Introduction

Most physicians would consider puerperal sepsis, known colloquially as childbed fever, to be a relic of the past which has long since been overcome with the introduction of Semmelweis’ hygiene measures in general practice. Puerperal fever does not feature in the ordinary experience of most people.

But puerperal sepsis caused by Group A Streptococci (Streptococcus pyogenes) may take a highly dramatic course and can result in lifelong damage [1]. There are regular reports of such cases in the literature [2–5].

We present a case of puerperal sepsis which occurred unusually early, describe its severe course and discuss the case in the light of the recent literature.

Case Report

A 42-year-old gravida III/para II was admitted to hospital in the 28 + 1 week of gestation for uncontrolled pre-existing arterial hypertension (BP 200/110) and suspicion of placental insufficiency on Doppler sonography. There were no indications of superimposed preeclampsia, and laboratory and urine parameters were within normal ranges. Fetal growth and amount of amniotic fluid were in the lower range of standard values, and the values for umbilical resistance and bilateral uterine flow were borderline pathological. Vaginal pH was 4; Pap smear and CTG done on admission were unremarkable. Subjectively, the patient had no symptoms. Apart from the hypertension, the patient’s medical history was unremarkable.

Betamethasone was administered (2 × 12 mg at an interval of 24 hours) to induce fetal lung maturation, and drugs were administered in an attempt to reduce blood pressure while shielding the patient. Doppler sonography showed a dramatic worsening of placental insufficiency after the administration of drugs for lung maturation, with zero umbilical flow and intermittent reverse flow. When CTG became suspicious, the infant was delivered by cesarean section under spinal anesthesia. Except for a large myoma on the anterior wall which displaced the uterine cavity and which had led to delayed development of the infant, findings were unremarkable and the amniotic fluid was clear. Single dose antibiotic prophylaxis (cefazolin 2 g) was administered intravenously after the infant was delivered. The neonate weighed 980 g (Apgar score: 1/6/8; pH: 7.35) and was transferred to the premature baby unit for further care.

Initially, the postoperative course was entirely unremarkable. But around 16 hours later, the patient developed acute shock. She presented with pronounced systemic inflammatory response syndrome (SIRS) with shortness of breath, a drop of oxygen saturation to 80% in room air, and tachycardia with a mean systolic pressure of 130 and a BP of 80/40 but without strong pain, fever or clearly attributable laboratory findings. The only remarkable finding was leukopenia of 2800/µl; the significantly increased CRP (C-reactive protein) level of 22.7 mg/l was considered to be a postoperative surge. The patient’s respiratory frequency and temperature were within normal ranges. Thoracic CT performed to exclude pulmonary embolism was unremarkable. Abdominal sonographies carried out to exclude secondary hemorrhage showed increasing amounts of free fluid in the abdomen. The patient’s clinical condition worsened alarmingly, and re-laparotomy was done because of a suspicion of secondary hemorrhage. Two liters of putrid fluid were found in the abdomen. The uterus was soft, and the scar of the cesarean section was clinically intact. A diagnosis of puerperal sepsis was made; a hysterectomy procedure with lavage was carried out; the retroperitoneal space was opened with revision.
surgery of the ovarian vessels up to the vena cava, aorta and renal vein to exclude septic thrombus. Revision surgery of the intestines was done in collaboration with colleagues from the Department of Abdominal Surgery (no pathological findings) with extensive abdominal lavage and the placement of large abdominal drains. The patient was transferred to the intensive care unit in a moderately stable hemodynamic condition, and anticoagulation therapy was initiated.

The patient required high doses of catecholamines and presented with severe oxygenation dysfunction with a PaO2 of 100 mmHg at 100% oxygen (oxygenation index 100). Because of the severity of symptoms, antibiotic therapy (which had commenced immediately preoperatively) was switched from cefazolin and metronidazole to meropenem as empiric therapy. CRP was now 142 mg/l. The laboratory findings of the swab obtained intraoperatively were not yet available at this point.

