A Case of Septic Abortion with Severe Maternal Morbidity

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Abstract

In spite of legalisation of MTP in India (1971 MTP Act) incidence of septic abortion is still high leading to severe maternal morbidity as well as mortality. A 28 year G3 P2L2 with divergent H/O surgical abortion was referred for Per vaginal bleeding & something coming out of vagina since 2 days. Examination revealed coils of intestine protruding through cervix. She underwent obstetric hysterectomy with resection anastomosis & colostomy. She was discharged after 35 days of surgery.

Introduction

Any abortion which is associated with clinical evidences of the infection of the uterus and its contents is called as septic abortion. It is characterised by either rise of the temperature of at least 100.4° F (38° c) for 24 Hrs or more, offensive or purulent vaginal discharge and other evidences of the pelvic infections such as lower abdominal pain and tenderness. Although abortion has been legalised in India for more than three decades, unsafe abortion continues to be a major contributor to maternal mortality and morbidity in the country, accounting for 15-20% of maternal deaths.[1] It is difficult to work out the incidence of the septic abortion. Overall 10% of the abortions that are requiring hospital admissions are septic abortions. While in majority of cases infection occurs following the illegal induced abortions but infection can occur even after the spontaneous abortion as well. The common cause is attempting abortion by untrained personnel, dais and quacks. Poverty, nonavailability of legal abortion services and uncontrolled unchecked growth of quacks, both in urban and rural areas contribute to the high incidence of illegal and septic abortions.[2,4]

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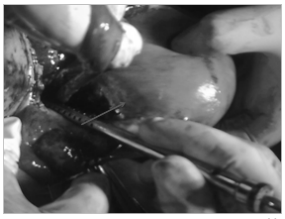
Case Report

Mrs. ABC, 28 year female, married since 8 yrs residing in Mumbai referred from the private hospital in view of bleeding per vaginum with history of something coming out per vaginum since 2 days. There was history of associated colicky pain in abdomen with fever on and off. Patient gave divulging history of surgical termination of pregnancy 4 months ago. Her L.M.P. was on 10/12/2012 (?2 months amenorrhoea). Previous menstrual cycles were regular. She had two full term normal deliveries, female children of 6 and 5 years alive and well. Urine pregnancy test was positive. On Examination general condition was fair, patient was conscious, oriented afebrile with moderate pallor, Pulse-96/min, BP-100/70 mmHg. Respiratory and Cardiovascular examination was normal. Per abdomen there was tenderness and guarding without rigidity, however bowel sounds were absent. Per speculum examination revealed foul smelling discharge and blood stained gauze piece in vagina. After removal of gauze some tissue was seen coming out through the vagina, about 15 cm long with fat tags attached to it, ? coils of intestine, ?omentum (Fig.1). There was no

PER/SPECULUM EXAMINATION

INTESTINAL MUCOSA MODE A WAY THROUGH THE PERFORATES UTERUS INTO THE VAGINA

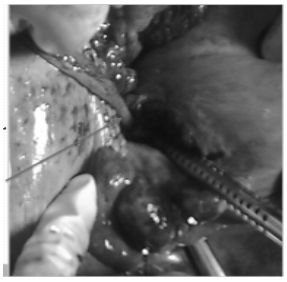
active P/V Bleeding. On per vaginal examination uterus was 12-14 wks size, deviated to left side firm in consistency and restricted mobility. Per rectal examination confirmed size of uterus and Rectum was empty and ballooned out. Provisional diagnosis was of septic abortion with uterine perforation. USG findings were as following - bulky uterus, 2.8 cm long discontinuity in the anterior wall on the right side suggestive of uterine perforation with herniation of the bowel loops through it. Bowel loops were of normal diameter with sluggish peristalsis. There was mild ascites and borderline hepatomegaly. All emergency investigations were sent, surgeon standby was taken and Pt. was explored immediately with simultaneous blood transfusion. In Situ findings - 1000 cc haemoperitoneum, products of conception found in the peritoneal cavity, size of uterus was 14 weeks. There was a rent of 6 x 2.5 cm on the posterior wall of uterus near fundus (Fig.2). Another horizontal



rent measuring 4 x 2 cm on anterior wall at the level of isthmus was found (Fig 3). Bowel mucosa was

INTRA-OPERATIVE FINDINGS

POSTERIOR WALL OF THE UTERUS SHOWING THE RENT WITH THE HERNIATION OF THE INTESTINES THROUGH IT.



avulsed and pouting with mucosa herniating through the rent on posterior wall (Fig.4). Anterior wall of the

INTRA-OPERATIVE FINDINGS

ANREIOR WALL OF THE UTERUS SHOWING THE RENT

distal end of sigmoid colon was perforated and splayed open. Descending colon upto the splenic flexure was devitalised and gangrenous. Bilateral fallopian tubes and ovaries were normal. Total obstetric hysterectomy was performed. Devitalised descending colon from the distal 2/3rd upto the lower end of the sigmoid colon resection done by the surgeons. Hartmans pouch created at the lower end of the sigmoid colon. Transverse colon end colostomy done in the left hypochondriac region. Post operative course was uneventful. Pt was treated with higher antibiotics. Total parenteral nutrition given and patient discharged after 35 days of surgery.

Discussion

Even after extensive efforts of health education, promotion and provision of various contraceptive methods as well as emergency contraceptives septic abortion still remains a significant contributory factor for maternal mortality and morbidity. Our pt. was 28 year young and many studies show high incidence in the age group of 26 - 30 years. Himalayan Institute of medical sciences has reported 37.5% cases of septic abortion at 26-30 years, a 2004 study of septic abortion done at LTMGH, Sion hospital reported mean age of 25.4 among 27 cases of septic abortion, Dr. Bhattacharya S. and Mukharjee also reported 70% cases in early thirties out of 132 septic abortion

cases.[1,2,3] Unwanted pregnancy was the reason for undergoing MTP in our pt. Himalayan Institute reported the same reason for 81%. MTP is quite safe procedure in skilled hands however may be life threatening in unskilled hands and unsterile conditions. Hence MTP conducted by untrained persons remains the most important cause of septic abortion. Promotion of family planning and legalisation of abortion services will go a long way in reducing the incidence of septic abortion and its associated complications.[5]

Conclusion

This pt. underwent hysterectomy as it was not possible to conserve the uterus due to multiple perforations. Resection anastomosis and colostomy, blood transfusion and intensive care further increased morbidity. Maternal death review (MDR) conducted every month is an important strategy to improve the quality of obstetric care and reduce maternal mortality and morbidity. Similarly maternal morbidity review and study of near miss obstetric cases will further help in reducing maternal morbidity and quality care. Education and easy accessibility of contraception, quality abortion services by trained abortion providers remain the key to limit mortality and morbidity arising from unsafe abortion.

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CT coronary angiography clarifies diagnosis

Coronary angiography by computed tomography clarifies the diagnosis in patients with suspected angina and helps identify appropriate treatment, shows the SCOT-HEART study, reported in the Lancet.

CT coronary angiography reclassified the diagnosis of angina caused by coronary heart disease in 23% (481) of patients, while the diagnosis changed in only 1% (23) of those given standard care (P<0.001).

Clinicians said CT coronary angiography markedly increased the certainty of the diagnosis of angina (relative risk 3.76 (95% confidence interval 3.61 to 3.89); P<0.001) and reduced the frequency of angina diagnosis by 22% when compared with standard care (relative risk 0.78 (0.70 to 0.86); P<0.0001).

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