Volume : 2 | Issue : 8 | August 2013 • ISSN No 2277 - 8179

Research Paper

Medical Science

KEYWORDS :

An Interesting Case Of Post-Coital Bleeding

R.S Bharatwaj — Associate Prof, Dept Of Community Medicine, Sri Lakshminarayana Institute Of Medical Sciences, Pondicherry-605502

Vijaya.K — Associate Prof, Dept Of OBG, Sri Lakshminarayana Institute Of Medical Sciences, Pondicherry-605502

Post coital bleeding (PCB) is defined as bleeding occurring during or immediately after sexual intercourse at a time distinct from menstruation. It can be a symptom in women experiencing any type of abnormal vaginal bleeding. PCB has many causes, the most serious of which is cervical cancer.

Our patient was a co-participant, a 30 Yrs old female from the USA and a nurse by profession in a meditation retreat that I was a part of. When she felt comfortable enough with me she wanted to consult about a gynaecological problem. She had been having profuse foul vaginal discharge for more than ten years and had been identified as a cervical intra epithelial neoplasia II (CIN II) on PAP smear seven years back following which a LEEP (Loop Electrosurgical excision procedure) for the cervix was done and she was on bi-yearly PAP for the first year followed by yearly PAP smear follow ups. According to her a few months after the surgical procedure she started having post coital bleeding. This post coital bleeding happened with every act of coitus but only in the second part of her cycles. Also she gave history of spotting during the same phase of her cycles. This consisted of fresh blood and there was no pain or discomfort associated with coitus. The patient had visited a couple of hospitals on separate occasions in India where at first they suspected pelvic inflammatory disease with PCOS but had ruled it out on further visits based on the investigations.

The patient had attained menarche at 14 yrs age and her cycles had been regular and without any associated problems. Currently also her menstrual cycles were regular and she was consulting me because she was concerned with the post coital bleeding as in her own words 'it was a very messy thing'.

She became sexually active in her late teens and had had at least five partners till seven years back when she was diagnosed as CIN II and a LEEP procedure was performed on her. Since the LEEP procedure she has had three partners. She was having profuse vaginal discharge for the last ten years. Interestingly the patient's vaginal discharge was so profuse that she had to use sanitary pads all the time. But that did not seem to be of any great concern to her as she said her mother too had the same trouble and she had got used to it. In the past according to her she had been prescribed many different oral antibiotics and inserts for the cervical discharge but she did not trust and was not convinced to take them and the problem of discharge never got controlled. Also she said her cervical discharge had never been cultured so far in any of her consultations.

She has never been pregnant so far. In her personal habits the patient had been a non-smoker so far in her life. She had adopted a vegetarian diet pattern since the last two years and occasionally consumed alcohol.

She was on birth control pills for two short occasions (2-4 months each time) in the last 7 years to help control her acne, which they did. However, the last time she took them at the beginning of 2009, she took them continuously without taking the 7 day placebo pills as she felt it would control her hormones better. After stopping those in April of 2009, her periods were very sporadic and she even went through a period where she did not have a cycle for 8 months. Since the period returned, the cycle has been regular. She did not have intercourse from April 2009 to July 2010, so at this time there was not post coital bleeding or bleeding between periods. She went on many different herbs from 2008-2012 without using any allopathic medicines mainly for the acne and hormone balance. She did not until 2011 go on any herbal treatment for cervicitis, and that was only for 1 month without cure.

I consulted my colleague from the OBG dept over phone and she suggested 1. A culture of the vaginal discharge immediately 2.A PAP smear 3. A Transvaginal USG in the second part of the cycle 4. Suction curettage in the second half of the cycle for histopathology and a 5. Colposcopy during the second part of the cycle to locate the site of bleeding if possible.

I accompanied this patient to a multi-specialty hospital at the place of the meditation retreat and visited a gynecologist for further investigations. This doctor had work experiences from USA and UK and was a very senior person. When I told her the history and the investigations suggested she took her time and gave her opinion that there would be nothing gained from, Trans-vaginal USG in the second part of the cycle or a Suction curettage in the second half of the cycle for histopathology. She examined the patient and the only abnormal physical finding was profuse frothy vaginal discharge, a 'dirty pelvis' in her own words, for which she prescribed betadine local suppositories and did a PAP smear during the same visit asking us to come back for a follow up in three days by which time the PAP results would be ready. Also her speculum examination she said revealed no abnormality in the vaginal or cervical morphology.

When I communicated the same to my OBG colleague, she was disquietened that a PAP had been done when the patient had such a profuse discharge as it can mask the results for a neoplasia. We went back for the smear results three days later and the results were normal. Meanwhile there was no significant change in the vaginal discharge.

