BROAD LIGAMENT ABSCESS

(A Case Report)

by

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Abstract

Acute parametritis following a criminal abortion usually is common, but suppuration in the parametrial tissue especially in broad ligament is quite rare sequala. An young adult female tried to procure criminal abortion with a stick. She developed febrile illness, and a boggy tender mass above the right poupart's ligament which was thought of as the common "pelvic abscess" which on surgical exploration proved to be an uncommon pelvic suppuration i.e. abscess between the layers of the broad ligament. Through suprainguinal, extraperitoneal route the abscess was drained as described by Cullen. The characteristic slow and protracted break down of infected paramaterial tissue to purulent material before the healing process is complete was manifest in the present case. A brief review of various pelvic infections in the female patient is also discussed.

Introduction

The pelvic infections in the female can be intraperitoneal or extraperitoneal. The usual intraperitoneal infection, pelvic abscess, is quite commonly encountered. The pelvic extraperitoneal abscesses may be prevesical, parametrial, pelvirectal and presacral in location (Edwards *et al*, 1975). Though some degree of parametritis is present in all acute infections of the uterus and fallopian tubes, suppuration in parametritic effusion in quite uncommon and even if the effusion points and has to be incised, it is rare for frank pus to be evacuated (Hawkins *et al*, 1976). It is rare for such an abscess to point anterolaterally in the wall of abdomen (Cullen, 1917). Not many case reports of broad ligament abscess are available in the literature, though the nature and management were well understood as early as 1917 by Cullen. The rarity, the difficulties in diagnosis and management and the long period required for complete resolution make this entity an interesting study.

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CASE REPORT

A female patient aged 30 years attempted criminal abortion with a stick. She had some bleeding per vaginum and pain in the abdomen. She was admitted in General Hospital 2 days later, on 10-9-1977. She had moderate temperature. She was given intravenous fluids and antibiotics. While under treatment she developed moderate distension of the abdomen with no bowel sounds on auscultation.

The case was transferred to Surgical Ward. With nasogastric tube aspirations, intravenous fluids and antibiotics, the abdominal distension subsided and bowel sounds could be heard. She was given fluids by mouth. The pyrexia persisted in spite of 10 days of antibiotic therapy. There was a fixed mass of 3" x 4" size in the right iliac fossa. Vaginal examination revealed slight induration and tenderness in right lateral and posterior fornices. A cervical laceration was seen on the right side.

Pelvic abscess was suspected but no pus was tapped from the pouch of Douglas on aspiration. The abscess was approached through Mac-Burney's incision. The appendix was normal. There was no purulent exudate in the pelvis. The broad ligament on the right side appeared much indurated. The peritoneal cavity was closed. The suspected broad ligament abscess was approached extraperitoneally by blunt finger dissection down to the pelvis towards the broad ligament, when about 20 ml. of pus issued forth from the wound. A rubber drain was inserted in the space. The patient had persistent purulent discharge for a period of 15 days. E.Coli group of organisms were isolated from the pus and they were reported to be sensitive to Streptomycin and Kanamycin. The patient was given Streptomycin 1 G. daily for 15 days. Later she became apyrexial and the discharge of pus decreased to only a few ml. per day. The patient got discharged against medical advice at this stage. A month later she was readmitted in the hospital as the purulent discharge from the wound had increased and the wound was not healing. Surgical drainage was again done. The purulent discharge started subsiding afterwards. One month later she was discharged with a completely healed wound.

Discussion

The common antecedant pathology for the parametrial infection is either a postabortal endometrial sepsis or a hematoma in the broad ligament. Symptoms appear usually by the second week, following child birth or abortion. A continuous septic course following acute parametritis may be an indication of a broad ligament abscess. The treatment of established broad ligament abscess is surgical drainage, either by posterior colpotomy or, when the abscess points above the poupart's ligament extraperitoneal drainage by suprainguinal approach by a gridiron type of incision. Even if no pus is found, drains are inserted as eventually the tissue may break down along the drainage tract. Drainage of pus from such an area of cellulitis is often of long duration but ultimate resolution is the usual outcome (Te Linde T. W. 1970).

References

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