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RUPTURE OF A SUBCAPSULAR HEMATOMA OF THE LIVER: ABOUT A CASE

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ABSTRACT

Subcapsular hematoma of the liver (HSCF) is defined as an anatomo-clinical entity corresponding to the appearance of a hematic collection located between the intact GLISSON capsule and the hepatic parenchyma. It is a rare complication of pregnancy with high maternal-fetal mortality, most often occurring in the context of pre-eclampsia or HELLP syndrome (Hemolysis, Elevated Liver enzymes, and Low Platelets Syndrome). case described in acute hepatic steatosis during pregnancy. We report the case of a 25-year-old parturient, primiparous, without history, admitted to the emergency room for a state of shock on a pregnancy of 29 weeks of amenorrhea. Ultrasound showed a subcapsular hematoma of the ruptured liver. Urgent surgical exploration was required, during which a rupture of the subcapsular hematoma of the liver was revealed, accompanied by a state of hemorrhagic shock. Treatment consisted of polytransfusion with suturing of the liver lesion without paking. The evolution was favorable with clinical and biological normalization and the patient was declared discharged on D10 of her hospitalization.

INTRODUCTION

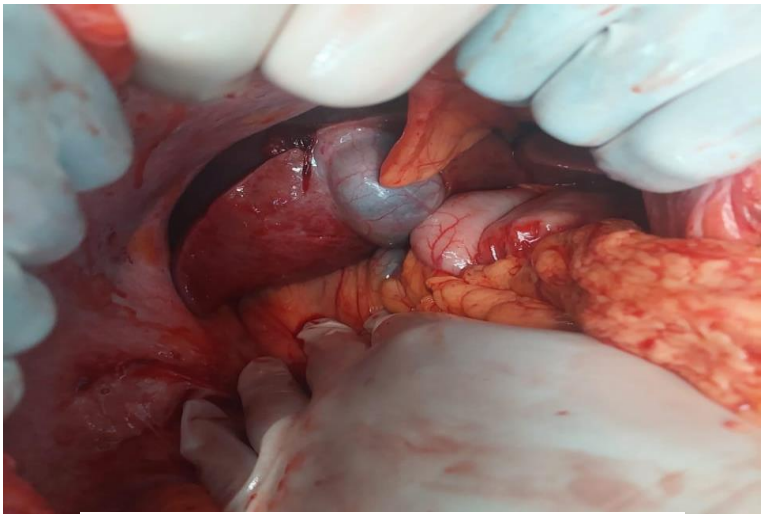
The subcapsular hematoma of the liver (HSCF) is a rare but serious complication of pregnancy, it has an incidence estimated between 1/45,000 and 1/225,000 births. Diagnosis must be rapid and management appropriate in this serious and fatal pathology for both the mother and her child (1,2). Broken its prognosis is pejorative, it is associated with significant maternal and fetal mortality, the picture is often characterized by hemorrhagic shock (3). We report the case of a patient whose HSCF was ruptured.

OBSERVATION

25-year-old patient, I gesture, I pare, 29 weeks pregnant with amenorrhea, no history, was admitted to the emergency room, minimal dark bleeding, on clinical clinical examination: patient concite, BP: 10/6 HR: 120 beats/min, proteinuria at + + + labstix, with uterine contracture, preceded for 3 hours by vomiting with pain in the right hypochondrium. The obstetrical ultrasound objectified a non-evolving monofetal pregnancy. Hepatic ultrasound revealed: an appearance in favor of a subcapsular hematoma of the right liver in the process of liquefaction associated with a layer of effusion. Biology found a complete Hellp syndrome (ASAT: 327 IU/L, ALAT: 96 IU/L, LDH: 327 The blood count showed a platelet count of 86,000 elements/mm3, hyperleukocytosis at 17,760/mm3 with hemoglobin at 8.7 g/dl Prothrombin count was at 75% INR at 1.5 Serum creatinine at 15 mg/l, blood urea at 0.28 mmol/l, Creat: 7.9. the clinico-biological context an exploration by high way was posed.

In the operating room, the patient was under GA, the management consisted of vascular filling with saline serum, transfusion of a red blood cell, 2PFC and 6CP. a stillborn, sex M, weight: 900g. The artificial delivery objectified a cup of HRP. On the liver exploration after widening of the incision in the median: hematoma under capsular of the liver, taking all the right lobe ruptured with a blood clot, from where the realization of the liver sutures hemostasis, then the patient benefited from peritoneal lavage.

The evolution was marked on day 5 post-op by the normalization of the biological assessment, thus a control ultrasound to objectified: an almost stable appearance of the subcapsular hematoma of the liver, with disappearance of the peritoneal effusion. The patient was declared discharged on D10 post-op.



Liver exploration showing ruptured right lobe HSCF

DISCUSSION

The subcapsular hematoma of the liver (HSCF) is defined as an anatomo-clinical entity corresponding to the appearance of a hematic collection located between the intact GLISSON capsule and the hepatic parenchyma.

The incidence of HSCF during pregnancy varies between 1/40,000 and 1/250,000 pregnancies,[2] It is most often associated with a picture of pre-eclampsia or Hellp syndrome, rarely a acute steatosis of pregnancy.[4] This complication mainly concerns women around their thirties with a greater predilection in multiparous and elderly primiparous women. It appears in the third trimester in 60% of cases, although this complication is revealed before labour, 15% of cases have been reported immediately postpartum. case of pain in the right hypochondrium or epigastrium with or without vomiting, with or without jaundice in a context of hypertension.[5] However, the subcapsular hematoma of the liver is frequently discovered when the clinical picture is complicated by hemorrhagic shock, which is the case of our patient.[1]

Faced with non-specific clinical symptomatology, the diagnosis is essentially based on imaging means, thus liver ultrasound is systematic in front of this clinical picture, it shows a heterogeneous hypoechoic image compared to the rest of the parenchyma. The association with an intraperitoneal effusion raises the suspicion of a fissure or even a rupture of the hematoma.[6] Liver ultrasound also helps in the event of surgical abstention.[7]

The use of CT or MRI, although they are more effective in liver exploration, are little used in practice given the urgency of the clinical picture. Hepatic angiography is thus rarely possible in an emergency.[6]

Faced with a rupture of HSCF, management was first an emergency caesarean section for fetal extraction.[2] Thus the management of HSCF is well codified, it includes packing or tamponade with different hematic substances, ligation of the hepatic artery or one of its branches, arterial embolization with hepatic transplantation.[8] Thanks to these different techniques, the mortality rate of subcapsular hematoma of the ruptured liver decreases: from 70% in 1960 to 10% around the 1990s.[2]

In African environment, ruptured, due to the lack of surgical techniques necessary in the management, the prognosis of subcapsular hematoma of the ruptured liver remains pejorative. five cases of death out of eight patients presenting with a subcapsular hematoma of the liver, four of which by rupture of the hematoma have been reported by EL Youssfi and All the diagnosis of HSCF should ideally be made before the rupture, the priority of which for the obstetrician and to ensure uterine evacuation as soon as possible. The present observation raises the interest of the realization of an abdominal echography in front of signs of appeals.[1]

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