



A CASE OF ANTEPARTUM HEMORRHAGE DUE TO EXTRA PLACENTAL CAUSE –RUPTURED VAGINAL VARICES

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ABSTRACT

Vaginal varix during pregnancy is a rare condition that may be a concern for hemorrhage risk during childbirth. A 32yr old female G3P2L2 with NVD at 30 weeks of gestational age presented to OBG Department (Labor Room) with massive vaginal bleeding without known history of trauma nor any evidence of Placenta previa. On examination: Vital status is unstable and upon pelvic inspection- A stream of blood through a ruptured vein in vagina (Vaginal varices). Immediately vein is clamped with artery forceps and patient is stabilized by crystalloids, Dopamine, Nor-adrenaline and 4 PRBC transfusion and under short general anesthesia (ketamine) transvaginal ligation of vaginal varices is done and pregnancy is prolonged in view of threatened preterm labor (by Isoxsuprine) and terminated by 37 weeks of gestational age by EL.LSCS., Spontaneous resolution of vaginal varices occurred.

KEYWORDS : Ruptures vaginal varicose veins, Pregnancy, Antepartum Hemorrhage

INTRODUCTION

Vaginal varicosities contribute to 5% of extraplacental causes of antepartum hemorrhage⁽¹⁾. Vaginal varicosities are part of larger set of complications arising due to venous congestion and obstruction in pregnant women. Incidence being less than 2% of pregnancies. They usually develop after 12-14 weeks of pregnancy and self resolve after delivery⁽²⁾. With rupture and massive bleeding being the life-threatening complication. This has led to the ability of cesarean section to avoid the risk of hemorrhage due to ruptured varices during normal vaginal delivery.

Case Report:

A 32 yr old pregnant woman with G₃P₂L₂ referred to department of OBG with acute spontaneous vaginal bleeding. The woman was at 30 weeks of gestation with fetus having cephalic presentation with good fetal heart rate. On Ultrasonographic Examination there is no evidence of placenta previa nor abruption placentae. On pervaginal inspection a stream of blood is noted through a ruptured vein vagina (Vaginal varices). On Examination patient vital parameters were unstable with unrecordable pulse and blood pressure. Immediately vein is clamped with artery forceps. Patient is stabilized concurrently by crystalloids, Dopamine, nor-adrenaline drip and 4 Packed Red blood cell transfusion. and after 12 hours under short general anesthesia (ketamine) transvaginal ligation of vaginal varices is done as shown in below image.



Image Showing Ligated Vaginal Varix

In view of threatened preterm labor and prematurity of fetus pregnancy is prolonged upto 37 weeks by Isoxsuprine (a beta-adrenergic) and doppler ultrasonography is done in order to rule out varices in association with lower limb varicose veins and usg abdomen is done in order to rule out hepatic causes of varices. As there is high risk of rupture of vaginal varices in normal vaginal delivery, the pregnancy is terminated by Elective lower segment cesarean section and vaginal varices were gradually resolved.

DISCUSSION

- **Pelvic congestion syndrome:** Pregnancy itself causes several physiologic changes that favor varicosities formation. A study by Gant et al. demonstrated that pregnancy normally leads to acquired vascular refractoriness to Angiotensin II (ATII)⁽³⁾.
- Prostacyclin (PGI₂) which has been implicated in angiotensin resistance during normal pregnancy is increased during late pregnancy⁽⁴⁾.
- Femoral venous pressure rises gradually from approximately 8 mmHg at the beginning of pregnancy to approximately 24 mmHg at term⁽⁵⁾.
- However, antecubital venous pressure does not change. These asymmetrical venous pressure changes are likely a product of IVC compression by the growing fetus. The venous blood of the pelvis drains mainly through three pathways: internal iliac vein, femoral vein, and ovarian vein. Incompetence of the femoral vein is the most common cause for vulvar varicosities in nonpregnant women⁽⁶⁾.
- However, in pregnant women decreased pelvic venous return and IVC occlusion due to the enlarging uterus contribute to the formation of vulvar and vaginal varicosities⁽⁷⁾.
- **Klippel-trenaunay syndrome** is a rare disease, occurring in approximately 1 in 30000 live births. It is characterized by a triad of capillary malformations, vascular anomalies, and hypertrophy of bony and soft tissues. It can also present as varicosities in variable locations⁽⁸⁾.
- Hepatic diseases that induce portal hypertension such as liver cirrhosis, NASH, and chronic hepatitis can contribute to varicosities formation⁽⁹⁾. However our patient did not exhibit any prior symptoms of this Klippel-Trenaunay syndrome nor did she have a history of hepatic disease, making these two conditions unlikely explanations for her varicosities.

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