ASYMPTOMATIC BROAD LIGAMENT HAEMATOMA FROM RUPTURE OF UTERINE VESSELS FOLLOWING NORMAL VAGINAL DELIVERY

by

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A case of normal vaginal delivery having asymptomatic unilateral broad ligament haematoma detected during the time of abdominal tubal ligation is reported.

CASE REPORT

Patient K.D. 35 years Hindu female was admitted on 14-5-79 at 1 p.m. with labour pains following 9 months amenorrhoea. There was no history of vaginal bleeding or leakage. She had 5 full term normal deliveries at home, 3 girls and 2 boys without any complication and the last child birth was two and half years back. Her menstrual history was normal and regular, however she could not remember her last menstrual period. Family history, past history and personal history were not significant.

ON EXAMINATION

The built and nutrition was of a tall Indian woman with 5' 4" height and 65 Kgs. body weight. There was no anaemia, no lymphadenopathy and no oedema. Blood pressure on admission was 130/85 mm of Hg. with a pulse rate of 84 per minute.

Cardiovascular and respiratory systems were within normal limits. Examination revealed full term size uterus, longitudinal lie, cephalic presentation, R.O.A. position, engaged head, adequate liquor and normal foetal heart sounds. Uterine contractions were mild.

On vaginal examination, the cervix was 75% effaced, thin and 5 cm dilated with vertex in R.O.A. position. At 3.25 p.m. as there was hypotonic type of uterine inertia I.V. drip with 2 units of syntocinon in 500 ml of 5% dextrose solution was started. Shortly afer the syntocinon drip, at 4 p.m. she delivered a male baby weighing 2.9 Kgs. with apgar score of 9 without any tear or postpartum haemorrhage. Patient was motivated for tubectomy. At 5.50 p.m. patient was complaining of headache and pain in abdomen. Physical examination revealed no abnormality and patient was simply sedated. On 16-5-79 pre-operative check-up revealed blood pressure to be 120/80 mm of Hg. with pulse 88 per minute. Under spinal anaesthesia, abdomen was opened and the right tube was identified and tubectomy was done by modified Pomeroy's technique. When left tube was being looked for, a big haematoma 3" x 3" occupying the whole meso-salpinx and upper one-third of the broad ligament leaving some free space both medially as well as laterally was seen. An attempt was made to arrest the bleeding point using two clamps put just at the adjoining healthy areas in an angular fashion along with a portion of the tube. This was replaced by transfixation stitches. But oozing was still continuing from both the cut edges. Reinforcement was made with figure of eight stitches. Proper haemostasis could not be maintained inspite of pressure with hot mops. Haematoma was extending below and medially. Decision for immediate hysterectomy was made and after getting the written consent from the husband, subtotal hysterectomy was performed. Perfect haemostasis was maintained after the operation. There was no tear or laceration

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detected in the hysterectomy specimen. A drain was put through the left flank and after cleaning the peritoneal cavity the abdomen was closed in layers. Patient received one bottle of A Rh. positive blood during the operation. Her immediate post-operative blood pressure was 118/90 mm of Hg. Her post operative recovery period was uneventful and she was discharged on 25-5-79 i.e. on the 11th post operative day in almost normal state of health.

Cases reported so far were diagnosed at the time of laparotomy for intraperitoneal bleeding with obvious signs and symptoms. In the case reported here, it was diagnosed incidentally during tubectomy before the patient presented clinically. It should have manifested clinically as an acute abdomen in due course if tubectomy was delayed further.

In this case the rupture was at the anastomotic site between the ovarian and uterine vessels at the left mesosalpinx on the upper portion of the broad ligament. The aetiology of haematoma in this case is not clearly understood. Forceful uterine contractions, augmented by syntocinon drip might have produced spontaneous rupture of the weak vessel at the anastomotic site. Being a small leak, which nature had tried to seal or being of recent onset, it had not extended too far. But attempt to insert transfixation stitches for perfect haemostasis failed and haematoma spread further downwards and medially leaving no alternative but emergency subtotal hysterectomy. Spontaneous broad ligament haematoma is usually unilateral.

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