Post abortal broad ligament abscess: report of a case

M. A. Abdul, N. Ameh and A. U. Bako

Department of Obstetrics and Gynaecology, Ahmadu Bello University Teaching Hospital, Zaria, Nigeria
Reprint requests to: Dr. M. A. Abdul, Department of Obstetrics and Gynaecology, Ahmadu Bello University Teaching Hospital Zaria, Nigeria

Abstract

A case of postabortal Broad ligament abscess following an illegal induced abortion is presented. The diagnosis was made intraoperatively and the abscess drained at laparotomy. The difficulty in preoperative diagnosis of broad ligament abscess and problems of unsafe abortions in developing economies are highlighted. Preventive measures against morbidities/mortalities from unsafe abortions are suggested.

Key words: Illegal abortion, Broad ligament, abscess, diagnosis

Introduction

Unsafe abortion remains a major public health problem in many parts of Sub - Saharan Africa. Of the 600,000 maternal deaths that occur annually World wide, 13% of these are attributed to unsafe abortion.[1] In some parts of Africa, abortion complications accounted for 25 - 35% of maternal deaths.[2] [5] In a recent survey in Nigeria, [6] the incidence of induced/unsafe abortion is about 25 abortions per 1,000 women aged 15 - 44 or 14 per 100 lives births, and over 60% of these abortions are performed by non - physician providers.

The high maternal morbidity and mortality from unsafe abortion in Africa has been attributed to restrictive abortion laws, poor or non-availability of post abortion services and low contraceptive usage. [2,3] The complications of unsafe abortion from reported series [4,7,8] are well known and include genital tract lacerations (including perforation of the uterus), haemorrhage, incomplete evaluations, injuries to the bowel and bladder, genital sepsis infrequently with endotoxic shock, pelvic abscess, anaemia, cervical incompetence, chronic pelvic pain, ectopic pregnancy and infertility. Deaths from unsafe abortions are principally attributed to haemorrhage, anaemia, sepsis and renal failure. [7,8]

Broad ligament abscess is rare. Intraligamentous haematoma is however not infrequently encountered and often complicates genital tract injury. [9] We report a case of Broad ligament abscess following an induced (illegal) abortion.

Case report

A 30-year-old Housewife admitted with

moderate vaginal bleeding of five days duration following an induced abortion by Dilatation and Curettage in a local chemist shop. Associated with the vaginal bleeding were lower abdominal pains and fever. There was no history of fainting attacks, vomiting or diarrhoea. Her last menstrual period was 4 months prior to presentation. She was para 7+0 (7 alive). All previous deliveries were normal and her last childbirth was April 1996. She was the only wife of a low income civil servant and not known to have any chronic medical disease.

She was acutely ill mildly dehydrated and pyretic (temperature 39°C) but not pale or icteric. Her pulse rate was 120/min and blood pressure was 100/70mmHg. Her abdomen was full and soft. There was marked tenderness over the lower abdomen with rebound tenderness. The liver spleen and kidneys were not palpably enlarged. There was no demonstrable intraperitoneal fluid collection. Pelvic examination revealed bloodstained vulva. The cervix was deviated to the left, one centimetre dilated, soft, and with positive motion tenderness. The uterus was bulky consistent with 12 - 14 weeks gestation, soft and tender. The right adnexum was full and markedly tender with an ill - defined cystic mass. The left adnexum was normal and the pouch of Douglas was empty.

The working diagnosis was that of incomplete (induced) abortion and right tubo - ovarian abscess. Pelvic ultrasonography revealed a bulky uterus with retained product of conception within the endometrial cavity. There was also a cystic right adnexeal mass measuring 81× 62mm with some echogenic areas and the pouch of Douglas contained minimal fluid. The packed cell volume was 29% and there was mild leucocytosis and neutrophilia. She was commenced on intravenous dextrose - saline and ampiclox, gentamycin and metronidazole. At laparotomy, there was a a right-sided broad ligament abscess containing about 500mls of pus, blood and a foetus that had a Crown - Rump length of about 60mm(equivalent to 12wks and 6 days). The right fallopian tube and ovary were inflamed. There was a traumatised area (about 3cm in diameter) on the right lateral uterine wall about four centimetres from the right cornua, which was not actively bleeding. The left fallopian tube and ovary were normal. The appendix and the rest of the bowel were normal.

