POSTERIOR COLPOTOMY IN PELVIC ABSCESS

(Report of Eight Cases)

by

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Introduction

Recently, aggressive management of pelvic abscess in form of immediate surgery is being advocated (Kaplan *et al*, 1967). But we, like many others, still believe that medical therapy consisting of maintenance of fluid and electrolyte balance, antibiotics and sedatives along with drainage of abscess still remain life saving in desperately ill patients. Drainage can be accomplished vaginally or rectally and in some rare cases abdominally.

In this paper we are presenting 8 desparately ill cases of pelvic abscess treated conservatively by posterior colpotomy. One patient died due to endotoxic shock and others responded satisfactorily to the treatment.

Case 1

Mrs. K.M., 30 years, $P_3 + 0$, a housewife was admitted on 28-9-1974 with the history of amenorrhoea of 3 months, pain in abdomen and bleeding per vaginam for 3 days. She also gave history of some interference outside. On examination general condition was very low, P/R-130/26/min, temperature 101°F, B.P. 110/80 mm of Hg. per abdomen—the lower abdomen was distended rigid, tender and skin was oedematous. A mass about 24 weeks pregnant uterus was felt. Vaginally, os admitted one finger cervix was tubular, the whole pelvis was felt to be indurated and the uterus could not be felt separately from the mass. The patient was put on conservative therapy for septic abortion. On 2-10-1974 the patient complained of diarrhoea. On vaginal examination there was no definite bulging anywhere but the whole pelvis was indurated, more so on the posterior aspect. Posterior colpotomy was done after needling and about 6 oz of pus was drained out. Condition of the patient improved remarkably on the next day. Three days after posterior colpotomy a small, macerated fetus about 14-16 weeks' size came out through the colpotomy wound. After an initial improvement the patient complained of pus like discharge coming out through the right flank and thereafter temperature came down to normal. The wound in the flank healed with regular dressing and the patient was discharged on 8-11-1974. Patient did not turn up for follow up examination.

Case 2

Miss. L.D., 19 years, was admitted on 16-11-74 with the history of vomiting for 4-5 days, constipation, retention of urine and bleeding per vaginam for 4-5 days. No definite history of amenorrhoea was available. On examination the general condition of the patient was low P/R-120/24/min, temperature-103°F, B.P. 100/60 m.m. of Hg. On abdominal examination a tender mass was felt occuping the whole of the lower abdomen. Vaginally, cervix was felt to be pushed forward the pouch of Douglas and both the lateral fornices were filled up with firm mass. The uterus could not be felt separately from the mass. The patient was on usual therapy sus-

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pecting this to be a case of acute pelvic inflammation. On 18-11-1975 the patient complained of diarrhoea and on vaginal examination there was tense bulging of the pouch of Douglas. Posterior colpotomy was done to drain out pus. The condition of the patient showed remarkable improvement and she was discharged on 5-12-1975.

The patient failed to turn up for follow up.

Case 3

Mrs. B.H., 28 years, $P_1 + 0$, was admitted on 14-1-1975 with the complaints of bleeding per vaginam for two weeks, pain in abdomen and fever for two days. The patient gave history of scanty menstruation for last two months but no definite history of amenorrhoea was available. General condition was fair with slight tenderness and rigidity in lower abdomen. On vaginal examination, uterus was slightly bulky and pushed to the right, thickening and tenderness in the lateral fornices. Blood stained discharge was present. She was being treated as a case of pelvic inflammation with poor response and a mass appeared in the lower abdomen. Gentamycin was started as vaginal swam culture showed growth of E. coli sensitive to gentamycin. After an initial response, temperature went high again varying from 102°-103°F. On vaginal examination there was slight bulging of the pouch of Douglas but there were no rectal symptoms. Posterior colpotomy was done on 7-2-1975 and pus drained out. She was discharged on 21-2-1975. Follow up examination revealed only slight thickening of both the parametrium. The patient had no other trouble.

Case 4

Mrs. S.S, 20 years, $P_0 + 0$, married for 3 months, was admitted on 27-7-1975 with the history of amenorrhoea for 10 weeks, bleeding per vaginam for 10-12 days and fever. She also gave history of some interference outside. General condition was low, P/R-116/26/minute, temperature 102°F, BP. 100/60 mm. of Hg. Abdominal examination showed only some rigidity in the lower abdomen. Vaginally, uterus was normal in size, os closed. Serosanguinous discharge was present. The patient was being treated as a case of septic abortion with peritonitis. On 29-7-1975 the patient complained of diarrhoea and a mass appeared in the lower abdomen. On vaginal examination there was fullness in the pouch of Douglas. Pus was drained by posterior colpotomy. Twelve hours after posterior colpotomy the patient developed endotoxic shock with severe hypotension and rise of temperature with rigor. The patient responded to treatment with high doses of corticosteroid and blood transfusion along with other measures. Thereafter temperature persisted varying from 100°-106°F. Although vaginal swab culture showed growth of E. Coli sensitive to gentamycin yet the patient failed to respond to gentamycin. Ampicillin also failed to bring back temperature to normal. The patient ultimately responded to septran and was discharged on 31-8-1975.

