Paedal gangrene: an unusual complication of septic abortion

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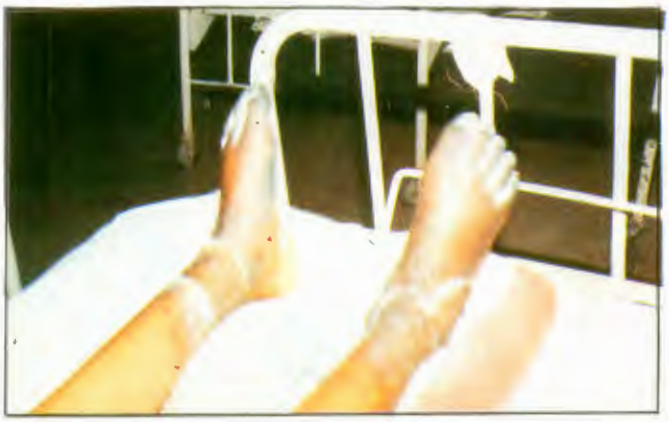
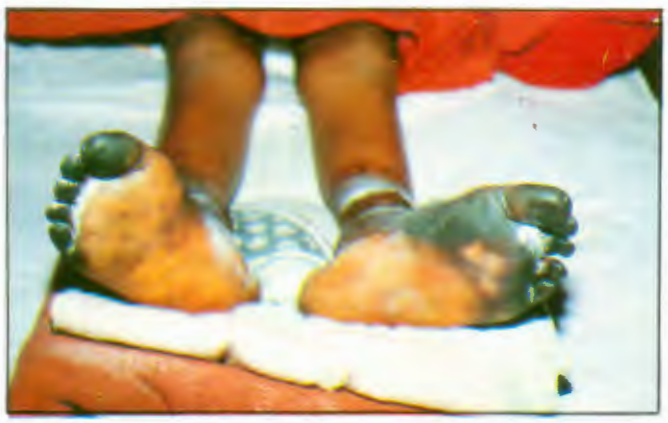
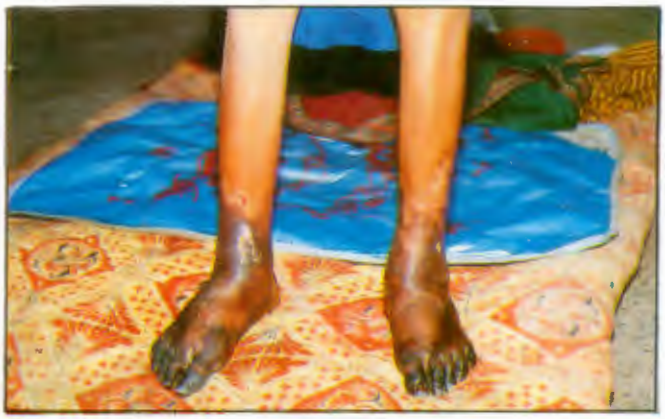
Patient Girija, 28 years old, a multiparous Hindu female was admitted on 4.2.97 in Department of Obstetrics and Gynaecology of Sarojini Naidu Medical College, Agra with pain in lower abdomen and distension of abdomen following illegal abortion of 1½ months amenorrhoea 5 days back by a local dai in the village. She gave history of insertion of some batti per vaginum following failure of oral medicines for 3 days (? ergot intake). She had 4 normal home deliveries and 1 spontaneous abortion. Last child birth was 3 years back.



Dorsal aspect of patient on fourth post operative day showing paedal oedema



Plantar aspect of patient on fourth post operative day showing paedal gangrene



Showing scaling of skin of patient

On examination, her blood pressure was 110/70 mm Hg, pulse 110/min. and she was afebrile. On per abdomen

General condition of patient after one month when she could stand and walk unsupported

examination, there was rigidity and tenderness in lower abdomen. Bowel sounds were sluggish. On per speculum examination, cervix was oedematous and congested and there was blood stained foul smelling discharge. On per vaginum examination, uterine size could not be assessed because of tenderness. Her ultrasound study showed matted loops of bowel and collection of fluid in the flanks. On local examination, blackish patches were noted on the lower part of both her lower legs and dorsum of feet and toes. Bilateral femoral, popliteal, posterior tibial and dorsalis paedis pulsations were present. Movements and sensations were present.

Laparotomy was done under general anaesthesia on 7.2.97. Per- operative findings were:

- Abdomen was full of pus.
- Uterus showed fundal perforation. Subtotal hysterectomy with bilateral salpingo-oophorectomy was done and sent for histopathological examination.
- On examination of bowel, it was coated with flakes of pus, but no bowel perforation was seen.
- Peritoneal toileting was done.

On first post-operative day, gangrenous patches drastically increased and extended over the toes, dorsal and ventral aspect of feet extending up to extensor surface of lower part of both legs. Both feet and lower part of legs became oedematous and dorsalis paedis became feeble and movements at distal interphalangeal joint became restricted with sensory loss over all the toes. The patient was managed conservatively in the form of heavy antibiotics, pentoxyphyllin, aspirin, dextran-40, bed rest and elevation of legs. Patient was advised color doppler but it could not be done because of some reasons. The oedema progressed for 3-4 days but from 5th post operative day, patient started responding. The oedema over both lower legs gradually subsided and necrotic skin peeled off. Intensity of peripheral pulses increased, movements of toes increased and sensations returned. Gradually the legs and feet returned to near normal condition but in the toes dry gangrene had set in along with sensory and motor loss, for which amputation was advised. There was slight discharge from stitch line which responded to antibiotics. Patient was able to walk unsupported and was discharged in satisfactory condition on 7.3.97.