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Postcoital Vulvar Hematoma in Late Pregnancy: A Case Report

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ABSTRACT

Introduction: Hematoma of the lower genital tract is rare especially during pregnancy, and it is potentially fatal if left undiagnosed and untreated. Therefore, early detection and prompt treatment of this condition is essential.

Case presentation: A 25-year-old Gravida 2 para 1⁺⁰ at 36 weeks and 1 day gestation presented with a rapidly enlarging vulvar hematoma following sexual intercourse. She was managed by examination under anesthesia, and surgical evacuation of the hematoma. This case reports the importance of timely diagnosis and intervention in preventing complications associated with vulva hematomas in pregnancy.

Conclusion: Hematoma in pregnancy after sexual intercourse is rare. Early diagnosis and prompt management is essential in preventing complications.

Keywords: Pregnancy; sexual intercourse; vulvar hematoma

INTRODUCTION

Vulvar hematomas are a rare condition in obstetric practice but can be life-threatening when they occur. They can occur from trauma, which may result from sexual activity, blunt trauma from accident or obstetric procedures. Due to the rich vascular supply of the vulva, hematomas can progress rapidly, leading to pain and worsening hemodynamic status. Early recognition and intervention are essential to avoid adverse maternal and fetal outcomes (Haciveloglu *et al.*, 2012; Oong & Eruo, 2023; Bono *et al.*, 2022). This case entails the management of a postcoital vulva hematoma in a pregnant woman at 36 weeks gestation.

CASE REPORT

A 25-year-old gravida 2 para 1⁺⁰ hairdresser, presented at 36 weeks and 1 day gestation to the emergency obstetrics and gynecology ward with a complaint of vulva swelling following consensual sexual intercourse. She reported that the swelling began approximately 30 minutes after intercourse and progressively increased in size over the next three hours. The swelling was accompanied by severe vulva and left thigh pain, making it difficult for her to lie on her side. There was no associated dizziness, fainting, or fever, and no previous history of bleeding disorders or previous vulva swelling. The patient denied any history of interpersonal violence in her marriage,

aggression, coercion, or penetration with other objects by her husband. There was no evidence or any history of bleeding diathesis.

On examination, the patient was anxious, not pale. Her vital signs included a temperature of 36.7° C, blood pressure of 130/80 mmHg, heart rate 88 beats per minute, and respiration 17 breaths per minute. Abdominal examination revealed a symphysio-fundal height of 36 cm, singleton fetus in longitudinal lie, and cephalic presentation. There was no abdominal tenderness or rebound tenderness. The pelvic examination showed a tense, tender swelling involving the left labia majora and minora, measuring approximately 10 × 12 cm, not extending beyond the midline. The cervix was posterior, firm, and os close and no active bleeding.

Obstetric ultrasonography showed a live singleton fetus with appropriate measurements of fetal biometry for gestational age. Laboratory assessment showed packed cell volume of 32%, blood group A positive, and viral markers were negative for hepatitis B, C and lentiviral screenings. Clotting profiles yielded no abnormal findings. A diagnosis of postcoital vulvar hematoma was made. Patient was counseled for surgery due to the enlarging hematoma and unbearable pain. Under general anesthesia, a 10 × 12 cm hematoma was identified followed by a 6 cm vertical incision made on the thinnest portion

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of the vaginal mucosa and the hematoma and approximately 500 mls of clotted blood was evacuated. Within the cavity, multiple bleeding areas were noticed, and hemostasis was maintained by suturing with polyglactin number 0 (Vicryl®). The incision was sutured by polyglactin number 2-0 (Vicryl). A tight bandage was applied over the wound area to obtain further hemostasis in the immediate postoperative period. The procedure was well tolerated. Postoperatively, the patient remained stable. Oral antibiotics and analgesics were commenced, and she was encouraged to take sitz baths. She was counseled to abstain from sexual intercourse for at least six weeks to allow complete healing.

On the second postoperative day, her condition was satisfactory, and she was discharged home with a follow-up appointment scheduled in two weeks. At term, she had spontaneous vaginal delivery of a healthy baby with Apgar scores of 8 and 10 in the first and fifth minutes, respectively. No postpartum complication or recurring vulva hematoma.



Fig 1. Vulvar haematoma during pregnancy.



Fig. 2. The view seen after surgical drainage of the haematoma.

DISCUSSION

Vulvar hematomas are a rare but potentially serious complication in both obstetric and non-obstetric contexts. They are most often associated with trauma, including childbirth, sexual intercourse, or physical assault. During pregnancy, the vulva's rich vascular supply, along with hormonal changes that increase vascular fragility, predisposes it to significant hematoma formation even with minimal trauma (Hacivelioglu *et al.*, 2012). This case detailed the importance of prompt recognition, diagnosis and intervention. Delays in diagnosis or management may lead to complications such as infection, tissue necrosis, or progression to life-threatening hemorrhage (Benrubi *et al.*, 1987). In our patient, the hematoma expanded rapidly, causing severe pain and necessitating surgical evacuation. The surgical approach included examination under anesthesia, evacuation of 500 ml of clotted blood, and meticulous hemostasis with Vicryl sutures. These interventions prevented further bleeding and allowed for optimal and quick recovery (Benrubi *et al.*, 1987).

Management options for vulvar hematomas depend on the size, rate of progression and or expansion, and the patient's hemodynamic stability. Small hematomas that are less than 4cm can be managed conservatively with observation, analgesia, and antibiotics. However, large or expanding hematomas, such as in this case, require surgical intervention. The benefits of surgical evacuation include immediate relief, reduced risk of infection, and prevention of chronic pain or fibrosis due to prolonged tissue compression (Egan *et al.*, 2009).

In pregnancy, the decision to operate must also consider fetal well-being. Continuous fetal monitoring is essential, as surgical interventions and hematoma-related complications may compromise fetal health. Fortunately, in this case, the fetus remained stable throughout the perioperative period, and she eventually had delivery of a healthy baby at term, underscoring the importance of multidisciplinary care (Hacivelioglu *et al.*, 2012).

Education and enlightenment on safe sexual practices during pregnancy is crucial, particularly in the later trimesters when tissue fragility increases. Counseling on postpartum care, including abstinence from intercourse during the healing period, is equally vital to prevent recurrence. Overall, this case highlights the importance of prompt diagnosis, appropriate surgical management, and comprehensive postoperative care in optimizing outcomes for both mother and fetus (Hacivelioglu *et al.*, 2012).

Postcoital vulvar hematomas, though rare, can increase the risk of maternal and perinatal morbidity and/or mortality if not promptly diagnosed and treated. This case highlights the need for early surgical intervention and multidisciplinary care to ensure favorable maternal and fetal outcomes. Future efforts should focus on increasing the awareness of vulvar hematomas among healthcare providers and patients especially during antenatal period for pregnant women, especially those in late pregnancy. Counseling on risk factors and potential complications could aid

in early presentation and management, ultimately improving both maternal and fetal outcomes.

Consent: Written informed consent was obtained from the patient for publication of this case report and accompanying images.

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