The specialist at the hospital now said that she would like for a cervical biopsy to be done and that too under general anesthesia for which she advised routine investigations for anesthesia fitness. Further she went on to say that for the cervix since blood supply was poor it was nearly impossible to clear an infection by medications given orally. By this time the patient had done some research on the internet and rightly was not convinced with the specialist's opinion. So she confided in me and I agreed with her and thence she put her trust on me totally for the next step in management.

The first thing we worked out in consultation with my OBG colleague was to not go for the biopsy immediately but to clear the infection that was causing the profuse vaginal discharge. Cervical infection as a cause of the post coital bleed was the first thing we wanted to rule out. Since betadine was already started it was not advisable to go for a culture at this point. So on an empirical basis we decided to add along with the betadine suppositories, a combination of oral Azithromycin 500 mg OD for five days and ornidazole 500 mg stat. The patient was at first a bit reluctant to start on any oral medications but was convinced by the reasons given for the same and then agreed to go ahead.

At the end of the course she had a complete resolution of her vaginal discharge and also interestingly the post coital bleeding which was on for seven years and was the main cause for all her

anxiety also stopped. I have been following up over phone since the last three months and still she maintains normalcy.

Vaginal and cervical infections caused by Trichomas vaginalis is a common finding in gynaecological practice. TV worldwide prevalence is 180million women per yr and accounts for one third of all vaginal discharge complaints .In india prevalence is 6-10%.[1] Kreiger et al in his study of men attending STD clinic-found that 11% of them had T.V in the urethra , but only 54% of these were symptomatic.[2]

A past study opines that gynaecological referral of every case of PCB for immediate investigations will be impractical, expensive, invasive, and worrying for women [3]. Currently, PCB alone is not an absolute indication for colposcopy. [4] Genital swabs, urine, and/or blood are used to detect sexually transmitted disease in a woman who present with PCB but it is unclear if assessment is necessary in all women with PCB or only those whose medical history or physical examination suggests a risk[5]. Many authors suggest that triple swabs "High vaginal swab, Endo-cervical swab and Chlamydial swab" are important investigations in women referred with PCB. In a study of Chlamydia Trachomatis infection, PCB was observed in 38.3% of Chlamydia positive patients [6].

In our case, by giving azithromucin and ornidazole along with betadine we covered for all these potential organisms. The points of interest in this case were that the patient was a nurse from USA and had not been able to get a proper cure at her place. The one reason I could get out was that the more the complaints one spells out in their medical records the higher is the insurance premium one has to pay. That was interesting. The fact that the patient had not taken the antibiotics and inserts that had been prescribed for the cervical discharge may reflect badly on her compliance and definitely she has contributed to her being not properly treated in a big way. But what we can contend is that somehow a doctor patient relationship of trust was not established and the follow up process was poor at least in this particular case. The patient had not maintained the record of her reports and was experimenting with alternative modalities of treatment.

Further in her visits to other hospitals as simple a thing as as chronic cervicitis or vaginitis was either missed or not treated appropriately and she was carrying on with so uncomfortable a condition and even got used to her vaginal discharge wearing a sanitary pad all the time.

I bring this up here not as a criticism of any health system in particular but just as a point in case to show how a patient as educated as a nurse from a western background could go untreated for a common condition for such a long time owing to her own lack of trust and openness with the system. Of course this may not be the case with all or even majority of the cases. But a healthy critical evaluation of the system even based on one case only serves to augment its efficacy. It reiterates the need for a constant and dynamic re evaluation of the system in the light of patient psychology and may be more importance given to patient based counseling and follow up to ensure compliance and thus healing.

Further, in this case, post coital bleeding, only in the second half of the cycle as a sign of cervicitis or vaginitis was something new in our own experience. The patient was advised to continue her yearly PAP and also to get her partner/s treated so as to maintain the cure as a couple.

REFERENCE

1. Fule SR, Fule RP, Tankhiwale NS, Clinical and laboratory evidence of Trichomonas vaginalis infection among women of reproductive age in rural area. . Indian J Med Microbiol. 2012 Jul-Sep;30(3):314-6 | 2. Kreiger JN .Trchomoniasis in men:old issues and new data Sex.Transm Dis1995;22:83-96. | 3. Fraser IS, Petrucco MO. management of Intermenstrual and postcoital bleeding. Australian and New Zealand Journal of Obstetrics and Gynaecology 1996; 36: 67-73. | 4. Jha S, Sabharwal S. Outcome of colposcopy in women presenting with postcoital bleeding and negative or no cytology. Journal of Obstetrics and Gynaecology 2002; 22: 299-301. | 5. Shapley M, Jordan J, Croft PR. A systematic review of postcoital bleeding and risk of cervical cancer. British journal of general practice2006; 6: 453-460. | 6. Shalini R, Amita S, Neera MA .How alarming is postcoital bleeding .Gynaecology and Obstetric investigation 1998; 45:205-208.