BOWEL INJURIES SECONDARY TO INDUCED ABORTION: A DILEMMA

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ABSTRACT
Objective: To study the pattern of bowel injuries incurred by induced abortion, and the morbidity and mortality associated with them.
Design & Duration: Prospective descriptive study from December 2002 to December 2005.
Setting: Surgical Unit III, and Gynaecology and Obstetrics Unit II, Civil Hospital, Karachi.
Patients: All patients with bowel injuries due to induced abortion.
Methodology: Detailed data of all the patients was collected and analyzed.
Results: A total of 22 patients, mostly young with an average age of 26.86 years, presented with bowel injuries following induced abortion. Severe hemorrhage occurred in 8(36.4%) patients while 11(50%) had ileal perforation; 9(40.9%) underwent primary repair and 2(9.1%) ileostomy formation. Two (9.1%) patients with jejunal perforation had primary repair, whereas two with both jejunal and ileal perforations underwent resections with anastomosis in one and ileostomy in another. Seven (31.8%) with large gut involvement had colostomy formation. Septicemia and wound infection occurred in 7(31.8%) patients each, faecal fistula and abdominal wound dehiscence in 3(13.6%), and pelvic abscess in 1(4.6%) patient. The total mortality in this series was 6(27.3%) patients.
Conclusion: Iatrogenic injuries during induced abortion, most commonly caused by quacks, can be minimized substantially if the procedure is performed by qualified medical personnel in proper health care facilities. There is a need for radical overhauling of the mind set in our society together with legislation.
KEY WORDS: Induced Abortion, Bowel Injuries, Colostomy, Ileostomy

INTRODUCTION
By reason of it being a social taboo and legally a prohibition, makes the commission and performance of abortion, shrouded in secrecy, many a times by unqualified persons and in conditions far short of the appropriate minimum requisites. Hence, it is often associated with significantly increased susceptibility and possibility of iatrogenic injuries, particularly to the gut. More importantly, these injuries go unnoticed and unrecognized by these unqualified personnel compounding the complications further as the time elapsed between the occurrence of the complications, their recognition and management is prolonged. Some of these ill-fated patients are in their teen age and are unmarried. Our religious, social and ethical implications obviously predispose to late referral and redress of complications. Uterine and subsequent gut perforations may occur following any instrumenta- tion and are associated with great maternal morbidities and mortalities. In our society induced abortion is illegal unless the pregnancy is dangerous to the mothers health. Timely and appropriate management of complications can reduce morbidity and prevent mortality.

PATIENTS & METHODS
All patients who were admitted with the diagnosis of induced abortion along with gut injuries were included in the study. These unfortunate patients were treated in collaboration with the Department of Surgery, Unit III. Initially the patients were resuscitated in emergency.
entery pulled out of the vagina and resected, considering them to be the cord. Both these patients were exsangui-
nated and subsequently expired. The rest were in varying
grades of anaemia, tachycardia, toxaemia, peritonitis,
distension, hemorrhage and oliguria.

Exploratory laparotomy was done in all the cases. Eleven
(50%) patients had perforation of the ileum and 2 (9.1%)
involvement of the jejunum alone. Another 2 (9.1%)
patients had partly resected ileum and the jejunum. Six
(27.3%) cases had perforation of the sigmoid and one
(4.6%) that of the transverse colon (Table III).

Nine (40.9%) patients with ileal and the two with jejunal
perforations underwent primary repair after thorough
cleansing, washing and refreshing of the margins, as
they had presented in the first 48 hours and with minimal
soiling. Amongst these 3 (13.6%) developed leakage
from the repair site necessitating re-exploration and
exteriorization. Two (9.1%) patients with ileal perfora-
tion, who presented late and had excessive soiling were
treated by ileostomy (Table III).

Both the cases with small gut pulled out through vagina
and resected had widely devascularised residual seg-
ments due to associated excision of the mesentery. They
required further resection up to the apparently viable
segment with primary anastomosis in 1 (4.6%) and ileo-
stony in another.

Five cases of sigmoid and the one case of transverse

### Table I. Timing of Induced Abortion

<table>
<thead>
<tr>
<th>Timing</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>06-08 weeks</td>
<td>7</td>
<td>31.8</td>
</tr>
<tr>
<td>09-10 weeks</td>
<td>7</td>
<td>31.8</td>
</tr>
<tr>
<td>11-12 weeks</td>
<td>5</td>
<td>22.8</td>
</tr>
<tr>
<td>12-14 weeks</td>
<td>3</td>
<td>13.6</td>
</tr>
</tbody>
</table>

### Table II. Presentation after Induced Abortion

<table>
<thead>
<tr>
<th>Timing</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 24 hours</td>
<td>4</td>
<td>18.2</td>
</tr>
<tr>
<td>24-48 hours</td>
<td>3</td>
<td>13.6</td>
</tr>
<tr>
<td>03-09 days</td>
<td>9</td>
<td>40.9</td>
</tr>
<tr>
<td>&gt; 09 days</td>
<td>6</td>
<td>27.3</td>
</tr>
</tbody>
</table>

### Table III. Type of Bowel Injury following Induced Abortion and the procedure performed

<table>
<thead>
<tr>
<th>Type of Gut Injury</th>
<th>No. of Patients</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ileal perforation</td>
<td>11 (50.0%)</td>
<td>Primary repair (9), Ileostomy (2)</td>
</tr>
<tr>
<td>Jejunal perforation</td>
<td>2 (9.1%)</td>
<td>Primary repair</td>
</tr>
<tr>
<td>Ileal + Jejunal resection</td>
<td>2 (9.1%)</td>
<td>Primary repair (1), Ileostomy (1)</td>
</tr>
<tr>
<td>Transverse Colon</td>
<td>1 (1.6%)</td>
<td>Colostomy</td>
</tr>
<tr>
<td>Sigmoid Colon</td>
<td>6 (27.3%)</td>
<td>Colostomy (5), End Colostomy + Mucus fistula (1)</td>
</tr>
</tbody>
</table>
The study done by Obed and Wilson. Contrary to the finding by Oludiran and Osime, majority of the patients in our cohort were married and were grand multipara. The commonest sites of involvement were ileum and the pelvic colon as stated by other colleagues also. Delayed presentation with accompanying complications was a common finding by other authors also; the reason being the retrogressive social, cultural, religious, legal milieu and the attached stigmata.

Early presentation with minimal contamination particularly with small bowel involvement had a better outcome even following primary repair. In contrast, late presentation, greater degree of contamination or established sepsis, especially with colonic involvement, had a more protracted stay and poorer outcome in terms of the development of fecal fistulae, abdominal wound dehiscence, etc.

CONCLUSION

To successfully avert the deleterious complications of unsafe abortions it is necessary to understand the scope of the problem and related factors as close to reality as possible. These findings definitely necessitate the realization of implications arising there from and justifying the advocacy for breaking the shackles of retrogressiveness and oppressive social, legal, tribal, religious taboos and inhibitions, and redefining as well as refining our society on civilized, scientific, logical and realistic lines.

The provision of appropriate training in induction techniques and management of its complications should be ensured on war footings on a mass scale as timely and appropriate management of complications can reduce the morbidity and prevent mortality. Also it is important to realize that the provision of knowledge on sex education and family planning to adolescents has a major role in the prevention of unwanted pregnancies and hence minimize unsafe abortions.

REFERENCES


