

Postpartum Endometritis and Sepsis

A plain-English guide for you and your family

WHAT IS HAPPENING

After you deliver a baby, your uterus should shrink back down and heal cleanly. The cervix (the opening to the womb) closes, the raw tissue where the placenta was attached starts to heal, and the womb steadily empties old blood and tissue. But if bacteria from your vagina climb up into the uterus — especially after a C-section, long labor with broken water, or if the doctor had to pull out the placenta by hand — they can settle into the raw lining and multiply. Your body fights back with fever, the uterus gets sore and tender, and you may see foul-smelling discharge. Your heart beats faster to pump more immune cells and oxygen to the infection. If antibiotics don't reach every hiding spot or if pus collects in a pocket, the infection can spread into your bloodstream and turn dangerous. That's why doctors watch closely and give strong antibiotics by vein until the fever has been gone for two full days — they want to be sure every germ is dead and your womb is healing safely.

What you might feel

- Fever (usually 100.4°F or higher) starting 1–3 days after delivery
- Lower belly pain or tenderness over the uterus
- Foul-smelling vaginal discharge (lochia)
- Heavy vaginal bleeding (more than a normal period)
- Fast heart rate (tachycardia, over 100 beats per minute)
- Chills or shaking
- Feeling very weak, confused, or short of breath
- Blood pressure dropping (systolic under 90 mmHg) or very low urine output

Call the doctor right away if...

- Confusion, extreme sleepiness, or trouble staying awake (sign that the brain is not getting enough oxygen)
- Blood pressure under 90/60 or very fast breathing (over 24 breaths per minute)—signs of septic shock

- Skin that looks mottled, cold, or bluish, or urine output that stops or drops way down (kidneys and circulation failing)
- Severe belly pain that spreads, or belly becomes hard and rigid (infection may be spreading beyond the uterus into the abdomen)

What the care team will do

- Obtain two sets of blood cultures from different sites before starting antibiotics, then give first IV antibiotic dose within 1 hour
- Start continuous monitoring of heart rate, blood pressure every 15 to 30 minutes, oxygen saturation, and temperature until patient is stable for 2 hours
- Give IV fluid bolus of 30 milliliters per kilogram lactated Ringer solution or normal saline over 2 to 3 hours while monitoring lung sounds and urine output
- Measure urine output every hour using a Foley catheter and report if less than 30 milliliters per hour or 0.5 milliliters per kilogram per hour
- Perform fundal assessment checking uterine firmness and position every 4 hours and note any severe tenderness beyond normal postpartum discomfort
- Assess lochia amount, color, and smell every 4 hours and report foul odor or clots larger than a golf ball immediately
- Keep patient NPO except ice chips until fever resolves and pain improves in case imaging shows abscess needing percutaneous drainage or surgery
- Do not stop breastfeeding unless mother is critically ill or on contraindicated antibiotics; assist with pumping if separation needed

Medicines you may be given — and why

Clindamycin plus gentamicin (or piperacillin-tazobactam as a single drug), given through an IV

After birth, especially after a C-section, bacteria from the vagina and bowel can climb into the womb lining and multiply, causing infection. The two most common mixes of bacteria are anaerobes (bacteria that grow without oxygen, like *Bacteroides*) and aerobes (oxygen-loving bacteria, like *E. coli* and *Streptococcus*). Clindamycin stops anaerobic bacteria from building their proteins—without proteins, they cannot grow or spread. Gentamicin punches holes in the outer wall of aerobic bacteria, killing them quickly. Piperacillin-tazobactam works as a single drug by blocking the bacteria's ability to build their cell walls (piperacillin) and also stopping the enzyme many bacteria use to break down antibiotics (tazobactam), so it covers both aerobic and anaerobic bugs in one shot. You keep giving the antibiotics through the vein until the mother has had no fever for a full 48 hours—this tells you the infection is truly under

control. If she is not better after 48 hours of IV antibiotics, you take pictures (ultrasound or CT scan) to look for pockets of pus (abscesses) or pieces of placenta still stuck inside. If you find a pocket of pus or leftover tissue, you drain the pus or remove the tissue with surgery. If blood clots are blocking pelvic veins (septic pelvic thrombophlebitis), you add heparin to thin the blood and break up the clots. If the mother is very sick with sepsis (the infection has spread into the bloodstream and is shutting down organs), you follow sepsis protocols—give fluids fast, check blood oxygen, support blood pressure, and switch to even stronger antibiotics if needed.

Where this information comes from

- CDC – Maternal Morbidity and Mortality
- ACOG Practice Bulletin No. 195: Prevention and Management of Obstetric Lacerations at Vaginal Delivery (2018)
- WHO recommendations on maternal and newborn care for a positive postnatal experience (2022)
- Surviving Sepsis Campaign International Guidelines (2021)

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