Damage to the Right Rectus Abdominus Muscle and Hematoma of the Right Uterine Broad Ligament: Rare Complications of a Road Accident during Pregnancy

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Summary

Severe damage to the right rectus abdominus muscle associated with a uterine broad right ligament hematoma is a rare complication of an accident during pregnancy. We report the case of a 31 years old primiparous pregnant woman, who had been victim of a road accident at 28 weeks of pregnancy, when as a pedestrian she was hit by a car. The site of impact was in the right anterolateral area of the abdomen. The pregnancy continued normally and she was ultimately delivered vaginally at 41 weeks of gestation. The baby was normally grown and had Apgar scores of 9 and 10 at 1 and 5 minutes of life. She underwent a laparotomy in the immediate postpartum period for a significant hemoperitoneum; this revealed the lesions and allowed treatment. The postoperative course was uneventful and the patient was discharged on the 6th post-partum day.

Keywords: Abdominal trauma; Fetal outcome; Pregnancy

Introduction

Trauma during pregnancy has become relatively common. In developed countries where statistics are well defined, 6 to 7% of road accidents involve pregnant women [1-3] and are the commonest non-obstetric cause of fetal death. In severe injuries the fetal death rate is near 60% and the maternal death rate close to 10% [4]. We report a case of a road accident in a pregnant woman without consequences for the mother and child until after delivery.

Case Presentation

Mrs. EB, a 31 year-old primiparous pregnant woman, who had a four year old child born vaginally, was 28 weeks pregnant when she was hit by a taxi. The impact site was at the right anterolateral area of the abdomen and projected her for about 2 meters from the site of impact. There was no initial loss of consciousness. Without waiting for the arrival of emergency medical assistance, she was transported to a medical center. The general practitioner here diagnosed that there would be no problem, because her hemodynamic status was stable and the fetal heart rate was normal. The patient was not observed further and no further investigations were performed. She received only analgesics and dressing of a contused wound of the right knee. The rest of antenatal consultations with midwives and an outside referral service were apparently normal although she did indicate she had some abdominal pain requiring analgesic and antispasmodic therapy.

Three months after the accident, she was admitted to our service in labor at 41 weeks gestation. On admission, the general condition of the patient was good and the blood pressure was 130/80 mmHg. The abdomen was soft between contractions but slightly sensitive at the hypogastric level. The uterine height was 34 cm. At the time of admission the cervix was 4 cm dilated, the membranes were still intact and the cephalic presentation was fixed in the pelvic cavity but not engaged. Fetal heart rate monitoring was normal and reactive with a baseline rate of 148 bpm.

Two hours after admission, she was delivered vaginally of a newborn male baby weighing 3100 gm, 49 cm in length and with a head circumference of 34 cm. The Apgar scores were 9 and 10 at 1 and 5 minutes of life. The placenta was delivered by controlled cord traction as is practiced in our service followed by the continuous infusion of oxytocin. Three hours after delivery, the patient complained of sharp pelvic pain. Clinical examination noted a fall in blood pressure (BP=90/05 mmHg), conjunctival pallor and pelvic tenderness with slight release tenderness. The uterus was well contracted, and vaginal blood loss was not increased. Because we do not have ultrasound in the delivery room, a culdocentesis was performed and revealed a hemoperitoneum. This finding resulted in an emergency laparotomy being performed, preceded by a fluid and electrolyte resuscitation including a blood transfusion. The hemoglobin level before surgery was 61 g/L.

Intraoperatively, we found significant damage to the lower third of the right rectus abdominus muscle, associated with a right broad ligament hematoma extending from the right edge of the uterus to the base of the ligament. There was also an abundant hemoperitoneum. The uterus was well contracted and was intact.

The surgical procedure then involved a flattening of blood clots within the muscle with hemostasis and clot removal (about 200g of old clots) after dissection of the broad ligament followed by abdominal toilet. Blood pressure at the end of surgery was 80/60 mmHg. The blood loss was estimated at 1.8 liters, with the patient receiving a blood transfusion of a liter of red cells intra and post-operatively. The post-operative course was uneventful and discharge from hospital occurred on the 6th post-delivery day.

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Received October 01, 2013; Accepted October 10, 2013; Published October 15, 2013


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Discussion

Trauma during pregnancy is common, however in Cote d’Ivoire there are no reliable records of accidents and studies on large populations in our country. Only a short series of seven cases resulting in fractures in pregnant patients has been reported [5]. In developed countries road accidents affect 5 to 7% of pregnancies [1-3] and are the leading cause of maternal deaths of non-obstetric origin between the age of 14 and 44 years [1]. These injuries are underestimated and represent 55% of non-penetrating abdominal trauma in pregnant women [1,6,7]. Whether minor or serious, traffic accidents are prone to complications in both the mother and the fetus. The risk of perinatal complications is directly proportional to their intensity and especially the mechanism of abdominal trauma [8]. The most common obstetric complications are premature rupture of membranes and preterm delivery, placental abruption, fetal injury (fracture, acute fetal distress, and fetal death), uterine rupture and feto-maternal hemorrhage [8-10].

The detachment and the damage of the rectus abdominus muscle associated with a hematoma of the right broad ligament, as observed in our patient, appear exceptional as does the fact they were of no real significance to the mother or her fetus until after delivery. The absence of placental abruption, fetal injury or uterine rupture in our case seems difficult to explain given the state of the right rectus muscle and the broad ligament hematoma which presumably resulted from the trauma in that region. If a placental abruption had occurred, signs related to it would probably would have attracted the attention of the general practitioner who examined the patient soon after the accident.

In general, the management and monitoring of a pregnant victim of a road accident (regardless of gestational age, the seat of the traumatic impact point and the importance of shock) must be performed in a specialized service. The initial physical examination, given its fundamental forensic significance [9] must be complete and thorough as clinical symptoms in pregnant women traumatized may wander due to physiological changes associated with pregnancy. In our department, Ultrasonography is routine at the time of admission to assess fetal well-being and look for fetal harm, renewed after 48 to 72 hours because of the risk of a previously undetected placenta abruption. International studies indicate that cardiotocographic assessments of the fetal heart rate should be performed repeatedly for at least 24 hours and that a full blood examination and Kleihauer test should also be performed.

When all these tests are normal, an injured pregnant woman should be hospitalized for 72 hours and consideration given to the use of preventive or curative tocolysis. She can then be discharged in the absence of non-obstetric injuries requiring care in other specialties. Antenatal clinic attendances are then necessary until the end of the pregnancy, with the possibility of reduced fetal growth resulting from a lack of any resulting shock, is a potential danger to both the mother and fetus. The complete and thorough initial examination and a methodical and rigorous para-clinical supervision in a specialized service is necessary to allow the early detection of any complications and to provide better overall care.

Conclusion

Trauma to a pregnant woman, irrespective of its intensity and the lack of any resulting shock, is a potential danger to both the mother and fetus. The complete and thorough initial examination and a methodical and rigorous para-clinical supervision in a specialized service is necessary to allow the early detection of any complications and to provide better overall care.

References