

RARE CAUSE OF POST COITAL BLEEDING

Objective- A case of post coital bleeding due to portal hypertension is presented. Cervix can appear abnormal, but biopsy is hazardous.

Case report: A 54-year-old lady presented with post coital bleeding and haematuria. She attained menopause six years ago. She had three vaginal deliveries. She is diabetic, hypothyroid and had chronic liver disease due to Hepatitis C, treated with antiviral and interferon therapy. Prophylactic endoscopic variceal ligation (EVL) was done thrice in last five years for high-risk oesophageal varices. She had decompensated cirrhosis with grade two encephalopathy, six months prior to presentation, treated conservatively. There was no history of ascites or hepatorenal syndrome. She underwent laparotomy 25 years ago for unknown reasons. She was a non-smoker and teetotaller.

She was anicteric with good nutritional status. Abdominal examination revealed old laparotomy scar with no signs of ascites. On examination, ectocervix appeared healthy. Congested vessels were noted near the fornix. Pap smear done.

Investigations- Haemoglobin and AFP normal. Bilirubin 5.5mg/dl, INR-1.5 with MELD (model for end-stage liver disease) score of 18. Ultrasound showed dilated pelvic veins. Triphasic CT showed cirrhosis and portal hypertension with patent portal and hepatic veins; with no evidence of hepatocellular carcinoma or ascites. Significant periumbilical, para-uterine, peri-vesical and para-vaginal collaterals were seen.

Discussion- Pap smear, assessment of endometrial thickness and hysteroscopy are recommended for postmenopausal bleeding. In cirrhosis, sinusoidal fibrosis increases portal pressure, leading to splanchnic vasodilatation and portosystemic collaterals. Common variceal sites are oesophagogastric junction, paraumbilical (caput medusae) and haemorrhoids. Treatment options are beta blockers, EVL, TIPS (trans jugular intrahepatic portovenous shunt) and eventually liver transplant. Common presentation is upper gastro intestinal variceal bleeding. Peristomal (colostomy/ileostomy), duodenal and genitourinary varices are rare. Shunts may open at unusual sites following ablation of varices, as in our patient.

Conclusion: Awareness is important in avoiding cervical biopsy due to risk of bleeding from the portal hypertension. TIPS, coil embolization of pelvic varices and sclerotherapy are options for refractory pelvic varices. Management of the underlying liver disorder is the key.

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