CASE REPORT

An Induced Abortion Complicated by Fallopian Tube Incarceration in the Uterine Cavity

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Introduction

Induced abortions continue to be practiced, despite availability of contraceptive-based methods. Their commonest immediate and early complications are hemorrhage, retained products of conception, genital tract infections, and lacerations. Uterine perforation can be complicated by injuries to small intestines, bladder, rectum, appendix, and rarely to fallopian tubes. We report here on a case of uterine perforation during manual vacuum aspiration with incarceration of the distal part of the fallopian tube in the uterine cavity.

Case Report

Manual vacuum aspiration (MVA) was carried out by a resident on November 25, 2010 at 7 weeks 3 days of gestation on a 36-year-old woman, single, 4 term deliveries, 0 premature delivery, 2 abortions and 4 living children

(G7P4LAA2). A painful aspiration was done followed by a persistent pelvic pain. Then, she was transferred to us. On admission, she complained of persistent pelvic pain and slight vaginal bleeding. Her past history revealed two prior induced abortions followed by four normal term vaginal deliveries. On physical examination, the hypogastrium was tender. A diagnosis of complicated induced abortion was suspected. An emergency laparotomy revealed two uterine fundal perforations with incarceration of the left fallopian tube (Fig. 1). The bowels were without injuries. Then, with a thymb forceps, the perforation hole was slightly increased, and the fallopian tube was extracted. After extraction, the left fimbria and part of the ampulla were necrosed. A left total salpingectomy was carried out. The uterine cavity was curetted and the perforations closed with Vicryl® 1. Post-operative recovery was good, and the patient was discharged on day 6 after an intensive counseling.

Discussion

MVA has many advantages over sharp curettage. These include decreased blood loss, less pain, and shorter duration of the procedure. Hence, MVA is increasingly being used worldwide. Nevertheless, few complications of MVA have been published. These include uterine perforation with an incidence of around 0.19 %. Uterine perforation can be followed by incarceration within the myometrium or within the uterine cavity of the appendix [1] or of the fallopian tube as in this studied case. As appendix,

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Fig. 1 Incarcerated *left* fallopian tube in the fundal uterine perforation

fallopian tube can easily be incarcerated in the uterine cavity after uterine perforation because of its mobility. Similar cases of fallopian tube incarceration have been published [2]. Other possible complications are hemorrhage and cervical tear.

The main risk factor for uterine perforation during MVA in about 95.6 % of the cases is operator's inexperience. In our case, the procedure was carried out by a resident. Other risk factors are advanced gestational age, advanced maternal age, previous uterine surgery like cesarean section and previous history of endometritis. After uterine incarceration, there is progressive constriction of the fallopian

tube due to uterine retraction, thus reducing the vascularization of the fallopian tube. The final result will be distal end tubal necrosis. That is why, in our case, the distal part of the fallopian tube was ischemic.

Conclusion

This case report reminds us that, to minimize uterine perforation with fallopian tube incarceration, uterine evacuation must be conducted by a trained operator who can avoid uterine perforation or who can easily recognize signs of perforation and stop the procedure. Furthermore, an ultrasound scan done during the procedure, especially for difficult cases, may help the operator in avoiding or diagnosing early uterine perforation [3].

References

1. Dignac A, Novellas S, Fournol M, et al. Incarceration of the appendix complicating a uterine perforation following surgical abortion: CT aspects. *Emerg Radiol.* 2008;15(4):267–9.
2. Trio C, Recalcati D, Sina F, et al. Intrauterine fallopian tube incarceration after vacuum aspiration for pregnancy termination. *Int J Gynaecol Obstet.* 2010;108(2):157–8.
3. Acharya G, Morgan H, Paramanantham L, et al. A randomized controlled trial comparing surgical termination of pregnancy with and without continuous ultrasound guidance. *Eur J Obstet Gynecol Reprod Biol.* 2004;114(1):69–74.