

Management of massive PPH in a case with completely closed stenosed cervix

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Objectives:

Management of the severe atonic post-partum haemorrhage during CS in a case with severe cervical stenosis due to X2 cervical treatment (X2 LLETZ), how her uterus was saved from hysterectomy and how was she followed up after the CS till she got pregnant and how was her next CS.

Case report:

32 years old female, admitted to the antenatal ward for induction of labour due to reduced fetal movements.

She had a history of 1ry infertility for 2 years. She was under the infertility clinic, but this pregnancy was spontaneous. In addition to X2 LLETZ procedures in her 20s for precancerous cervical lesions which caused severe cervical stenosis, needed dilatation of the cervix to treat hematometra.

Few hours after the start of the induction of labour, she developed hyperstimulation, Propess removed and had terbutaline, settled for about 2 hrs. However hyperstimulation again, vaginal examination done which revealed the cervix is flush with the vaginal vault and was stenosed and fibrosed, findings explained, decision made to go for emergency CS, baby delivered safely in very good condition, the uterus was completely atonic, management of the PPH started as per the hospital and RCOG guidelines, the uterine incision angles secured, the blood was still collecting in the uterine cavity and examination revealed that the cervix was completely closed and stenosed, the internal os couldn't be felt, Bimanual compression, bilateral uterine artery ligation done, vaginal examination in lithotomy position done but the cervical os couldn't be identified, no bleeding noted in the vagina, atonic PPH still ongoing, as a final measure B-Lynch tamponade stitch was applied.

To sort out the problem of drainage of the blood and lochia from the uterine cavity, size 18 Fr Foley's catheter inserted intrauterine to drain the cavity, came out from the middle of the uterine incision and from the abdominal wall incision as well.

Patient given cover of antibiotics and kept under close monitoring in central delivery suite.

Patient made a good recovery in the post-operative period, and the intrauterine drain was working well draining the minimal bleeding and lochia.

She started to get vaginal bleeding after 3 days, by day 7 the uterine drain was removed.

Patient decided bottle feeding so we had a discussion to be started on GnRH analogues to avoid possible development of hematometra due to very tight cervix, the patient agreed to the plan and given a course of 6 months.

Follow up after the end of that course revealed that she was suffering from severe lower abdominal pain and USS revealed hematometra, admitted for ultrasound guided dilatation of the cervix under GA twice which helped with the pain and the flow of the period bleeding.

Spontaneous pregnancy after 18 months, the patient requested elective repeat CS + bilateral tubal sterilization (which was done by the same team who did her 1st emergency CS as per her request), blood loss was normal but again the internal cervical os couldn't be felt and vaginal examination during the CS didn't reveal any blood coming from the top of the vagina, so an intrauterine drain left again but this time kept only for 3 days as she started to have vaginal bleeding from day 1, most probably due to previous cervical dilatation.

Discussion:

Cervical treatment is a recognized cause of cervical fibrosis and stenosis which is associated with increased risk of preterm labour, this risk is significantly increased if the patient had a repeat procedure, these issues should be clearly discussed with the patient during her antenatal care. It is important also to assess the cervical length during pregnancy which will be of great help with counselling the patient. Unfortunately, this part of the care was missed in this case.

It's a good practice when performing a CS on a patient with such history to routinely check the internal cervical os is open to avoid the possibility of having a problem of collection of the blood in the cavity and developing intrauterine haematoma which will be difficult to deal with.

The new simple technique of using foley's catheter as intrauterine drain was successful in dealing with the problem and saved the patient from having the risk of ending up with hysterectomy.

The continuity of care of this patient was a model of providing the best care to the patient either in the obstetric part or gynaecology part, the patient was quite satisfied and felt safe to be treated by the same team who dealt with her successfully before, it's worth mentioning that both the patient and her husband developed PTSD following the 1st traumatic experience and the continuity of care meant a lot to them.

Conclusion:

Introduction of Foley's catheter as a method of draining the uterine cavity during CS in cases of completely stenosed cervix is a simple and effective measure which may save those women from the risk of ending up with hysterectomy.

The patient with a history of cervical treatment or operations that carries the risk of stenosis and fibrosis of the cervix should be properly counselled and investigated during pregnancy. Plan of care and possible outcomes needs to be clearly explained for the patient to be prepared and to avoid any traumatic mental health outcomes.

It will be very helpful if more research about the incidence of cervical dystocia following cervical treatment is done to improve our ability in providing evidence-based counselling for these patients.