



CASE REPORT ON RARE SCENARIO LATE IUF D WITH SEVERE PPH DUE TO RETROPLACENTAL HEMATOMA.

1MUNEE SWARI JEYACHANDRAN, 2SUBASRI DINESH
 1PHD NURSING SCHOLAR, 2PHD NURSING SCHOLAR
 1The Tamilnadu Dr. M.G.R. Medical University, Chennai- 32,
 2The Tamilnadu Dr. M.G.R. Medical University, Chennai- 32

ABSTRACT

Intrauterine fetal demise is also called as stillbirth describes the death of fetus inside the uterine cavity. This term is usually adopted for loss of baby at / after 20th week of gestation. There are two types of stillbirths according to the gestational age which includes Early and Late still birth. Early stillbirth occurs from the Gestational week of 20 to 27 which is only insignificantly prevalent than Late stillbirth occurs from the Gestational week of 28 and or above. **Conclusion:** Retro placental hematoma results due to lack of oxygen and excess of carbon dioxide in the blood which is caused by partial or total suspension of respiration termed as asphyxiation. Intrathoracic petechial is a significant factor of acute asphyxia or suffocation in stillborn infants. The histological characteristics of Retro placental hematoma can be preceded utilizing benchmark for intrauterine duration of fetal death.

INTRODUCTION

Centers for Disease Control and Prevention claims that IUF D occurs in 1:100 pregnancies globally. Even though the precise cause is unknown, only a few causes were identified as IUF D causes. Though it is not easy to understand the exact cause(s) of IUF D, some of them may include Difficulties with the placenta preventing the fetus from developing normally, Irregularity in genetics, Umbilical cord complications, Suffocation from severe bleeding due to a ruptured uterus. All expectant mothers need to be aware of common symptoms which include less Fetal movements, Abdominal pain, High fever, or infection and/or bleeding from the vagina etc. With help of Ultrasound, Non-stress testing, Biophysical profile, and Umbilical Artery Doppler velocimetry to diagnose a case of IUF D.

CASE REPORT

27 years old Multigravida pregnant women was admitted to Labor and delivery room during afternoon with the complaints of absence of fetal movement since the morning. PV bleeding and tensed abdomen was observed on the way to hospital. At the time of admission, she was G3P2A0, Gestational age 38+3weeks, Blood group: B positive. Her vitals were stable BP 120/75 mmHg, Pulse 94bpm, RR 22bpm, uterus contraction was supported with frequent massage. Since mild blood-stained urine was noted in urobag, an urometer was used for further monitoring. Pediatrician assessed the baby as per protocol. After 30 minutes, bleeding was under control, hence vaginal pack was removed. Patient was connected to Continuous cardiac monitoring, ECG leads attached for close monitoring. Blood samples were sent for RFT, LFT, coagulation profile & CBC. Baby was wrapped and taken to the mortuary as per protocol, Duty doctor and Obstetric consultant monitored the patient in stable condition. Uterus well contracted below the level of umbilicus. No active PV bleeding seen. She does not show any abnormal symptoms / ECG Changes in cardiac monitor. Urine output was clear and adequate. Couple was counselled.

Blood report showed Hb picked up to 11.9 gm/dl, WBC-15.7, mild low platelet 27000, high INR-1.33, Na⁺ -134 mmol, Serum K⁺ - 6.0 (↑) suspected due to massive blood transfusion with citrate preservative in blood bags causing hyperkalemia, AST 50.0 U/L (↑). Inj. Syntocinon 20 units drip maintained for 8 hours. Bedside Scan showed uterine cavity with minimal

clots, 4.4 x 3.1cm collection seen just above the cervix and hence vaginal pack removed. Normal lochia noted. Patient complained about on & off cough and referred for physician and followed by ECG which indicated no deviation. Physician and anesthetist reviewed the case, blood results, and advised to shift patient immediately to ICU for DIC evaluation. Patient was shifted to ICU for potassium correction. No history of medical, surgical, blood transfusion and Allergy. On arrival strong contractions felt on palpation and mildly distressed with fresh PV bleeding on pad, vitals stable with normal blood pressure throughout pregnancy. FHR could not be traced in CTG. Duty doctor called for emergency and performed bedside ultrasound which showed that Cephalic, matching 38 weeks, estimated fetal weight 3.2 kg, liquor good, placenta upper, retroplacental echogenic area inconclusive, Hematoma could not find FHS and hence confirmed as IUFD.

