

Research Article

Ileal Evisceration Per Vaginum: A Serious Complication of Clandestine Abortions

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Abstract

Per vaginum evisceration through uterine perforation is a rare but potentially serious complication of clandestine abortion. early diagnosis and aggressive volume resuscitation enable major surgical management and reduce patient mortality. Serious complications include haemorrhage, infection and damage to surrounding organs (intestinal, urological). This is the report of two observations of evisceration per vaginum during a clandestine abortion by endo-uterine maneuver. The first patient, aged 20, nulliparous, presented to the emergency department with externalization of the bowel and ileal loop necrosis 3 hours after the abortion. In the majority of cases, surgical management is by laparotomy, but a laparoscopic procedure can be performed if the externalized viscera is the omentum. The post-operative course is straightforward, but the obstetrical prognosis remains guarded due to the sequelae of induced abortion. Despite efforts to raise young girls' awareness of the harmful effects of clandestine abortions and legislation against such practices, young girls are still being encouraged to undergo abortions with serious complications. Conclusion: we describe two cases of post-abortive intestinal evisceration, despite efforts to raise young women's awareness of the harmful effects of illegal abortions. Vaginal evisceration is a surgical emergency and treatment is mandatory without a diagnostic assessment. Efforts must be made to reduce the number of unsafe abortions.

Keywords

Clandestine Abortion, Uterine Perforation, Ileal Evisceration

1. Introduction

Clandestine induced abortion remains a real public health problem in developing countries. It is practised under cover of illegality. It is performed clandestinely, in inadequate health facilities and by unqualified staff. [1, 2] Numerous complications have been described, of which evisceration per vaginum remains one of the rarest and most serious. Management of these maternal complications sometimes requires long hospital stays. [3] Two cases of ileal evisceration requiring laparotomy and large intestinal resection are reported to highlight

the seriousness of clandestine abortion.

2. Patient and Observation

Observation 1:

On 06/05/2023, a 20-year-old nulliparous primigravida patient was admitted to the gynecology and obstetrics emergency department with abdominal pain, vaginal externaliza-

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tion of anus, and discharge of serohematic fluid. The patient was pregnant with an estimated gestational age of 22 weeks' amenorrhea (SA), and had consulted a local doctor's surgery on the same day for a voluntary interruption of pregnancy (IVG). Six hours earlier, the patient had undergone an attempted termination by endo-uterine instrumental maneuver. Pelvic and epigastric pain, abundant metrorrhagia and a small exit through the vagina had forced her to stop the procedure and be referred to emergency.



Figure 1. Ileal evisceration per vaginum with meso disinsertion and loop necrosis.

On admission, the patient's general condition was preserved, with blood pressure at 95/41 mmHg, pulse at 69 beats/minute and temperature at 37.8°C. Conjunctivae were pale. The abdomen was painful throughout, with sharp pelvic tenderness. Gynaecological examination revealed blood at the vulva, with perforation of the small loop, disinserted from its meso, blackish 160cm long (figure 1), on vaginal touch the cervix was dilated to 4cm, the uterus was 21-22 SA in size.

The haemogram showed a haemoglobin level of 8.7 g/dl and a white blood cell count of 12700/ml. The chest x-ray was unremarkable.

Resuscitation was initiated with an infusion of Geloplasma and the transfusion of two bags of group O-positive blood. Antibiotics (ceftriaxone 1g; metronidazole 500mg; Gentamycin 160mg) and analgesics (Perfalgan* Acupan*) were administered.



Figure 2. Uterine perforation with ileum incarceration on posterior surface of uterus.

At laparotomy, there was a 4 cm perforation of the posterior surface of the isthmus with a haematoma, and incarceration of the terminal ileum 25 cm from the ileo-caecal junction (figure 2). The peritoneal cavity contained 150cc of blackish fluid and some placental debris. The uterus was not necrotic, had the size of 22 SA containing the remains of fetal debris, there was no stool in the cavity.

Our gestures were

1. resection-anastomosis,
2. a release and removal of the part
3. digital curettage through the orifice
4. uterine breach trimming and suturing with separate vicryl stitches
5. peritoneal cavity cleansing and drainage
6. Vaginal extraction of fetal remains and placenta



Figure 3. A. placenta; B: fetus with amputated thorax and lower limbs; c: resected necrotic ileal loop.

Observation 2: A 35-year-old female with 3 parity and 2 live children was admitted to the emergency department with evisceration after 4 days of endouterine maneuver abortion. Physical examination revealed spontaneous evisceration during a coughing effort, pelvic pain, and a normal haemogram apart from a leukocyte count of 10,700 cells per cubic millimetre and haemoglobin of 11g per decilitre. Creatinemia was normal. The preoperative diagnosis evoked was per vaginum evisceration by post abortum uterine eschar fall.



