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Case Report

A stone age conduct of unsafe abortion in adolescent: Complicated by gangrenous uterus and bowel

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ABSTRACT

Unsafe abortion in adolescents is of great public health challenge and it occupies a large armamentarium in contemporary adolescent reproductive health issues. This case report was that of induced unsafe abortion, done without analgesia and inside a sitting room, in a 15-year-old, secondary school girl, nullipara; complicated by gangrenous uterus and bowel for which she had subtotal hysterectomy, bowel resection, and anastomosis. Primary preventive strategies should be the cornerstone of prevention with more emphasis on advocacy for adolescent sexuality and reproductive health education, information, and family planning/emergency contraception.

Key words: Adolescent; complication; unsafe abortion.

Introduction

Unsafe abortion in adolescents and young adults is of great public health challenge[1] and it occupies a large armamentarium in contemporary adolescent reproductive health issues. Unsafe abortion, as defined by World Health Organization, is unintended termination of pregnancy by a person lacking the necessary skills or in an environment lacking the minimum standard or both.[2] Over 210 million of pregnancies occur worldwide yearly, half of which are unplanned and unwanted. About 42 million of these unwanted pregnancies are induced, of which about 22 million are unsafe.[2] Studies have shown that at least one-third of the unsafe abortions occur in adolescents and young adults.[3-5] The high incidence of unsafe abortion in adolescents is not unconnected with their peculiar physical and psychosocial state which directly affects their sex negotiation skills and tendency culminating in unsafe sex, unwanted pregnancy, and unsafe abortion among other complications. Another big vacuum in adolescent reproductive health care is low contraceptive prevalence among adolescent boys and girls, especially those that are already exposed to sexual intercourse. This is partly because of the socio-cultural lens that sees prescription of adolescent contraceptives as being sacrilegious, evil, and morally inappropriate. This is further worsened by the negative attitude of parents towards educating adolescents on sexuality and reproductive health issues. Thus, the adolescents are often left unequipped with the right reproductive/sexual health information which is their fundamental human right. In addition, our ill-defined restrictive abortion law and stigmatizing nature of abortion have encouraged

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clandestine procurement of unsafe abortion in order to avoid public embarrassment.

This case report was that of a stone age (done without analgesia and inside a sitting room) picture of unsafe abortion complicated by uterine and bowel injuries in a 15-year-old schoolgirl. The case report would reveal, to some extent, some intrigues and peculiarities of unsafe abortion in adolescent population; which should shed more light to the needs of adolescent population in the areas of sexuality and reproductive issues.

Patient and Observation

A 15-year-old senior secondary school 1 student, nullipara, presented with 12 weeks' amenorrhoea, 2 weeks' history of lower abdominal pain, and 2 days' history of protrusion of cord-like material per vaginum. Patient was in her usual state of health until two weeks before presentation when she attempted terminating a pregnancy, having missed her period for 3 months and confirmed pregnancy with urine test trip. The termination of pregnancy was by dilation and curettage which was done on a dining table in the sitting room of the abortionist, who happened to be an auxiliary nurse. Her boyfriend (a classmate) took her to the auxiliary nurse place. The procedure was carried out without any pain relief; patient was able to cope with the severe pain under unusual petting with occasional threats. She was asked to come the second day for the completion of the procedure which she did. There was associated moderate bleeding during the procedure which eventually reduced to vaginal spotting. She was given paracetamol, doxycycline and ciprofloxacine during discharge. However, lower abdominal pain associated with foul smelling vaginal discharge persisted.

Patient decided to go back to the auxiliary nurse when her pains deepened, now with the passage of foul-smelling cord-like material per vaginum. However, the auxiliary nurse reassured her that it was a retained umbilical cord of the fetus and that it would soon be expelled, and she subsequently helped the patient clamp the cord-like material with umbilical cord clamp and asked her to go back home. Patient, however, decided to tell her parents when she could no longer bear abdominal pains associated with nausea and vomiting. This necessitated her presentation at our facility. She was the only girl in a monogamous family of four children. She was aware of modern contraceptive methods but had never used any as she was always told that contraception was for married people. She was having her first sexual experience with the boyfriend.

Significant findings at presentation included a febrile young girl (38°C); moderately dehydrated, mildly pale, with moderately distended abdomen and generalized rebound tenderness, devitalized foul smelling loop of small intestine protruding through the vagina, clamped with umbilical cord clamp [Figure 1]; digital examination could not be done because of severe tenderness. Complete blood count done showed moderate leukocytosis with left shift and toxic granulations with a packed cell volume of 29%; platelet count was normal, electrolyte, urea and creatinine were normal; hepatitis B surface antigen and Human immunodeficiency Virus screening were negative. Ultrasonography showed dilated bowel loops, a uterus with central mass of mixed echo (?intestine) with significant fluid in the pouch of Douglas. The working diagnosis was that of septic induced abortion with uterine perforation and intestinal injury.

