

Case report

A FALSE TRACT TO A POTENTIAL GRAVE; UNSAFE ABORTION WITH PERFORATED CERVICAL INJURY AND CONSEQUENTIAL SEVERE HAEMORRHAGE. A CALL FOR MULTI-SECTORAL ACTION. "CASE REPORT"

Abstract.

Unsafe abortion is a major contributor to maternal mortality. About 68,000 maternal deaths yearly are due to unsafe abortion and among those that survive the complications of the procedure, approximately 5 million suffer short term and long term disabilities. This case reports an experience of a young unmarried woman who suffered a life threatening hemorrhage from punctured injury to the cervix resulting in false tract creation during the procedure of unwanted pregnancy termination performed by a quack. She was successfully managed, offered post abortion counselling and contraceptive among other post abortion care.

Unsafe abortion is a global phenomenon unlimited by national boundaries. The brunt is deeply suffered by women in the developing countries. To tackle these problems multi-sectoral efforts should be aimed at improving access to contraceptives in a non judgemental, adolescent friendly manner. Human right issues surrounding illiteracy, unemployment and socio-cultural deprivation infringe upon women should be eradicated through gender sensitive legislations and women friendly policies. Global approach involving political stakeholders and public health to discuss the alarming rate of unsafe abortion and galvanize resources at improving family planning services.

Keywords

Unsafe abortion, cervical punctured injury, life threatening hemorrhage, post abortion care, gender sensitive legislations.

Introduction

Unsafe abortion is a major contributor to maternal mortality. Of over 210 million pregnancies that occur every year globally, half of these are unplanned and unwanted.[1,2] Nearly 42 million of these pregnancies are voluntarily terminated and 50% are through an unsafe means. About 68,000 maternal deaths yearly are due to unsafe abortion and among those that survive the complications of the procedure, approximately 5 million suffer short term and long term disabilities.[1,2] According to World Health Organization, unsafe abortion is termination of unintended pregnancy either by a person lacking the required skills or in an environment lacking the minimal standard or both. [1]

The highest burden of unsafe abortion takes place in Africa, Latin America and South Asia.[1,2] In Nigeria, where there is restrictive law prohibiting induced abortion, it is surprising that the proportion of women who procure induced abortion is on the increase and most unintended pregnancy ended up being terminated by non medical personnel, in an unhygienic and unsafe manner thus resulting in complications. [3-6] Women with intentions of terminating unwanted pregnancies end up procuring the service of untrained persons in order to avoid the judgemental attitude of the medical personnel and ultimately escape being prosecuted in countries with restrictive abortion law.[3,6] However, they are consequently put in harm's way. Among the numerous short term complications of unsafe abortion are hemorrhage, genital injuries such as cervical laceration, uterine perforation,

bowel injury and sepsis. [1-6] Late complication may include infertility, ectopic gestation, and uterine synechia, cervical incompetence, psycho-sexual problems among many others.

[1-6] This is a case report of a young unmarried woman who suffered severe consequence of unsafe abortion performed by a patent drug seller who carried out procedure of induced abortion with a metallic sharp instrument on a table inside the room where he sells drugs, resulting in life threatening haemorrhage from perforating injury to the cervix in an attempt to gain access into the uterine cavity.

Patient and observation

Patient information : A 24 year old G2P0+1 single university student was referred from a peripheral hospital on account of bleeding per vagina of 12 hours and severe body weakness of 2 hours duration. She was amenorrhic for 8 weeks 5 days and confirmed pregnancy with positive pregnancy test kit. She opted for termination of the pregnancy and a patent drug seller offered her medication which was inserted into her vagina. Following which she started having profuse bleeding per vagina and she was rushed back to the same shop where she was offered surgical procedure to remove the remains of the fetal tissues from her uterus. The procedure was said to have been carried out with a hook like metallic instrument which resulted in severe pelvic pain and uncontrollable bleeding from the vagina. This necessitated her presentation in the referring hospital before she was eventually sent to our facility for expert care. She had voluntary termination of pregnancy at gestational age of 6 weeks done 2 years before the index presentation and it was through medical means. There was no post abortion complication.

