

# Case Report

## Health Consequences of Induced Abortion

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Perforation of the uterus presents one of the gravest complications of emptying the pregnant uterus. Induced abortion has emerged as one of the major share-holders of maternal mortality in third world countries. Of particular importance is the fact that most of the illegal abortions, performed in the underdeveloped and developing countries, are attempted in older, multiparous women, increasing the risks many-fold. In the present article, a typical case of induced abortion, resulting in severe bowel injury, is presented followed by a discussion of the extent of the problem and its moral, social, and financial implications. Attention is drawn to the important role obstetrician / gynecologist can play, by providing better maternal / child health services, in an effort to reduce the incidence of induced abortion.

**Key words:** Abortion, induced

Fertility control is as old as mankind, and has been utilized throughout recorded history and in societies representing all levels of socioeconomic development. Abortion has been one of the most prevalent methods of effective fertility regulation. Techniques are extremely varied. Perforation of the uterus is one of the most frequent complications of emptying the pregnant uterus. The incidence is quite variable. According to Nathanson it varies between 0.5 and 10 per 1,000 abortions. Since the fault is usually the operator's, most cases fail to find their way into the literature.

The following case of induced abortion, resulting in serious, and potentially lethal, bowel injury is being presented as a prototype of what is happening around us. The intent is to underscore the graveness of the situation and to emphasize the need for better public education.

### Case Report:

B.B a 35 year old woman, gravida 8, Para 7+0, was admitted through the emergency department of the Lady Willingdon Hospital, Lahore, on 11-8-04. She presented with five weeks amenorrhoea and had undergone a D & C by some LHV (Lady Health Visitor) one day prior to admission. During the procedure she developed severe bleeding and lower abdominal pain which promoted referral to the hospital. There was no history of syncope, nausea or vomiting.

At physical examination, she was observed to be a thin, lean, woman showing signs of extreme dehydration and severe anaemia. She was fully conscious and cooperative. Her blood pressure was 120/80 mmHg, pulse 115 / min., temperature 98.8°F respirations 20/min. Abdomen was slightly distended and diffuse abdominal tenderness was present. Muscle guarding and rebound tenderness were elicited but there was no rigidity. Bowel sounds were present and there was no evidence of fluid in the abdomen. Uterus could not be palpated.

On pelvic examination, a 30cm loop of, distended, dark-black, small intestine was found in the vagina and

protruding through the introitus. There was no external bleeding. Examination was discontinued, the loop was replaced into the vagina and a moist warm pack was inserted. A diagnosis of uterine perforation with bowel injury was made and arrangements were made for an urgent laparotomy.

As soon as blood became available transfusion was started and the patient was taken to the operation theater. Laparotomy was performed through a midline incision. On entering the peritoneal cavity no fluid or blood was found. A multiparous size uterus was found perforated at the fundus, on its anterior aspect, in the midline. A loop of ileum was caught in the perforation and the uterus has tightly contracted over it. The perforation was enlarged by an elliptical incision so as to withdraw the bowel loop easily. Before pulling out, an atraumatic bowel clamp was applied to the proximal end of the loop. The retracted loop was isolated from the operative field with hot moist towels. On examination of the incarcerated bowel, a large rent was found in the mesentery but bowel wall was not damaged. However, a 60cm segment, starting 40cm proximal to the ileo-coecal junction, was found gangrenous. This was resected with 2.5cm healthy margins giving a shallow V incision in the mesentery. End to-end anastomosis was performed in two layers. Uterine rent was repaired after debridement of the edges. All viscera were examined and found to be intact. Bilateral partial salpingectomy was performed for sterilization. Peritoneal cavity was washed thoroughly with normal saline and abdomen closed. Two units of blood were transfused intraoperatively.

Except for the first 60 hours, she remained afebrile and postoperative recovery was rapid. On third postoperative day oral liquids could be started progressing to semisolids on fifth day. She was discharged on 10<sup>th</sup> day in good health.

On follow-up two weeks later she had no complaints and the wound had healed satisfactorily. Iron was continued.

**Discussion:**

It is no exaggeration that more has been learned about induced abortion as social phenomenon and as a medical procedure during the past 15 years than during the proceedings 15 centuries. Incidence of induced abortion, both legal and illegal, varies widely in different parts of the world depending upon the legal status as well as the social and religious factors.

Recent estimates have ranged upto 55 millions, compared with about 130 millions live births. The abortion aggregate is highly speculative since it is based on country aggregates that are, in many instances, of questionable validity. King has estimated that about 40 to 50 million abortions are performed worldwide, each year, half of them are illegal.

Illegal abortion carries a greater risk of death from sepsis than either legal or spontaneous abortion. Several explanations could account for the higher rate, especially inadequate techniques or unsafe methods and also a delay in seeking treatment or failure to admit uterine manipulation due to criminal implication. The Reporter on Confidential Enquiries into Maternal Deaths in England and Wales have highlighted the fact that abortion has been major cause of maternal mortality.

Uterine damage may lead to hemorrhage, shock and even death. Cervical tears or corporeal rupture may occur. Bladder, ureters and bowel may all be damaged and without prompt surgical intervention death may follow. Renal damage may ensue. In cases not immediately fatal, especially if there is also an infective element. Haemorrhage may occur due to uterine atony, trauma, coagulation disorder or a combination of these. The long-term complications are incalculable, but relate to the same basic factors. It has been estimated that septic abortion occurs in 25% of patients with incomplete abortions and that approximately 3% to 17% of septic abortions are complicated by septic shock. 7, 8.

We the obstetrician / gynecologists, have moral obligation, as providers of maternal and child health services, to call to public attention the appallingly high incidence of septic abortions, the unnecessary mortality

accompanying this, and the long – term social and financial implications of such practices. In addition, we should promote responsible parenthood and protect the health of women and children by providing safe, effective, acceptable and economical contraceptive services in an effort to reduce the practice of induced abortion.

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