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RESEARCH ARTICLE

IATROGENIC COMPLICATION-BLADDER INJURY FOLLOWING SECOND TRIMESTER SURGICAL MTP

Dr. Banavath Gowthami and Dr. Shamshad Begum

Manuscript Info | *Abstract*

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Introduction:-

Embryologically,urinary system and genital system have a common origin and anatomincally they are in a close proximity.Unsafe abortion constitutes a major threat to the health and lives of women.In India ,safe services are not available to all women . Perforated of uterus , injury to the bladder and bowel , cervical tear and extension of pre existing infection are well known complications during MTP.

Case Report-

We report a case of 26 year old female with para 1 living 1 with post abortal day 0 with one previous section history was referred from a community health centre with complaints of Frank hematuria.

Patient had history of expulsion of dead fetus of about approximately 22 weeks along with placenta after consumption of unwanted kit from nearby hospital on the way to the CHC.History of surgical evacuation done at CHC in view of retained products of conception.Then referred to our tertiary care centre in view of ? bladder injury with her vitals on presentation are : Patient is clinically pale
Pulse rate -97/min
BP- 100/70mmhg
Spo2%-98% with room air
Per abdomen - uterus retracted well and of about 16-18 weeks size with no active bleeding.

BME- a defect in the anterior uterine wall near cervix at prior scar site and leakage of urine was observed per vaginally with Frank hematuria in urobag.

Her Hb - 5.4%, platelets - 2 lakhs , Hematocrit -12.

Immediately packed cell transfusion was done and USG was done to rule out bladder injury and uterine perforation.

USG guided normal saline was passed through foleys catheter and bladder filling was noted with leakage into the uterovesical pouch indicating that there was an abnormal connection formed between uterus and bladder.

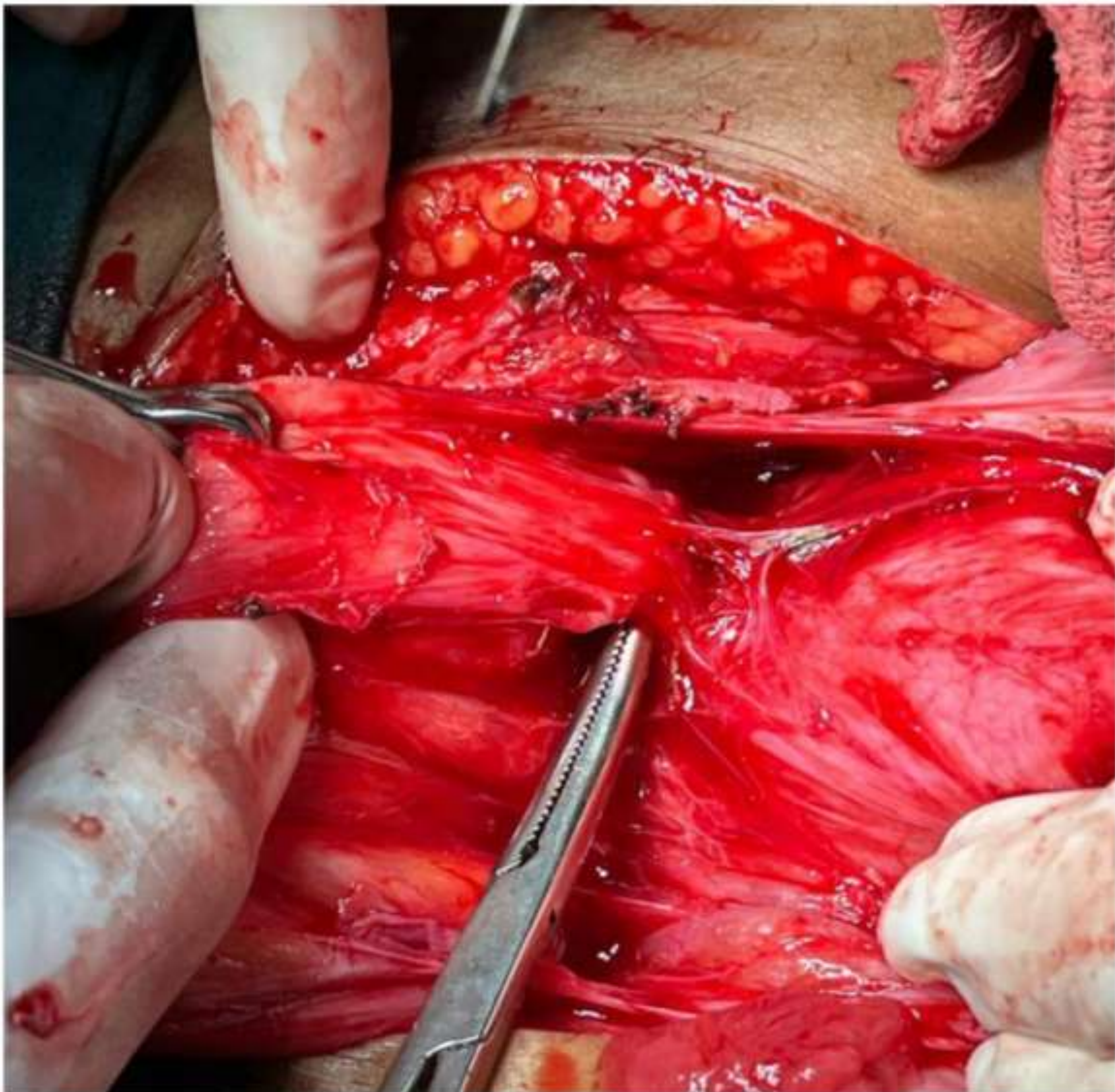
Urologist opinion was taken and after 2 packed cell transfusions,patient was posted for emergency laparotomy.Under general anaesthesia,infraumbilical midline incision was given upto pubic symphysis and abdomen

