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Massive haematochezia after uterine evacuation: an uncommon cause of lower gastrointestinal bleeding

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Summary

We report a case of a 30-year-old Para 2 + 1 who presented with massive haematochezia 7 days after uterine evacuation for an incomplete abortion. Difficulty in pre-operative diagnosis in this type of presentation and treatment is highlighted and the literature reviewed.

Keywords: *Haematochezia, uterine evacuation, incomplete abortion.*

Résumé

Nous avons rapporté un cas de para 2 + 1 chez une femme de 30 ans qui avait une hématochésie massive après 7 jours de l'évacuation utérine d'un avortement incomplet. Les difficultés de diagnostic après l'opération de ce type de présentation et traitement est démontré et la littérature revue

Introduction

Acute massive haematochezia is one of the greatest challenges to the physician. Though a good number of patients stop bleeding spontaneously, many require urgent diagnostic and therapeutic procedures. We report a case with an uncommon cause of lower gastrointestinal bleeding seen in the University of Ilorin Teaching Hospital, Ilorin on 11th November 1996. We are not aware of a similar presentation in this region.

Case Report

Mrs. S. R., a 30-year-old lady presented at the emergency unit with a 2 day history of passage of clotted and altered blood per rectum. She had associated colicky abdominal pains that usually preceded the episodes of haematochezia. She had uterine evacuation 7 days prior

to presentation for an incomplete abortion of a pregnancy of 3/12 gestation. The procedure and immediate postoperative period was uneventful.

She was seen in a Primary Health Centre where she was managed as a case of bleeding peptic ulcer disease before she was referred to this centre. She was given 2 units of blood.

On examination at presentation, she was pale and afebrile. She had a pulse rate of 110/min with diminished volume. Her blood pressure was 120/80mmHg. She had a tender vague mass in the right iliac fossa. Vaginal examination revealed a bulky uterus of about 10/52 size. Rectal examination showed altered blood in the rectum.

A diagnosis of lower gastrointestinal bleeding was made and resuscitation started with whole blood. An abdomino-pelvic ultrasound suggested a normal sized uterus with loops of intestine around the right side of the fundus. The sonologist suggested a possible uterine perforation. Proctosigmoidoscopy only revealed altered blood in the lower 30cm of the gut. Episodes of haematochezia continued despite replacement with whole blood.

She had an exploratory laparotomy on the 3rd day of admission after receiving 5 units of whole blood. A retroverted uterus of about 10-week size was found. Loops of small intestine, caecum and ascending colon were adherent to the right side of the fundus. The myometrium bled profusely after separating the adherent loops of intestine but there was no demonstrable breach of the endometrium.

A limited right hemicolectomy with an ileocolic anastomosis was done and bleeding points on the uterus suture ligated. Post operatively, she had an intraperitoneal collection that was drained. Culture of the pus yielded *Escherichia coli*, *Klebsiella* and *Coliform sp.* She was discharged home after 6 weeks and had 3 follow-up visits before she was discharged from clinic.

Discussion

Lower gastrointestinal haemorrhage is a common presentation of gastrointestinal disease in our environment. It is considered to be massive and serious in nature if three to five units of blood are required over a

24-hour period to maintain haemodynamic stability[1]. Other criteria include orthostatic changes in blood pressure and a requirement of any quantity of blood products[2].

The causes in this environment include bleeding internal haemorrhoids, bleeding fissure in ano, typhoid enteritis with associated bleeding, neoplasm of the colon and rectum and bleeding peptic ulcer disease. Diverticular disease, arteriovenous malformations and coagulopathies are less common. Iatrogenic causes include bleeding after diagnostic and therapeutic endoscopy and bleeding from anastomotic sites.

Diagnosis of cause and site of bleeding is often difficult in acute lower gastrointestinal haemorrhage. It is also known that up to 85% of cases of acute lower gastrointestinal haemorrhage stop spontaneously [3,4]. However, emergency procedures and sometimes emergency surgery with associated significant morbidity and mortality may be required to arrest haemorrhage.

There is no universally accepted sequence of investigation in these patients and emergency surgery is often done without a specific diagnosis[5]. Proctosigmoidoscopy and abdominal ultrasonography were quite useful in the management of this patient. Arteriography and Technetium – 99m labelled red blood cell scanning might have been useful and might identify the source of haemorrhage. They are however not available in this centre.

Intestinal injuries following induced abortions commonly occur in the sigmoid colon, the small intestine and the caecum. They usually present with peritonitis within 48 hours of injury[6]. This patient's presentation is uncommon and no similar case was seen in the literature reviewed.

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