament and ovarian haematoma were ruled out by careful examination. The uncomplicated recovery of the patient after evacuation of the uterus also rules out their existence.

(4) The only other possibility is regurgitation of the uterine bleeding through the left fallopian tube. A few drops of menstrual blood may occasionally be found in the pouch of Douglas at laparotomy after a menstrual period. Jeffcoate says, "Retrograde menstruation is a common phenomenon as can be seen during laparotomy. It is said to be more common when the uterus is the seat of myomas or when it is retroverted." But it is very unusual to find 6 ozs. of free blood into the peritoneal cavity by retrograde flow through the tube. The insertion of the placenta to the left side of the anterior wall of the uterus, high tension inside the uterus due to collection of blood and a closed cervix, and the appearance of blood from the left fallopian tube on milking the tube contribute largely to this conclusion.

Perhaps the method of collection of blood in the peritoneal cavity in this case is somewhat similar to that of Sampson's theory of Transtubal Regurgitation of menstrual blood as a causative factor of endometriosis.

The author will be grateful to be informed of similar findings by any other surgeon.

Summary

A case of haemoperitoneum due to transtubal regurgitation of blood from a pregnant uterus has been reported.

Acknowledgment

The author wishes to thank Dr. Satis Chandra Dutta, M.B., Dr. B. Bhattacharjee, D.A., and Dr. M. Bhattacharjee, D.G.O., for their help.

Reference

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