

Evisceration of the Small Bowel in the Vagina Following Endo-Uterine Maneuvers for Clandestine Abortion (APC) at CHU Gabriel Touré, Bamako, Mali

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Abstract

Intra-uterine manual aspiration is the recommended maneuver for abortive endo-uterine evacuation. It must be performed in a medical setting for therapeutic purposes, while respecting its contraindications and asepsis rules essential for its implementation. The ignorance of anatomical structures by the authors of clandestine abortions is marked by the presence of utero-adnexal lesions, digestive lesions and vesical lesions or evisceration by the vagina. Vaginal evisceration of the small bowel is a rare and serious complication of manual intrauterine aspirations and induced abortions. Their late diagnosis and clandestine practice are responsible for unpredictable severe secondary complications and remain an important cause of morbidity and mortality. The development of a policy of continuous training of agents on the technique of manual intrauterine aspiration, broad information on contraceptive methods and a multidisciplinary, rapid and adequate management of complications will provide minimum morbidity and mortality. Conclusion: Abortion is a serious source of life-threatening complications.

Keywords

Evisceration, Abortion, Surgery, Mali

1. Introduction

The abortion is illegal in Mali [1]. Abortion is the termination of pregnancy with

complete expulsion or not of the product of conception before 22 weeks of amenorrhea (SA) [2]. The gesture usually involves curettage (empty the uterus of what it contains without destroying the endometrium). Its practice is clandestine, in inadequate sanitary environments and by people who are insufficient or unskilled, clandestine induced abortions (APC) remains frequent with high morbidity [3]. It is then a source of serious life-threatening complications. Uterine perforation occupies an important place among its various complications [4]. However, evisceration through the vagina is an exceptional situation. Thus, we report a case in the aftermath of endo-uterine maneuvers for clandestine induced abortion (APC).

2. Patient and Observation

We report the observation of TD, 38 years old, divorced, sex worker, G6P6V4D2, HIV-1 positive for 1 year on ARV in unobservance of care for about 8 months, under contraceptive (implant levonorgestrel), having consulted obstetric emergencies for retention of abortive debris. The anamnesis found hypogastric pain like cramps, of constant variable intensity, without periodicity, radiating in the back, associated with metrorrhagia made of scarce incoagulable blood, micturition, vertigo, unquantifiable fever and vomiting occurred in a self-medication and traditional potions challenge for the purpose of abortion, suspected pregnancy on the basis of symptoms (three-month amenorrhea, vomiting, vertigo and asthenia) despite the presence of a (levonorgestrel implant).

An ultrasound performed, 18 hours after the onset of symptoms, in a cabinet of a gold panning area, reported urethral bleeding and the presence of abortive debris (according to the health worker), which was followed by manual aspiration intrauterine resulting in uterine rupture with evisceration of the small bowel in the vagina. Examination upon admission found: a conscious patient GCS: 15; good general condition, colored connective, febrile at 39°C, his hemodynamic constants were: PAS: 113 mm hg; PAD: 51 mmHg; tachycardia at 121 b/min; polypnea at 28 c/min, free lungs; on the abdominal examination, a painful abdomen with little flexibility and peri-umbilical defense without inflammatory signs; a contracture, diffuse dullness on percussion, and diminished hydro-aerial noises upon auscultation; a vulva moistened with blood and the flexible vaginal parrot on gynecological examination with evisceration of hail at the necrotic margins of about 30 cm through the vagina (**Figure 1**); tonal rectal sphincter toned, cul de sac sore and dull, a fingerstall bringing traces of stool normal

She was classified ASA IIIU, Altemeier IV. After conditioning (Monitoring, taking two 18 G peripheral venous pathways on each forearm, bladder catheterization) a biological assessment was carried out and found: rhesus group = O +, an infectious syndrome with hyperleucocytosis at 16,000 GB/mm³ (N = 4000 – 1000/mm³) and anemia: hemoglobin = 09.8 g/dl (N = 12.5 - 15.5 g/dl), hematocrit = 29.2% (36% - 48%), blood glucose, serum creatinine, serum uricemia were no particularity, urinary BHCG negative. Under antibiotic coverage (metronidazole and ceftriaxone), after filling test, macrolide 500 ml, and prediction



Figure 1. Woman with intestinal loops coming out of vagina.

of labile blood products, the patient was sent to the operating room in the presence of the team of general surgery and gyne-obstetric. Taking under general anesthesia plus orotracheal intubation, 8 ml/kg/h of crystalloid supplies, prevention of post operative pain with paracetamol and nefopan.

