A Rare Case on Anticoagulant Therapy with Recurrent Intraperitoneal Haemorrhage

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Intraperitoneal haemorrhage with ovulation is a known though rare complication of anticoagulant therapy. We present here a young patient on oral anticoagulants who had massive intraperitoneal bleeding and survived a very stormy post-operative course.

Miss P.M., 20 years old, was admitted in August '99 at NKP Salve Institute of Medical Sciences with right sided lower abdominal pain since two days, and no history of vomiting or bladder or bowel disturbance. Her menstrual cycles were regular, last period being 16 days prior to admission. She was a known case of atrial septal defect with mitral regurgitation with mitral valve prolapse, and tricuspid regurgitation and pulmonary hypertension. Mitral valve replacement with patch closure of atrial septal defect was done two years earlier. She was on oral anticoagulant therapy – acitrom (nicoualone) 4 mg/day since then.

Interestingly, four months earlier in May '99 she was admitted in our hospital ICCU with abdominal pain, vomiting and loose motions. Limited haemoperitoneum was detected on ultrasound, confirmed by paracentesis but the same resolved spontaneously and she was discharged.

This time patient's general condition was fair, pulse was 84/mt., respiration was quiet, scar of cardiac surgery was present and lungs were clear. Per abdomen there was no mass, tenderness, rigidity or guarding. Her clotting time was within normal limits (7 minutes). She was kept under observation. Her condition remained steady for sometime but 20 hours after admission her condition suddenly deteriorated with pallor, tachycardia, hypotension and signs of free fluid in the abdomen. As the patient was on the 16th day of her menstrual cycle and on anticoagulants a diagnosis of haemoperitoneum secondary to ruptured corpus luteum was made. Emergency laparotomy was undertaken with findings of 2 litres of haemoperitoneum and actively bleeding small right sided ruptured haemorrhagic cyst of ovary. Right sided ovariotomy was done (histopathology confirmed corpus luteum haematoma). Intensive post-operative care was instituted and blood replacement done. Immediate prothrombin time and PTTK was prolonged for which injection vitamin K 10 mg. IM was given as an antidote. On 4th post operative day patient developed ARDS and was treated with ventilatory support. She also developed septicaemia and DIC which were treated with broad spectrum antibiotics and multiple fresh frozen plasma transfusions respectively. She was discharged in good condition three weeks after the admission.

It was decided to inhibit the ovulation to prevent similar future episodes. As O.C. pills are contraindicated in view of her cardiac condition we thought of putting her on Injection NET-EN 200 mg. but the patient has so far not returned for follow-up.