



# An Unusual case of secondary post partum haemorrhage following caesarean section

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Postpartum haemorrhage is a dreadful complication of labour which takes a number of maternal lives each year. Secondary postpartum haemorrhage even though rare, occurs usually after caesarean section. The main factors being retained bits of placenta or membranes, haematoma or rarely fibromyoma. We report successful management

of severe secondary postpartum haemorrhage due to a fibroid polyp in a young woman. Smt. S. S. aged 26 years, unbooked primipara was admitted to Jawaharlal Nehru Hospital & Research centre, Bhilai, on 9.7.1997 through Casualty Services for repeated bouts of fresh bleeding per vaginum on and off of 3 months' duration, following by lower segment caesarean section done for prolonged second stage of labour at a private nursing home. She had her first and second bleeding episodes (approximate blood loss 600 ml. each time) within 6 weeks of LSCS, after uneventful post-operative stay for 8 days. She received one unit of compatible blood along with other conservative measures at the same hospital. Third and fourth bleeding episodes were more sudden and severe (total blood loss 800 ml.). Patient received two units of compatible blood and underwent dilatation and curettage at the same hospital. The tissue obtained for histopathological examination was not significant.

Hence she was referred to our hospital for further investigations and treatment, when she had another bout of fresh bleeding. On examination, patient was anaemic, pulse rate 130/min., BP 110/80 mm of mercury, CVS examination: tachycardia and haemic murmur over pulmonary area respiratory system normal. Per abdomen

examination: transverse healthy scar of LSCS present, PS examination: cervix and vagina normal, clots were removed from vagina, uterus appeared bulky, well involuted, mobile. Both fornices were free, os was closed, fresh bleeding through os was noticed.

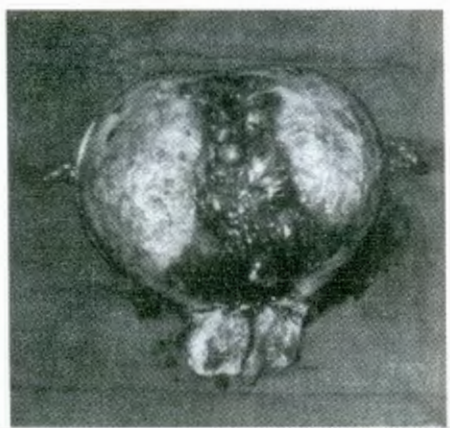


Fig I. Cut section of uterus showing fibromyomatous polyp

Laboratory investigations: Hb 5gm/dl, blood group 'O' Rh +ve, bleeding time, clotting time, prothrombin time normal. Platelet count 2,40,000/cmm. Serum total protein 5.9 gm/dl. (albumin 4.4 gms/dl), blood urea, creatinine, glucose, serum electrolytes normal. Fibrin degradation products 10 microgram/ml. Urine analysis normal, culture sterile. ECG showed sinus tachycardia, skiagram chest showed globular heart, serum chorionic gonadotropin normal 7.8 miu/l, urine for gravindex test negative, pelvic USG showed normal findings, no focal lesion in uterus seen. She received total 8 units of blood, supportive therapy and put on regesteron haematinics, antibiotics. Packing was done as temporary measure with roller gauze during bleeding episodes.

Inspite of the above measures, patient went into severe oligaemic shock followed by sudden bout of torrential bleeding. She was resuscitated and decision was taken for abdominal hysterectomy. Under GA, abdominal hysterectomy was done. Cut section of the uterus showed small polyp arising from the fundus of the uterus (Fig. I). Histopathology confirmed fibromyomatous polyp, patient had speedy uneventful post-operative recovery and was discharged on the 8th day after surgery. On follow-up after one month she was well.