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Case Report

Obstetrics and Gynaecology Section

Revisiting the Importance of History Taking and Clinical Examination in a Postpartum Case!

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ABSTRACT

Secondary Postpartum Haemorrhage (PPH) is an uncommon but potentially life-threatening complication that occurs between 24 hours and 12 weeks postpartum. Retained Products of Conception (RPOC), a condition in which placental or foetal tissue remains in the uterus following childbirth, miscarriage, or abortion, is one of the leading causes of secondary PPH. Haematological conditions such as Von Willebrand's disease and thrombocytopenia, choriocarcinoma and infection and dehiscence of the caesarean section scar are some of the rarer causes of secondary PPH. This condition can lead to complications such as abnormal uterine bleeding, infection and endocrine disruptions. Hereby, authors present a case of secondary PPH due to RPOC, in which the patient presented with complaints of intermittent, dull-aching lower abdominal pain and occasional passage of small clots per vaginum. Although the patient was symptomatic, she believed that it was a normal phenomenon to experience irregular vaginal bleeding postdelivery and therefore did not mention it initially. This history was elicited, which further led us to conduct a thorough clinical examination.

Keywords: Postpartum haemorrhage, Puerperal period, Retained products of conception

CASE REPORT

A 34-year-old primiparous woman presented to the obstetric Outpatient Department (OPD) at five weeks postpartum for a regular follow-up, with complaints of intermittent, dull-aching lower abdominal pain and the occasional passage of small clots per vagina. She had been registered antenatally and had no co-morbidities and an uneventful antenatal period was noted. She underwent an uncomplicated preterm vaginal delivery at 34 weeks of gestation, with minimal blood loss and no immediate postpartum complications. The baby was kept in the Neonatal Intensive Care Unit (NICU) for about one week.

Upon further elicitation of her history, she reported intermittent spotting since delivery, which she thought was a normal process in the puerperal period; hence, she did not report it to the doctor earlier. On examination, the patient was haemodynamically stable. Her vital signs were as follows: blood pressure 100/60 mmHg, pulse 92 bpm and temperature 98.0°F. Abdominal examination revealed mild suprapubic tenderness and on speculum examination, there was foul-smelling lochia. On per vaginal examination, the uterus was approximately 10 weeks in size. Following history-taking and clinical examination, a provisional diagnosis of RPOC leading to subinvolution of the uterus was made.

The patient was advised to be admitted, but initially, she refused, as she felt asymptomatic. However, she later agreed to admission after counselling about the possible risks. To confirm the diagnosis, the following investigations were ordered: laboratory tests including an endocervical swab for culture and sensitivity were sent, which were within normal limits. Serum Beta-human Chorionic Gonadotropin (β-hCG) was measured to rule out gestational trophoblastic neoplasia and its value was 5 mIU/mL, which was within the standard range for a non pregnant state. A Transvaginal Ultrasound (TVUS) was performed, revealing an echogenic mass in the endometrial cavity measuring 3×2.5 cm, with an approximate volume of 7 cc, suggestive of RPOC. Doppler ultrasound showed increased vascularity, raising suspicion of RPOC with possible placental tissue.

The patient was stabilised with intravenous fluids and broad-spectrum intravenous antibiotics were initiated to prevent infection. The following medications were administered for three days:

Inj. Ceftriaxone 1 gm i.v. twice a day

Inj. Gentamicin 80 mg i.v. thrice a day

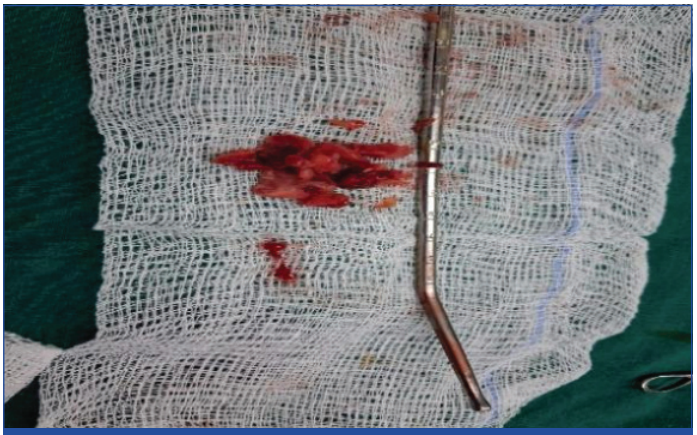
Inj. Metronidazole 100 cc i.v. thrice a day

