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The postpartum urinary retention (PPUR) after vaginal delivery: Assessment of the prevalence and associated factors

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ABSTRACT

Objective: We sought to determine the prevalence of PPUR and the association between maternal, obstetrics and fetal factors with PPUR. **Method:** This is a prospective observational study involving women who delivered vaginally at gestational age of 37 weeks and beyond in Hospital Raja Perempuan Zainab II from November 2019 till February 2020. The first void urine volume and symptoms at 6 hours of delivery were gathered. Post void residual bladder volume (PVRBV) was measured using standard ultrasound scan machine if the void urine volume less than 200 ml. **Result:** There were 1,017 cases recruited into the study. 40 cases were identified as PPUR with PVRBV of more than 150 ml giving the prevalence of PPUR 3.9%. 12 out of 40 (1.2%) were overt PPUR with symptoms such as urinary frequency (5.0%), dysuria (7.5%), abdominal distension (10%) and combination of symptoms (7.5%). 2 cases of overt were concurrently noted to have positive nitrite on urine analysis. 27 cases were asymptomatic giving the prevalence of covert PPUR 2.7%. In this study, forceps assisted delivery (Adjusted OR 14.020, 95%CI 3.297-59.618, p<0.0001), episiotomy (Adjusted OR 3.201, 95% CI 1.330-7.701, p=0.009), and pain score of moderate to severe (Adjusted OR 46.433, 95% CI 7.456-289.169, p<0.0001) were independent factors associated with PPUR. **Conclusion:** PPUR is a common obstetrics condition during immediate postpartum period. Covert PPUR is at most risk due to having no symptoms. Among the risk factors putting a woman at higher risk to develop PPUR are those delivered via forceps assisted delivery, sustained episiotomy and having moderate to severe pain score during review at 6 hours post-delivery.

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Placental site trophoblastic tumor: A case report

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ABSTRACT

Introduction: The placental site trophoblastic tumour (PSTT) is a rare form of gestational trophoblastic disease, with variable spectrum of clinical presentation. We have managed three cases of placental site trophoblastic disease since 2003, and this is the recent one. **Case Description:** A 45-year-old lady, Para 3, with latest antecedent pregnancy was a live birth, 5 years prior to presentation, delivered via caesarean section. She presented with uterine mass and abnormal prevaginal bleeding and had history of attempting an endometrial sampling via dilatation & curettage at a private centre but abandoned due to massive bleeding. With raised human chorionic gonadotrophin (HCG) and radiological assessment (computed tomography), empirical diagnosis of PSTT was made and planned for hysterectomy. She presented with massive bleeding before the planned surgery and total hysterectomy with bilateral salphingo-oophorectomy had to be performed as emergency. Intraoperatively, it was noted that the trophoblastic tissue has invaded the bladder serosa, and the tumour was located at lower half of uterus. Histopathological examination confirmed the diagnosis of PSTT. She received a total of 4 cycles of chemotherapy, bleomycin, etoposide, and platinum (cisplatin) and achieved complete clinical response. She was well and disease free for more than 6 months since completed treatment. **Discussion:** To make a diagnosis of PSTT is challenging, moreover on managing the case. Patient may present with unexpected life-threatening event, and without high index of suspicion, surgical intervention might be delayed and may result in death of a patient. A decision for the appropriate adjuvant chemotherapy regime might also be difficult due to the rarity of this condition.