Clinical findings: presentation she was lethargic, pale, anxious, dehydrated, afebrile, with temperature of 36.8 degree centigrade and nil pedal edema. Her pulse rate was 120 beats

per minutes small volume, blood pressure was 90/60mmhg. Respiratory rate was 26 cycle per minutes. Abdomen was full moves with respiration, there was suprapubic tenderness, no guarding, no rebound tenderness and bowel sound was normoactive. Pelvic examination revealed vulva that was smeared with fresh blood and vagina canal packed with gauze. Speculum examination revealed a closed cervical Os, with a punctured injury on the posterior wall of the cervical body at around 6 o' clock position, measured about 3 cm x 3cm communicating with the uterine canal. [Figure 1,2,3] There was product of conception protruding through the punctured wound. A sponge holding was used to remove the product of conception plugging the punctured false tract and the bleeding abated afterwards.

Diagnostic assessment : samples were taken for full blood count, blood group and cross match of 4 units of blood, retro-viral screening and serology for hepatitis. Packed cell volume was 18%, a white blood cell count of 8.5×10^6 , platelet count of 200,000/ml. Blood group was O positive, HIV 1 and 2 were non reactive, Hepatitis B surface antigen and Hepatitis C virus screening were negative. Urinalysis was essentially normal. Urgent abdomino-pelvic ultrasound scan revealed a bulky uterus measuring 6cm by 8cm with a thickened and irregular endometrial lining but no product of conception was noted. The internal Os is about 8mm opened. The adnexa are bilaterally free and there was no fluid collection in the pouch of Douglas. The bowel echoes were normal with adequate peristalsis. No bowel wall thickening, the stomach contained some fluid content, no gaseous accumulation. Other abdominal organs were sonographically normal. There was no evidence of fluid in the peritoneal cavity. Chest x ray was done and there was no air under the diaphragm, erect abdominal x ray was also normal.[Figure 4]

Diagnosis: An assessment of hypovolemic shock secondary to unsafe incomplete miscarriage with punctured injury to the cervix to rule out uterine perforation and bowel injury was made.

Therapeutic Interventions: She was admitted into the gynaecological emergency ward, had 2 wide bore cannulae fixed and Immediate resuscitation with normal saline was commenced. Intravenous fluid with 20 unit of oxytocin in 500ml of saline was commenced to run over 4 hours, had 3 units of blood transfused in quick successions and her vitals became stable. She also had intravenous coamoxiclav 1.2 g 12 hourly, metronidazole 500mg 8 hourly, gentamycin 80mg 8 hourly for 48 hours, tetanus toxoid 0.5ml stat, 1500 IU of anti-tetanus immuno-globulin was also administered. The punctured wound site on the cervix was cleaned with antiseptic solution and repaired with vicryl 2 suture in continuous fashion starting from one centimetre above the apex of the wound.[Figure 5] All these were done to stabilize the patient before the radiological investigations were sent for after she became stable several hours later. She was placed on nil per oris and abdominal girth was measured at the level of the umbilicus daily for 48 hours and it remained 67cm.

She remained stable with no feature of bowel injury, medications were converted to orals and commenced oral feeding after 48 hours of observation. Her post transfusion packed cell volume was 26%. Another two units of blood were transfused and post transfusion packed cell volume was 31%. She was counselled on the danger of unsafe abortion and the need for her to use contraceptive in order to prevent future occurrence. She made satisfactory recovery and was subsequently discharged home on 4th day on antibiotics and haematinics.

Follow up and outcome of interventions: She was seen at the gynaecological clinic 2 weeks later without complaint, the cervix had healed and she was considering implanon insertion.

Her second follow up visit 3 weeks later was satisfactory, she had just finished her menstruation and eventually had implanon insertion done in the same visit. To prevent sexually transmitted infection, she was counselled on the use of barrier contraceptive as well and to keep a mutually exclusive sexual relationship.

