Unusal MTP Complication

S. Chandra • D. N. Buhariwalla • D. Amonkar
Dept. of Obstetrics and Gynaecology and General Surgery, Goa Medical College, Goa.

Mrs. Y. H. 30 years, para 3 was admitted on 29/03/95. She was referred for vaginal bleeding by a private practitioner. MTP had been done that same forenoon by the referring practitioner as stated by the patient.

O/E Pallor was marked, pulse 140/mt.

B.P. 90/70 mm Hg, resp. rate 28/mt. There was abdominal distension with tenderness and shifting dullness.

On P/S: There was profuse bleeding.

Cervix could not be well visualised.

On P/V: OS was closed, cervical lips felt normal. There was a rent in the anterior fornix through which two fingers could be easily inserted into the peritoneal cavity, while a bulge was felt in the posterior fornix. Clear urine was obtained on catheterization.

With the diagnosis of hemorrhagic shock with hemoperitoneum, the patient was immediately shifted to O.T. for exploratory laparotomy. P/S exam was repeated in O.T. there were no cervical tears; there was bleeding through torn anterior fornix.

Laparotomy findings

There was hemoperitoneum, surface damage of the uterus at level of internal OS, right broad ligament & uterovesical fold were torn; tubes & ovaries were normal.

Total abdominal hysterectomy (TAH) was done & while this was in progress attention was suddenly distracted by the wriggling round worms in the peritoneal cavity. On completion of TAH when bowel exploration was contemplated it was absolutely horrifying to realize that the total length of ileum and 95% of jejunum right from iliocaecal juntion to the duodenojejunal flexure (except a small length of 5 cm. of jejunum) had been sheared off & removed through the torn anterior fornix. The mesentery had ragged edge with areas lacerated & thrombosed.

General Surgeon was called at this stage and he did an end to end anastomosis between the jejunal remnant & the caecum alongwith hemostasis of the mesentery.

The patient received a total of nine units of blood transfusion. She remained under ICU care for four days.

Thereafter, in the ward I/V alimentation alongwith I/V ciprofloxacin, metrogyl & continuous Ryle's tube aspiration (RTA) was maintained. Patient had spikes of fever ranging 100°-120°F for 3 days. From 8th post operative day intermittent RTA was done & Ryle's tube removed on the 11th post operative day. She was put on high protein liquid diet and after another week switched over to normal diet. Patient was discharged on 22.4.95. She reported 3 weeks later for followup & seemed well. The effect of the absence of the ileum on her health in the long term remains a question.