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Case Report

Intra-abdominal fetal head - a consequence of illegal abortion

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ABSTRACT

Unsafe illegal abortion is an important social and public health problem that causes significant morbidity and mortality, especially in the developing world. Prompt diagnosis and appropriate intervention does provide a better outcome. Early referral and safe abortion practices by skilled personnel in peripheral centers are necessary to limit maternal mortality and morbidity.

Keywords: Illegal abortion, Intestinal perforation, Vesicovaginal fistula, Fetal head

INTRODUCTION

Unsafe abortions refer to a procedure conducted by unskilled personnel and more often than not carried out in a non-accredited facility.[1] In third World countries, high maternal morbidity and mortality can be attributed to unsafe abortions. As reported by different studies, the incidence of uterine perforation varies from 0.4 to 15 per 1000 abortions.[2] Although, most uterine perforations occur at the time of curettage during first trimester abortion, they go unrecognized and untreated leading to serious complications. In rural areas of developing countries, illegal abortions conducted by unqualified inexperienced hands with or without minimal medical knowledge are not uncommon, consequently endangering the lives of patients.[3]

CASE REPORT

A 26 years old lady, with an obstetric history of 3 pregnancies (including the present one) with 2 live children and no abortions (G3P2L2A0), visited the outpatient department with amenorrhea of 04 months, complaining of dull lower abdominal pain, high grade fever and passing flatus/gas and stools per vagina involuntarily since 04 days. She attributed the pain to a fall from stairs which occurred 15 days ago with no history of nausea, vomiting, pain on passing stools or dysuria. On questioning the patient and her husband, they vehemently refused any incident of instrumentation during this period.

During examination, the patient was conscious, but looked unwell and febrile having temperature of 103.4ºF. Pulse rate of 100/min and B.P-100/60 mm Hg with pallor respectively.

Abdominal examination revealed no distension; there was generalized tenderness with mild guarding in the pelvic region but no rigidity. Firm, mildly tender, ballotable intra-abdominal mass and no obvious free fluid was found to be present because of guarding and tenderness, examination under anesthesia was done, revealed a round hard foetal head corroborated with the abdominal radiograph. Rectal examination was normal with bogginess felt in pouch of douglas (POD) having no blood on finger stall. Proctoscopy was normal and speculum examination showed fecal matter emerging out of the External Os. On vaginal examination, the uterus was anteverted, soft, 14-16 weeks in size, cervix was tender, adenexa was normal and an ill-defined mass which was felt posterosuperior to the uterus.

Laboratory investigations showed low hemoglobin, raised counts and normal renal functions. Radiograph of the chest showed no free intra-peritoneal air. Abdominal plain radiograph reveals an ossific density, ovoid curvilinear radio-opacity in the region of the pelvis suggestive of fetal skull as given in Figure 1.

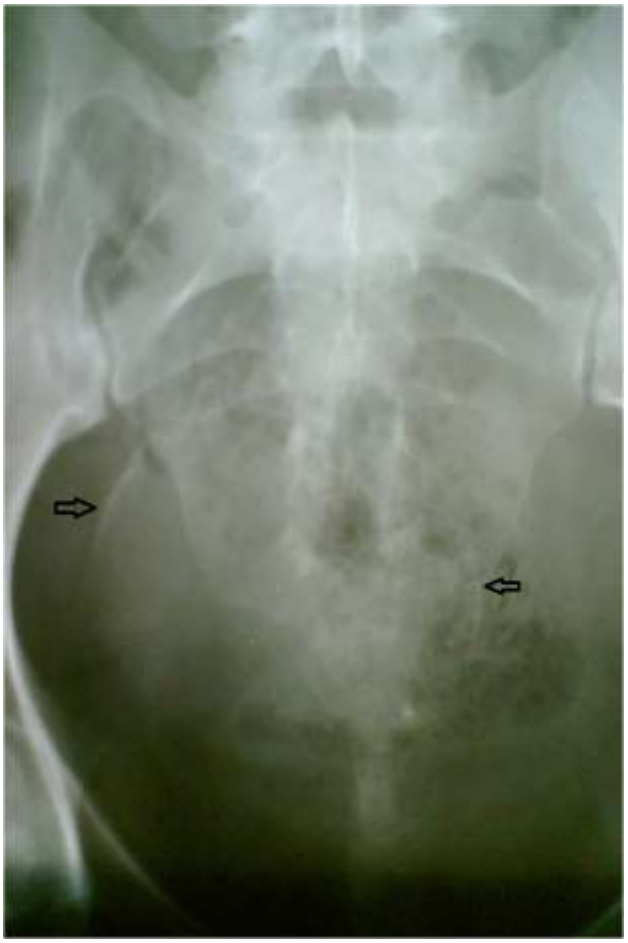

Figure 1: Plain AP radiograph of the abdomen.

