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Case Report

## Aseptic Necrosis of Hysterorrafia: A Case Report

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### Background

The Aseptic Necrosis of Hysterorrafia (ANH) is an uncommon cause of late bleeding in cases of post cesarean section (CS) often iteratives. The bleeding does not decrease with the classic treatments and start at any moment and stop at any moment too. It can be serious enough to affect the patient health. In the past, the usual resolution was the hysterectomy.

**Keywords:** Aseptic Necrosis Hysterorrafia; Postpartum Bleeding; Uterine Plastic

### Case

A 35 years old patient with uncontrolable methrorragia post cesarean section treated with surgical conservative technique.

### Conclusion

Not all cases of ANH need an Hysterectomy as a definitive treatment. A conservative approach is successful.

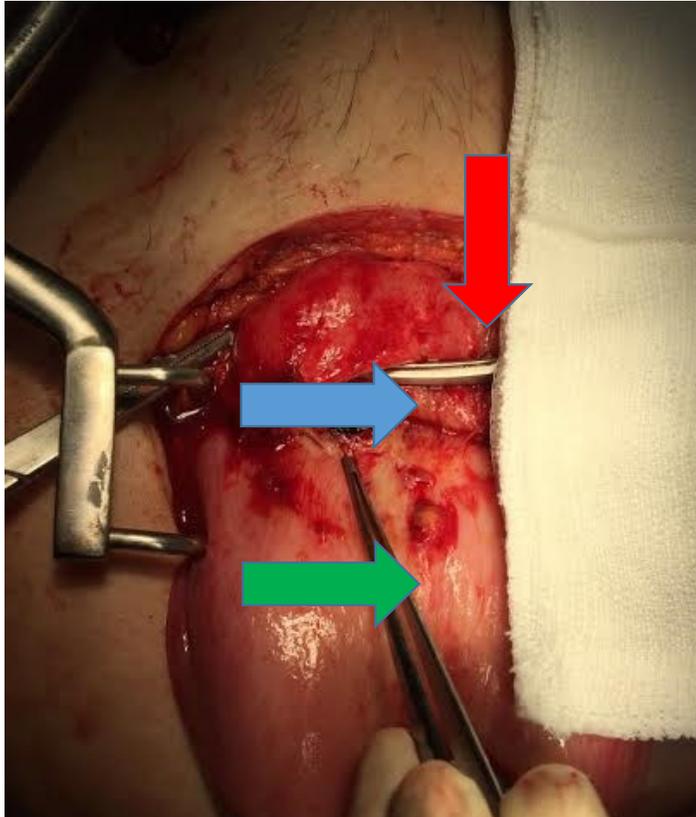
Aseptic necrosis of hysterorrafia was described more than 80 years ago as a bleeding syndrome that occur after CS mainly when they are iteratives. Apparently, in some of the CS, the accidental occlusion of one of uterine arteries produce an infarct of the miometrium and as a consequence, the bleeding appears, sometimes scarce and sometimes heavy, affecting the mother's health. The bleeding does not decrease with conventional treatments, and stop spontaneously, as it started [1-3]. It is red blood, rutilant, abundant, without any pain. The known measures to stop bleeding in puerperium does not work in this cases, neither drugs nor surgical treatments.

### Case

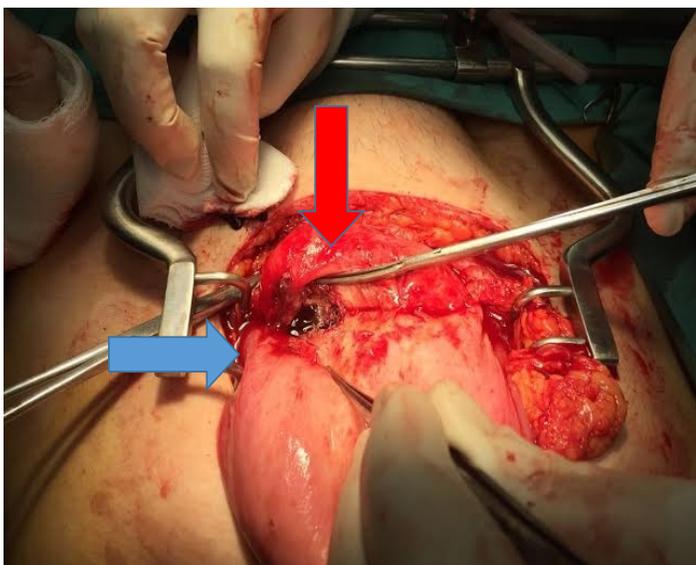
A 35 years old patient underwent to second CS because a previous CS. The surgery was uneventful and she was discharged from Hospital 72 hours after surgery. About 10 days later, she complained of vaginal bleeding, not had seen any damage of neither vagina nor cervix. It was a methrorragia. She started with nasal oxitocyn every 6 hours and apparently she did well.