As the noradrenalin doses were increased, a PICCO catheter (for pulse contour cardiac output measurement) was inserted for close hemodynamic monitoring. Cardiac ultrasound was done and demonstrated a good pump function of the left heart. Volume loading did little to decrease the high lactate levels. Oxygenation improved very gradually. Acute renal failure additionally set in after revision surgery, requiring continuous hemodiafiltration (CVVHDF) to treat early hyperkalemia. The patient received coagulation factors (PPSB = prothrombin complex concentrate) and thrombocyte substitution with ROTEM®-assisted monitoring (rotational thromboelastometry to measure the full blood coagulation profile) because of coagulation failure and clinical bleeding tendency.

At this point, incipient hypoglycemia developed, indicating impaired hepatic synthesis, and substitution was required. Repeat abdominal ultrasound showed no change in findings. Because of the patient’s poor hemodynamic condition, the patient was sedated with midazolam and ketamine (Richmond Agitation-Sedation Scale [RASS]: minus 4).

The patient continued to require high doses of noradrenalin. Antibiotic therapy was expanded on the 2nd postoperative day to include linezolid because of the limited effectiveness of meropenem against Gram-positive cocci and the continued rise of CRP to 182 mg/l. Therapeutic anticoagulation values were achieved. The patient developed therapy-refractory lactate acidosis which could not be remedied by CVVHDF or by the continuous administration of TRIS buffer solution (Tris(hydroxymethyl)aminomethane hydrochloride to treat metabolic acidosis). Because of the high catecholamine doses which indicated catecholamine-resistant shock, methylene blue was administered intermittently to reduce NO-induced relaxation of the smooth vascular muscles. Ongoing coagulation failure required continuous substitution with thrombocyte concentrate. Heparin/platelet factor 4 antibody test was done to exclude heparin-induced thrombocytopenia type II. There were no bleeding stigmata.

Streptococcus pyogenes was detected on the abdominal swab obtained intraoperatively during re-laparotomy. The microbes were also detected in the vaginal smear obtained during the same operation. Histological analysis was unable to find the foci. The uterine scar was adequate with no evidence of inflammation. The myoma was histologically unremarkable. Nevertheless, the presumption remains that the cause was ascending infection caused by Streptococcus pyogenes, although the origin of the Streptococci remains unclear, given the unremarkable familial history of diseases caused by Streptococci such as angina or scarlet fever. Pathological investigation only found extensive fibrinous peritonitis with adipose tissue necrosis.

The initially high levels of markers for infectious disease gradually dropped with anti-sepsis therapy, and anti-microbial therapy was de-escalated to ampicillin/sulbactam. Catecholamine administration was discontinued on the 9th postoperative day, and the patient’s pulmonary and metabolic condition continued to stabilize. The patient was put on parenteral nutrition.

After being administered antagonist drugs to reverse sedation, the patient opened her eyes but was not yet fully conscious at that point. CT scan of the skull showed no significant intracranial pathological findings. CT of the thorax and abdomen were also done at the same time. In addition to pleural effusions, the images showed bilateral hypodense hepatic lesions as well as thrombosis of the right external iliac vein. Findings were also suspicious for diffuse pulmonary infiltrates, compatible with scattered septic foci.

Further revision surgery of the abdominal wall was done on the 12th postoperative day because of pronounced impaired wound healing, which presented as necrotizing fasciitis on histological examination. Extensive wound debridement was done with subsequent placement of a VAC (Vacuum-Assisted Closure) system. No evidence of bacteria could be found. After revision surgery, the patient again required high doses of catecholamines. The continued absence of diuresis meant that CVVHDF also had to be continued. When the patient again presented with fever, leukocytosis and increased procalcitonin values, antibiotic therapy was switched to meropenem and linezolid. At the same time all central venous catheters including all dialysis catheters were changed. The exchange proved to be difficult because of thrombi in both internal jugular veins.

Revision surgery of the abdominal wall was done repeatedly, and the fascia could gradually be closed, although VAC therapy was continued. The patient developed wet gangrene of the 2nd toe on her left foot in consequence of the lengthy catecholamine administration, and the toe had to be amputated.

