Case Report

Massive secondary haemorrhage after vaginal hysterectomy: A life threatening event

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Abstract

This is a case report of a case of massive secondary haemorrhage after vaginal hysterectomy. She presented with 3rd degree uterine prolapse with severe anaemia. She underwent vaginal hysterectomy with anterior colporrhaphy and posterior colpoperineorrhaphy after correction of anaemia with blood transfusion. From 4th postoperative day, she had watery motions and haemorrhagic collection in the abdomen. On 8th postoperative day, she suddenly started with profuse vaginal bleeding for which laparotomy with vaginal exploration was done. Active bleeding from the vaginal vault was there which we controlled by taking haemoatatic sutures. This is a rare case of massive secondary haemorrhage which was life threatening for the patient and managed successfully.

Keywords: secondary haemorrhage, vaginal hysterectomy.

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INTRODUCTION

Secondary haemorrhage is the haemorrhage that develops 24 hours or more after the surgery. It is rare but a life threatening complication which may require prompt medical and surgical intervention[1]. Although the overall incidence is low, secondary haemorrhage of varying degrees of severity may develop after hysterectomy. There are few studies which show the overall incidence of haemorrhage as 0.2 to 2%, which includes reactionary and secondary haemorrhage after hysterectomy[2]. Here we are reporting a rare case of massive life threatening secondary haemorrhage after vaginal hysterectomy.

CASE REPORT

40 year old Para 4 live 4 (all full term home deliveries), was admitted in our hospital with complaint of something coming out of vagina since 2 years. On examination, she had 3rd degree uterine prolapse with cystocoele and rectocoele with severe anaemia (Hb- 5.4gm%). Patient was given 4 units of packed cell volumes (Packed RBCs) for correction of anaemia.

After preoperative evaluation, we posted her for vaginal hysterectomy with Anteriorcolporrhaphy and Posterior colpoperineorrhaphy on 05/04/2014. Post operatively Patient was stable for 3 days. On 4th postoperative day she developed mild distension of abdomen and watery stools with no history of fever. We managed her conservatively by giving lactobacilli preparations and drugs to decrease gut motility. She was started with higher antibiotics (initially she was on ciprofloxacin and metronidazole, and we changed to ceftriaxone and metronidazole). We did her Ultrasound to rule out pelvic abscess. But it was suggestive of intra- abdominal collection of approximately 500ml. Haemoglobin was 8gm% and TLC was 5,200/cmm. She was given 1 unit whole blood transfusion and, managed conservatively with monitoring of vital signs and abdominal girth. Over a period of 2 days, her frequency of stools decreased and stool consistency also changed. Patient was stable

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clinically. On 7thpost operative day, her abdominal girth increased by one inch. On review Ultrasonography, intra-abdominal collection increased to 800-900ml. So decision for laparotomy was taken and she was posted for laparotomy next day morning as she was stable clinically. But, next day early morning patient suddenly started with profuse vaginal bleeding with passage of clots, tachycardia and hypotension (BP- 80/60mm Hg). We shifted her immediately to operation theatre for exploratory laparotomy with vaginal exploration keeping everything ready for Internal Iliac artery ligation. Intraoperative, there was around 700-800ml of haemorrhagic fluid collection in the abdominal cavity and oozing from the vaginal vault. Oozing was controlled by taking haemostatic sutures at the vaginal vault with Vicryl 2-0. On vaginal exploration, there was active bleeding from left end of the vault. Bleeding was controlled by taking 3 haemostatic sutures. Vaginal pack was kept which we removed after 24 hours. Blood transfusion of 2 units was given during the procedure. And postoperative also she was given 2 units of whole blood, 4 units of FFP and 1units of platelet. She was kept on higher antibiotic (Piperacillin and sulbactam). Her postoperative period was uneventful.

DISCUSSION

Secondary haemorrhage is the haemorrhage that occurs 7 -14 days after surgery. Although the overall incidence of secondary haemorrhage is low, gynaecologist do come across secondary haemorrhage of varying severity[3]. Paul *et al* reported incidence of secondary haemorrhage as 0.98%[1]. While Saima *et al* reported it as 0.63%[4]. In our hospital, this is the only case of massive secondary haemorrhage reported over a period of last 4 years. In our case, patient was stable for 3 days after the hysterectomy. On 4th postoperative day, she complained of 8- 10 episodes of watery stools and mild abdominal distension. There was no history of fever or vomiting. Stool examination was sterile. So we had suspicion of pelvic collection and we did Ultrasonography. Her ultrasound was suggestive of collection in the abdomen of approximately 500ml. On tapping, it was haemorrhagic fluid which we sent for biochemical examination to rule out ureteric injury and to see whether it is exudative or transudate fluid. Biochemical examination was normal and IVP (Iintravenouspyelography) was also normal which ruled out ureteric injury. Haemoglobin was 8gm% and TLC count was 5,400/cmm. Patient was managed conservatively as she was stable clinically. Over a period of 2 days, her frequency of stools decreased and consistency of stools also changed. But on 7thpostoperative day, abdominal girth increased by 1 inch. So ultrasound was repeated which shown increase in the amount of collection to 800-900ml. So, decision of laparotomy was taken but, as patient was stable clinically, we posted her next day morning. But, on the day of operative, in early morning, she suddenly started with profuse bleeding per vaginum with passage of clots, tachycardia, and hypotension (BP- 80/60mmHg). We immediately shifted her to operation theatre. On table her BP dropped to 50mmHg systolic. Intraoperative there was 700-800ml of haemorrhagic fluid and oozing from the vaginal vault. Oozing stopped by haemostatic sutures. On vaginal exploration, there was active bleeding from the left end of vault with clots in vagina. Bleeding was controlled by taking haemostatic sutures and internal iliac artery ligation was not required. Vaginal pack was kept which we removed after 24 hours. We transfused 2 units of whole blood intraoperative and 2 units of whole blood, 4 units of FFP (fresh frozen plasma) and 1 unit of platelet were transfused in the post operative period. She was started on higher antibiotics (Inj. Piperacillin-sulbactamand metronidazole) Secondary haemorrhage is usually due to infection or sloughing away of the blood vessels. In our patient, there was no history of fever, no leucocytosis and no signs of sepsis but still she had secondary haemorrhage. This is mostly because of subclinical infection and sloughing away of the blood vessel.

CONCLUSION

Secondary haemorrhage is a life threatening complication that needs medical and surgical intervention. It may occur in the presence of subclinical infection. Careful monitoring in the postoperative period is important for early detection and treatment of secondary haemorrhage.

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