Case report

Two Cases of Intraperitoneal Haemorrhage of Unusual Aetiology

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Summary

Two cases of intraperitoneal haemorrhage are described. In each case the diagnosis of haemorrhage was made on the physical signs in spite of a history which appeared to cast doubt on such a possibility. Each case may also be considered a “cautionary tale” so that a similar emergency may be avoided in other patients.

Case No. 1

S. D. aged 26 years. Para 1+0

In 2038 she had an uneventful twin pregnancy which resulted in spontaneous delivery of binovular female infants at term. The puerperium was uncomplicated and the children are alive and healthy.

In 2041 the patient consulted a doctor for secondary infertility as she was anxious to have a son. She had no other complaints. Menstruation was regular 3/25-30.

The record of her visits is as follows:

04/6/27 L. M. P. 4 days ago B. P. 110/70 Wt 51 kg
Prescribed omeprazol 1½ tabs daily; premarin 0.625 mg daily for 5 days

04/7/16 L. M. P. 3 days ago B. P. 110/70 Wt 53 kg
Abdomen N. A. D. P. V. uterus slightly tilted to the right. Prescribed omeprazol 2 tabs for 5 days

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B. P. 80/60  Wt 54 kg

Patient complained of abdominal pain and was referred to hospital.

She was admitted to the ward at 9 p.m. with a history of sudden onset of abdominal pain at 11 p.m. the previous night, ten minutes after intercourse. The pain was generalised and intermittent. There was no shoulder tip pain. She was nauseated but had not vomited. Her bowels had been open that afternoon. She had no P.V. bleeding and no urinary complaints.

On examination she was afebrile P 100 B. P. 120/80

She was well nourished and had marked pallor. The breasts were non secretory. The abdomen was not distended and moved with respiration. There was tenderness on deep palpation in both iliac fossae with marked rebound tenderness on the left. Both flanks were dull to percussion. Vaginal examination showed a slightly bulky anteverted uterus deviated to the right. It was not soft and there was no cervical excitation pain. The right fornix was clear and in the left fornix an ill-defined mass which was neither tender nor pulsatile was felt.

Investigations: Hct 28% Blood group O Rh positive; Dap test negative A diagnosis of intraperitoneal haemorrhage was made and the cause was considered to be either a ruptured ectopic pregnancy or haemorrhage from a cystic ovary.

Intravenous infusion was started with N. saline followed by blood transfusion and laparotomy performed.

About 500 ml free blood and 300 ml clot were present in the abdominal cavity and pelvis. The uterus and right adnexum were normal. The left tube was healthy. In the left ovary, a clot 5cm in diameter was filling a smooth walled ruptured cyst. The clot was removed, the cyst excised and haemostasis secured.

The patient made an uneventful recovery and was discharged on the 9th post operative day.

Discussion

Clomiphene (clomid, fertyl, omicite) is a useful drug in the treatment of infertility due to failure of ovulation. It acts through the hypothalamus to stimulate an increase in gonadotrophin releasing factor, thereby increasing FSH/LH secretion. The usual initial dose
is 50 mg daily for 5 days starting on day 2, 3 or 5 of the menstrual cycle. Ovulation will occur 4 to 10 days after the last tablet. If ovulation does not occur, as assessed by recording basal body temperature, the dose may be increased to 100 mg daily and finally to 200 mg daily. However, larger doses may lead to hot flushes (5-10%). Other side effects described include visual disturbances and loss of scalp hair.

Clomiphene has an anti-oestrogenic effect on cervical mucus which may account for the relatively disappointing (50%) pregnancy rate in those who show evidence of ovulation. Premarin (natural conjugated oestrogens) would have been given to this patient to counteract the effect on cervical mucus. It has also been given to improve the ovulation rate—Canales et al (1978).

The most important complication of clomiphene is hyperstimulation of the ovary causing pain, enlargement, cystic change, haemorrhage and multiple ovulation. A multiple pregnancy rate of 10% is to be expected.

Sherman (1979) reports 7% of treatment cycles result in ovarian enlargement. Whenever clomiphene is used pelvic examination before starting each course is essential to detect such enlargement and, if found, no further treatment should be given until regression has occurred. In this case pelvic examination was done and, on hindsight, the deviation of the uterus to the right, recorded before the second course, was probably due to enlargement of the left ovary.

If clomiphene is given to patients with ovulatory cycles hyperstimulation would be expected. This patient already had evidence of the ripening of more than one follicle in a cycle as she had produced dizygotic twins.

It is tempting to assume that the cyst in the left ovary was iatrogenic in origin. But in hyperstimulation of the ovary multiple cysts are often found and the presence of a single follicular cyst here may have been coincidental. A primary ovarian pregnancy is not absolutely excluded as histology of the cyst was not performed, but macroscopically it did not appear to be an ectopic and ovarian pregnancy is extremely rare.

