

# A Rare Case of Acute Post-Coital Vulva Haematoma in a Primegravida with Acute Urinary Retention Managed at Mbale Regional Referral Hospital in Eastern Uganda a Case Report

Collins Nabulili<sup>1</sup>, Denis Okidi<sup>2</sup>, Julius Nteziyaremye<sup>3,4,\*</sup>

<sup>1</sup>5th Year medical student, Department of Obstetrics and Gynaecology, Faculty of Health Sciences, Busitema University.

<sup>2</sup>Year 2 Senior House Officer, Department of Obstetrics and Gynaecology, Mbale Regional Referral Hospital.

<sup>3</sup>Department of Obstetrics and Gynaecology, Faculty of Health Sciences, Busitema University and Obstetrician and Gynaecologist Mbale Regional Referral Hospital.

## \*Correspondence:

Nteziyaremye Julius, Department of Obstetrics and Gynaecology, Faculty of Health Sciences, Busitema University and Obstetrician and Gynaecologist Mbale Regional Referral Hospital.

Received: June 09, 2026;

Published: June 29, 2026

## How to cite this article:

Nabulili C, Okidi D, Nteziyaremye J. A Rare Case of Acute Post-Coitus Vulva Haematoma in a Primegravida with Acute Urinary Retention Managed at Mbale Regional Referral Hospital in Eastern Uganda a Case Report. *J Surg Pract Case Rep.* 2026;2(2):1-4.

## Abstract

### Background

Genital trauma is common in gynaecologic practice and causes tend to differ depending on the age of the patient. Although more common in obstetrics with an incidence of 1-2 per 1000 deliveries, there are a rare occurrence in Gynaecology with incidence of 3.7% and constitute 0.8% of all gynaecological emergencies. We present a rare case of post-coital vulva haematoma with acute urinary retention in pregnancy that was successfully surgically managed with subsequent positive pregnancy outcome.

### Methods

We present a case of a 19year old, NA. She was a black African Ugandan, primigravida at 21 weeks of amenorrhoea. She presented with a 16hours history of post-coital painful genital swelling and acute failure to pass urine.

On examination, abdominal findings revealed a symphysis-fundal height corresponding to 22 weeks of amenorrhoea, distended urinary bladder and a tender cystic left vulvar swelling extending to involve the labia minora on the right.

On day two, the mass was noted to have increased in size with necrotic edges.

Management: Involved surgical evacuation of the haematoma with insertion of the catheter drain. She healed well and had Cul de sac catheter drain removed on day 6 and urethral catheter removed on day 8. She was enrolled into antenatal care.

### Conclusions

Gynaecology emergency attendees must be suspicious of the rare causes of vulvar haematomas such as coitus and exclude them from common ones such as Bartholin's abscess and cysts, vulva varicosities and folliculitis.

Although vulva haematomas can be managed conservatively, those that are tender, increasing in size and debilitating need surgical intervention and the procedure is safe in pregnancy.

**Keywords:** acute urinary retention, primegravida, post-coital, vulva haematoma.

## Introduction

A vulvar haematoma refers to collection of blood in the vulva that normally results from either direct or indirect trauma to the branches of pudendal artery branch of the anterior division of the internal iliac artery that divides into the inferior rectal artery, posterior labial artery and transverse perineal branches<sup>1,2</sup> but can

also be venous in origin.<sup>2</sup> Because the pudendal artery passes through the greater sciatic foramen and enters the ischioanal fossa through the external genitalia and perineum, extension of a hematoma in this area is limited by the Colles fascia and the urogenital diaphragm, and is therefore directed towards the skin.<sup>3</sup>

Although more common in obstetrics with an incidence of 1-2

per 1000 deliveries,<sup>4</sup> there are a rare occurrence in Gynaecology with incidence of 3.7% and constitute 0.8% of all gynaecological emergencies<sup>5</sup>

We present a case of post-coital vulvar haematoma in pregnancy.