Meanwhile, V/E done, Cervix 2-3 cm, 50% effaced, and membrane ruptured with thin blood-stained liquor and passed around 100ml of fresh blood clots during V/E. Explained the critical condition to the couple by Obstetrician. Big bore cannula inserted and sent routine blood investigation such as CBC, coagulation profile, & Cross matching for emergency purpose and hydrated with Ringer lactate. She distressed with more contractions and hence sedated with Inj. Pethidine 100 mg and Inj. Metoclopramide 10 mg IM. Hemoglobin dropped to 10.5 gm and was advised to keep cross matching blood ready. Cardiocography showed mild to moderate contractions with normal vital signs and augmented with 5 units syntocinon in 500 ml of RL titrated up to 48ml/hr. Obstetrician done bed side ultrasound which showed suspected big retroplacental hematoma. Now, patient progressed to 8cm dilation and 80% effaced and was instructed the patient to push if pain or contraction. Patient looked pale, Obstetrician advised to arrange 4 pints of PRBC & 4 units of FFP. Patient was pushing in pain, fully dilated on V/E findings, and was prepared for delivery.

Patient looked severely pale and suspected with high risk for PPH, inserted another big bore cannula and sent repeat CBC and given bolus Voluven 500ml (Volume Expander) and Normal saline. She delivered a fresh still birth baby with one loop cord around the neck but not tight by SVD. Along with baby, around 500ml of big blood clot was evacuated and another big clot was passed after delivery, birth weight was 3.800 kg, Length-50cm. Active Management of inj. Syntocinon 10 units IM followed by 20 units IV commenced. Placenta delivered by controlled cord method and Inj. Methergin 0.2 mg IM given, and noted big clots was still passing. As per obstetrician instructions, Inj. Methergin 0.4mg IV incorporated with lactated ringer commenced and followed by Carbectocin 100mcg IV & Inj. Carboprost Tromethamine 250mcg IM given.

As patient looked pale and continued passing of blood clots with severe trickling and massive blood transfusion PRBC with blood transfusion pump was started. On speculum examination, cervix intact and mild oozing from cervix were noted. Uterus massaged continuously but still with trickling of blood. Trail of intrauterine of Bakri Balloon was done by obstetrician under ultrasound guided but failed as the tube was kinked and vaginal pack inserted meanwhile found small laceration which was sutured with normal vitals. Fasten inj. Syntocinon 20units drip rate. Inj. Ceftriaxone 2gm with normal saline dilution IV given. 2 pint of Fresh Frozen Plasma commenced same time. Repeat Hb dropped to 8.1gm/dl and 2nd dose of Carbectocin 100mcg IV was administered Patient was catheterized with Foley catheter Fr. 14 and 50ml of clear urine collected in urometer for strictly maintain Intake and output. Second dose of Inj. Syntocinon 20units and inj. Methergin 2 ampoules (0.4mg) diluted with 500ml of Ringer lactate fasten in the IV drip. 3rd big bore cannula inserted and sent 3rd repeat CBC. Patient was still being passing the blood clots with severe trickling of blood and 3rd dose of Inj. Carbectocin 100Mcg IV was administered as per obstetrician. Followed by 3rd dose of inj. Syntocinon 20units IV commenced. Estimated blood loss was 1600ml. Placenta examined, mild calcified with 3 cord vessels weighed with 540 gm and fully completed. Then 3rd and 4th pint of PRBC & FFP were administered. Obstetrician removed the soaked vaginal pack and inserted another vaginal pack again. While shifting patient was conscious and coherent. BP: 130/80 mmHg, Pulse: 94-98 bpm, SPO2: 97-100%. With ongoing IVI Plain Ringer Lactate, Foley's catheter and all IV cannula's salinized and secured. Transferred patient to ICU by bed accompanied by husband in stable condition and Endorsed to ICU staff.

