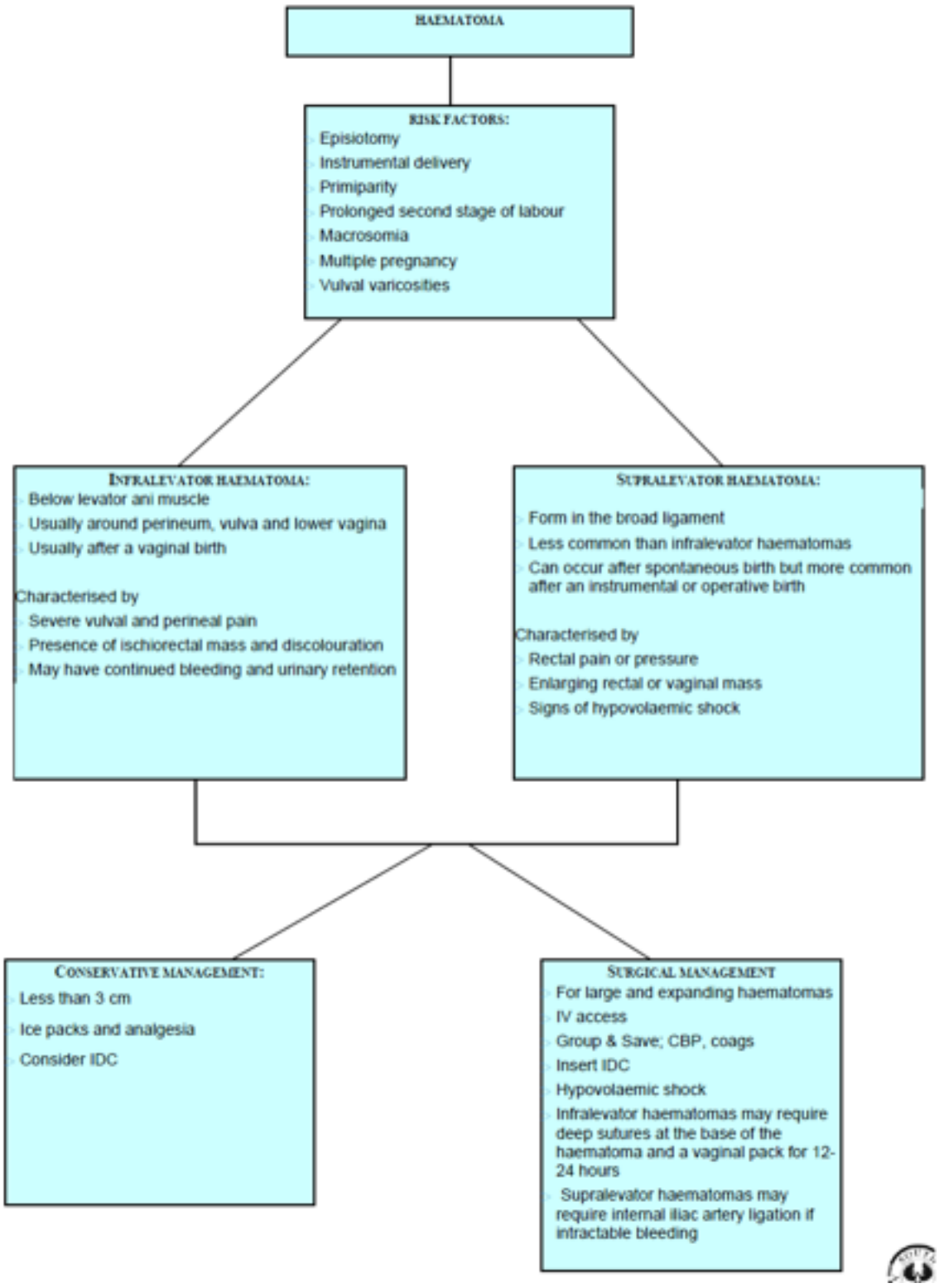
Puerperal genital haematomas

Puerperal genital haematoma



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Definitions

Puerperal genital haematomas are described as infralevator or supralevator haematomas

Infralevator haematomas:

- Occur below the levator ani muscle, usually around vulva, perineum and lower vagina
- Usually associated with vaginal birth

Supralevator haematomas:

- Form in the broad ligament, may be due to an extension of a tear of the cervix, vaginal fornix or uterus
- Less common than infralevator haematomas
- May occur after spontaneous birth, but more commonly occur following operative vaginal birth or a difficult caesarean section

