

Life-threatening Haemorrhage following Over-the-Counter Use of MTP Pills in a Patient with Uterine Fibroid: A Case Report

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ABSTRACT

Cervical and lower uterine segment leiomyomas can closely mimic Retained Products of Conception on grey-scale and Doppler ultrasonography, particularly when encountered in the setting of acute post-abortion haemorrhage. Hereby, the authors present a case of a 28-year-old Gravida 3 Para 2 Living 2 (G3P2L2) female with two previous caesarean deliveries who presented with heavy vaginal bleeding after intake of Medical Termination of Pregnancy (MTP) pills at 12 weeks of gestation. Transabdominal ultrasound revealed a heteroechoic lesion with internal vascularity in the lower uterine segment, initially interpreted as Retained Products of Conception (RPOC) or subchorionic haematoma. Emergency suction and evacuation were performed, with persistent bleeding necessitating uterotonics, intrauterine balloon tamponade, and blood transfusion; a subsequent postoperative fall in haemoglobin to 7 g/dL necessitated a second transfusion. Repeat post-procedure ultrasound demonstrated a homogeneously hypoechoic mass with persistent peripheral vascularity, raising suspicion of a leiomyoma; Magnetic Resonance Imaging (MRI) subsequently confirmed an intramural lower uterine segment fibroid. The present report focuses on the diagnostic dilemma between RPOC and a co-existing lower uterine segment leiomyoma. Unsupervised MTP pill use was the precipitating event, but the principal clinical learning point is the recognition of fibroid-mimicking sonographic patterns in post-abortion bleeding.

Keywords: Diagnostic dilemma, Doppler imaging, Leiomyoma, Lower uterine segment, Magnetic resonance imaging, Medical termination of pregnancy, Retained products of conception, Uterotonics

CASE REPORT

A 28-year-old female, G3P2L2, with a history of two previous caesarean sections, presented to the Obstetrics and Gynaecology (OBGYN) Outpatient Department (OPD) with complaints of bleeding per vaginum for the past four days, requiring five to six pad changes daily and associated with passage of clots. Based on her last menstrual period, her gestational age was 12 weeks and five days. She reported intake of MTP pills six days earlier without prior ultrasonography. There was no significant past or family history.

On examination, the patient was pale and febrile (temperature 38°C), with a pulse rate of 96/min and blood pressure of 100/70 mmHg. Systemic examination was unremarkable. Abdominal examination revealed a healthy Pfannenstiel scar, and the uterus was palpated at 14 weeks' size. Per speculum examination showed a ballooned cervix with active bleeding, and per vaginal findings confirmed a firm, 14-week-sized uterus. Laboratory investigations at admission demonstrated mild anaemia with otherwise unremarkable haematological, biochemical, coagulation, and serological parameters; the complete profile is summarised in [Table/Fig-1].

An urgent transabdominal pelvic ultrasound was performed using a curvilinear 3.5 MHz probe. The uterus was anteverted, bulky, and measured approximately 14 weeks' size. The endometrial cavity showed heterogeneous contents in the upper segment consistent with RPOC. A well-defined heteroechoic lesion measuring 7.1×5.6 cm was identified in the lower uterine segment, extending towards the cervix. The lesion displayed mixed echogenicity with predominantly hypoechoic areas interspersed with hyperechoic foci, and its margins were partially ill-defined, blending with the adjacent myometrium and endometrial contents.

On colour Doppler interrogation, the lesion demonstrated internal vascularity with a peripheral and intra-lesional flow pattern. The Resistive Index (RI) of the feeding vessels was in the low-to-

Parameters	Value (Reference range)
Haemoglobin	9.5 g/dL (12.0-15.5) - mild anaemia
Total leucocyte count	9,800/mm ³ (4,000-11,000)
Platelet count	2.4×10 ⁵ /mm ³ (1.5-4.5×10 ⁵)
Prothrombin time/INR	12.4 s/INR 1.0 (11.0-13.5 s; INR 0.8-1.2)
Activated partial thromboplastin time	28 s (25-35)
Random blood sugar	96 mg/dL (70-140)
Blood urea	22 mg/dL (15-40)
Serum creatinine	0.7 mg/dL (0.5-1.1)
HIV/HBsAg/Anti-HCV/VDR	Non reactive
Blood group	B+

[Table/Fig-1]: Laboratory investigations at admission.

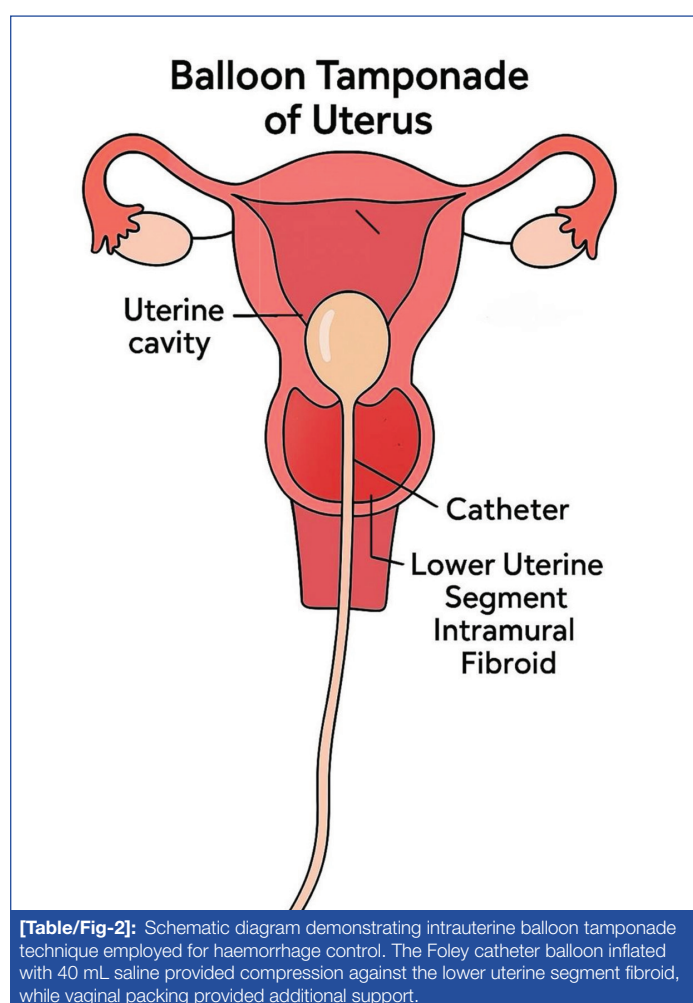
INR: International normalised ratio; HIV: Human immunodeficiency virus; HBsAg: Hepatitis B surface antigen; Anti-HCV: Antibodies against Hepatitis C virus; VDR: Venereal disease research laboratory

moderate range, which was not definitively characteristic of either a fibroid or vascularised RPOC. The lesion occupied the lower uterine segment and appeared to distort the cervical canal, making it difficult to delineate the precise boundary between the cervix and the lower uterine segment.

The initial sonographic differential diagnosis included: (a) RPOC with organised clot in the lower uterine segment; (b) subchorionic haematoma; and (c) a lower uterine segment or cervical fibroid. The overlapping sonographic features- mixed echogenicity, internal vascularity, and mass effect in the lower segment- made definitive differentiation challenging on ultrasound alone. The clinical context of recent MTP pill intake with active bleeding further biased initial interpretation towards retained products or haematoma rather than a pre-existing structural lesion.

The patient was shifted to the operating theatre within 90 minutes of admission for emergency suction and evacuation. At induction

(T0), pulse rate was 96/min and blood pressure 100/70 mmHg. Intraoperatively, RPOC measuring approximately 80 mL in volume were evacuated, with the suction and evacuation completed at approximately T0+20 min; estimated intraoperative blood loss was 1,200 mL based on visual estimation and weighing of soaked packs. Within 10 minutes of completing the evacuation (T0+30 min), bleeding became brisk and the patient developed haemodynamic instability with pulse rising to 124/min and blood pressure falling to 86/54 mmHg, classifying the event as Class III haemorrhagic shock according to the Advanced Trauma Life Support (ATLS) haemorrhagic shock classification [1]. Resuscitation was initiated with two large-bore peripheral lines, warmed crystalloids, and transfusion of one unit of packed red cells. Step-wise haemostatic measures were administered: intramuscular carboprost (250 µg) at T0+35 minutes, intravenous methergine (0.2 mg) at T0+40 minutes, and per-rectal misoprostol (800 µg) at T0+50 minutes. As bleeding continued, a Foley's catheter inflated with 40 mL saline was placed intrauterine along with a vaginal roller pack [Table/Fig-2] at T0+55 minutes, after which haemodynamic parameters stabilised within 20 minutes (pulse 98/min, blood pressure 110/72 mmHg) and visible bleeding reduced to a trickle.

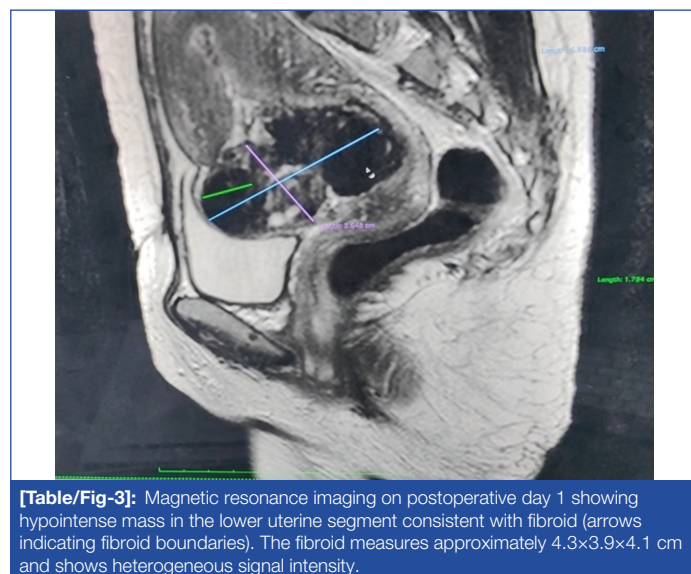


Postoperatively, the patient received oxytocin infusion, tranexamic acid, and intravenous antibiotics. On postoperative day 1, the intrauterine catheter and vaginal pack were removed, but bleeding continued. Methergine 0.2 mg IM (intramuscular) every eight hours was started. Repeat haemogram revealed Hb of 7 g/dL, requiring a second transfusion.

A follow-up transabdominal ultrasound on postoperative day 1 revealed that the previously identified heteroechoic mass had partially reduced in size, now measuring 4.3×3.9×4.1 cm. Notably, the lesion now appeared more homogeneously hypoechoic with well-defined margins and demonstrated persistent internal vascularity on Doppler-features more consistent with a solid myometrial mass

(fibroid) than with residual products of conception, which would be expected to show progressive decrease in vascularity following evacuation. The endometrial cavity appeared empty with no residual products.

