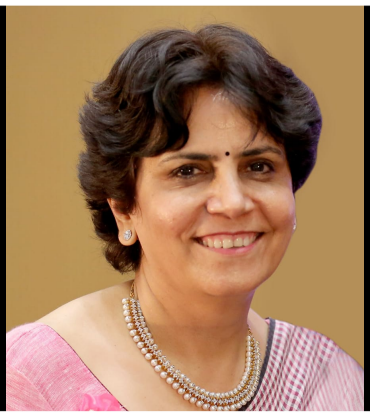


Learn simply

Postpartum Endomyometritis

Hard work

Routine implementation of practices to prevent postpartum endomyometritis

- Avoidance of frequent vaginal exams and unnecessary uterine instrumentation during delivery (including avoidance of manual removal of placenta at cesarean)
- **Routine antibiotic chemoprophylaxis (cephalosporin or clindamycin/gentamicin) administered 20–60 min prior to cesarean delivery**

Symptoms/signs suggestive of postpartum endomyometritis[2]

Initial management

- Consider admission for observation
- Check CBC, blood cultures, urinalysis
- Confirm the diagnosis[2]
- Exclude other diagnoses[3]
- Exclude maternal complications[4]

Unable to confirm diagnosis

- Consider continued inpatient management
- Withhold antibiotic therapy
- Serial clinical examinations
- Patient may continue to breastfeed

Clinically stable

- Discharge home
- Withhold antibiotic therapy
- Patient to follow symptoms (fever, chills, discharge)

Follow-up outpatient visit in 4–7 days

Continued suspicion for endomyometritis

- Consider continued inpatient management

Diagnosis confirmed

- *Consider continued inpatient management*
- Analgesia and antipyretic therapy, as needed
- Consider D&C if retained products of conception is suspected clinically or on ultrasound examination
- Patient may continue to breastfeed

Start iv broad-spectrum antibiotic treatment[5]

Adequate clinical response

- Continue antibiotic therapy
- Discharge home once stable[6]

Follow-up outpatient visit in 4–7 days

Inadequate clinical response[7]

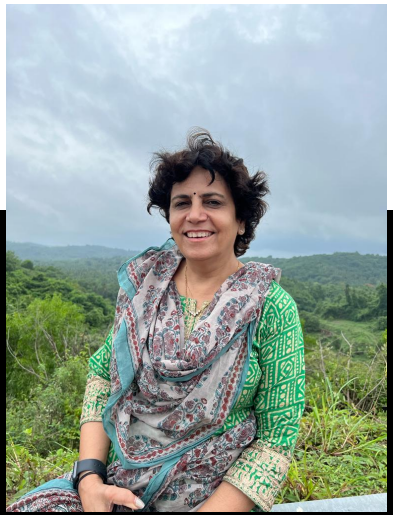
- **Consider incorrect antibiotic, resistance, inadequate dosage (esp. of aminoglycosides)**
- *Consider ID consult*
- Consider evaluating for alternative diagnoses abscess, septic pelvic thrombophlebitis

1. Postpartum endomyometritis refers to a polymicrobial infection of the uterine cavity following delivery.

2. It complicates approximately 6–8% of all deliveries. Risk factors for postpartum endomyometritis include cesarean delivery, prolonged rupture of the fetal membranes (>24 h), low socio-economic status, diabetes, multiple vaginal examinations, manual removal of the placenta, and internal fetal monitoring.

3. Postpartum endomyometritis is a clinical diagnosis characterized by fever, uterine tenderness, a foul purulent vaginal discharge, and/or an increase in vaginal bleeding during the puerperium. It occurs most commonly 5–10 days after delivery.

4. Constitutional symptoms (chills, malaise) and an elevated white cell count are common findings, but are not required for the diagnosis. There is no place for radiologic imaging studies or culture of the endometrial cavity to confirm the diagnosis; however, imaging studies may be useful to exclude other possible diagnoses (such as retained placental tissue or septic pelvic thrombophlebitis).

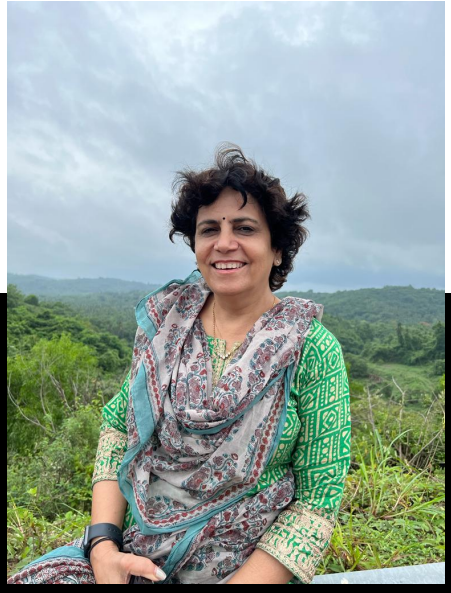


1. The differential diagnosis of postpartum endomyometritis includes retained products of conception, mastitis, septic pelvic thrombophlebitis, pelvic/bladder flap hematoma or abscess, surgical site (wound) infection, infected episiotomy, and other infections (such as appendicitis, pyelonephritis, and pneumonia).

2. Maternal complications include necrotizing fasciitis, pulmonary edema, sepsis, adult respiratory distress syndrome (ARDS), and subsequent Asherman syndrome (especially following uterine instrumentation).

3. Prompt administration of intravenous broad-spectrum antibiotics will reduce maternal febrile morbidity and duration of hospitalization. Intravenous ampicillin 2 gq6h plus gentamicin 1.5 mg/kg q 8 h (after confirmation of normal renal function) are the antibiotics of choice following vaginal delivery. After cesarean delivery, clindamycin 900 mg iIV q 8 h should be added.

4. If an abscess is suspected or renal impairment develops, aztreonam can be substituted for gentamicin.



1. Intravenous antibiotics should be continued until the patient is 24–48 hours afebrile and asymptomatic. There is no role for oral antibiotics once the patient is discharged (aside from patients with positive blood cultures who likely require antibiotics for a total of 10–14 days).

2. Ten percent of patients with symptomatic postpartum endomyometritis will fail to respond to intravenous antibiotics within 48–72 hours; 20% will be due to resistant organisms. Consider evaluating for other sources of infection such as pyelonephritis, an intra-abdominal abscess, or septic pelvic thrombophlebitis.