Figure 4. Ileum evisceration without loop necrosis.

Emergency laparotomy was therefore indicated. A general anaesthetic with orotracheal intubation was administered, and the approach was a median. On opening, the peritoneal cavity was clean, and exploration had noted incarceration of a segment of ileum in the uterine breach without intestinal necrosis (Figure 3). Treatment consisted of removal of the ileal segment and closure of the uterine breach.

Postoperative feeding was authorized on D3, and the post-operative course was straightforward.



Figure 5. Perforation of the posterior surface of the uterus with loop incarceration.

3. Discussion

Africa is the region of the world with the highest annual number of abortion-related deaths. At least 9% of maternal mortality in Africa is attributable to unsafe abortion. The most frequent complications of abortion are incomplete abortion, excessive blood loss and infection. [4] In Africa, the abortion methods used are often crude and traumatic [1] evisceration per vaginum post abortum, a traumatic incarceration of the intestinal tract through a uterine opening. This is a rare clinical complication of induced abortion. [5, 6] This rarity may be due to the fact that very few cases are reported in the literature. All cases of per vaginum evisceration have been recorded in Africa. [3, 6] In the first case, the rupture occurred during the manoeuvre, with the mesentery being disinserted over 120 cm from the ileum. Another form, uterine perforation with incarceration of the small loop in the uterus. [1, 5] Two similar cases of evisceration are also reported by Takongmo et al. [14] These “unsafe” abortions are performed by someone who lacks the required skills, using unsafe materials and techniques, or in an environment where minimum medical standards are not met. [10, 11] The young age of our patients, found in the literature. [3, 8] This can be explained by the sexual activity of this age group: the first patient was a “girl of joy” who had

to multiply her partners to make a good sum of money, and keeping a pregnancy in a foreign country would be a hindrance to her profession. The second patient, a single mother abandoned by her partner, didn't want another pregnancy because of her precarious situation. This kind of poverty has been noted in other African series. [1, 3, 11, 16] prostitution is also found in Dabo's study in Mali [16].

The mean age of pregnancy in our observations was 22 and 14 SA. In contrast to Lebeau and Ka, the mean ages were 11 and 12 SA respectively. [1, 3]

The diagnosis was clinical. The clinical picture was marked by the externalization of a length of more than one meter of small intestine. These maneuvers were carried out by paramedics who had no knowledge of abortion management. Ultrasound or CT scan can be used to diagnose a suspected perforation with insertion of the small intestine into the uterus, or insertion of an omentum fringe. These investigations are particularly important in the case of long-standing perforations. [8, 9, 12, 13]

However, magnetic resonance imaging (MRI) to identify uterine lesions with omentum incarceration after abortion has received little attention in the literature. [7, 8]

Many authors maintain that abortions in Africa are carried out by inexperienced and unauthorized hands. [3, 6, 10, 14] Laparotomy remains the most commonly used approach.

According to other authors, perforations with omentum incarceration can be treated by laparoscopy, with disincarceration and closure of the breach. [9] In the literature, one case of incarceration of the omentum was treated hysteroscopically. [13] However, surgery remains the cornerstone of treatment for this entity, providing both diagnostic and therapeutic management. [12] Intraoperatively, a resection-anastomosis was performed, with associated removal of the suture from the uterine breaches. Post-operative management was straightforward in both cases. In contrast, in the case of Ngowe et al. the anastomotic resection was complicated by postoperative peritonitis requiring reoperation. [6] In the study by Singla et al. a 160cm resection followed by jejunostomy was performed with recovery 3 months after surgery. [17]

The type of procedure, the age of gestation, the patient's comorbidities, the clinician's experience and, above all, the safety or unsafety of the abortion influence complication rates. [8, 17, 18] These complications can be infectious, hemorrhage requiring hysterectomy or death. [15, 16]

4. Conclusion

Early identification of intestinal prolapse, aggressive resuscitation and prompt surgery can reduce the adverse consequences and deaths associated with such injuries. The seriousness of the problems evoked in these observations calls for reinforced education and the benefits of contraception.

Abbreviations

g	Gram
ml	Milliliter
mg	Milligram

Author Contributions

Camara Mamadouba: drafted and corrected the manuscript

Traoré Adama: read and approved the final version of the manuscript

Camara Mamadou: wrote the second case and approved the final version

Cissé Fodé: read and approved the final version of the manuscript

Conflicts of Interest

The authors declare no conflicts of interest about an observation.

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