There was a clinical suspicion of an intra-abdominal bleeding. A CT scan (see Figures 1 and 2) and subsequent CT angiography were performed and showed subcapsular blood with a rupture of the left lobe of the liver and an intraperitoneal haematoma. A single arterial bleeding locus could not be localized. The treatment was primarily conservative with continuous haemodynamic and laboratory monitoring. The surgical "wait-and-see" policy was initially effective. After blood transfusion and resuscitation with fluids the patient became more haemodynamically stable. However, over the course of the following hours the patient became anuric. His plasma creatinine level rose from 93 to 238 micromol/l. Intra-abdominal pressure (IAP), measured via a urinary bladder catheter, was 40 cm H₂O. Intra-abdominal hypertension and renal dysfunction were considered to be related. Urgent surgical evaluation was obtained for abdominal decompression, removing more than 2000 ml blood from the peritoneal cavity. A capsular laceration was seen on the ventral side of the liver of segments 2 and 3 with a rupture of the left lobe of the liver and an intraperitoneal haematoma. After laparotomy the IAP fell and diuresis was seen. The patient recovered fully and was discharged after 5 days.

Traumatic laceration of the liver or of other intra-abdominal organs is uncommon after CPR. Anticoagulation and concomitant antiplatelet therapy adds to the risk of sudden massive intra-abdominal haemorrhage. Various intra-thoracic as well as intra-abdominal traumatic complications have been reported after CPR, including: aortic dissection, haemato- and pneumothorax due to rib and sternal fractures, lung and cardiac contusion, rupture of the trachea, liver or spleen lacerations, and gastric perforation [2-6]. Liver rupture and other liver injuries after CPR have been reported in about 3% of post-mortem studies [6]. The traumatic complications are especially high when CPR is performed by untrained subjects [1].

It is important to notice that haemodynamic instability after CPR is not always caused by myocardial dysfunction or infarction, but is sometimes ascribed to traumatic visceral laceration and bleeding. Therefore treatment must be focused on the underlying cause. Determining the need for surgery depends on the clinical condition of the patient and the suspected underlying cause. The presence of persistent haemodynamic instability, need for ongoing blood transfusion and development of abdominal compartment syndrome are urgent indications for surgical treatment.

References