
Management Of Post Abortion Complication

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Abstract

A 20 year-old, Para 1,unmarried woman admitted with features of peritonitis after induced abortion, was managed by laparotomy, where repair of perforated uterus and bowel was performed and the patient was covered with broad spectrum antibiotics. The management of abortion complication is discussed.

CASE REPORT

A 20 year-old, Para 1,unmarried woman gave a history of abdominal pain of 5 days duration, involving the lower abdomen and later becoming generalized. This was associated with gradual swelling of the abdomen, more below the umbilicus.

She noted a change in her bowel habits: She was not able to pass faeces and flatus for the past 2 days prior to admission, and this was associated with non-projectile vomiting.

She gave a history of having a dilatation and evacuation due to an abortion of a 4 month pregnancy, a week prior to admission, at a peripheral dispensary. She was prescribed an unknown medication afterwards, presumed to be antibiotics. She denied history of vaginal bleeding, vaginal discharge, or fever.

On physical examination, she was in pain, slightly pale, afebrile (temperature 37.1 °C), and not jaundiced with no oral thrush and no palpable lymph nodes. Vital signs were as follows: blood pressure 80/50 mmHg, pulse rate 138 beats/minutes, and respiratory rate 18 breaths/minute.

She was found to have distended abdomen, the distension was more below the umbilicus. Movement with respiration was not observed and there was generalized tenderness with muscle guarding. Bowel sounds were reduced.

On pelvic examination, vulva was stained with whitish discharge; normal vaginal wall was felt; cervix was closed and healthy, no discharge from external cervical os, cervical excitation was positive; there were bilateral adnexal tenderness, and uterus could not be appreciated due to tenderness/guarding.

Investigations ordered were, hemoglobin 9.1g/dl, plain abdominal x-ray which revealed air-fluid levels, pelvic scan which showed features suggestive of pelvic abscess and a normal uterus. Diagnosis of peritonitis following induced abortion was made.

Patient was counseled and agreed to an emergency laparotomy, she was kept on nil per oral, and nasal gastric tube was inserted. Resuscitative measures were started with intravenous fluid and parenteral antibiotics were initiated.

Emergency laparotomy was performed under general anaesthesia, through extended midline incision. Findings were as follows: Fluid mixture of fecal matter and pus equivalent to three litres in the peritoneum. There was a uterus with a small fundal perforation. However, it appeared normal in texture and colour. Both ovaries and tubes were normal and the bladder was not involved. The ileum was injured 90cm from the ilio-cecal junction. It had two small perforations, 1cm and 0.5cm in diameters, which were surrounded by inflammatory areas, but the tissue was viable. The rest of the bowel was not involved, though it did not seem to have peristaltic movement. The liver, spleen and appendix appeared normal.

Procedure: The edges of holes on bowel were refreshed; purse string and Lambert's sutures were used to repair the 2 perforations on the ileum. The uterine perforation was repaired with catgut suture following by extensive peritoneal lavage. A rubber drain was left in-situ. The abdomen was repaired in layers. Patient tolerated the procedure well.

Post-operative diagnosis was bowel injury and uterine perforation with fecal peritonitis. Patient was put on nil per oral for three days and antibiotics were continued for seven

days, her post-operative was complicated with wound dehiscence on tenth day, she was managed with tension sutures in theatre. There were no complication following re-laparotomy and tension sutures were removed after two weeks. Patient was lost to follow up after discharge.

DISCUSSION

The diagnosis of septic abortion in this patient was suggested by history of severe abdominal pain, fever, vomiting following presumed evacuation of a 4 months pregnancy at a periphery clinic in a young unmarried woman. This impression was further supported by finding of an ill looking patient who was in severe pain, with rather toxic with a rapid pulse of 138/min and a lowered blood pressure of 80/50mmHg . Her abdomen showed distension with tenderness and guarding with positive release tenderness suggesting peritonitis.

Even without an abdominal /pelvic scan (which suggested presence of a pelvic abscess) the diagnosis was sufficiently adequate to justify an exploratory laparotomy.

During laparotomy longitudinal incision was favored rather than pfannenstiel incision; the former allow wide exploration of the abdomen, and accessibility to upper abdomen organs [1].

Two small perforations were found on ileum, repaired by Connell and Lambert's sutures instead of resection and anastomosis. Two perforations were very small in diameter though with some features of inflammation. Refreshing of the wound and suturing sufficed. Uterus was not removed from this woman as there was just evidence of perforation

seen without any sign of inflammation or infection. Because of the variety of bacterial agents that can be associated with septic abortion, not one antibiotic agent is ideal [2, 3]. So patient was covered with triple therapy, aiming at covering different species of microbes.

The risk of death from post abortion sepsis is highest for young women, those who are unmarried, and those who undergo procedures that do not directly evacuate the contents of the uterus [2]. With more advanced gestation, there is a higher risk of uterine perforation and retained tissue. A delay in treatment allows the infection to progress to bacteremia, pelvic abscess, septic pelvic thrombophlebitis, disseminated intravascular coagulopathy, septic shock, renal failure, and death [2].

Morbidity and mortality from septic abortion are infrequent in countries where induced abortion is legal but are widespread in the many developing countries where it is either illegal or inaccessible [2]. Abortion remains a primary cause of maternal death in Third World countries. The World Health Organization estimates that 25 to 50 percent of the 500,000 maternal deaths that occur every year result from illegal abortion [2].

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