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Case Report

Retzius space haematoma with retroperitoneal dissection after spontaneous vaginal delivery: an unusual presentation of ruptured paravesical plexus managed by bilateral internal iliac artery ligation



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ABSTRACT

Introduction: Abdomino-pelvic hematomas during pregnancy, labor or postpartum are severe and rare hemorrhagic complication that result from rupture in the pelvic vessels. Principles of surgical management of pelvic hematomas and postpartum hemorrhage are well known and documented and are of high clinical interest.

Aim: We report a rare case of hematoma following vaginal delivery.

Case study: A patient with a Retzius space hematoma after vaginal delivery presented with hemodynamic instability and abdominal distension with suprapubic bulge in the postpartum period. Ultrasound examination showed a heterogeneous mass between bladder and uterus suspicious of hematoma with another retroperitoneal one associated with right hydronephrosis.

Results: Exploratory laparotomy was performed that revealed a hematoma in the Retzius' space with infiltration of the wall of the bladder with extension to the paracolpos space and the right broad ligament to the retroperitoneal space. The bleeding source was suspected to be the blood vessels in the wall of the bladder that were hemostatically sutured. Bilateral uterine artery ligation with bilateral internal iliac artery ligation were done to control hematoma and atony and vertical vertical compression sutures were done for uterine atony. The hemorrhage was found to be secondary to rupture in the paravesical venous vessels.

Discussion: Hematoma in the Retzius' space is a rare complication. It needs urgent diagnoses and management. Few cases were reported in the literature. The condition may pose diagnostic problems, as pelvic bones let only a limited examination, but requires an undelayed handling. This was illustrated by determining a complete extent of the hematoma only intraoperative. The authors made an accurate diagnosis and applied a necessary treatment in an urgent situation. The technique of the vessel ligation was a demanding, but optimal solution.

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Conclusions: This article focuses attention at an uncommon obstetrical situation and delivers actual and practical advice for management.

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1. Introduction

Abdomino-pelvic hematomas during pregnancy, labor or postpartum are severe and rare hemorrhagic complication that result from rupture in the pelvic vessels.^{1,2}

Puerperal hematomas are classified as vulvar, vulvovaginal, vaginal, or subperitoneal³ that might represent a significant hemorrhage and should be considered as obstetric emergencies. The extent of hematoma during vaginal delivery corresponds to the degree of progression of parturition and the volume of blood accumulated. Puerperal hematomas are generally involving the branches of the hypogastric artery.⁴ Most hematomas will present within 24 h of delivery. External ureteral obstruction by a retroperitoneal hematoma is rare, but embolization or ligation of the involved artery is effective treatments.

Large pelvic hematomas are very uncommon after spontaneous vaginal delivery and there are very few similar case reports. On the other hand, pelvic hematomas are well known after traumatic instrumental vaginal deliveries. From management point of view, there is no much difference between the two situations. Principles of surgical management of pelvic hematomas and postpartum hemorrhage are well known and documented and are of high clinical interest.

2. Aim

We report a rare case of puerperal hematoma in primipara following vaginal delivery that was successfully managed with conservative measures.

3. Case study

A 20-year-old primipara was admitted to our hospital after vaginal delivery at home since 3 h before admission without any medical attendance except for a daya and she gave birth for a viable full-term male fetus. Her relatives indicated that she had not suffered from blood coagulation disorders and had not taken any special drugs. They indicated delivery of the placenta was done with no episiotomy, they indicated also that the labor was short, ended in 1 hour (precipitate labor) she deteriorated after delivery with severe abdominal pain especially in the suprapubic area, urine retention and disturbed consciousness.

General examination revealed hemodynamic instability with drowsy state. Heart rate was 120 bpm and blood pressure was 90/60 mmHg with hemoglobin level of 7 g%, platelet count 150 000/mcL and prothrombin activity was 60%. Intravenous fluids with blood transfusion were initiated immediately. A pelvic examination revealed a gravid uterus extending to level of 28 weeks with deviation to the left side and a painful, non-mobile and soft mass extending suprapubically about 20 cm in dimension mainly on the right side. Vaginal examination revealed swollen vulva by edema with no cervical or vaginal lacerations or incisions, and vaginal bleeding moderate in amount from the soft enlarged uterus. Foley's catheterization of the bladder revealed smoky red urine.

On transvaginal and transabdominal sonography, the abdominal mass was confirmed about 20 × 15 cm heterogeneous mass between the uterus and the bladder, mainly on the right side and no free fluid in the Douglas pouch or Morrison pouch, but there was heterogeneous mass about 15 cm beside

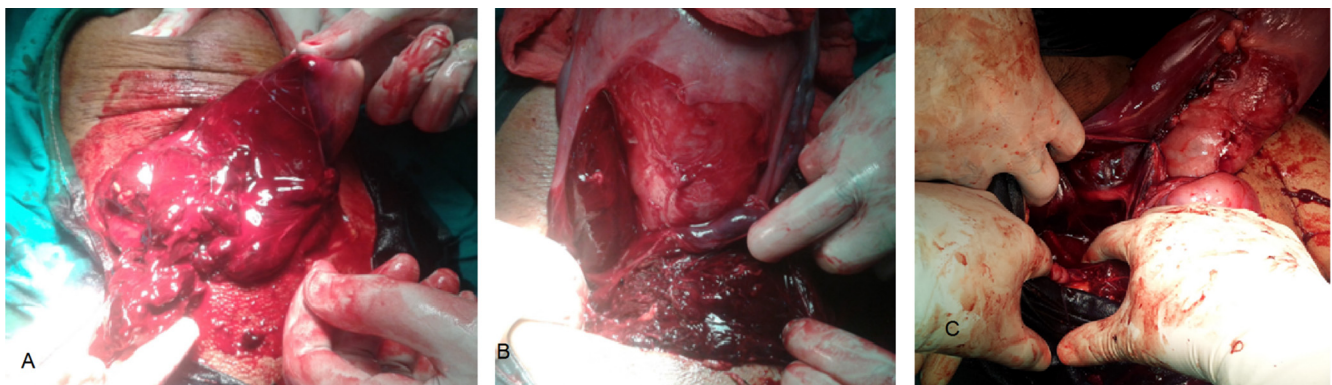


Fig. 1 – Hematoma in space of Retzius before opening the visceral peritoneum (A); hematoma covering the bladder wall extending in the right broad ligament with the uterus and cervix free and intact (B); dividing the right round ligament showing extension of the hematoma in the paracolpos space with the ureter seen up and external iliac artery below (C).

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