Abstract:
Rectus sheath haematoma is an uncommon condition characterized by acute abdominal pain and the appearance of an abdominal wall mass which leads to diagnostic dilemma in pregnant women. Here a case report of a 32 years old patient, a G4P3L3, a post caesarean pregnancy with 28 weeks gestation who presented with painless bleeding per vaginum. After stabilisation and sonological evaluation she was diagnosed as a case of placenta praevia with degenerating fibroid and was managed conservatively. Emergency Caesarean Section was performed for uncontrolled bleeding per vaginum at 32 weeks which revealed a 20x30 cm rectus sheath haematoma in the anterior abdominal wall. Mother recovered well. Both mother and child were discharged in good health. Rectus sheath haematoma can mimic many other clinical conditions and high index of suspicion should be maintained by the clinician to identify this highly masquerading and potentially manageable entity.

Keyword: Rectus sheath haematoma, pregnancy, fibroid uterus

INTRODUCTION
Rectus sheath haematoma is an uncommon condition characterized by acute abdominal pain and the appearance of an abdominal wall mass. It is more common in women and older individuals. In young women, rectus sheath haematoma is often seen in association with pregnancy. Rectus sheath haematoma is a rare but potential cause for abdominal pain. It can lead to serious diagnostic dilemmas in the setting of pregnancy. Here an interesting case of rectus sheath haematoma masquerading as degeneration of uterine fibroid is presented.

CASE REPORT:
Patient was a 32 years G4P3L3, a post caesarean pregnancy with 28 weeks gestation presented with painless bleeding per vaginum for 4 hours. Her menstrual cycles were regular with moderate flow. She had two prior home deliveries and one emergency LSCS done for failure to progress.
On admission she was very pale with signs of chronic anaemia. Her vitals were stable. Uterus was 28 weeks size, not acting, not tense, not tender; fetal heart sounds were heard. Ultrasound revealed placenta praevia type 2 anterior. Hemoglobin was 6.6 g/dl and PCV was 20%. Liver function test, renal function test and coagulation profile were normal. She received 2 units of packed cell on admission. After 2 weeks she was started on parenteral antibiotics for respiratory tract infection with fever and cough. Two days later patient complained of a vague abdominal pain. On abdominal examination a diffuse, firm, ill-defined mass of size 10x10 cm was felt in right iliac fossa. Ultrasound revealed a 15x9.5x12cm hetero echoic mass in right adnexa with cystic changes with a narrow pedicle provisionally reported exophytic fibroid with degeneration.

Patient was managed conservatively as a case of pregnancy complicated by placenta praevia, fibroid with red degeneration and anemia. Subsequently, 24 days after her admission, patient underwent emergency Caesarean Section for a severe bout of bleeding per vaginum. On opening the abdomen, surprisingly, a large mass of about 20x30 cm was found in the anterior abdominal wall, in close approximation with the uterus. LSCS was proceeded to deliver an alive baby of weight 2.1 kg. The mass was defined by separating the layers of rectus sheath. An organized haematoma of about 1000 grams was present. The Haematoma was evacuated and dead space was obliterated. Abdomen closed in layers with drains. 2 units of whole blood and 4 units of FFP was transfused intra operatively. Patient required a total of 14 units of blood and 4 units of Fresh Frozen Plasma throughout her hospital stay.
This condition is more common in women. The rectus abdominis muscle lies within the sheath, together with the epigastric vessels. The lower segment of the muscle is the longest and, at this segment, shortening with contraction is greatest. This may explain the higher incidence of haematomas in lower abdominal regions. In addition, during pregnancy spontaneous haematoma occurs when the abdominal distension causes stretching of the epigastric vessels\(^{1,2,3}\). The haematoma results from rupture of epigastric vessels or by tearing the fibers of the rectus abdominis muscle. It may be caused by trauma, coagulation disorders, or in patients on anticoagulant therapy\(^4\). Collection of the haematoma usually occurs in the lower part of the abdomen because of the absence of posterior rectus sheath below the level of the umbilicus\(^{1,2}\). The haematoma thus formed because of its direct contact with the peritoneum may cause peritonism, confusing the attending obstetrician of potential obstetric complications like abruptio placenta and rupture uterus\(^4\). Ultrasonography and CT are the diagnostic methods of choice\(^5,6\). Whereas USG findings are not specific\(^5,7,8\) and sometimes even inconclusive as in the present case; in such cases, CT scan may give the exact diagnosis. The hazards of CT scan towards the fetus, although trivial should be born in mind. Most cases of rectus sheath haematoma are managed conservatively\(^10\), although huge ones may require repeated blood transfusions and increased operative interventions\(^11\). In pregnancy, size of the haematoma and the haemoglobin status of the patient should be carefully monitored, apart from the fetal well being.
CONCLUSION
In conclusion, a high index of suspicion is needed on the part of the attending obstetrician to diagnose a case of spontaneous rectus muscle haematoma in pregnancy, which may mimic other conditions like degenerating fibroid, abruptio placenta and rupture uterus, which is possible by careful clinical evaluation aided by appropriate radiological tools.

REFERENCES: