INSTRUMENTAL PERFORATION OF GRAVID UTERUS*

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Accidental perforation of the uterus by a dilator, a curette or an ovum forceps sometimes occurs. It is more likely during evacuation of products of conception from a soft bulky uterus. The condition is easy to recognise, the instrument passing without hindrance further into the uterus than could possibly occur if the perforation were not present. No sooner perforation is diagnosed, the operator should stop the operation, as failure to recognise perforation results in serious and frequently fatal complications e.g. omentum or loop of intestine may be pulled down into the vagina with serious consequences. The sharp curette and the ovum forceps are particularly dangerous instruments and should not be used during evacuation of a gravid uterus (Masani).

CASE REPORT

Mrs. R. R. aged, 36 years, gravida 4, was admitted on 31-8-1966 at 3-30 p.m. in Upper India Sugar Exchange Maternity Hospital, Kanpur, with a big loop of intestine hanging out of the vulva, sent with a note by a private doctor. The contents of doctor's notes were "this lady attended my clinic with the history of bleeding per vaginam for the last 15 days, after 1½ months' amenorrhoea. I did a D. & C. this morning, but during operation she had profuse bleeding on account of adherent placenta. So I gave her an injection of morphia and Veritol, as her B.P. was low. Bleeding has stopped but I noticed that a loop of intestine is coming out of the vulva and she is also complaining of severe pain in the lower abdomen."

History of present illness: Patient stated that she had 1½ months' amenorrhoea, followed by bleeding per vaginam for 15 days. For the above complaints she consulted some private practitioner. On her advice she had a minor operation done this morning. Since then she had developed severe pain in the lower abdomen and was given two injections in the doctor's clinic. (Injection verital and morphia according to the doctor's note). On further enquiry from the patient, it was found that the loop of gut, which was small and outside the vulva, had been pulled out further by her.

On examination: A middle-aged, well built woman; general condition satisfactory but pale; pulse-120/mt., B.P. 100/70 mm.Hg., temperature 102°F. tongue and lips—dry, Hb-10.6 gm%.

Systemic examination: Nothing abnormal detected. Abdominal examination: Abdomen was soft and tender, resonant on percussion. Bowel sounds present. Abdominal girth—30".

Vaginal examination: More than 2 feet loop of small intestine was hanging out of the vaginal introitus without attached mesentery. It was unhealthy looking, bluish in colour. On speculum examination it was detected that this loop of intestine was coming out of the cervical os. Slight bleeding was present.

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Treatment: Patient was immediately prepared for laparotomy. Pre-operatively the following treatment was given—I.V. 275 mgm. Reverin, 5% glucose saline drip started; prophylactic dose of injection A.T.S. and A.G.S.

Operation: Gas and oxygen anaesthesia was given. Abdomen was opened by subumbilical median incision. Free blood was present in the abdominal cavity. Loop of intestine that was lying outside the vaginal introitus was gently pulled up into the abdominal cavity. On examination, the affected part of the small intestine was 3 feet in length, unhealthy, bluish in colour, dimensions very much reduced; marked laceration of mesentery was present. Blood was oozing out from the torn vessels of the lacerated mesentery. Affected part of small intestine was excised and end to end anastomosis was done. Torn vessels of mesentery were ligated and continuity was restored in the mesentery by interrupted catgut stitches. On inspection of the uterus—it was well contracted and slightly bigger than the normal size. Perforation rent, about 2 cm. in diameter, was present in the anterior wall of the lower uterine segment. The rent was repaired and the tubes ligated by modified Pomeroy's technique. Abdomen was closed as usual. Two pints of blood were transfused during operation. Post-operative period was febrile for the first five days. Reverin injection for the first 3 days and then injections of penicillin and streptomycin for the next 5 days. Ryle's tube suction was done for the first 36 hours. I.V. fluids for the first 3 days and then semi-solid diet from the 4th day onwards was given. Patient was discharged on the 12th day of operation. Condition of patient was satisfactory on discharge. Patient did not have bleeding per vaginam during her hospital stay.

Discussion

Dilatation and curettage is a simple and most widely performed operation. The very simplicity of the procedure tempts very junior and inexperienced medical persons to perform this operation for legitimate or illegitimate purposes. These days criminal abortions are done in large numbers with, at times, disastrous consequences. The various complications arising from the apparently simple operation have been discussed by Masani in his article in detail, e.g. traumatic and haemorrhagic as immediate complications and secondary amenorrhoea and incompetent internal os, due to over-stretching, as remote complications. Though cases of perforation remain mostly unreported for obvious reasons, there is no doubt that even experienced persons meet this dreaded complication. An experienced person will immediately recognise perforation of the uterus but the inexperienced one is likely to continue the operation which may have disastrous results.

It is interesting in this case that the patient with such a big loop of intestine hanging outside the vaginal introitus was not in a condition of shock on admission and also stood the operation well. Besides, her postoperative period was quite uneventful.

Summary

A case of instrumental perforation of gravid uterus by curettage is described and danger of dilatation and curettage is discussed in brief.

References

1. Masani, K. M.: J. Obst. & Gynec. India, **12**: 696, 1962.