Case report

A pyo-hydropneumothorax with sepsis, secondary to *Gardnerella vaginalis* infection in a post-partum female

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1. Case

A 20 year old female, 14 days post partum (Gravida 0 Para 1) presented to the Emergency Department complaining of severe left-sided pleuritic chest pain, shortness of breath and pyrexia. She was 14 days post-partum following a normal vaginal delivery. Her symptoms began 2–3 days post-partum and were attributed to a musculoskeletal source. Lack of symptom resolution prompted treatment with broad-spectrum oral antimicrobials; oral amoxicillin-clavulanic acid 625 mg TDS for presumed lower respiratory tract infection. However, when her symptoms deteriorated she self-presented to the Emergency Department 2 days later, in severe respiratory distress with absent chest expansion, dullness to percussion and reduced air entry on the left side. Imaging of her chest on admission revealed a left tension hydropneumothorax with significant mediastinal displacement and mixed density fluid containing air within the fluid component of the hydropneumothorax (Figs. 1 and 2).

Initial haematological investigations showed leukocyte count: 30 × 10^9/L; neutrophils: 28 × 10^9/L; haemoglobin: 9.8 g/L; C reactive protein (CRP) 370 mmol/L. Blood cultures yielded no growth. A chest drain was inserted which provided symptomatic relief and 1500 mL of Fig. 1. Erect chest radiograph on day of admission showing left tension hydropneumothorax with significant mediastinal displacement.
cloudy-brown, malodourous fluid was drained. She was commenced on empiric broad-spectrum intravenous (IV) anti-microbial therapy with Piperacillin-Tazobactam 4.5g TDS and Vancomycin 15mg/Kg (1g) BD. The pleural fluid drained was sent for biochemical and microbiological analysis with the following results:

- Gardnerella. vaginalis on culture
- pH < 6.3
- Leucocytes 388,800/μL (80% polymorphs)
- Protein 48g/L, glucose 0.6mmol/L, cholesterol 2 mmol/L, triglyceride 0.7 mmol/L

Despite medical management with these IV antimicrobials and interventional management with a chest drain, she did not show signs of clinical improvement. A repeat chest radiograph on day 7 showed extensive loss of volume and consolidation in left hemithorax (Fig. 3) thus an additional third antimicrobial, clindamycin 800mg IV TDS, was commenced.

Notwithstanding draining 4.2L of pleural fluid, repeated CT thorax and chest radiograph at day 14–16, showed a persistent loculated complex pyohydro pneumothorax remaining, which was refractory to management with a chest drain (Figs. 4 and 5).

She was transferred to a cardiothoracics tertiary facility and underwent a video-assisted thoracoscopic surgery (VATS), followed by a decortication procedure. At her 6-month interval follow up she was clinically well, a bronchoscopy was unremarkable and the hydro pneumothorax had resolved with some residual volume loss on left side (Fig. 6).
To our knowledge, this extraordinary case is the first documented case of pyohydropneumothorax due to *G. vaginalis*, in a healthy, immunocompetent female during the post-partum period.

2. Discussion

*G. vaginalis*, previously known as *Corynebacterium vaginale* and *Haemophilus vaginalis* [1], is a facultative anaerobic, Gram-variable staining bacterium that is typically a small non-spore forming coccobacillus [2]. It is not part of the normal vaginal flora at birth but rather is acquired through sexual transmission from an infected partner. It is primarily confined to genitourinary (GU) system and is associated with bacterial vaginosis (BV), the most common vaginal infection worldwide [3]. Its presence can be considered a ‘dysbiosis’ rather than overtly virulent [4,5], however in obstetric patients, *G. vaginalis* is a recognized, although rare pathogen, contributing to puerperal sepsis, chorioamnionitis and fetal sepsis [5,6].

Interestingly, it has also been cited as an aetiological factor in male bacteremia [7] and perinephric abscess formation in a male patient [8]. In this case, *G. vaginalis* was isolated in the pleural fluid 2 weeks post-partum. Though extremely rare, there are occasional reports of *G. vaginalis* causing infection at sites distant from the GU tract (please refer to Table 1); in one case causing osteomyelitis of the spine [9] and in another case, *G. vaginalis* was isolated from pulmonary abscesses in a male alcoholic [10].

It has been hypothesized that the proliferation of organisms in the immediate post-partum period is due to their opportunistic spread from the vagina, via the placental bed following mucosal injury during delivery [5,6]. In our patient, *G. vaginalis* was isolated from pleural fluid 2 weeks post-partum, presumably via haematogenous extension following trauma to the GU tract post-delivery. Despite repeated blood and urine cultures, *G. vaginalis* isolation from pleural fluid was the only source of the patient’s respiratory empyema and sepsis. We hypothesise that the patient’s treatment with broad-spectrum antibiotics in the days preceding her admission, may have prevented isolation of *G. vaginalis* from her blood cultures. An alternative hypothesis is that oral aspiration of bodily secretions may have occurred during the vaginal delivery.

In summary, to our knowledge, this is the first documented case of *G. vaginalis* causing pyohydropneumothorax and associated respiratory sepsis in the post-partum period. Although unusual, this case highlights the need for physicians to be cognisant of *G. vaginalis* as a potential pathogen when treating post-partum empyema, and indeed, even as a potential pathogen when treating any pulmonary complications in the obstetric patient, which will lend to prompt initiation of appropriate antimicrobial treatment.
Conflict of interest

No conflict of interests have been identified for any author.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.rmcr.2019.01.007.

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