

Intraperitoneal Extrusion of a Second-Trimester Fetus through Uterine Perforation: A Case Report

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Abstract: *Uterine perforation with complete extrusion of a second-trimester fetus into the peritoneal cavity is a rare, life-threatening complication of unsafe abortion. A 21-year-old gravida 3 para 1 living 1 abortion 1 woman at 18 weeks 5 days, with a previous cesarean delivery, presented five days after dilatation and evacuation with lower abdominal pain, vaginal bleeding, fever, and breathlessness. She had severe pallor, fever, tachycardia, tachypnea, generalized abdominal tenderness, cervical motion tenderness, hemoglobin of 6.6 g/dL, and markedly elevated C-reactive protein. Blood and high-vaginal swab cultures grew *Staphylococcus aureus*. Ultrasonography demonstrated a suspected lower uterine segment perforation with fetal bones and air pockets in the pelvis. Emergency laparotomy revealed approximately 1 L of foul-smelling hemorrhagic fluid, a dead fetus adherent to bowel, placenta in the peritoneal cavity, and a 3 × 2 cm anterior uterine defect. The fetus and placenta were removed, the defect was repaired, and bilateral tubal ligation was performed after prior consent. Prompt recognition, resuscitation, antimicrobial therapy, and surgical source control are essential.*

Keywords: septic abortion, uterine perforation, intraperitoneal fetus, second-trimester abortion, exploratory laparotomy

1. Introduction

Unsafe abortion remains a preventable cause of maternal morbidity and mortality. Major complications include hemorrhage, infection, uterine perforation, and injury to intra-abdominal organs [1]. Septic abortion refers to pregnancy loss or termination complicated by infection of the uterus or its contents and can rapidly progress to peritonitis, septic shock, disseminated intravascular coagulation, multiorgan dysfunction, and death [2].

Uterine perforation during evacuation is uncommon when performed under appropriate conditions, but the risk increases with advanced gestational age, inadequate cervical dilatation, distorted uterine anatomy, prior uterine surgery, untrained instrumentation, and delayed recognition [3–6]. Complete extrusion of a fetus and placenta into the abdominal cavity is exceptionally rare. This report describes such a presentation in a woman with a previous cesarean scar.

2. Literature Survey

Published reports of unsafe abortion describe uterine perforation complicated by bowel prolapse, bowel incarceration, bowel perforation, degloving injury, necrosis, bladder injury, and peritonitis [4–10]. Ultrasound is usually the first-line investigation and may show an empty or disrupted uterine cavity, free fluid, retained products, or extrauterine fetal parts. Contrast-enhanced computed tomography can help define bowel, urinary tract, vascular, abscess, or retroperitoneal injury in a hemodynamically stable patient, but should not delay surgery when peritonitis or shock is present.

The present case differs from many earlier reports because an intact second-trimester fetus and placenta were found in

the peritoneal cavity, with the fetus adherent to bowel and an anterior uterine defect.

3. Problem Definition

A patient presenting after attempted second-trimester abortion with persistent fever, abdominal pain, vaginal bleeding, uterine size smaller than gestational age, and peritoneal signs may have occult uterine perforation with intra-abdominal contamination. Delay in diagnosis can result in severe sepsis, visceral injury, and maternal death. The clinical problem is to recognize the complication early, define the extent of injury, and achieve rapid source control.

4. Methodology / Approach

4.1 Patient Presentation

A 21-year-old woman, gravida 3 para 1 living 1 abortion 1, at 18 weeks 5 days of gestation presented with lower abdominal pain and vaginal bleeding for five days, associated with fever and breathlessness. She had one previous cesarean delivery. Available history indicated dilatation and evacuation at a local facility with reported vaginal instrumentation; procedural records were unavailable.

