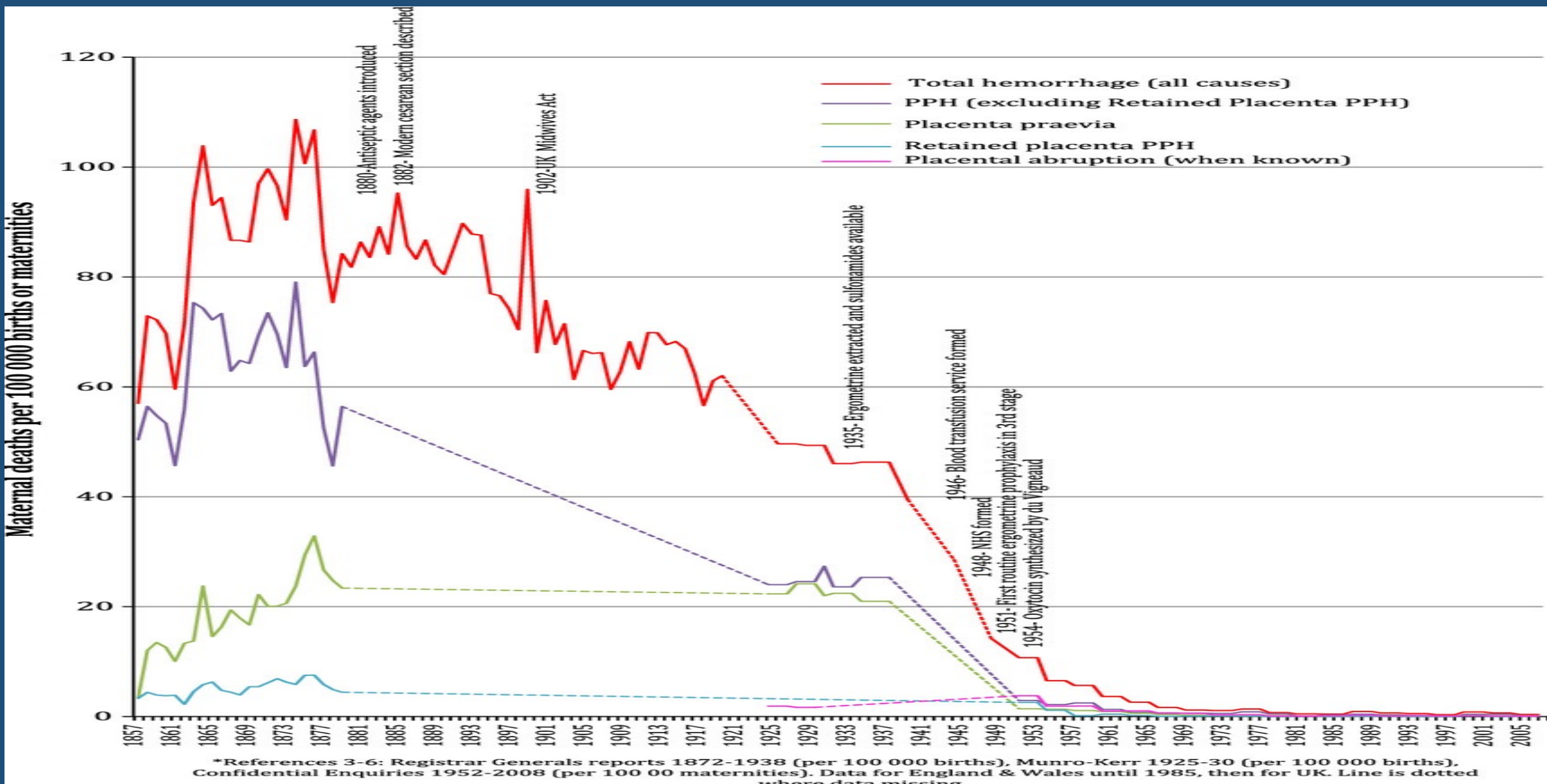
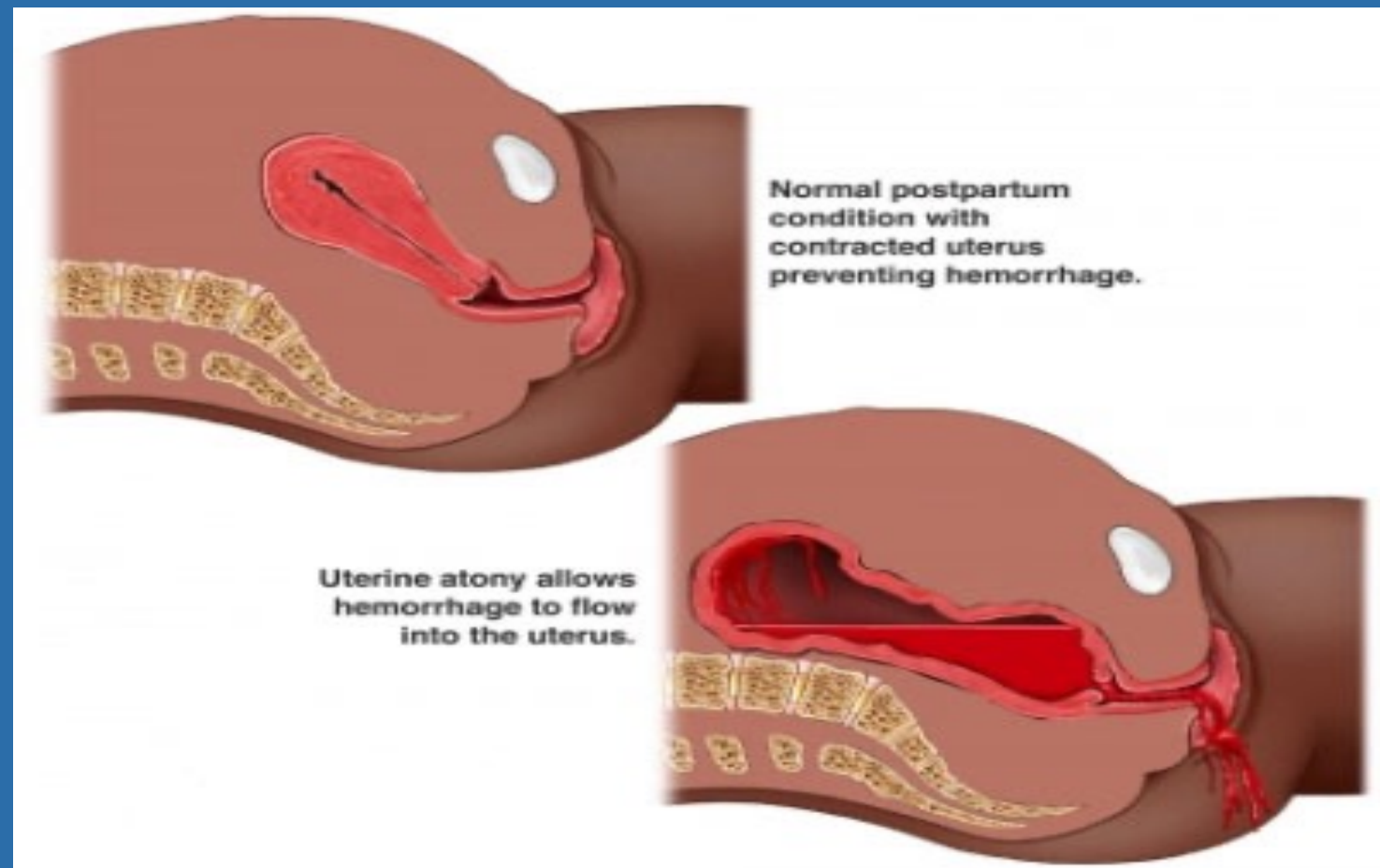