After the antibiotic regimen was changed on the 12th day the patient’s hemodynamic condition continued to improve. Hemodiafiltration finally achieved negative equilibrium. The patient developed critical illness polynuropathy/polymyopathy, and on the 18th day in the intensive care unit a tracheotomy was performed to help with weaning from mechanical ventilation. The abdominal wall was closed on the same day.

Feeding was changed from parenteral nutrition to enteral tube feeding through a stomach tube. But despite the assistance of prokinetic drugs, the passage of nutrients through the gastrointestinal tract continued to be difficult. The enteral load was gradually increased until nutrition was adequate. Weaning off mechanical ventilation was protracted because of critical illness polynuropathy/polymyopathy. After the patient’s hemodynamics had stabilized and there were no more signs of infection, antibiotic therapy was de-escalated again after the 19th postoperative day and finally terminated. The patient now received intermittent dialysis via a single-lumen (Demers) catheter. However anticoagulation therapy was continued with sustained administration of up to 35 000 IE/d heparin. Further revision surgeries of the abdominal wall followed by VAC treatment for impaired wound healing were required.

After weaning from mechanical ventilation the patient began her first attempts at swallowing and speaking. The symptoms of crit-
Group A Streptococci are very common bacteria which have a
erichia coli
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patients are young and fully immunocompetent. But the mortal-
nosis extremely difficult, and diagnosis is often only made when
remain unremarkable for a long time [8]. This makes early diag-
periodic pain and a generalized feeling of fatigue. Laboratory val-
verge cases in particular may often have no increase in tempera-
table. Patients often only have a slight increase in temperature; se-
other infectious diseases. The infection therefore often goes un-
known [4, 5, 8,13, 14]. The therapy of choice for streptococcal infections is high doses of
penicillin G, as resistance to penicillin G has not been reported [4, 8]. If determination of the pathogen is not possible, the clinical
the benefits of this approach. But in the current interna-
tional literature, hysterectomy is considered an essential part of the
surgical removal of septic foci in patients who do not respond
immediately to adequate antibiotic treatment [21–22]. As Group
A Streptococci rapidly attack all organs, in theory there is no single
focus of septic infection any more. But the pathogen is never
detected in time, meaning that surgical revision may be the only
potentially life-saving approach that remains if conservative
therapy fails. In a patient with manifest sepsis which does not re-
spond to antibiotic treatment within a few hours, we are of the
opinion that surgical revision must be done soon and must in-
clude the removal of all potential septic foci, followed by exten-
sive lavage. This approach is indicated even if the pathogen has

Discussion

There is currently no reliable data on the incidence of puerperal sepsis, even though all deaths in Germany from puerperal sepsis
must be registered. Reports range from 0.2 to 1.0 deaths for every
100 000 births [1, 2, 6, 7]. Compared with a death rate of up to 20% of
women who gave birth in the pre-Semmelweis era, this ap-
ppears very low; however, it is estimated that a significant number of
cases go unreported [8].

Puerperal sepsis is the most serious form of puerperal fever, which is defined as an infection affecting women following child-
birth or a miscarriage. It is associated with a mortality of up to
50%. The center of infection is usually the uterus with its large
open wound after discharge of the placenta, which represents a
portal of entry for microorganisms even under the most hygienic
conditions. Physiologically, ascending bacteria are removed by
the lochia, but decreased or retained lochia increases the risk of
infection. The most common infectious microorganisms are Esch-
erichia coli, Staphylococci and Streptococci [7–10]. The risk of in-
fec tion is significantly increased after cesarean section compared
to vaginal delivery [11, 12]. The pathophysiological cause of this
is unclear but it could be due to the decreased amount of lochia
after cesarean section.

Typical early signs of puerperal sepsis, particularly if the infection is
caused by Group A Streptococci, differ from the early signs of
other infectious diseases. The infection therefore often goes un-
recognized, and crucial antibiotic treatment is often started too
late. Patients often only have a slight increase in temperature; se-
vere cases in particular may often have no increase in tempera-
ture at all [4,5,8]. The main symptoms of puerperal sepsis are ab-
dominal pain and a generalized feeling of fatigue. Laboratory val-
ues, particularly complete blood count without differential, may
remain unremarkable for a long time [8]. This makes early diag-
nosis extremely difficult, and diagnosis is often only made when the
patient has developed full blown sepsis, usually with pro-
nounced respiratory insufficiency. Actual sepsis is relatively rare,
as antibiotic therapy is often initiated ex juvantibus to treat pa-
tients with persistent unspecific symptoms, and the majority of
patients are young and fully immunocompetent. But the mortal-
ity associated with advanced stage sepsis is enormously high
with reported rates of 20–60% [3–5, 8, 13, 14].

