RARE SURGICAL COMPLICATIONS OF INDUCED ABORTION
(Report on 2 Cases)

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Abortions, whether spontaneous or induced, are almost always fraught with hazards. While incomplete abortion, haemorrhage, sepsis and their sequelae are common complications following abortion, injury in particular is a dreaded complication of induced abortion. We are presenting reports on 2 cases of induced abortions in the hands of inexperts—where one woman developed both vesico-vaginal (V.V.F.) and vesico-uterine fistulae and the other had extensive uterine injuries where in the process of removal of conceptus, the foetal head was dislodged through the uterine rent and stuck-up in the left renal region forming later on a dense mass with intestine and posterior peritoneum. Both the cases were admitted and treated in the Department of Obstetrics and Gynaecology S.S.K.M. Hospital, Calcutta.

CASE REPORTS

Case 1

Mrs. R. B., aged 40 years, para 8 + 1, was admitted on 9-7-79 complaining of continuous leakage of urine per vaginam for the last 5 years following an attempt at induction of abortion by a village quack who introduced some stick. Her previous obstetric performance was normal—the last child was born alive and well 7 years ago.

On general examination, she had no abnormality. Vaginal examination revealed a fistula nearly one cm. in diameter in the anterior vaginal wall close to the cervix. Cervix was torn and irregular. Uterus was normal-sized, anteverted and with mobility slightly restricted. She was examined under anaesthesia on 9-8-79 when V.V.F. was confirmed.

With a diagnosis of V.V.F. only, a local repair was performed (by D.L.). Further dye test following repair of V.V.F. demonstrated clearly leakage of urine through the cervix. V.V.F. healed perfectly with usual postoperative care. A retrograde cystogram done on 28-9-79 showed that the dye from the bladder passed to the uterus (Fig. 1).

Repair of the utero-vesical fistula was performed on 11-10-79 (by R.B.) through an infraumbilical midline abdominal incision and a transvesical approach. The urinary bladder was opened in the midline. A big fistula (about 2 cm. diameter), adherent and indurated, was found connected with the uterus just above the isthmus. The site of the tract was just above the trigone of the bladder on the left side and the ureteric orifices were clearly demonstrated. Extra-vesical mobilisation of the superior surface of the bladder and the uterovesical pouch was done until the grossly fibrosed fistulous tract was reached. The tract was excised. The repair of the rent in the posterior wall of the bladder was carried out in 3 layers transvesically. The rent in the uterine body was repaired in 2 layers using 0/1 chromic catgut and interrupted sutures. A patch of omental graft was made to lie in the utero-vesical pouch between the 2 repaired openings. The bladder incision was closed in layers leaving a suprapubic catheter. Tubal ligation was done and

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the abdomen closed in layers. A urethral catheter was also inserted.

Postoperative period was fairly uneventful and a good drainage of urine was ensured. The suprapubic catheter was removed after 2 weeks and the urethral catheter after 3 weeks. The patient voided urine normally and remained perfectly dry. The frequency of micturition, the stream and the control were found to be fairly satisfactory. The patient left hospital on 21-11-79.

At follow-up examination on 7-1-80, the patient had no complaints except persistent amenorrhoea.

Case 2

Mrs. J. S., aged 25 years, para 3 + 1, was admitted on 17-9-79 at 10-00 hours in a state of grave shock. History revealed that the patient underwent vaginal instrumental abortion by a village doctor on 16-9-79 forenoon while carrying nearly 4 months. Following the procedure, she started severe vaginal bleeding. The vaginal bleeding lessened but without any improvement of her general condition when, after nearly 24 hours, she was referred to this hospital in a moribund state.

On general examination, the patient was severely anaemic, pulse was thready 140 per minute, B.P. 60/40 mm. of Hg. and temperature 37.5°C. Abdomen showed some fullness and slight tenderness all over. Vaginal bimanual examination revealed a bulky uterus with open but intact external os. A finger introduced through the os went straight into the abdominal cavity through an anterior cervical and corporeal rent. Vaginal bleeding was slight.

The patient was immediately resuscitated. Haemoglobin level was only 6 Gms. per cent. The patient was put for laparotomy after nearly 4 hours of admission when B.P. was 88/60 mm. of Hg. Blood for transfusion was not available.

Laparotomy by infraumbilical midline incision showed blood in the peritoneal cavity with some offensive smell. Uterus was about 10 weeks' size with irregular tear of anterior surface involving almost whole of body and cervix. The uterine cavity was found completely empty. Considering the nature of injury and potential sepsis, hysterectomy was performed. Superficial injuries on superior surface of bladder were repaired. As the condition of the patient was critical, before closing the abdomen, a quick exploration was done, but unfortunately nothing could be detected and the abdomen was closed after inserting a peritoneal drain.

Blood for transfusion (600 ml) was available the next day (18-9-79) and the condition of the patient improved following the transfusion. Postoperative period was fairly uneventful. The peritoneal drain was removed on the 3rd day and the abdominal sutures were moved on the 8th day. Skin union was good.

On the same day (25-9-79), an intraabdominal firm, fixed and slightly tender lump was noticed in the left lumbar and hypochondriac region. As the patient had no complaints, the swelling was carefully observed and it reduced to a mass confined to left lumbar region only close to the kidney. A straight X-ray of abdomen (Fig. 2) taken on 10-10-79 showed a radio-opaque nearly circular shadow of about 4 cm. diameter corresponding to left lumbar region but resembling a foetal head. Urinary surgeon examined the woman to explore the possibilities of any renal swelling. An intravenous pyelogram taken on 29-10-79 (Fig. 3) showed the mass separate from the left renal shadow with normal pelvi-calyceal pattern.

Laparotomy performed on 15-11-79 through a left upper paramedian incision showed a densely adherent mass of intestines and posterior peritoneum in the left renal region. Attempts at dissection and separation of intestinal mass caused a rent in a segment of intestine. Foetal skull was removed from the mass. Intestinal resection and end-to-end anastomosis was done and the abdomen was closed after inserting a peritoneal drain through the left flank.

The postoperative period was uneventful and the drain was removed on the 3rd day. The abdominal wound healed nicely and the patient was discharged on 1-12-79 in a satisfactory condition.

In the first case, the quack made not only a vesicovaginal fistula but also a uterovesical fistula while performing abortion with some stick.

In the second case, the village doctor while attempting D & E in a 4 months' gestation, removed all the parts of conceptus except the head which escaped high-up in the abdomen through the large uterine wound forming later on a dense

mass with intestines and peritoneum. Interestingly, even after 2 months, the foetal head did not lose its contour.

The presented two cases are worth noting in that in the first case the quack inflicted both V.V.F. and uterovesical fistula directly with a stick, which in the 2nd case the untrained doctor, adopting inappropriate technique, not only injured the uterus markedly but could not remove the foetal head which escaped high in abdomen and formed a dense mass in left lumbar region mimicking a renal swelling.

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See Figs. on Art Paper XII