CRIMINAL ABORTIONS—OUTCOME

(Report of 3 Cases)

by

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SUMMARY

Three cases of criminal abortion by a stick, a nail were found on exploration.

The object of presenting these three case reports is to enlight the ideas of rural people even after legalisation of pregnancy termination for 8 years and how the facts are concealed endangering the life of the patients for erroneous diagnosis.

Case 1

On 15-10-81 a patient (D.D., 18 years Md) was admitted to the hospital for severe pain in abdomen for last 3 months with a palpable painful lump over upper abdomen. Constitutional symptoms like intermittent fever, anorexia, loss of weight were present. There was history of irregular menses with intermittent foul smelling vaginal discharge for last 10 months. She was of poor socio-economic status and her husband had left her alone.

On examination, G.C. was poor. There was a very tender, parietal lump (5″ x 2″) over right upper abdomen. Uterus was retroverted fixed ond fornices were thickened and tender.

She was treated with antibiotics, analgesics, anti-inflammatory drugs (Tab. Brufen, Tab. Chymoral etc.), Vitamins, haematinic preparations, anabolic steroids and high protein diet for two weeks.

When her G.C. improved she was examined under anaesthesia and exploratory laparotomy was done through right paramedian incision. By careful disection through the extensive adhesions the large bowel could be defined well but a mass of coiled up ileum was found to be adherant to the parietal peritoneal mass. On further dissection, a hard projecting object was felt at the middle of the ileal coil and its tip was adherant to the centre of the parietal mass. Surprisingly on pulling the object an abortion stick (11″-12″ long) came out. It was a branch of some unknown tree. On following its path in a retrograde way it appeared that the stick had perforated the uterus, entered the peritoneal cavity, pierced the mesentery, filled up by connective tissue mass. The parietal tumour mass was the result of chronic inflammation due to chronic irritation of parietal peritoneum by the tip of the stick.

Resection of nearly 2 feet of jumbled up ileal mass followed by end to end anastomosis of ileum was performed in the usual way. The parietal tumour mass was resected and removed. Abdomen was rapidly closed. Post-operative management was as usual for intestinal surgery with adequate blood transfusion.

Mother of the patient gave the history of criminal abortion when she was told the critical condition of her daughter and abortion stick was shown.

Case 2

M.S., 18 years, had attended the O.P.D. with history of recurrent rectal bleeding and pain in lower abdomen and rectum along with primary

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infertility of 2 years duration. Her menstruation was regular.

On examination, G.C. was average.

Lower abdomen was tender more on the right side. Uterus was R.V. fixed with a vague tender mass in right fornix. Rectal palpation could reveal a vague tender nodule higher up near rectosigmoid junction. H.S.G. showed blocked tubes and bariun esema-X-ray was normal. When conservative treatment for 3 months failed to improve the condition exploratory laparotomy was done. There were extensive intrapelvic adhesions. Whilel separating the adhesions bridge of tissue from posterior wall of uterus on right side to rectum was detected which was not possible to cut with scissors due to metalic hard consistency. On manipulating and pulling it, a "nail" 5" long came out tearing the rectal wall where the head of the nail was burried. Rectal wall was closed in two layers.

Case 3

C.D., 17 years, H.F., single was admitted to hospiatl on 15-1-83 with severe pain in abdomen over right iliac fossa and vomiting.

On examination, she was in shocked state. P-108/m. B.P. 100/90 mm, Pallor ++, Provisional diagnosis was "acute appendicitis' and was operated by general surgeon.

On opening the abdomen throgh Mc. burney's incision appendix was found normal but intra-abdominal haemorrhage was detected. Gynaecologist was summoned. After closing Mc. burny's incision abdomen was opened through intraumbilical incision. The posterior wall of uterus was found to be perforated and lacerated. Injury was noted at rectosigmoid junction with escape of focal matter inside the pelvic cavity. Itepar or uterine tear and bowel injury was done. Blood transfusion etc. was given. Post operative period was uneventful and on 3rd post operative day when the patient was apparantly normal she confessed that she had amenorrhoea for 3 months and induced abortion was attempted by some abortion stick by a local 'Dai'.