IDIOPTHAT Spontaneous Intraperitoneal Haemorrhage
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ABSTRACT
Idiopathic spontaneous intraperitoneal haemorrhage is a rare and potentially fatal condition. Pre-operative diagnosis is difficult or rarely possible. Urgent surgical exploration is the treatment of choice. We report a case of spontaneous intraperitoneal haemorrhage that was observed undergoing sudden deterioration of her condition while in a hospital ward. She was attending to her child admitted in the ward. She developed lower abdominal pain and extreme weakness. Hospital staff recognized her to be gradually undergoing a state of shock. She was resuscitated and urgent ultrasound abdomen revealed free fluid in the abdomen and pelvis. Immediate laparotomy confirmed the diagnosis of spontaneous intraperitoneal bleeding, however, no significant cause of bleeding was found except for a very small area of breached peritoneum in the pouch of Douglas. Haemostasis was secured by two stitches of vicryl. Postoperative CT scan of abdomen and pelvis did not reveal any abnormal finding. Patient was followed-up in the OPD for 6 months and she was symptom-free and in a healthy state.

Key Words: Idiopathic spontaneous intraperitoneal haemorrhage, Abdominal apoplexy, Abdominal stroke.

INTRODUCTION
Idiopathic Spontaneous Intraperitoneal Haemorrhage (ISIH) is a condition of spontaneous bleeding in the abdominal cavity, without a significant cause. Also known as abdominal apoplexy or abdominal stroke, ISIH is rare in occurrence. However, it is a true emergency warranting a high index of suspicion to save life of the patient. It should be considered in any patient with atypical abdominal pain, nausea, vomiting and hemodynamic instability. Pre-operative diagnosis is rarely possible. Immediate exploratory laparotomy remains the treatment of choice.

A number of cases of ISIH have been reported from all over the world, however, no such case has been reported from Pakistan. We present such a case in which pre-operatively no cause could be established.

CASE REPORT
A young mother, 25 years of age, G3 P3+0, developed sudden pain in her lower abdomen with a feeling of extreme generalized weakness while she was in hospital attending to her 3 years old son admitted in the hospital for gastroenteritis. The duty nursing staff observed signs of impending shock, called the doctor and started resuscitation. The patient was conscious with pulse rate 117/minute and blood pressure of 90/50 mm of Hg. She was afebrile and developed marked pallor within a short span of time. There was tenderness in the lower abdomen with fullness of hypogastrium and vaginal fornices. Her Hb was 6.8 g/dl, platelets were 323 x 109/ml, and TLC was 13.6 x 109/L.

The patient’s was P3+0. Her youngest son was three years old and she had her last periods one week back. The couple was observing barrier contraceptive measures.

A provisional diagnosis of intraperitoneal haemorrhage with a strong suspicion of a ruptured ectopic pregnancy was made. Urgent ultrasound scan of abdomen and pelvis confirmed an area of mixed echogenecity 5.1 x 4.9 cm in the left adnexal region and free fluid in abdomen and pelvis. All other organs were found normal. An emergency exploratory laparotomy was carried out under general anaesthesia. The peritoneal cavity was found to be full of blood and blood clots. Fallopian tubes, ovaries and uterus were found intact and healthy. The bleeding source was in the pouch of Douglas. A small 8 x 3 mm of breached peritonem was seen on the anterior wall of rectum. Rest of the anterior wall of rectum was completely normal with no palpable mass or lesion. Oozing of fresh blood was also seen from the lesion. Haemostasis was secured with two stitches of vicryl. Postoperative CT scan of abdomen and pelvis did not reveal any abnormal finding. Patient was followed-up in the OPD for 6 months and she was symptom-free and in a healthy state.

Figure 1: An 8 x 3 mm of breached peritoneum in the pouch of Douglas.
figure of eight stitches with vicryl 2/0. Pouch of Douglas was packed and thorough exploration of the abdominal and pelvic cavity was performed. All the organs were found healthy and normal. There was no adnexal mass seen peroperatively as was observed in pre-operative ultrasonography. Abdomen was closed with a pelvic drain. Two units of red cell concentrate were transfused during the procedure.

The patient was followed-up four weekly. She had regular menstrual periods. Digital rectal examination, done one week postoperatively was normal. No mass, fissure or haemorrhoids were observed. Serum βHCG send postoperatively was within normal limits. CT scan abdomen and pelvis showed normal study with no evidence of any adnexal mass. She had no bowel, urinary or gynaecological complaints before or after laparotomy.

**DISCUSSION**

Intraperitoneal haemorrhage is a collection of blood in the abdominal cavity. Common causes include abdominal trauma, ectopic pregnancy, malignancy of solid organs (renal, hepatic or pancreatic), aneurysmal rupture or inflammatory erosive process (pancreatitis). In addition to these, it may be idiopathic, also known as abdominal apoplexy or replaced by a newer term - Idiopathic Spontaneous Intraperitoneal Haemorrhage (ISIH). The first case of ISIH was reported by barbour 1909, while the term abdominal apoplexy was first used by Green and Powers in 1931. Majority of cases present in 5th and 6th decades of life with male: female ratio of 2 - 3:1. Review of literature showed a number of these cases, upon exploration, were due to bleeding from splanchic vessels. Some reported cases in the past were due to bleeding from the female organs (other than tubal pregnancy), from microscopic aneurysms or from other obvious pathological states. Other causes reported in the literature include bleeding from visceral artery rupture like middle colic, pancreaticoduodenal, gastro-deudenal and splenic artery. Small abdominal vessel ruptures have also been reported in some cases.

Although called idiopathic and spontaneous, bleeding in these cases is most likely due to some underlying vascular lesions. Most frequently this lesion is a micro-aneurysm. Arterial aneurysms can occur at secondary or tertiary branch points from aorta, 60% involving splenic artery, 22% renal and 10 - 20% hepatic artery with common celiac and mesenteric arteries being least common. Arteriosclerosis resulting in weakness of tunica media, may be associated with spontaneous rupture during an episode of hypertension. Inflammatory and necrotizing processes like polyarteritis nodosa and rheumatoid arthritis may result in less frequent cases. Venous rupture is associated with portal hypertension.

This patient did not have any obvious cause of bleeding. Moreover, the site of bleeding was also unusual. She did not have any co-morbid conditions like hypertension. However, there might have been a microscopic underlying lesion.

**REFERENCES**