

SECONDARY POST-PARTUM HAEMORRHAGE

by

BILQUES JAMEELA*

and

WAZIRA KHANUM**

Introduction

Clinical experience shows that secondary postpartum haemorrhage is still a hazard in obstetric practice. Most obstetric textbooks dealing with the subject briefly, state that the haemorrhage is usually due to the retained fragments of placenta which should be removed surgically.

Moir (1964) devotes a little more space to it and suggests that, although retention of portions of placenta is the most common cause other causes are retention of blood clots and pieces of membrane, backward displacement of the uterus, a submucous fibroid and in later cases chorioepithelioma.

McIntyre (1949) and Theobald (1950) make brief mention of it in papers dealing with obstetric haemorrhage in general. Both suggest that bleeding is usually due to retention of placental fragments and recommend exploration of the uterus and removal of the pieces.

In view of possible increase in the frequency of secondary postpartum haemorrhage, especially in cases of home delivery it appeared that review of this subject might be appropriate (Agarwal and Amrit Kaur 1979).

Material and Methods

Seventy-five cases of secondary postpartum haemorrhage were collected from January 1976 to February 1978. Haemorrhage occurred between 10 hours and 30 days after normal delivery.

Out of these 75 cases, 70 were admitted in the hospital as emergency cases following delivery at home. Only 5 cases having delivered in the unit were readmitted. Examination seldom revealed a definite cause for the bleeding although a number of cases with bulky uterus and widely open cervix during second week puerperium or later gave a strong indication that something was retained inside.

Results

TABLE I
Day of onset of bleeding

Total cases	1-7	Day 8-14	Day 15-21	Day 22+Day
75	20 (26.6)	30 (40.0)	23 (30.7)	2 (2.6)

Discussion

Retention of fragments of placenta is an important cause of secondary postpartum haemorrhage. Table I shows that time of onset of bleeding is variable. Maximum cases are in 2nd week. 70 cases were treated surgically and 5 conservatively as shown in Table III. The currettings of surgically treated cases were subjected for histopathological examination and placen-

*Assistant Professor.

**Associated Professor.

Government Medical College, Srinagar.

Accepted for publication on 31-10-79.

TABLE II
Physical Findings

	No. of cases	Percentage
1. Haemoglobin		
10 gms	45	60.0
less than 10 gms	30	40.0
2. Morbidity		
Temp. 98°F	30	40.0
Above 98°F	45	60.0
3. Shock due to		
i. Secondary PPH	10	13.3
ii. No shock	65	86.6
4. Uterine tenderness		
i. With Subinvolution	50	66.6
ii. No Tenderness	25	33.3
5. Bacteriological Smear & Culture		
i. Positive	25	33.3
ii. Negative	30	40.0
iii. Not done	20	26.6

TABLE III
Mode of Treatment

Surgical Evacuation	70
Conservative	5

TABLE IV
Histopathological Examination

	No. of Cases	Percentage
Retained Products present	50	66.6
No retained products found	25	33.3

tal fragments were seen in 50 cases (66.6%). Placental tissue were detected in 27.0%, 32.0%, 41.0% and 52.63% in Lester *et al* (1956), Dewhurst (1960), Rome (1975) and Agarwal and Amrit Kaur (1979) series respectively.

It is obvious from our series that placental tissue was found in good number of cases as 70 cases of total series admitted were home delivery cases. Home

deliveries are usually conducted by untrained 'Dias' under poor hygienic condition. The results of treatment support the contention of the previous writers that surgical exploration of uterus will generally be wise. Some mild cases may settle without operation if ergometrium is given for a few days. When the blood loss is more marked, however, operation should not be delayed for long. Donald (1964) emphasizes this point. Conversely it is evident that evacuation of the uterus will not always be simple procedure to be carried out by residents with little experience. In these cases an instrument passes through the uterine wall and it is not thought that the operator had been careless in any of these. In 1 case uterus perforated during evacuation and laparotomy was done immediately to repair the rent. It is very important to carry out light exploration first and if an instrument is to be used, great care is required. Abdomen should be opened if uterine injury is suspected. In 2 cases an episiotomy haematoma was discovered which required exploration and restitching. Blood transfusion was given in both cases. Paravaginal haematoma was found in 2 cases of Dewhurst (1966).

The analysis of physical findings from Table II shows that temperature of 98°F and uterine tenderness was present in maximum number of cases. It shows that there is strong association between retained products of conception and morbidity at the time of secondary haemorrhage.

There were 2 cases who had chronic inversion of uterus responsible for irregular excessive vaginal bleeding following delivery and who were seen after 3 weeks of delivery. Both of them were operated.

One of the cases among the series presented with PPH after 72 hours of delivery which could not be controlled by

evacuation of uterus. Cavity was found to be irregular. Patient had recurrent bouts of bleeding. She was diagnosed provisionally as a case of fibroid and hysterectomy was done (Fig. 1) as the patient had completed her family.

Summary

Seventy five cases of secondary post partum haemorrhage were studied between 10 hours and 30 days after normal delivery. 70 emergency cases delivered at home and the rest delivered in the hospital were readmitted.

Placental fragments were found in 50 cases (66.6%). Subinvolution of uterus was present in 66.6% and temperature

above 98°F was found in 45 cases (60.0%).

BIBIOGRAPHY

1. Agarwal, A. and Amarjeet Kour: J. Obstet. Gynaec. India. 28: 828, 1979.
2. Dewhurst, C. J.: J. Obstet. Gynaec. Brit. C'wealth. 73: 53, 1966.
3. Donald, I.: Practical Obstetric Problems. 3rd ed. Lond. Lloyd-Luke, 597, 1964.
4. Lester, W. M. and Others: Am. J. Obstet. Gynaec. 72: 1214, 1956.
5. McIntyre, W. K.: Med. J. Aust. 2: 836, 1949.
6. Moir, J. C.: Operative Obstetrics. 7th ed. 1964. Lond. Bailliere Tindall & Cox, 867.
7. Rome, R. M.: Brit. J. Obstet. Gynaec. 82: 289, 1975.
8. Theobald, G. W.: Brit. Med. J. 2: 659, 1960.

See Fig. on Art Paper III