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Research Paper

Varicose Veins of Vagina in a Term Pregnancy leading to LSCS

Medical Science

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ABSTRACT

Varicose veins in the vagina during pregnancy is a rare occurance. The spontaneous laceration of these varices during vaginal delivery can cause significant blood loss. We present here an unusual case of a young hospital attendant who presented with dilated engorged veins in the vagina at 32 wks of pregnancy. She ultimately underwent LSCS at term for fear of torrential haemorrhage from these extremely dilated vaginal varicose veins which had become irreducible and painful.

Introduction

Varicose veins occur in 10% of pregnant women and is a relatively common phenomenon in the Second Trimester of pregnancy. It is common in the legs but may develop over vulva infrequently. Prolonged standing worsens this condition which is relieved with rest. But vaginal varices are very infrequent and usually asymptomatic. Few are associated with a sense of heaviness or spontaneous vaginal bleeding. The appearance of varicose veins during pregnancy and its precocity, the intensity of its development, the uncommon symptoms and mainly the rapidity of its regression in puerperium are the peculiar aspects of varicose veins in pregnancy. (Callam, 2004)

Case Report

A 20 yr old lady working in the hospital as an attendant came to the OPD with Amenorrhoea 8mths and a mass coming out per vaginum causing discomfort and mild pain for the last 5 days. This mass typically increased in size on prolonged standing but disappeared on lying down.

She was G_2A_1 with previous missed abortion 1yr back for which D&E had been done. She was not sure of her LMP in this pregnancy and had irregular ANC. She had a anomaly scan at 19 wks. As per this report she was 32 wks now.

On General Examination – Wt 38 kg, BP 100/70 mm of Hg, Pallor – Mild, Chest and Heart – NAD, P/A Ut 32 wks, Cephalic, Not Engaged, Relaxed, FHS – 142/min. On examination of perineum (Fig – 1) there was 5 x 4 cm bluish mass coming out of vagina arising from the Right lateral wall just above the introitus. It was irregular in outline, soft to touch and could be partially reduced by compression. There were other dilated tortuous veins above the mass in the vagina. This mass was non tender. A diagnosis of varicose veins of vagina was made and she was advised to avoid prolonged standing and lie down every few hours to avoid the pain and discomfort. No other varicose veins were seen over the legs or perineum.

Due to financial constraints she did not take rest and next came with labour pains at 37 wks along with increased pain in the mass in the vagina which was not being relieved by lying down.

O/E – Ut – Term size, Cephalic 3/5, Contraction 1-2/10 mins each lasting 15 – 20 secs, FHS -138/min, pv –(done with difficulty) Cx was mid position, soft, short and ext os admitting 1 finger, Pelvis seemed adequate. The mass was tense and tender. A LSCS was planned as haemorrhage during vaginal delivery or episiotomy was a definite possibility.

She delivered a healthy male child weighing 2.7 kg by LSCS and the baby cried immediately after birth. There were no other dilated veins over uterus or in the pelvis. The uterus and abdominal wall were sutured and she had an uneventful recovery. The varicose veins were grossly reduced on the 7th POD (Fig – 2) and she was discharged. At the time of follow up at 6 wks vagina was absolutely normal with no trace of the varicose veins.

Discussion

The three main causes attributed to development of varicose veins in pregnancy are

- Increased levels of progesterone causing blood vessels to relax. This allows the valves to separate and so cannot prevent the backflow of blood.
- The enlarged uterus presses on the large veins in the pelvis region.
- Family history of varicose veins

In a multivariate analysis, it was observed that pregnant women with a family history of the disease have a 3.56 time more chance of acquiring varicosities during pregnancy (Boivin, Cornu & Charpak, 2000). This patient did not have a family history of varicose veins but her profession as an attendant in the hospital made her stand for long hours in the hospital after which she could not get any rest at home due to her poor socio – economic status.

The mechanical compression theory explains the vulvar varicose veins that frequently occur in the last trimester of pregnancy. Through a duplex scanning and phlebography it was demonstrated that the speed of blood flow in femoral veins progressively decreases proportionate to the increase in uterine volume until diminishing to 50% in the third trimester especially with the patient in dorsal or right lateral decubitus position. The occurance of varices in the vaginal wall is rare, although it is more common in the vulva. Genital varices usually appear during the later months of pregnancy and regress spontaneously after delivery. (London & Nash, 2000)

Most varices are asymptomatic and escape detection during the ante natal period. Few are associated with severe local discomfort and sometimes spontaneous vaginal bleeding. A case has been reported with fetal death due to significant maternal bleeding from the ruptured varices, with the bleeding spot seen as a hole in a localised varicosity of a vein. (Bell, Kane, Liang, Conway & Tornos, 2007)

It is important to recognise the possibility of associated anatomical or pathological diseases. It may include leg varices, venous malformation of labia, clitorial area or vagina with or without arteriovenous malformation on limbs or trunk (Klippel-Trenaunay Syndrome). (Watermeyer, Davies & Goodwin, 2002)

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Treatment of pregnancy varices differs from ordinary varices in that they regress spontaneously after delivery. The best way to manage them is to avoid long periods of sitting or standing. She should rest with legs lifted, sleep on the left side more and avoid sitting with legs crossed. Wearing compression stockings also helps. If vaginal varices and their symptoms persist for more than 12 wks postpartum they can be treated with sclerotherapy. (Hobbs, Bergan & Yao, 2007)

Conclusion

There is usually no danger or permanent threat from vaginal varicose veins. But obstetricians need to be aware that the possibility of vaginal varices can exist in patients complaining of vaginal bleeding in the later months of pregnancy and vulvar varicose veins can be a part of Klippel – Trenaunay syndrome. It is important to avoid laceration to the vaginal varicosities even going for a caesarean section to minimise risk of genital trauma and subsequent rupture of these vaginal varicose veins.

Figure 1 Vaginal varicose vein at 32wk pregnancy

Figure 2 The remnant of vaginal varicose vein on 7th Post op day of LSCS

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