AMJ Australasian Medical Journal [AMJ 2025;17(4):1281-1286]

Postpartum Hematoma of the Labia Majora: A Rare Case Report and Review of Recommendations

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RESEARCH

Please cite this paper as: Hafsi M, Yaich O, Zouaghi A. Postpartum Hematoma of the Labia Majora: A Rare Case Report and Review of Recommendations. AMJ 2025;18(4):1281-1286.
86https://doi.org/10.21767/AMJ.2025.4086

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ABSTRACT

Introduction
Postpartum vulvar hematomas are rare but potentially severe complications that can occur without evident risk factors, impacting maternal prognosis.

Methods
We report the case of a 35-year-old multiparous woman (P7G7) who presented on the 5th day postpartum with a painful hematoma of the labia majora following an unassisted vaginal delivery at home without instrumentation or episiotomy. Clinical examination and perineal ultrasound confirmed a moderate-sized encapsulated hematoma, managed conservatively with symptomatic treatment, prophylactic antibiotics, and close monitoring.

Results
The hematoma resolved nearly completely by the 15th day postpartum, with the patient resuming normal activities without complications.

Discussion
This case highlights the importance of rapid diagnosis and individualized management to minimize complications. We discuss pathophysiology, therapeutic options—which remain non-consensual—and recommendations based on current literature.

Conclusion
Early diagnosis and conservative management are key for moderate vulvar hematomas, emphasizing the need for structured postpartum follow-up.

Key Words
Postpartum Vulvar Hematoma, Labia Majora, Perineal Ultrasound, Conservative Management, Obstetric Complication.

Introduction
Postpartum vulvar and perineal complications, though often considered benign, can significantly affect patients both physically and psychologically. Among these, vulvar hematomas are rare but serious conditions that can compromise maternal recovery, even in the absence of identifiable risk factors. The literature estimates their incidence at less than 1 per 1,000 vaginal deliveries, though this may be underreported due to inadequate documentation[1].

Vulvar hematomas typically result from the rupture of subcutaneous small veins or arteries, often triggered by obstetric trauma or coagulation disorders. If undetected or mismanaged, they can lead to severe complications such as infection, tissue necrosis, or vascular and nerve compression[2]. This article aims to detail a rare case of a late-onset vulvar hematoma presenting on the 5th day postpartum, while exploring optimal diagnostic and therapeutic strategies based on available evidence.

Case Presentation
A 28-year-old multiparous woman (P7G7) with no significant medical or surgical history delivered vaginally at home, spontaneously giving birth to a 3.2 kg newborn without complications. No significant perineal trauma was reported, and neither obstetric instruments nor episiotomy were used.

On the 5th day postpartum, the patient presented to the emergency department with intense, throbbing pain in the

right perineal region. She reported increasing discomfort while walking and sitting, accompanied by visible swelling. No systemic symptoms, such as fever or severe fatigue, were noted.

Physical examination revealed a firm, tense swelling of the right labia majora, approximately 6 cm in diameter, with blue-purple discoloration of the overlying skin (Figure 1). There was no fluctuation or purulent discharge (Figure 2), and palpation elicited marked pain without signs of necrosis or active bleeding.

A perineal ultrasound confirmed an encapsulated subcutaneous hematoma measuring 6 × 4 cm, with no deep extension or communication with pelvic tissues. Laboratory tests showed a hemoglobin level of 10.1 g/dL, indicating moderate blood loss.

The patient was admitted for close monitoring due to concerns about potential lesion expansion. A conservative approach was chosen given the absence of rapid progression or compression of surrounding structures. Treatment included paracetamol (1 g every 6 hours) and nonsteroidal anti-inflammatory drugs (NSAIDs) for pain relief, ice application every 3 hours to reduce inflammation and prevent hematoma growth, a semi-reclined position to minimize perineal pressure, and twice-daily vaginal cleansing. Prophylactic amoxicillin-clavulanic acid was initiated to prevent secondary infection.(Figure 1 and 2).

Regular clinical assessments monitored the hematoma's evolution. Within 72 hours, the swelling and pain decreased noticeably. The patient was discharged with home follow-up instructions. By the 15th day postpartum, examination confirmed near-complete hematoma resolution, with the patient resuming normal daily activities uneventfully.

Discussion

Postpartum vulvar hematomas often arise from direct vessel injury during delivery, typically within 48 hours. However, late-onset cases, as seen here on day 5, may be linked to gradual pelvic pressure increases during postpartum recovery[1]. These hematomas commonly develop in the anterior and posterior urogenital triangles, confined by resistant fascial layers that limit expansion. In the anterior triangle, the fascia of Colles and the urogenital diaphragm restrict deep spread, while in the posterior triangle, perirectal and anal fascia provide barriers[2]. Consequently, expanding hematomas present as blue-purple masses, as observed in this case, and are usually self-limiting, though they may cause pressure necrosis of the skin if untreated[3]. Management varies based on size and progression. Small-to-moderate hematomas (<8 cm), like this patient's, often resolve with conservative treatment, including analgesics, ice, and rest, as demonstrated by the successful outcome here[4]. Large hematomas (>8 cm) or those with compression signs (ischemia, severe pain) require urgent surgical drainage and ligation of bleeding vessels (e.g., hypogastric or uterine arteries), with embolization as an alternative in hemodynamically unstable cases[5]. Some advocate conservative management even in stable larger cases, arguing that hematoma pressure can tamponade bleeding vessels, promoting spontaneous hemostasis. Surgical evacuation might relieve this pressure, risking rebleeding, making conservative approaches appealing, especially where embolization is unavailable[6].

