Date of visit: 4/7/2026
Source of information: Self
Reliability: Reliable
Mode of transport: Self

Chief complaint: “I’ve had vaginal bleeding and abdominal pain since this morning.”

HPI: Pt is a 29 year old female G3P0020 at 33 weeks gestation, with past medical history of pre-diabetes prior to pregnancy, now with gestational diabetes who presents to OB triage for vaginal bleeding and lower abdominal pain since this morning. Pt reports noticing light pink vaginal spotting over the past week, but noticed darker red blood on the toilet paper after urinating earlier this morning. Pt denies heavy bleeding, has not required pad use, and reports no passage of clots, but became worried and wanted to come in for evaluation. The bleeding is accompanied by cramping lower abdominal pain rated 6/10, with minimal relief from Tylenol. The cramping is constant and not occurring at regular intervals. Reports good fetal movement. Prenatal course has been uncomplicated. Pt denies any aggravating factors. She has been compliant with daily prenatal vitamins and denies abnormal vaginal discharge, leakage of fluid, dysuria, recent sexual activity, fever, headache, nausea, vomiting, or vision changes. No recent trauma or substance use.

Past Medical History
- Pre-diabetes before pregnancy
- Gestational diabetes currently

OBGYN History
G3P0020
Spontaneous abortion in first trimester x 1 (2019)
Induced abortion in second trimester x 1; sp D&C (2015)

Immunizations:
- Never had COVID-19 vaccine
- Flu vaccine last in 2016
- HPV vaccine (Gardasil) done in 2013 (2 dose series)

Past Surgical History
- Dilation and curettage of uterus for IAB in 2015 at QHC, no complications

Medications
- Prenatal vitamin 28-0.8 mg tablet; take 1 tablet by mouth in the morning

Allergies
Allergy to pineapple, kiwi, and mushrooms; gets itchy throat.
No known drug or environmental allergies.

Family History
- Mother is alive and well, age 61; pt denies any PMHx of mother
- Father is alive and well, age 65; PMHx of type II diabetes
- Sister is alive and well, age 25; no PMHx

Social History
Habits: denies smoking, drinking alcohol, or illicit drug use.
Diet: endorses healthy diet; drinks about 8 bottles of water daily.
Occupation: currently not working due to pregnancy; job is dental assistant.

Exercise: does not exercise.
Travel: no recent travel.
Sleep habits: endorses healthy sleeping habits; about 7 hours per night.
Marital status/living situation: married to and lives with husband.
Sexual history: sexually active with husband only, last intercourse 2 months ago; not on any contraception; no hx of STDs

Screenings:
Last pap smear with HPV reflex: 11/3/2025, no abnormalities

ROS
General: denies weight loss, loss of appetite, fatigue, weakness, fever, chills, or night sweats
Skin: denies rash, itching, excessive sweating or dry skin
Genitourinary: reports urinary frequency and nocturia secondary to pregnancy; denies urgency, dysuria, hematuria, incontinence, or flank pain
Gastrointestinal: reports lower abdominal pain; denies nausea, vomiting, diarrhea, constipation, fecal incontinence, or decreased appetite
Musculoskeletal: denies lower back pain, swelling, redness, deformity, or trauma
Endocrine: denies thyroid gland enlargement, heat or cold intolerance, changes in facial or body hair, or excessive hair growth; weight gain secondary to pregnancy
Pulmonary: denies cough, SOB, orthopnea, sputum, hemoptysis, or wheezing
Cardiovascular: denies chest pain, jaw pain, palpitations, or swelling of legs or feet
GYN: reports vaginal bleeding; denies vaginal burning, dryness, discharge, malodor, itchiness, or dyspareunia.

Physical Exam
General: 29 year old female, well nourished, well developed and well groomed. Pt appears stated age and is in no acute distress.

Vital Signs:
Blood pressure: 126/82 mmHg
Respiratory rate: 20 breaths per minute, unlabored
Pulse: 97 BPM, regular rate and rhythm
Temperature: 98.3 F
SpO2: 99% on RA
Height: 5 feet 5 inches
Weight: 218 pounds
BMI: 36.3

Skin: warm and moist, good turgor. Nonicteric, no lesions.
Pulm: symmetrical expansion with respiration. No intercostal retractions, or tenderness. Breath sounds equal bilaterally. No rales, wheezes, or rhonchi auscultated.
CV: regular rate and rhythm. S1 and S2 heard. No murmur, thrills, or clicks.
Abdomen: gravid uterus, fundal height measured at 33 cm. Minimal tenderness to palpation of lower abdomen; no guarding. No inguinal hernia. No palpable lymphadenopathy. Striae and linea nigra noted.
Extremities/MSK: no obvious deformities, clubbing, cyanosis, or edema noted. No visible joint swelling or erythema. Normal ROM. Bilateral upper and lower pulses present.
Pelvic exam: no inguinal adenopathy. External genitalia without erythema, lesions, or masses. Vaginal mucosa pink; cervix is closed, not effaced, and posterior (c/L/p). No adnexal tenderness. Sterile speculum exam: no active or old blood visualized, closed os, (+) thick white discharge at vaginal vault.

