PERFORATION OF UTERUS FOLLOWING A INDUCED ABORTION

SWAPNA
Department of Obstetrics and Gynaecology,
MADRAS MEDICAL COLLEGE AND GOVERNMENT GENERAL HOSPITAL

Abstract:
Septic induced abortion is a major public health problem. An infected abortion complicated by fever, endometritis, parametritis and rupture uterus remains one of the most serious threats to women's health worldwide. Mortality and morbidity from septic abortion are infrequent in countries in which induced abortion is legal. Septic abortion is a paradigm of preventive medicine relating all levels of prevention, primary, secondary and tertiary. A 25 years old patient 2ndgravid was admitted in a septic ward in our institute with complaints of oliguria, abdominal pain, vomiting following a dilatation and curettage that had history of two months amenorrhoea and ultrasound finding of incomplete abortion. Patient was initially treated with antibiotics later suspected as rupture uterus and referred to our institute for further management.

Keyword: perforation of uterus, septic abortion, induced abortion.

Introduction:
The most important public health effect of legalisation of abortion is near elimination of death from illegal abortion. Illegal abortion deaths are disproportionately high due to infection. 62% of illegal abortion deaths, 51% of spontaneous abortion deaths were from infection, whereas only 21% of legal abortion deaths were from infection. With more advanced gestation the risk of perforation and retained tissue increases. Delay in treatment allows progress to bacteraemia, pelvic abscess, septic pelvic thrombophlebitis, disseminated intra vascular coagulation, rupture uterus, septic shock, renal failure and death. The WHO estimates 68,000 deaths from unsafe abortion every year constituting 13% of maternal deaths.

Case Report:
25 years old lady P1L1A1 married for past 4 years, with last child birth 3 years back admitted in our institute with complaints of abdominal pain, vomiting, oliguria history for a period of 5 days. History of spotting per vaginum on and off for 15 days, no history of diarrhoea or any foul smelling vaginal discharge. Her previous obstetric history was a full term.
vaginal delivery. Post natal period was uneventful. Patient followed barrier contraceptive for 3 years. Patient again conceived spontaneously with history of 60 days amenorrhoea. Patient confirmed pregnancy by urine pregnancy test. Patient had spotting per vaginum since then on and off for one week. Patient consulted a private practitioner who advised ultrasound. The ultrasound finding was a missed abortion for which she was advised dilation and curettage. Patient underwent the procedure on the same day which was uneventful and was discharged the next day. Three days later patient developed oliguria, vomiting and pain abdomen. She consulted the same doctor and was advised antibiotics and analgesics for two days. But since patient continued to have symptoms she was again advised ultrasound. Since in ultrasound they suspected a rupture uterus, patient was referred to our institute for further management. Patient was admitted in septic ward. Vitals monitored, blood investigations were taken. Her WBC count was 13,800, haemoglobin was 8gms, blood sugar was 110 mg/dl, bleeding time was 2mins 30secs, clotting time was 6mins 40sec, platelet count 1,00,000. Her pulse rate was 110 beats per min, BP was 90/60mmHg, and respiratory rate was 22/min, temperature 99°F. Ultrasound was done for both abdomen and pelvis (findings – non homogenous mass lesion close to right side of fundus of uterus of 5x5cm, both ovaries normal, pouch of Douglas – minimal fluid collection was present, impression –? perforation on the right side of fundus of uterus with mass of 5x5cm near the fundus of uterus). Patient was immediately started on Intravenous fluids, IV antibiotics; blood was made available and planned for laparotomy. INTROP FINDINGS – matted bowel loops seen, minimal free fluid in peritoneal cavity seen. Complex organised mass of 6x7cm in right adnexa adherent to pouch of Douglas and lateral pelvic wall was seen. Both ovaries was congested.In Uterus 3cm rupture seen in the posterior aspect of fundus on the right side through which product of conception seen. There was a small serosal tear in the recto sigmoid colon noted. Laparotomy proceeded to total abdominal hysterectomy in view of septic abortion type II. The serosal tear was sutured. One unit of blood was given intra operatively. Postoperative period was uneventful. Patient was discharged on 10th postoperative day.

**Discussions:**

Unwanted pregnancy is a significant public health problem both in developed and developing countries. Morbidity and mortality in developed countries is much less due to adequate medical facilities and liberalization of laws of abortion but in our country due to legal restrictions after 20 weeks of gestation and religious beliefs women turn to nearby dais and lady health visitors for unsafe abortion and become prone to high risk of haemorrhage, infection, trauma to genital tract and intestines. Worldwide millions of women conceive unwanted pregnancy, outcome of which will be effected by the age of the patient, family size, socio-economic status and availability of abortion services. Influence of the rest of the family members especially of husband and in-laws is also strong.In our country government hospitals are the only source of safe medical care to the poor communities 3Components of safe surgical abortion services:Confirm diagnosis of pregnancy with urine pregnancy test provide non-judgmental counseling.Evaluate patient for active illness that might complicate
procedure or choice of anaesthetic, and evaluate for allergies. Perform physical examination. Perform pelvic examination with attention to uterine size and position, other pelvic pathology. Obtain ultrasound examination if length of gestation is uncertain, there is a discrepancy between length of amenorrhea and uterine size, there is a pelvic mass, or gestational age is beyond early midtrimester. Perform minimal laboratory testing: blood type and Rh. Provide prophylactic antibiotics. Encourage local anaesthesia: Paracervical block. Dilate cervix with tapered dilators or use hygroscopic dilators. Use vacuum cannula diameter appropriate for uterine size. Perform fresh examination of tissue to exclude incomplete or failed abortion, ectopic and molar pregnancy. Alternatively, provide medical abortion with mifepristone and misoprostol, or misoprostol alone if mifepristone is not available. Provide access to 24-hr follow-up services. Actively track high-risk patients.

Conclusion:
The tragedy of septic induced abortion is totally preventable. It only needs definitive commitment to women’s health. The need of the day is prevention, mainly by providing effective contraception and safe abortion. Prompt diagnosis of any septic complications and their effective treatment at tertiary hospitals would avoid serious consequence.

References:
1 septic abortion phillip G.stubblefield,and davida.grimes n engl j med 1994;331:310-314.
2 septic abortion prevention and management Phillip G. Stubblefield, MD, David A. Grimes, glob libr women’s,med (ISSN 1756-2228) 2008 DOI10.3843/GLOWM.10438
4 Das Vinita, Agarwal Anjoo, Mishra Amita, Deshpande Preetam Department of Obstetrics and Gynecology, King George’s Medical University, Lucknow. J Obstet Gynecol India Vol. 56, No. 3: May/June 2006 Pg 236-239