

Case Report

Bowel Prolapse and Strangulation Following Induced Abortion: A Case Report and Review of Literature

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ABSTRACT

Bowel prolapse and strangulation is an uncommon and life threatening complication of induced abortion. It is commonly seen in countries where abortions are performed by untrained personnel and unskilled medical practitioners. A case is reported of a 25-year old woman with missed abortion at 5 months gestation who had instrumental evacuation complicated by hemoperitoneum, bowel prolapse and strangulation. Patient subsequently had exploratory laparotomy, bowel resection and primary anastomosis with good postoperative outcome.

Key words: Bowel prolapse, Bowel strangulation, Induced abortion.

INTRODUCTION

Unsafe abortion is a public health problem and constitutes a major threat to the life of women in the reproductive age group. Worldwide, over 19 million abortions are done yearly by individuals without the requisite skills, or in environments short of minimum medical standards, or both. The vast majority of these unsafe abortions (97%) occur in developing countries. [1,2]

In spite of the fact that the Nigerian law prohibits induced abortion for socio-cultural and religious reasons, it is estimated that 25 per 1000 women of reproductive age group have it done annually. [3] Perhaps, this may be an underestimation as most cases are performed in secrecy and complications arising from the procedures are often concealed. Even in some countries, such as India, where abortion law has been liberalized for over three decades, access to competent care remains restricted because of other barriers and the share of unsafe

abortion as a cause of maternal mortality continues to be alarming. [4]

Induced abortion is associated with many complications. [5] The most common visceral injury is to the uterine wall but all genital organs (vagina, cervix), intestines (jejunum, ileum, sigmoid colon and rectum) and the urinary bladder can be damaged. Bowel injuries are dreaded complications and could be in different forms ranging from perforation with peritonitis, mesenteric injury, bowel prolapse with intestinal obstruction and/or strangulation and fistula formation. [6-9]

The possibility of these injuries and requirement for expertise care makes general surgeon's evaluation and management imperative and most often patients are co-managed with the gynaecologists.

CASE PRESENTATION

A 25yr old married woman, G3p1+1

(1alive), who resides in Ado-Ekiti presented at our facility with bowel protrusion from the vagina of 3hours duration. She initially presented at a private hospital due to her inability to perceive fetal movement 3weeks prior to the time. An ultrasound scan done confirmed non-viable fetus at estimated gestational age of 14 weeks+3 days. She was immediately scheduled for instrumental evacuation by a medical personnel. In the process, a tubular structure protruded out of the vagina which was further pulled-out by the medical officer.

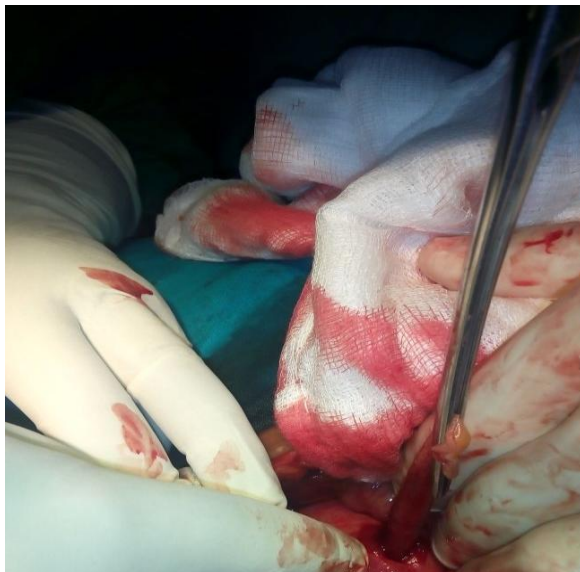


Figure 1: Prolapsed bowel from vagina.

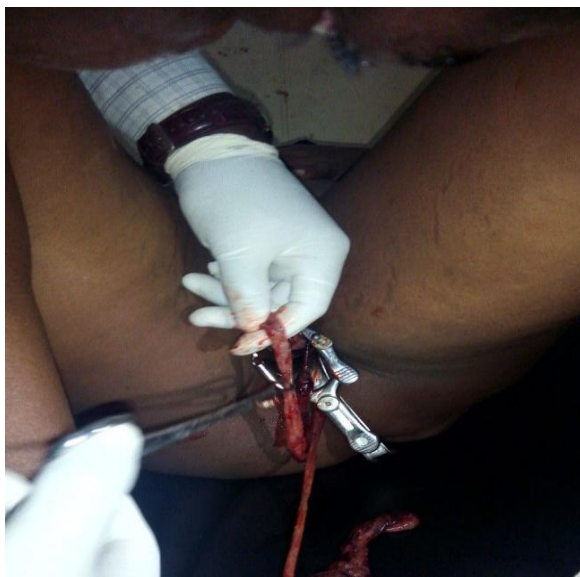


Figure 2: Bowel prolapse through uterine perforation.

Examination at the emergency department showed a young woman who was pale, tachypneic and tachycardic but no

fever. Blood pressure was 110/70 mmHg. There was diffuse lower abdominal tenderness with guarding. Vaginal examination revealed a dusky atonic bowel segment about 16cm long from the introitus with some clotted blood plugging cervical os (Figure 1). Par rectum examination was insignificant. A provisional diagnosis of prolapsed strangulated bowel secondary to uterine perforation was made.

