Gazette of Medicine
A Peer-reviewed Medical Journal of the Association of Resident Doctors
University of Port Harcourt
Teaching Hospital,Port Harcourt,
Rivers State, Nigeria
Volume 10 No 1, June. 2022 - Nov, 2022

HUGE VULVAR HAEMATOMA FOLLOWING SPONTANOUS VAGINAL DELIVERY: SURGICAL EVACUATION

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ABSTRACT

Vulvar haematoma during normal vaginal birth is rare. It is often recorded in traumatic or iatrogenic injury during forceps delivery or poorly managed episiotomies. Other causes of haematoma include traumatic stride injuries, coital injury, rape, or as sexual abuse.

The highly vascularized peri anal tissue in pregnancy can bleed massively, leading to subsequent post-partum hemorrhage and compromise of the cardiovascular status of the woman as in this case. An estimated evacuated blood loss of 1.4 liters was recorded.

Keywords: *Vulvar, Haematoma, Vaginal Delivery*

INTRODUCTION

Vulvar haematoma is an uncommon development at birth but may occasionally result from traumatic episodes following stride injuries to the perineum during the application of obstetric forceps, poorly repaired episiotomy, or poor conduct of labour.[1,2]

The diagnosis is mostly clinical based on massive extensive concealed haemorrage at the vulvar.[3] It may occasionally complicate a difficult vaginal delivery. Worthy of note is the severe pain at the perineum and gluteal region due to the expansive accumulation of blood from the tear or rent. This if not detected early could lead to dizzy spells and post-partum collapse.

Cardiovascular resuscitation, evacuation of the haematoma, and repair of injuries remain the mainstay of treatment.[3,4]

Skilled management of deliveries and good knowledge of pelvic anatomy among the birth attendants, midwives, and medical officers will eliminate the physical, and psychological trauma and agony that ruins the joy of safe vaginal birth.

CASE REPORT

Mrs. S. N. was a 31-year-old housewife Para $_2^{+1}$ who reported to the unbooked unit of the labour ward at the University of Port Harcourt Teaching Hospital as an emergency following a sudden collapse after vaginal birth. She had a difficult but successful vaginal delivery two hours after a very short period of labour at the home of a traditional birth attendant. The outcome of the delivery was a 3.2kg male baby, who cried well at birth.

She presented with a 2-hour history of penetrating pain in the vagina, weakness, difficulty in breathing, and shock.

The pain after delivery got worse despite medications, she was unable to lie down or sit with comfort. Clinical examination revealed a semi-conscious patient that was markedly pale, pulse rate was 150b/m. Her blood pressure was not recordable; the respiratory rate was 25 cycles per minute.

Her chest was clinically clear. The abdomen was soft, uterine size was 26/52 moderately contracted. The liver, spleen, and kidney were not palpable.

Examination of the vulva and vagina revealed an obvious, massive vulva swelling extending to the gluteal region with a bleeding rent from the right labia majus and obliterating the entire vaginal canal, measuring 26cmx15cm

stretching to the right gluteal region. An average haematoma collection of 1,400litres.

Her haemoglobin concentration was 5.0g/dl. She was resuscitated with intravenous fluid and two units of whole blood transfusion. Her bladder was catheterized. Exploration of the vulvar haematoma and evacuation was conducted under regional anaethesia in the theatre and the entire genital tract was explored and found to be intact. The uterus was well contracted. She received intravenous antibiotics for 48 hours. She also had rectal diclofenac 100mg twice daily for three days, oral ampicillin/cloxacillin 500mg three times a day for five days, and Metronidazole 400mg three times a day for five days. She also had vulvar toileting twice daily for five days. The outcome of the procedure was satisfactory.

She received two additional units of whole blood. She was ambulant on the 3rd day after surgery without significant pain.

She was counseled on timely access to standard healthcare facilities where skilled birth care can be properly provided for subsequent pregnancies. She was discharged and seen at the post-natal clinic two weeks later. Her clinical condition was satisfactory.

Figure 1: Massive vulvar swelling from accumulation of blood, this caused unbearable peri-anal and submerged the urge for defecation and micturition, causing postural discomfort while sitting and lying down.

