



CASE REPORT

POST-CAESAREAN RECTUS SHEATH HAEMATOMA: A CASE REPORT

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ABSTRACT

The author reports a case of rectus sheath haematoma after lower segment caesarean section (LSCS). The haematoma extended to the pelvic wall. The aberrant course of vessels or injudicious dissection may contribute to this catastrophe. Clinical suspicion, Carnett's test and ultrasonography were used to confirm the diagnosis. The management was conservative.

Keywords: Rectus sheath hematoma, Post caesarean

SEZARYAN OPERASYONU SONRASI GELİŞEN REKTUS KILIFI HEMATOMU: VAKA SUNUMU

ÖZET

Alt segment sezaryen operasyonu sonrasında rektus kılıfı hematomu saptanan bir olgu sunulmuştur. Hematom, pelvis duvarına kadar uzanmakta idi. Damar yapısı veya diseksiyon hataları bu olumsuz tabloya neden olmaktadır. Klinik şüphe nedeni ile Carnett's testi ve ultrasonografi kesin tanı için kullanılmıştır. Hastaya konservatif tedavi uygulanmıştır.

Anahtar Kelimeler: Rektus kılıfı hematomu, Sezaryan operasyonu

INTRODUCTION

In developing countries, where simple diagnostic facilities are not available all times, diagnosis of rectus sheath haematoma remains elusive and has to rely on the doctors clinical judgment to diagnose this uncommon, but well-documented mimic of acute abdominal pain¹. A keen clinical sense, ultrasound and the invaluable Carnett's test for diagnosis is available in developing countries. Prompt consideration of this rare mimic of acute abdominal pain may reduce the burden of performing expensive and invasive diagnostic tests and in some cases unnecessary hospitalization and laparotomy².

CASE REPORT

A 26-year-old female was referred to our surgical services with persistent lower abdominal pain of two days duration .She had undergone LSCS three days previously. She was primi. The patient has already received pain killers. Initially, the pain was attributed to the wound site pain of LSCS. Tachyardia was present. The rest of parameters were normal. Perabdominal examination revealed tenderness on palpation of lower abdomen. Due to the tenderness, no swelling could be assessed. Carnett's test was positive. Haemoglobin was 10 gm%. There was no significant finding on the abdomen X-ray.

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Abdominal sonography showed a multiseptate cystic swelling of 11.4×8.1 cm. in front of the bladder extending into the anterior abdominal wall, as shown in Fig.1 suggestive of rectus sheath haematoma. In our case, the abnormal course of vessels in the rectus sheath, abnormal insertion of the rectus muscle which was torn during insertion with lax and thinned out abdominal wall layers may account for rectus sheath haematoma. The patient was managed conservatively, discharged on the seventh day and is routinely attending our follow up clinics.



Figure 1: A multiseptate cystic swelling in front of the bladder extending into the anterior abdominal wall, suggestive of rectus sheath hematoma.

DISCUSSION

Rectus sheath hematoma has been a well-known entity from the ruin of ancient Greece³ Rectus sheath presents as acute abdominal pain. Females are more prone to develop rectus sheath haematoma. The presentation is a painful, tender abdominal swelling of sudden onset. This haematoma results from bleeding into the rectus sheath due to damage to the superior and the inferior epigastric arteries or their branches, or a direct tear of the rectus muscle when small branches bleed. Sometimes it can expand and lead to hypovolemic shock and subsequent death. This haematoma usually lies posterior to the muscle. Haematomas near the umbilicus are rare. Considered causes for rectus sheath are severe exertion⁴, pregnancy⁵, insulin injection⁶, laparoscopy and cholecystectomy⁷. Berna et al, proposed that rectus sheath haematoma should be suspected in women of advancing age undergoing treatment with anticoagulants who present with triad of acute abdominal pain, infraumbilical mass and anemic syndrome⁸. Other causes being coughing, thrombocytopenia and contusion⁹. Ultrasound is a good investigation for diagnosis¹⁰, showing the mass of mixed echogenicity with no internal vascularity⁵. CT abdomen in particular is more useful, permits a more correct diagnosis and is considered the investigation of choice¹¹. Technetium -99 labeled red blood cell (RBC) scintigraphy confirms the presence of the haematoma, site of bleeding and reveals continued bleeding⁶. Selective percutaneous transcatheter arterial embolisation is considered an effective haemostatic in the treatment of a patient with a large haematoma¹². Because of the diagnostic dilemma of differentiating this condition from other acute abdominal conditions the majority of cases are treated with operative procedures³. Non-surgical therapy is considered appropriate, but leads to a greater need for analgesics. Surgical intervention is necessary in cases with large haematomas or free intra operational ruptures¹⁰. Early diagnosis permits conservative management even in large haematomas.



Stress is laid on clinical examination, Carnett's test and ultrasonography in the diagnosis of rectus sheath haematoma. A persistent pain in the lower abdomen should arouse suspicion of rectus sheath hematoma in post LSCS. Management is most of the time by conservative measures.

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