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Gynaecology

SEPTIC ABORTION: WHOM TO SAVE; MOTHER OR UTERUS?

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ABSTRACT Septic abortion is the result of an unsafe abortion defined as termination of pregnancy carried out by a person lacking necessary skills or in an environment lacking minimal medical standards or both. It is one of the important causes of maternal mortality. The incidence of septic abortions is 10%.We report here a case of septic abortion and the dilemmas in its management.
A 12 year old unmarried girl presented to surgery OPD with acute abdominal pain, fever and vomiting. X Ray showed gas under diaphragm. Exploratory laparotomy was done by surgeons with suspicion of intestinal perforation. Intraoperatively, when uterus was found to be gangrenous, gynaecologists were called. Decision was taken to conserve the uterus considering the age of the patient and non- availability of parents and proper history. Postoperative enquiry revealed history of clandestine abortion at 3 months amenorrhoea in the village. Initial post-operative period was uneventful except for occasional fever spikes. However, on Day 14 when suture removal was done, there was wound dehiscence. The patient was taken up for re-exploration on account of fever spikes with suspicion of burst abdomen. Intraoperatively, defect was found in fundus of uterus. Bony spicules were found in uterine cavity. Hence, decision of total abdominal hysterectomy was taken. The patient recovered well and went home on day 45. Dilemmas in diagnosis and options of management will be discussed.

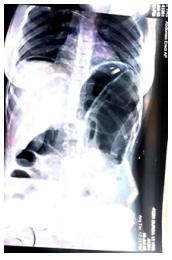
KEYWORDS : abortion, perforation, burst abdomen

Introduction

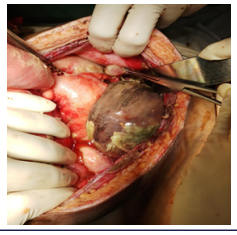
A septic abortion is a result of an unsafe abortion due to termination carried out by a person lacking necessary skills or in an environment lacking minimal medical standards or both. [1] Sepsis can occur following spontaneous or induced abortion. It is an important cause of maternal morbidity and mortality. Illegal abortions are frequently performed in India with disastrous consequences in spite of liberalisation of Medical Termination of Pregnancy Act. [2] The incidence of septic abortions overall is 10%. Of these, 90% of septic abortions are seen in developing countries including 13% of maternal deaths.[3] According to a study conducted by Indian Council of Medical Research in rural areas, the rate of illegal abortion was 13.5 per 1000 pregnancies in comparison to legal abortion 6.1 per 1000 pregnancies.[4] In the metropolitan city of Mumbai, it is unusual find such cases. One such case is discussed here.

Case Report

A 12 years unmarried girl was brought to the Surgery OPD by her grandmother with complaints of acute abdominal pain, fever and vomiting since 3 days. X-ray abdomen was done and it was suggestive of gas under diaphragm. [Fig 1]



Exploratory laparotomy was done by surgeons with suspicion of bowel perforation. However, intra-operatively uterus was found to be gangrenous and hence we (gynaecologists) were called.[Fig 2]



Intra-operatively, there was 750 cc haemorrhagic peritoneal fluid, which was sent for culture and sensitivity. Pus flakes were present on the bowel. The uterus was 14-16 weeks in size; gangrenous at fundus, soft and irregular.Both the fallopian tubes and ovaries were normal. On per vaginal examination in the operation theatre, there was foul smelling discharge and no foreign body was felt. After discussion with seniors and debate with surgeons, decision was taken to conserve the uterus as legal guardians (parents) were not available. Wash was given with 2 litres warm saline and drain was kept. Patient was given higher antibiotics and vaginal swab was sent for culture and sensitivity.After coming out of anaesthesia, the next day, on enquiry patient revealed that she had undergone abortion in a hospital at Bihar 3 months ago. However, papers were not available. Ultrasound on second post-operative day revealed grossly bulky uterus with multiple air foci. The vaginal swab showed Gram negative bacilli, which was sensitive to Amikacin. MRI was also done at the same time which revealed enlarged heterogeneous uterus with fluid intensity necrosis involving fundus and upper half of uterus, a defect in anterior wall with extensive fluid collection in lower abdomen and pelvis and absent enhancement in upper segment suggestive of necrosis. Lower part enlargement with non-enhancing foci with possibility of abscess. [Fig 3] The patient was kept in the ICU for 1 day for observation. She was shifted to ward on Day 2. She was kept nil by mouth for 24 hours. In the wards, antibiotics (Piptaz, Metro), analgesics and IV fluids were given to her. Her postoperative period was uneventful except for few occasional spikes.Drain output had reduced to less than 50 cc. Hence, it was removed on Day 7. Patient was reassessed on 9TH post-operative day. On per vaginal examination, cervix was downwards and forwards and os was closed. There was no bogginess in the fornices. Uterus was midposed but size could not be assessed.

