RECURRENT POST PARTUM HAEMORRHAGE: A RARE COMPLICATION OF LOWER SEGMENT CAESARIAN SECTION

by

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Introduction

Recurrent bleeding from the lower segment scar as a late complication of lower segment caesarean section is extremely rare. Steward and Evans (1975) reported only 1 case in which they performed hysterectomy as a last resort to control the bleeding five-and-a-half months after delivery. In our experience, in the last 20 years of obstetrics practice in this State, we have on our record only 1 case of recurrent bleeding after caesarean section. Literature is still very scant on this topic. Review of our hospital records till 1979 of 812 caesarean sections reveals no such complication after caesarean operation. This prompted us to report the present case.

CASE REPORT

Mrs. B.D., 28 years old a second gravida, was admitted as an emergency in labour at term on 23-1-79, with hand and cord prolapse. She was unbooked and had no antenatal care throughout her pregnancy. On admission, her temperature was 38°C; B.P. 130/80 mm of Hg; Pulse 98/min; Hb 9.6%; Urine N.A.D. An emergency lower segment caesarean section was performed on the same day and a fresh still born baby girl 3.4 kg was delivered. Placenta, membranes and cord were normal. She had an uneventful post operative recovery with normal lochia and uterine involution. She was discharged home on the 12th post operative day in a satisfactory condition.

She reported to our emergency on 5-2-79 with the history of having recurrent bleeding since the last two days (14th day of the operative delivery). She was severely anaemic with B.P. 100/70 mm Hg., Pulse 120/Min and Temperature 39°C. Other systemic examinations revealed no abnormality except tachycardia and tachypnoea. The abdominal scar was healthy with mild induration and the abdomen was soft with normal bowel sounds.

Vaginal examination showed slight bleeding from the cervical os and the uterus was of normal size (6 weeks) freely mobile; os just patulous; fornices free. She was kept under observation with conservative regime of antibiotics, blood transfusion and inj. methergin.

After proper resuscitation, uterine exploration and evacuation was done on 12-2-79 and her bleeding episode was controlled with curettage and tight vaginal packing. The packing was removed after 6 hours as there was no fresh bleeding. She had another episode of bleeding on 14-2-79 and went into shock and became severely anaemic. She was given active resuscitative therapy with blood transfusion, steroids and packing. On removing the packing after 16 hours, there was no bleeding and we gave her a low vaginal douching. She improved well and became quite normal till 22-2-79 morning when bleeding started, became quite severe and she went into shock again. Active anti-shock therapy with usual line of

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transfusion and steroids was immediately instituted. She was re-examined in O.T. and decided to perform emergency laparotomy the same evening. On opening the abdomen, the entire lower segment scar was found gapping but no bleeding point could be seen. The uterine rent was found well covered by a fold of peritonium and bladder. Using our own technique, the uterine gap was repaired by an abdomino-vaginal approach. No further vaginal bleeding was seen but we still kept a vaginal pack to be on the safer side.

She recovered well and was afebrile till 29-2-79 when suddenly her temperature shot upto 105°F for a day. The wound healed well and the stitches were removed on the 10th day of the laparotomy.

She started having bleeding again on 3-3-79 and a vaginal pack was kept for 24 hours. On 5-3-79 and 7-3-79 she had vaginal bleeding episodes but it was controlled by simple vaginal packing. Subsequently, the bleeding recurred every 6th to 7th day inspite of the vaginal packing. But surprisingly no frank bleeding point or uterine source could be detected on examination. As there was no other way to control recurrent bleeding we decided to perform hysterectomy.

As a last attempt, vaginal examination for final assessment of the case was made and surprisingly on everting the anterior cervical lip a raw area was detected on the right side of the cervix, which was oozing on further exploration. The cervical os was dilated upto No. 8 Hegar and a simple through and through haemostatic stitches were put on two raw areas of the cervix on the right. She had no more recurrent bleeding after the stitches and was discharged home on 30-4-79 on the 29th day of the final stitching. She attended twice our O.P.D. for checkup and we found her in perfect sound health.

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