One week later, she complained again for the same symptoms and was medicated in the same way. But, some days later, she complained again, and we started to think in the possibility of ANH. We performed blood tests found an hematocrit of 28%, she was asymptomatic, and the ultrasound informed a cyst over the hysterorrafia with a size of 10cm long and 5cm wide. With this finding, we decided to perform a laparotomy with presuntive diagnosis of ANH, haematoma or absces. Notewor-

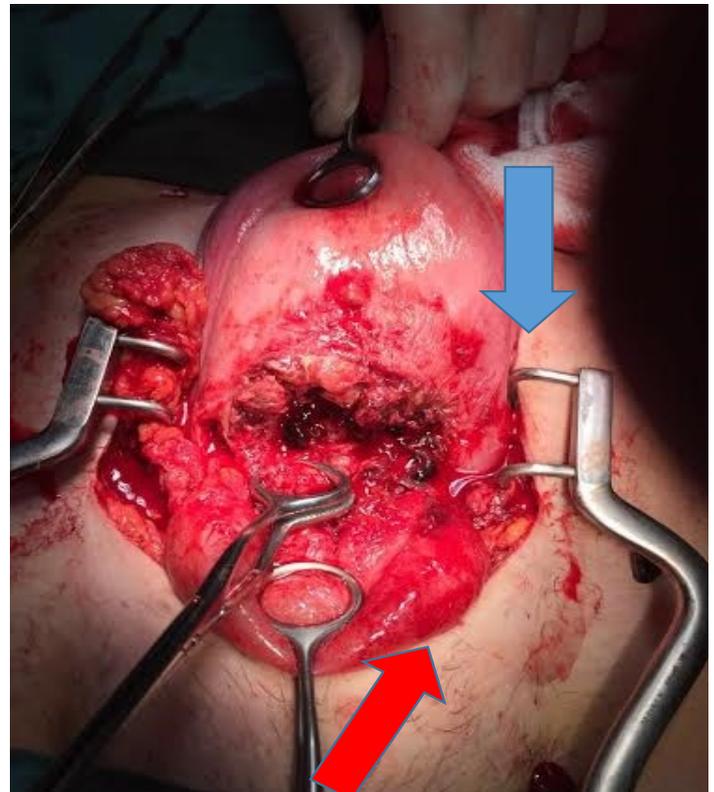
thy, we left the bladder well down in the vesicouterine space by the time of CS because we did not performed peritonization of the hysterorrafia. When opened the abdomen, we saw the bladder over the hysterorrafia (Figure 1) and when we started to separate the bladder from the uterus, we found the necrotic procces (Figure 1-2).



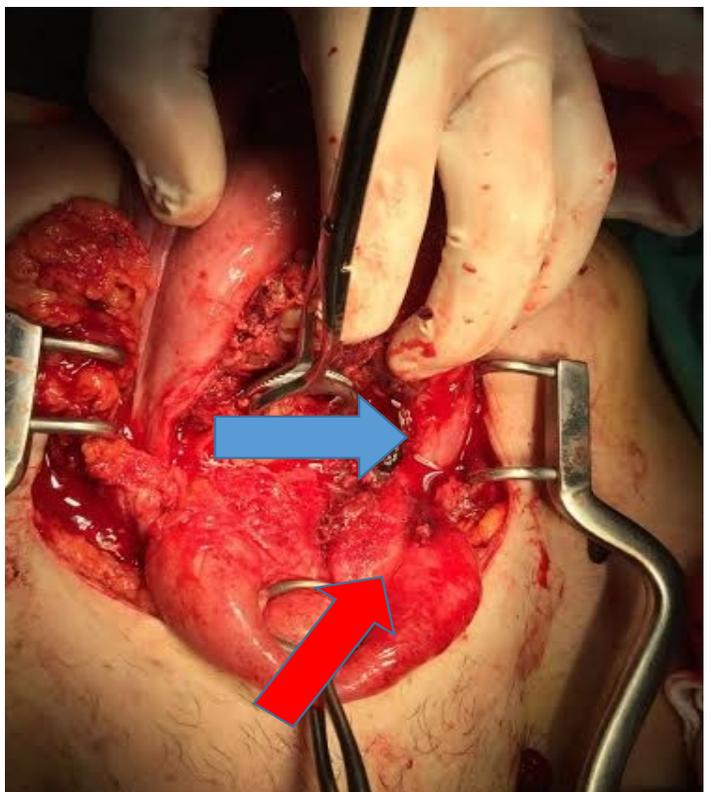
**Figure 1.** We can observe the uterus (green arrow), the bladder occluding the hysterorrafia (red arrow) and the necrotic area (blue arrow).