The hospital team comprising of social workers, doctors and servicom unit staffs were sent to the address of the personnel that performed the procedure on a fact finding visit and for counselling on the need for him to refrain from such an illegal, life threatening act, however the drug store was met closed.

Patient perspective

She was excited with the quality of care provided to her by the staffs of the hospital during her stay. She promised to educate her colleagues on the negative impacts unsafe abortion could have on their well-being and preventive strategies to forestall such occurrence.

Informed consent

Informed consent was obtained from the patient for the pictures and information provided in this case report.

Discussion

Unsafe abortion is a global phenomenon as it is unlimited by national boundaries. [1-2] The brunt is deeply suffered by women in the developing countries as they lack access or prohibited from safe abortion services due to socio-cultural, economic, religious and political factors.[3-6] This serious reproductive health neglect has posed grave threat to overall health of millions of women of reproductive age group and the society at large. Unsafe abortion accounted for about 68, 000 death yearly, most of which occurred in

developing world. Until unsafe abortion is dealt with, the vulnerable groups will continue to suffer the grave aftermath of termination of unwanted pregnancy done either in an unsafe environment or by non qualified personnel. [1,2]

Patients with complications of unsafe abortion account for significant proportion of gynecological inpatient admissions in developing countries such as Africa. [7] This means that regardless of restrictive laws, abortion seekers still procure the procedure in an illegal, unsafe and clandestine manner with its attendant consequences as it was seen in the index case. Mortality is common among adolescent and young women due to lack of fund to access quality care and are most liable to seeking poor quality abortion service, delay in hospital presentation for post abortion care after unsafe abortion. [5,7] The index case was a near miss, fortunate to survive due to the seeming timely presentation in tertiary facility even though she had suffered a life threatening hemorrhage from punctured injury to the cervix resulting in false tract creation during the procedure of unwanted pregnancy termination. The mediocrity and lack of knowledge of female genital tract on the part of the personnel who performed the procedure was displayed by the failure to identify the external Os of the cervix and the eventual creation of false tract through the posterior cervical wall to gain entrance into the endometrial cavity. This is quackery and such is an abomination in any modern society. She was offered immediate resuscitative measures including blood transfusion, antibiotics and removal of the remnants of products of conception from the uterine cavity. Debridement of the avulsed cervical tissues and repair of the injury was done. She was subsequently evaluated for an accompanied uterine perforation and bowel injury which were not present. Before she was discharged from the hospital, she was offered post abortion counselling which include the use of contraceptives,

safe sex practices and educated on other essential reproductive services that can be of immense benefits to her in the future as components of post abortion care.

Evidence based strategies have been postulated in curbing the menace of unsafe abortion in Africa, among the main root cause of unsafe abortion identified include high rate of illiteracy among female gender, poverty, lack of access and low use of modern day contraceptives, abysmal and poor quality reproductive health services and abortion laws.[3-10]

To tackle these problems, multi-sectoral efforts should be at improving access to contraceptives in a non judgemental, adolescent friendly manner with medical personnel upholding confidentiality. Human right issues surrounding illiteracy, unemployment and socio-cultural deprivation infringe upon women should be eradicated through gender sensitive legislations and women friendly policies aim at breaching the lacuna that has been in existence for hundreds of years.

A global approach will be to call for public forum involving political stakeholders and public health experts across the world to discuss the alarming rate of unsafe abortion and galvanize resources at improving family planning services especially for women in the developing countries.

Lastly, the health authorities should regulate and from properly monitor the activities of patent medicine outlets, maternity homes and clinics as most of these clandestine pregnancy termination take place therein. Training and retraining of lower cadres healthcare workers on safe procedures to assist women with incomplete miscarriages should be encouraged as it's apparent that some women still ended up with complications even after seeking such care from some trained medical personnel.