Case 5

Mrs. S.M., 35 years, $P_5 + 0$, was admitted on 4-10-1975 with the complaints of amenorrhoea for 2 months, severe pain in abdomen and bleeding per vaginam for 10 days. She also gave history of some interference outside. On examination P/R-110/22/minute, temperature 101.4°F. B.P. 110/70 mm. of Hg. Lower abdomen was tender on palpation. On vaginam examination size of the uterus could not be determined and there was some thickening and tenderness in the pouch of Douglas. There was no bleeding. The patient was being treated in line of septic abortion. On 6-10-1975 the patient complained of diarrhoea and on vaginal examination there was bulging of pouch of Douglas. By posterior colpotomy pus was drained. The patient ultimately responded to chloromycetin and was discharged on 11-10-1975.

Case 6

Mrs. P.B., 30 years, $P_3 + 0$, was admitted on 26-10-1975 with the history of amenorrhoea for 6 weeks, acute pain in abdomen for 3 days and diarrhoea. Pregnancy in this case was terminated by suction evacuation in a teaching institution on 23-10-1975. General condition was low, P/R-116/24/min, temperature 101°F. B.P. 100/10 m.m. of Hg. Lower abdomen was tender. On vaginam examination uterus was normal in size, fornices were tender and a cystic mass was felt in the posterior pouch. After conservative treatment for 24 hours posterior colpotomy was done. The patient responded satisfactorily and was discharged on 6-11-1975.

Case 7

Mrs. A.M., 35 years, $P_4 + 2$, was admitted on 23-12-1975 with the history of pain in abdomen. Fever following an abortion at 22 weeks induced

by an abortion stick. On examination the general condition of the patient was low, P/R-120/24/ minute, temperature—101.6°F, B.P. 110/70 m.m. of Hg. Lower abdomen was distended and tender. There was a mass in the lower abdomen about the size of 16 weeks pregnancy. On vaginam examination size of the uterus could not be determined, parametritis ++, foul smelling discharge was present. Inspite of conservative treatment temperature could not be controlled. There was no sign of rectal irritation but some oedema of the anterior abdominal wall gradually became evident. The patient was examined under anaesthesia and the uterine cavity was explored gently. A few retained bits of placenta were removed. Since there was slight fullness on one side of the uterus needling was done and pus came out. This was followed by posterior colpotomy and about 500 c.c. of pus was drained. The mass in the abdomen almost disappeared. Though vaginal swab was sterile on culture yet temperature could not be controlled even with gentamycin. The patient ultimately responded to Gramonag (Nalidoxic acid) was discharged on 11-2-1976. Stay in hospital—49 days.

Case 8

Mrs. S.D., 32 years, P_3 + 0, was admitted on 10-1-1976 for amenorrhoea for 6 weeks, pain in abdomen and bleeding per vaginam for 8 days. She gave H/O some interference outside. General condition was low, P/R-120/24/minute, temperature—101°F, B.P. 100/80 m.m. of Hg. Lower abdomen was distended and tender, vaginally, uterus was bulky, but actual size could not be determined. Os was closed and foul smelling discharge was present. The patient was being treated in the line of septic abortion with peritonitis. Two days after admission there was mucous diarrhoea and on vaginal examination there was fullness in the pouch of Douglas, but no definite bulging was detected. Pus was drained by posterior colpotomy. Condition of patient improved remarkably after drainage. Vaginal swab cuture showed streptococci sensitive to gentamycin. The patient ultimately responded to Gramonag. But on the 8th day following posterior colpotomy the patient suddenly developed respiratory distress with features of shock. She was treated with cortisone, blood transfusion, and fluids but without any improvement and expired after 35 hours on 25-1-1976.

All the patients in the present series received blood transfusion and in all cases antibiotics were started after taking high vaginal swab for culture and sensitivity test.

Summary and Conclusion

This paper describes 8 desperately ill cases of pelvic abscess treated conservatively along with drainage by posterior colpotomy with satisfactory results. The patients were relatively young coming from low middle class families. In most of the cases pelvic abscess occurred as a complication of original abortion. E. Coli was the commonest organism isolated from vaginal swab culture. Clinical response with penicillin, streptomycin and chloromycetin was found to be satisfactory. The problem of endotoxic shock still remains puzzlling. One patient died due to it. The scope of aggressive management in the acute phase of the disease condition in young patients still remains controversial.

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