Labs/imaging
Sonogram: fetus in breech position, anterior placenta, amniotic fluid index (AFI) 11 cm, biophysical profile (BPP) 8/8
Category 1 tracing
Urine dipstick: (+) glucose, trace ketones, trace blood, 1+ protein
Finger stick: 136

Past results:
11/1/25: Horizon results negative for 27/27 diseases; panorama (NIPT) low risk
11/3/25: GCT 135; GTT 89/183/163/128
3/30/26: US shows singleton gestation with normal amniotic fluid volume, normal fetal growth.
4/2/26: HgA1c 6.5%

Assessment
Pt is a 29 YOF G3P0020 at 33 weeks gestation, with PMHx of pre-diabetes, now with gestational diabetes, who presents with light vaginal bleeding and constant lower cramping abdominal pain since this morning. Denies heavy bleeding or passage of clots. Physical exam is notable for thick white discharge at vaginal vault; no old or active bleeding visualized. History and physical most consistent with candidiasis in setting of pregnancy, however preterm labor and placental abruption were considered and evaluated given third trimester bleeding and abdominal pain.

Differential Diagnoses:
1. Vulvovaginal candidiasis
    A. Given the sterile speculum exam findings of a thick white discharge, this is the most likely diagnosis. Pregnancy predisposes patients to candidal overgrowth secondary to hormonal changes in the vaginal environment. Her history of pre- and gestational diabetes and elevated HgA1C also increases the risk of yeast infection. Although candidiasis more commonly presents with pruritus, irritation, and discharge rather than vaginal bleeding, it can still lead to mild spotting from irritation and inflammation of the vaginal mucosa or cervix.
2. Preterm labor
    A. This should be kept high on the differentials because pt is 33 weeks gestation and presents with abdominal pain and vaginal bleeding/spotting, which can be early warning signs of preterm labor. Even though on exam, cervix is closed, long, and posterior, very early labor should not be excluded since contractions and cervical change may evolve over time. Preterm labor is less likely than candidiasis because of the cervical findings on exam, no regular contractions (ie pain is constant), and reassuring fetal status. It should still be considered given the gestational age and potential consequences if labor progresses.
3. Placental abruption
    A. This should be considered in any 3rd trimester patient with vaginal bleeding and abdominal pain, as this is a classic presentation of placental abruption. Because the bleeding is light, there are no clots, pt is hemodynamically stable, and abdomen is only minimally tender, this is less likely. Further, US shows an anterior placenta and reassuring fetal status, although a normal US does not completely rule out abruption.
4. Cervicitis
    A. Because the cervix becomes more vascular in pregnancy, it may cause mild irritation or inflammation and easily bleed. This can present as vaginal spotting, especially when the bleeding is only seen on toilet paper and not associated with hemodynamic instability. Cervicitis can also explain discharge, although candidiasis fits the white thick discharge on exam better. This differential is less likely because pt denies any trauma, including recent intercourse, and has no STI history. Exam is not notable for cervical erythema, mucopurulent discharge, or friability. Cervical irritation is still a possibility for minor spotting in a stable patient with a closed cervix and no obvious intrauterine source of bleeding.
5. Bacterial vaginosis

A. BV results from a decrease in lactobacilli and overgrowth of anaerobic bacteria in the vagina, causing vaginal mucosal irritation and inflammation. This can make the cervix and vaginal walls more friable, resulting in vaginal spotting, especially in pregnancy when tissues are already more vascular. BV is clinically important in pregnancy because it is associated with an increased risk of preterm labor, which can account for pt's intermittent cramp-like abdominal pain. However, BV is less likely in this pt because she lacks classic symptoms such as thin gray discharge with fishy odor (instead she has thick white discharge on exam, more consistent with candidiasis).

Plan/Workup

- CBC to assess for anemia in setting of vaginal bleeding
- KOH prep to confirm candidiasis
- Wet mount to r/o BV
- GC/CT NAAT to r/o cervicitis
- Continuous fetal monitoring/tocometry to detect uterine contractions and evaluate for preterm labor (for at least 20 minutes)
- Give oral hydration with water

Medications:

- Tylenol PRN for pain
- Prescription: Terconazole 0.4% vaginal cream

Patient education:
We explained to pt that her symptoms are most consistent with vaginal candidiasis, or a yeast infection, which is common in pregnancy and especially in patients with diabetes. She was instructed to take Terconazole as prescribed, and to insert 1 applicator into the vagina nightly for 7 days, even if symptoms start to improve early. She can take Tylenol as needed for pain. Pt was advised to avoid douching, scented soaps, and tight clothing to prevent further irritation. Pt counseled on the importance of rest and daily hydration with water.

She was also advised to count fetal movements/kicks to monitor fetal status. Pt was educated on the importance of glycemic control to reduce complications, and she should continue logging her fingersticks and adhering to diabetic diet.

Fetal status was reassuring and no contractions were seen on tocometry, so pt to be discharged with return precautions. She was told to return to triage for any loss of fluid, continued or worsening vaginal bleeding, regular contractions/lower abdominal or back pain, fever, or decrease in fetal movements. She has upcoming appointment in OB diabetic clinic on 4/16/26 and she confirmed that she will follow up.