CHALLENGES AND COMPLICATIONS ASSOCIATED WITH UNSAFE ABORTION: A CASE REPORT

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ABSTRACT

Introduction: Unsafe abortion and associated consequences remain familiar, albeit the occurrence being inadequately documented. Due to the circumstances under which abortions are performed, quantification of the magnitude of the problem, and the extent of morbidity and mortality, has remained inadequate. Hence, there is a need to both conduct studies and highlight examples of severe morbidity and mortality related to abortion to raise awareness and pave ways towards informed policy development.

Methodology: We followed the patient prospectively followed up for seven months with diligent documentation of events, investigations, and outcomes from admission to discharge. Informed consent for publication was obtained during this period.

Findings and management: The patient presented three weeks after failed medical abortion and a manual vacuum aspiration trial at 16 weeks of gestation in a private slum-based clinic. She had fulminant sepsis complicated by pelvic and subphrenic abscesses, which were drained. There was suture-line dehiscence that was complicated by an extensive subcutaneous abscess that necessitated drainage, during which there was inadvertent small bowel injury. A high-output enterocutaneous fistula, associated with severe morbidity, developed. Due to severe morbidity, conservative management was deemed as more preferable. Intravenous alimentation and supportive antibiotic therapy did not result in spontaneous healing, and repair was undertaken when the patient was stable.

Conclusion: This case exemplifies the cascade of adverse outcomes in unsafe abortions and the consequent high risk of maternal mortality. Hence the need for educational interventions to avert such incidences.

Keywords: unsafe abortion, septic abortion, enterocutaneous fistula, multi-specialty approach

INTRODUCTION

Unsafe abortion is a significant cause of maternal morbidity and mortality, with high potential for a long term and short term complications, including Maternal Near Miss (MNM)[1,2]. In Kenya, restrictive laws may contribute to the preponderance of unsafe abortions, which are often complicated by haemorrhage and sepsis, and hence the risk of maternal mortality[1,3]. This case exemplifies the cascade of severe consequences of septic abortion that are likely to occur when unsafe abortions are performed.

According to the World Health Organization (WHO), the unearthed cases constitute a nominal iceberg phenomenon[4]. Since data collection is incomplete, only estimates are used in consideration of possible interventions[4,5]. Despite attempts to renew interest in this area over the last decade, this has not resulted in adequate data accumulation. Thus, this report should stimulate both practitioners and academicians to get

involved in the case and incident documentation and evolve research strategies to define the extent of the problem and evidence-based interventions.

CASE PRESENTATION

The case was of a 28-year-old para 2+1 domestic worker, whose last delivery was in 2011. She had separated from her husband approximately five years before her hospital admission. She was on injectable contraceptives, but the use was inconsistent. She had an unintended pregnancy. She attempted to procure a medical abortion at 16 weeks. Manual Vacuum Aspiration (MVA) was performed by an inexperienced para-medical practitioner in a slum-based private clinic, culminating in uterine perforation, severe sepsis with per-vaginal exudation of copious purulent material, severe lower abdominal pain, marked tenderness with guarding, and fever.

An ultrasound, done on admission, three weeks after the attempted abortion, showed abdominopelvic fluid collections, thereby necessitating exploratory laparotomy. The extent of the infectious morbidity necessitated the extension of the sub-umbilical incision cephalad to near the xiphisternum. The gut and pelvic structures were matted, with subphrenic and pelvic abscess collections. Pus was drained in all regions and products of conception retrieved from the pouch of Douglas. Also, peritoneal lavage was done with normal saline and a negative pressure drain left in situ for nine days. The patient was put on intravenous ceftriaxone, metronidazole, and analgesics. Microbiological microscopy, culture and sensitivity of the pus sample taken intraoperatively showed no growth. Surgical site infection occurred, with copious drainage of pus. An abdominopelvic ultrasound showed a percutaneous surgical site abscess indicating wound dehiscence (Figure 1).

Surgical drainage of the subcutaneous abscess was scheduled. During the surgery, there was an inadvertent opening of the rectus sheath with injury to an adherent small gut. Primary repair was performed, and then the patient was transferred to the surgical ward. The patient was put on intravenous fluids, analgesics, and antibiotics. A Central Venous Catheter (CVC) was also inserted for total parenteral nutrition and invasive cardiovascular monitoring during this period of clinical instability.