Group A Streptococci are very common bacteria which have a
tendency to colonize the throat of around 20% of the population
in the winter months without giving rise to symptoms. Transmis-
sion occurs by droplet and smear infection. In the majority of
cases, Group A Streptococci originate from the vaginal area,
which was colonized by the microorganisms prior to the birth.
The bacteria enter the body through the endometrium or a vagi-
nal injury, where they find ideal growth and propagation condi-
tions. In addition to the rapid and systemic spread of the bacteria
from the portal of entry throughout the whole body, the bacteria
also release toxins which attack cells directly. Mortality from
Group A streptococcal sepsis is precipitated by impaired pulmo-
nary function and coagulation [4,8].

So-called “toxic shock syndrome” represents a particular compli-
cation of Group A streptococcal sepsis [15–18]. Toxic shock syn-
drome can progress to multiple organ failure due to the potential
for arterial leakage and tissue necrosis. Antibiotic therapy is un-
successful to treat such cases as symptoms are no longer caused
by the bacteria themselves but by the toxins released in large
amounts by the bacteria [19]. The toxins cause a cytokine cascade
with subsequent activation of neutrophils and mediators, leading
to respiratory failure, excessive vascular permeability and shock;
mortality is more than 50%, even under the most modern medi-
cal conditions [16–18].

The diagnosis of puerperal sepsis is based on direct clinical ex-
amination of the patient. Cardinal symptoms include severe, gen-
eralized malaise, with or often without fever, as well as increased
levels of the inflammatory marker CRP, results of a hemogram
may initially be unremarkable. But there is a large gray area be-
tween a normal postpartum/postoperative course, local infection
due to abscess, and puerperal sepsis, and experience is needed to
differentiate between them in the early stages. It is often not pos-
tible to determine the specific pathogen, as smears or blood cul-
tures are often only done after the patient has received initial
doses of antibiotics. What is usually found are the resistant colo-
nizing bacteria [8]. Nevertheless, it is important to continue
searching for the pathogen by means of blood cultures and smear
tests. In patients with sepsis the search for the pathogen should
be an essential part of diagnosis and must start prior to the ad-
ministration of antibiotics.

The therapy of choice for streptococcal infections is high doses of
penicillin G, as resistance to penicillin G has not been reported [4, 8]. If determination of the pathogen is not possible, the clinical
symptoms should determine the choice of treatment, which
should preferably take the form of a broad spectrum combination
therapy [4,8,20]. Empirically, the therapy of choice consists of a
combination of piperacillin with a β-lactamase inhibitor, or alter-
natively meropenem [20]. The importance of a hysterectomy in
patients with puerperal sepsis is largely ignored in the German
specialist literature, and in the textbooks it is generally consid-
ered as a last resort. There are no studies or Cochrane analyses
showing the benefits of this approach. But in the current interna-
tional literature, hysterectomy is considered an essential part of the
surgical removal of septic foci in patients who do not respond
not (yet) been determined and is often carried out [9,21,22]. Hysterectomy removes a potential focus of septic infection. Clinically, uterine subinvolution may also be present which can encourage infection. Patients require careful examination to detect or exclude septic thrombus and loop abscess. Lavage of the abdomen reduces the bacterial and toxin load. Sepsis and ovarian vein thrombosis, which are otherwise only found on autopsy, can be detected in time and treated. Consequently, surgical revision continues to be beneficial and can be life-saving.

Summary

Puerperal sepsis is a rare but serious and potentially lethal syndrome. It is imperative that severe postpartum malaise is taken seriously; early initiation of antibiotic therapy before sepsis becomes manifest can save lives.

Conflict of Interest

None.

References: