CASE REPORT

CARCINOMA OF THE CERVIX AS A CAUSE OF SECONDARY POST PARTUM HAEMORRHAHE – A CASE REPORT

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SUMMARY

A case of a 30 year old P^{5+0} patient with carcinoma of the cervix presenting as severe Post partum haemorrhage is presented. Resuscitation with intravenous fluids and blood transfusion was done. Subsequent examination under anaesthesia revealed a bleeding clinical IIIa cancer of the cervix, from which biopsy was taken and haemorrhage arrested with figure of 8 stitches and temporary vaginal packing. The patient was subsequently referred with the histology report to radiotherapy.

Key Words: Post partum haemorrhage, cervical cancer.

INTRODUCTION

Post partum haemorrhage is a well known cause of maternal morbidity and sometimes mortality in obstetric practice[1-3]. The well known aetiological factors of post partum haemorrhage include, uterine atony, laceration of the birth canal, retained placental fragments or membranes, uterine inversion, coagulation defects, and sometimes inadequate haemostasis of an episiotomy repair[2,3].

However, carcinoma of the cervix as a cause of severe post partum haemorrhage is rare, even though it is known that delivery per vaginum in the presence of cervical cancer can lead to increased bleeding peripartum[4,5]. We report a case that was recently managed in our centre.

CASE REPORT

The patient was a trader, para 6^{+0}, 5 alive who was admitted into the emergency ward of the Maternity Hospital Wing of University of Ilorin Teaching Hospital, Ilorin, Nigeria, on 14th October, 1998. She delivered a live male child at a Traditional Birth Attendant's (TBA) home one week prior to presentation. The pregnancy was said to have been characterized by occasional bleeding plus offensive vaginal discharge which usually abate with leaves inserted into her private part by the TBA. These events were in the last 6 weeks prior to delivery. The blood lost at delivery was also said to have been heavier than usual but, this resolved spontaneously and normal lochia had continued until the day prior to presentation. On this day, there was sudden gush of blood with clots which was not controllable by the treatment offered by the TBA which necessitated her referral to our hospital. Her last childbirth was 2 years prior to presentation and, the obstetric events were normal. There was also no history of previous post coital bleeding per vaginum before she became pregnant.

Physical examination revealed an ill looking young women with marked conjunctival pallor and cold extremities. Her pulse rate was 120/minute and small volume, blood pressure was 70/30 mmHg and respiratory rate was 30/minute. Both heart sound I & II were normal and the chest was clinically clear. The abdomen moved with respiration and was not tender; the uterus was firm and about 16/52 palpable per abdomen. Liver, spleen and kidneys were not clinically palpable. Vaginal examination revealed blood soaked loin cloth. The cervix was firm with hard ragged right lateral side. No identifiable products of conception were found in the expelled blood clots from the vagina. Her packed cell volume was 18%.

She was resuscitated with intravenous normal saline infusion and blood transfusion. Intravenous ergometrine 0.5mg was given and syntocinon injection 80 international unit added into 1 litre of Dextrose saline which was made to run at 30 drops per minute. Bleeding persisted despite the firmly contracted uterus and examination under anaesthesia was performed. Intravenous injection of unasyn, 1,500mg was given bolus.

At examination under anaethesia, the uterus was found to be empty, while bleeding persisted from the cervix at about 3$^{0'}$ clock position. The site was hard and ragged. A punch biopsy was taken at this point to include the adjacent normal looking vaginal skin which also felt indurated. Figure of 8 stitches were then applied above the area of biopsy. The parametrium in the lateral were felt indurated, but certainly no the pelvic side wall: Rectal examination done was normal. A vaginal pack was then put in place after the examining had glove was changed.

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The vaginal pack was removed 12 hours later in the ward with haemostatis achieved. She was continued on tablets of unasyn at 750mg 12 hourly for another 5 days and was given a total of 3 pints of blood. The patient's post transfusion PCV was 28%. 48 hours after presentation. The results of electrolytes, urea and creatinine as well as the intravenous urogram were normal. She was subsequently referred for radiotherapy as a case of clinical stage IIIa cervical cancer after a histological confirmation of a moderately differentiated squamous cell carcinoma.

The patient was seen once, three weeks after referral for treatment of vulva excoriation following the first course of radiotherapy before she was lost to follow up.

DISCUSSION

The reported incidence of carcinoma of the cervix in pregnancy was 1 in 200 to 5000 pregnancies[6]. This incidence is likely to increase with the reported increase in the incidence of cervical cancer in young women with reproductive potentials[7]. The consequence is that presentation in pregnancy is likely to increase too, necessitating an increase in awareness among obstetricians especially in developing countries where many pregnant patients book late or not at all. This will somtimes present as obstetric haemorrhage[5].

In the patient presented, the attendant haemorrhage could have been prevented if she had booked early and had a proper pelvic examination done. This might have detected the cervical cancer at an earlier stage of the disease (moderately and poorly differentiated cancers are rapidly progressive), and definitive treatment given in form of radical hysterectomy after therapeutic abortion or radiotherapy which on its own will cause fetal demise initially in the course of treatment. Foetal viability could also be awaited if the patient is seen around twenty weeks when a caesarean hysterectomy and adjuvant radiotherapy would have sufficed[4,5].

Sultamicillin (UNASYN) prophylaxis was used because it is penicillinase resistant and it is also active against gram negative organisms. This action was necessary because the sterility of the Traditional Birth Attendant's home could not be guaranteed. The very low PCV of 18% at presentation could also have been contributed to by other causes of anaemia since the patient was unbooked. We postulate that the severe post partum haemorrhage in this patient might have been due to interference with contraction and retraction of the cervical tissue by the malignancy or indeed an erosion of the cervical branch of the uterine artery.

In conclusion, it is suggested that routine pelvic examination including speculum examination should be done at booking to detect cases of cervical cancer in early pregnancy. Same is indicated in cases of obstetric haemorrhage where other well known causes have been excluded. This will prevent untimely death since the patients can live to receive appropriate definitive treatment which was radiotherapy in this case because of the stage of the disease and the time of presentation. Moreover, radiotherapy has been shown to give equal or better treatment outcome in carcinoma of the cervix at all stages[4,6-8].

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