Intrapartum Hemorrhage Secondary to Decidua Peritonea

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Abstract

Endometrial implants have long been noticed to deciduate during pregnancies. They have been reported in a variety of locations in the pelvis and abdomen. These lesions are usually noted incidentally with no negative sequela. This is not always the case and we present a case of massive hemorrhage from decidualized endometriotic lesions during a cesarean section.

Keywords: Decidua Peritonea; Endometriosis; Peritoneal implants; Hemorrhage

Introduction

The presence of decidualized endometrial implants has been widely reported in the past. These generally involve the ovaries, the uterus and cervix [1]. They have also been reported in old cesarean section and episiotomy scars [2]. Less commonly they can be found involving the peritoneum. They are often asymptomatic and discovered during cesarean sections. They have also been detected histologically in visceral serosa of various abdominal organs and in retroperitoneal lymph nodes [3]. We present a case report of peritoneal implants involving the parietal peritoneum and the fallopian tubes in an asymptomatic 33-year-old, prima-gravida Asian woman undergoing a primary cesarean section.

Case Report

A 33-year-old prima-gravida female, admitted at 39 weeks 4 days of gestation, for prolonged monitoring when the NST at her PMDs office showed 2 variable decelerations. Her history was significant for endometriosis and infertility, with pregnancy achieved by in vitro fertilization. Prenatal course was unremarkable except for sero-positivity of HSV II for which she was on Valacyclovir. She was found to be dilated and admitted for delivery. She progressed in labor and after she had an epidural developed hypotension which was resolved subsequently she developed a non-reassuring fetal tracing and taken to the operating room for urgent abdominal delivery. She was delivered of a female infant weighing 6lb 9.1oz, with APGAR’s of 9/9 by Manuscript Click here to download Manuscript corrected Decidua Peritonea.docx Cesarean Section. The approach was through a pfannenstiel incision with a low transverses uterine incision in the standard fashion. Intraoperatively, after closure of the uterine incision the uterus was noted to be well contracted. However, excessive bleeding was noted from the posterior aspect of the uterus and on inspection the entire Cul-De-Sac and pelvic side walls and fallopian tubes were noted to be covered with small papules, whitish in color and measuring 1 mm to 5 mm in size. The underlying serosa of the entire area appeared hyperaemic and “beefy red”, which easily bled with any contact. This was more severe of the left fallopian tube, where bilateral hydro-salpinx and adhesions were also noted. Hemostasis was eventually achieved using a combination of electro-cautery, Surgiflo® hemostatic matrix and Evicel® fibrin and a left partial salpingectomy. Estimated blood loss was 2,500 ml, resulting in drop of H/H from 13.7/38.8 on admission to 6.8/19.7. Tranexamic acid was given intravenously as well as 4 units of PRBCs, one unit of Cryoprecipitate and FFP each, intraoperatively resulting in a post-operative H/H of 14.7/40.8. The patient was observed in the intensive care unit overnight and had an unremarkable post-partum course and discharged home on day 4.

Pathological Findings

Standard Hematoxylin and Eosin stain was used. Decidualized tissue, with large polygonal eosinophilic cells was noted partially covered by mesothelium attached to the fallopian tube (Figures 1 and 2). Mitotic activity, nuclear polymorphism or nuclear membrane irregularities were not observed. No endometrial glands or desmoplastic reaction were noted.

Discussion

Ectopic decidualized implants have been widely reported in various locations in the pelvis and abdomen. Invariably these are thought to have developed as a result of progesterational effect of pregnancy hormonal milieu and resolve spontaneously at pregnancy termination [4]. Rare cases involving post-menopausal patient have also been reported [5]. They are often asymptomatic and noted during cesarean sections with no significant sequela.
already distributed in the peritoneum. Deciduosis is a clinicopathologic process distinct from endometriosis [18,19].

**Conclusion**

The acute presentation in this case in an asymptomatic patient and its subsequent complication of acute bleeding, large volume blood loss and ICU admission was not easily predictable or preventable. However, awareness of its possibility in patients with pre-existing endometriosis must be considered by the clinician in order to facilitate patient education and management planning to assure an acceptable outcome. This could be potentially a critical step to consider the decidualization of endometriotic lesions. More over further evaluation should be made to see what predisposing factors, if any can contribute to this process, as it is clear that not all endometriosis decidualizes.

**References**


