



A CASE OF SEPTIC ABORTION AND ITS PREVENTION AND MANAGEMENT

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ABSTRACT

Septic abortion, a serious complication arising from unsafe or incomplete abortion practices, can lead to systemic infections with life-threatening consequences. One of the most severe manifestations is peritonitis, an acute inflammation of the peritoneum resulting from the spread of infection from the uterus into the abdominal cavity. This condition often presents with abdominal pain, fever, tenderness, and signs of systemic toxicity. Delayed diagnosis and treatment can lead to septic shock, multi-organ failure, and death. Early recognition, broad-spectrum antibiotic therapy, prompt surgical intervention when necessary, and supportive care are essential to improve patient outcomes. This review explores the pathophysiology, clinical presentation, diagnostic approaches, and management strategies of peritonitis in the context of septic abortion, highlighting the need for improved reproductive health services and access to safe abortion care to prevent such complications. Here we report a case of a 31 year old female, P3L3A1 with previous vaginal delivery day 15 of spontaneous abortion followed by check curettage with foul smelling vaginal discharge with USG suggestive of ill defined hypoechoic collection of 150-200 cc in right adnexa and air foci are seen within and collection is seen extending into the pouch of Douglas and its management.

KEYWORDS : Septic abortion, Peritonitis, Safe Abortion, Reproductive Health Services

INTRODUCTION

Uterine perforation is a medical condition in which there is a full-thickness injury to the wall of the uterus, often creating a hole. It is a potential complication of gynecological procedure. Uterine perforation and lower-genital-tract laceration are uncommon but potentially serious, and rates also rise with gestational age. Risk factors include operator inexperience, prior cervical surgery or anomaly, adolescence, multiparity, and advanced gestational age. Most common causes are dilation and curettage (D&C), intrauterine device (IUD) insertion or removal, hysteroscopy, surgical abortions, manual vacuum aspiration. Perforation is usually recognized when the instrument passes without resistance deep into the pelvis. If the uterine perforation is small and fundal, as when produced by a uterine sound or narrow dilator, observation for vital sign changes or uterine bleeding is usually sufficient. If a suction cannula or sharp curette passes into the peritoneal cavity, considerable intra abdominal damage can ensue. With spontaneous or induced abortion, organisms may invade myometrial tissues and extend to cause parametritis, peritonitis, and septicemia. This may complicate both medical and surgical methods. Classic clinical findings include fever, lower abdominal pain, uterine tenderness, and foul vaginal discharge. Vaginal bleeding and sonographic evidence of retained uterine tissue are other findings.

Case :-

A 31 year old female, married since 14 years, P3L3A1 with previous all vaginal delivery, came with complain of pain in abdomen with intermittent fever since 10 to 15 days. Patient has history of spontaneous abortion 15 days back following which check curettage was done.

On examination, abdominal guarding present.

On per speculum examination, bulky cervix seen with foul smelling discharge from cervix.

On admission, her haemoglobin was 11.6g/dl, total counts 14000 /cu mm and platelets 414000 /cu mm. All other investigations were within normal limits.

Ultrasonography was suggestive of an ill defined hypoechoic collection measuring approximately 150- 200 cc in volume is

seen in the right adnexa. Multiple hyperechoic areas and air foci are seen within. The collection is seen extending into the POD.

Contrast enhanced computed tomography (CECT) report was suggestive of a large thick walled pelvic collection measuring 4.8*5.7*12 cm is seen extending from fundus of uterus in POD. Anteriorly and Left Laterally -it is seen abutting small bowel loops anteriorly with loss of fat planes? adherent. Right laterally - it is seen abutting right adnexa and caecum with loss of fat planes likely adherent to adnexa. Posteriorly - not reaching rectum. Superiorly - it is seen reaching L4 vertebra. It is seen abutting small bowel loops with loss of fat planes? adherent. Inferiorly - extending into pouch of douglas. Significant pelvic fat stranding seen. Uterus shows heterogeneous post contrast enhancement with vascular content within endometrium

- suggestive of retained products of conception. A rent of approximate width 8 mm is seen in fundus of uterus. Uterine endometrium and pelvic collection are seen communicating through this defect. Left adnexa appears unremarkable.

