An Interesting Case of Birth Trauma:

Severe Pubic Symphysis Diastasis and Bilateral Adductor Haematomas Following Spontaneous Vaginal Delivery

Background

Pubic symphysis diastasis (PSD) is an uncommon and often debilitating complication of pregnancy and delivery.

Aims

This case describes an extreme presentation of PSD with rare sequelae.

Discussion

Postpartum pain is frequently attributed to the normal physiological strains of labour, leading to potential delays in diagnosing PSD. This case highlights an extreme presentation of PSD with multiple rare complications not previously described in the literature.

A multidisciplinary approach was crucial in managing the extensive complications. This case underscores the need for:

- Early recognition of PSD to prevent progression to severe morbidity.
- Awareness of rare complications, including venous thromboembolism and secondary infection.
- Strategies to address social stressors that contribute to delays in care and repeated DAMA events.

Case

Labour and Immediate Postpartum Course

A 36-year-old multiparous woman presented in spontaneous labour and proceeded to a vaginal delivery in lithotomy. Upon mobilisation, the patient immediately reported severe bilateral medial upper thigh pain. After review by junior medical officer, impression was musculoskeletal pain, and she was advised to manage with simple analgesia and heat packs. Due to complex social stressors, she discharged against medical advice.

Subsequent Presentations and Clinical Deterioration

Day 1: Represented with persistent right-sided pelvic pain. X-ray revealed severe PSD (20mm separation). Orthopaedics recommended conservative management. DAMA.
Day 3: Represented with ongoing pain and new right-sided thigh pain.
Day 5: USS: 3cm non-occlusive right femoral deep vein thrombosis. Started on therapeutic clexane.
Day 7: CT: severe PSD with presumed bilateral adductor haematomas, resulting in right common femoral vein compression and partially occlusive DVT.
Day 9: Clinically infected. Surgical drainage of bilateral haematomas (70mL from right side). Cultures showed heavy growth of Streptococcus milleri.
Day 13: MRI findings: Large bilateral complex medial thigh intramuscular haematomas (Right: 13x12x11cm, Left: 11x8x5cm) extending to adductor origin. smaller anterior pelvic haematoma (3x7x4cm) with peripheral enhancement. Findings consistent with infected haematomas and fasciitis.
Day 13: DAMA. Discharged to Hospital in the Home (HITH) for warfarin bridging.
Extensive allied health involvement and multi-team discussion throughout admission.

Outpatient Follow-up and Ongoing Morbidity

Despite initial improvement on antibiotics, follow-up imaging demonstrated persistent bony oedema, muscle oedema, and lymphadenopathy concerning for chronic osteomyelitis. The patient continued to experience chronic pelvic pain. Repeat MRI 3 months off antibiotics showed no significant change from the previous scan—ongoing oedema and enhancement but no definitive evidence of active infection. Follow-up is ongoing.

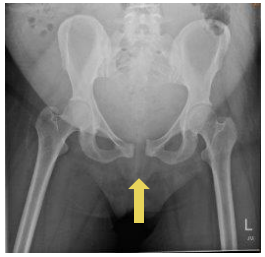

Figure 1: Marked pubic symphysis separation

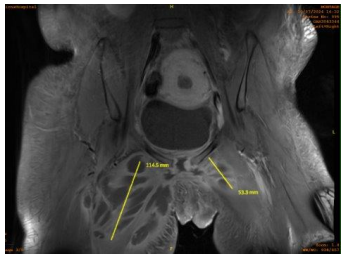

Figure 2: Bilateral adductor haematomas R>L

This case illustrates the importance of timely diagnosis, comprehensive multidisciplinary management, and a patient-centred approach. Increased awareness of PSD complications may improve postpartum outcomes and prevent chronic disability.

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