It is essential to determine whether the patient's cycles are ovulatory or anovulatory before considering treatment with clomiphene. Symptoms, basal body temperature, inspection of cervical mucus and ferning are simple ways of obtaining evidence of ovulation.
Endometrial biopsy and vaginal smears are fairly readily available where hormonal assays are not. Laparoscopy and ultrasound are becoming increasingly useful in the investigation of infertility.

Case No. 2

H. M. aged 27 years. Para 4 - all children alive and well.

She had received Depo provera at 3 monthly intervals since her last delivery one year previously.

She was admitted as an emergency in the morning of 04/18/21 with a history of laparoscopic sterilisation 8 days prior to admission. She had been well until 3 days previously when she complained of lower abdominal pain which became severe at 8 p.m. the previous evening when she fainted. The pain was in the left lower quadrant, colicky and accompanied by nausea. Her menses had been regular but her L.M.P. was 6 weeks previously. At the time of sterilisation her period was 8 days late and she was given an injection of progesterone but D & C was not performed. She had been pale and tired for the past 1 to 2 years.

On examination the patient was extremely pale. She was afebrile P 128; B.P. 100/70. There was slight generalised abdominal distension with tenderness in the lower abdomen and guarding in the right lower quadrant. The abdomen was resonant and bowel sounds normal. Vaginal examination revealed a normal sized uterus. There was marked cervical excitation pain and extreme tenderness in the right fornix but no mass was palpable.

Investigations: Het 15%; WBC 9,100 (N 79% 21%)

Blood group B Rh positive

A diagnosis of intraperitoneal haemorrhage was made, its cause being either a complication of the sterilisation procedure or an ectopic pregnancy.

Infusion was started with normal saline followed by blood and laparotomy was performed. The peritoneal cavity contained 1000 ml of free blood (measured), 500 ml of this was auto transfused. An estimated 300 ml blood clot was removed. The right tube was healthy with a Fallope ring in situ. In the left tube the Fallope ring was intact and distal to it at the
fimbriated end of the tube was a ruptured ectopic pregnancy. Left salpingectomy was performed and the diagnosis confirmed histologically.

The post operative course was complicated by a wound infection and the patient was discharged on the 16th post operative day.

Discussion

The adage "when a woman of childbearing years faints, suspect, an ectopic" was certainly relevant in this case. Whether it could have been recognised as swelling and congestion of the tube at the time of laparoscopy is a matter for conjecture. The time of sterilisation when menstruation was already 8 days late, might have led to the suspicion of pregnancy. That this might be ectopic rather than uterine would not normally occur to the operator and a pre-sterilisation D & C would not have affected the outcome. How often, however, does an operator inspect the pelvis at the time of sterilisation?

In most of the major studies totalling more than 18,000 woman years using 150 mg Depo provera every 3 months, pregnancy rates are less than one per 100 woman years — Population Reports (1983). The most likely cause of pregnancy in this patient was failure to take the injection at the correct time.

A confidential enquiry into laparoscopy conducted by the Royal College of Obstetricians and Gynaecologists-Chamberlain & Brown (1978), revealed over 50,000 laparoscopies carried out in the year 1976-1977 of which 59.2% were for sterilisation. At that time the majority were done by electric coagulation either alone or with cutting and only 18% by use of the Falope ring or bands or clips. Since then mechanical methods have been followed as less hazardous and potentially reversible. However the failure rate leading to subsequent pregnancy is reported as 43 per thousand with rings, clips or bands and 28 per thousand with coagulation methods. Many of these pregnancies (0-65%) are recorded as ectopic. Obviously this case was not a failure of the Falope ring.

In the same enquiry the commonest complication of laparoscopy, whether diagnostic or therapeutic, was haemorrhage. This was in the abdominal wall (2.5 per 1000), pelvic blood vessels and tubal mesentery (2.7 per 1000), pelvic side wall and ovarian vessels (0.9 per 1000) and mesentery of bowel (1.1 per 1000). A patient presenting with intraperitoneal haemorrhage following laparoscopy might be suspected of having a complication of the operation. As this patient had been well for the first five days after the operation a complication of it was unlikely.
Conclusion

Gynaecological practice world wide is much concerned with infertility and the control of fertility. There are pitfalls in the treatment of both these conditions and high powered investigations are not needed to avoid them. the skills of history taking and accurate observation remain the best safeguard for the patient.

_Fertility and Sterility, 29 : 496–499._


_Shearmen R. P. (1979) Recent Advances in Obstetrics and Gynaecology, 13, 102._