OPEN ACCESS

Scholars International Journal of Obstetrics and Gynecology

Abbreviated Key Title: Sch Int J Obstet Gynec
ISSN 2616-8235 (Print) | ISSN 2617-3492 (Online)
Scholars Middle East Publishers, Dubai, United Arab Emirates
Journal homepage: https://saudijournals.com

Case Report

Vulvo-Vaginal Thrombus about a Case at the Fousseyni Daou Hospital in Kayes (Mali)

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DOI: https://doi.org/10.36348/sijog.2024.v07i12.009 | **Received:** 07.11.2024 | **Accepted:** 12.12.2024 | **Published:** 19.12.2024

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Abstract

Puerperal hematomas are a rare cause of postpartum hemorrhage. Their adequate management requires expertise and an adapted technical platform. To our knowledge, no case has been published in Mali. We report the case of a 38-year-old woman, multiparous 6th procedure 5th par with 5 living children, evacuated from a community health center located 90 km away, in a state of hemorrhagic shock occurring one hour after a home birth. She was surgically treated for an expansive vulvo-perineal hematoma. This case allows us to draw the attention of practitioners to the seriousness and singularity of this highly morbid pathology.

Keywords: Vulvar thrombus, postpartum hemorrhage, Kayes (Mali).

INTRODUCTION

Genital thrombus, whose international term is perigenital puerperal hematoma, corresponds better to the pathology since there is no real intravascular thrombus; it is a fairly rare situation. The diagnosis of genital thrombus is most often easy in the face of fairly pathognomonic symptoms: perineal pain in the immediate postpartum period associated with a sensation of rectal tenesmus; it can exceptionally be the cause of extensive forms in which the picture is that of shock due to internal hemorrhage. The most common etiologies are: uterine atony, coagulopathies, retention of placental debris, placental insertion anomalies, retention of fetal membranes and lacerations of the genital tract [1, 2]. Among the unusual causes are puerperal hematomas (also called peri-genital thrombi) with a frequency of 1/1000 deliveries [3]. The management of this pathology is simple in the majority of cases. It is important to treat quickly by incision, evacuation, tamponade. In the majority of cases this treatment will be sufficient.

PATIENT AND OBSERVATION

Mrs. M S, aged 38, married, housewife, multiparous 6th procedure 5th parous with 5 living children, evacuated from a community health center located 90 km away, for management of a vulvar swelling in a state of hemorrhagic shock, occurring one hour after a home birth. The onset was marked by the occurrence after the home birth of a very abundant vaginal bleeding, followed by a very painful vulvar swelling (right labia). Faced with this picture, the staff of the community health center had implemented the following measures: uterine massage, uterine revision, placement of an intravenous line with 5% glucose serum

containing 20 international units of oxytocin. When the vaginal bleeding stopped, a cutaneous and mucosal pallor was observed, as well as the appearance of a progressive and very painful swelling of the right labia majora. She is blood group A, rhesus negative. The systematic investigation found intense thirst, extreme asthenia and dizziness. On physical examination, the general condition was altered by pallor and asthenia. The temperature was 37.5 degrees Celsius, the pulse was 94 beats per minute, the blood pressure was 90/66 millimeters of mercury, and the respiratory rate was 24 cycles per minute. The conjunctivae were pale. The abdomen was soft and painless. Hydro-aeric sounds were present and the uterus was well contracted. Inspection of the external genitalia revealed a swelling of the right hemi-vulva. Internally, the mass pushed back the labia minora and protruded into the vaginal wall (Fig 1). Palpation was extremely painful and made exploration of the mass difficult without anesthesia. Its large diameter was anteroposterior and measured 14 centimeters while its small, transverse diameter measured 9 centimeters.

