

Case Report

Postcoital bleeding - an unusual cause for abdominal apoplexy

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Key words : postcoital bleeding

A 28 year old woman came to our out patient department on 25th June 2005 at 11.00 a.m. with severe right sided abdominal pain and vomiting three times since 10.30 p.m. of previous night. Her menstrual cycles were regular. She was in the 23rd day of the menstrual cycle. She was married since 7 years and had two normal vaginal deliveries. Her last childbirth was 5 years ago when she underwent sterilization.

On examination, she was markedly pale, her pulse was 90/minute and regular blood pressure was 90/60 mm Hg in the upright position. Abdomen was distended and on deep palpation, there was right iliac fossa tenderness, without any guarding or rigidity. On auscultation bowel sounds were sluggish. Bimanual pelvic examination revealed anteverted normal sized uterus, with cervical motion tenderness. Fullness was felt in the posterior fornix.

An urgent ultrasound scanning at 11:20 a.m. revealed about 200 mL free fluid in the pelvis. Uterus was normal sized and endometrium showed posterior enhancement suggestive of secretory phase. Both ovaries were visualized separately. Her hemoglobin was 6.9 g. Leukocyte count, bleeding time, and clotting time were

normal. The urine gravindex test for pregnancy was negative. Blood group was A₁ positive.

With the above clinical picture, a provisional diagnosis of hemoperitoneum was made and an emergency diagnostic laparoscopy was carried out on 25th June, at 12:30 p.m.

Laparoscopic findings

Hemoperitoneum was present and about 400mL of blood was drained. Uterus and both the tubes were normal. An active bleeding site was noted in the right ovary, which was arrested with electrocautery. At the base of the left broad ligament, two transverse tears of 2cm length were noted close to the attachment of the left uterosacral. There was bluish discoloration along the borders of the tears, with no active bleeding. Few organized blood clots were seen close to the broad ligament, which were left undisturbed. Peritoneal lavage was done and the abdominal incisions were closed after securing perfect hemostasis. Postoperatively she was given one unit of blood and 5 doses of 1g cefuroxime. She had an uneventful postoperative period. She was discharged on 3rd postoperative day, and advised to avoid sex for 2 months.

She was examined at follow up visits one week after discharge and after subsequent 2 months. She had no complaints. Examination and sonography showed no abnormality.

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Discussion

This rare condition, wherein spontaneous intra peritoneal hemorrhage is present is known as abdominal apoplexy. This case is presented, to highlight the difficulty in diagnosis when the bleeding occurs slowly, without pain and without known etiology. In this case we were not clear about the cause for the tears. Considering the time of onset of pain, the patient was questioned and admitted that she had the onset of pain following intercourse.

Such cases of intraperitoneal postcoital bleeding without associated vaginal injuries is an extremely rare entity and only few cases have been reported till date in the literature. In this case the bleeding was from ovarian laceration and broad ligament tears. The other sites of internal injuries reported in the literature are ovarian cysts of adhesion bands, laceration of the round ligament, peritoneal vessel rupture in the pouch of Douglas¹⁻³ and rupture of a lienal aneurysm⁵. In the diagnosis of inapparent intraabdominal bleeding, history of preceding intercourse, which is usually not readily given by the concerned patient and ultrasonography play a vital role^{3,4}. As far as the

management is concerned, immediate laparoscopic or surgical exploration remains the obvious choice in such situations. This diagnosis is to be considered in patients with postcoital bleeding, even if vulvar or vaginal injuries are absent.

References

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