Conclusion

Unsafe abortion is a global issue with most of the havocs among women of the developing countries. A multi-sectoral approach including female empowerment, widespread provision of contraceptives, gender sensitive legislation and women friendly policies, and also proper regulation of activities of community patent medicine outlets and private clinics where most of these clandestine abortion practices take place will reduce the scourge of unsafe abortion in our society.

References

1. World Health Organization. Safe abortion: clinical and policy guidance for health systems. Geneva, WHO 2003.
2. World Health Organisation. Unsafe abortion: Global and regional estimates of incidence of and mortality due to unsafe abortion with a listing of available country data. Geneva, World Health Organization, 1998 (WHO/RHT/MSM/97.16);14
3. Bankole A, Oye-Adeniran BA, Singh S, Adewole IF, Wulf D, Sedgh G, Hussain R. Unwanted pregnancy and induced abortion in Nigeria: causes and consequences. New York: Guttmacher Institute, 2006.
4. Umoh AV, Umoiyoho AJ. Complications of unsafe abortion: case reports and the need for curriculum review in Nigeria. Nigerian Journal of Clinical Practice Sept. 2009 Vol. 12(3):321-323
5. Oye-Adeniran BA, Adewole IF, Umoh AV, Fapohunda OR, Iwere N. Characteristics of abortion care seekers in South Western Nigeria. AfriJ.ReprodHealth2004;8(3):81-91.
6. Oye-Adeniran BA, Umoh AV, Nnatu SNN. Complications of unsafe abortion: A case study and the need for abortion law reforms in Nigeria. Reprod Health Matters 2002;10(19):18-21.

7. Singh S. Hospital admissions resulting from unsafe abortion: estimates from 13 developing countries. *Lancet*. 2006 Nov 25;368(9550):1887-92.
8. Fetters T, Samandari G, Djemo P, Vwallika B, Mupeta S. Moving from legality to reality: how medical abortion methods were introduced with implementation science in Zambia. *Reprod Health*. 2017;14(1):26.
9. Gelman A, Rosenfeld EA, Nikolajski C, Freedman LR, Steinberg JR, Borrero S. Abortion stigma among low-income women obtaining abortions in western Pennsylvania: a qualitative assessment. *Perspect Sex Reprod Health*. 2017;49(1):29–36
10. Warriner IK and Shah IH, eds. Preventing unsafe abortion and its consequences: Research and action, New York: Guttmacher Institute, 2006.

