A CASE OF UTERINE AND RECTAL PERFORATION IN SEPTIC ABORTION CAUSED BY UNTRAINED PERSONNEL AT PERIPHERAL CENTER

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ABSTRACT

Intestinal perforation is a rare complication of surgical abortion. It occurs where abortions are performed by some untrained personnel lacking necessary skills and the knowledge of anatomy. Intestinal perforation occurs when the posterior vaginal wall or uterus is violated. The ileum and sigmoid colon are the most commonly involved structures due to the relative fixity. Here we report a case where a surgical abortion performed by an untrained person led to uterine and rectal perforation.

Key words: Abortion, perforation, rectum

INTRODUCTION

Unsafe abortion is defined as the terminating an unintended pregnancy either by individuals without the necessary skills or in an environment that does not conform to minimum medical standards, or both. There is an annual rate of around 50 million abortions worldwide, one-third of which are unsafe. Incidence of uterine perforation varies from 0.4 to 15 per 1000 abortions as reported by different studies. Most of uterine perforations at the time of curettage during first trimester abortion go unrecognized and untreated but serious complications do occur. An illegal abortion by unqualified inexperienced hands without or with minimal medical knowledge in rural society of developing countries is very common. Complications can endanger the life of mother if proper medical or surgical intervention is not offered in time.

CASE REPORT

30 years multigravida (P2+1L2) presented to us with per vaginal bleeding and multiple episodes of vomiting (20 to 25 episodes) for 1 day. She had a history of intake of mifepristone 200 mg followed by 4 tablets of misoprostol 10 days back at overdue of 4
Figure 1. Perforation in posterior uterine wall.
Figure 2. Repair of posterior uterine wall perforation.
Figure 3. Anterior rectal wall perforation.
Figure 4. Colostomy bag after completion of surgery.
month. This was followed by dilation and curettage 2 days back for retained products of conception at some peripheral Centre by untrained personnel. Patient was not passing flatus and stool for last 2 days. Her last menstrual period was 4 months back. Previous cycles were regular with average flow. She had history of previous one normal delivery and one cesarean.

On general examination patient was conscious but drowsy with pallor. Her pulse was feeble (140/min), BP not recordable. On abdominal examination: guarding was present, bowel sound absent. Per speculum examination: cervix was normal. No active bleeding was present. Per-vaginal examination: Uterus was bulky around 10 week size.

Initial resuscitation was done with crystalloids and blood transfusion. Patient’s vitals became stable. Ultrasound was done which showed posterior wall uterine perforation with retained products of conception in lower endometrial cavity. Urgent exploratory laparotomy was done and per-operative findings showed a rent 4cm size in the posterior wall of uterus (Figure1). 20 cm longitudinal rectal laceration was present (Figure 2). Other bowel loops and adnexa were normal. Primary repair of uterine and rectal perforation was done (Figure3). Sigmoid loop colostomy was done (Figure 4). Saline lavage was done. Intra- abdominal drain was put in situ. Abdomen closed in layers.

Patient was stable in post op period. She was kept nil orally for 5 days along with Ryle’s tube aspiration of gastric contents. Total parenteral nutrition was given. 4 units of albumin transfusion were done. Broad spectrum antibiotics, analgesics and proton pump inhibitors were given. Chest physiotherapy was advised. Stitches were removed on post op day 16.

DISCUSSION

Annually around 50 million women undergo abortions, out of which about 19 to 20 million of them are unsafe abortions\(^3\). Approximately, 68,000 women die annually, because of abortion and a high proportion of these deaths are due to illegal and unsafe abortion\(^3\).

According to WHO, every 8 minutes, a woman from a developing nation is dying due to complications arising from unsafe abortion, making it one of the important yet preventable causes of maternal mortality (13%)\(^3\).

Bowel perforation is a rare and serious complication of induced abortion, which is often performed illegally by untrained persons in developing countries. The incidence of bowel injury has varied between 5 to 18\% cases in different studies\(^4\).

The complications of induced abortion include abnormal vaginal discharge, genital sepsis, and hemorrhage, pelvic infection with peritonitis and abscess formation, uterine and bowel perforations.

Foreign bodies inserted into the uterus to discontinue the pregnancy can damage the uterus and internal organs, including bowel even urinary bladder. The bowel may be injured with the curette, ovum forceps or uterine sound, or even the plastic cannula, Knitting needles, a flexible rubber catheter, or straight wooden stick\(^5-7\).

The early complications of abortion include uterine perforation, blood loss, retained products of conception, endometritis, pelvic infection, and peritonitis.
Unsafe abortion has also been associated with long term sequel including abnormal vaginal discharge, vesico-vaginal fistula, recto-vaginal fistula, bowel resection, chronic pelvic inflammatory disease (PID) and infertility. Although most perforations occur at the time of curettage during first trimester abortion, they go unrecognized and untreated leading to serious complications. The risk of perforation increases significantly with advancing gestational age. The commonest site of myometrial perforation in uterine surgeries is the relative avascular anterior or posterior midline surfaces. Perforations are more likely to be troublesome if the rent is located laterally, the defect is more than 1.2 cm, they occur after first trimester, or there is associated bowel injury. In most of the abortion related cases, perforation is recognized by the operator during the procedure. However in many cases perforation may remain clinically undiagnosed and the patient is discharged. Some of these patients present subsequently with serious complications. The usual presenting complaint is abdominal pain and not excessive bleeding per vaginum. If there is associated bowel perforation then the presenting symptoms may be non-passage of flatus or stool, abdominal distension, pain abdomen, fever and vomiting. Surgery is the treatment of choice in such patients. However, late presentation and diagnosis, lack of diagnostic facilities, inadequate preoperative resuscitation and delayed operation are common in developing countries. Early recognition, aggressive resuscitation and prompt surgery of intestinal perforation are the key to successful management of such patients. The surgical management of small intestinal injuries is fairly straightforward with minimal squeal. The management of large bowel injury is more controversial especially when the left colon is involved. A simple colostomy has been reported to be the safest approach in the management of these injuries. Other options are primary repair, resection and primary anastomosis, and repair with a proximal protective colostomy. A simple colostomy is easier and faster in these poor surgical risk patients. However, the major drawback of colostomy is the need for a second operation to restore intestinal continuity, the specialized care before closure and cost which reduces its popularity.

CONCLUSION

Unsafe abortion is a social and public health problem with significant morbidity and mortality. Early diagnosis and appropriate intervention might provide better outcome. Therefore early referral and safe abortion services by skilled personnel in peripheral centers are necessary to limit mortality and morbidity of unsafe abortion. It is the combined responsibility of the government and health care providers to provide access to safe abortion services and to create social awareness regarding safe and legal abortion methods.

CONSENT

Written informed consent was obtained from the patient for publication of this case report.
COMPETING INTERESTS

The authors declare for no competing interest.

REFERENCES


APPENDIX

Untrained person means a person who does not have any medical degree and not trained under gynecologist sometime an illiterate lady in village. They are legally not allowed to do MTP. In India for unmarried girl pregnancy is a stigma. They do not want to disclose to parents and they goes to unauthorized person for abortion but land up in too many complications.

Peripheral center means a village where medical facilities are not there and doctor is not available.