A Rare Case of Recurrent Disseminated Intravascular Coagulopathy Postpartum

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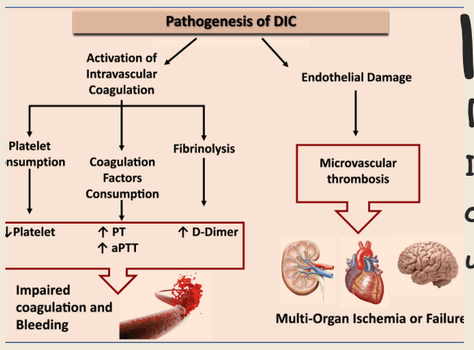


Introduction

Disseminated Intravascular Coagulopathy

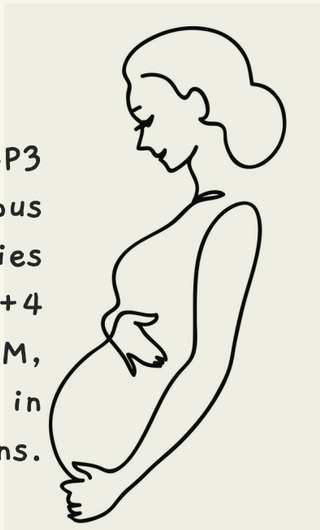
Is a haematological condition precipated by multiple factors, that results in a wide spread coagulopathic state with microvascular and macrovascular clot formation, resulting in excessive uncontrolled bleeding and multi-organ dysfunction.

Background

*Postpartum Haemorrhage secondary to DIC is a severe obstetric complication that remains a threat to maternal survival.

*Not enough is known about secondary PPH due to recurrent DIC.

Patient



*38yo woman , G4P3

*3 previous uncomplicated spontaneous vaginal deliveries

*Presented to a tertiary centre @ 37+4 weeks gestation with blood stained SROM, contracting with severe abdominal pain in beteween contractions.

Situation

*Spontaneous rupture of membranes @ 37 weeks, associated with brisk PV Bleeding and Significant abdominal pain.

*haemodynamically unstable.

*CODE BLUE Caesarean Section called.

*Major placental abruption confirmed intra-op.

*Massive blood loss- total estimate 4L.

*Managed with massive transfusion protocol- 15units Cryoprecipitate, 4units PRC, 1 unit platelets, Fibtem on ROTEM at the time being 4mm.

*Transferred to ICU in alternate hospital for concern for need for haemodyalisis with significant AKI developing secondary to Acute tubular necrosis form massive haemorrhage.

Outcome

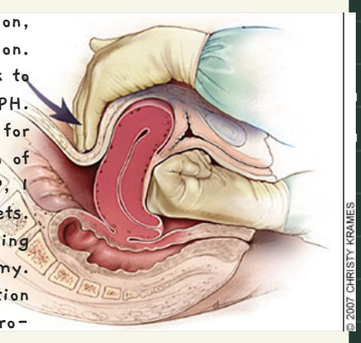
*Initially settling in ICU, requiring ongoing management of hypertension, HELLP syndrome confirmed and likely cause of placental abruption.

*Recurrence of PV bleeding on day 10 post-op, decision to transfer back to O&G tertiary hospital for management of secondary PPH.

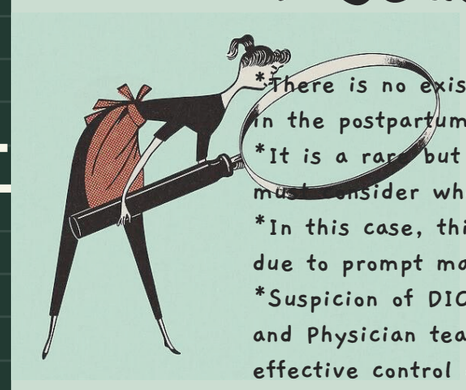
*Unstable on arrival, CODE BLUE called, transferred straight to OT for insertion of Bakri balloon, further EBL of 4.5L, requiring correction of coagulopathy with significantly abnormal ROTEM. 6units PRC, 4 units FFP, 1 unit Platelets.

*Ongoing bleeding through Bakri- further 1.5L loss, proceeded to life saving hysterectomy.

*The final diagnosis was DIC mediated by a massive placental abruption secondary to Pre-eclampsia, recurring post-partum with likely Micro-angiopathic haemolytic anaemia(MAHA), and suspicion of haemolytic uraemic syndrome(HUS).



Discussion



*There is no existing reporting regarding the recurrence of DIC in the postpartum period.

*It is a rare but potentially fatal phenomena that the clinician must consider when managing secondary PPH.

*In this case, this patient was fortunate and had a full recovery due to prompt management, diagnosis and decision making.

*Suspicion of DIC led to early involvement of the Haematology and Physician teams in patient management, and contributed to effective control of the complications of DIC.

Conclusion

*In the setting of a tertiary women's hospital, recurrent DIC was readily suspected and managed. *However, in a lower resourced situation, a delay in diagnosis could be fatal.

*This case highlights the need to consider this rare diagnosis and act early with regards to a multidisciplinary team approach to management.

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