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RESEARCH ARTICLE

SMALL BOWEL MUCOSAL STRIPPING DURING MEDICAL TERMINATION OF PREGNANCY: A RARE COMPLICATION

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ABSTRACT

Dilatation and curettage (D&C) is one of the most frequently performed procedures for first trimester surgical abortion. The mortality and morbidity of D&C are very low, and perforation of uterus is rare. But curettage of a large, soft postpartum uterus can be a formidable undertaking because the risk of perforation is high and the procedure commonly results in increased rather than decreased bleeding. Although many perforations are innocuous, others lead to infection, hemorrhage, and trauma to abdominal contents. Bowel perforation is a rare complication, it persists as an important cause of peritonitis and sepsis. Stripping of the mucosa through the perforation is very rare complication and Hence we report a case who suffered intestinal perforation with stripping of 40 – 50 cm mucosa during D&C.

INTRODUCTION

The mostcommon complications of induced abortion includegenital sepsis, haemorrhage, pelvic infection with peritonitisand abscess formation, uterine and bowel perforations[1,2].Bowel perforation is a rare but serious complication ofinduced abortion.Thehigh incidence of perforation in most developing countrieshas been attributed to late diagnosis resulting fromlate presentation to health facilities[3].The bowel may be injured with the curette, ovum forcepsor uterine sound, or even the plastic canula. Bowelperforation occurs when the posterior vaginal wall isviolated, allowing the instrument to pierce the underlyingstructures[4]. The ileum and sigmoid colon arethe most commonly injured portions of the bowel dueto their anatomic location[1].The management of cases with intestinal injuriesfollowing induced abortion poses some major challenges to surgeons and gynecologists practicing inresource-limited countries[1]. Surgery is considered thetreatment of choice in order to improve the chances ofsurvival of patients with this condition. However, latepresentation and diagnosis coupled with lack of diagnosticfacilities, inadequate preoperative resuscitation anddelayed operation are among the hallmarks of the diseasein most developing countries including India[1]. Early recognition and prompt surgical treatmentof bowel perforation following D & Cis of paramount importance[1]. A successful outcome is obtained by prompt recognitionof the diagnosis, aggressive resuscitation and early institutionof surgical management.

CASE REPORT

A 26 years old patient with history of 4 months amenorrhea came with chief complaints of pain in the abdomen and bleeding per vagina since 2 days. She was referred from outside hospital where dilatation and curettage was done 2 days back. On examination the patient was dehydrated, febrile with pulse rate -124/minute and B.P-100/60 mm Hg. She was having severe pallor. Per abdominal examination showed diffuse guarding and rigidity. Per vaginal examination revealed presence of bowel loops outside the introitus. The patient was taken for emergency surgery.

Operative Findings

On opening the abdominal cavity, haemoperitoneum was present. The uterus was 12 weeks size and a 2cm size rent was present in the posterior wall of uterus through which a segment of bowel was herniating. Around 40 – 50 cm of bowel from the point where it was herniating in uterus was gangrenous. On taking out the herniated bowel it revealed 40 – 50 cm of mucosa was stripped out through a small opening in the ileum.

Operative procedure

The haemoperitonium was drained out. Peritoneal lavage given.Gangrenous small bowel of about 40 – 50cm was resected. The mesentery of the resected bowel was excised and sutured. End to end small bowel anastomosis was done. Postoperatively the patient was given broad spectrum antibiotics. Postoperative period was uneventful. Patient recovered well and was discharged after 8 days.

DISCUSSION

A study conducted by Gupta *et al.* [5]reported 0.05 % incidence of bowel injury during medical terminationof pregnancy (MTP) procedure. In cases of bowelinvolvement, interval lapse between injury and surgery is animportant factor for the survival of the patient. If reparativesurgery of small bowel is performed within 24 h, the survivalchances are good, and prognosis becomes better[5].Garg *et al.*[6] reported a bowel complication in whichan abortionist pulled out 50-cm mucosa of colon, whileSherigar *et al.*[7] reported a case of induced

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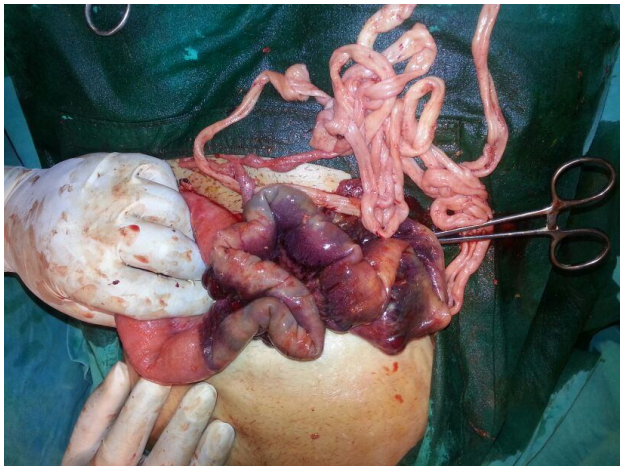

Fig 1. Gangrenous bowel with stripped mucosa

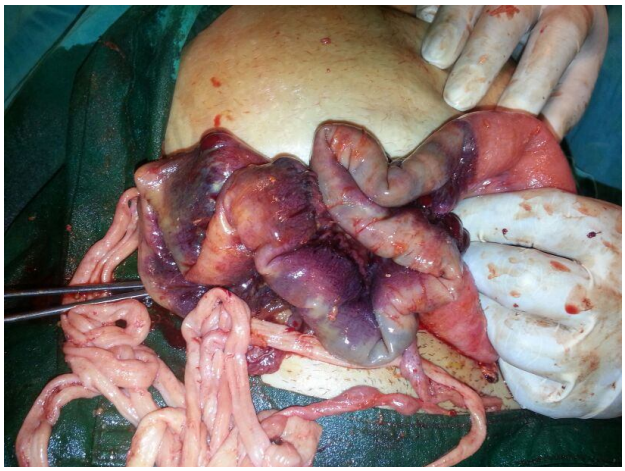

Fig 2. The stripped out mucosa

abortion withnearly four metres of small bowel loops being seen protrudingout at vaginal introitus. However, early surgicalexploration and bowel surgery saved the patient in both theabove reports. Rehman *et al*.[8] in his prospective study ofbowel injury secondary to induced abortion noticed somecases of bowel being pulled out through vagina that expiredsubsequently of septicemia and haemorrhage.

Although most perforations occur at the time of curettageduring first trimester abortion, they go unrecognizedand untreated leading to serious complications. Unfortunately, if any complication arises, both the patient's familyand the abortionist, fearing legal consequences, do not seekhelp from specialist centers. The lack of tertiary health carefacilities, except in a few major cities, further compoundsthe delivery of timely medical care.Our case was referred from a peripheral hospital as soon as obstretician realized that uterus has been perforated and bowel has been pulled through the rent.Timely intervention could save the life of patient.

Conclusion

Bowel injury with stripping of mucosa during D & C is a rare complication but carries high morbidity and mortality. Early recognition and timely intervention is the key to save the patient.

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