

**CASE REPORT**

Uterine Perforation with Bowel Infarction in a case of Unsafe Abortion

Kailash Singh, Shyam Gupta, Dinesh Gupta*, Pinki Pargal

Abstract

We report a case of a 30 year old female who presented with features of septic abortion with peritonitis 2 days after unsafe abortion of a 20 week pregnancy with uterine perforation with intrabdominal fetus with mesenteric and bowel injury that required bowel resection.

Key Words

Unsafe abortion, Uterine perforation, bowel injury

Introduction

The World Health Organisation defines unsafe abortion as a procedure for terminating an unwanted pregnancy that is performed by someone lacking the necessary skill or in an environment lacking minimal medical standards or both (1). As per the world health organization estimates for the year 2000, about 19 million unsafe abortions occurred worldwide, resulting in the deaths of about 70,000 women (2). Unsafe abortion is entirely preventable. Yet, it remains a significant cause of morbidity and mortality in much of the developing world. Among the causes of maternal mortality in developing countries, unsafe abortions account for 13% of maternal deaths (3), the risk of death is estimated at 1 in 270 unsafe abortion procedures (4).

Case Report

An 30 year old gravida I para 0 female presented 2 days after an unsafe abortion of a 20 week pregnancy by a Dai at a far flung area of our state. She was brought to the gynae/obstetrics department with complaints of pain abdomen, bleeding per vaginum, fever, distension of the abdomen and vomitings, from where she was referred to us for management of peritonitis. On Examination She was pale, dehydrated, Pulse=106/mt RR=24/mt B.P. = 100/60 mmHg. Temperature = 100oF. Examination of abdomen revealed distension of the abdomen rebound tenderness whole abdomen, rigidity & absent bowel sounds. On P/V Examination uterus was bulky and tender. It contained foul smelling products. Bleeding was present. Investigations HB 7.2 gm %, TLC 11,000/cu mm, DLC P80 L15M5, Blood gp B+ve, Na+139 meq/dl, K+3.8 meq/dl, Blood Urea 21 mg/dl, S. Creatinine 1.0 mg/dl, S. Bilirubin 0.6 mg/dl, X Ray Chest Normal study. USG Abdomen showed enlarged uterus with retained products of conception and large interloop fluid. She was admitted,

assessed clinically and investigated. Diagnosis of septic abortion with peritonitis with septicemia was made. She was resuscitated with intravenous fluids, blood and broad spectrum antibiotics covering both aerobic and anaerobic microorganism were started. She was allowed nothing by mouth and a nasogastric tube was placed Exploratory laparotomy was done once she was clinically stable and fit to withstand surgery. The peritoneal cavity contained about 2 litres of feculent fluid. Uterus was bulky and edematous and showed a big vertical perforation in its posterior wall (*Fig-1*), through which the fetus had come out into the peritoneal cavity. The fetus was lying in the left paracolic gutter with left leg near the lower pole of the spleen. The right leg below the knee, both arms, head and neck were missing (*Fig-2 & Fig-3*). Both right knee & the remaining upper torso of the fetus showed signs of traumatic separation. The uterine cavity contained large amounts of clots. The anterior wall of the upper 1/3rd of the rectum was missing. Anterior half of the walls of the rectosigmoid, sigmoid & descending colon were missing, the transverse colon showed complete transection in the middle (*Fig-4*). Both the hepatic & splenic flexures showed gangrenous changes. The ascending colon had a large perforation in the middle part involving more than 2/3rds of the lumen. The mesentery of the transverse and sigmoid colon showed multiple wedged shaped defects. The fetus was removed. Thorough peritoneal lavage and mopping was done. The uterus was completely evacuated. The posterior uterine wall was closed in two layers with vicryl one number. Total colectomy with terminal ileostomy was done. The upper end of middle one third of rectum was identified, closed with 20 prolene, the suture was kept long and was fixed to the lateral wall for identification of the rectal stump during future surgery.

