A Case Study

Concealed Accidental Haemorrhage

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An interesting case of Abruptio placentae with severe degree of coagulation failure and marked oliguria, treated with heparin with an excellent result.

Mrs. 'X' 27, para two, gravida third, was admitted in the labour room with the history of 38 weeks amenorrhoea and mild labour pains of 24 hours duration. She had no history of leaking liquor, not of bleeding per vaginum, but she was complaining of having sluggish foetal movements. On enquiry, she gave the history of having severe epigastric pain, headache, vomitting and giddiness for the last 3/4 days before admission. She was handled by a local Midwife who did vigorous abdominal massage to give relief from epigastric pain.

Regarding the obstetric history, she had two term normal labours in the same hospital 5 years and 3 years back respectively and the puerperium was uncomplicated each time.

The routine examination on admission after the usual toileting of the genitalia revealed that the patient was found to be clinically slightly anaemic. Her temerature was 98.4°F., pulse 96/min. with good volume and tension. Respiration was 20/min. and blood pressure 110/70 mm of Hg. No. albumin, sugar or acetone was detected in the urine.

On abdominal examination the uterus was found to be corresponding to the period of amenorrhoea, the lie was longitudinal with L.O.A. position. Foetal heart sounds were not audible and there was a marked rigidity all over the abdomen.

After admission, she vomited twice, vomits consisting of 6 to 8 ozs. of yellowish fluid each time. Intravenous drip of 5% Dextrose solution was given according to the advice of the doctor. The patient was kept under observation. Intake and output chart was maintained.

Fluid chart (3 a.m.—7 a.m.)

Intake		*Output*	
By mouth	300 ml. of glucose water	Urine	120 ml.
I.V. drip	425 ml of 5% Dextrose Solution	vomit	600 ml.
Total :	725	Total :	720 ml.

At 7-40 a.m. on the same day, the patient was examined by the Obstetrician. Vaginal examination revealed that cervix was partially taken up ; membranes were felt to be tense, no placental tissues or cord was felt. Pelvis was found to be normal. Head was above the pelvic brim. Abdominal girth was 41".

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At 9 a.m. labour was induced by artificial rupture of membranes as the patient was in distress : clear liquor was drained out. Soon after A.R.M. the patient had a bout of fresh bleeding per vaginum. Clot observation test showed failure of coagulation. Urgent haemoglobin estimation was done. It was found to be 7.3 gm%. Blood transfusion was arranged. Blood fibrinogen level was found to be 200 mg.%. Blood pressure dropped to 90/60 mm Hg. diagnosis of accidental haemorrhage with coagulation failure was made.

Blood transfusion was started immediately and the patient was sedated with 10 mg of morphine intravenously. Heparin 1,000 units was given intravenously and repeated every hour with the advice to prepare the patient for Caesarean section after improvement of blood pressure and coagulation defect. In about one hour, the condition of the patient improved, blood pressure came up to 106/80 mm. Hg. and the pulse ranged between 130 and 150/min. Bed side clot observation test showed slight improvement. She had four pints of blood and 2000 units of intravenous heparin. At 11 a.m. she was prepared for Caesarean section. Phenergan 12.5 mg. was given intravenously as premedication. Catheterization was done and 10 ml. of urine was withdrawn.

Under general anaesthesia, a lower segment Caesarean section was done. A dead foetus was extracted. On examination a big retroplacental clot measuring about 720 ml. was found. Uterus and abdominal walls were closed in layers.

Post-operatively, Inj. crystalline penicillin 500,000 units six-hourly and Inj. Streptomycine 0.5 gm daily intramuscularly ; mannitol 100 ml. by intravenous drip and syntocinon one unit with 5% Dextrose solution by slow intravenous drip were given. Strict intake and output chart was maintained ; blood pressure, pulse and respiration were recorded at frequent regular intervals. Blood pressure was maintained between 120/70 and 140/90 mm Hg and pulse between 100 and 130/min. Inj. Paraldehyde 10 ml. was given intramuscularly at 4-10 P.M. as the patient was restless. She slept fairly well at night without any further complaints.

Fluid Chart

	Intake		*Output*
Blood	2000 ml.	Urine	500 ml
5% Dextrose Soln	800 ml.	Retroplacental clot	720 ml
Mannitol	200 ml.		
Total :	3000 ml		1220 ml

On the second post operative day, the patient had low grade pyrexia, ranging between 99° F and 102°F.

Blood urea and serum electrolytes were found to be within normal limits ; blood pressure was within normal range and pulse between 70 and 90/min. Abdomen was soft and lochia was normal. Antibiotics were continued as on the previous day. Her urine output was only 400 ml, in 24 hours.

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