Patient was stabilized with rocephin (ceftriazone) among other measures and, following consent, had exploratory laparotomy, subtotal hysterectomy and bowel resection and anastomosis. Intraoperative findings were: serosanguinous peritoneal fluid (about 200 mls); 14 weeks uterine size, extensive uterine perforation with circumferential avulsion of uterine tissue creating a rent of about 6 by 6 cm; through which about 20 cm devitalized segment of the small intestine was herniating; devitalized and gangrenous body of the uterus down to the level of uterovesical peritoneal reflection; ovaries and tubes were normal. Postoperative period was uneventful. She was discharged home 10th post-operative day to be followed-up. She was, however, lost to follow up.

Discussion

The case report, to appreciable extent, essentially revealed the summary of the burden of unsafe abortion in adolescents; which studies have shown to be a strikingly vulnerable age group in the reproductive age spectrum.[3-5] This school

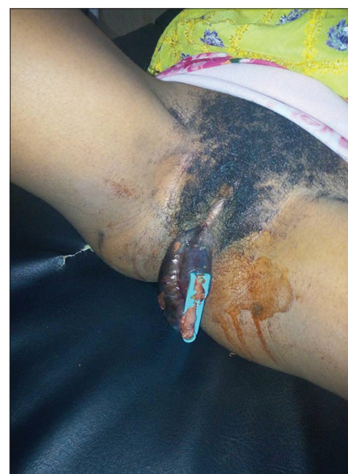

Figure 1: A case of unsafe abortion complication in a 15-year-old, secondary school girl, nullipara; showing part of the bowel loop pulled out of the vagina and clamped with umbilical cord clamp

girl relatively presented late in seeking health attention despite being amenorrhoeic for 12 weeks. This finding is line with the findings of related studies that adolescents delay in seeking attention especially when the condition is pregnancy-related.[6,7] This may not be unconnected with fear of being stigmatized and embarrassed by virtue of young age and position of our "abortion law". It is interesting but not surprising to find out that the sexual partner of the patient who took her down for abortion without parents' consent was a classmate of about the same age bracket. This is a consequence of peer pressure effect, sexual experimentation marking the adolescent period.[6]

It is also pathetic to discover that despite the fact that the patient was aware of modern contraceptive methods she never used any because of the negative attitude of the community towards adolescent contraception which studies have identified as a major gap in the preventive strategies for unsafe abortion in this age group.[3] Furthermore, for many pregnant adolescents, their major concerns are the socio-cultural challenges of unwanted pregnancy like poverty, fear of parental disapproval, abandonment by boyfriend, financial responsibilities of childbearing, in ability to secure husband when there is child out of wedlock and expulsion from school; and not the risks associated with unsafe abortion. Thus, their problem is further worsened by the difficulty to procure safe abortion due to the prevailing medical, cultural, and legal barriers in our community which opposes what obtains in most developed communities. Common complications of unsafe abortion include retained products of conception, hemorrhage, sepsis, and uterine perforation/bowel injury, most of which were also identified in the patient. However, gangrenous uterus which necessitated subtotal hysterectomy in this patient is a very rare complication of unsafe abortion in adolescent age group. In addition, the fact that the patient was lost to follow up agrees with the general assertion that adolescents have poor health seeking behavior.

Unsafe abortion in adolescents is a big reproductive/public health problem and primary preventive strategies should be the cornerstone of prevention. Advocacy for adolescent sexuality and reproductive health education and information is key. This advocacy should incorporate various adolescent help-link initiatives involving sensitization programs on unsafe abortion on television and radio; in handbills, published articles, and books on adolescent reproductive/sexual health issues. This spread of health information and education should involve the use of emails, facebook and websites. The roles of visiting schools, churches, communities, and organizing adolescent/teens' programs cannot be overemphasized. There should be direct access to medical experts' directories for health information, education, and other forms of medical consultations including lodging reproductive health-related complaints. All efforts should be directed towards marking our health facilities adolescent friendly; the initial focus should be the private facilities as most adolescents would prefer private health facilities to public health facilities due to factors of privacy, health workers' attitude, and waiting time.

In addition, the importance of abstinence and sex negotiation skills should be emphasized for both exposed and unexposed adolescents. Family planning/emergency contraception will play a central role in primary prevention of unsafe abortion in adolescents. Initial effort should be created at changing orientation and negative attitude of the older folks towards adolescent contraception. Access to affordable and acceptable contraception is the legitimate right of the adolescents especially for those that have already been exposed to sexual intercourse. Early exposure to contraceptive knowledge and information could have prevented the highlighted severe complications (including loss of the uterus) experienced by this adolescent girl. In addition, effective and efficient contraception could remove the stress and confounding issues surrounding the ill-defined "abortion law". Government has a central role of creating an environment that encourages collaborative and multi-disciplinary approach to provide curative, preventive, and rehabilitative care in unsafe abortion management in adolescents. This will involve various stakeholders like non-government organizations, schools, religious bodies, parents, and the community. These will go a long way to transform unsafe abortion policy in adolescents to action and practice. There should be early diagnosis of pregnancy in this group of people; with counseling, guidance and follow-up instituted very early. Efforts should also be directed towards immediate and long-term handling of abortion complications through Postabortal Care Network (PACNET) and training of trainers in postabortal care should be a sustained program.

Conclusion

Unsafe abortion in adolescents remains a huge burden globally. Greatest attention should be directed on primary prevention with more emphasis laid on advocacy for adolescent sexuality and reproductive health education, information, and family planning/emergency contraception.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other

clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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