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Case Report

Uterine Perforation With Subtotal Small Bowel Prolapse – A Rare Complication of Dilatation and Curettage

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Abstract:

Uterine perforation is the well known complication of induced abortion. We report a rare case of uterine perforation with subtotal prolapse of small bowel following first trimester abortion by an unqualified physician. Early surgical exploration with resection and anastomosis of bowel performed. Patient discharged uneventfully after postoperative recovery.

Key Words: Abortion, Conception, Mesentery, Curettage, Jejunum and Ileum

Introduction

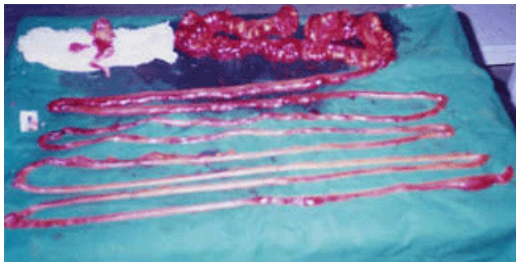
Incidence of uterine perforation varies from 0.4 to 15 per 1000 abortions as reported by different studies.¹ Although most uterine

perforations at the time of curettage during first trimester abortion go unrecognized and untreated serious complications do occur. Inexperienced physicians have been reported to perforate the uterus more frequently than experienced physicians.² 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.

Case Report

A 34 year old Indian lady, gravida 6, para 5 with 12 weeks gestation, presented with loops of bowel hanging at the introitus following dilatation and curettage by an unqualified physician. She attended the accident and emergency department of a tertiary referral hospital an hour and a half after the procedure. There was no previous history of abortion or caesarian section. She was not on any contraception.

On examination, the patient was very anxious, hypotensive with pulse rate of 120 beats per minute. About four meters of small bowel loops were seen protruding out at vaginal introitus. Full length of bowel loops were bare tubes without any mesentery. Per vaginal examination revealed loops coming through the cervical canal. Palpation of abdomen revealed signs of peritonitis. Given the clinical findings, no imaging or sonogram could be done before the surgical procedure.



Photograph showing resected coils of intestine

Patient was resuscitated with crystalloids. She had an emergency laparotomy. Perforation was noted at the fundus with loops of jejunum and ileum entering into the uterus. Mesentery was stripped off from the bowel loops at mesenteric border without serious vascular disruption. There was about 500 ml of blood in the pelvis. Large bowel was intact. Remnants of the small bowel loops were clamped and four meters of bowel was resected. End-to-end anastomosis was done with remaining three feet of jejunum and two feet of ileum. Uterine perforation was sutured. Mutilated fetus that migrated during curettage was

found at right paracolic gutter. Tubectomy was not done as the patient refused to give consent pre-operatively for permanent sterilization. She recovered well following surgery. On follow-up ultrasonogram, uterus showed no product of conception. Patient was discharged after a week with advice on diet and family planning.

Discussion

First trimester abortion is a simple and commonly performed procedure. However several complications can arise. Early complications include uterine perforations, blood loss, retained product of conception, postabortal secondary hemorrhage, endometritis, pelvic infections and peritonitis. Late complications are less defined and may include secondary infertility, ectopic pregnancy, cervical incompetence, endometrial synechiae and endometriosis.⁵ Uterine perforations are usually recognized at the time of the procedure. In case of first trimester fundal perforation, observation is all that is required. In rare cases, in addition to colonic and small bowel perforations, bowel, ureter or fallopian tube may be inadvertently aspirated during abortion. Surgical intervention should not be delayed in such cases. The important determinants of this complication are the skill of the physician and the position of the uterus with a much greater likelihood of perforation if the uterus is retroverted.

In our case curettage was done by an unqualified physician. Lack of education, social stigma 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 injury. Abortion when legal should be safe. The most effective way to reduce the number of morbidity and mortality would be to prevent unwanted pregnancies by informed and effective use of contraception. Easy accessibility of abortion services, curb on unauthorized

medical practice can reduce the complication rate.

Extensive research indicates that induced abortion continues to be a procedure requested by women. It is important for health care provider to understand the process of induced abortion to recognize the potential risks, benefits and complication of this procedure. It is an obligation of medical profession to keep it safe.

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