

# Can We Complete 2<sup>nd</sup> Trimester Abortion after 6 Month? A Case Report

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## 1. Introduction

Intrauterine retention of foetal bones is uncommon but recognised complication of late termination of pregnancy. Pelvic pain, secondary subfertility, abnormal uterine bleeding and vaginal discharge are the usual presenting complaints. We report a case of prolonged retention of foetal bones for 6 month in a woman who presented with chronic pelvic pain. Hysteroscopic examination is diagnostic. Retained foetal bones are an uncommon intrauterine cause of chronic pelvic pain that should be considered particularly when a woman with history of termination of pregnancy presents with pelvic pain. Hysteroscopic guided evacuation is curative.

**Keywords:** Retained foetal bones, Hysteroscopy, chronic pelvic pain

## 2. Case Report

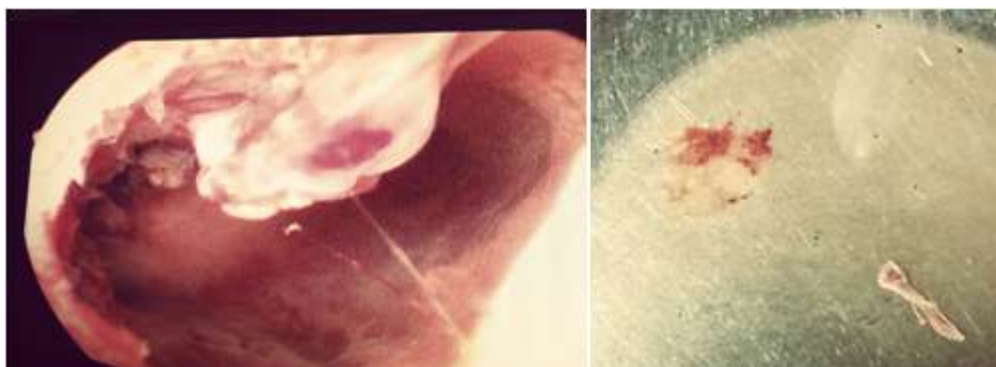
A 25-year-old P1A4L1 Woman referred from private hospital as a case of retained intrauterine foetal bones. Patient presented with chief complain of chronic pelvic pain since 6 month. No complain of vaginal discharge, irregular bleeding. Her last menstrual period was on 14/7/2018. Her past menstrual cycles were regular, moderate in amount and painless. In obstetric history there were 3 spontaneous abortion at 2-3 month of amenorrhoea followed by full-term emergency caesarean for placenta previa before 3 year.

There was no history of MTP or contraception. In past history, 6 month before, In January 2018 she had 3.5 month of amenorrhoea. She developed one episode of bleeding per vaginum. She went to private hospital where on transvaginal ultrasonography revealed absent cardiac activity, for that

dilatation and evacuation was performed in that private hospital. After that she had on and off complaint of pelvic pain since 6 month. She visited several hospitals and taken symptomatic treatment. On admission her pulse rate was 96/min, BP-120/80mmhg, Spo2-99% on air. On examination her abdomen was soft. On per speculum examination no abnormality detected. On per vaginal examination cervix os was closed and bilateral adnexa were clear. Initial investigations revealed Hb-11.3gm/dl, WBC-11300/mm<sup>3</sup>, platelets-3,30,000, RBS-98mg/dl, RFT,LFT and electrolytes were within normal limits. On her USG pelvis revealed anteverted normal size uterus with anterior uterine wall calcific lesion of 33x18mm size at the level of isthmus. No e/o adnexal mass on either side. No e/o free fluid in pelvic cavity.



Diagnostic hysteroscopy followed by hysteroscopy guided curettage was done under spinal anaesthesia and retained foetal bones were removed and sent for histopathological examination and confirmed.



### 3. Discussion

Intrauterine foetal bone retention is a rare complication; it mostly occurs after incomplete curettage resulting intrauterine retention of foetal bones. Residual foetal bone often causes dysfunctional uterine bleeding, menorrhagia, dysmenorrhea, pelvic pain, abnormal vaginal discharge, infertility and so on. Once diagnosed, the detected residual foetal bones should be removed surgically. The removal of residual foetal bones under hysteroscopy and B-mode ultrasound monitoring not only can ensure safety and reduce the occurrence of complications, but also timely detection and removal of residual bones embedded in the uterine wall guarantee the effectiveness of surgical treatment.

Hysteroscopic inspection of uterine cavity is a simple, outpatient and well-accepted method for intrauterine pathology. Direct visualization in vivo, real time, real colour, hydrated, well illuminated and augmented vision of uterine cavity make this diagnostic tool very accurate to detect minute focal endometrial pathology and small lesions otherwise not possible, complemented to the ability of performing guided direct biopsies and treatment on same diagnostic procedure.

### 4. Conclusion

The retention of foetal bone may cause chronic pelvic pain, and removal of the residual bone may relieve symptom. Hysteroscopy allows direct visualization of uterine cavity, the improvement in hysteroscopy made it feasible to diagnose and remove the bones. The present case highlights the importance of examining the intactness of the removed foetus.

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