



Unsafe Abortion Presenting as Gut Prolapse: A Case Report

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ABSTRACT

An illegal abortion by unqualified inexperienced health personnel without or with minimal medical knowledge in rural society of developing countries is not uncommon. Complications can endanger the life of mother if proper medical or surgical intervention is not offered in time. Among all complications, bowel injury is the most dangerous. It leads to significant number of deaths. The ileum and sigmoid colon are the most commonly injured portions of bowel due to their anatomic location.

KEYWORDS

Unsafe Abortion, Bowel Injury, Gut Prolapse.

INTRODUCTION:-

Globally around 41.6 million abortions occur annually out of which 35 million occur in developing countries and 19 million (55%) of these are unsafe with a mortality of around 70,000 each year¹. Unsafe abortion is defined by the World Health Organization as a procedure for terminating a pregnancy performed by persons lacking the necessary skills or in an environment not in conformity with minimal medical standards, or both¹. Even legal abortions may be unsafe because of poorly trained clinicians, inadequate facilities, or both. In India, where abortion has been legal for more than 30 years, about three unsafe abortions take place for every two safe procedures killing woman every two hours. The main causes of death from unsafe abortion are hemorrhage, infection, sepsis, genital trauma, and necrotic bowel. The fifth United Nations Millennium Development Goal² recommends a 75% reduction in maternal mortality by 2015 and unsafe abortion is one of the easiest preventable causes of maternal mortality which is a staggering public health issue. We are presenting a rare case of gut prolapse secondary to unsafe abortion in Chhattisgarh, where rate of institutional abortions is only 32.0% according to census 2011.

CASE PRESENTATION:

A G4P3L3, 26 year woman was rushed in the emergency room at midnight in state of shock with history of termination of pregnancy about 6 hours back at her village PHC. Her chief complaint was pain in abdomen. She had LMP around 4 months back. On general examination patient had severe pallor, tachycardia (130 beats per min) and hypotension (80 / 60 mmHg). On palpation abdomen was tense, rigid, and bowel sounds were absent in all quadrants. On Per speculum examination two vaginal packs were removed and with that about 3 feet bowel prolapsed out (FIG 1). It was small gut, showing extensive injury along its entire length, with torn mesentery. The bowel was blackish brown in colour with features of ischemic injury. There was no active bleeding from the vagina. On per vaginal examination cervix was centrally placed, external os was open, gut was felt coming through the os and uterus was about 8 weeks size, well contracted with no active bleeding. Immediately diagnosis of uterine perforation with gut prolapse was made. Patient was resuscitated with intravenous fluids and blood and decision for exploratory laparotomy was taken and surgeon was also called. On opening the abdomen about 1000ml blood was seen in the peritoneal cavity, loop of bowel was seen herniating into the uterine fundus to the exterior (FIG 2). On further exploration about 3 feet of terminal ileum was seen transected nearly 8-10 cm from the ileocaecal junction

with torn mesenteric border (detached from mesentery). Ischemic changes were present in the bowel with active bleed was present at multiple sites over the torn mesenteric border. Rest of the bowel, mesentery, omentum & other viscera were normal. Ischemic bowel was resected upto the fresh margins between intestinal clamps. The gut about 3 feet dangling from the introitus was pulled out vaginally by the assistant. A horizontal rent in uterine fundus was clearly visible about 2 inches long. Uterus was empty with no retained products hence rent was repaired in two layers with vicryl no.1 and the proximal loop was emptied of its contents by slowly milking out the contents. End to end ileo-ileal anastomosis was done in two layers using Gambee's technique and mesenteric gap was approximated. After thorough peritoneal wash, drain was put and abdomen was closed in layers. Patient had excellent post op recovery and was discharged on eighth day. Her husband underwent vasectomy prior to the discharge of the patient.

DISCUSSION.

Incidence of uterine perforation varies from 0.4 to 15 per 1000 abortions as reported by different studies with most uterine perforations at the time of curettage going unrecognized and untreated. Inexperienced physicians have been reported to perforate the uterus more frequently than experienced physicians. An illegal abortion by unqualified inexperienced hands without or with minimal medical knowledge in rural society of developing countries is not uncommon. Complications can endanger the life of mother if proper medical or surgical intervention is not offered in time.^[3] In a study in India, they show that among all complications, bowel injury is the most dangerous. It leads to significant number of deaths, which mostly occurred among women undergoing abortion where criminal methods were used and where no proper medication and follow-up was there. The ileum and sigmoid colon are the most commonly injured portions of bowel due to their anatomic location. However colonic injuries are predominantly encountered in first trimester¹.

In our case nearly 3 feet of ileum was sheared off along with the mesentery and pulled out through the uterine rent up to the exterior which is very rare. Most of the silent perforations may go unnoticed initially and the patient later on presents with number of complaints including severe abdominal pain, abdominal distension, fever and chills, vomiting or diarrhoea. When a patient presents with any of these symptoms, a high index of suspicion may be maintained for uterine perforation. In our case woman did go to the service provider at PHC level but lack of training and appropriate knowledge but high

level of confidence prompted the nurse to do dilatation and curettage in second trimester pregnancy at nearly 16 week gestation without referring the patient to higher centre where trained gynaecologists would have delt it with better medical options available nowadays if there was any indication to terminate the pregnancy.

Providing safe abortion is a big challenge in a situation where almost 70-80% of abortion providers are in private sector with an overwhelming number of them unregistered and untrained. Still it is our duty to find out where the lacunae are so that a woman could have access to safe and hygienic abortion facilities if she desires to terminate her pregnancy.

Existing literature says second trimester abortions constitute 10-15% of all induced abortions worldwide but are responsible for two-thirds of major abortion-related complications. During the last decade, medical methods for second trimester induced abortion have been considerably improved and become safe and more accessible. Second-trimester abortion remains a necessary procedure despite higher risks and costs compared to first-trimester procedures due to advances in antenatal diagnosis; decreased access to timely, early abortion care; and medical complications of pregnancy in the second trimester³

Conclusion

The position of uterus, gestational age, physician skill and method adopted for termination are the important determinants in causing uterine perforation. A much greater likelihood of it is seen in retroverted uterus. The skill of the physician accounts for reduction in the incidence of uterine perforation. Lack of education, social stigma, female foeticide and other barriers to abortion, force women to seek abortion in secrecy at a high cost, leaving the poorest, least educated women to unskilled and highly unscrupulous executors and hence the greatest risk of injury⁴. Abortion when legal should be safe. The most effective way to reduce the morbidity and mortality would be to prevent unwanted pregnancies by informed and effective use of contraception. Also the society should be educated to accept the female child. Easy accessibility of abortion services, curb on unauthorized medical practice can reduce the complication rate. ⁵ The present case of prolapsed omentum appearing as mass per vagina is reported for its rarity and need for education regarding safe abortion, as it is one of the important public health problems.

FIG 1 Showing the Intestine coming out per vaginally



FIG 2 Uterine rent and the distorted anatomy around the rent.

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