**Case**

NA, a 19 years old black African Ugandan, presented to us on the 18th.October.2025 as a primigravida with last normal menstrual period (LNMP) of 11th.May.2025 and expected data of delivery (EDD)18th.Feb.2026 and thus at 21 weeks of amenorrhoea. She came in with a 16hours complaint of painful genital swelling that had gradually developed following sexual intercourse and acute failure to pass urine. She asserted that while she had had intercourse before during this pregnancy, this time the aftermath did not feel usual. She initially felt a burning like sensation on the left side of her genitals and it progressed to throbbing pain and a gradual swelling that increased in size with time.

She reportedly took over the counter paracetamol 1g but with no relief. The pain worsened as the swelling grew in size. To her dismay, at the point she felt like passing urine, she could not due to severe pain and that is the point at which she decided to come to hospital. She denied any history of trauma or a fall. She denied any history suggestive of any bleeding disorder.

Important regarding the pregnancy, she reported having felt the index foetal kicks about 3 weeks prior to this incident and still felt them on the day of admission. She had not had any antenatal care contact.

Other aspects of the history were largely unremarkable.

On arrival at the emergency Gynaecology ward, she was wailing in pain and cried of failure to pass urine. We quickly prepared and inserted a urethral catheter to relieve the urinary obstruction.

General exam, showed a young lady, afebrile with temperature=36.60C, no pallor of the mucous membranes, had no petechiae or ecchymoses. And no lymphadenopathy. Her blood pressure=105/78mmHg.Pulse rate =102beats per minute.

**Obstetric exam:** Symphysio-fundal height (SFH) was 22cm, with a breech presentation. Foetal heart rate using a hand-held Doppler was 134beats per minute.

**Pelvic exam:** Revealed a vulva mass largely involving the left labia majora and minora and extending to involve the right labia minora with a bleeding point at the inferior edge of the left labia minora. The mass was 10x8 cm, cystic and occluding the urethra (Figure 1). It was moderately tender to touch. On day two the mass had developed necrotic areas and grown bigger in size to measure 14x12cm across the plane.

**Diagnosis:** PG at 21 WOA with post-coital vulva haematoma and acute urinary retention. Differential diagnoses included - Bartholin’s gland abscesses, Bartholin’s cyst, vulva varicosities and folliculitis.



figure 1: from left to right showing various stages of haematoma at presentation with acute urinary presentation and the next day with haematoma demonstrating increase in size and peeled off edges.

**Management of the post-coital vulva haematoma and the timelines.**

Serial number	DAY and complaints	Patient management
1	Day 1: Presented with acute onset of vulva swelling and failure to pass urine.	Urethral catheterisation to relieve the acute urinary retention. Intravenous (IV) paracetamol 1g 8hourly for 3 days alternating with IV tramadol 100mg in 500mls of tramadol for 24hrs. These were for anaesthesia. Iv ceftriaxone 2g as prophylactic antibiotics. Intravenous dexamethasone 8mg once a day for two days with oral omeprazole 20mg twice a day for 5 days. Dexamethasone was given as an inflammatory drug. Omeprazole was given as a proton pump inhibitor to block the ulcerogenic effects of dexamethasone.
2	Day 2: The swelling progressed and developed an ulcer with necrotic edges.	we substituted the tramadol with 2.5mg of oral morphine 6hrly and 5mg at bed time with Oral bisacodyl 5mg as a laxative. Obstetrics ultrasound scan revealed a viable singleton intrauterine pregnancy with no anomalies and estimated gestational age of 24 weeks. Ultrasound scan revealed a vulvar cystic mass. Full blood count revealed haemoglobin count of 8g/dl with adequate platelet count of 256x106/µml
3	Days 3-5:	Surgical management with evacuation of the haematoma, ligation of the bleeding vessels and closure of the Cul de sac and vulvar repair. We inserted a Forleys catheter drain gauge 16 to evacuate any possible post-surgical haematoma. Patient was transfused with 1 unit of whole blood cells to correct the anaemia. (Figure 2) Post-operative management: She was maintained on IV ceftriaxone 2g every 24hrs for 3 days, IV metronidazole 500mg 8hrly for 3 days and IV paracetamol 1g 8hrly for 3 days. Oral morphine was stopped on postoperative day 1.

