Post-Abortive Pyrexia

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Day 1. 11:30 pm, Ain Shams University-Maternity Hospital (ASU-MH) - Emergency Room (ER).

A Para 0+2, 35 years old lady presented to the reception room with the complaint of vaginal bleeding and lower abdominal pain following an evacuation and curettage 24 hours earlier.

This operation was the third one for first trimesteric missed miscarriage since her marriage 2 years earlier.

The patient was alert and well oriented with a fair general condition despite the apparent discomfort due to her abdominal pain. The blood pressure was 100/60 mmHg, her pulse was 90 bpm with full volume and her temperature was 36.8º C.

Day 2. 12:00 am. ASU-MH-ER - Observation Room (OR).

The patient was reviewed by the 2nd-on-call physician (the assistant lecturer on-duty). She had diffuse lower abdominal tenderness with mild guarding and rigidity but no rebound tenderness. Pelvic examination revealed a tender, soft and bulky uterus and no masses in the adnexal or Douglas pouch. Mild vaginal bleeding was revealed through a closed, normal looking cervix.

The patient gave a history of absolute constipation since the operation. Examination revealed audible but sluggish intestinal sounds, P.R. examination revealed stools in the rectum.

Day 2. 1:00 am. ER- OR.

Pelvic ultrasonography revealed a bulky uterus, with a 3 X 4 cm echogenic shadow in the uterine cavity and a small fluid collection in the pouch of Douglas. Abdominal X-rays in erect and supine positions showed no abnormalities. Consultation of the general surgery department could not conclusively exclude or confirm the suspicion of intestinal injury.

A decision was taken for continued observation of the general condition, abdominal symptoms and signs under cover of broad spectrum antibiotics, analgesia, intravenous fluids and nill by mouth regimen.

Day 2. 9:00 am. In Patient Ward

The patient started to look toxic and pale, her pulse gradually rose to 105 bpm but her temperature and blood pressure were still the same since admission. Intestinal sounds were audible but her abdomen became more rigid and tender.

Day 2. 10:00 am. ER- Operating Theatre II

The patient was transferred for exploratory laparotomy. A midline abdominal incision revealed fecal peritonitis. A small uterine fundal perforation had caused a 1x1 cm ileal perforation.

The general surgeons summoned to theatre performed resection-anastomosis, then the uterine cavity was evacuated and the perforation was repaired.

Discussion

In most instance, evacuation and curettage is considered one of the simplest obstetric maneuvers.

It is one of the easiest decisions taken by the senior staff and of the commonest procedures done by the junior staff. However, complications occur frequently, through mostly unnoticed and usually are self limiting.

Surgical evacuation of a missed miscarriage represents a difficult confrontation to everyone of us, requiring proper selection and surgical technique to avoid complications such as sepsis, incomplete evacuation and uterine perforation.

Preoperative use of prostaglandin E1 reduces those risks, and so does evacuation under ultrasound guidance. Medical evacuation by mifepristone and prostaglandins is still not available to Egyptian patients, but may be a safe alternative to surgery in selected cases.

This patient's clinical presentation should alert clinicians to the differential diagnosis of incomplete evacuation, septic abortion and traumatic injury to the uterus and other intra-abdominal organs.

When uterine perforation is suspected intraoperatively, the operating surgeon must always stop the procedure immediately, call for assistance and never try to confirm the perforation by introducing any further instruments. Laparotomy (or laparoscopy) should be done to confirm the perforation and if one is found, then whole bowel exploration is needed to exclude any possible intra abdominal trauma. The patient should be kept under anesthesia until a senior obstetrician/gynecologist decides that she does not need immediate laparotomy. The latter is indicated if remnants of conception are thought to be still left in the uterus or if the curettage was being done for septic abortion, gestational trophoblastic disease or if intraabdominal injury is suspected (hemorrhage, passage of stools or omental fat, perforation by ring forceps).

Patients presenting postoperatively with abdominal signs of uterine perforation may be managed conservatively if their general condition is stable, they have no symptoms or signs of intestinal injury and provided the initial procedure was not potentially septic (e.g. criminal or septic abortion).

Conserative management then would consist of nil by mouth regimen, I.V. antibiotics (metronidazole plus either penicillin-garamycin or 3rd generation cephalosporin), intravenous fluids and analgesia.

Close observation and senior staff consultation are the cornerstones in management of such cases.

If postabortive intrauterine remnants or bleeding due to sepsis is met, then ecbolics and antibiotics should be the first option of treatment to minimize the risk of surgical perforation of the uterus and would also give chance for antibiotic cover in case where surgery is indicated after failed medical treatment.

Conclusion

Intestinal injury must always be suspected in similar cases. Attending clinicians must bear in mind that not all cases will present with the full blown picture of peritonitis and that surgical exploration would cause less morbidity than a neglected fecal peritonitis.