An Atypical Presentation of Late Postpartum Hemorrhage: A Case Report

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In this case report, late postpartum cyclic uterine bleeding is demonstrated and is unique in literature with its clinical course. A 21 year old patient admitted with massive vaginal bleeding. It was learnt that the patient had cesarean delivery 40 days ago. In pelvic examination there was active vaginal bleeding. The uterine involution was completed. In ultrasonography uterus was normal and there was not any placental rest in uterine cavity. In laboratory; hemoglobin was 7.2gr/dl, other values were normal. Oxytocin infusion, methylergobasine maleate and antibiotic were administered. Blood transfusion was done. Patient was discharged after follow-up. Patient admitted twice again with same symptoms with 1 month intervals. Laparotomy was planned. During laparotomy, uterine incision site was opened. Hemorrhage was present within endometrial cavity. There were vessels bleeding on the right side of incision and 2x2 cm sized rest of amniotic membrane. The rested tissue was extirpated and vessels were sutured. The patient was discharged after 3 days of follow-up.

Key Words: Late cyclic postpartum hemorrhage, Placental rest, Laparotomy

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Introduction

Postpartum bleeding that is observed in the period between 24 hours after delivery and up to 6 weeks in the postpartum period is also known as 'secondary' or 'delayed'. Since late postpartum hemorrhages affect morbidity rather than mortality compared to bleeding within 24 hours of deliveries, they take a little less interest. Sub-involution of uterus and retention of placental fragments are the leading causes of delayed postpartum bleedings.[1]

In this case report, a late postpartum cyclic uterine bleeding is demonstrated and is found to be unique in literature with its clinical course.

Case report

A 21 year old patient was referred to our clinic with late postpartum massive uterine hemorrhage. It was learnt that patient was primiparous and had cesarean delivery 40 days ago in another clinic. In history, it was learnt that there were not any medical problems preoperatively and postoperatively. The patient had no systemic disease and had been discharged from the hospital on the postoperative second day. In pelvic examination there was active vaginal bleeding and there was no vulvovaginal laceration. The uterine involution was completed. In transvaginal ultrasonography (USG), there was hemorrhage within uterine cavity and not increased any suspicion to placental rest. At the level of uterine incision, there was a vascular orifice-like structure giving turbulence image. There was not any fluid within abdominal cavity. In laboratory findings; hemoglobin was 7.2gr/dl, clotting time, thrombocyte count, sedimentation and C reactive protein were found normal. Crystalloid, oxytocin infusion, methylergobasine maleate and blood transfusion were administered. Appropriate antibiotic was started. Vaginal bleeding of patient has disappeared on follow-up. After cessation of hemorrhage, hysteroscopy was performed, but there was not any significant pathology. The patient was discharged after 3 days of follow-up. The patient admitted once more with similar symptoms just 1 month after discharge. In pelvic examination active vaginal bleeding was detected, the ultrasonographic findings were also similar. Similar treatment modalities were applied and beside curettage were performed for probable placental rest risk. No material was obtained from curettage. The patient was discharged from the hospital after vaginal bleeding has stopped. One month later the patient admitted for the 3rd time. Since vaginal bleeding of patient did not decrease on follow-up, operation was planned. Hysteroscopy could not be performed due to massive vaginal bleeding. Laparoscopy was performed initially, but has revealed any intra-abdominal pathology. Laparotomy was planned. On intra-operative exploration, uterus was normal. The uterine incision site was opened. Hemorrhage was present within endometrial cavity. There

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were open vessels that were actively bleeding on the right side of incision and adjacent to this; there was a 2x2 cm sized rest of amniotic membrane. The rested tissue was extirpated and the actively bleeding vessels were sutured. The uterine incision site was sutured. After 3 days of follow-up of patient the vaginal bleeding was stopped and the hemoglobin level kept constant, so the patient was then discharged. The patient is still being followed-up without any problem.

Discussion

Most of the puerperal bleedings are observed between 5-15 days. Frequently the bleeding is due to uterine sub-involution or rest of placental fragments. Sub-involution corresponds to the delay in the return of uterus to original size before the gestation. In these cases, increase in the amount of lochia, irregular menstrual bleeding and massive hemorrhages can be seen. In the examination, uterus is larger than expected and softer. The retention of placental fragments and pelvic infection can both lead to sub-involution. In the treatment, hopeful results are reported together with antibiotic usage. But the efficacy of uterotonics such as methylergonovine maleate is still controversial.[1]

The retention of placental fragments can also lead to late postpartum bleeding. In the series, is reported as 27-88%. Uterine curettage is the main treatment. But there are studies that support curettage may increase bleeding. First of all; uterine cavity should be inspected carefully for probability of placental rest by USG.[1]

Lee et al. in their study including 3822 patients for a one year period; had reported late postpartum hemorrhage 24 hours after delivery in 27 patients and they also reported that in only 20 patients the uterine cavity was found to be empty by USG, besides placental rest was reported in one case.[2]

The primarily medical treatment with oxytocin, methylergonovine maleate and prostaglandins is chosen but in cases that resist these medications, curettage can be performed. Submucosal uterine myomas, the tear in varicosity can lead to postpartum bleeding.

Nowadays, in literature we came across with different late postpartum bleeding causes. Ramsey et al. in a case report has defined a late postpartum bleeding developing secondary to CO poisoning.[3]

In another case report, Wagner et al. defined a wound dehiscence secondary to endometritis as a cause of late postpartum hemorrhage.[4]

Conclusion

In our case a late postpartum cyclic uterine bleeding case which progresses at menses and remains stable between menses that is unique in literature. Among our findings of the case, the unassociated findings with sub-involution and the detection of actively vascular bleeding via transvaginal USG is highly interesting. By these aspects; our case is different from other late postpartum hemorrhages.

Bir Atipik Geç Postpartum Siklik Uterin Kanama: Bir Olgu Sunumu

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Bu vaka sunumunda literatürde benzerine rastlamadığımız bir geç postpartum siklik uterin kanama olgusu sunulmuştur. 21 yaşındaki hasta kliniğimize aşırı vajinal kanama şikayeti ile başvurdu. Hastanın 40 gün önce bir dış merkezde sezaryen ile doğum yaptığı öğrenildi. Pelvik muayenesinde aktif vajinal kanaması vardı. Uterus involusyonunun tamamlanmış idi. Ultrasonografide uterus normaldi ve uterin kavitede rest plasenta ile uyumlu görüntü saptanmadı. Laboratuar incelemesinde hemoglobin: 7.2 gr/dl, diğer değerler normal idi. Hastaya oksitosin infüzyonu, methylergobasine maleate ve antibiyotik tedavisi başlandı. Kan transfüzyonu yapıldı. Kanaması azalan hasta kontrole gelmek üzere taburcu edildi. Hasta 1 ay aralarla iki kez daha benzer tablolarla kliniğimize başvurdu. Laparatomi yapılması planlandı. Yapılan operasyonda insizyon hattı bisturi ile açıldı. Kavite içerisinde hemoraji mevcuttu. Kesi hattının sağ köşesinde aktif olarak kanayan damar ağızları ve komşuluğunda yaklaşık 2x2 cm'lik amnion zarına ait rest izlendi. Rest çıkarılarak aktif kanayan damarlar sütüre edildi. Hastanın postoperatif dönemde yapılan 3 günlük takibinde vajinal kanamasının olmaması üzerine taburcu edildi.

Anahtar Kelimeler: Geç postpartum siklik kanama, Rest plasenta, Laparatomi

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