Incidence

- Clinically significant haematomas occur in between 1:500 and 1:900 vaginal births (Thakar and Sultan 2009)
- Commonly occur as a result of failure to achieve haemostasis, particularly at the apex of an episiotomy or tear. However, about 20 % of cases occur from a concealed ruptured vessel with an apparently intact perineum (Thakar and Sultan 2009)

Risk factors

- Episiotomy
- Instrumental delivery
- Primiparity
- Prolonged 2nd stage of labour
- Macrosomia
- Multiple pregnancy
- Vulval varicosities

Clinical Features

- The classical presentation is pain, restlessness, inability to pass urine and rectal tenesmus (constant need to empty bowels) within a few hours after birth
- Women with a large haematoma may suffer collapse

Infralevator haematoma:

- Severe vulval / perineal pain and swelling
- Presence of ischiorectal mass and discoloration
- May be continued bleeding or urinary retention

Supralevator haematoma:

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- Rectal pain and pressure
- Enlarging rectal or vaginal mass
- Signs of haemorrhagic shock may occur if the amount of blood in the haematoma is large
- Observe for clinical signs of shock: e.g. elevated pulse, decreased blood pressure, pale, sweaty, clammy, dizzy

Management

- No randomised studies on the management of vulvovaginal haematomas were found

Initial management

- Offer analgesia (oral or intramuscular opioid)
- Prompt examination of vulva, perineum, vagina to identify site of haematoma, and determine whether it is still expanding
- Estimate blood loss, monitor ongoing blood loss
- Consider need for resuscitation measures (see below)

Conservative management

- Ice packs and analgesia for non-expanding haematomas < 3 cm
- Indwelling catheter may be required if swelling is large to avoid possible urinary retention (for further information, refer to the PPG 'Postpartum bladder dysfunction)

Infralevator haematoma:

- The exact origin of the bleeding is rarely identified
- May require surgical exploration in theatre to insert deep sutures at the base of haematoma
- Incision need not be closed
- Indwelling catheter
- Vaginal pack 12 – 24 hours to tamponade raw edges

Supralevator haematoma:

- Haematoma distention displaces the uterus to the other side, bulging into the upper vagina
- Conservative management
- Check haemoglobin
- Blood transfusion may be necessary
- May need to consider surgical evacuation of clot and packing the cavity for 24 hours
- Consider internal iliac artery ligation if there is intractable bleeding
- Consult an interventional radiologist, if available, to consider occlusion of the internal iliac artery/ies by balloon catheter or embolisation as an alternative to laparotomy for internal iliac artery ligation

Surgical management

- May be indicated for large or expanding haematomas to prevent pressure necrosis, septicaemia, haemorrhage
- Indwelling catheter

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- IV access
  - Group and save
  - Complete blood picture
  - Coagulation profile if actively bleeding

Signs of hypovolaemic shock / decreasing haematocrit:

- Intravenous fluid replacement with crystalloids / colloids (e.g. Hartmann's, sodium chloride 0.9 %, Gelafusine) +/- blood transfusion
- Arrange prompt surgical intervention

Postpartum care

- Monitor bleeding,
- Offer adequate analgesia, including regular paracetamol and non-steroidal anti-inflammatory analgesia (e.g.diclofenac [Voltaren®] 50 mg tds), unless contraindicated
  - NSAID contraindications include: postpartum haemorrhage, preeclampsia, renal disease, concurrent use of other NSAIDs, aspirin, digoxin
- Avoid rectal administration of analgesics
- Indwelling catheter until stable (for further information, refer to the PPG 'Postpartum bladder dysfunction)
- Consider need for broad spectrum antibiotic cover

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Abbreviations

cm	Centimetre(s)
Coags	Coagulation profile
CBP	Complete blood picture
e.g.	For example
G & S	Group and save
Hb	Haemoglobin
IDC	Indwelling urinary catheter
IV	Intravenous
<	Less than
NSAIDs	Non-steroidal anti-inflammatory drugs
+/-	Plus or minus

Version control and change history

PDS reference: OCE use only

Version	Date from	Date to	Amendment
1.0	21 July 04	25 Jan 05	Original version
2.0	25 Jan 05	25 Mar 08	Review
3.0	25 Mar 08	22 May 12	Review
4.0	22 May 12	current	

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