Rectus Sheath Hematoma from Inferior Epigastric Artery Bleed

A 71-year-old woman with *Clostridium difficile* colitis was anticoagulated for deep vein thrombosis. When she developed right lower abdominal pain, it was initially believed to be due to her colitis. Because of worsening pain, along with tachycardia and hypotension, noncontrast (A) and contrast-enhanced (B) CT imaging was performed, demonstrating a large right-sided rectus sheath hematoma (RSH) (A) with active extravasation resulting in a fluid-fluid level (B). A digital subtraction angiogram showed active extravasation from the right inferior epigastric artery (arrow, C), with subsequent successful gelfoam and coil embolization (D).

Reported complications of RSH include hypovolemic shock, hematoma, infection, abdominal compartment syndrome, and death. Recurrence rates of 1% to 2% have been associated with resuming anticoagulation. Mortality for all causes of RSH has been reported at 4%, 18% for iatrogenic RSH, and as high as 25% for patients on anticoagulation.

CT is the modality of choice for RSH detection, with intravenous contrast helping to detect active hemorrhage. While supportive therapy and anticoagulation cessation can resolve mild RSHs, management depends on presentation and hemodynamics. RSHs with persistent hemorrhage often require surgical ligation or percutaneous embolization, with transcatheter arterial embolization now considered first-line therapy due to its decreased risk profile and high-technical success rate.

**REFERENCES**


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