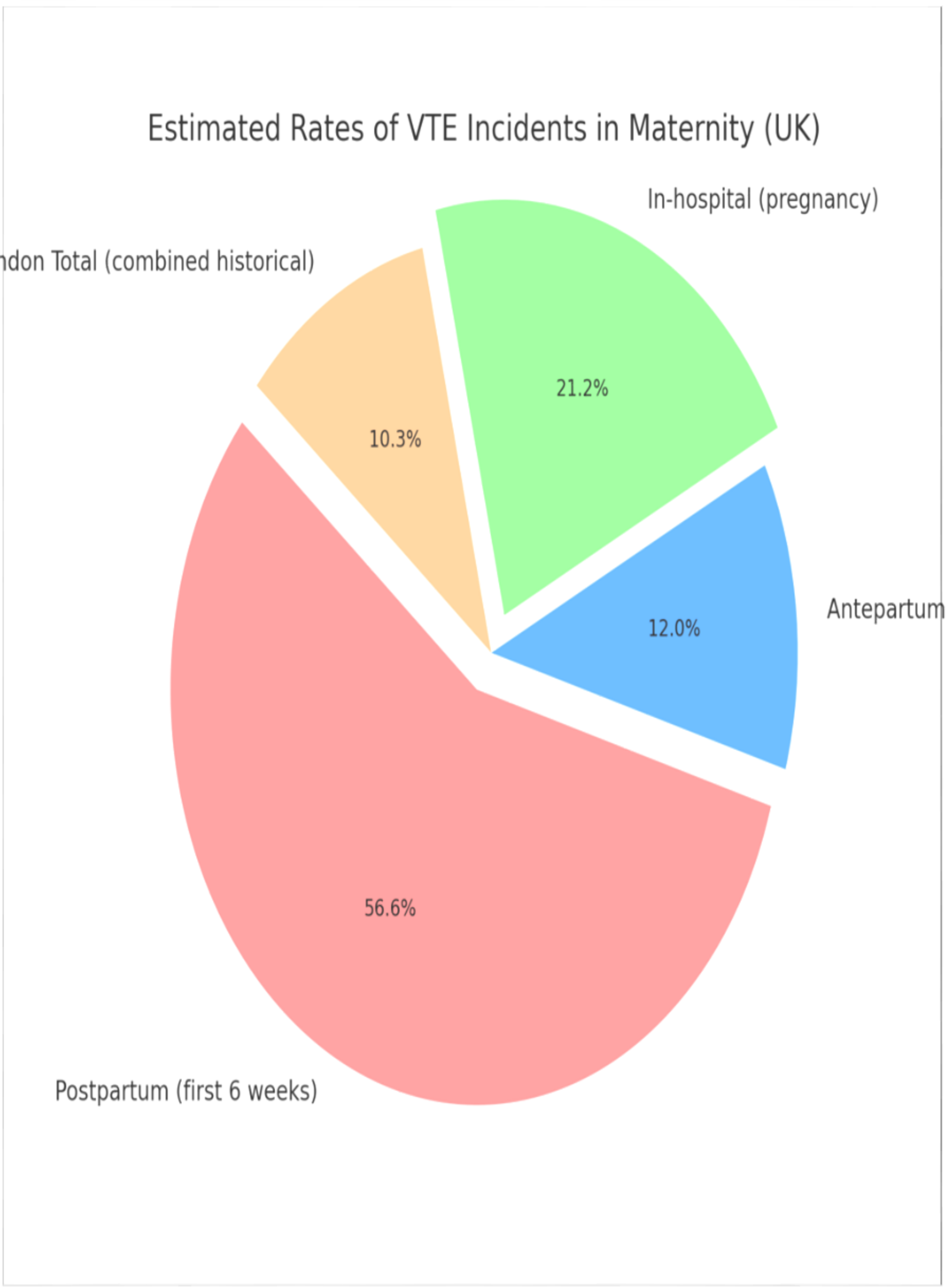
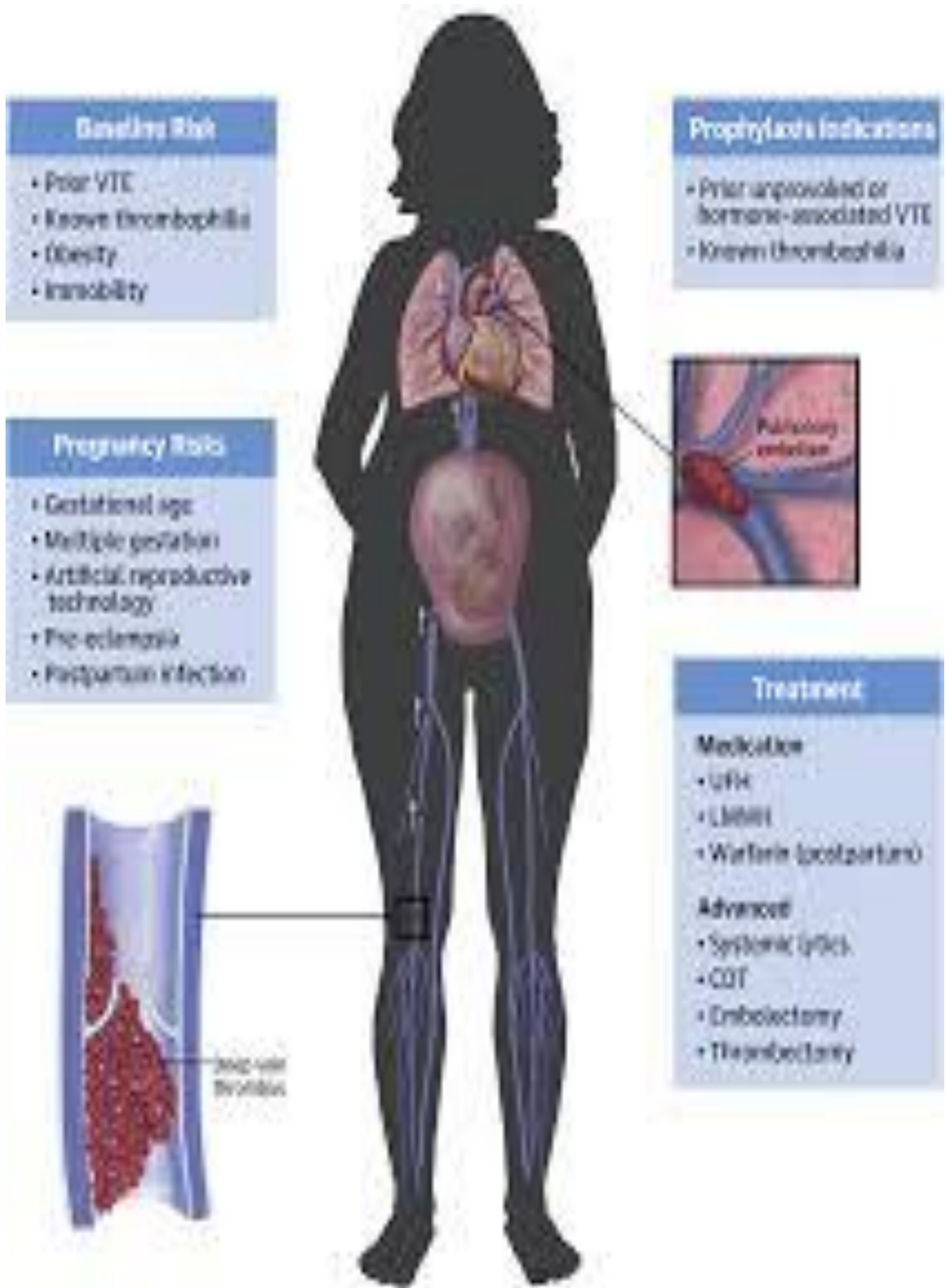