Inj. Tranexamic acid 500 mg i.v. twice a day

Inj. Pantoprazole 40 mg i.v. once a day

T. Misoprostol 200 mcg P/O twice a day

After counselling, she underwent uterine evacuation via suction and curettage under ultrasound guidance, as the patient did not give consent for hysteroscopic evacuation, which is the treatment of choice. An examination was performed under anaesthesia, confirming that the uterus size was approximately 10 weeks. The cervix was serially dilated using Hegar's dilator. Suction and evacuation were carried out using Karman's cannula number 10. Significant products of conception, approximately 4×3 cm in size, were removed [Table/Fig-1]. Upon gross examination, these appeared to be retained placental bits. The procedure was



[Table/Fig-1]: Retained Products of Conception (RPOC) evacuated via suction and curettage.

successful with minimal blood loss and the removed tissue was sent for histopathological examination, which confirmed RPOC.

Postoperatively, the patient experienced resolution of her symptoms. She was discharged on oral antibiotics and iron supplements, including T. Cefuroxime axetil 250 mg P/O twice a day for five days, and ferrous ascorbate and folic acid tablets P/O once a day for one month. She was advised to follow-up after one week and again one month later. At the follow-up, she remained asymptomatic and a repeat ultrasound was performed one week later at the request of the patient, which showed an empty endometrial cavity.

DISCUSSION

Secondary PPH is defined as any significant vaginal bleeding that occurs between 24 hours after placental delivery and during the following six weeks [1]. Although the incidence of secondary PPH is low, it is one of the causes of maternal morbidity. The diagnosis of secondary PPH is based on the subjective perception of increased bleeding 24 hours after delivery, and there is no reliable method to measure the amount of blood loss. RPOC and infection are the most frequent causes of secondary PPH. Endometritis, retained products, subinvolution of the placental implantation site and, less frequently, a large blood clot or a submucous fibroid are the most likely causes [2,3]. With an incidence of 1-6% [4,5], RPOC after delivery is uncommon and appears to be influenced by the gestational age of the pregnancy, peaking after second-trimester delivery or pregnancy termination [6]. Typically, patients present with vaginal bleeding, pain, infection, or hypomenorrhoea and infertility due to intrauterine adhesions [7]. Asymptomatic patients may be diagnosed with RPOC during routine postpartum examinations. TVUS often identifies increased endometrial thickness and volume to diagnose RPOC. Additionally, the diagnosis of RPOC is influenced by the presence of complex endometrial fluid or hyperechoic material within the cavity [8-10]. With an overall reported sensitivity of 44-85% and specificity of 88-94%, RPOC is known to present variably on sonography [11]. Secondary PPH due to RPOC is a significant concern, requiring prompt recognition and management to prevent severe haemorrhage and infection. TVUS plays a crucial role in diagnosis and management options include medical therapy with uterotonics, uterine evacuation, or hysteroscopic removal [12]. In this case, timely intervention resulted in a favourable outcome. The risk of operative morbidity, such as uterine perforation and severe haemorrhage, associated with surgical procedures cannot be disregarded; hence, management should likely be guided by the clinical presentation, as there appear to be no clear risk factors that could predict the presence of RPOC and secondary PPH. Furthermore, the rate of false positive diagnosis with sonography is high [13]. RPOC can disrupt the endocrine balance necessary for lactogenesis, particularly by maintaining elevated levels of β-hCG and inhibiting the decline of progesterone, which is essential for milk production. Prompt recognition and removal of RPOC can restore normal hormonal physiology, facilitating lactation [14]. Clinicians should consider RPOC as a differential diagnosis in postpartum women presenting with impaired lactation and persistent abnormal uterine bleeding. Early intervention can improve maternal wellbeing and successful breastfeeding outcomes.

CONCLUSION(S)

The patient's false beliefs and lack of scientific knowledge about the puerperal period were barriers to the attending the Outpatient Department (OPD). It was the detailed history-taking and thorough clinical examination that led to the diagnosis of RPOC in this case. Therefore, a detailed history, a comprehensive clinical examination and the education and awareness of the patient are important, as they provide insight into normal and abnormal conditions in the puerperal period. Clinicians should maintain a high index of suspicion in postpartum patients with persistent or heavy bleeding, ensuring timely intervention to prevent complications.

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