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CASE REPORT

Faeces per Vaginum: A Combined Gut and Uterine Complication of Unsafe Abortion

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Introduction

Unsafe abortions (defined by the World Health Organization as those performed by unskilled individuals, with hazardous equipment, or in unsanitary facilities) carry a high risk of maternal death and other complications. For unsafe procedures, the mortality rate has been estimated as up to 70,000 women per year worldwide [1, 2]. Even in countries where the procedure is legalized, often inadequate and inaccessible health system, religious, social and ethical implications predispose to unsafe abortions and late referrals of complications. Trauma to the bowel is one of the most dreaded complications of induced abortion. While these injuries are usually recognized during the procedure itself, there could be late presentation too. Rarely, the symptoms may take up to 2 months to occur as it happened to be in the present case.

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We present here an unusual case of bowel injury following induced abortion presenting after 52 days.

Case Report

A 22-year-old para 3 female presented to the surgical emergency with signs of sub-acute obstruction. She gave a history of (unsafe) termination of pregnancy done 45 days prior for 2-month amenorrhea along with Cu-T insertion performed in a rural setup. She carried with her, old X-ray (Fig. 1) and ultrasound report confirming a misplaced extrauterine Cu-T. She was treated conservatively for sub-acute obstruction for 1 week after which she had an episode of bleeding per vaginum followed by passage of stools per vaginum i.e. 'faeces per vaginum'. On speculum examination, stool was seen being expelled out from the cervical os (Fig. 2), and no other fistulous tract was found originating from rectum into the vagina. On vaginum examination, uterus appeared to be of apparently normal size, mobility and mildly tender. Ultrasound indicated bowel loops prolapsing into the uterine cavity through the perforated posterior uterine wall (Fig. 3). Contrast-enhanced computerized tomography revealed a fistulous tract between the uterine cavity and distal bowel loops. Cu-T was lying extrauterine between uterus and bladder. Patient was explained regarding the need for a major gynae-surgical procedure and a guarded prognosis. Exploratory laparotomy showed a prolapsed and

gangrenous terminal ileum through a perforation in the posterior uterine wall. Posterior and lateral wall of the uterus were infected and necrosed. A subtotal hysterectomy with the reduction of ileo-uterine intussusception with resection of ileum with end-to-end ileocecal anastomosis was performed by a multidisciplinary team consisting of bowel surgeons and gynaecologists. Her postoperative period was uneventful.

Discussion

A study conducted by the ICMR (Indian Council of Medical Research) in rural India revealed the incidence of unsafe abortions to be still as high as 13.5 illegal abortion per 1,000 pregnancies [3]. Incidence of uterine perforation varies from 0.4 to 15/1,000 abortions as reported by various studies [4]. Grimes et al. found 3 % incidence of bowel perforation in cases of uterine perforation [5]. Gupta et al. [6] reported 7.5 % cases of bowel injury in cases of septic-induced abortion versus 0.05 % during medical termination of pregnancy (MTP) procedure. In cases of bowel involvement, interval lapse between injury and surgery is an important factor for the survival of the patient. If reparative surgery of small bowel is performed within 24 h, the survival chances are good, and prognosis becomes better [6]. Garg et al. [7] reported a bowel complication in which an abortionist pulled out 50-cm mucosa of colon, while Sherigar et al. [8] reported a case of induced abortion with nearly four metres of small bowel loops being seen protruding out at vaginal introitus. However, early surgical exploration and bowel surgery saved the patient in both the above reports. Rehman et al. [9] in his prospective study of bowel injury secondary to induced abortion noticed some cases of bowel being pulled out through vagina that expired subsequently of septicemia and haemorrhage.