DISCUSSION

Most cases of vulvar haematoma occur in association with episiotomies and traumatic forceps deliveries.[5] Vulvar haematomas following vaginal deliveries are rare in modern obstetrics. The incidence varies from 1 in 300 to 1 in 15,000 deliveries.[5]

The presentation is to highlight and draw attention to the rare but possible event/ occurrence during delivery and heighten the index of early suspicion in parturient presenting with perineal pain after delivery. This is emphasizing the need to train more healthcare professionals and also puts a searchlight on the consequences of the unskilled practice of traditional birth attendants in low-resource settings.[6,7]

Traditional birth attendants (TBAs) lack the basic knowledge and skills to offer adequate care in labour during birth.

Training is required to help prevent such obstetric complication that was seen in this case. Such training should emphasize the importance of early referral when labour is not following the usual/normal pattern that achieves delivery for them.

The mainstay of management of vulvar haematoma is the surgical evacuation of the accumulated blood. Carefully locating and ligating the bleeding vessels.[6,7,8] This again will require the help of trained personnel who has the basic knowledge of pelvic anatomy and good surgical craft.

Surgical exploration is needed to prevent pressure necrosis of the surrounding tissue and decrease the risk of infection and necrotizing fasciitis. This surgical intervention entails re-approximation of the tissue while trying to avoid leaving a dead space. Delayed absorbable sutures are preferable, and the sutures are locked to achieve adequate hemostasis.

Early complications of vulva hematoma include hemorrhage, anaemia, postpartum collapse, shock as noted in this case, and even death.

Some of the late complications include Sheehan's syndrome, infection, ischiorectal abscess, pelvic haematocele, pelvic peritonitis, dyspareunia, chronic pelvic pain, fistula formation as well as depression.

Mrs. S.N. reported having had postpartum collapse which was one of the factors that alerted the caregiver of the severity of the condition. There was a need to explore and examine the entire genital tract to exclude any possible tears and lacerations along the genital

tract the rent on the uterus, and cervical lacerations. The prompt care she received prevented maternal mortality.

CONCLUSION

Birth injuries following a poorly supervised labour and delivery can lead to dire complications like vulvar haematoma which has a serious postpartum risk of morbidity and mortality. Prompt surgical exploration, ligation of bleeding vessels, and repair are key for a good outcome of management.

REFERENCES

1. Nnaji HC, Nwankwo TO, Aniebue UU, Asogwa AO. Large Vulva Haematoma Following Spontaneous Vaginal Delivery: Successful Conservative Management in Enugu, South East Nigeria. *Advances in Reproductive Sciences.* 2019 Dec 18;8(1):31-5.
2. Lewis FM. Vulval Trauma. *Ridley's The Vulva.* 2022 Jun 17:403-11.
3. Gupta A, Kaushal V, Sharma C, Kumar R, Vij A, Gupta B. Non-obstetric vulval hematoma is not so uncommon. *International Journal of Reproduction, Contraception, Obstetrics, and Gynecology.* 2018 Feb 1;7(2):753.
4. Ayegbusi EO, Archibong MS, Adeyanju TB, Adeyiolu AT, Gyadale AN, Fadare OO, Ubom AE, Abe AT. Postpartum Shock Following Vulvovaginal Haematoma, Rare but Keeps Coming: The Complete Case Report. *J Clin Haematol.* 2022;3(1):28-32.
5. Tilahun T, Wakgari A, Legesse A, Oljira R. Postpartum spontaneous vulvar hematoma as a cause of maternal near miss: a case report and review of the literature. *J Med Case Rep* 2022;16(1):4–7.
6. Saxena P, Chaudhary G, Laul P, Kadam VK. Spontaneous Vulvar Hematoma in Labor: A Rare Presentation. *The Journal of Obstetrics and Gynecology of India.* 2022 Feb;72(1):81-2.
7. Akpa MA, Alabi OJ, Akogu SP, Odi TO. Fetal vulva laceration during an attempted vaginal breech delivery. *Int J Case Rep Images.* 2020;11:101179Z01MA2020.
8. Gölbaşı C, Gölbaşı H, Bayraktar B, Ertaş İE. Surgical management and clinical follow-up of post-coital severe vulvar hematoma in a 14-year-old adolescent girl: a case presentation.

Acta Bio Medica: Atenei Parmensis.
2021;92(Suppl 1).