From the PG Department of Surgery and *Anesthesia, Govt Medical College, Jammu J&K -India

Correspondence to : Dr Kailash Singh, Registrar, Department of G. Surgery, Jammu, J&K-India



Drains were kept in the pelvis and morrison's pouch and mass closure of the abdomen was done with one number prolene. Skin was kept open and was closed on the 5th post operative day. The patient was discharged after suture removal on 19th post operative day (Fig 5). She has been coming for regular follow ups and is doing fine. We plan to do a ileorectal anastomosis in the future.

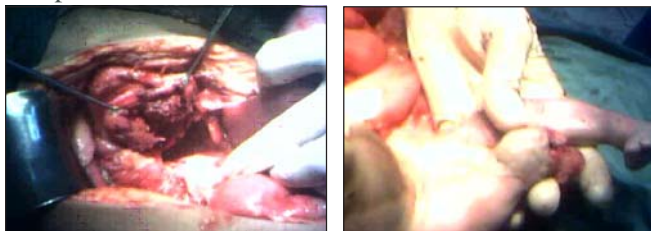


Fig 1 & 2. Showing Perforation in the Posterior Uterine Wall and Missing Right Leg with Signs of Traumatic Separation

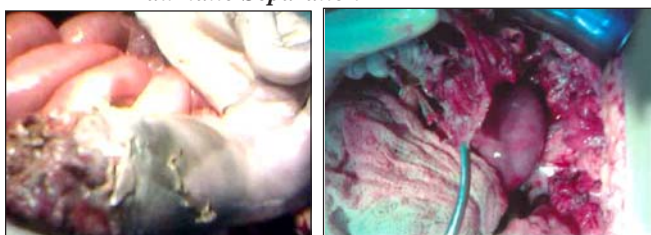


Fig 3 & 4. Showing Missing Both Arm, Head & Neck with Signs of Traumatic Separation & Complete Transaction of The Transverse Colon and Missing Anterior Wall of The Left Colon



Fig 5. Showing Ileostomy and Skin Incision Kept Open

Discussion

The WHO estimates that nineteen out of every twenty unsafe abortions take place in the less developed region of the world(5). In addition, of every five women who had unsafe abortion, at least one suffers a reproductive tract infection as a result (6). In India, although abortion was legalized in 1972 (7), an estimated 4.7 million abortions are performed annually outside the approved facilities. Women resort to unsafe abortion for the following reasons:1)Legal and administrative constraints. Only 22% of countries have abortion laws which allow abortion on request. 2) Low government priority. Abortion services are not accessible nor affordable to women who have low socio-economic status.3) Attitude of service provides. Some providers tend to appear unsympathetic to women with unwanted pregnancies

because of legal, ethical, religious or their own personal views.4)The general policy of health facilities depends upon the legal status of abortion or the officials of the health facilities. 5)Non-use of contraceptives. The incidence of unsafe abortion is a reflection of the degree of unmet need in family planning.The factors that determine the risk that a woman undergoing an abortion will experience medical complications or die from the procedure are i) The abortion method usedii) The provider's skill iii) The length of gestation iv) The accessibility & quality of medical facilities to treat complications if they occur.Second trimester abortions have greater risk of serious complications including perforation (8). Uterine perforation may lead to intestinal trauma necessitating bowel resection, uncontrolled hemorrhage leading to hysterectomy, infection and even death. Injury to bowel or other pelvic structures may occur by direct trauma from the instrument used for conducting abortion, or the bowel may be indirectly injured from vascular mesenteric interruption. In this case, there was likely both direct bowel and mesenteric injury resulting from perforating instruments as well as sharp fetal structures. Most of the perforations may go unnoticed initially and the patient later on presents with number of complaints including severe abdominal pain, abdominal distention, fever and chills, vomiting or diarrhea. When a patient presents with any of these symptoms, a high index of suspicion may be maintained for uterine perforation and its sequelae.Although sonography is a helpful adjunct in detecting retained products of conception, it is important to note that the diagnosis of perforation & bowel injury is based primarily on clinical suspicion. In this case clinical presentation and sonography was helpful in making the diagnosis, surgical exploration provided the definitive diagnosis.The timely recognition & appropriate management can reduce morbidity & mortality.

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