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Review Article

Retroplacental Hematoma with Non-Term Live Fetus; a Relevant Indication for Vaginal Caesarean Section

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Abstract

The objective is to report a clinical case of vaginal caesarean performed to save a fetus in distress by retroplacental hematoma. For this indication, the vaginal caesarean can be an alternative to the classic caesarean because of its short duration and the preservation of the possibility of future childbirth by natural means. However, this surgical technique described since the 19th century is still unknown to many practitioners and few publications exist on the subject throughout the world. Considered obsolete by some practitioners, it retains all its advantages in the practice of modern obstetrics. We report this case of fetal rescue performed by vaginal caesarean section at the Reference Health Center of the Sanitary District (District Hospital) of Bla in Mali in a 34-year-old patient, admitted for retroplacental hematoma with live fetal on a non-term pregnancy in latency phase of labor.

Keywords: Vaginal cesarean, retroplacental hematoma, live fetus, prematurity.

INTRODUCTION

Vaginal caesarean section, defined as extraction of the fetus from a hysterotomy performed through the vagina, was first described in 1896 by Dührssen [1]. Despite its distribution in France by Malinas [2], it remains unknown to many practitioners. It has long been opposed to dilators as an alternative, although each of the two methods had its own advantages and limitations. The bibliography on the subject is rare and the majority of the articles are old [4]. This is a surgical technique that is little taught to the youngest and therefore little used. Its practice requires experience in vaginal surgery [5]. It was from 1987 that the practice of the intervention experienced a certain boom in France. Several recent publications recognize the advantages of vaginal caesarean section, not as an alternative to cervical dilators, nor to abdominal caesarean section, but as a complementary intervention which has its own advantages such as the ease and convenience of the intervention minimal blood loss, short post-operative hospital stay and preservation of chances of normal vaginal delivery. Experiences reported in Africa on the subject are rare [6]. We report here a case of fetal rescue by vaginal caesarean section on retroplacental hematoma.

PRESENTATION OF THE CASE

34-year-old patient, housewife, domiciled in Bla, 4th gesture, 3rd parent, 2 living children, 1 stillborn during the last delivery. Admitted to the Bla Reference Health Center on July 05, 2022 at 5:15 p.m. for minimal metrorrhagia and abdominal pain in a non-term pregnancy.

HISTORY OF PREGNANCY

Badly followed pregnancy, the date of the last rules not known, a single prenatal consultation carried out with blood pressure figures at 120/70 mmHg, Rhesus O positive group, Iron + Acid due 1 tablet per day. The ultrasound performed during the consultation concluded that an evolving single-fetal pregnancy without morphological abnormality was 15 weeks of amenorrhea and 4 days.

The examination on admission of the patient notes: colored conjunctivae, blood pressure 170/110 mmHg, edema in the lower limbs, poor relaxation of the uterus, uterine contractions of regular low intensity, uterine height at 33cm, audible irregular fetal heart sounds at 110 beats per minute in left lower quadrant. On vaginal examination, the cervix is 4 cm dilated, membranes intact, cephalic presentation, lower segment formed. The age of pregnancy estimated at 37 SA+1 day according to the ultrasound performed at 15SA. The diagnosis of retroplacental hematoma with live fetus was retained. A minimum preoperative balance sheet requested noted a hemoglobin level of 11g/dl and massive proteinuria +++.

The need for immediate delivery for fetal collapse was raised in the following clinical context:

- Prematurity and sudden fetal hypoxia (HRP).
- Risk of hemorrhagic shock and bleeding disorder for the mother.
- Cervix dilated only 4 cm.

We chose the vaginal caesarean because of the short duration of the intervention, and the low risk of preoperative bleeding. Caesarean section performed vaginally under general anesthesia has among with a moderate expression on the uterine fundus the cephalic extraction of a newborn in 4 min of female sex weighing 2400g, resuscitated. The Apgar score was estimated at 6/10 at the 1st minute and 8/10 at the 5th minute after birth. Uterine revision brought back a 100g clot, intraoperative bleeding was minimal. The caesarean lasted 28 minutes. Mobilization was authorized 6 hours after the intervention and food after resumption of transit. The newborn was put to the breast immediately after the mother woke up. Vulvo-vaginal care was provided by the staff on duty due to vulvo-vaginal cleansing 3 times a day with povidone iodine diluted at 10% with physiological saline. No antibiotic therapy was administered. On the 2nd day, the blood pressure figures stabilized at 12/8, with the disappearance of edema and normal diuresis. The control hemoglobin level was 10.5g/dl. The discharge of the mother and the newborn was authorized on the 3rd day after the cesarean section. She was seen in postpartum consultation on the 42nd day after the caesarean section. Normal healing of the cervix was noted. For the contraceptive method, she chose the intrauterine device.

DISCUSSION

The indications for caesarean section had been described very broadly by Dührssen [1]. It has long been used as a technique for legalized late abortions; then abandoned in favor of obstetric dilators. The ideal indications for the operation have been summarized by some authors in the absence of cervical dilation, the occurrence of severe maternal hemorrhage during the intervention to terminate the pregnancy, or during the expulsion of the uterine contents towards the end of the second trimester by asking the question if there is a place for vaginal caesarean section when the fetus is alive [7]. Some learned societies of practitioners such as the National College of French Gynecologists and Obstetricians, had held days of consensus and updating on the subject. In the recent literature on the subject, there are cases of live newborns and indications for fetal rescue. In a series of 7 cases in Senegal, Gueye and his collaborators [6] reported 3 live newborns with an average Apgar score of 5 out of 10 at birth. Verma and his collaborators [8] reported in India a case of caesarean section for fetal distress by cervical dystocia on a uterine prolapse which allowed to save a newborn of 2500g. The case of a living non-term fetus in the context of a retroplacental hematoma constitutes an obstetrical emergency that requires rapid and effective decision-making to save the fetus, prevent significant blood loss and the occurrence of coagulation disorders and preserve the obstetrical future of the mother. These factors are taken into account by the practice of vaginal caesarean section. The case we report was carried out in a clinical context of:

- Risk of fetal death in the event of delay in the practice of the vaginal delivery intervention.
- Risk of coagulation disorder in the event of prolonged bleeding due to delayed expulsion.
- Risk of abundant blood loss in the event of major surgical trauma via the upper route.

The practice of vaginal caesarean section saves the newborn and minimizes blood loss and hospitalization time.

CONCLUSION

Vaginal caesarean section is a surgical technique that retains its place in modern obstetrics practice. The vitality of the fetus is not a limit to its practice. Its realization requires training in vaginal surgery.

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