Patient was resuscitated and subsequently had exploratory laparotomy after 3hours of admission. Intraoperative findings were: An estimated 1Litre of hemoperitoneum, mesenteric injury, a perforation at the posterofundal aspect of uterus 3cm in diameter (Figure 2) and prolapsed strangulated ileal segment about 25cm in length. She had ileal resection and end-to-end anastomosis, evacuation of retained products and closure of uterine perforation.

Postoperative period was uneventful and patient was discharged home on the 6th day of admission.

DISCUSSION

Unsafe abortion with its various complications is a major public health problem in Nigeria and other African countries with a high rate of maternal morbidity and mortality. [3,5,7,9] Social restriction and legal prohibition of abortion often allows backstreet abortion in the developing countries and under conditions far from being ideal with patients falling victims of untrained personnel and unskilled practitioners.

Bowel prolapse and strangulation is an uncommon and life threatening complication of induced abortion as seen in this case report. Other abdominal and visceral complications include: intestinal fistula, bowel perforation and infarction, pelvic abscess, hemoperitoneum, vaginal, cervical and uterine lacerations. [7,10,11]

The most common sites of intestinal injuries are the ileum and pelvic colon but more proximal bowel injuries involving the jejunum have also been reported by other

colleagues. [7,12] The surgical management in small intestinal perforation is fairly straightforward. Primary closure is usually carried out after the edge of perforation is freshened. However, resection and primary anastomosis may be required in multiple perforations of a bowel segment.

Vaginal evisceration of bowel is a surgical emergency and treatment is mandatory even without didactic diagnostic workup. Most times there is associated mesenteric injury and vascular compromise of the involved bowel segment that usually warrants resection and primary anastomosis. [9,13]

The management of large bowel injury is more controversial especially when the left colon is involved. In delayed presentation with gross peritoneal contamination, a simple colostomy appears to be the safest approach. Other surgical options include primary repair, resection and primary anastomosis, and repair with a proximal protective colostomy. However, resection and primary anastomosis is not advisable in poor risk patients with uncorrected anaemia, gross intraperitoneal soilage with sepsis and hypovolaemia as these factors are causes of anastomotic failure and abdominal wound dehiscence.

Our index patient presented early and had bowel resection with good outcome. The prompt referral was perhaps due to the fact that the abortion was not done clandestinely or by a quack. Early presentation usually carries a good prognosis even with primary bowel resection and anastomosis. This is in contrast to most studies where there is delayed presentation and post-abortal complications are concealed for stigmatization, socio-cultural and religious reasons with attendant high morbidity and mortality. [6,12]

CONCLUSION

Unsafe abortion is still a significant health problem in our settings. Instrumentation in inexperienced hands for termination of pregnancy has resulted in

several visceral injuries. Safe sexual practices, liberalization of abortion laws, adequate training in the techniques of pregnancy termination, prompt recognition and expert management of complications will significantly reduce the associated morbidity and mortality.

REFERENCES

1. Grimes DA, Benson J, Singh S, Romero M, Ganatra B, Okonofua FE, Shah IH. Unsafe abortion: the preventable pandemic. *Lancet*. 2006; 7(9550):1908–1919.
2. World Health Organization. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and association mortality in 2003. 5. Geneva: WHO; 2007.
3. Henshaw SK, Singh S, Oye-Adeniran BA, Adewole FA, Iwere N, Cuca YP. The incidence of induced abortion in Nigeria. *Inter FamPlannPersp* 1998; 24(4):156–164.
4. Jain V, Saha SC, Bagga R, Gopalan S. Unsafe abortion: a neglected tragedy. Review from a tertiary care hospital in India. *J ObstetGynaecol Res*. 2004 Jun; 30(3):197-201.
5. Aboyeji MP, Fawole AA. Complications from unsafe abortion, presentation in Ilorin (Nigeria) *Niger J Med*. 2002; 11:77–80. [PubMed]
6. Rehman A, Fatima S, Gangat S, Ahmed A, Memon IA, Soomro N: Bowel injuries secondary to induced abortion: a dilemma. *Pak J Surg*. 2007, 23: 122-125.
7. Ntia IO, Ekele BA. Bowel prolapse through perforated uterus following Induced Abortion. *Afr J Med* 2000; 19(13): 209-11.
8. Coughlin LM, Sparks DA, Chase DM, Smith J. Incarcerated small bowel associated with elective abortion uterine perforation. *J Emerg Med*. 2013 Mar; 44(3):e303-6.
9. Ngowe N, Atangana R, Eyenga V, Sosso M. Intestinal infarctus following dilatation and uterine curettage. *Case Rep Gastroenterol*. 2008; 2:125–127. doi: 10.1159/000104976.
10. Okobia MN, Osime U, Ehigiegba AE. Intestinal injuries from complicated

- abortion a report of five cases. Nig J ClinPract. 1999; 7(2):61-4.
11. Jhobta RS, Attri AK, Jhobta A. Bowel injury following induced abortion. Int J Gynaecol Obstet. 2007; 96(1):24-7.
 12. Oludiran OO, Okonofua FE. Morbidity and mortality from Bowel Injury secondary to Induced Abortion. Afr J Reprod Health 2003; 7(3): 65-8.
 13. Kambiss SM, Hibbert ML, Macedonia C, Potter ME. Uterine perforation resulting in Bowel infarction: Sharp traumatic bowel and mesenteric injury at the time of pregnancy termination. Milmed 2000; 165(1): 81-2.

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