

BACKGROUND

A 19 year old woman presents to A&E with abdominal pain 3 days following termination of pregnancy at 16 weeks by dilatation and curettage. She has also had PV bleeding which has been quite heavy. She describes passing large clots and fresh blood mixed with purulent discharge.

She has no other medical history and takes no regular medication.

Examination

Observations: HR 130, BP 90/55, RR 24, SPO2 98% on air, temperature 39 degrees.

She appears flushed, diaphoretic and looks unwell. She is lying stock still and she winces in pain with any movement.

Her capillary refill is 2-3 seconds centrally and her abdomen is tender suprapubically with guarding.

QUESTIONS

1. What is your diagnosis?
2. How will you manage her?

ANSWERS & DISCUSSION

1. Diagnosis - Retained Products of Conception

The term “retained products of conception” refers to placental or foetal tissue remaining in the uterus after miscarriage, planned termination or following delivery. As the products undergo necrosis, infection by cervicovaginal flora follows. This causes endometritis and if left untreated sepsis may follow. PV bleeding with or without associated infection is another complication.

Clinical features

- PV bleeding
- Purulent vaginal discharge
- Pelvic pain
- Uterine tenderness, rigidity, guarding
- Fever
- Sepsis syndrome

It is normal to have some PV bleeding and discomfort following miscarriage or termination. Assume the bleeding is abnormal if it is heavy or prolonged (bleeding usually lasts 8-11 days but may last for two weeks or more). Cramping lower abdominal pain and tenderness may last hours to days, but pain that is progressive, difficult to control with simple analgesia or does not resolve over a few days may be abnormal.

Clostridium sordellii is part of the normal vaginal flora and may cause toxic shock syndrome - a severe illness with a high mortality rate (approx 70%). It is a Gram positive spore-forming bacillus. Some strains produce an exotoxin which causes capillary leak with oedema, pleural and pericardial effusions, ascites and shock. Fever is usually absent.

If the uterus was instrumented during the termination, as in this case, consider the possibility of uterine perforation or injury to an adjacent organ. This is usually evident at the time of the procedure, but occasionally there is a delayed presentation with peritonitis, anaemia, PR bleeding (if bowel injury) or haematuria (if bladder injury).

Consider other causes of sepsis such as urinary tract infection and appendicitis.

2. Management

This patient is septic, likely due to retained products of conception. Assess ABCDE and treat accordingly. In particular aim to complete the “Sepsis 6” within the first hour:

- Oxygenate
- IV fluids
- Blood cultures
- Lactate
- IV antibiotics
- Catheterise to monitor urine output

Antibiotics alone are unlikely to cure infection as penetration into the infected necrotic tissue is limited - refer to the O&G on-call doctor for surgical evacuation of the uterus. The empiric antibiotic regime is the same as that for severe pelvic inflammatory disease:

- Ceftriaxone
- Doxycycline
- Metronidazole

Blood loss may be contributing to her haemodynamic compromise. Check haemoglobin and send a cross match for 2-4 units. If you observe ongoing heavy blood loss and you think shock could be due to hypovolaemia rather than sepsis (pale conjunctiva, profoundly anaemic, peripherally cold) consider early use of O negative blood and activation of the major haemorrhage protocol.

Products of conception or a large blood clot may become lodged in the cervical os leading to cervical shock. In the presence of haemodynamic instability it is worth performing a speculum examination to determine if this is the case and remove any material in the cervical os. Otherwise leave such an examination to the O&G team.