A case of massive rectus sheath haematoma after emergency CS

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Objective
To present a case report of an abdominal wall haematoma after emergency CS. This is the second most common complication after a C/S and delay in the diagnosis can lead to serious, even life threatening complications. It does not only affect the patient's recovery but there is also an economic burden associated with it. It occurs in approximately 1.2% of the C/S. Diagnosis of rectus sheath hematoma remains elusive and depends upon the clinical judgement. Rectus sheath hematoma is an uncommon and often misdiagnosed condition. Hematoma can develop due to rupture of epigastric vessels or its branches or tear of rectus abdominis muscle, extending potentially towards preperitoneal space or into free peritoneum. Fortunately it is an uncommon complication but is well documented and often mimics acute abdominal pain. Clinical examination and imaging such as USS and CT scan is invaluable for the diagnosis. Prompt diagnosis avoids unnecessary intervention and laparotomy. During the C/S, the tearing of branches of inferior epigastric vessels is the most likely cause. The patient was managed conservatively and discharged home on day 9 with regular follow up.

Methods
This is a case report.

Results
A 44 years old patient, G4P3 (one CS 11 years ago at 32 weeks for twins), had conceived spontaneously with uneventful ANC. She had been known to have an upper segment anterior wall fibroid. She was anaemic, Hb was 10.7 g and she was on oral iron. She was admitted in active labour at 40 weeks and had an EMCS at full dilatation as the head was high with suspicious CTG. A straight forward CS was carried out and a male infant was born, weighing 3700 g with the cord being around the neck twice. The baby was delivered in a good condition. The patient had VTE prophylaxis and on the third day she started complaining of abdominal pain, which was treated with analgetics. On the fifth day she looked pale, a swelling was noted around the flanks of the abdomen, more prominent on the right side, with visible bruising. Hb had dropped down from 13 g preoperatively to 7 g. 3 units of blood were transfused and the patient was advised to have a surgical drainage. She declined it and she was discharged home on the 11th day. She was seen regularly in the outpatient clinic. USS and CT were performed and confirmed a massive rectus sheath haematoma measuring 8.5 x 20 x 15 cm, an intramural fibroid measuring 8 x 9.5 x 8.5 cm and a bulky uterus with empty cavity. A repeat USS after 2 weeks suggested there is a heterogenous collection within the anterior abdominal wall, measuring 13.3 x 9.9 x 8.0 cm, which was decreasing in size and was in keeping with the diagnosis of an organising haematoma. 3 weeks later it showed further reduction to 7.7 x 3.7 cm and it had completely disappeared by the 8th week.

Conclusion
Postoperative observation and vigilance should facilitate the timely detection and appropriate management. Meticulous care should be taken during the opening of the abdominal wall and tearing should be minimised, especially during emergency or repeat C/S. The treatment may be either conservative or surgical. Conservative treatment is appropriate for patients who are haemodynamically stable and have a small non-expanding hematoma and if symptoms are mild, and the diagnosis is certain. It includes rest, analgesics, haematoma compression, ice packs, treatment of predisposing conditions, and blood transfusion, if necessary. Surgical intervention is needed for those with hemodynamic instability, expanding hematomas or symptomatic anaemia and includes evacuation of the haematoma and ligation of bleeding vessels.