The dilemmas in management were risk of sepsis, possible near-miss mortality, medico legal case, and consent and assent issues, conservative versus surgical management .Differences of opinion within the unit and between departments further added to the dilemmas. Surgeons from the beginning were insisting on hysterectomy. Parents and grandmother were counselled about conservative versus operative intervention. They opted for conservative management with trial of antibiotics and surgery SOS in case of any deterioration.

On Day 14, when alternate sutures were removed, a 3 cm wound gape+ with serosanginuous discharge was found. A wound swab was sent which showed Accinetobacter sensitive to Inj Amikacin and

Gentamycin. There was a suspicion of burst abdomen (1 cm gap in rectus sheath). Surgery opinion was taken and daily dressing was done. However, on account of repeated fever spikes and suspicion of burst abdomen; re-exploration was done on Day 16.

On re-exploration, intra-operatively, uterus was 12- 14 weeks in size and a necrotic bluish mass was found at level of fundus, fundus was open and cavity was deficient, bowel- bladder was adherent to abdominal wall. Adhesiolysis was done by sharp dissection and necrotic mass was removed. There were bony spicules in the uterine cavity. Hence, decision to remove infective focus (genital organs) was taken. Total Abdominal Hysterectomy with bilateral salpingectomy was done. Serosal tears in bowel were sutured and drains were kept in the pelvis and Morrison's pouch. The patient was shifted to SICU on ventilator for monitoring. She was weaned off the ventilator on the second day. The drains were removed on post-operative Day 7 and Day 12. Delayed alternate suture removal was done on Day 17. A 1 cm superficial wound gape was present which was managed conservatively. The remaining sutures were removed on Day 21.The patient recovered well and was discharged on Day 25.

Discussion

Septic abortion is an important cause of maternal morbidity and mortality. Despite legalisation, only 10% are registered or legal in India. Lack of education, social taboos and not reaching of services to masses is a major cause.[5] If diagnosis is delayed, devastating complications like haemorrhage, infection, sepsis, genital trauma and death can occur[6] Septic abortion occurs due to improper, unsafe or inadequate removal of products of conception. When products of conception become infected, bacteria infiltrate placenta and infection spreads to the uterus resulting in bacteraemia.[7] Diagnosis is based on history and physical examination which are crucial, routine blood investigations, Aerobic and anaerobic blood and cervical cultures, ultrasound to rule out retained products of conception

Management like other sepsis includes resuscitation with IV fluids and antibiotics which is the mainstay of treatment. Vasopressors and blood transfusions may be needed. Antibiotics should cover all potential aerobic and anaerobic pathogens. Prompt obstetric consultation for evacuation of infected products forms the most critical step. If no clinical improvement is seen despite antibiotics, IV fluids and curettage, hysterectomy is required

Conclusion

Gas under diaphragm is an unusual cause. Even in an unmarried female, history of sexual activity should be asked. Though legal abortion is available in India, issues of access and social taboos come in way of utilisation of proper services. Discretion is the better part of valour, caution is required in medico legal cases. Counselling, consent and choices should be offered to all. Saving life is more important than saving uterus even in young girl.

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