

AUTOTRANSFUSION IN RUPTURED TUBAL PREGNANCY

Pages with reference to book, From 78 To 79

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Abstract

A 27-years old grand multipara with an uncommon Blood Group (B, Rh. Negative) presented with ruptured tubal pregnancy. She was successfully transfused with her own extravasated blood after filtering out the clots.

Though somewhat antiquated, this method of resuscitation still has a place in our country for saving a patient's life under adverse circumstances (JPMA 37:78 , 1987).

HISTORY AND EXAMINATION

A 27 years old lady was admitted to the labour room with six days' history of pain in the lower abdomen and shoulders associated with frequent vomiting. Though her period was overdue by four days she attributed her vaginal bleeding to normal, albeit delayed, menstruation. She had had six normal children in the past who were all alive.

On examination she was grossly anaemic with a heart rate of 100/minute and a blood pressure of 100/60 mm Hg. Her abdomen was tender, silent and moderately distended. An ant everted and bulky uterus with tenderness in the left and .posterior fornix was noted on pelvic examination. Cervical motion was manifestly painful. Systemic examination was otherwise unremarkable. Her haemoglobin was 5.8 G/dl.

OPERATION

The abdomen was opened through a median subumbilical incision. The peritoneal cavity contained large amounts of blood and clots. The blood was scooped out with a small sterile bowl and filtered into a larger sterile bowl through two layers of sterile linen gauze. The filtered blood was transferred to a standard commercial bag containing anticoagulant and transfused to the patient. In the meanwhile a left-sided ruptured tubal pregnancy was dealt with by, left salpingoophorectomy.

Apart from a mild cough and transient pyrexia for a couple of days her postoperative progress was uneventful. She was discharged on her 7th postoperative day after removal of sutures.

DISCUSSION

Transfusion of blood shed into the peritoneal cavity was common in the days when transfusion service was not developed. It was done more often in cases of ectopic pregnancy and ruptured spleen. Tiber¹ reported 123 autotransfusions in ruptured ectopic pregnancy with only one death. In another series reported by Pathak and Stewart² blood in the peritoneal cavity of 40 percent cases was unsuitable for transfusion because it was haemolysed or clotted. In 50% who had autotransfusion additional donor blood was also transfused. Of two patients who had reactions, one developed hypotension and oliguria and the other had fever with rigors. Mollison³ suggested that a sample of blood obtained from the peritoneal cavity should be centrifuged to check for haemolysis. Blood that has been in peritoneal cavity for more than 24 hours should not be reinfused. Complications like haemoglobin uria, anuria and jaundice following autotransfusion may be due to transfusion of blood which had been in the peritoneal

cavity for some days⁴.

Blood transfusion is often a life-saving therapeutic measure in surgical and obstetric practice. In the developed countries with commercial or voluntary transfusion services there is seldom any shortage of suitable blood or blood products for such purposes. Consequently there is rarely, if ever, any need for autotransfusion.

Our socio-clinical milieu is totally different. Adequate amounts of suitable blood are not always available even in major urban centres. Patients' relatives are generally reluctant to donate blood because of morbid fears based on ignorance. Our mass media have paid scanty attention to educate the public in this field. Most of the blood in our hospitals comes from professional donors who are malnourished, drug addicts and or harbour communicable diseases. Their blood, instead of raising the patient's haemoglobin level, may transmit serious diseases.

Autotransfusion can be a life-saving measure in an emergency, especially in a patient with an uncommon blood group. Ruptured tubal pregnancy is obviously an ideal situation for employing autotransfusion. The method, however, could possibly be utilised in cases of thoracic and abdominal injuries provided that the extravasated blood has not become contaminated. The only equipment required is an unused transfusion bag containing suitable anticoagulant.

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4. Grossmann, H. Eigebluttransfusion mit todlichen ausgang. Zbl. Gynak, 1924, 48:2065 (Quoted by P.L. Mollison. . Vale 2, infra).