4.2 Clinical Examination

The patient was conscious and oriented with severe pallor. Temperature was 102°F, pulse 128 beats/min, and respiratory rate 30 breaths/min. blood pressure was 90/60 mmHg. And SPO2 was 94% on room air with adequate urine output. Mild abdominal distension and generalized tenderness were present. Speculum examination showed cervical erosions, a closed external os, and no active bleeding. Vaginal examination revealed a 12–14-week-sized

uterus with restricted mobility, cervical motion tenderness, and forniceal tenderness.

4.3 Investigations

High-vaginal swab: *Staphylococcus aureus*

Blood culture: *Staphylococcus aureus*

Urine microscopy: Bacteria +++; pus cells 1–2/HPF

C-reactive protein: 229.738 mg/L

Total leukocyte count: $10.16 \times 10^3/\mu\text{L}$

Hemoglobin: 6.6 g/dL

Transabdominal ultrasonography showed a bulky heterogeneous uterus measuring $10.9 \times 7.7 \times 6.3$ cm, with a possible perforation at the lower uterine segment and multiple fetal bones with air pockets in the pelvis, suggesting intraperitoneal fetal parts.



Figure 1: Ultrasonographic image showing fetal osseous structures outside the expected uterine cavity

4.4 Surgical Management

Emergency exploratory laparotomy was performed after informed consent, including prior consent for permanent sterilization. On opening the abdomen peritoneal fluid was taken and sent for cytological examination and culture. Approximately 1 L of old, foul-smelling hemorrhagic fluid was drained. A dead female fetus was found in the abdominal cavity adherent to bowel, and the placenta was also intraperitoneal. A 3×2 cm rent was identified in the anterior uterine segment. The fetus and placenta were removed, the uterine defect was repaired, and bilateral tubal ligation was performed. Bowels were explored for any signs of damage but there was none. Patient was put on piperacillin with tazobactam and metronidazole for anaerobic cover. Patient was put in high dependency unit and one unit of packed red cells were transfused.



Figure 2: Intraoperative images showing removal of the intraperitoneal fetus and the uterine defect



Figure 3: Extracted fetus and placental tissue.

5. Results and Discussion

The operative findings confirmed complete extrusion of the fetus and placenta through an anterior uterine perforation, with grossly contaminated peritoneal fluid and bacteremia. The key diagnostic clues were the discrepancy between gestational age and uterine size, persistent fever and bleeding after instrumentation, generalized abdominal tenderness, and ultrasonographic demonstration of fetal bones and gas outside the uterine cavity.

Septic abortion is frequently polymicrobial. Although blood and high-vaginal swab cultures in this case grew *Staphylococcus aureus*, initial treatment should provide broad aerobic and anaerobic coverage while culture results are awaited [2]. Surgical source control is essential when uterine perforation, peritonitis, free intraperitoneal fetal tissue, hemodynamic instability, or possible visceral injury is suspected.

Prior cesarean delivery may alter lower uterine segment anatomy and increases concern for injury at or near the scar during second-trimester instrumentation. The operative record should specify whether the anterior defect involved the previous cesarean scar. Because the fetus was adherent to bowel, the final manuscript should also document whether the bowel was inspected by a surgeon and whether perforation, ischemia, serosal injury, or resection was present.

The main limitation is incomplete information regarding the outside procedure and the postoperative course. These details must be retrieved from the original case record before submission. Neutral, evidence-based terminology should be used, and the label 'unsafe abortion' should be retained only when supported by the documented history.

6. Conclusion

Persistent fever, abdominal pain, vaginal bleeding, uterine size smaller than gestational age, peritoneal signs, and extrauterine fetal parts after attempted abortion should raise immediate suspicion of uterine perforation with intra-abdominal sepsis. Rapid resuscitation, broad-spectrum antimicrobial therapy, prompt surgical source control, and systematic assessment for bowel and urinary tract injury are central to survival.

7. Future Scope

Improved access to evidence-based abortion care, trained providers, early referral, contraception, and respectful post-abortion care can reduce preventable complications. Future case reports should include complete perioperative data, microbiology, histopathology, detailed bowel assessment, postoperative recovery, and meaningful follow-up. Prospective clinical audits may help identify delays in referral and opportunities to improve emergency response.

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