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Case Report

Vagino-peritoneal fistula - a rare complication of unsafe abortion

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Introduction

One woman somewhere in the world dies every minute from a complication related to pregnancy or childbirth. Ninety-nine percent of these deaths occur in developing countries. Of the 46 million pregnancies that are terminated each year around the world, only about 60% are carried out under safe conditions. However, an estimated 19 million unsafe abortions occur worldwide each year, resulting in death of about 70,000 women[1]. The MTP Act has legalized abortions in India. The number of induced abortions is still very high at about 28% mainly in women not using contraception[2]. Complications can endanger the life of the mother if proper medical or surgical intervention is not offered in time. Here we report a rare case of vaginoperitoneal fistula following first trimester abortion by an unqualified person.

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Case report

A 35 year lady, $P_4A_0L_4$ came to our gynecology outpatient clinic with complaints of fever, pain in lower abdomen and purulent vaginal discharge for 7 days following vaginal instrumentation for an amenorrhea of 10 weeks. She had normal vaginal deliveries at term at home, the last delivery being 3 years back. She was not using any contraceptive. On examination she was conscious and well oriented, with low general condition viz., pulse 110/minute with low volume, blood pressure 90/50 mm of Hg, respiratory rate 17/minute, temperature 100^0F and mild pallor. Abdominal examination revealed generalized distension (abdominal girth of 64.5), with tenderness, guarding and rigidity more of the lower abdomen, and absent bowel sounds. Speculum examination, showed a tan opening in the anterior vaginal wall about 2 cm above the introitus on the right side. Pus was coming out through the opening. Cervical os was admitting the tip of a finger, the exact uterine size could not be made out, and an organized mass (3x3cm) was felt through the right fornix. Her blood reports, and liver and renal function tests were normal. Ultrasonography of the abdomen and pelvis showed a bulky uterus with retained products of conception and an organized collection anterior and to the right of the uterus, behind the bladder. However, any rent in the uterine wall was not seen. Cystoscopy was normal. Plain x-ray of the pelvis

showed the opening in anterior vaginal wall as a separate opening from the normal bladder opening and the uterine cavity (Figure 1). At laparotomy flimsy adhesions were present between the anterior abdominal wall, bowel, omentum, uterus and fallopian tubes. After separating the adhesions, a rent of approximately 1.0x0.5cm was visualized on the right side at the level of reflection of uterovesical fold of the peritoneum, the rent was communicating with the opening in the vagina through a fistulous tract. (Figure 2). Total abdominal hysterectomy was done along with excision of the fistulous tract. The vault was closed and abdomen was closed after placing the abdominal drain. The patient had an uneventful postoperative recovery. She was discharged on 10th postoperative day. On follow up after 4 weeks she was doing well with no complaints of vaginal discharge.

Figure 1. Plain X-ray of pelvis showing the uterine dressing forceps (a) in the fistulous opening, the uterine sound (b) in the uterine cavity. Vulsellum (c) holding the anterior lip of cervix.

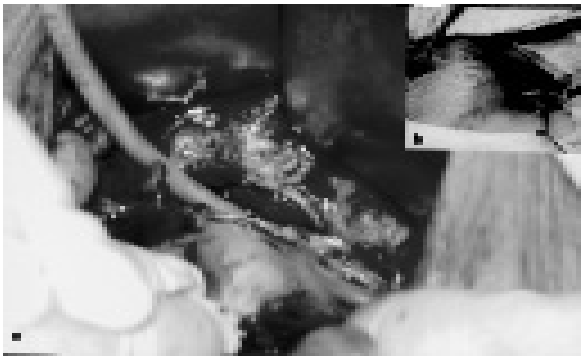

Figure 2. Photograph at laparotomy showing a plain rubber catheter passed through the opening in the vesico-vaginal space on right side (a) communicating externally through the vagina.

Discussion

The term unsafe abortion, proposed by World Health Organization (WHO) means 'abortion performed by people lacking the necessary skills or in an environment lacking the minimal medical standards or both'[3]. It is one of the highly neglected problems of health care in developing countries. In India it accounts for about 41.9% of the maternal deaths[4]. Although unsafe abortion is entirely preventable, it remains a significant cause of maternal morbidity and mortality in the developing world. Unsafe abortion is mostly performed by untrained persons, chiefly dais and untrained midwives with its antecedent complications. Complications include uterine perforations, blood loss, retained products of conception, postabortal hemorrhage, endometritis, pelvic infection and peritonitis. Visceral injuries due to instrumental perforation of the uterus have been reported, but development of vaginoperitoneal fistula is rare. Lack of education, social stigma and other barriers to abortion, force women to seek abortion in secrecy at a high cost, leaving the poorest, least educated women to unskilled persons. Key messages on health education and information regarding safe abortion options should go beyond the urban elite and reach even remote and marginal communities of India. All attempts must be made to reduce the incidence of illegal abortion by creating awareness about and increasing availability of contraceptive and abortion services.

References

1. Grimes DA. Unsafe abortion: the silent scourge. Br Med Bull 2003;67:99-113.
2. Varkey P, Balakrishna PP, Prasad JH et al. The reality of unsafe abortion in a rural community in South India. Reprod Health Matters 2000;8:83-91.
3. The World Health Report. Geneva. World Health Organization, 2005.
4. Verma K, Thomas A, Sharma et al. Maternal mortality in rural India; a hospital based, 10 year retrospective analysis. J Obstet Gynaecol Res. 2001;27:183-7.