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Case Report

Non-obstetric vulval hematoma is not so uncommon

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ABSTRACT

Non-obstetric vulval haematoma is infrequently seen following blunt trauma to perineum. We, here present a series of six cases of non-obstetric vulval haematoma which were reported in our institution in recent years. Evacuation of haematoma and repair of lacerated tissues were successfully performed. Our experience confirms that prompt surgical intervention is the best modality in treating such patients as it reduces the associated morbidity and minimize hospital stay.

Keywords: Hematoma, Non-obstetric, Traumatic

INTRODUCTION

Non-obstetric haematoma of the vulva is not an uncommon condition these days. Accidental injuries and athletic trauma are the most common etiologic factors. The perineum is a highly protected but may be easily damaged by blunt trauma, which crushes the highly vascular vulvar tissues against the bony pelvis leading to haematoma formation. Management of vulvar hematomas may range from a conservative approach to surgical drainage. Incision and drainage is advised in more severe cases to reduce infective complications and hospitalization.[1] We present here six cases of vulval hematoma. There were two cases due to cattle goring, two unusual following falls from tree and slipping in bathroom, one following injury to perineum due to roadside accident, and another injury following an athletic trauma.

CASE REPORT

Case 1

A 19 years girl was referred to Dr. RPGMC Tanda from a CHC with the history of being hit by a bull, following which she had pain swelling and bleeding from the vulval area. There was h/o urinary retention as the patient was examined at tertiary institute following 6-7 hours of injury. On examination general condition of the patient was good and her vitals were normal. Local examination showed a hematoma of size 7 × 6 cm on left side of clitoral and labial area along with lacerations over urethral area. On catheterization a rent of 0.5 × 0.2 cm (approximate dimensions) was noticed in anterior aspect of urethra.

Case 2

A multi-parous 42-year-old lady presented with complaints of severe perineal pain and swelling in the vulval region, following a fall (about 10-12 feet height) from the tree leading to injury on the perineum, about 10 hours back. Patient complained of increase of pain and swelling on vulval region over the next half an hour. After symptomatic management at local hospital the patient was referred to Dr. RPGMC Tanda for further management. The patient had passed urine after two hours of injury, which was not blood stained. There was no past history of any bleeding diathesis in the patient. Her previous three deliveries were normal deliveries.

Examination of the patient revealed fair general condition, good orientation to time, place and person with a pulse rate of 68 beats per minute. Her B.P was 120/70 mm of hg. Pallor was present. Per abdomen examination revealed no abnormality. Local genital examination revealed a swelling 6 × 6 cm on the right vulva, extremely tender to palpation with a bluish skin hue. Per vaginal examination was not possible due to extreme pain to the patient.

Case 3

An unmarried girl of 16 years presented with the complaint of pain and swelling in the vulval region following a bicycle trauma while she was riding on it. After fall from bicycle she was taken to some private clinic where she was given inj. T. Toxoid and some analgesics, following which she was sent home. After about 4 hours she started complaining of increase in swelling and pain in vulval region and anorectal area. Then the patient was taken to government hospital from where she was referred to Dr. RPGMC Tanda. On examination the general condition was fair, pulse was 88/min, B.P was 90/60 mm of hg. Mild pallor was present. On abdominal examination no significant abnormality detected. Local examination of the vulval region revealed a tender swelling of about 12×8 cm on left postero-lateral aspect of vulval region.

Case 4

An unmarried girl of 13 years age studying in 8th class reported in emergency with referral from local hospital having a chief complain of pain and swelling in the vulval region for about 5 hours. There was a history of fall on a blunt stone when she was running. Following fall the patient went home and after about 4 hours she noticed a painful swelling in the vulval region. There was no significant previous history. On general physical examination patient was conscious, cooperative and well oriented to time, place and person. Her pulse was 120/minute, B.P-110/70 mm hg. PA examination was normal. On local examination of the vulva there was a tender, firm swelling of the size about 10 × 10 cm on the right side of vulva. There was bluish red discolouration present over the affected area.

