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Case Report

Spontaneous hemoperitoneum: a clinical dilemma

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Case report

A 34 year old lady was admitted on 2nd October, 2004 as an emergency in a surgical unit with symptoms of worsening pain in the right iliac fossa (RIF) for over six hours with diarrhea and vomiting. She had undergone a vaginal hysterectomy 8 years back for stage 1 carcinoma cervix. She subsequently developed chronic pelvic pain and ovarian pathology had been ruled out on sonography.

She was tender in the RIF with guarding and rebound tenderness. Initial suspicion was that of appendicitis. She was managed conservatively as her baseline investigations (full blood count, coagulation profile and C-reactive protein were normal. An ultrasound scan showed a 4 cm simple cyst in the right ovary with some free fluid. In view of these findings she was transferred to our gynecological unit. Her pain worsened overnight and she was found to be tachycardic and pyrexial the next morning. Of significance was the drop in hemoglobin concentration from 9.8 g/dL to 5.4g/dL. An emergency laparoscopy done on 3rd October 2004 confirmed about a liter of blood in the peritoneal cavity with some adhesions from her previous pelvic surgery and a simple right ovarian cyst. There was no evidence of a complication of the cyst or a pelvic source of the bleed.

A general surgeon was asked to review the case. He performed a midline laparotomy. No obvious source of bleeding was identified in spite of a thorough exploration of all intraperitoneal and pelvic organs and retroperitoneal space. The bleeding appeared to have stopped spontaneously. Four units of blood were transfused intraoperatively. The patient made a steady recovery in the intensive care unit and was discharged after a week in a stable condition. Of interest was the fact that following extensive investigations, the patient did not have any evidence of congenital or acquired bleeding diathesis nor was she on any drugs or medications such as anticoagulants that could predispose to a spontaneous bleed. The patient requested a bilateral oophorectomy at her review appointment to avoid encountering a similar episode in the future. This was not done and she was given the information pertaining to a premature menopause following the oophorectomy and advised to come for follow up in 2 months.

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Interestingly, she came in again as an emergency case on 14th February 2005 with similar symptoms of abdominal pain and a 4 cms hemorrhagic cyst was noted in the left ovary. Her Hb rose from 11 g/dL to 20 g/dL within 12 hours and her pulse rate increased from 78 / minute to 160/minute. She developed abdominal distension and anuria with peripheral shutdown which along with hemoconcentration led to the rise in hemoglobin. She needed morphine for pain relief. The surgeons reviewed her and a diagnosis of subacute intestinal obstruction was made. A repeat laparotomy under general anesthesia on the day of admission revealed 180 cm of gangrenous bowel (following twisting of bowel loops around the adhesions) that was removed and simultaneously a bilateral oophorectomy was performed. The patient made a good recovery from the procedure and was discharged in a stable condition on 22nd February 2005.

Discussion

Hemoperitoneum is usually associated with trauma or rupture of an aneurysm involving aortic, adrenal or splenic arteries[1], liver or splenic tears[2] following blunt trauma, ectopic pregnancies, ovarian bleed and other rare causes like postcoital hemoperitoneum[3], rupture of uterine artery by erosion from endometriotic lesion[4] and spontaneous subserosal venous rupture overlying uterine leiomyoma[5]. Idiopathic spontaneous hemoperitoneum is very rare and this case is one such example. The use of secondary ultrasound examination to increase sensitivity of identification of abdominal injuries and hemoperitoneum within 24 hours of the first scan and use of interventional radiology to detect a bleeding vessel and occlude the bleeding artery has been reported[6]. Failure to identify a source of bleeding at the first laparotomy could be accounted for by an initial drop in the blood pressure intraoperatively. Subsequently however when her blood pressure did stabilize, the bleeding ceased spontaneously with no sign of recurrence or coagulopathy.

The interesting turn is her second presentation with similar symptoms due to bowel involvement.

An undiagnosed source of bleeding leaves us with concern for the future. The only point of contentment being that the patient was evaluated and managed appropriately despite the lack of proper diagnosis especially during the first laparotomy.

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