

Case Report

Conservative Surgical Management of Post Partum Haemorrhage in Different Scenarios - A Case Series

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ABSTRACT

Introduction: Post partum haemorrhage remains one of the deadliest challenges faced by an obstetrician. The treatment of patients with PPH has 2 major components: resuscitation and management of obstetric hemorrhage and identification/management of the underlying cause(s) of the hemorrhage. Conservative measures may be successful in some cases, although the benefits and risks of outcome should be weighed accordingly.

Case Series: Here we are presenting a case series of PPH patients in different scenarios managed with conservative surgery.

Discussion: Morbidity and mortality due to PPH are largely preventable through skilled care. The above cases presented with PPH in different scenarios, which were managed successfully with conservative surgery at our centre which is a secondary health centre with limited resources catering to a large drainage area with referrals from many maternity homes. All interventions were supported with ecbolics and blood/blood product transfusions for volume replacement.

Conclusion: The key to management of PPH is to recognize excessive bleeding before it becomes life-threatening, identify the cause, and initiate appropriate interventions. Conservative surgery supported by blood/blood product transfusions and ecbolics, has a definite role even at secondary/primary level care.

Key Words: Conservative, Surgery, Haemorrhage, Scenarios.

INTRODUCTION

Post partum haemorrhage remains one of the deadliest challenges faced by an obstetrician. Postpartum hemorrhage (PPH) is responsible for around 25% of maternal mortality worldwide, ^[1] reaching as high as 60% in some countries. PPH can also be a cause of long-term severe morbidity, and approximately 12% of women who survive PPH will have severe anemia. ^[2] Additionally, women who have severe PPH and survive (“near misses”) are significantly more likely to die in the year following the PPH. ^[3] PPH may occur due to many causes, uterine atony being the commonest. The associated risk factors are large for gestational age babies,

polyhydramnios, multifetal gestation, augmentation of labor, adherent placenta, hypertensive disorders, anemia, high parity, non-progress of labor, instrumental delivery, etc. Other less discussed causes are traumatic/genital tract injuries, coagulopathies, etc. The treatment of patients with PPH has 2 major components: resuscitation and management of obstetric hemorrhage and identification/management of the underlying cause(s) of the hemorrhage. Decision making needs to be quick and requires experienced obstetric care.

Although various algorithms are given in management of PPH, uncontrolled hemorrhages often land up

into complications requiring advanced surgical interventions like obstetric hysterectomy. Conservative measures may be successful in some cases, although the benefits and risks of outcome should be weighed accordingly. Of course one needs luck to be successful!

Here we are presenting a case series of PPH patients in different scenarios managed with conservative surgery.

CASE REPORTS

Case 1: 25 year old, Primigravida with full term gestation, unregistered/unimmunised, with head on perineum came to the labor room. No antenatal USG was available. Her BP was 150/110 mm Hg and pallor ++. Haemoglobin was 5.6 gm/dl. Healthy 3.2 kg baby was delivered. Episiotomy could not be given. Anti hypertensives were started. Bleeding was present per vaginum. On exploring vagina in OT, there was cervical tear at 4 o clock position and a transverse 5 cm posterior forniceal tear. Haemostatic sutures were taken on the cervical tear. Forniceal tear was sutured with vicryl 2-0 interlocking sutures. Haemostasis was achieved. Blood loss ~ 1200 ml. Patient received 3 pints blood transfusion and BP was controlled on anti-hypertensives. Patient was discharged on day 6 in healthy condition.

Case 2: 26 year old, Gravida 4 Para 3 Living 3, with 35 weeks gestation, with irregular ANC follow-ups, with previous 3 caesareans, came with complaints of pain in abdomen. On examination pulse was 110/min, BP was 90/60 mm Hg, pallor +, on per abdomen scar tenderness was present. On per vaginum examination patient was 3 cm dilated. 32 weeks USG was suggestive of an anterior placenta, upper segment. Haemoglobin was 8.5 gm/dl. Emergency caesarean was done. On opening - dense adhesions over upper segment were present which were lysed with sharp dissection. Uterine scar rupture present, liquor meconium stained in abdomen and head of the baby protruding

from the rupture site. A 2.5 kg baby was delivered and required initial resuscitation. Rupture was extending 3cm from both lateral angles towards broad ligament and scar site was with ragged margins. Placenta adherent and removed in bits and pieces. Uterus atonic and bleeding + Inj methergine followed by Inj carboprost were given. Compression sutures applied. Ragged margins were freshened and uterus closed with interlocking sutures. Haemostatic interlocking sutures were applied on raw areas over upper segment. Blood loss ~ 1000 ml. Patient received 2 pints blood transfusion. Patient recovered well post-op.