4	On Day 6: Resolution of the swelling and pain. Patient was able to move	Patient was discharged on oral cefixime 400mg once daily for 5 days, oral metronidazole 400mg 8hrly for 5 days, first dose of sulphadoxine –pyrimethamine (as intermittent treatment for malaria), oral haematenics for 1 month and paracetamol 1g 8hrly for 5 days. We removed the drain since there was no evidence of active drainage and or any swelling of the vulva.
5	Day 8:	Reviewed the patient and removed urethral catheter. Patient was doing well. Patient has been enrolled into and is continuing with antenatal care.

## Discussion

Although more common in obstetrics with an incidence of 1-2 per 1000 deliveries,<sup>4</sup> there are a rare occurrence in Gynaecology with incidence of 3.7% and constitute 0.8% of all gynaecological emergencies. Coitus is responsible for about 40% of non-obstetric injuries to the genital tract.<sup>5</sup>

In gynaecological practice the most common cause of genital trauma in children are straddle injuries<sup>6</sup> while in the adolescent and young women, coitus (consensual or nonconsensual), physical assault, cold waxing and tight clothing are the leading causes.<sup>7</sup> Whereas in obstetrics the leading cause is child birth, in gynaecologic practice the leading cause is coitus in adolescents and young women.<sup>5</sup>

In cases where trauma is not evident, spontaneous vessel rupture is considered as the cause as the cause of the haematoma.<sup>7</sup> However in our case, the haematoma was a result of a coital injury.

In contrast to our case in which the haematoma was on the left, about 70% vulva haematomas, occur on the right.<sup>8</sup> Although no clear reason has been given, we suggest that this could be due to differences in the drainage pattern of the pudendal veins. Although both the right and left pudendal veins are venae comitantes, the right pudendal vein drains more directly into the right internal iliac vein, has fewer collaterals and is predisposed to uterine dextrorotation in comparison to the left pudendal vein, in that, although it drains into the left internal iliac vein, it has rich venous plexuses and is less susceptible to uterine pressure thus offering better venous drainage and pressure distribution.

Although most vulva haematomas are small and can be conservatively managed,<sup>7</sup> those that are large (>10 cm in diameter) or progressively enlarging haematomas causing intense pain and distress and /or cause hemodynamic instability, or urological or neurological signs and symptoms to the patient require surgical intervention.<sup>2,9</sup> In cases where patient experiences difficulty in passing urine just like it was in our case, a urinary catheter may be inserted. It must as well be noted that conservative management of large haematomas is associated with a longer hospitalization and greater need for antibiotics and blood transfusion in addition to more subsequent operative interventions.<sup>10</sup> In our case, there was evidence of expansion (Figures 1), difficulty in passing urine and signs and symptoms of distress despite patient being managed on oral morphine 2.5mg 6hry, oral paracetamol 1gm 8hry and intravenous dexamethasone 16mg start.

The surgical procedure involves evacuation of blood clots, and ligation of bleeding vessels and closure of the dead space using vicryl 2/0 under spinal anaesthesia. We carefully inspected the base to rule out pressure necrosis. We inserted a Foley catheter size 14 to work as drain (Figure 2). More advanced surgical techniques that are largely unavailable in our low resource settings can be employed. These include procedures such as selective

arterial embolization, first described by Brown et al. in 1979. Although costly, it is associated with shorter hospital stay.<sup>2,9</sup> Pelvic angiography is done prior to selective embolization to investigate and locate bleeding vessels.<sup>11</sup>

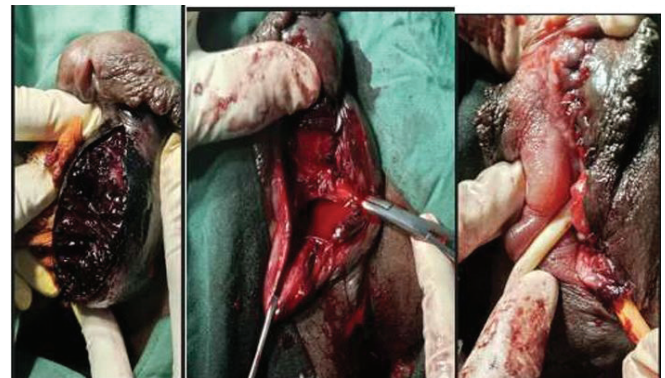


Figure 2: from left to right showing the stages of surgery for haematoma evacuation. On extreme right we show a second CATHETER (Inferior one) inserted in the cul de sac to prevent further formation of haematoma.