At the laparotomy, a pyo-stercoral liquid of 300c was discovered, an externalization of the hail by an opening of the uterus with the necrotic banks (**Figure 2**), the gestures realized were a pus sample for bacteriological examination and antibiogram, an extrication of the hail in the uterine orifice, ileal resection over 3 meters, then ileo-ileal anastomosis, tubal ligation hysterorrhaphy, abundant washing of the peritoneal cavity with 10 liters of saline and set up drains and closure plan by plan. There was no accident during surgery, three (3) accidents with induction hypotension, at 30 mn, and 75 mn, were provided and quickly corrected by the filling and ephedrine chloridrate 6 mg. The duration of the intervention was 3 hours, anesthetic time three hours twenty-six ammunition (3H26). The patient was extubated on the table and transferred to an intensive care unit for postoperative management (PEC). The follow-up was simple, the patient was transferred to surgery two (2) days post-operative and seven (7) post-operative ex postoperative days.

3. Discussion

Intra-uterine manual aspiration is the recommended maneuver for abortive endo-uterine evacuation. It must be performed in a medical setting for therapeutic purposes, while respecting its contraindications and asepsis rules essential for its implementation. It is not insignificant because it can cause complications

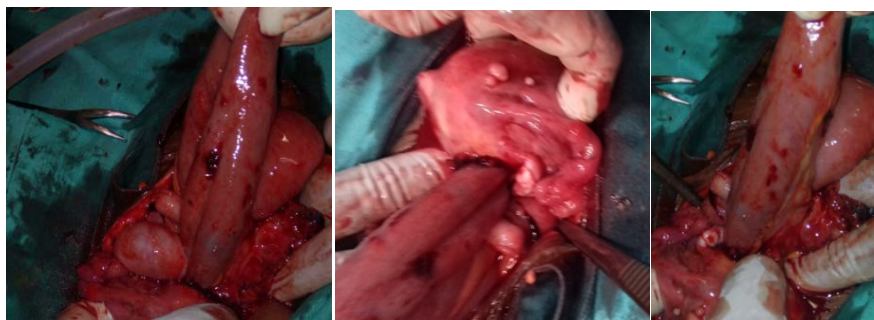


Figure 2. Perop image with incarceration of intestinal loops in the uterus.

as underlined by Cremieu *et al.* [4]. The immediate morbidity of this clandestine abortion type of peritonitis not traumatic section of the small bowel Trans-urethral eviscerated in the vagina. Was due to clumsiness, lack of knowledge of the anatomy and complications related to the act of the abortion agent and the brutal methods and means used. Several factors may explain the use of untrained staff in the practice of abortion [4] [5], and are solicited by single young women between the ages of 15 and 30, our patient was divorced and elderly more advanced but was professional sex.

The Malian social context is a factor predisposing women to a request for abortion is prohibited in Mali [1]. As in a number of African countries, which make the clandestine, carried out in precarious conditions by inexpert hands and are a source of serious complications and at the non-measurable risks of infection of the other patients, because of the incompetence of the practitioners and the environments of realization of these illegal abortions. Note that the status of our patient was ignored by the abortionist.

According to several African authors [6] [7] [8], as in our patient, uterine perforation and vaginal evisceration of hail occur in the aftermath of an APC. The ignorance of anatomical structures by the authors of clandestine abortions is marked by the presence of utero-adnexal lesions, digestive lesions and vesical lesions or evisceration by the vagina. The other aggravating factor of the lesions is the delay in the interpretation of the signs of complications. Intense or prolonged pain, chills with fever, severe blood loss, nauseating vaginal discharge are late signs of complications [7]. They are related to a poor general state of patients upon arrival in the surgical services. Such an evolution explains the high mortality rate of 15.6% in several African series [8] [9] [10] [11], the delay in the intra-hospital care would be incriminated. Our patients were admitted to stage III of the ASA classification but had received immediate and adequate (multidisciplinary) management.

Mircea *et al.* [12] advocated the practice of continuous peritoneal lavage with good results. This technique seems to have a favorable effect on renal function, which would encourage it in patients with severe sepsis and impaired renal function. Our patient was admitted into a severe sepsis table, she benefited preoperatively and postoperatively from an antibiotic coverage and a peritoneal lavage abundant intraoperatively, the after-effects were simple, the hospitalization did

not last only seven (7) days.

4. Conclusion

Vaginal evisceration of the small bowel is a rare and serious complication of manual intrauterine aspirations and induced abortions. Their late diagnosis and clandestine practice are responsible for unpredictable severe secondary complications and remain an important cause of preventable morbidity and mortality in women.

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