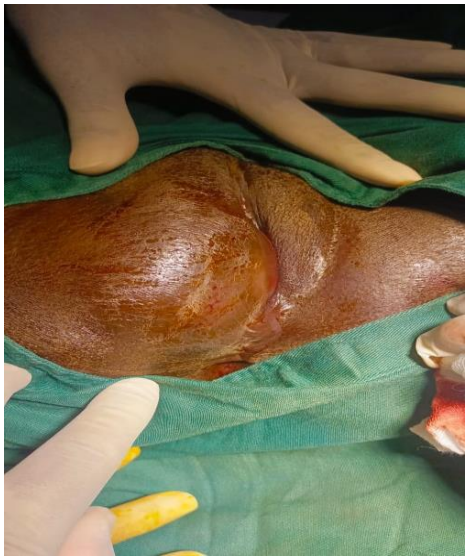

Fig. 1: Expanding hematoma of the right vulva

Surgical management under general anesthesia and a blood transfusion of 1000 milliliters of rhesus negative whole blood with a hemoglobin level of 7.9 grams/deciliter were performed. Intraoperatively (Fig 2, 3) a 250 gram hematoma was found located between the superficial and deep planes of the perineum. After evacuating the hematoma, we successfully performed several simple hemostatic sutures followed by drainage of the hematoma site with a wick. The postoperative course was simple.

Fig. 2: Incision area of hematoma evacuation

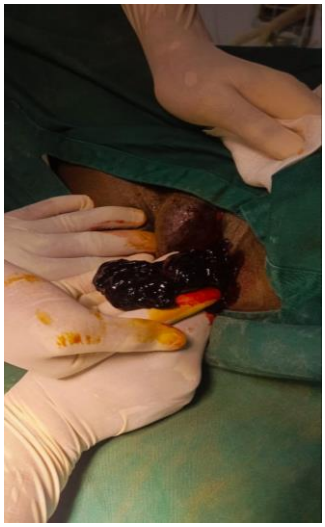

Fig. 3: Externalization of the vaginal hematoma

Fig. 4: Clots from puerperal hematoma of vulvovaginal thrombus

DISCUSSION

The frequency of vulvovaginal thrombus varies depending on whether its volume is small (1 case per 700 deliveries) or large (1 case per 4,000 deliveries) [3]. The risk factors for perigenital puerperal hematoma recognized in the literature are: primiparity, instrumental fetal extraction, preeclampsia, twin pregnancies, macrosomia and vulvovaginal varices [3]. In our patient, the delivery took place at home by an unqualified person. We have not found other studies on this pathology with home delivery. As reported in the literature, the clinical picture in our patient was dominated by the occurrence of pain and swelling, generally unilateral, a few moments or immediately after delivery [3, 6]. Uterine atony was associated and would explain the abundance of bleeding observed as well as the hemorrhagic shock that followed. The literature review reports several topographical forms of puerperal hematomas: vulvar hematoma, vaginal hematoma, vulvovaginal hematoma, and pelvic-genital or subperitoneal hematoma [3]. Treatment is based on hemostasis and correction of hemodynamic disorders and adjuvant measures including antibiotic prophylaxis and analgesics [3, 4, 6]. Hemostasis can occur on its own by compression of the vascular lesion by the clot constituting the hematoma [3, 6]. Otherwise, a hemostatic procedure is required as was the case in our patient by surgical management of the hematoma site (incision - evacuation of the hematoma - hemostatic sutures, drainage - wicking). The main difficulty is to locate the hemorrhagic vessel in an operating field masked by the flow of blood [3]. In the postoperative period, the most delicate step is the removal of the wick which can give rise to a recurrence of bleeding. In case of immediate failure of surgical hemostasis or recurrence of hemorrhage, the next step is ligation of the uterine arteries [3,6]. If this fails, selective embolization of the pudental and inferior gluteal arteries represents the last therapeutic recourse; its implementation remains however limited by the need for a technical platform and an experienced interventional radiology team [3,5,6]. In our context this technology is not available.

CONCLUSION

Postpartum genital thrombus or perigenital puerperal hematoma is a rare but potentially very severe complication of childbirth. The risk factors are well known, however it can occur in the absence of risk factors.

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