Case Report

Uterine Perforation & Abortion- A Case Report

Sultana MA[1], Uddin R[2], Hussain RF[3], Khatun M[4]

Abstract

Sreemoti Ratna Sarker 30 years old lady presented to us with the complaints of amenorrhea for 5 months, lower abdominal pain for 5 days, slight per vaginal bleeding for 2-3 days, a cord like structure is coming down p/v on the day of admission. On general examination she was stable and on p/v examination there was cord prolapse. A gentle traction was given and it was expelled out along with a small piece of placental tissue without any fetal parts and bleeding. Then she was advised for USG of abdomen. USG reported a fetus like structure in the abdominal cavity and the empty uterine cavity . She was managed surgically. Now she is doing well.

Keywords: *Uterus, Perforation, Abortion, Laparotomy.*

Introduction

An abortion is the expulsion or extraction of all or any parts of the placenta or membranes without an identifiable fetus or with a fetus (alive or dead) weighting less than 500gm. In the absence of known weight an estimated duration of gestation of under 20 completed weeks calculated from the first day of LMP may be used. The commonest early pregnancy complication is spontaneous miscarriage. The actual figure, from community based assessment may be up to 30%, as many cases remain unreported to hospital[1]. Between 1 & 2% of fertile women will experience recurring miscarriage[2]. The emergence of the early pregnancy unit in many hospitals has addressed the need for a delicate clinical area for the diagnosis of miscarriage & patient support at a distressing time[3]. An abnormal karyotype is present in approximately 50% of spontaneous abortions occurring during first trimester. The incidence decreased to 20%-30% in second trimester & to 5%-10% in third trimester. Other suspected cause of spontaneous abortion account for a smaller percentage of losses and include infection, anatomic defect, endocrine factors, immunologic factors & maternal systemic disorders. In a significant percentage of spontaneous abortion, the etiology is unknown. Clinically abortion may be-threatened, inevitable, incomplete, complete, missed & blighted ovum. Also it may be recurrent & septic abortion[4].

Case Report

Sreemoti Ratna sarkar 30 years old lady, came from Kazipur, sirajgong, got admitted in Gynae word with the complaints of amenorrhea for 5 months, lower abdominal pain for 5 days, slight per vaginal bleeding for 2 days & cord like something coming down per vagina on the day of admission. It was her 3rd conception with history of D & C one year back. After conception her 1st trimester of pregnancy was uneventful. Once, suddenly she developed lower abdominal pain for 5 days, slight per vaginal bleeding for 2 days, then she admitted in a clinic for better management where the duty doctor diagnosed it as an incomplete abortion & try to expel it but the failed. Also it become complicated & then she was referred to KYAMCH for proper management.

1. Dr. Mst. Atia Sultana, Assistant Professor & Head, Department of Gyne & Obst, KYAMCH Sirajgonj.
2. Prof. Dr. Rakib Uddin, Professor & Head, Department of Surgery, KYAMCH, Sirajgonj.
3. Dr. Rubiyat Farzana Hussain, Assistant Professor, Department of Community Medicine, KYAMC, Sirajgonj.
4. Dr. Masuma Khatun, Registrar, Department of Gyne & Obst, KYAMCH, Sirajgonj.

Correspondence: Dr. Mst. Atia Sultana, Assistant Professor & HOD, Department of Gynae & Obst, KYAMCH, Enayetpur, Sirajgonj, Bangladesh. E-mail: dr.atia77@gmail.com

On Examination

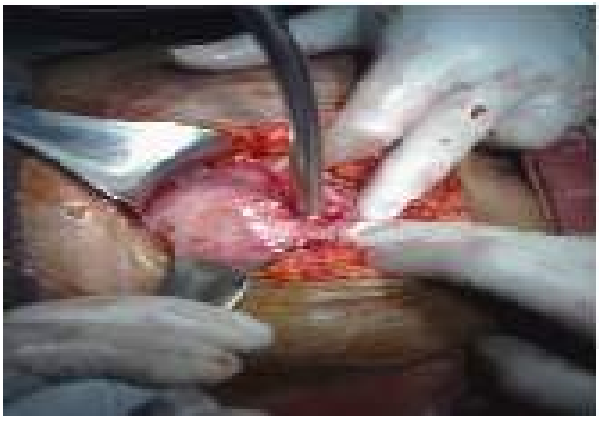
She was anxious, haemodynamically stable, looked pale. Her abdomen was soft & slightly tender. On pelvic examination-vulva, vagina looked normal. A cord like structure was seen in vagina, with a gentle traction a but fleshy mass came out which was nothing a small placenta & cord without any fetal parts. There was slight p/v bleeding, uterus was bulky & cervix was 2 cm dilated.

Investigations

CBC-Normal. Hb%-11.3gm/dl, RBS-5.73mmol/L, Blood group-B+ve, Urine RME-Normal, USG of lower abdomen showed-Uterus-Bulky with empty endometrial cavity. There was a large irregular heterogeneous mass in the right tubo-ovarian region. The mass was ill-defined in outline and surrounded by bowel gas, on careful examination, it reveals a macerated fetus, having length was 33mm which corresponds to about 20 wks of gestation.

Management

During pelvic examination with slight traction the cord & placenta was removed and the patient was sent for ultrasonography. Report showed there was a macerated fetus within the abdominal cavity. Laparotomy was planned. During laparotomy the following findings were found-there was no intra peritoneal hemorrhage or bleeding, there was a small healed perforation (about 3×2cm) near the fundus of the uterus. It was not a recent perforation, its margins were healed & there was no bleeding point but uterus was bulky about 11×4×7cm. An organized mass in which a fetus of about 20 wks size with extremity without skull bone was present in the Rt. fuboovariaw area. After removal of the fetus & repair of the uterine perforation, proper toileting of peritoneal cavity was done abdomen & was closed.



Uterine perforation

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Discussion

Severe or persistant hemorrhage during or following abortion may be life threatening. The more advanced the gestation, the greater the like hood of excessive blood loss. Sepsis develop most frequently after self-induced abortion. Infection, intrauterine synechiae & infertility are other complications of abortion, perforation of the uterine wall may occur during D & C because of the soft & vaguely outlined uterine wall & may be accompanied by injury to the bowel & bladder, successful management of abortion depends on early diagnosis. Proper history, examination and laboratory studies real wired for early diagnosis.

If the diagnosis is threatened abortion, complete bed rest & pelvic rest are recommended. Prognosis is good when bleeding & or cramping resolve. If diagnosis is inevitable or incomplete abortion-evacuation of the uterus by surgical method should be considered. The prognosis of the mother is excellent if the retained tissue is promptly and completely evacuated. If the diagnosis is complete abortion, the patient should be observed for further bleeding. The product of conception should be examined. Treatment of complications are dealt accordingly. In case of uterine perforation diagnostic, laparoscopy followed by laparotomy to be performed to determined the extent of injury and repair[5].

Conclusion

It was a rare case. It was not cleared that how the perforation occurred & how the fetus was entered into peritoneal cavity. Because the perforation was small but fetus was about 20 wks size. Further study needs to performed on such obscured condition to evaluate the exact etiology.

Reference

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Correction Notice

The article "Thyroid Function in Normal Pregnancy'' Author Dr. Md. Hafizur Rahman, Dr. Mahbub Ara Chowdhury and Dr. Sabiha Yasmin Moni Published in previous publication Vol.-4, No.-2, January-2014 is an original article. But unfortunately it was grouped as Review article.

We are sorry for this unwilling mistake.

Editor-In- Chief
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