

Unrecognised Abruption In A Rural Nigerian Woman: A Case For Early Referral And Intervention

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Abstract

Placenta abruption is one of the obstetrics emergencies with considerable morbidity and mortality for both mother and baby. We present the case of a 34 year old Nigerian Woman, gravida 4, Para 3+0, who had spontaneous vagina bleeding at term (39 week gestation) and was referred to our centre (Jos University Teaching Hospital-JUTH, Jos) from a rural health clinic. She had emergency lower segment caesarean section with delivery of a live male baby weighing 3.55Kg and a retro-placenta clot of about 250mls. Her postoperative recovery was uneventful and she was discharged home after one week of surgery. This was the preferred mode of delivery due to the previous uterine scar, absence of continuous electronic intrauterine fetal monitoring and normal hematological profile in the presence of a live fetus.

CASE REPORT

A 34 year old housewife, para 3 + 0, 3 alive, whose last menstrual period was 6/3/95 with an estimated gestational age of 39 weeks was referred to us from a rural hospital with a 2 day history of progressive vagina bleeding. She started experiencing abdominal pain 2 hours before presentation to our unit. The fetal movement was reportedly normal with no drainage of liquor. She had no obvious uterine contractions. A few days before onset of above symptoms however, she was hit on her abdomen by her last child while playing. She booked index pregnancy at the same hospital at 20 weeks of gestation and had several uneventful visits. Her 3 previous pregnancies ended in 2 spontaneous vertex deliveries at term while the last was an emergency cesarean section due to fetal distress at term. She had uneventful puerperiums in all of them.

Physical examination revealed a pregnant woman with a previous vertical sub umbilical scar and a symphysio-fundal height of 40cm. There was moderate suprapubic tenderness with minimal guarding but, no rebound or obvious contractions. There was a singleton fetus in longitudinal lie presenting cephalic in right occipito-anterior (ROA) position. The head was engaged and the fetal heart rate was 140 beats per minute. An impression of Abruption Placenta to rule out placenta praevia was made. Ultrasound scan on the pregnant uterus showed a live fetus, with a postero-fundal placenta. There was a little retro placenta blood clot (shown

by a dark hypo echoic shadow), which was centrally located. The blood pressure was 140/90 mmHg, pulse 120 beat per minute and a temperature of 37C. Her PCV was 29% and all the clotting profiles were within normal. The routine serum biochemistry was also normal.

She was resuscitated and counseled for emergency Caesarean section after she was grouped and cross-matched with 4 units of blood. She was operated via the previous scar. The intra-operative findings included a hyperemic gravid uterus especially at the fundal region with a well formed lower segment which showed prominent veins. A male live baby in ROA position was delivered weighing 3.55kg. The apgar score at delivery was 7 and 10 at one and ten minutes respectively. A retro placenta clot of about 250mls was found. She made an uneventful postoperative recovery and was discharged home with her infant one week after the surgery. Her puerperium was normal.

DISCUSSION

Premature partial or complete separation of the normally implanted placenta after viability, but before the delivery of the fetus is called abruption placenta². It is one of the obstetrics emergencies with considerable morbidity and mortality for both mother and the baby especially in the developing world.

The reported frequency for placenta abruption is 1 in 75 to 90 deliveries¹. In Nigeria, the incidence is quite low with

figures varying from 0.24 – 0.5³. The low incidence in Nigeria may be racial, since low socio-economic status, high parity, hypertension and folic acid deficiency anaemia, all suspected etiological factors in abruption placenta are quite prevalent in Nigeria⁴. Other causes related to medical abortion such as gestational age > 6weeks at abortion, a curettage after abortion, and a longer interpregnancy interval may increase the risk of abruption⁵. The effect of surgical abortion on placenta complications of subsequent pregnancies have occasionally been reported^{6,7,8}.

The presentation of vaginal bleeding which was initially painless and a history of previous operative abdominal delivery gave a confusing picture of the type of antepartum hemorrhage. This was made worse due to the absence of a raised blood pressure, obvious trauma and ultrasonographic evidence of a clear diagnosis from the referral unit. The onset of abdominal pain on arrival at our center two days later coupled with a remote history of trauma and sonographic placenta localization confirmed the diagnosis of abruption placenta, although its main use is to rule out placenta praevia, since a negative finding does not exclude life threatening abruption placenta^{1,9}. At the rural health center, it is obvious that although this patient was a high risk case, due to her previous abdominal delivery, she was set for vaginal birth after cesarean even in the absence of trained personnel and institutional capacity. In the presence of experienced and competent staff and facilities to carry out cesarean section, even in the absence of sonographic evidence early intervention would have been the option. Examination under anaesthesia (EUA) usually necessary to rule out unrecognized placenta praevia before surgical intervention was not done because of the availability of ultrasonography. The presentation of vagina significant vagina bleeding with abdominal pain and a previous history of ante partum, coupled with a tender uterus and a remote history of trauma although, suggestive of the diagnosis of abruption placenta, placenta praevia could not be ruled out in this patient. This was confirmed by ultrasonography although its main use is to rule out placenta praevia since a negative finding does not exclude life threatening abruption placenta.

The timing of delivery usually depends on gestational age, volume of haemorrhage, maternal haemodynamic stability, coexistent coagulopathy, and fetal well-being. In most cases, volume replacement, component blood therapy and treatment of coagulopathy allow a vaginal delivery⁹. Abdominal delivery, although not ideal for abruption

placenta was done in this patient because, of the absence of continuous fetal monitoring and risk of oxytocin on the scarred uterus. Early presentation without several confounding factors, could have probably given us the opportunity to assess her more correctly for possible vagina delivery.

She was not transfused blood because of the increasing incidence of blood borne infections especially, human immuno-deficiency virus (HIV), a moderate blood loss with a retroplacenta clot of 250mls (Sherr's grade II)^{1,2} and her haemodynamic stability. There was also no associated coagulation abnormality usually seen in more severe cases. Bleeding tendencies as a result of coagulopathy seen in some cases of placenta abruption especially following surgery therefore did not occur in this patient.

The risk of recurrence of abruption placenta in another pregnancy is much higher in this patient^{1,2}. This singular factor makes any other subsequent pregnancy a high-risk pregnancy. A management of the subsequent pregnancy is made difficult by the fact that the placenta separation may occur suddenly at anytime, even remote from term¹. This patient's condition could be further complicated in her future pregnancies as a result of two previous caesarean sections.

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