Ultrasonography of abdomen and pelvis was suggestive of perforated/ ruptured gravid uterus, with incomplete fetal parts (macerated partial fetal bony structure indicating skull) lying outside the uterus within the abdomen, approximately a gestation of 18 weeks. No evidence of fetal movements/ fetal cardiac activity was observed. Free air was present in the endometrial cavity and cervical canal, suggesting endometritis, a collection was also noticed in the POD. The patient was taken in for emergency surgery by the surgeon and the gynecologist.

Operative findings

On laparotomy, the uterus was found to be 16 weeks in size, with dense adhesions in POD. The fetal head commensurated to approximately 18 weeks gestation, lying superior to the uterus, densely adhering to the omentum, with no evidence of any other body parts present in the peritoneal cavity as shown in Figure 2.

On further examination, a rent was seen on the posterior aspect of fundal region of the uterus, forming a fistulous communication with the sigmoid colon. The other intra-abdominal organs were found to be normal.

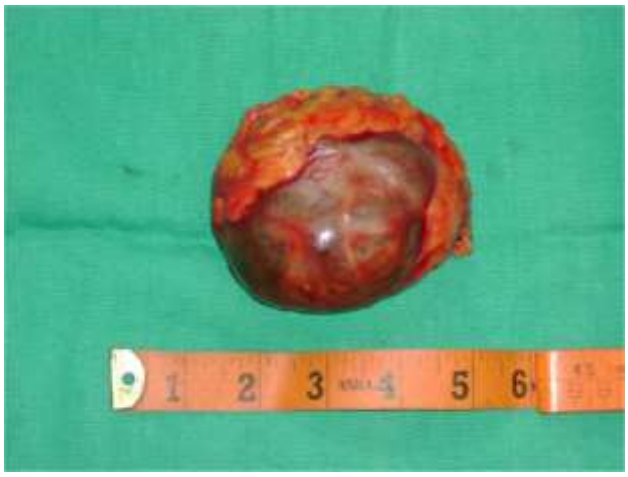

Figure 2: Fetal head on removal from intra-abdominal cavity.

Operative procedure

A mid line incision was given and the fetal head was freed from the omental adhesions. Primary closure of the sigmoid colon perforation and a diverting transverse colostomy was performed. Repair of sigmoid colon, subtotal hysterectomy done. In addition, peritoneal lavage and placement of two abdominal drains were carried out.

The patient was administered antibiotics such as Cephalosporin, aminoglycoside and Metronidazole. The post-operative period was uneventful, wound was healthy and the patient was discharged on 10th post OP day. A barium enema to confirm the healing of the sigmoid colon perforation without stenosis was carried out. Colostomy closure was performed after 4 weeks.

DISCUSSION

According to World Health Organization, in the developing countries, every 8th woman dies due to complications arising from unsafe abortion, making it one of the leading causes of maternal mortality.[1]

As per the Census of 2011 in India, Maternal Mortality Rate (MMR) is 212 per 100,000 live births and unsafe abortions kill a woman every two hours.[2] It is important for the health care provider, to understand the process of an induced abortion and to be able to recognize the potential risks, benefits and complications of this procedure. It is an important obligation of the medical profession to keep abortion safe.[3]

Foreign bodies inserted into the uterus to disrupt the pregnancy can damage the uterus and internal organs, including bowel and urinary bladder.[4] A further study in

India, showed that though the small intestines were most commonly involved however the mortality of large bowel injuries was higher.[5,6] Sooner the reparative surgery, better was the prognosis.[7]

Commonly bowel perforation occurs when the posterior vaginal wall is violated, allowing the instrument to pierce the underlying structures. The ileum and sigmoid colon are mostly the injured portions of the bowel because of their anatomic location. Unsafe abortions have also been associated with long-term adverse complications such as vesicovaginal fistula, rectovaginal fistula, chronic pelvic inflammatory disease (PID) as well as infertility.[8]

In the case under discussion as per the standard surgical practice, a simpler option could have been to just exteriorize the sigmoid with perforation but since the fistulous communication of the uterus and sigmoid colon was approximately less than 1 cm and was well attached to the fundus of the uterus, a spot decision to carry out a primary closure of the colon was taken along with a colostomy. Though no initial history of instrumentation was revealed by the patient, on subsequent questioning and evaluation it was concluded that perhaps an unqualified practitioner may have performed a curettage and removed the fetal parts from neck downwards, pushing the fetal head through the uterus into the abdomen, causing a perforation of the sigmoid colon, which would result in aborting the female fetus.

CONCLUSION

Unsafe abortions are hazardous to social and public health leading to high rate of morbidity and mortality, especially in the developing world. Prompt diagnosis and appropriate intervention certainly provide a better outcome. Early referral and safe abortion practices by skilled personnel in peripheral centers are necessary to check maternal mortality and morbidity.

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