UNDER PEER REVIEW

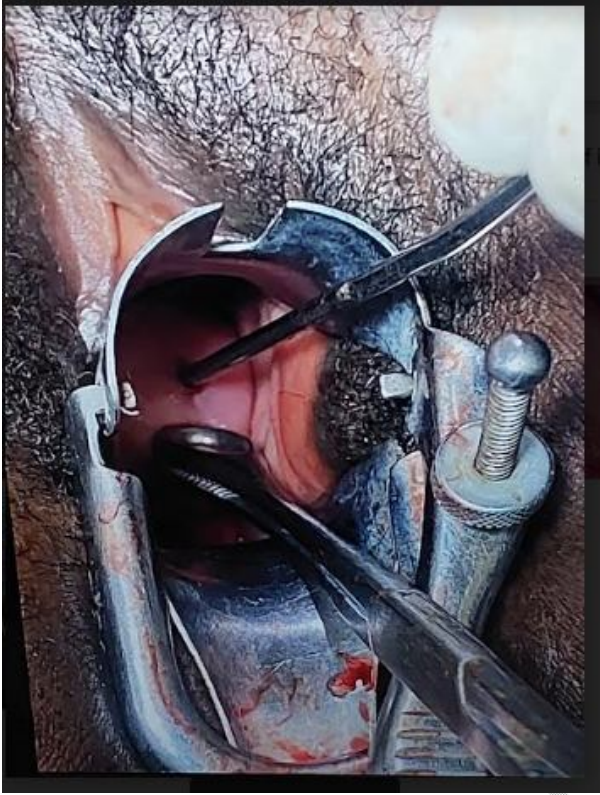


Figure 1: speculum examination showing the position of the cervix Os

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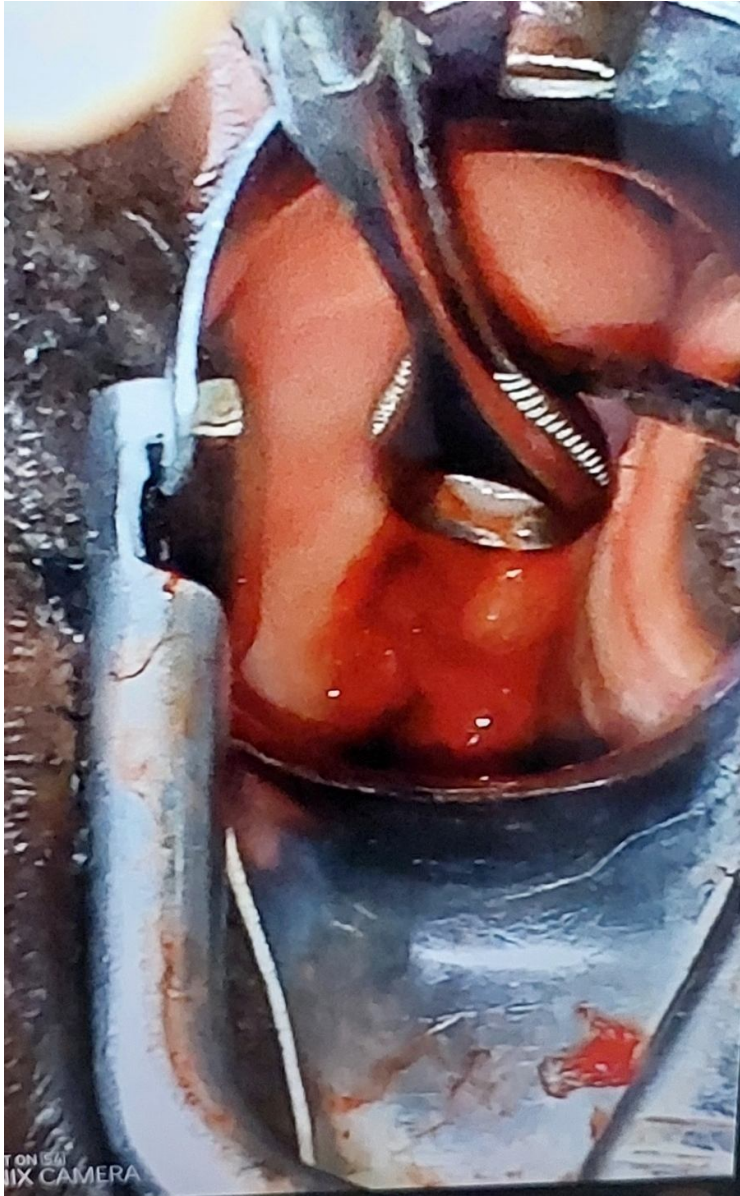


