

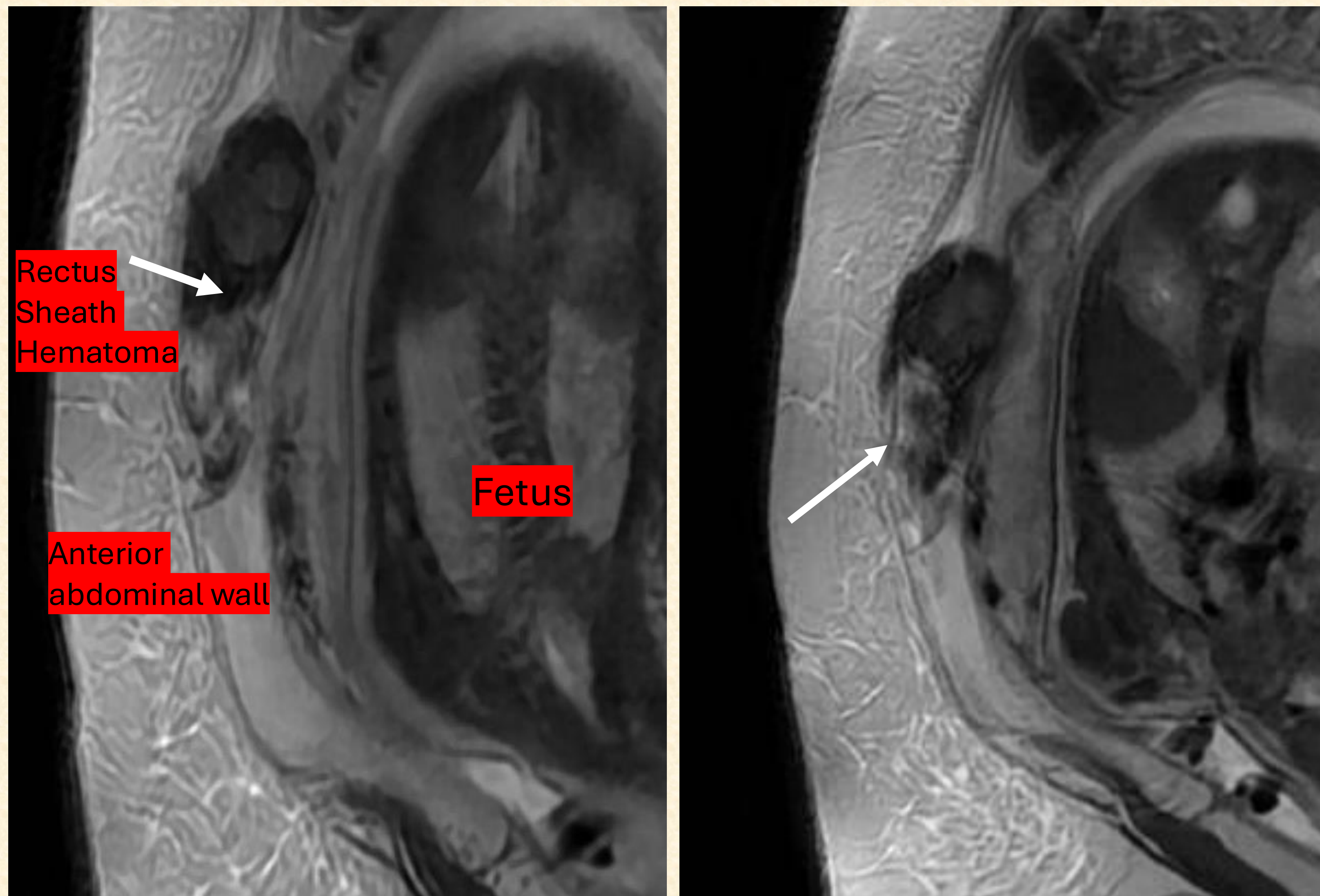


Spontaneous Rectus Sheath Hematoma in Pregnancy: A rare case report

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OBJECTIVES

To emphasise the diagnostic consideration of rectus sheath hematoma (RSH) as a non-obstetric source of abdominal pain in pregnant women, especially those with known risk factors such as high BMI, prior cesarean deliveries, and gestational diabetes.



MRI abdomen: There is a 14cm x 13cm x 3cm size swelling that lies between the supra-umbilical left rectus abdominis muscle belly and the posterior rectus sheath. It has a low signal on the T2 sequence. There are high signal foci within on the T1 sequence. The appearance is that of a rectus sheath hematoma.

CASE REPORT

A 40-year-old woman, gravida 3 para 2, at 37+3 weeks of gestation with a BMI of 37.6 and prior twin cesarean delivery, presented with sudden left upper quadrant pain after a coughing episode. Her medical history included hypothyroidism, bipolar disorder, anxiety, and insulin-managed gestational diabetes.

She also reported reduced fetal movements and generalized edema. Urinalysis revealed proteinuria with a raised protein-creatinine ratio (PCR 158), though her blood pressures remained below the hypertensive threshold.

Initial ultrasound detected a mixed echogenic area in the upper abdomen measuring 8.7 x 2.8 x 6.6 cm, prompting further evaluation.

MRI confirmed a left-sided rectus sheath hematoma measuring 14 x 13 x 3 cm, located between the rectus abdominis and its posterior sheath (see images).

Surgical review recommended conservative management given stable maternal and fetal status.

Despite clinical improvement, she returned at 38+2 weeks with persistent RFM and non-reassuring cardiotocography. A Category 2 caesarean section was performed, during which a large organized hematoma and significant adhesions were encountered above the rectus sheath. A bilateral salpingectomy was carried out for sterilisation at the patient's request. Postoperative recovery was uncomplicated.

DISCUSSION

Rectus sheath hematoma is an uncommon but significant cause of abdominal pain in pregnancy, potentially mimicking obstetric emergencies. Risk factors include advanced maternal age, obesity, anticoagulation, prior abdominal surgery, and increased intra-abdominal pressure from straining or coughing. Clinical diagnosis may be delayed in pregnancy due to altered abdominal anatomy. While ultrasound is often the first-line imaging modality, it may not be definitive. MRI offers higher sensitivity and anatomical clarity.

Management is typically conservative unless hemodynamic instability or obstetric indications necessitate surgical intervention. This case illustrates the importance of a thorough diagnostic approach and multidisciplinary collaboration to ensure appropriate care.

CONCLUSION

Non-obstetric causes such as rectus sheath hematoma should be included in the differential diagnosis of acute abdominal pain in late pregnancy. MRI should be considered when ultrasound findings are inconclusive. Most cases resolve without intervention, but careful monitoring is essential, particularly when obstetric factors demand timely delivery.