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BLOODY DISCHARGE IN THE CONSERVATIVE MANAGEMENT OF PREMATURE RUPTURE OF MEMBRANES AS AN INDICATOR OF AMNIOTIC BAND SYNDROME

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ABSTRACT

In this case report, it is our purpose to relate our findings concerning bloody discharge as an ominous sign in the conservative management of premature rupture of membranes, (PROM) as well as to present relevant findings of the amniotic band syndrome such as amputation of one leg, constriction rings in two fingers, and pseudosyndactyly in the toes of the remaining foot in a 28 week old newborn. The bloody discharge was caused by the gradual amputation of these organs.

INTRODUCTION

In most studies of conservative management of premature rupture of membranes and amniotic band syndrome, bloody discharge has not been described as a symptom. In a few it is mentioned, but only in conjunction with other causes such as placental detachment. This symptom was found in the case presented here, after ruling out other causes of bleeding.

CASE REPORT

A pregnant 22 year old woman at 25 weeks gestation was admitted to the Rahnamon University Hospital in Tehran because of amniotic fluid leakage and vaginal bleeding for one week. The patient was gravid 3, para 2, with unknown L.M.P. Previous pregnancies were terminated by cesarean section, the first due to transverse position of the fetus.

During initial examination, the patient was in good condition and other than amniotic fluid leakage which was seen during speculum examination, no other positive signs were observed. The fundus of the uterus was 2 centimeters above the umbilicus. Sonography demonstrated a single 27 week cephalic fetus with severely reduced amniotic fluid and placenta in fundus.

The patient was conservatively managed as is routine in this condition: temperature chart, pulse check, fetal heart rate check, daily white blood cell count, control of mother's general condition, pad counting and speculum examination.

The cervix was unremarkable and no antibiotic was prescribed. One week after admission the fluid leakage became bloody, causing concern, and the pregnancy was eventually terminate by cesarean section.

The newborn was a boy with a 7-9 Apgar score and a weight of 1300g. The left leg was amputated under the knee, and the amputated atrophic limb was floating in the uterus, surrounded with a fibrotic band. In addition, syndactyly was present in the right foot and two small fingers of the hand had constriction rings (Fig 1).

The newborn was kept in an incubator under intensive care but died on the 10th day after birth due to septicemia. The mother was discharged one week after surgery in good health.

Fig 1: The picture of a new born baby following premature rupture of membranes, The left leg was amputated under knee, floating in the uterus surrounded by a fibrotic band (Amniotic Band Syndrome).

DISCUSSION

Conservative management of premature rupture of membranes is considered high risk for both mother and fetus.[5] For the mother, there may be an increased risk of chorioamnionitis and endometritis and for the fetus, in addition to a higher risk of infections, deformities and malformations, the risk of amniotic band syndrome increases, especially if rupture occurs in early gestation and is prolonged.[4] Sonography may be helpful but is not decisive, because aberrant bands in the amniotic sack are equivocal,[2] and because finding defects in the presence of oligoamnion will be difficult. However, the finding which this article wishes to emphasize (bloody discharge) is a decisive symptom of amniotic band syndrome. The blood originates from the amputated organ and when larger ones are involved the discharge is significant. Other wise it will be unremarkable and may be missed.

In this patient, intermittant bloody discharge aroused our concern, resulting in a cesarean section while the mother's vital signs were stable.

This symptom was not found in other studies, and was possibly mistaken for placenta previa or abrubtio placenta. In our patient, sonography and surgical findings ruled out placenta previa and abrubtio placenta.

The incidence of amniotic band syndrome is one in 1200 to 1500 births, but the incidence in premature rupture of membranes is unknown.

In Torpin's extensive review of 400 fetuses with amnion rupture, only three fetuses escaped injury However, in other studies the risk appears small.[3] This is surprising and may be the result of two factors: (1) the extent and time of rupture effects the degree of severity of the syndrome, and (2), other factors also play a role. For example, our patient had a history of cesarean sections, the first due to transverse position of the fetus.

REFERENCES

1. Higginbottom MC, Jones KL: The amniotic band disruption complex. Timing of amniotic rupture and variable spectra of consequent defects. J Pediatrics, 95:544, 1979.
2. Mahony BS, Filly RA, Callen PW: The amniotic band syndrome. Antenatal sonographic diagnosis and pitfalls. Am J Obstet Gynecol, 152:63, 1986.
3. Beydown SN, Yasin SY: Premature of membranes before 28 weeks: conservative management. Am J Obstet Gynecol 155:471-79
4. Nimrod C, Varela-Gittings F, Machin G: The effect of very prolonged membrane rupture on fetal development. Am J Obstet Gynecol, 148:540, 1948.
5. Andreko JL, Phnchen C, Sherman AT, Emilligan J: Results of conservative management of premature repture of membranes. Am J Obstet Gynecol. 148:600, 1984.

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