PPH CASE REPORT

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Objectives:
PPH is one of the leading causes of maternal mortality and morbidity worldwide and accounts for nearly one-quarter of all maternal deaths. Here is a case of PPH resulting from uterine atony, exacerbated by gestational proteinuria, APH and subsequent development of DIC.



Case report:
•A 45 yrs. old, Gravida 2 Para 0+1, with 27+6/40, IVF conception, BMI 22, presented to maternity triage at around 2000 hrs with fresh PV bleeding and abdominal pain. She was known to have a low anterior placenta and had a prior triage attendance at 25+1/40 for non-significant PV bleeding. She was kept as inpatient and underwent CAT 1 EMCS, in view of placental abruption as diagnosed by clinical findings of a tense abdomen with ongoing APH, abnormal CTG and bedside Ultrasound suggestive of blood clots in the cavity. Intra-operatively, incision made through placenta and baby delivered via breech. The cavity found to be filled with multiple clots which were removed. Major obstetric haemorrhage alerted, and the uterine atony managed with oxytocic's and B-lynch sutures. Abdomen closed after placement of a drain. Within couple of hours, she returned to theatres as her observations deteriorated and the drain had >500mls of bright red blood. Her bloods at this point- Albumin 24, CRP 7, Bilirubin 6, ALT 27, Na 139, K 4.3, Creatinine 60, Hb 84, WCC 30.17, Platelets 68, PT 15.8, APTT 32.2, Derived fibrinogen 0.89. Relaparotomy, re-suturing of the LUS, insertion of Bakri balloon, B lynch suturing over the deflated balloon followed by inflation of Bakri balloon performed. Total EBL was 7 litres. She was given a total of 12 units of PRBC, 12 units of FFP,4 units of cryoprecipitate & 1 unit of platelet and was sent home on iron supplements and LMWH.



Discussion:
•In this patient, haemorrhage due to uterine atony was complicated by an underlying gestational proteinuria, low lying placenta, APH & subsequent DIC. Prompt delivery, supportive treatment with blood product transfusion; rigorous clinical and laboratory surveillance; prompt involvement of Obstetrics, midwifery, anaesthetics and haematology Consultants was well appreciated.

Conclusion
•This case of postpartum haemorrhage resulting from intraoperative uterine atony as a complication of placental abruption, gestational proteinuria, during the preterm gestational period in a 45 yrs old woman, is one of a kind in the obstetrics medical literature. Maternal and neonatal outcomes were good following timely emergency caesarean section, prompt recognition of emergence of DIC in the post-op period, followed by re-laparotomy with placement of Bakri balloon and B-lynch sutures.

