The patient presented ecchymosis over left trunk after a bout of violent cough.

The CT scan revealed a big hematoma over left abdominal wall without evidence of extravasation (arrow).

A 73-year-old male farmer with a history of chronic obstructive pulmonary disease, hypertension, benign prostatic hyperplasia and gastric ulcer presented pain and ecchymosis over left trunk area for hours without traumatic history (Picture 1, panel A). He had recently suffered from cough. About ten hours before symptoms occurred, he felt pricking pain over left lower quadrant abdomen after a bout of violent cough and subsequently ecchymosis developed gradually. The patient’s vital sign was stable and the complete blood count, biochemistry and coagulation profiles were all within normal limit.

The computed tomography (CT) scan revealed a giant hematoma in the left abdominal muscle layer without evidence of blood extravasation (Picture 1B). He was then admitted with supportive treatment and closely observation. Under stable condition, he was discharged two days later and was quite well for five months after discharge.

Abdominal wall hematoma is a rare but well-known clinical entity. The most common presenting signs and symptoms are acute abdominal pain and an abdominal wall mass (1, 2). Abdominal wall ecchymosis is a rare presentation of abdominal wall hematoma. The study of Cherry and Mueller showed that only 17% of patients present abdominal wall ecchymosis (3). In addition to abdominal blunt trauma, predisposing factors of spontaneous abdominal wall hematoma include: (a) a severe coagulational defect such as hemophilia, von Willebrand disease or anticoagulant administration (b) weakness of the vessel wall (c) overcontraction of the muscle such as coughing, straining or vomiting (d) a rare complication of pregnancy, laparoscopy and insulin injection (2, 4, 5). CT scan is the gold standard for the diagnosis of abdominal wall hematoma. Ultrasonogram can only
be an initial investigation because of the lower sensitivity (1, 2). Conservative treatment is suggested if no hemodynamic dysfunction or complications are present. Surgical intervention or transcatheter arterial embolization is recommended when conservative management fails (6).

References