MASSIVE REMOVAL OF SMALL BOWEL DURING CRIMINAL ABORTION

by

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That the gravid uterus may be perforated during criminal abortion is well known. Intestine, mostly the small bowel, may protrude through such a perforation and become gangrenous due to the strangulating effect of uterine retraction. Large segments of bowel may very occasionally be thus lost. Five such cases have been reported in the English literature, and we present here the sixth case.

Wolff and Kimarzi (1946) reported the case of a 30 year-old woman presenting with 50 cm of gangrenous small bowel prolapsing through the internal os. The bowel was devoid of its mesentery, and at operation 150 cm. of gangrenous small bowel were excised. The perforation in the uterus measured 3 cm. She made a good recovery. Simon *et al* (1951) described the case of a woman, aged 25 years, who presented with the small bowel prolapsing through the internal os. It was at least three days before laparotomy and resection of the damaged bowel was carried out. In spite of the delay her general condition remained satisfactory. After the operation she made a good recovery. Potts and Petzing (1953) and Howkins (1952) recorded one case each of bowel injury associated with perforation of the gravid uterus.

Shenoi *et al.* (1966) reported the case of a 25 years old woman, in whom all but 20% of her small bowel was lost. 360 cms of small bowel had been removed by the abortionist per vaginam and a further segment of gangrenous jejunum and ileum was excised during the subsequent operation. The patient had at the end only 110 cm of small bowel left. She was followed up for one year and remained well, though she continued to have very considerable steatorrhoea. She suffered no major metabolic disturbance but seemed likely to develop vitamin B_{12} deficiency, if not treated.

CASE NOTES

Mrs. F., 21 years, third gravida, last delivery 1 year 8 months ago, presented with a history of lower abdominal pain of 48 hours' duration and suppression of urine for 24 hours. She was bleeding pervaginam. An untrained midwife had procured an abortion of her 6 weeks' pregnancy by using sticks. Her symptoms followed soon after. She felt intensely thirsty.

On examination, her blood pressure was 90/60 mm of Hg. Pulse 116 p.m. Temp. 102°F; tongue was dry and coated. The

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lower abdomen was tender, with guarding and rebound tenderness. Bowel sounds were absent. Vaginal examination revealed a thin foul smelling blood-stained discharge and a long cord protruding out of the vaginal orifice. When unwound this cord measured 167 cms, and was identified as gangrenous small bowel.

The patient was prepared for laparotomy. I.V. drip of 10% plain fructodex was started after a venous cut down. Two bottles were rapidly transfused. Her B.P. improved and her pulse increased in volume. I. V. Reverin and I. M. Decadron were also administered. Using a lower mid-line incision the abdomen was opened. A mass of gangrenous bowel was seen in the pelvis and a gangrenous loop of small bowel was seen plugging a tear in the fundus of the uterus. Traction on the cord-like intestine protruding out of the vagina pulled more of the gangrenous bowel inside the uterus and out of the vagina. The normal viable bowel was then resected from the gangrenous bowel and continuity restored by an end-to-end anastomosis. The gangrenous bowel was removed partly by pulling out of the vagina and partly per abdomen. The tear in the uterus was closed and both the fallopian tubes ligated. At the end, the patient was left with only 83 cms of small bowel. The ileo-caecal valve was preserved.

Post-operative course was stormy, marked by hyperpyrexia and episodes of hypotension. From the fourth day onwards, she maintained steady progress, but severe wound infection followed. After 41 days, she was fit to be discharged home. Mexaform orally seemed to do good to her otherwise inconvenient diarrhoea. Seven months after operation, she was well and had gained weight since her discharge from the hospital. A barium meal examination revealed almost the whole of the barium in the large bowel 35 minutes after ingestion. (Fig. 1).

Comments

Haymond (1935) maintained that normal life could continue after removal of one-third of the small bowel, but that when more than 50% was removed major problems of management arose. However, Linder *et al.* (1953) reported many years survival in a patient with only 18 cms of jejunum left. Jackson (1958) reported absence of major metabolic disturbances after as much as two-thirds of the small bowel had been excised. Shenoi *et al.* (1966) reported an identical observation in their patient with only 110 cms of small bowel left. Our patient was well 7 months after her operation. According to Aird (1958), symptoms are often slight even after extensive resection and may amount to no more than occasional mild diarrhoea.

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See Fig. on Art Paper III