Figure 2: speculum examination showing bleeding from the cervical injury

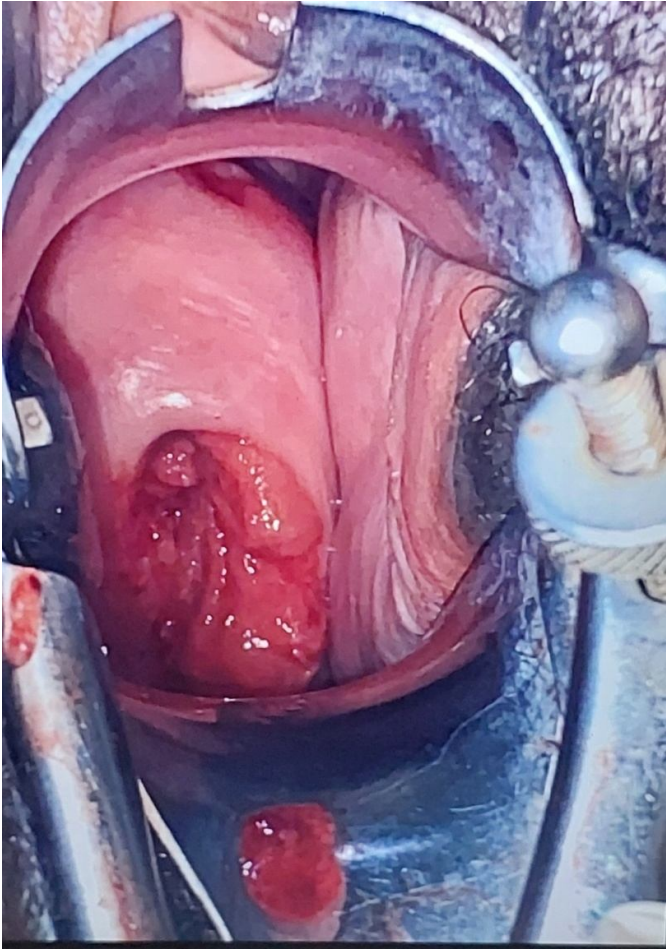


Figure 3: speculum examination showing the cervical Os and the false tract created on the posterior part of the cervix after the cessation of bleeding

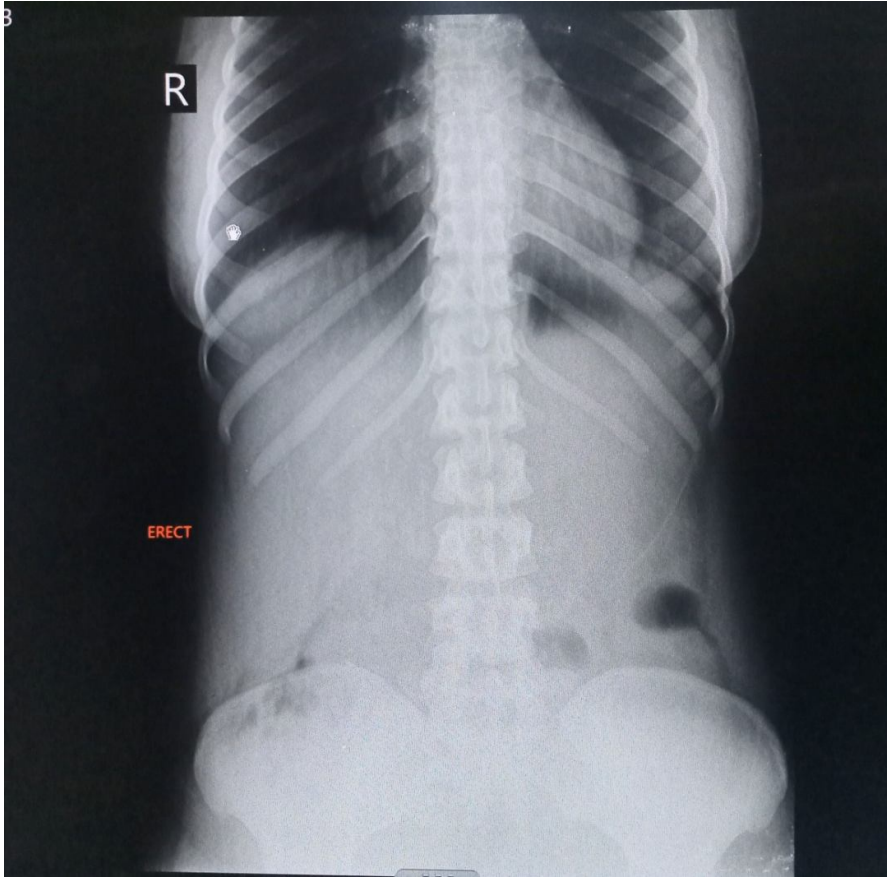


Figure 4: Abdominal X ray in the erect view



Figure 5: Appearance of the cervix immediately after successful cervical perforation repair was done