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Conservative management of vulvar hematoma after oral sex in pregnancy

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ABSTRACT

Non-obstetric vulvar hematomas are extremely rare, and there are insufficient case reports and studies in the literature. As a result, clinicians have no clear agreement about their treatment. There are also no guidelines or treatment protocols. The treatment can be either conservative or surgical. For the most part, cases can be treated conservatively. In some cases, surgical treatment is required. In this case report, we present a conservative approach to treating a traumatic vulvar hematoma following oral sex during pregnancy.

Keywords: Trauma; vulvar hematoma; conservative treatment; oral sex

INTRODUCTION

The vulva comprises loose connective tissue and smooth muscle supplied by branches of the pudendal artery, which branches from the internal iliac artery. The labial branches of the internal pudendal artery are found in the superficial fascia of the anterior and posterior pelvic triangles. Injury to these labial branches can result in severe vulvar hematomas. At the same time, the vulva is protected from trauma by dense fatty tissue beneath the labium majus.[1]

Except for during labor and delivery, a traumatic vulvar hematoma is uncommon. Non-obstetric traumatic vulvar hematomas cause about 0.8% of all gynecologic emergencies.[2] Non-obstetric causes of traumatic vulvar hematoma are as follows: blunt trauma (most commonly bicycle, automobile trauma, etc.), violent coitus, acts of sexual assault, foreign body insertion into the vagina and vulvar surgery.[3]

In this case report, we describe the approach to a 28-week pregnant patient who developed vulvar hematoma after oral sex.

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CASE REPORT

A 32-year-old, gravida 1, parity 0.28+3 weeks pregnant woman presented with vulvar swelling after oral sex. On examination, an 8x6 cm vulvar hematoma was found on the left labia majora and labia minus, causing midline deviation, palpation pain, and covering the clitoris, urethra, and vagina (Image 1). The ultrasound revealed a single viable intrauterine fetus at 28-weeks.

Her vital signs remained stable, and there was no significant change in laboratory parameters during the follow-up. In our follow-up, we used IV paracetamol, cold compression, and *eau de goulard pet* treatment. The vulvar hematoma was large enough to close the urethra, so a bladder catheter was inserted. After 24 hours, the vulvar hematoma was found to be organized (Image 2), the bladder catheter was removed and the patient was discharged after the pain complaint regressed.

DISCUSSION

Vulvar hematoma is more common in obstetric conditions, occurring in 1/300 to 1/1000 deliveries.[4] Except in obstetric situations, traumatic vulvar hematomas are extremely uncommon. The known incidence of non-obstetric vulvar hematomas is around 3.7%. Non-obstetric traumatic vulvar hematomas cause about 0.8% of all gynecologic emergencies.[2]

There is no consensus on how to treat non-obstetric traumatic vulvar hematomas. They can be treated using either conservative or surgical methods. It is critical to take a conservative approach whenever possible. This lowers the risk of bacterial contamination. Conservative treatment, typically cold compresses and pain relief, is appropriate for pain control.[5] If the hematoma prevents urine output due to its size, a bladder catheter should be inserted. If there is a suspicion of sexual assault, it should definitely be addressed as a judicial case. Labiums, clitoris, hymen, perineum, and rectum should be examined individually. Antibiotics for prophylaxis are unnecessary. Hymen examination should definitely be included in the childhood and adolescent period.

Surgical treatment should be considered if there is a hematoma with expanding borders, significant pain that does not go away with pain medication, signs of infection (worsening of the clinical picture, increase in acute phase reactants, etc.), significant blood loss with associated hemodynamic instability, or conservative treatment fails.[3,6]

When surgery is planned, a long enough incision is made to observe the bleeding veins. If active bleeding vessel orifices are visible, they are ligated. The subsequent cavity formed is closed