The MRI of the pelvis was performed on postoperative day 1 once the patient had stabilised haemodynamically and active bleeding had become controlled, on the indication of a persistent mass on follow-up ultrasound that remained sonographically equivocal between a residual leiomyoma and an organised hematoma. MRI was prioritised at this point rather than in the acute setting because: (a) bleeding was no longer torrential, allowing safe transfer to the imaging suite; (b) management decisions regarding myomectomy versus expectant care hinged on accurate tissue characterisation; and (c) MRI offered superior delineation of the cervical-lower uterine segment boundary, which transabdominal ultrasound could not reliably resolve. On T2-weighted imaging, the lesion appeared as a well-circumscribed, homogeneously hypointense mass in the lower uterine segment, characteristic of a leiomyoma. MRI clearly delineated the fibroid's intramural location within the lower uterine segment, its relationship to the cervical canal, and the absence of any residual products of conception [Table/Fig-3]. Based on its location and relationship to the myometrium, the lesion was categorised as a FIGO Polyp, Adenomyosis, Leiomyoma, Malignancy and hyperplasia-Coagulopathy, Ovulatory dysfunction, Endometrial, Iatrogenic, Not otherwise classified (PALM-COEIN) Type 4 leiomyoma (purely intramural, without contact with the endometrium or serosal surface) [2].



After stabilisation and observation for 48 hours, the patient was discharged in stable condition. Following confirmation of a lower uterine segment leiomyoma, a tiered management plan was discussed. She was started on combined oral contraceptives (ethinylestradiol 30 µg + levonorgestrel 150 µg, one tablet orally once daily for 21 days followed by a 7-day pill-free interval) after resumption of menses and advised to repeat the ultrasound after three months. At 1-week follow-up, the patient was asymptomatic. On 3-month follow-up ultrasound, the fibroid had reduced to 3×2.6×2.4 cm in the lower uterine segment and she had no menstrual complaints. She was advised to continue combined oral contraceptives for a further three months and to follow-up with annual transvaginal ultrasonography.

DISCUSSION

The MTP Act of India, legalising abortions, was passed with the aim of reducing the number of maternal deaths due to unsafe abortions, but still, 8% of maternal deaths are attributed to unsafe abortions in India [3]. Unsupervised medical abortion pill intake is becoming a public health hazard. Because of the over-the-counter availability of

MTP pills, many women tend to buy them on their own, or they are freely prescribed by local dais and quacks [3]. Unsafe abortion mostly leads to complications like severe anaemia, uterine perforation, cervical trauma, ectopic pregnancy, incomplete abortion, sepsis, shock, and sometimes even death [4]. One study reported that the majority of women (63.4%) seeking medical abortion were from rural areas, and nearly one-fourth (22.3%) had consumed abortion drugs beyond nine weeks of gestation [5].

The present case highlights the significant risks associated with the unsupervised use of over-the-counter MTP pills, particularly in women with pre-existing uterine abnormalities such as fibroids or a scarred uterus. The risk of uterine rupture is significantly higher in women with a history of two previous Lower Segment Caesarean Sections (LSCS), particularly when abortion is attempted in the second trimester [6]. The chance of scar rupture in post-caesarean pregnancy following first-trimester medical abortion is non-existent, but the risk of rupture is 0.28% in second-trimester abortions [7].

A closely analogous case was reported by Mason TC, in which red degeneration of a uterine leiomyoma presenting four weeks postpartum masqueraded as RPOC, with serial ultrasound and clinical course initially indistinguishable from incomplete abortion until the underlying fibroid was identified [8].

The present case supports a tiered imaging approach: ultrasound as the first-line modality for acute assessment, with MRI reserved for cases in which ultrasound findings are equivocal or clinical response is unexpected.

Tigdi J and Chan C reported a case of an obstructive pedunculated cervical fibroid that posed challenges during uterine evacuation, highlighting the diagnostic and surgical difficulties such fibroids can create in abortion care [9]. Their case, like present, emphasises the need for comprehensive pre-procedure sonographic evaluation of the lower uterine segment and cervix to identify structural lesions that may complicate surgical management.

CONCLUSION(S)

The MTP in the presence of uterine fibroids can be more challenging, potentially impacting the efficacy of the procedure and increasing

the risk of complications. The present case underscores the central role of ultrasonography in the diagnostic evaluation of post-abortion complications. Sonologists should maintain a high-index of suspicion for structural lesions, particularly lower uterine segment and cervical fibroids, which can mimic RPOC. When ultrasound findings remain equivocal, timely MRI should be pursued to guide definitive management.

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