An Enterocutaneous Fistula (ECF) was diagnosed five days after the iatrogenic bowel injury's primary repair. On day 9, the output rose to 600ml in 24 hours, making it a high output enterocutaneous fistula. An abdominopelvic Computerized Tomography (CT) scan confirmed the diagnosis.

Multidisciplinary care, which included supportive care by nutritionists, wound care teams, and counsellors, was preferred. Parenteral and enteral feeding, stoma care, surveillance of total blood count parameters, hepatic and renal functions, and psychosocial care were done. The clinical condition of the patient remained unstable over the following six months, with recurrent electrolyte imbalance episodes, essentially constituting an MNM. When the condition stabilized, the ECF was repaired, and she was discharged 10 days after the repair, approximately seven months since admission.

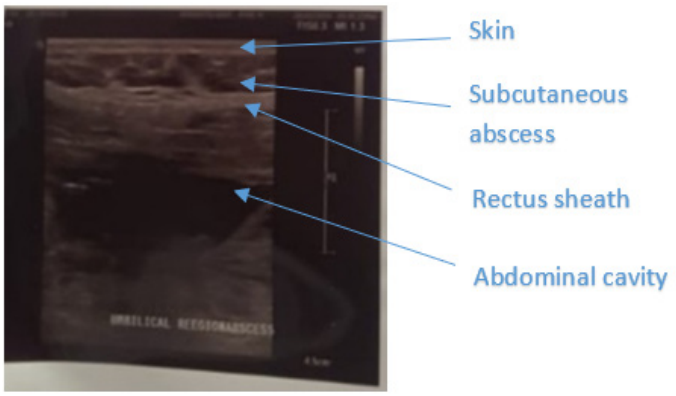

Figure 1: Ultrasound showing a cutaneous incisional abscess within the surgical site.

DISCUSSION

This case classically exemplifies the progression of the risks of unsafe abortion that results in MNM. Disregard of gestational age in performing MVA resulted in severe genital tract injuries and severe abdominopelvic infectious morbidity, thereby requiring multi-specialty interventions. Also, the inability to recognize the potential for complications of MVA when the gestation is advanced, including uterine perforation and failed uterine evacuation, made the prognosis of the patient precarious. The resultant delay in seeking appropriate specialized health care indicates deficiencies in knowledge about septic abortion by the patient and the initial service provider[2].

Delay in seeking appropriate health care predisposed the patient towards more severe morbidity culminating in an MNM[1]. In this case, the cascade of events necessitated multiple surgical interventions with inadvertent gut injury and consequent development of a high output ECF, which is challenging to manage and is often associated with severe morbidity[6,7]. A multi-speciality care team, including nutritionists, wound care specialists, and counsellors, was essential in managing this patient. Imaging studies such as a CT scan to determine the fistula's site, laboratory investigations to assess the extent of biochemical parameter derangement and surveillance for infection are essential in managing patients with enterocutaneous fistula[8].

Delay in seeking health care by the patient also culminated in bleak future reproductive capacity given the sepsis, which could result in tubal, uterine, and endometrial factor infertility[9]. The socio-economic implications were massive in terms of cost of care and high opportunity costs in earnings[5,10]. The cost of management of the potential complications of infertility and chronic pelvic pain are also colossal[10]. Thus, the risk of perpetuation of the poverty cycle is maintained[5]. Social stigma influences the choice of abortions and, therefore, influences delay in seeking appropriate medical care as well [1,3,5,11].

This case shows that lack or inconsistent contraceptive use predisposes to unintended pregnancies and high risk of abortion-related morbidity and mortality, which could be avoided[11,12]. Thus, a critical preventive measure includes providing comprehensive contraceptive education and services to prevent unintended pregnancies and complications associated with unsafe abortions[11, 12, 13].

CONCLUSION

This case depicts the consequences and the determinants of unsafe abortions. The need for a preventive strategy, public education, and a multi-speciality approach, as highlighted, are the core measures to avert morbidity and mortality in unsafe abortion cases.

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