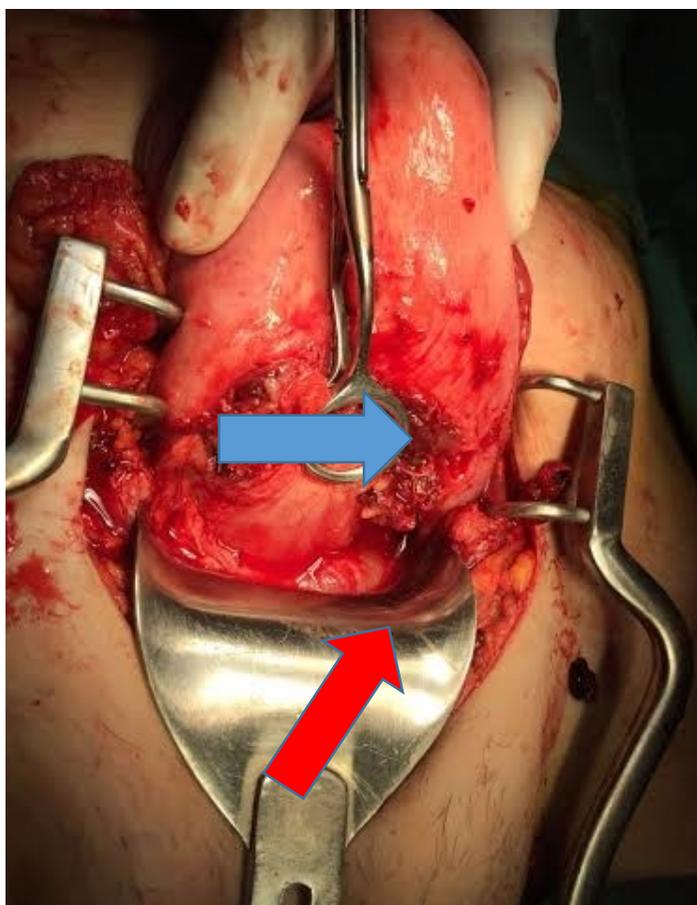
**Figure 2.** We descended the bladder (red arrow) and the necrosis is bigger (blue arrow).



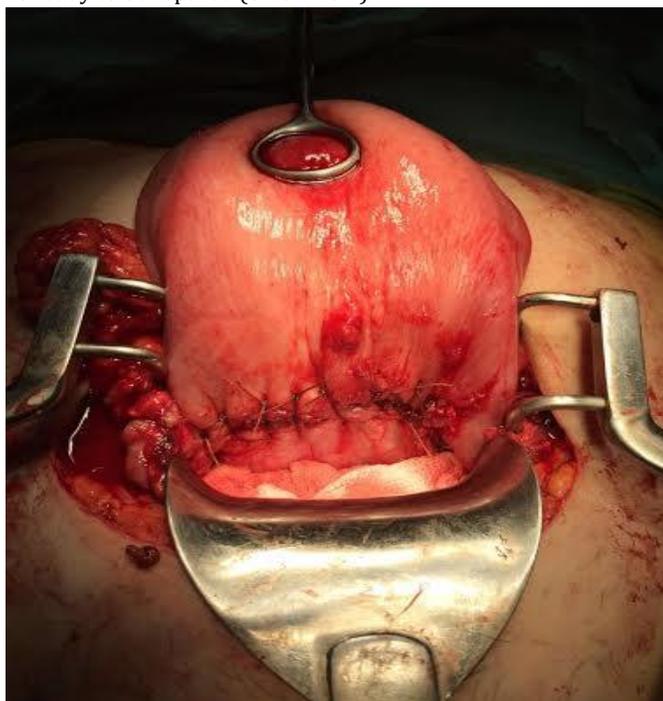
**Figure 3.** The bladder liberated from the hysterorrafia (red arrow) and the necrotic area in the uterus (blue arrow).



**Figure 4.** Observe the bladder moved down (red arrow) and the liberation of the inferior lip of the hysterorrafia (blue arrow).



**Figure 5.** The bladder completely descended (red arrow) and the uterus ready to be repaired (blue arrow).



**Figure 6.** The uterus repaired.

We removed the necrotic tissue and rebuild the hysterorrafia with separate stitches with catgut (Figure 4-5-6). The bladder was descended and the necrotic procces was bigger (Figure 2-3). With a good uterine retraction and good haemostasia, we closed the abdomen. The patient did well and was discharged 48 hours after surgery and she remain asymptomatic for more than a two month. She still does not reassumed her menses because she continue breastfeeding her baby.

### Discussion

ANH is an entity described long time ago, and the usual treatment was the hysterectomy. We presented a case solved by conservative surgery, allowing the normal gynecologic evolution and perhaps a new future pregnancy. Some authors have commented in unpublished discussions that the origin of the problema is an anomalous vascular supply of the uterus. But, none of them, have performed an arteriogram before pregnancy to support this argument against the presence of neovascularization for the necrosis and inflamatory procces. So, we continue sustaining the old description about the origin of ANH and propose that the treatment should be conservative instead to remove the uterus.

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