JOGECA 2012; 24(2): 56-57

Post-coital vulval haematoma: case report and review of the literature

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Abstract

Traumatic vulval haematomas are very rare by virtue of anatomical location of the vulva- by and large shielded from external forces. Major trauma to the vulva most often occur when young girls experience injuries as a result of sledding or bicycle accidents leading to haematoma and occasional laceration. Trauma can also result from sexual assaults and obstetric injuries.

This was a case of traumatic vulval haematoma following vigorous sexual intercourse in a pregnant parous woman. It was successfully managed by surgical evacuation, analgesia, prophylactic antibiotics and other supportive measures.

Key words: Post-coital, Vulval, Haematoma

Introduction

Vulval haematomas in adults are very rare hence there is very scanty literature on the same in adults or genital injuries of a similar nature other than those related to obstetrics injuries or sexual assault such as would occur in rape or violent trauma directed at the genitalia with either a sharp or a blunt object. It is also a complication of perineal operations (1). A case of an adult who sustained a vulval haematoma subsequent to a sexual act in a marital relationship while she was pregnant is presented. She presented with a history of swelling and pain on the left vulval region. The swelling occurred soon after sexual intercourse with her husband the previous night. He had come home after taking alcohol. She described the sexual act as having been vigorous, rapid, painful and short lasting approximately 3 minutes. The swelling initially increased in size then rapidly stopped.

Case report

AN was a 27 year old para 2+1 gravida 4 at 28 week gestation whose first delivery was a spontaneous vertex one and the second was a cesarean delivery due to a big baby (cephalo-pelvic disproportion). She had a spontaneous abortion at 2 months and uterine evacuation done via Manual Vacuum Aspiration (MVA).

Examination of the patient revealed fair general condition but she grimaced in obvious pain. She walked with frog leg posturing, was afebrile and not pale with normal vital parameters. Genital examination revealed a 7x5 cm tender left blood filled vulval swelling with a hemorrhagic 1.5cm mucus membrane bruise.

Under GA, a vertical incision of approximately 4 cm was made through the bruised mucus membrane on the medial aspect of the haematoma. A huge blood clot was found in the swelling. It was evacuated, bleeders ligated, dead space obliterated with 2/0 catgut, mucosa approximated leaving a 0.5 cm opening with sofratule and compressed with a gauze pressure pack.

Post operatively a foley's catheter, the sofratule and vulval pack were retained for 24 hours with analgesia, prophylactic antibiotics and warm saline sits baths. She was discharged on the fourth post-operative day to continue with her antenatal clinics and the site recovered well.

Discussion

Major trauma to the vulva most often occur when young girls experience injuries as a result of sledding or bicycle accidents (2). Haematomas and occasionally lacerations can develop when the vaginal area forcefully comes into contact with the cross-bar of a bicycle as during a fall from a bicycle seat or when the girl is thrown from the sled against an obstacle such as a tree or fence. However sexual assault such as would occur in rape or violent trauma directed at the genitalia with either a sharp object or a blunt object would be predisposing factors. Generally, most injuries to the genitalia during childhood are accidental. Many are of minor significance, but a few are life threatening and require major surgical procedures (3). There was one reported case of obstructed labor secondary to a vulval haematoma in Nigeria (4).

Management of most vulval haematomas is conservative by ice packs, foley catheter drainage of urine, bed rest, analgesics – narcotics then NSAIDS. Operative management of large haematomas reduces the period of convalescence. If the source of bleeding cannot be found, the cavity should be padded with gauze and a firm pressure applied. This pack is removed after 24 hours (5). In the case of our patient, packing was done after the evacuation of the haematoma and ligation of bleeders in order to avoid a re-accumulation

of haematomas from microbleeders or oozes. Besides, sofratule lining was included in the pack for its soothing effect and its antiseptic properties. Prophylactic broad spectrum antibiotics may be advisable as was the case with our patient who was commenced on oral co-Amoxyclax post operative.

If the haematoma is not expanding it should be followed conservatively. If however the clot becomes secondarily infected, it requires prompt evacuation and drainage. Laceration into the urethra or rectum should be repaired spontaneously (6). The patient presented did not develop any of the above complications.

The prevention of vulval injuries including haematomas is avoidance of the situations predispose to them. A modest approach to sexual intercourse with sufficient foreplay to encourage lubrication of the female genitalia should be the answer. Incidences of marital rape have been known to occur and could not be ruled out here. Seemingly the husband was in a hurry to quench his sexual desire after his bout of alcohol.

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