An Unusual Presentation and Management of Septic Abortion

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Case History

Thirty-one year old para 1 presented with history of bleeding per vaginum for 15 days. She had undergone termination of pregnancy at 2 months of amenorrhea in a nursing home. Products of conception were reportedly seen on the histopathological examination of the curettings. Following the termination of pregnancy she had excessive vaginal bleeding and high fever for 15 days for which she was referred to our hospital.

At admission on 19/10/1998 she was febrile and had tachypnoea and tachycardia. Blood pressure was 120/80 mm Hg. Abdomen was as uniformly distended with rebound tenderness. Minimal free fluid was present. The uterus was 10 weeks in size and the os open. There was foul smelling discharge with bleeding PV, with tenderness and fullness in all the fornices. A degenerating mass within the uterus and multiple loculated collection of fluid around the uterus were seen on sonography. Total blood counts, coagulation parameters, renal and liver function tests at admission were normal. A diagnosis of septic abortion with generalized peritonitis was made. She was started on intravenous fluids, Ceftriaxone and metronidazole. However as her condition deteriorated she underwent emergency laparotomy on 21/10/1998 under general anaesthesia.

At laparotomy, one liter of foul smelling pus was drained. Pus was sent for microbial culture. Two perforations 4x4cms and 2x1cms on the fundus of the uterus were identified. There was oozing of blood from these sites. There was also exudative material around the uterus. The bleeding from the perforation site could not be controlled with pressure and suturing because of tissue friability. Her condition was deteriorating and therefore we decided to do [illegible] hysterectomy as a life saving procedure. Only [illegible] cervical hysterectomy was possible due [illegible] adhesions in the pelvis. There was bleeding [illegible] the floor of the pelvis. Internal iliac artery ligation was unsuccessful in controlling continuous bleeding from the operative area. The bleeding would stop temporarily with pressure but whenever the pressure was removed, there was oozing from the pelvic floor. No bleeders could be located. Six units of blood were transfused preoperatively. Since the patient's condition was deteriorating, we decided to close the abdomen. Six gelfoam and 6 laparotomy mops were left inside for pressure and the abdomen was closed in a single layer. Five more units of blood were transfused over the next 48 hours. Intravenous antibiotics were continued. She continued to be febrile with tachycardia and tachypnoea, which subsided slowly after 48 hours. Her general condition did not deteriorate any further and so we reopened her abdomen after 48 hours. There was a lot of foul smelling peritoneal fluid, but the bleeding had stopped. All the fluid was removed and peritoneal wash was given. This time we closed the abdomen in layers and placed two drains. She was on total parenteral nutrition for the next few days. After stormy intra and postoperative period she recovered well. Sutures were removed on the 8th postoperative days and the wound had healed well. She was discharged on 9/11/1998 after 3 weeks of stay in the hospital. The histopathological report of the uterus was – features favour acute inflammatory process with perforation. We saw her after a month and she is doing well.