## Conclusion

Though a rare cause of vulva haematoma, post-coital haematoma should be considered in young adults presenting with acute vulvar haematoma. Management strategies are tailored to the acute presenting symptoms and signs, and is possible in low resource settings like Mbale, in eastern Uganda.

## Highlights of the case

- This is a rare case of post-coital vulva haematoma in pregnancy.
- Post-coital vulva haematoma can be a cause of acute urinary retention.
- Surgical management was preferred to conservative management due to increasing size of the haematoma, pain and patient disability.

## References

1. Jaraquemada JMP, Mónaco RG, Barbosa NE, Ferle L, Iriarte H, Conesa HA. Lower uterine blood supply: extrauterine anastomotic system and its application in surgical devascularization techniques. *Acta Obstet Gynecol Scand.* 2007;86(2):228-234. doi:10.1080/00016340601089875.
2. Hong HR, Hwang KR, Kim SA, Kwon JE, Jeon HW, Choi JE, et al. A case of vulvar hematoma with rupture of pseudoaneurysm of pudendal artery. *Obstet Gynecol Sci.* 2014;57(2):168-171. doi:10.5468/ogs.2014.57.2.168.
3. Egan E, Dundee P, Lawrentschuk N. Vulvar hematoma secondary to spontaneous rupture of the internal iliac artery: clinical review. *Am J Obstet Gynecol.* 2009;200(1):e17-e18. doi:10.1016/j.ajog.2008.09.024.

4. Villella J, Garry D, Levine G, Glanz S, Figueroa R, Maulik D. Postpartum angiographic embolization for vulvovaginal hematoma: a report of two cases. *J Reprod Med*. 2001;46(1):65-67. PMID: 11209635.
5. Rabinerson D, Fradin Z, Zeidman A, Horowitz E. Vulvar hematoma after cunnilingus in a teenager with essential thrombocythemia: a case report. *J Reprod Med*. 2007;52(5):458-459. PMID: 17583256.
6. Irumba C, Baragaine J, Obore S, Mwanje H, Nteziyaremye J. An intricate vagina penetrating injury with a 22 cm cassava stick in situ for 6 months: a case report. *J Med Case Rep*. 2024;18(1):30. doi:10.1186/s13256-023-04339-5.
7. Jones IS, O'Connor A. Non-obstetric vulval trauma. *Emerg Med Australas*. 2013;25(1):36-39. doi:10.1111/1742-6723.12016.
8. Weir C, Jan A. Vulvar hematoma. In: *StatPearls* [Internet]. Treasure Island, FL: StatPearls Publishing; 2022. Accessed June 22, 2026. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK535456/>
9. Lapresa Alcalde MV, Hernández Hernández E, Bustillo Alfonso S, Doyague Sánchez MJ. Non-obstetric traumatic vulvar hematoma: conservative or surgical approach? A case report. *Case Rep Womens Health*. 2019;22:e00109. doi:10.1016/j.crwh.2019.e00109.
10. Benrubi G, Neuman C, Nuss RC, Thompson RJ. Vulvar and vaginal hematomas: a retrospective study of conservative versus operative management. *South Med J*. 1987;80(8):991-994. doi:10.1097/00007611-198708000-00014.
11. Özçam H, Uzunçakmak C, Kılıçkesmez N, Bacanakgil BH, Karakuş B, Mutlu İN. Angiographic embolization in the treatment of puerperal hematoma. *Oman Med J*. 2017;32(2):154-156. doi:10.5001/omj.2017.27.

