Research Article ISSN 2639-9342

Gynecology & Reproductive Health

Generalized Peritonitis Following A Double Uterine and Ileal Perforation after Clandestine Abortion

Lamrissi A, Mourabbih M, Wajih O*, Watik F, Benhaddouga K, Jalal M, and Bouhya S

Obstetrics department, hospital university IBN ROCHD of Casablanca, Morocco.

***Correspondence:**
Dr. WAJIH Oumaima, Obstetrics department, hospital university IBN ROCHD of Casablanca, 1 hospital district, Casablanca, Morocco.

Received: 02 Mar 2022; **Accepted:** 30 Mar 2022; **Published:** 05 Apr 2022

Citation: Lamrissi A, Mourabbih M, Wajih O, et al. Generalized Peritonitis Following A Double Uterine and Ileal Perforation after Clandestine Abortion. Gynecol Reprod Health. 2022; 6(2): 1-3.

ABSTRACT

In many underdeveloped countries, illegal abortion can result in maternal death due to infectious complications such as pelviperitonitis, generalized peritonitis, and even septic shock. We report the observation of a 36-year-old patient who presented with peritonitis four days after an illegal abortion. The exploration was in favor of a double uterine and ileal perforation leading to a generalized peritonitis.

Keywords

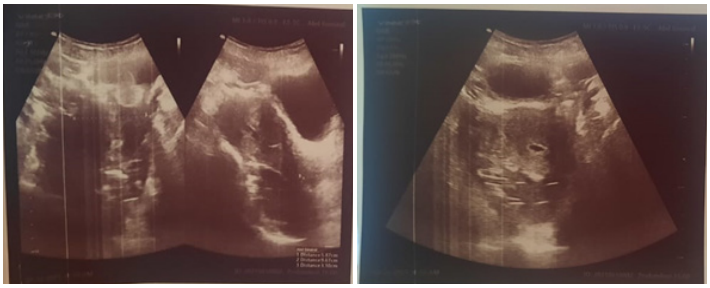
Clandestine abortion, Peritonitis, Uterine perforation.

Introduction

Clandestine abortion is a phenomenon that is still common in developing countries, where it constitutes a public health problem. Clandestine abortions are generally associated with poor hygienic conditions, and can be responsible for significant infectious risk and lead to pelviperitonitis or generalized peritonitis, which can result in maternal mortality by septic shock or embolism.

Case Report

Mrs. K.S., 36 years old, single, second pregnancy (mother of a child born by vaginal delivery), with no notable pathological history, from a poor background, presented to our institution with low-grade metrorrhagia associated with pelvic pain, after an amenorrhea of eight weeks. This situation followed a clandestine curettage performed four days before her admission. Clinically, the patient was conscious, pale, febrile at 39.5°, tachycardia at 120 beats per minute, hypotensive at 90/50 mmHg, polypneic at 25 cycles per minute. She had profuse sweating with cold extremities. Abdominal examination showed diffuse tenderness, associated with marked tenderness over the right iliac fossa. The speculum examination showed a small amount of bleeding of endouterine origin, mixed with brownish fetid leucorrhoea. Pelvic touching was painful. Biologically, the hemoglobin was 14.4g/dL, hyper leukocytosis was 25780/mm3 with neutrophilic predominance, CRP was very high at 314mg/L, and plasma B-HCG level was 3594. An abdomino-pelvic ultrasound was performed, showing intrauterine retention with a large pelvic effusion (Figures 1 and 2). An exploratory laparotomy was performed urgently, showing a double perforation; at the level of the uterine fundus of 1.5cm, (Figure 3) and of the small intestine of 2.4cm with stool output (Figures 4 and 5) , with false membranes at the level of the entire peritoneal cavity in the inter-anexus, and in the inter-hepato-diaphragmatic, associated with a large abundance of purulent and fetid effusion quantified at 1850cc. The surgical procedure consisted in a first step of a peritoneal sampling followed by an aspiration of the purulent liquid and a peritoneal cleansing with physiological serum. In a second step, a suture of the uterine perforation was performed with a lateral ileostomy in double gun barrel after the edges were restored and the posterior wall was made, followed by a drainage of the cavities. The patient was admitted to the intensive care unit for immediate postoperative care. She received a probabilistic antibiotic therapy (ceftriaxone 2g per day and metronidazole 500mg every eight hours) and continuous analgesia. The patient was declared discharged at 15 days postoperatively after a clear clinico-biological improvement, under oral contraception. The ileostomy was removed after four months with restoration of continuity. The patient did not present any complication during the follow-up consultations.



Figures 1 and 2: Abdomino-pelvic ultrasound showing intrauterine retention with a large pelvic effusion.