Case 3: 22 year old, Gravida 2 Para 1 Living 1, registered short statured patient, with 38 weeks gestation, with previous caesarean done in view of cephalo pelvic disproportion, came in labour. Pallor was +, Haemoglobin was 9 gm/dl. Emergency caesarean was done. Dense adhesions were separated with sharp dissection. Healthy 2.8 kg baby was delivered. Placenta adherent and was removed in bits and pieces. Uterus atonic and bleeding +, blood loss 1000 ml within 15 mins. Inj methergine was given followed by 1000 mcg PGE1 per rectal followed by 2 doses of Inj Carboprost. Interlocking haemostatic sutures were applied on raw areas of upper segment. Compression sutures were applied on upper segment along with Modified B-Lynch sutures, bilateral uterine and descending cervical arteries ligated. Haemostasis was achieved. Total blood loss 1500 ml. Patient received 3 pint blood and 2 pint FFP transfusion. Patient recovered well post op.

Case 4: 28 year old, Gravida2 Para 1 Living 1 unregistered patient, previous vaginal deliveries, 34 weeks twin gestation referred from a private practitioner, with a single 15 week USG available. Pallor ++, haemoglobin was 5.4 gm/dl. BP was 150/110 mm Hg, anti hypertensives started. Patient was fully dilated with first twin breech, 2.1 kg baby delivered. Second twin breech, 2 kg baby delivered. Post

delivery no perineal tear, but bleed + per vaginum was present. On tracing cervix no tear was present. Inj Pitocin 20 units in Ringers Lactate run fast, followed by Inj Carboprost IM 3 doses repeated. Bimanual uterine compression given. Haemostasis was achieved. Blood loss ~ 700 ml. Patient received 3 pints blood transfusion. Patient was discharged in healthy condition with healthy babies.

Case 5: 25 year old, Primigravida, with irregular ANC visits, with history of epistaxis episodes intermittently and fever few days back, haemoglobin 8.5 gm/dl and platelet count of 1 lakh, normal coagulation profile, with hepatosplenomegaly, in labor, was shifted for emergency caesarean section in view of thick meconium stained amniotic fluid with fetal distress. After delivery of healthy baby and placenta, uterus was atonic and bleeding ++, blood loss 1000 ml within 10 mins. Compression sutures applied. Bilateral uterine artery followed by descending cervical followed by ovarian vessel ligation done. Inj Carboprost 3 doses given. Haemostasis was achieved. Total blood loss 1500 ml. 3 pint blood and 4 pint FFP transfusion was given. Post op patient had 2 spikes of fever. Although fever profile was negative, anti malarials and higher antibiotics were started. Patient recovered well post op.

DISCUSSION

The traditional management of PPH includes the use of ecbolics, before proceeding to compression sutures, ligation of the internal iliac arteries and even hysterectomy. Morbidity and mortality due to PPH are largely preventable through skilled care.

The above discussed cases presented with PPH in different scenarios, which were managed successfully with conservative surgery at our centre which is a secondary health centre with limited resources catering to a large drainage area with referrals from many maternity homes.

Case 1 was a primigravida with severe anemia and PIH where forniceal and cervical tear suturing was done. Case 2 was a gravida 4 patients with previous three caesareans who had a scar rupture with extensions where uterus was salvaged. Case 3 was a gravida 2 patient who developed atonic PPH during caesarean and was managed with compression sutures with devascularization. Case 4 was a Gravida 2 patient with severe anemia and PIH with twin pregnancy in labor, which was managed by bimanual uterine compression. Case 5 was a primigravida with severe anemia and thrombocytopenia with? Coagulation disorder who developed atonic PPH during caesarean, which was managed with compression sutures and step wise devascularization. All interventions were supported with ecbolics and blood/blood product transfusions for volume replacement.

CONCLUSION

The key to management of PPH is to recognize excessive bleeding before it becomes life-threatening, identify the cause, and initiate appropriate interventions. Emergency hysterectomy done in young patients has a deep emotional and physical impact. The burden of it has to be carried on for the rest of her life. Decision making needs to be quick and all risks weighed for and against hysterectomy. Conservative surgery supported by blood/blood product transfusions and ecbolics, has a definite role even at secondary/primary level care.

ABBREVIATIONS

PPH – Post partum haemorrhage

PIH – Pregnancy Induced Hypertension

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