IATROGENIC PERFORATION OF THE UTERUS WITH PROLAPSE OF SMALL BOWEL

(Report of two cases)

by

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With the Medical Termination Act 1972 imposed in India since April 1972, we expect to see less number of criminal abortions and their associated complications. Unluckily in our part of the country, such cases are still not uncommon.

The following are the report of 2 cases who were referred to the labour room in low condition after they were handled in the interior area, 1 for medical termination and other for removal of placental tissue.

CASE REPORT

Case I

Mrs. B. Devi, aged about 35 years para 5, gravida 6th was admitted in the labour room of Bhagalpur Medical College Hospital on 8-10-1977 for amenorrhoea of 2 months and vaginal bleeding since a week. On 7-10-1977 she underwent some sort of vaginal operation by an untrained person practicing obstetrics in the rural area. After the manouver she noticed a long red cord like thing protruding from the introtus. This was brought to the notice of the so called obstetrician who then referred the patient to Bhagalpur Medical College Hospital.

She had 5 full term normal deliveries at home, the age of the last child was 2 years.

She was an average built woman coming from a low socio-economic strata with a pulse of 100/mt., B.P. 110/70 mm Hg. and moderate pallor.

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Cardiovascular and respiratory systems were within normal limit. Abdomen was soft with normal bowel sounds. There was no evidence of peritonitis.

On inspection of the genitalia, big loop of small intestine was seen lying outside the vagina introitus. The length of the loop later measured, was found to be 28."

A gentle bimanual examination revealed the uterus and adenexae normal. The loop was felt coming through the cervical os. Speculum examination confirmed this (Fig. 1). Diagnosis of iatrognic perforation of the uterus causing prolapse of small intestine was established.

Patient was immediately sedated with 10 mgm. pethidine I.M.; 5% Dextrose was started intravenously. Blood transfusion of 60 cc. was arranged and an urgent laparotomy was decided in consultation with a general surgeon.

On opening the abdomen there was a ragged rent over the fundus of the uterus through which the loop of small bowel was going inside the uterine cavity. Mesenteric vessels and the omentum were intact. Uterus was normal in size with healthy adenexae.

Resection of the involved small gut with end to end anastomosis was performed. The uterine cavity was explored through the rent and no products of conception were recovered. The urerine rent was repaired with chromic catgut No. I suture and bilateral tubectomy was also done.

Postoperative period was smooth. Stitches were removed on 10th postoperative day. There was mild wound infection which needed dressing for about a week and the patient was discharged on 31-10-1977.

Case 2

Smt. M. Devi, 37 years, para 3, gravida 4 was brought to the labour room on 4-11-1977 i

gasping condition. She had amenorrhoea for 5 months followed by spontaneous expulsion of the foetus at home but the placenta was retained and bleeding continued. She was brought to the nearest block dispensary where the medical attendant tried to remove the placenta in the theatre but her general condition deteriorated and she was then referred to this hospital.

On examination, the patient was deeply unconscious, markedly pale with imperceptible radial and brachial pulse and unrecordable blood pressure. The respirations were jerky and shallow. Abdomen was markedly distended. Fluid thrill was positive (due to collection of blood) as elicited after the death of the patient. On inspection of the vulva, big loop of small intestine was seen protruding from the vagina.

Oxygen inhalation was started as soon as she came. Efcorlin 200 mgm were pushed intravenously; 5% dextrose was infused by I.V. drip. Pethidine 100 mgm was also injected I.M. to combat shock. Blood transfusion of 300 cc was immediately arranged. Inpite of all our efforts to save her the patient collapsed and died within an hour of admission.

After the patient died we thoroughly scrutinised the loop lying outside. It was 30" long with multiple necrotic holes all over, through which foecal matter was coming out at several places and the loop of intestine was black and gangrenous.

On speculum examination, the intestine was coming out through the cervical os (Fig. 2).

Our request to do post mortem examination was turned down by the attendant.

Discussion and Comments

Both cases were interesting, as large loop of bowel was pulled down through the introgenic rent in the uterus.

Two causes might have operated for perforation in the present 2 cases. In the first case an attempt for evacuation, perhaps was made on a non-pregnant uterus and repeated attempt to remove the product pulled down the loops of intestine after perforating the uterus. In the second case, it is possible that digital exploration was ignored and the retained placenta was probably removed with the help of instruments, resuting perforation of the soft gravid uterus and pulling out of the loop of small bowel. Possibly in this case mesentric vessels were also injured leading to massive intraperitonal haemorrhage (clinically).

Logawaney, *et all* (1976) reported a case in which small bowel with vermiform appendix was pulled out through the iatrogenic rent. The appendix could be easily pulled out due to undue mobility of the caecum which they made note of at laparotomy.

In our first case laparotomy could be arranged within ½ an hour. Resection of the affected small bowel with end to end anastomosis and repair of the uterine rent with bilateral tubectomy by modified Pomeroy's method, were performed.

The other case could not be undertaken for laparotomy as she was brought in a very low condition and in spite of our best efforts she collapsed within an hour of admission. Request for postmortem examination was turned down by the attendant. The cause of death was probably the massive intraperitanial haemorrhage, as that patient was paper white and the abdomen was markedly distended with shifting dullness.

1. Logawaney, R., Vishisthta, K. and Gupta, A. N.: J. Obstet. Gynec. India. 26: 3, 452.

See Figs on Art Paper VI