IDIOPATHIC RETROPERITONEAL HEMATOMA; A RARE LIFE THREATENING PROBLEM. REPORT OF A CASE BY THE REVIEW OF THE LITERATURE

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ABSTRACT

Idiopathic retroperitoneal hematoma is a rare life threatening problem which is characterized by a sudden onset of bleeding from the splanchnic vessels into the retroperitoneal space. In cases of idiopathic retroperitoneal hematoma no definite cause can be identified. We report on a patient idiopathic retroperitoneal hematoma presenting as acute abdomen.

Key words: Idiopathic Retroperitoneal Hematoma, emergent surgery, abdominal pain

INTRODUCTION

Idiopathic retroperitoneal hematoma is a rare condition, and few cases have been described in the literature. It was first described by Barber in 1909. In the majority of cases, the cause can be identified, and may be due to trauma, ruptured aneurysm or tumor, or anticoagulant therapy. Acute retroperitoneal hemorrhage can cause intra-abdominal hemoperitoneum that can be fatal, so emergent surgery is required. The strategy for retroperitoneal hematoma depends on the vital signs and the cause of the hemorrhage.

CASE REPORT

A 68-year-old woman was referred to us from a periphery hospital, where she had presented with hypovolemic shock. On examination, she was hemodynamically unstable. She had a low-grade pyrexia of 37.8°C with a pulse rate of 120 beats/min and blood pressure of 60/40 mmHg. Cardio-respiratory examination was unremarkable and her abdomen was soft with mild lower abdominal tenderness. Routine investigations showed WBC to be 11x10³/μL, Hb 9 g/dL, and normal platelet count, bleeding time, clotting time and INR. Plain X-rays of the chest, abdomen and lumbar spine were normal. There
was no history of trauma or anticoagulant treatment, and after initial resuscitation, abdominal and pelvic ultrasound had revealed a large, mixed echogenic mass extending from the pelvis to the right upper abdomen. Enhanced CT scan of the abdomen and pelvis revealed a huge retroperitoneal hematoma on the right side of the abdomen and extending down to the pelvis. No other abnormality was seen (Figure 1). On laparotomy, the extended Kocher maneuver, with right-sided medial visceral rotation that consists of medial reflection of the upper part of the right colon and duodenum by incising their lateral peritoneal attachments, was performed. It revealed a clotted retroperitoneal hematoma. We removed the hematoma and placed a non-suction latex drain in the pelvis. As there were no postoperative complications, the patient was discharged from the hospital after 8 days. At 1-month follow-up, the patient was feeling well. Her clinical examination, laboratory findings and abdominal ultrasound findings were normal.

Figure 1. Enhanced CT scan of the abdomen and pelvis revealed a huge retroperitoneal hematoma on the right side of the abdomen and extending down to the pelvis.

DISCUSSION

Idiopathic spontaneous retroperitoneal hematoma (SRH) was first reported by Barber in 1909 and was later termed "abdominal apoplexy" by Green and Powers in 1931. Its true incidence is unknown. Injury or rupture of the splanchnic vessels and an eroding primary or secondary tumor of the liver or kidneys are the general causes of retroperitoneal hemorrhage (primarily vascular hemorrhage), inflammatory erosive processes (pancreatitis or pseudo cyst). Kobayashi et al. reported a case of unilateral adrenal hematoma. Spontaneous or idiopathic adrenal hematoma is also extremely rare, since most adrenal hematoma cases occur in association with trauma or similar causes of idiopathic retroperitoneal hematoma. Unfortunately the incidence of retroperitoneal hematoma is still unknown. Presentation of retroperitoneal hematoma may vary from abdominal pain, shock, peritonitis, metiorism and femoral nerve palsy. Nerve palsy is
due to compression by the hematoma. Retroperitoneal space forms a potential space due to loose attachments of peritoneum to the extra peritoneal structures in the posterior abdominal wall below the diaphragm. The presentation and clinical progression of abdominal apoplexy frequently follows a rather predictable course. Before rupture, there may be a history of vague abdominal pain which is the case of our patient. Hypotension may be present depending on whether the hemorrhage is contained or free intra-abdominal rupture exists.

Therapeutic management of SRH will mainly depend on two factors, the hemodynamic status of the patient and the cause of bleeding. If hemodynamic instability exists, volume replacement will be started using blood derivatives, colloids, and crystalloids. Once the patient is stabilized, an adequate diagnostic study for determining the etiology of the condition, based mainly on imaging tests, particularly CT, will be performed. CT scan is the principal method of diagnosis. By contrast, if hemodynamic stability of the patient is not achieved or instability occurs at any time during the diagnostic process, urgent surgical exploration and the resultant treatment will be required.

The decision should be made according to the presentation of these patients, whether in shock or with nerve compression, which demands urgent interference and control of bleeding and/or surgical decompression of the hematoma to release the pressure. The management is by laparotomy and control of hemorrhage from the bleeding point, and when the origin of the bleeding is not found, the prognosis is poor.

COMPETING INTERESTS

The authors declare that they have no competing interests.

REFERENCES