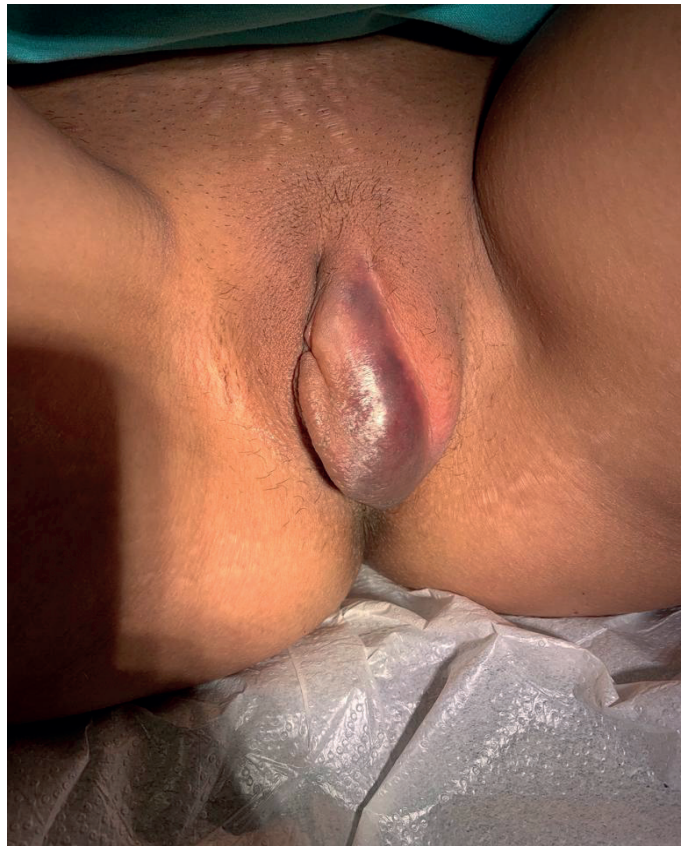

Image 1. First presentation

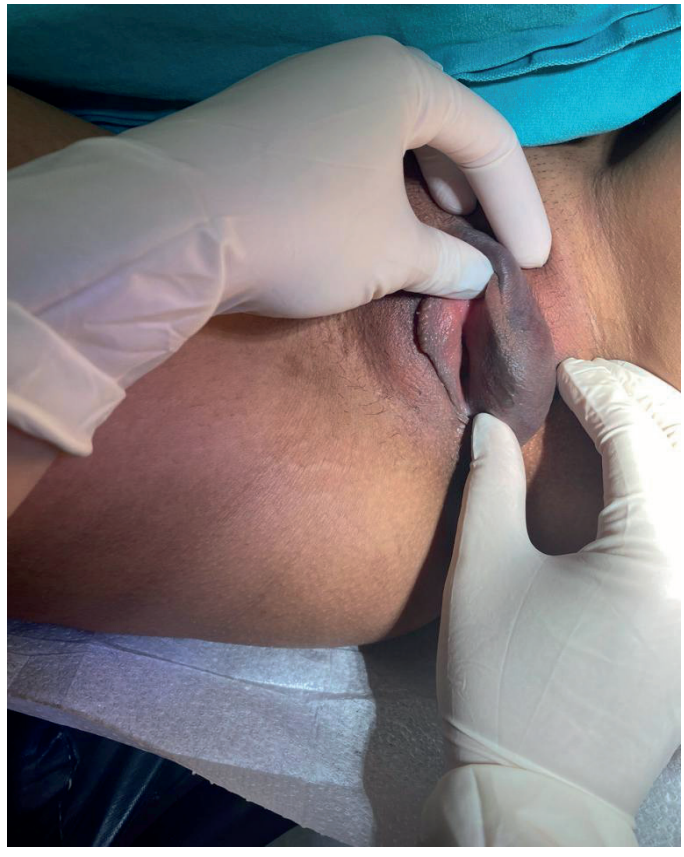

Image 2. Twenty-fourth hour post presentation

with sutures in the form of 8 or filled one by one. Absorbable monofilament sutures should be preferred. The incision should also be closed one by one when closing. A drain can be placed if necessary.[7] Vascular methods, such as embolization can be used in selected cases.[8]

CONCLUSION

Although non-obstetric vulvar hematomas are uncommon, they can have serious consequences if not properly diagnosed and treated. The neighbouring organs should also be evaluated. There are no guidelines for treatment protocols in the literature. Most cases can be treated conservatively at first, but surgical treatment should be considered if there is a hematoma with enlarging borders, clinical worsening (significant pain that does not go away, increase in acute phase reactants, etc.), significant blood loss, hemodynamic instability, or when conservative treatment is insufficient. There are insufficient studies or reviews on the topic in the literature. Studies are needed for the optimum approach.

ETHICS

Informed Consent: The patient and relatives gave informed consent to surgery and video recording

Acknowledgement: It was presented in 4th World Academy of Sexual Health (WASHE) Congress as oral presentation.

FOOTNOTES

Contributions

Surgical and Medical Practices: M.F.K., Concept: O.O., Y.K.A., Design: M.F.K., Data Collection or Processing: B.K.K., S.Ç., Analysis or Interpretation: B.K.K., S.Ç., Literature Search: O.O., Y.K.A., Writing: O.O., M.F.K.

DISCLOSURES

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