Case 5

A 62-year-old multiparous post-menopausal lady presented to the emergency with history of injury to perineum by being hit by Bull's horn about 6-7 hours earlier. Woman had good health and her vitals were normal. There was no h/o bleeding diathesis. Her Hemoglobin was 9.4 gm. % and blood group O+.

Patient had passed urine following injury. On local Examination she was found to have contused laceration of right labia minora along with a dark red hematoma of size 8×9 cm over right labia majora.

Case 6

A 22 years unmarried girl attended gynecological OPD with complaint of pain and swelling over perineum following injury with wall mounted tap when she slipped in bathroom. She presented to OPD after about 8 hours of injury. Her vital were normal. On examination a haematoma of size 3×3 cm was noted in the left side of clitoral area. Patient has passed urine twice following injury.

Management

In all the first five cases, the baseline investigations included blood hemoglobin, bleeding and clotting time, an X-ray A-P view of the pelvis to note for bony pelvic injury and an ultrasound to rule out intra peritoneal injury. Apart from fall in the Hb levels in two cases, the above-mentioned investigations were normal in all the six cases. A cross match and the necessary arrangements for blood were made for all the five the cases. Case 6 was kept on observation and managed conservatively.

Operative procedure

An incision and drainage were performed in all the first five cases, the incision line being on the inner aspect of the vulva. After evacuation of the clots and separately ligating the individual bleeding points, the dead space obliteration was done by interrupted stitches with 1-0 chromic catgut. Vulval skin was closed with interrupted 1-0 chromic catgut. Throughout the procedure, Foley's catheter was kept in situ to prevent an accidental injury to the urinary tract. Further in case 1, urethral rent was repaired by interrupted 3-0 vicryl sutures, para urethral tissue was approximated with vicryl 2-0 sutures. Postoperatively, all the five patients were kept on injectable analgesics and broad-spectrum antibiotics (ceftriaxone intravenously and metronidazole intravenously) for 24 hours.

The patient presented in case one was discharged on the 7th postoperative day along with indwelling Foley's catheter which was removed on postoperative day 14. In all other cases (Case 2 to Case 5). Foley's catheter was removed after 48 hours postoperatively and patients were discharged on day 5 postoperatively with an advice to complete the course of the prescribed oral antibiotics and a follow up after 3 weeks. Follow up after 3 weeks revealed no abnormality in all the cases. Case 6 was discharged after 48 hrs. of observation as there was no increase in the size of haematoma and patient was doing well with conservative management.

DISCUSSION

Non-obstetric haematoma of the vulva is a relatively rare condition but is not very uncommon these days.[1-4] It is usually seen after a blunt trauma. Athletic, accidental trauma and vigorous intercourse are the common

etiologic factors.[1-6] It usually constitutes 0.8% of all gynecological admissions, in tertiary and referral hospitals.[7] Unusual etiologies may include automobile accidents, goring by a cow and straddle bicycle seat bar accidents.[8,1] Diagnosis is usually not a problem when there is proper co-relation with the history, but sometimes, the vulval swelling could be mistaken for a Bartholin's gland duct abscess.[9]

Management of the vast majority of vulvar haematoma is conservative. Most resolve spontaneously when simple measures are taken, like tight vaginal packing. Serial examinations are necessary to distinguish uncomplicated haematomas from those requiring surgery.[10]

In a case series of 29 patients with vulval hematomas resulting from obstetric trauma and other causes, it was found that patients managed conservatively had more subsequent operative intervention and more complications, requiring antibiotics, transfusion, and more days of hospitalization than patients managed surgically. It was also found that an increased risk of complications and increased hospitalization was found with patients with hematomas managed conservatively when the product of the longitudinal diameter and the transverse diameter was 15 or greater.[3]

CONCLUSION

Severe non-obstetric vulval hematomas are well treated with urgent surgical intervention. Surgical evacuation of hematoma and hemostasis is often required to minimize hospital stay and complications. While conservative management is only restricted to minor perineal injuries.

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