The psychological impact of such complications should not be overlooked. Prolonged pain or delayed recovery can negatively affect the postpartum experience, highlighting the need for empathetic, holistic care alongside physical treatment[7]. This case's conservative success reinforces the efficacy of non-interventional strategies for stable, moderate hematomas, supported by ultrasound confirmation to rule out deep extension.

Conclusion

This case illustrates a rare, late-onset postpartum vulvar hematoma, emphasizing its clinical significance. Key takeaways include the critical role of early diagnosis via systematic perineal evaluation, the preference for conservative management in moderate cases, and the necessity of close monitoring to prevent complications. Structured postpartum follow-up and heightened healthcare provider awareness are essential to optimize outcomes and enhance patient experience. Further consensus on management protocols is warranted to standardize care for this uncommon condition.

References

1. Ridgway LE. Puerperal emergency: vaginal and vulvar hematomas. Obstetrics and gynecology clinics of North America. 1995 Jun;22(2):275-82. Doi: https://doi.org/10.1016/S0889-8545(21)00180-7
2. Propst AM, Thorp Jr JM. Traumatic vulvar hematomas: conservative versus surgical management. Southern medical journal. 1998;91(2):144-6. Doi:

https://doi.org/10.1097/00007611-199802000-00004

3. Zahn CM, Yeomans ER. Postpartum hemorrhage: placenta accreta, uterine inversion, and puerperal hematomas. Clin Obstet Gynecol. 1990;33(3):422-31.
4. Villella J, Garry D, Levine G, Glanz S, Figueroa R, Maulik D. Postpartum vulvar hematomas: a report of three cases and review of the literature. Obstet Gynecol Surv. 2001;56(11):683-7
5. Chin HG, Scott DR, Resnik R, Davis GB, Lurie AL. Angiographic embolization of intractable puerperal hematomas. American journal of obstetrics and gynecology. 1989;160(2):434-8. Doi: https://doi.org/10.1016/0002-9378(89)90467-5
6. Sheikh GN. Conservative management of vulvar hematoma: a case report and review. J Reprod Med. 1998;43(8):729-31.
7. Brooks VL, Petersen SM. Psychological aspects of postpartum recovery: a review. J Perinat Educ. 2002;11(4):26-33.

Figures

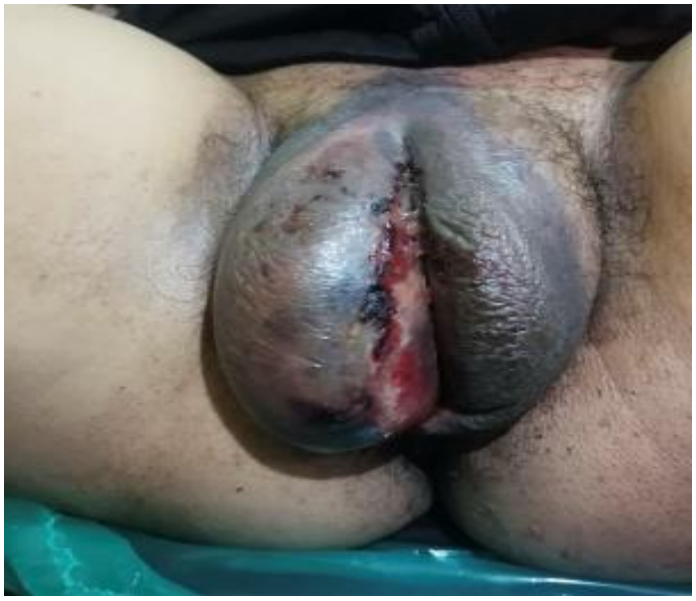

Figure 1: Clinical View Showing Blue-Purple Discoloration of the Labia Majora Hematoma

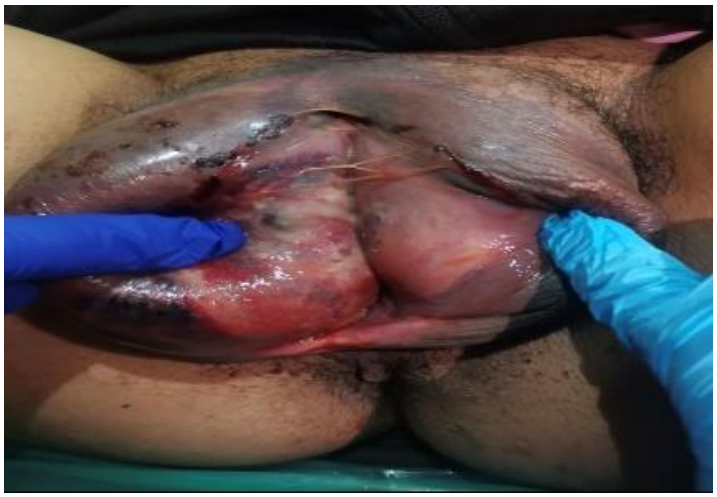

Figure 2: Examination Confirming Absence of Fluctuation or Purulent Discharge

Received: *03-Apr-2025, Manuscript No. AMJ-25-4086;* ***Editor assigned:*** *04-Apr-2025, PreQC No. AMJ-25-4086(PQ);* ***Reviewed:*** *18-Apr-2025, QC No. AMJ-25-4086;* ***Revised:*** *23-Apr-2025, Manuscript No. AMJ-25-4086(R);* ***Published:*** *30-Apr-2025*