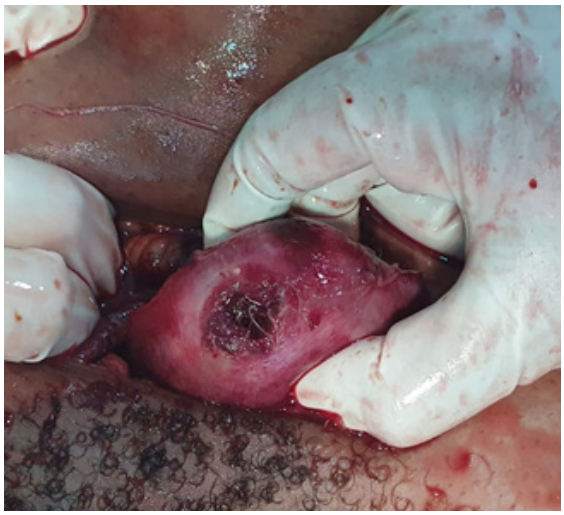
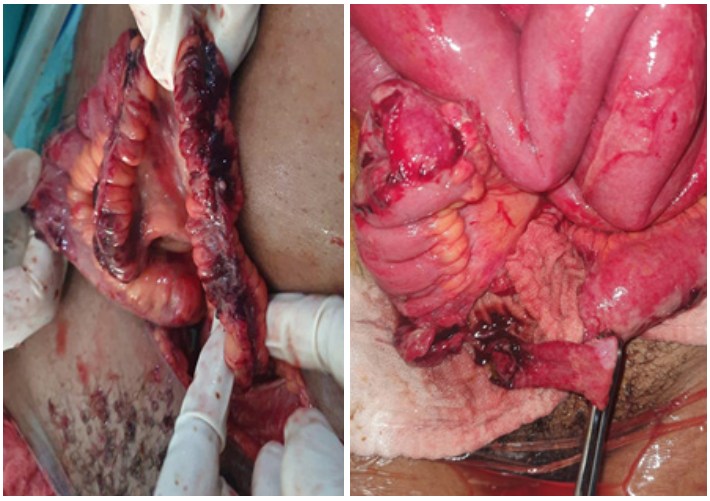


Figure 3: Uterin perforation.



Figures 4 and 5: Intestinal perforation.

Discussion

Clandestine abortion is a common phenomenon in developing countries. In Morocco, being illegal, it is difficult to determine its frequency. In Libreville, Gabon, its prevalence is estimated at 87.1% of abortions [1].

According to the literature, the average age of post-abortal peritonitis was 25.05 years, with an average age of pregnancy at the time of the procedure of 11 weeks [2]. The average delay between the abortive act and the consultation varied from 4 to 40 days according to a study in Madagascar, and seven days according to the study of Cissé et al. conducted in Senegal [2,3].

All the patients were received with critical symptoms, consisting of an altered general state and an infectious picture in favor of pelviperitonitis or even generalized peritonitis. This phenomenon can be explained by certain religious and social constraints within societies. Our patient was 36 years old, single, from a conservative and underprivileged background, having undergone a curettage four days before her consultation on a pregnancy of 8 SA.

Ultrasound is the most commonly used imaging technique in African countries and is of great diagnostic value [2]. Abdominal and pelvic CT scans may also be requested. In our case, ultrasound helped to orient the diagnosis and revealed intrauterine retention and a large peritoneal effusion, without however determining the origin of the symptomatology.

The manoeuvres used are generally traumatic and sharp (metal probes, wooden end). For there to be pelviperitonitis or generalized peritonitis, there must be a uterine perforation, or more rarely a vaginal perforation [4]. Intestinal lesions are also reported in the literature [5,6]. In our patient, the lesion was located in the uterine fundus and in the ileum, causing acute generalized peritonitis.

According to a study carried out at the university hospital of Dakar, at the gynecological and obstetrical clinic, out of 101 induced abortions, 4 cases of peritonitis were reported. Three cases were complicated by parietal suppuration, secondary peritonitis requiring repeat surgery, and an ileo-mesenteric infarction causing maternal death [3]. In Burkina Faso, three cases of post-abortal peritonitis out of eighty-two patients were transferred to the intensive care unit [7]. Post-abortal peritonitis is often complicated by mortality [8]. The best prevention of this phenomenon would be better sexual education, optimal use of contraception, thus avoiding any unwanted pregnancy that could push women to these dangerous practices.

Conclusion

Serious and life-threatening complications can result from illegal abortions. Illegal abortion must be prevented by better health education. Thus, abortion legislation should be discussed, but will be difficult given the religious, ethical and social context.

References

1. Mayi-Tsonga S, Diallo T, Litochenko O, et al. Prévalence des avortements clandestins au centre hospitalier de Libreville, Gabon. Bull SocPatholExot. 2009; 102: 230-323.
2. Fenomanana MS, Rakotoarivony ST, Riel AM, et al. Profilépidémio-clinique et thérapeutique des pelvipéritonitespostabortives à la maternité du CHU.

d'Antananarivo Madagascar. Revue d'anesthésie-réanimation et de médecine d'urgence. 2009; 1: 17-20.

3. Cisse CT, Faye EO, Cisse ML, et al. Perforation utérine après avortement clandestin. Med Trop. 1999; 59: 371-374.
4. Kambiss SM, Hibbert ML, Macedonia C, et al. Uterine perfo ration resulting in bowel infarction: sharp traumatic bowel and mesenteric injury at the time of pregnancy termination. Mil Med. 2000; 165: 81-82.
5. Coffman C. Bowel injury as a complication of induced abortion: a case report and literature review. Am Surg. 2001; 67: 924-926.
6. Jhobta RS, Attri AK, Jhobta A. Bowel injury following induced abortion. Int J Gynaecol Obstet. 2007; 96: 24-26.
7. Hilal GF, Thiam O, Leye PA, et al. A serious complication of induced illegal abortions: the septic shock secondary to peritonitis by cecal perforation with retention of instruments. Service d'Anesthésie Réanimation CHU Le Dantec Dakar (Sénégal). 2014.
8. Ibrahima Ka, Papa Saloum Diop, Amadou Bocar Niang, et al. Peritonite aigue généralisée par perforation utérine post abortum a propos d'une observation. Pan Afr Med J. 2016; 24: 98.