The right broad ligament was opened, abscess drained and tube drain (Nelaton's catheter size 24) left in - situ and brought to the exterior through the anterior abdominal wall. The abdominal and pelvic cavity was lavaged. Before closing the abdomen, manual vacuum aspiration of the uterine cavity was performed using Karman's syringe and about 100mls of retained product (mainly placental tissue) was obtained. Mass closure of the abdomen was then performed. She was transfused with one unit of whole blood.

She made an uneventful recovery and was discharged on the eighth postoperative day with a packed cell volume of 31%. She was counselled for contraception and referred to the family planning clinic. Follow-up at six weeks was normal. Histopathological examination of the product of conception confirmed infected placental tissue with no evidence of molar tissue or choriocarcinoma. Histopathological examination of the product of conception revealed no evidence of molar tissue or choriocarcinoma.

Discussion

This case highlights the problems of unsafe abortion in this environment.[2,4,7,8] Majority of these pregnancies are unplanned, unwanted, and terminated in an unhygienic environment by unqualified personnel. This patient had an the pregnancy terminated by an unqualified provider with resultant sepsis, anaemia, incomplete evacuation and uterine perforation. Unsafe abortion in this part of the world is largely due to

unwanted/unplanned pregnancies, which is not unconnected to the low contraceptive usage. The recent (1999) National (Nigerian) Demographic and Health survey puts contraceptive usage in Nigeria to be < 10%. [13]

Preoperative diagnosis of intraligamentous abscess is difficult. She was thought to have incomplete abortion with a tubo-ovarian abscess. The correct diagnosis was made intraoperatively. MRI or CAT scan would have helped in the correct preoperative diagnosis. The absence of these diagnostic tools should not lead to delay in exploratory laparotomy where intra-abdominal abscess is suspected. The uterus was perforated and the foetus extruded into the broad ligament leading to haematoma and subsequent infection.

Drainage of abscess under antibiotic cover by laparotomy or culdotomy (in selected cases) remained the traditional treatment modalities of pelvic abscess. Drainage under fluoroscopy or ultrasound guidance is an option where there is no suspicion of intra-abdominal injury. [14] Morbidity and mortality from unsafe abortion in our environment can be significantly reduced by education and making comprehensive postabortal care easily available, accessible and affordable. There is a need for increase in the knowledge and use of contraception including emergency contraception.

References

1. World Health Organization. Complications of abortions: technical and managerial guidelines for prevention and treatment. WHO, Geneva. 1994; 1 - 5.
2. Roystone E, Armstong S. Preventing maternal deaths. WHO, Geneva. 1989.
3. Prevention of mortality and morbidity from unsafe abortion in Nigeria. Population Council, New York. 1991.
4. Okonofua F, Onwudiegwu W, Odunsi O. A. Illegal induced abortion: a study of 74 cases in Ile - Ife Nigeria. Trop Doct 1992; 22: 15-18.
5. Kinleast B. E et al. Maternal mortality in Addis Ababa, Ethiopia. Stu Fam Plann 1976; 17: 288 -301.
6. Renshaw S. K, Singh S, Oye-Adeniran B. A. et al. The incidence of induced abortion in Nigeria. Int Fam Plann Persp 1998; 24: 156-164.
7. Anate M, Aboyemi O, Oyanloye O. Induced abortion in Ilorin, Nigeria. Int J Gynecol Obstet 1995; 49:197-198.
8. Unuigbe J. A, Oronsaye A. U, Orhue A. A. Abortion - related mortality in Africa: focus on abortion deaths in Benin City, Nigeria. Tropical Journal of Obstetrics and Gynaecology 1988; 1: 36-39.
9. Johnson R. Obstetric procedures. In: Edmonds D. K (ed). Dewhurst's textbook of obstetrics and gynaecology for postgraduates, Blackwell, Oxford. 1999; 323-327.
10. Maxwell C, Gawler D, Green J. An unusual case of acute postpartum broad ligament haematoma. Aust N Z J Obstet Gynaecol 1997; 37: 239-241.
11. Winkler M, Gans A, Fendel H. Parametrial haematoma after forceps delivery. Geburtshilfe Perinatol 1991; 195: 236 -237.
12. Parulekar S.V. Posthysterectomy broad ligament haematoma: a complication of vaginal packing? (A case report) J Postgrad Med 1979; 35: 51 -53.
13. Federal Ministry of Health (Nigeria). National demographic and health Survey. FMOH. 1999.
14. Wiesenteld H. C, Sweet R. l. Progress in the management of tubo-ovarian abscesses. Clin Obstet Gynaecol 1993; 36: 433 - 443.