SECONDARY POST PARTUM HAEMORRAGE

(Report of 2 Cases)

by

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Introduction

Uterine haemorrage occuring more than 24 hours after delivery is usually due to retained placental bits or infection. Infrequently delayed haemorrage may be due to bleeding from open placental sinuses or thrombi at placental site. Secondary PPH seldom occurs after a caesarean section as placenta is delivered completely under vision. Two unusual cases of PPH following caesarean are reported.

Case 1

Mrs. S., 20 years primigravida was admitted on 4-4-1978 with 36 weeks amenorrhoea and eclamptic fits. Fits were controlled after 4 hours of sedation. Labour was induced with artificial rupture of membranes and syntocinon infusion, but even after 36 hours, cervix was unfavourable and therefore lower segment caesarean section was done. An asphyxiated male baby weighing 2800 gs. was extracted. Placenta removed completely with membranes. On eighth post operative day patient had a sudden bout of vaginal bleeding which was controlled on conservative management. Patient was discharged on 20th day of operation.

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She returned on 25th post partum day, with profuse vaginal bleeding of three hours duration. On examination patient looked very pale, temperature normal, pulse 140/min, BP-100/60 mm Hg. On vaginal examination cervix admitted one finger, uterus 12 weeks and felt empty. Fresh blood transfusion, syntocinon drip and antibiotics were given.

Bleeding stopped completely on third day. Twelve days later she again had vaginal bleeding. This time dilatation and currettage was done. Cavity was found empty. Coagulation studies done at this time were found to be normal. Histopathology of currettings showed decidual endometritis. Vaginal bleeding continued inspite of infusion of syntocinon and blood along with antibiotics. On 22nd day of readmission she had a massive bout of bleeding and collapsed. Four units of blood were transfused. Patient improved by evening and remained so for another 8 days when she again had a moderate bout of bleeding. Examination under anaesthesia revealed vagina full of clots, cervical os closed, uterus bulky and fornices free. Cervix was dilated 5/8 and on currettage no tissue obtained. Since there was continuous oozing of blood even after currettage it was decided to do laparotomy.

There was small amount of free blood and few clots in peritoneal cavity (retrograde spill). Uterus and peritoneum were intact but on opening uterovescical pouch there was a small rent with necrotic edges on the right side of LSCS scar. Subtotal hysterectomy was done. Histopathology showed a gravid uterus covered with thick necrosed endometrium with infarction extending to myometrium. Patient is well after a 3 years follow-up.

Case 2

Mrs. S., 23 years, para 2, was admitted to casualty on 31-8-80 in collapsed state. She had delivered one month back by LSCS done for transverse lie with bicornuate uterus, in another hospital. One bout of secondary haemorrhage had occurred on 14th post operative day and digital evacuation was done in the same hospital.

On 2nd bout patient was brought to this hospital in collapsed state. Her general condition was poor, with marked pallor, feeble rapid pulse, BP 50 mm Hg and temperature 38°C. Per abdomen there was slight tenderness over lower abdomen. Bleeding P/V ++. On vaginal examination clots were removed from vagina ,os open, uterus 8 weeks, midposition. Few clots and infected decidua removed from uterus. Uterine scar intact. Patient settle after blood transfusion and antibiotics.

On 13-9-80 patient had another bout of bleeding in the ward and large clots expelled. Three units of blood given and cavity was curretted. Irregularity felt at posterior wall and angles, pale fleshy curretting were obtained. As cavity emptied bleeding stopped. Histopathology showed sheets of necrotic tissue.

Bleeding reoccurred 9 days later and hysterectomy was done on 22-9-80. On opening there were adhesions between bladder and uterus anteriorly. Tubes and ovaries normal. Cut section of uterus showed irregular area about 1 cm in the posterior wall of fundus and granulation tissue was present at the site of old LSCS scar. Histopathology of uterus showed decidual endometritis with thromboangitis of myometrium. Cervix was unremarkable. The patient is alright after 1 year follow up.

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