After 2 days, Vital signs and serum electrolytes were normal and back to postpartum ward in a stable condition.

DISCUSSION

IUFD is the end result of any of the maternal factor which include but not limited to, previous still birth, co-morbid chronic medical disorders, intrahepatic cholestasis in pregnancy, uterine abnormalities, socioeconomic factors, fetal factors (multiple gestation, platelet alloimmunization, genetic abnormalities, slow growth in womb, post-term pregnancy) and placental disorders causing an IUFD which are umbilical cord accident, abruption, premature rupture of membrane, feto-maternal hemorrhage and placental insufficiency. In this case study, mother had a risk of placental factor. Mother may experience pain in the abdomen, absence of fetal movements, infection or high fever, PV bleeding etc. There are several treatments to deliver or remove the dead baby from mother womb. To start labor with use of medicine, insertion of Foley's catheter and dilating cervix to remove the dead baby through birth canal. Delayed decision or keeping the baby inside the womb can cause severe complications includes blood clotting, infection etc. Heavy bleeding that leads to massive blood transfusion due to the risk of labor induction. The couple will be highly emotional and is crucial to support and counsel them.

CONCLUSION

Retro placental hematoma is composed by the blood insinuating itself between the separating placenta and the resting decidua basalis. Basal plate neutrophils are an appropriate early indicator of retro placental hemorrhage. In this case, retro placental hematoma seemed to be associated with sudden IUFD. The death of a fetus in late pregnancy can be disastrous. The nurse's role here is to be fully familiarized with the location of equipment, medications, and emergencies trolley to avoid any delay and chaos. They are expected to be emotionally stable and focused, and also to help the mother through the entire process by providing adequate support.

KEYWORDS

Hematoma, IUFD, PPH, Retro-Placenta, Absence of fetal movement, Fetal Heart Rate.

REFERENCES

1. Boyd, T. K. (2018). The placenta in intrauterine demise. *Apmis*, 126(7), 621-625.
2. Bendon, R. W. (2011). Review of autopsies of stillborn infants with retroplacental hematoma or hemorrhage. *Pediatric and Developmental Pathology*, 14(1), 10-15.
3. Malinowski, W., Koktycz, R., & Stawerski, P. (2005). The case of monochorionic twin gestation complicated by intrauterine demise of one fetus in the first trimester. *Twin Research and Human Genetics*, 8(3), 262-266.
4. Elovitz, M., & Wang, Z. (2004). Medroxyprogesterone acetate, but not progesterone, protects against inflammation-induced parturition and intrauterine fetal demise. *American journal of obstetrics and gynecology*, 190(3), 693-701.
5. Friebe-Hoffmann, U., et al., (2000). *Candida albicans* chorioamnionitis associated with preterm labor and sudden intrauterine demise of one twin. A case report. *The Journal of reproductive medicine*, 45(4), 354-356.
6. Petersen, I., & JuulNyholm, H. (1999). Multiple pregnancies with single intrauterine Demise, Description of twenty-eight pregnancies. *Acta obstetrica et gynecologica Scandinavica*, 78(3), 202-206.
7. Rizzo, G., Capponi, A., Soregaroli, M., Arduini, D., & Romanini, C. (1995). Early fetal circulation in pregnancies complicated by retroplacental hematoma. *Journal of clinical ultrasound*, 23(9), 525-529.
8. D'alton, M. E., et al., (1984). Intrauterine fetal demise in multiple gestation. *Acta geneticae medicae et gemellologiae: twin research*, 33(1), 43-49.
9. Hanna, J. H., & Hill, J. M. (1984). Single intrauterine fetal demise in multiple gestation. *Obstetrics and gynecology*, 63(1), 126-130.
10. Bromberg, Y. M., Salzberger, M., & Abrahamov, A. (1957). Does retroplacental hematoma contain fetal blood? *American journal of obstetrics and gynecology*, 74(3), 674-676.