Corresponding Author:- Dr. Banavath Gowthami

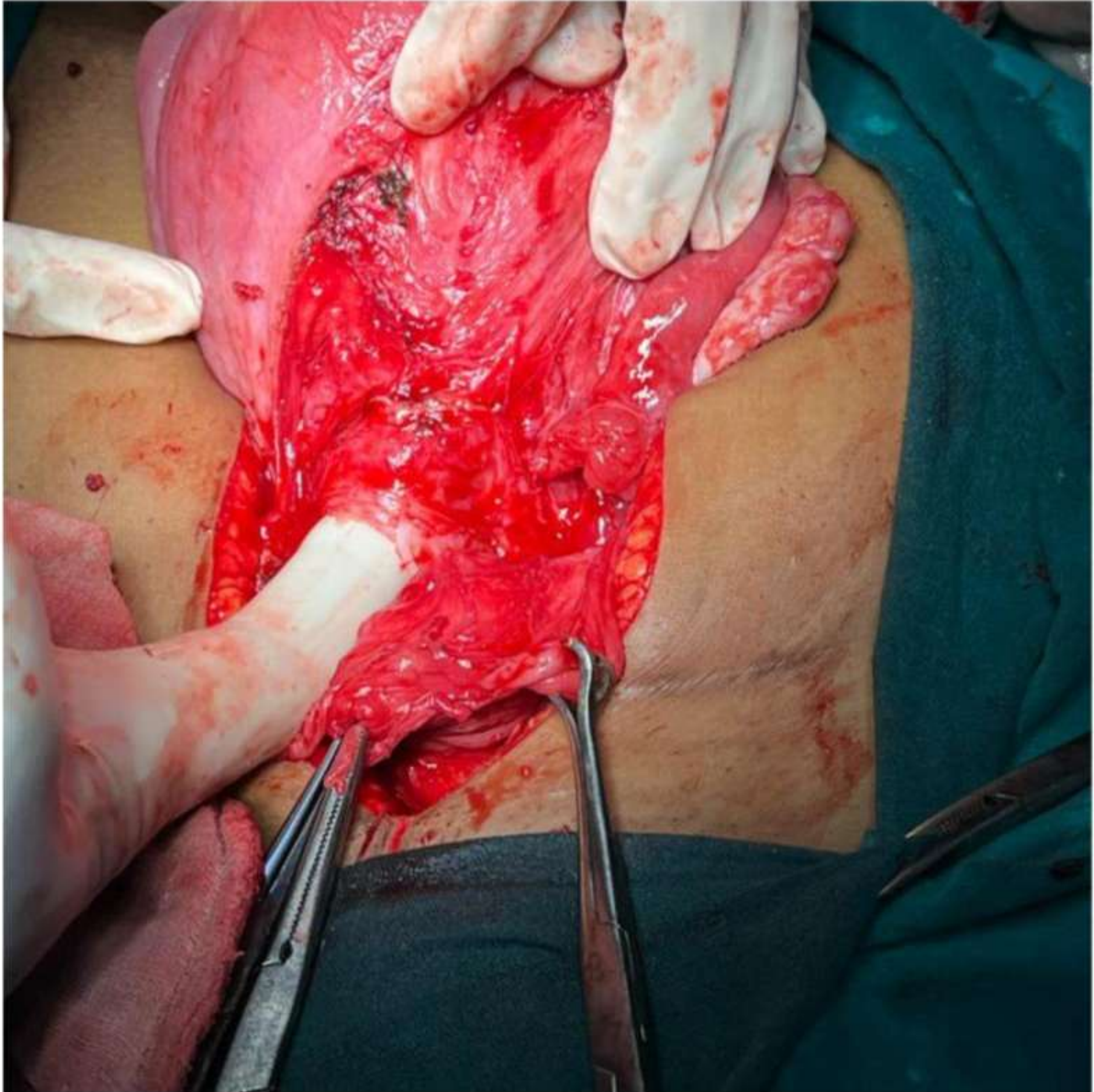
was opened in layers .A defect of about 3×4cm in posterior bladder wall connecting to the lower segment of the anterior uterine wall of the prior scar site noted .Dense adhesions around defect and bladder was separated from lower uterine segment and rent at the previous scar site was reported.Bladder injury was repaired with omental interposition flap and was irrigated with normal saline through foleysintraoperatively and no leak was noted.

ADK drain along with perivesical drain ,suprapubic drain were placed ,surgery was uneventful and patient was kept under broad spectrum antibiotic coverage.

Post operatively on day 1, patient developed shortness of breath orthopnea with productive cough with spo2 - 92%with room air and basal crepts were noted.ECG,2D ECHO and CT pulmonary angiography were done to rule out pulmonary thromboembolism.Consolidation of basal segments with bilateral pleural effusion noted as a postoperative complication and resolve after effective antibiotic coverage and post operative care.Patient was under urologist followup and outputs from all the drains were strictly monitored.Perivesical drain was removed on post operative day 19 and suprapubic drain was removed on post operative day25 and patient was discharged on postoperative day 30 with no bladder retention and is under follow up .



Defect noted in the posterior wall of bladder



Defect noted in the anterior wall of the lower uterine segment

Discussion:-

Injuries to uterus and bladder can present clinically in the early postoperative period .Signs and symptoms include -
Bleeding per vaginum
Frank hematuria
Apparent oliguria
Vaginal leak
Urinary ascites with elevated blood urea nitrogen and serum creatinine due to resorption.

Diagnosis can be made by retrograde filling of bladder with methylene blue stained saline .Vaginal mucosa stained blue in case of injury to the bladder and uterus.

Conclusion:-

Patients who undergo gynaecological and obstetric surgeries are more to vulnerable iatrogenic injuries.The most important surgical tool for a surgeon is his /her knowledge and understanding of the anatomy in which he operated and must have a high index of suspicion of risks in patients operated previously.

Here in our case,the defect was detected earlier and immediate intervention was taken and hence the patient was saved from morbidity by preventing uterovesical fistula and other complications.

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