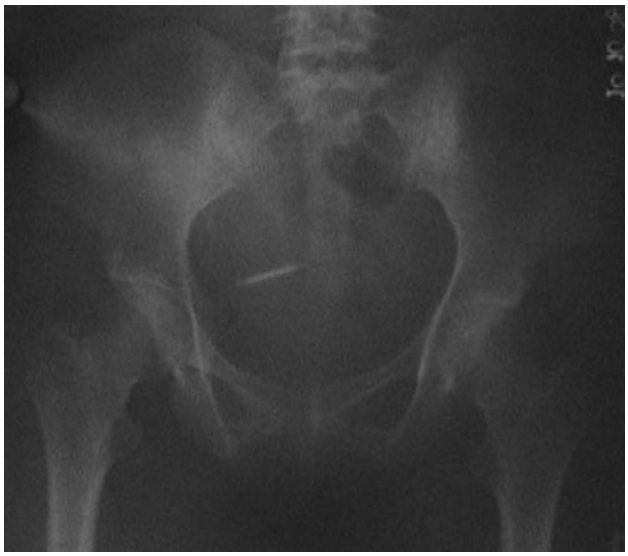

Fig. 1 Misplaced Cu-T seen in pelvis on plain radiographs brought by patient

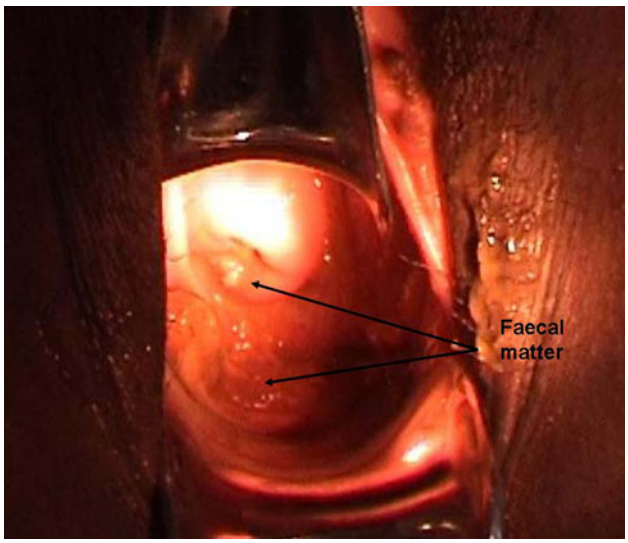

Fig. 2 Stool seen expelled from cervical os

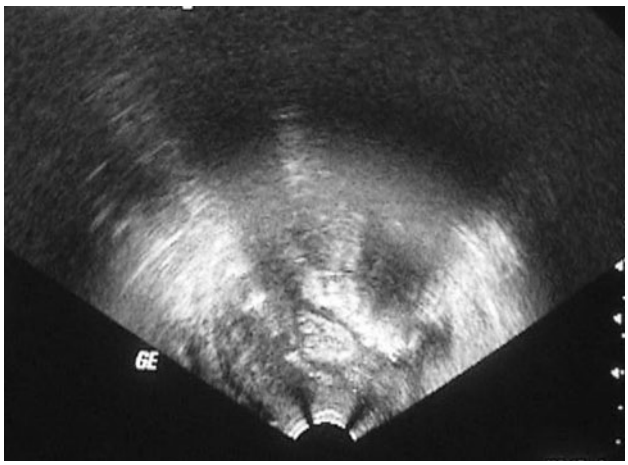

Fig. 3 Bowel loops prolapsing in uterine cavity through perforated posterior wall

Although most perforations occur at the time of curettage during first trimester abortion, they go unrecognized and untreated leading to serious complications. Unfortunately, if any complication arises, both the patient's family and the abortionist, fearing legal consequences, do not seek help from specialist centers. The lack of tertiary health care facilities, except in a few major cities, further compounds the delivery of timely medical care.

Our case is a delayed presentation of bowel herniation following uterine perforation complicated by necrosis and bowel dehiscence. Preassumptive pathogenesis in this case has been explained with the help of diagrammatic

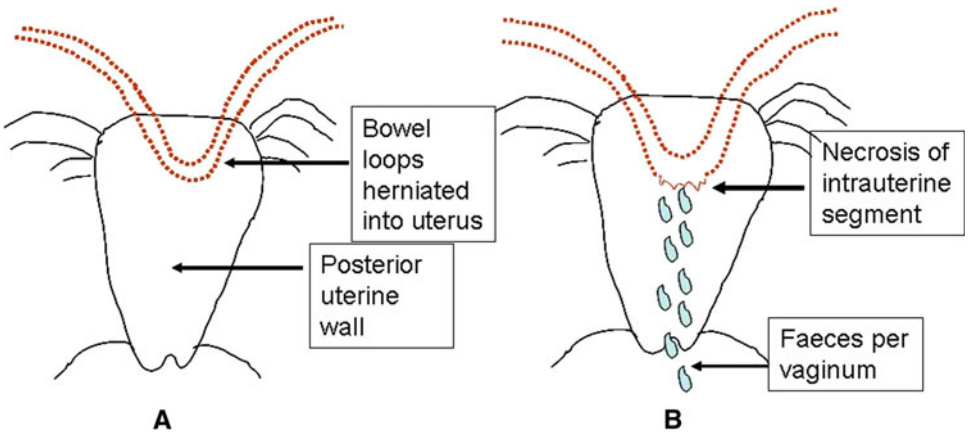

Fig. 4 **a**, **b** Pathogenesis of possible sequence of events leading to delayed presentation

representation (Fig. 4a, b). The uterus might have perforated during instrumentation during suction evacuation, and thus the Cu-T was outside the uterus (Fig. 4a). A loop of small bowel must have herniated into the uterus at that time, thereby presenting as sub-acute intestinal obstruction. Subsequently, intrauterine bowel segment got necrosed possibly following infection and sloughed off on day 52 post-evacuation presenting as passage of blood per vaginum (Fig. 4b). As the bowel changes were localized in the uterine cavity with no spillage of contents in the abdominal cavity, there were no signs of peritonitis. The final event was passage of faecal matter through the cervical os. The late detection of ileo-uterine intussusception and necrosed bowel and uterine wall compelled a major surgical procedure.

Early presentation with minimal contamination particularly with small bowel involvement has reported to have better outcome even following primary repair [6]. In contrast, late presentation, greater degree of contamination or established sepsis, especially with colonic involvement, has a more protracted stay and poorer outcome in terms of the development of faecal fistulae, abdominal wound dehiscence, etc. The delayed presentation of unsafe abortion led to complication of faecal fistulae in our patient. Leibner [10] had described a similar case of delayed presentation of acute omental incarceration with associated ischaemic and complete small bowel obstruction following unsafe abortion after 17 days.

Any patient presenting post abortal even a month after the event should arouse clinical suspicion in terms of late complications of abortion, such as sub-acute intestinal obstruction, as occurred in this case. This case was an eye-opener as a major complication of bowel stood being silent for days together and presenting finally in an unusual manner. In a case of unsafe abortion, bowel herniation following uterine perforation is a known complication. The clinical symptomatology of bowel herniations can be minimal, and might go undetected, if not suspected. An earlier detection of bowel herniation can decrease the magnitude of surgical procedure and significant patient morbidity.

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