Pregnancy in a Uterine Scar Sacculus - an Unusual Cause of Postabortal Haemorrhage

A Case Report

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SUMMARY

A patient who presented with incomplete abortion developed severe persistent haemorrhage from the genital tract after evacuation of the uterus, as a result of erosion of a major vessel in a sacculus in a previous caesarean section scar. Detection and management of this condition are discussed.

The common causes of persistent vaginal bleeding after evacuation of the uterus for an incomplete abortion are usually given as: (i) failure of complete evacuation of the uterus, with retained products of conception leading to continued haemorrhage; (ii) trauma to the uterus (perforation) or cervix (faceration by vulsellum or swab-holding forceps); (iii) poor contraction of the uterus, usually as a result of the use of halothane; (iv) more rarely, coagulation defects in patients with a mid-trimester missed abortion who develop a disseminated intravascular coagulopathy and then abort incompletely; and (v) the rare case of unrecognized cervical pregnancy.

Nidation in a deficiency in a previous caesarean section scar is a sixth but very rare cause. This condition has been observed twice during a comparatively short clinical career by one of us. Its early recognition in the second case undoubtedly led to earlier and more effective management. This case is therefore presented in the hope that awareness of this possibility will assist other clinicians.

CASE REPORT

The patient (gravida 2, para 1) was a 23-year-old Zulu woman. Her first child had been delivered by lower-segment caesarean section. She had menstruated last 46 days before admission. Two days before she was admitted she developed light vaginal bleeding which became heavy on the afternoon of admission, and was then associated with colicky lower abdominal pain. On examination, she was well nourished but significantly shocked, with very pale mucous membranes, a blood pressure of 100/50 mmHg and a pulse rate of 120 per minute. Her cardiovascular and respiratory systems were otherwise normal. On palpation of the abdomen, a small pelvic mass could just be detected. There were no other masses and no distension. Pelvic examination revealed a vagina full of blood clot, an open cervix with some products of conception in the os, and an 8-week uterus with normal adnexae.

She was resuscitated with intravenous fluids and blood, and given intravenous ergometrine. However, severe vaginal bleeding continued, necessitating evacuation of the uterus 5 hours after admission. The operative findings were as follows: The vagina was again full of blood clot, the cervix admitted 1 finger, the uterus was about 6 weeks in size, sounding only to 7.5 cm as measured with a large dilator, and the caesarean section scar could be felt, with a ruptured area palpable on the right-hand end of the scar. Curettings, removed by blunt means, were minimal but appeared to be products of conception. The adnexae were clear. An oxytocin infusion of 40 U/l at 30 drops/min was commenced and bleeding appeared to have ceased. Accordingly, the patient was returned to the ward, but heavy vaginal bleeding started again within 1½ hours. She was therefore taken back to the theatre and laparotomy was undertaken through the previous midline scar. The operative findings were as follows: The tubes and ovaries were normal and the uterus was enlarged 6-8 weeks in size, with a small mass palpable under the uterovesical peritoneal reflection on the right-hand side. The peritoneum was opened at this point, and a sacculus (2.5 cm in diameter) containing products of conception was exposed, opening through a defect in the previous caesarean section scar into the uterine cavity. The pregnancy appeared to have eroded into a major branch of the uterine artery on that side. The conceptus was evacuated, the sacculus obliterated with interrupted chromic catgut sutures, and the uterine artery tied off to achieve haemostasis. The area was again peritonealized and the wound closed in layers. The patient’s postoperative course was uneventful and she was discharged 8 days later.

COMMENT

Any previous caesarean section scar should always be carefully explored in a case of incomplete abortion, especially if bleeding is inordinately heavy. Should a deficiency in the scar be found, the possibility of bleeding from pregnancy in a scar sacculus should be considered; this applies particularly if only minimal uterine curettings are obtained. If one concludes that bleeding is in fact coming from the scar sacculus, no further attempt should
be made to control it vaginally. Laparotomy, with reflection of the overlying peritoneum and incision into the sacculus, is essential. The products of conception can usually be very easily evacuated by blunt dissection; it only remains to obliterate the sacculus and guarantee that it does not reform by careful excision of the edges of the old scar if necessary. Tubal ligation should of course be considered in any patient with a reasonable-sized family.

REFERENCES

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**Hepatoblastoma in a Middle-Aged White South African Woman**

**A Case Report**

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**SUMMARY**

Hepatoblastoma is a primary embryonic liver tumour usually found in children. It extremely rarely occurs in adults and, when it does, is usually found in men, although it has been postulated that in women it may be associated with use of the oral contraceptive pill. We present a case of a 51-year-old White woman with no history of oral contraception. The features of this tumour are reviewed.


**CASE REPORT**

A 51-year-old White spinster was admitted to hospital in February 1977. She was born in Johannesburg and had apparently always lived there. She had had no previous major illnesses and had never consulted a doctor. For about 1 year she had been feeling slightly off colour and had been losing weight. For 5 months she had noticed a swelling in her abdomen, gradually increasing in size, but was too nervous to consult a doctor. For 1 month she had severe abdominal pain and progressive dyspnoea which led her family to take her to their general practitioner; on the same day she was admitted to hospital.

On admission she was thin, obviously unwell, and pale, but not jaundiced. She had a large, firm, central epigastric mass, 20 × 12 cm, which was both visible and palpable, and a right-sided pleural effusion. She was postmenopausal and had a slightly bulky uterus due to fibroids. Her social history was not significant; she was a non-smoker, had an occasional sherry and took no medicine. She had never been on the oral contraceptive pill. Initially, it seemed that the most likely diagnosis was carcinoma of the stomach with secondaries in the lungs. A plain radiograph of the abdomen showed a soft-tissue epigastric density 22 cm in diameter, displacing the colon inferiorly and laterally; a chest radiograph confirmed the pleural effusion. A barium meal showed a retrogastric mass. The pleural effusion contained malignant cells suggestive of adenocarcinoma. It seemed likely that the mass arose from the liver and a liver scan was done. According to the first report there was a patchy uptake throughout the liver, and this was thought to be due to ascites. After reviewing this scan, it was decided that there was a large midline defect in the right lobe of the liver. Ultrasonography showed the mass to be an enlarged liver with multiple areas of irregular echoes, possibly due to primary neoplasia or metastatic areas. The serum liver enzyme levels were persistently elevated with increases in SGOT, SGPT and alkaline phosphatase. The serum α-fetoprotein test was negative.

A laparotomy was necessary to reach a diagnosis, but at this point the patient developed an iliofemoral deep vein thrombosis. She was given anticoagulants but her condition deteriorated, and she became anuric and died a few days later. The terminal event was probably renal failure.

At autopsy a large, round, smooth-surfaced encapsulated tumour was found adherent to the undersurface of the liver with diaphragmatic infiltration. The tumour measured 12 × 10 × 10 cm and, on section, showed haemorrhagic and cystic areas in the centre as well as peripheral firm white tissue. There were metastases in the abdominal lymph nodes.