DEGLOVING INJURY OF SMALL BOWEL - A RARE COMPLICATION OF SEPTIC ABORTION

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Abstract

As a complication of induced abortion, intestinal injury may occur in the form of contusion, hematoma, perforation or transection. During induction of abortion, degloving of the intestine is the rarest form of injury which has not been previously reported. In a span of 3 years, 3 cases were seen in Guru Teg Bahadur Hospital, Delhi. In this case report presentation the salient clinical features, pathology and management are discussed.

Key words: Septic abortion, Degloving, Bowel injury, Medical termination of pregnancy.

Introduction

Estimates reveal that throughout the world, approximately 529,000 women die every year from pregnancy related causes.¹ Death due to unsafe abortion remains close to 13% of all maternal deaths.² Between two and seven million women survive unsafe abortion but sustain complications such as incomplete abortion, hemorrhage, infection, infertility, injury to internal organs e.g. uterine perforation and intestinal injury which are under reported.³ Intestinal injury may occur in the form of contusion, hematoma, perforation and transection. Degloving of intestine is the rarest form of injury during induced abortion.

Degloving of intestine is described as circumferential tear of seromuscular layer of intestine, which separates from underlying mucosa due to shearing force and the thinned out mucosal lumen bulges away from serosa (Figure 1). It has been mostly reported as part of the seatbelt injury syndrome during motor vehicle accidents that produce blunt and/or penetrating abdominal trauma.⁴ Degloving of intestine due to septic abortion has not been reported in gynecological practice till date.

Case Reports

Three cases of degloving injury of the small intestine following septic abortion at unauthorized centers were referred to Guru Teg Bahadur Hospital with almost similar presentation.

Case 1

A 32 year old, P, L lady, reported to emergency with history of undergoing abortion at an unauthorized center two days before. She had complains of inability to pass feces or flatus and some mass hanging outside vagina. On examination, vitals were stable but features of peritonitis were there, along with a tubular loop of intestine hanging outside the introitus. X-ray abdomen showed no gas under diaphragm. On exploratory laparotomy, a degloving injury of the small bowel about one foot in length was seen (Figure 1). There was no fecal soiling. The devitalized mucosal segment was resected and end-to-end anastomosis done. Postoperative period was uneventful and patient was discharged after ten days.

Figure 1. Degloved segment of the small bowel

Figure 2. Resected segment of degloved bowel
Case 2
A 35 year old P. L. lady, presented with septic shock after abortion from an unauthorized center five days before. Examination revealed hypotension with features of peritonitis and a loop of intestine outside introitus. On laparotomy a degloving injury of the small bowel was noticed (Figure 2). There was a small mucosal breach due to necrosis, but primary gut anastamosis was possible. Postoperative period was uneventful and patient was discharged after ten days.

Case 3
A 26 year old nulliparous lady presented with history of instrumentation to procure abortion from an unauthorized center three days back. There was history of fever with obstipation. Examination revealed features of peritonitis and a loop of intestine outside introitus. On laparotomy a degloving injury of the small intestine, 5 cms from ileocecal junction was noticed but no fecal soiling. Similar management was done.

Discussion
Suction and evacuation for termination of pregnancy is a common procedure, with a complication rate of less than 1%. In India, unqualified and unskilled personnel are responsible for major life threatening complications. Injuries of viscus during induced abortion are not uncommon. They contribute between 0.07- 18 % of all complications. Commonly reported serious injuries are uterine perforation with or without peritonitis and bowel injury. Intestinal injuries are few but they increase morbidity and prolong hospital stay. These injuries can occur in the form of contusion, hematoma, perforation and transection; degloving of intestine is the rarest form. Less than ten cases of degloving injury have been reported in literature, mostly with blunt abdominal trauma or seat belt injuries.

Degloving injury of bowel during abortion is a unique injury as large segments of bowel can be lost. Patients may present late with features of peritonitis and the clinching sign of gas under diaphragm is absent, in patients with no mucosal breach. In blunt abdominal injury, CT scan appears to be a more sensitive than ultrasound in detecting this injury, but still lacks specificity. Fecal peritonitis was absent in all patients, which was an advantage as ileostomy or colostomy was avoided and patients managed with resection and primary anastamosis.

It is found that abortion is safe in countries where it’s legal, but dangerous in countries where it’s outlawed and performed clandestinely. In developed countries, nearly all abortions (92%) are safe, whereas in developing countries, more than half (55%) are unsafe.

Conclusion
In India abortion has been legalized for more than four decades but the hazards of unsafe abortion are still rampant. Awareness and education on safe abortion has to be undertaken on a war footing by policy makers. Recently, abortion through telemedicine is gaining popularity.

Primary prevention against unsafe abortion should include contraception promotion, use of safe abortion techniques such as manual vacuum aspirator and medical abortion, improvement of provider skills. Rapid transfer to the hospital and prompt repair of injuries is warranted immediately following injury. Public education and social upliftment can put an end to this gruesome malady that runs unbridled in India.

References