

DOI: <https://dx.doi.org/10.18203/2320-1770.ijrcog20211556>

Case Report

Spontaneous rupture of vaginal varicose veins mimicking placenta praevia

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Received: 15 March 2021

Accepted: 13 April 2021

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ABSTRACT

Vaginal varicosities are often an asymptomatic venous disorder that rarely occur in pregnant women. There is little information in medical literature concerning diagnosis and management.¹ We present an isolated incident of spontaneous rupture of vulvar varicosities mimicking the presentation of placenta previa. It was successfully managed with a simple surgical approach done under local anesthesia.

Keywords: Antepartum hemorrhage, Vaginal varicose veins, Varicosity, Placenta previa, Venous disorders

INTRODUCTION

Manifestations of per vaginal bleeding have serious and sometimes grave consequences in a pregnant female. It can be a sign of serious morbidity for the mother and the fetus. Antepartum hemorrhage is defined as bleeding from the genital tract that occurs in the second half of pregnancy. It complicates 2-5% of all pregnancies.¹ Vaginal varicose veins are an extremely rare cause of antepartum hemorrhaging. Vulvar varicosities are dilated veins present in the labia majora and the labia minora.² The occurrence of varicosities in the genital area is uncommon during pregnancy. They range in incidence from 2-4% of all pregnancies with vaginal varicosities being even rarer.

Most develop after 12-26 weeks of pregnancy and largely self-resolve shortly after delivery.³ A small number of these varicosities can become large enough that they can lead to rupture and subsequent hemorrhaging during pregnancy or at the time of labor.^{4,5} In this case we present a patient with spontaneous rupture of a vaginal varicose vein that mimicked antepartum hemorrhaging caused by a placenta previa.

CASE REPORT

A G2P1L1 with 7 months of amenorrhoea presented with complaints of sudden onset of bleeding per vaginam one hour back that was painless and not associated with abdominal pain. There were no clots. Single pad was fully soaked with fresh bright red blood. On admission, patient was hemodynamically stable, conscious and oriented to time, place and person, pulse rate was 80 beats per minute and BP was 100/60 mm of Hg. Per abdomen the uterus was 26-28 wks size and relaxed. Fetal heart sounds were present and regular. Local examination of perineal region revealed no active bleeding. There were no vulvar varicosities. Obstetric scan was done to rule out placenta previa as previous report (18wks) showed a low-lying placenta. Obstetric Ultrasonography revealed a single live fetus of 28 weeks gestation. Placenta was located in fundus-anterior region. Cervical length was 3.2 cms, liquor was adequate, no retroplacental or intraplacental clots were present suggesting that there was no placental abruption.

After ruling out placenta previa, per speculum examination was done. Per speculum revealed a ruptured varicose vein in the suburethral region just 0.5 cms beneath the urethral

opening. Bleeding was profuse. Surrounding area vaginal tissue was healthy, no signs of lacerations or trauma. Per vaginal examination was unremarkable. Cervical external os was closed. Blood investigations showed hemoglobin value of 9.4 mg/dl. Total count and platelet counts were normal. Coagulation profile was normal. A decision to ligate the vein was made. After sterilizing the vaginal introitus and perineum with povidone iodine solution, a hemostatic suture with chromic catgut no. 1 just 0.5 cms below the urethral opening was placed (Figure 1).

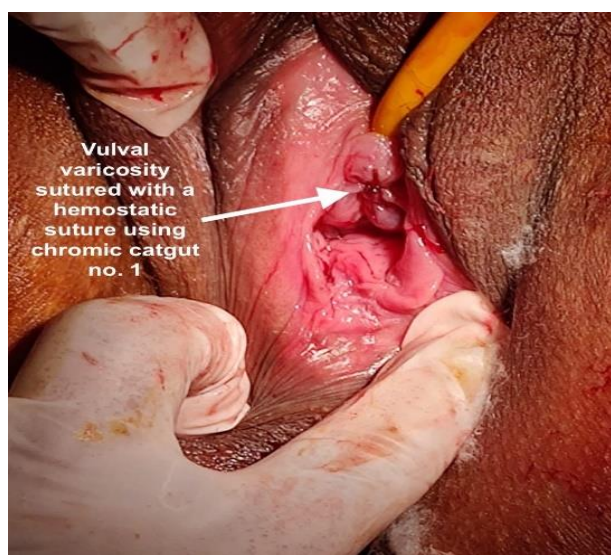


Figure 1: Hemostatic suture applied 0.5 cms below the urethral opening.

This single suture arrested the bleeding. Antibiotics and analgesics were administered. Patient was observed for one day in the hospital and then discharged further episodes of bleeding noted. Patient was followed up after three weeks. She was asymptomatic and did not have any further episodes of bleeding (Figure 2).



Figure 2: Follow up after 3 weeks showing no signs of further bleeding.

DISCUSSION

Pregnancy itself can cause several physiologic changes that favor the formation of varicosities.³ In pregnant women, decreased flow to the pelvic vessels and occlusion of the inferior vena cava due to the enlarging gravid uterus can contribute to the formation of vulvar and vaginal varicosities.⁶ There is little information as to how to conservatively manage such cases that do not self-resolve. This case shows a simplified technique of using a simple hemostatic application at the site of the varicose bleeding. Diagnosing such cases require a thorough inspection and per speculum examination of the perineal region, vagina and cervix. Clinical assessment and ultrasonography should be done to rule out major causes of antepartum hemorrhaging, such as placenta previa and abruptio placenta. Once these are ruled out, careful clinical and pelvic examination can help detect these unusual cases of antepartum hemorrhaging and immediate treatment should resolve the problem and allow for the women to successful continue the rest of her pregnancy. Treatment of vaginal varicosities include ligation or cauterization of vessels. Laser photocoagulation has been described. Topical treatment with astringent creams (phenylephrine hydrochloride cream) have been suggested. Sometimes wait and watch policy can be adopted.⁷

CONCLUSION

Vaginal varicosities are an unusual cause of ante partum hemorrhage and it should be considered as a differential diagnosis for the same.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: Not required

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Cite this article as: Yaliwal RG, Kori SS, Mudanur SR, Manne S. Spontaneous rupture of vaginal varicose veins mimicking placenta praevia. *Int J Reprod Contracept Obstet Gynecol* 2021;10:2122-4.