POSTPARTUM INFERIOR VENA CAVA THROMBOSIS

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INTRODUCTION/BACKGROUND

To report a case of inferior vena cava (IVC) thrombosis following postpartum hysterectomy in a triplet pregnancy complicated by severe preeclampsia and major haemorrhage.



CASE REPORT

A 34-year-old woman (G3 P0+2) booked at 6 weeks with a trichorionic triamniotic triplet pregnancy. She developed gestational proteinuria at 32 weeks and underwent elective Caesarean section at 34+4 weeks due to growth restriction and raised umbilical artery Doppler pulsatility index in two fetuses. The procedure was complicated by a 4.2L haemorrhage, necessitating a return to the operating theatre shortly after for a hysterectomy, with a total blood loss of 10L. Prophylactic dalteparin was omitted on the day of the hysterectomy and commenced on postoperative day 1. On postoperative day 2, clear fluid drainage from the abdominal drain site prompted a CT scan to investigate for urinary tract injury, which was excluded. However, imaging revealed an 8.5cm thrombus in the IVC extending from the infrarenal to suprarenal regions. An IVC filter was deemed unsuitable due to the risk of displacement into the right atrium, so anticoagulation with tinzaparin was initiated. Dosage adjustments were required due to thrombocytopenia secondary to HELLP syndrome, and lifelong warfarin therapy was later prescribed. A follow-up CT at three months confirmed complete thrombus resolution.

DISCUSSION

Venous thromboembolism (VTE) remains the leading cause of direct maternal death in the UK. This patient had a combination of risk factors, including triplet pregnancy, severe preeclampsia, preterm delivery, and major postpartum haemorrhage necessitating hysterectomy. Despite the absence of clinical signs or symptoms of VTE, an incidental IVC thrombus was detected. This case underscores the importance of utmost vigilance in high-risk patients and continuous VTE risk assessment throughout pregnancy and the postpartum period, together with multidisciplinary management to guide their care.

CONCLUSIONS

This case highlights the complex interplay of risk factors contributing towards postpartum IVC thrombosis following a triplet pregnancy. It emphasises the need for vigilant VTE risk assessment, individualised management of anticoagulation therapy in cases of thrombocytopenia, and multidisciplinary collaboration with specialities such as haematology, critical care and radiology. In this case, the favourable outcome of survival and full recovery with complete thrombus resolution demonstrates the potential for positive outcomes with timely intervention and tailored care. As VTE remains a leading cause of maternal morbidity and mortality, early identification and personalised management are crucial for improving outcomes in high-risk pregnancies.