Decision to take patient for exploratory laparotomy was taken

Intraoperative Findings: Matted omentum and bowel loops present. Uterus bulky with right adnexa adhered densely to omentum and abdominal wall. Uterine fundal rent seen. Fundus and posterior surface of uterus densely adhered with bowel with pus pockets present approximately 150 cc foul smelling purulent discharge present.

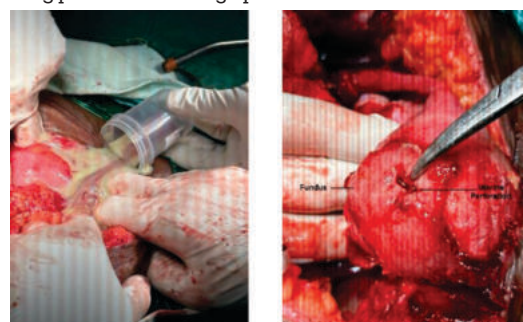


Fig no. 1- Purulent discharge from bowel**Fig no. 2-** Uterine fundal rent

Pus sent for culture sensitivity. Normal saline wash given, uterine rent, bowel adhesions and lacerations seen. Total abdominal hysterectomy with bilateral salpingectomy done.

**Fig no. 3-** Uterine fundal perforation

General surgeon took over case and performed resection and anastomosis of about 30 cm jejunum in view of bowel lacerations secondary to adhesions.

**Fig no. 3-** Resection & Anastomosis of Jejunum

Pus culture report suggestive of *Escherichia coli*. Histopathology report suggestive of infected retained products of conception.

DISCUSSION

Septic abortions usually result from use of nonsterile techniques for uterine evacuation after induced or spontaneous abortion. Septic abortions are much more common after induced abortion done by untrained clinicians (or the pregnant woman herself) and without adequate surgical equipment and sterile preparation, usually because there are legal, health care access, or personal barriers to receive professional medical care. Septic abortion could also result from an incomplete abortion that was secondarily infected due to an open cervical os. Typical causative organisms include *Escherichia coli*, *Enterobacter aerogenes*, *Proteus vulgaris*, hemolytic streptococci, staphylococci, and some anaerobic organisms (eg, *Clostridium perfringens*). Septic-induced abortion is acknowledged as a significant septicemia due to uterine gangrene. This contributes to maternal mortality and morbidity. The most common complication of septic abortion are pelvic abscess, uterine perforation, toxic shock syndrome, disseminated intravascular coagulopathy and intestinal perforation. The patient presents with fever, abdominal pain, vaginal bleeding and foul smelling discharge. Patient can subsequently develop multi organ failure, hepatic failure, encephalopathy and disseminated intravascular coagulopathy. The principal of management is to control sepsis, remove source of antibiotics, to give supportive therapy and to assess the

response. Indication for ICU management are persistent hypotension, raised serum lactate, creatinine, pulmonary edema, impaired consciousness, renal dialysis and hypothermia. Active surgical intervention is needed in case of injury to uterus, bowel, presence of foreign body in abdomen, unresponsive peritonitis s/o collection of pus, septic shock/oliguria not responding to conservative treatment.

CONCLUSION

The unsafe abortion is one of the great neglected healthcare problem in India and more so in rural India where lack of education and adequate trained health care providers and freely available quality abortion services led to very high maternal morbidity and mortality. Strengthening of family planning practices in society, rigid enforcement of legalised abortion in practice, proper antiseptic and aseptic measures and the procedure be done by senior only.

Declaration

Conflict Of Interest - None Disclosure - None

Informed Consent - Informed consent taken from patient.

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