

SECONDARY POST-PARTUM HAEMORRHAGE

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SUMMARY

Secondary Post-Partum haemorrhage sometimes becomes severe and dreadful, particularly when the haemorrhage occurs in post caesarean cases. Hysterectomy is necessary in some desparate case for haemorrhage from the uterus. There were five hysterectomies out of 8191 confinement cases where 2249 Caesarean sections were done. Incidence of Secondary P.P.H. is 1.35% and incidence of hysterectomy in post caesar cases is 0.22% i.e. one hysterectomy in 450 caesarean cases.

INTRODUCTION

Secondary post-partum haemorrhage is any abnormal or excessive bleeding from the birth canal which occurs 10 hours (Moir Myerscough 1977) to 12 weeks (Melogy 1949) after delivery. For all practical purposes haemorrhage occurring from genital passage 24 hours after delivery is considered as secondary post-partum haemorrhage.

Causes of Secd. Post partum haemorrhage are :

- a) Retained bits of placenta.
- b) Retained piece of membrane.
- c) Retention of clot of blood.
- d) Bleeding fibroid - specially submucous

variety.

- e) Infection of placental site of uterus or the repaired site of lower birth canal.
- f) Blood dyscrasia - specially lowering of Factor VIII.
- g) Primary post partum haemorrhage of any reason ending in secondary.
- h) Erosion of major branches of uterine artery or erosion of lateral angle of uterine wound in a case of caesarean section due to infection.
- i) Choriocarcinoma.

In case of caesarean section, there should not be post partum haemorrhage due to retained bits of placenta, membrane or clots, as the placenta and the membrane are removed under direct vision. The fibroid, intramural or submucous, is also seen during opera-

tion. In caesarean section, the delivery is done in operation theatre and the chance of infection should be minimum. But it does happen. The secondary post partum haemorrhage following caesarean section is always severe and it occurs two to three weeks after confinement. Most of such patients are readmitted for this complication in a state of shock after initial discharge from the hospital.

DIAGNOSIS

History of haemorrhage and sight of bleeding are obvious for the diagnosis. The general condition of the patient depends upon the amount of blood loss which may produce extreme shock or severe pallor. It is not unusual to see a patient of this type with haemoglobin 5 gm per cent or less, pulse rate 140 or more per minute, blood pressure 80 mm of Hg Systolic and unrecordable diastolic. The temperature is raised and the involution of uterus is not adequate in relation to puerperal period.

TREATMENT

General Management :

Resuscitation of the patient was done

by infusion and transfusion of blood and antibiotic. Cortisone is used for combating the shock and making the patient fit for local management. Two litres of infusion solution and two units of matched blood are absolutely necessary to make patient fit for minimal vaginal examination in extreme cases. Blood or plasma expander is used freely to combat the situation.

SPECIFIC TREATMENT

The specific treatment depends upon the site of the lesion. In case of bleeding from the vaginal tear or disruption at site of episiotomy wound or the cervical tear, repair is comparatively easy. Bleeding coming from the uterus requires exploration of uterus. The difficulty lies when the patient is a case of post-caesar and the bleeding comes from the cavity of the uterus. Exploration of such case is not very easy. It is not certain whether the haemorrhage is from the cavity of the uterus or sutured site. The manipulation itself can cause the separation of uterine scar and produce complication of treatment. If one reaches in that particular stage, next alternative lies in hysterectomy

Table I

No.of Confinement :	No.of Vaginal Delivery	No.of Caesarean Section
90-91	2315	625
91-92	3140	812
92-93	2736	802
Total	8191	2249

Table II

Total Confinement	Total No. of Secondary Post-partum Haemorrhage	Within one week	After one week
8191	111	72	39

Table III
Causes of Haemorrhage

	Vaginal tear, Laceration or haematoma	Retained bits of placenta	Atonic/infected
1990-91	6	9	14
1991-92	9	17	19
1992-93	7	13	17
	22	39	50

Table IV
Management of these

	Conservative	Exploration of uterus/D&C	Repair of Vagina	Hysterectomy
1990-91	10	14	3	1
1991-92	6	22	1	1
1992-93	19	19	2	3
Total	45	55	6	5

(below the suture line) or bilateral tying of anterior division of internal iliac artery.

8191 mothers confined in Ramakrishna Sarada Mission Matri Bhavan, Calcutta, from April, 1990 to March, 1993 (three years)(Table No.1). There were one hundred

eleven cases of secondary post-partum haemorrhage out of 111 cases, 72 cases had secondary P.P.H. during initial stay of the hospital i.e. within one week of confinement and 39 cases had late Secondary P.P.H. i.e. these cases were

Table V
Blood required for these patients

1990-91	20
1991-92	44
1992-93	49
Total	133

readmitted for the specific reason of haemorrhage (Table No.II). Causes of haemorrhage are as shown in Table No.III; 70% of these patients were associated with infection, clinically and 50% of these were confirmed bacteriologically. Type of management of these cases are shown in Table No.IV. More than half of these patients required some sort of surgery. Requirement of blood in managing such cases is mentioned in Table No.V.

DISCUSSION

Incidence of secondary post-partum haemorrhage in this series was 1.35% (111 in 8191). Conservative treatment with resuscitative measures and antibiotics helped in 40.6% patients and 59.4% required some sort of operative management. Unfortunate part of treatment in these cases was hysterectomy in 5 cases (4.5%). Incidence of hysterectomy was 0.061% in term labour cases and all of these 5 cases were post-caesarean. Naturally the incidence of hysterectomy in post caesarean cases was 0.22% i.e. one hysterectomy for secondary post partum haemorrhage in 450 caesarean cases.

Conservative treatment in 45 cases was very effective. No doubt retained products of conception were present in a few of

them but this appeared to be of little consequence and such tissue was probably either autolysed or lost in the lochia or menses (Rome 1975). Ultrasonography was not used here but it might be helpful in detecting retained bits of placenta (Malvern et al 1993) within the uterus.

In spite of satisfactory progress by conservative or operative management, these patients are liable to have post-partum haemorrhage in subsequent pregnancy. Hysterectomy was absolutely indicated in desparate cases but it seems, this is unfortunate for the patients as well as for the obstetricians.

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