A case of Disseminated intravascular coagulation following subtotal hysterectomy for placenta praevia accreta (case report)

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Disseminated intravascular coagulation is a rare complication in obstetrics. Such a case following subtotal hysterectomy for placenta praevia accreta is presented herewith.

M. Bibi, 25 years, Muslim, unbooked, 2nd gravida with a history of induced abortion at 8 wks gestation 2 yrs ago was admitted to Chittaranjan Seva Sadan, Calcutta on 15.9.97 at 11 A.M. as a case of A.P.H. from suspected placenta praevia at 36 wks of gestation having a live foetus in breech presentation, anaemia (Hb 7 gm%) and mild shock. Resuscitation was started along with arrangement for blood transfusion. Subsequent U.S.G, revealed type – II posterior placenta praevia with a viable foetus of 33 wks gestation. Conservative treatment continued and she received 3 units of blood. Due to recurrent bouts of bleeding PV, an emergency L.S.C.S was performed on 18.9.97. On opening the abdomen, a live foetus within an intact amniotic sac was found out side the uterus. A healthy male baby (2.4 kg) was taken out of the sac. The sac was adherent to the margins of the transverse rent over the fundus extending from one cornu to the other. There were no adhesions or any intraperitoneal haemorrhage from the ruptured site. The placenta was morbidly adherent to the posterior wall of the lower uterine segment, encroaching upon the internal os. Manual removal was attempted but due to severe bleeding and deterioration of the patient's condition, subtotal hysterectomy was performed removing placental tissue from the remaining part of the lower uterine segment as far as possible. Patient gradually recovered with fluids, blood, antibiotics (cefotaxime, amikacin, metronidazole), vitamins etc. Post operative period was uneventful and was discharged home with the baby on 27.9.97 (10th P.O. Day).

She was readmitted on 29.9.97 (12th P.O. Day) at 6 A.M. for abdominal pain, distension, severe pallor and moderate shock. Resuscitative measures were started along with naso-gastric suction and arrangement for blood transfusion. Abdominal paracentesis revealed haemorrhagic fluid for which continuous drainage was set up. Suspecting intraperitoneal haemorrhage from cervical stump, decision for laparotomy was taken. 7 hours after admission, she showed signs of a haemorrhagic disorder like gum bleeding, bruising, haematemesis, melena before blood was available and she could be taken to the O.T. So conservative treatment on the line of D.I.C. was considered instead of laparotomy. The patient was treated with fluids, 2 units of blood, 2 units of fresh frozen plasma, along with ofloxacin, tinidazole, vitamins etc. The blood picture on 29.9.97 showed Hb = 6.5 gms, platelet count 1.0 Lac/ cumm and Fibrinogen degradation product (FDP) 7500 ng/ ml. Although her condition deteriorated slightly on 30.9.97 with the appearance of vaginal bleeding, the same conservative treatment continued with 2 units of fresh frozen plasma, one unit of blood each day with Inj. Botropase, Calcium gluconate etc. The blood picture on 2.10.97 showed – Platelet 82,000/ cumm, Fibrinogen 80 mgm/ dL, FDP 9000 ng / ml and serum electrolytes were within normal limits.

From 3rd October'97 her condition gradually improved without any sign of bleeding disorder. Blood picture on 3.10.97 was Hb 12.2 gm%; Fibrinogen 280 mg / dl, Platelet 1.52 Lac/mm^3. Prothrombin time 26 Secs (control 13 secs). From 4.10.97 oral feeding was started omitting I/V fluid and other drainage tubes. She recovered gradually and was discharged home on 20.10.97.