

Endometritis secondary to infected abortion – Case report



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ABSTRACT

Early pregnancy loss takes many forms, with miscarriage being the loss that occurs in the first trimester of pregnancy. We can subdivide abortion into different forms, namely: spontaneous, retained, unavoidable, incomplete, recurrent, complete and septic abortion. Septic abortion is defined as any abortion that evolves to a more complicated

condition due to the presence of endometritis, parametritis or infection of the upper genital tract and the treatment usually includes the use of antibiotic therapy, associated with evacuation of the retained conceptus. In this case report, the patient (female and 34 years old) presented bleeding at 14 weeks of gestation associated with vaginal discharge of contents similar to "flesh", foul odor and high fever. The diagnostic hypothesis was that she had an infected abortion, and she was requested for complementary tests, and she was referred for uterine emptying associated with antibiotic therapy. The patient progressed with improvement of clinical symptoms and was discharged from the service with the use of antibiotics. However, the patient returned 9 days later with abdominal pain in the lower abdomen with greenish discharge and ultrasound with signs suggestive of endometritis. The patient underwent magnetic resonance imaging that confirmed the hypothesis associated with a risk of sepsis, therefore, she underwent subtotal hysterectomy and bilateral salpingectomy.

Keywords: Abortion, Retained, Infection, Sepsis, Curettage, Uterine emptying.

1 INTRODUCTION

Early pregnancy loss takes many forms, with miscarriage being the loss that occurs in the first trimester of pregnancy or before 20 weeks. We can subdivide abortion into different forms, namely: spontaneous, retained, unavoidable, incomplete, recurrent, complete and septic abortion [1,2].

Infected abortion, which will be addressed in this case report, is defined as an abortion complicated by an intrauterine infection and may be associated with abortion induced by inadequate and unsafe techniques. These infections are usually polymicrobial and therefore require broad-spectrum antibiotic treatment and surgical removal of the material retained in the uterus. This condition can evolve with serious complications such as uterine perforation, hemorrhage, gas embolism, and pelvic infection [3]. In addition, a risk of sepsis can also be visualized, for example, due to endometritis and other infections [4].



Among the other complications, acute endometritis not associated with pregnancy stands out in this context, which consists of an alteration in the endometrial microbiota, leading to an infectious process. In 85% of cases, endometritis is associated with sexually transmitted infections, but more rarely, it can be related to uterine instrumentation, such as biopsy and IUD placement [5,6]. According to the case studied, there was intrauterine manipulation through uterine curettage, causing the endometritis process presented.

2 CASE REPORT

In this report, the patient (female and 34 years old) presented bleeding at 14 weeks of gestation associated with vaginal discharge of contents similar to "flesh", foul odor and high fever. The diagnostic hypothesis was that of an infected abortion, complementary tests were requested, and the patient was referred for treatment through uterine emptying associated with antibiotic therapy. There are no reports of attempted induced abortion. She underwent two uterine curettage procedures due to the persistence of symptoms and fetal remains. The patient progressed with improvement of clinical symptoms and was discharged from the service with the use of antibiotics. However, the patient returned 9 days later with abdominal pain in the lower abdomen with greenish discharge and ultrasound with signs suggestive of endometritis. The patient underwent magnetic resonance imaging that confirmed the hypothesis, in view of the diagnosis and the risk of sepsis, and underwent subtotal hysterectomy and bilateral salpingectomy.

3 OBJECTIVES

To expose a rare case of infected abortion, which progressed to hysterectomy. Deepen knowledge in relation to the subject and expand the area of study within Gynecology and Obstetrics.

4 METHOD

Information was obtained through a review of medical records, interviews with the patient, and a review of the literature.

5 DISCUSSION

Delayed abortion presents as an asymptomatic death of the fetus, without uterine contractions, capable of expelling the embryo [1]. Ultrasonography (USG) is important for diagnosis, allowing the differentiation between complete and incomplete abortion as it allows the identification of the gestational sac, embryonic remains and vital activity of the embryo [7]. In the patient presented, the imaging test suggested an incomplete abortion due to the presence of heterogeneous material [8].



Therefore, in the report cited The patient reported cramping-like abdominal pain, vaginal bleeding, foul odor, high fever, associated with loss of material vaginally similar to flesh. Based on the clinical picture exposed, the suggested diagnostic hypothesis was infected abortion, which consists of an infectious process with clinical signs pertinent to those mentioned, which may be restricted to the endometrium or expand to other adjacent structures [3]. This condition is usually associated with inappropriate attempts to terminate the pregnancy, so it is always important to ask the patient [3]. In this sense, she was questioned and denied having taken any kind of action to induce the abortion.

Due to the infectious condition, antibiotic therapy was started and, as the pregnancy was more than 12 weeks gestation, which evolved with infected abortion and the The primary treatment is the removal of infected and devitalized tissues, even in the presence of continuous fetal heartbeats, the use of misoprostol 200 micrograms was indicated for cervical dilation, followed by two uterine wintercurettages [4,9]. This procedure is done with the use of dilators and promotes the scraping of the uterine cavity in order to detach and remove the retained material [10]. If the pregnancy was less than 12 weeks, manual intrauterine aspiration (MVA) could be the best indication, since it is a less invasive procedure for the patient and does not cause endometrial injury, avoiding the occurrence of uterine synechiae after the procedure.

The abortion scenario involves several complications, including post-abortion infection or endometritis, which involves microorganisms such as Gram-positive and negative bacteria and anaerobic organisms [5]. The diagnosis is clinical and the incidence is higher in unsafe abortions, with severe cases being more infrequent (5.1% of unsafe abortions) [11]. Treatment consists of broad-spectrum antibiotic use and surgical intervention may be necessary if the infection produces a collection of drainable fluid in the cavity, if there are greater risks, Evidence of organ perforation and/or tissue necrosis in a septic abortion [12]. In addition, the The presence of gas in the myometrium on radiological imaging is suggestive of the presence of *Anaerobic clostridium in* infection, which in many cases requires a hysterectomy to remove infected tissue [13].

In this sense, according to the persistence of the condition, associated with complementary imaging tests that demonstrated an enlarged uterus (905.5 cm³) and the presence of fluid in the cavity. The patient in question was referred to the operating room for treatment (subtotal hysterectomy with bilateral salpingectomy). Other sonographic alterations, which when present speak in favor of post-abortion infection and endometritis, are increased myometrial vascularization, hydrosalpinges, or an adnexal mass, which may suggest an abscess [14].

6 CONCLUSION

Finally, infected abortion, despite not being present among the most common types, can evolve with serious complications, putting female fertility at risk, that is, evolve with more serious infections,



such as endometritis, and consequently lead to sepsis. The underlying treatment consists of immediate evacuation of infected uterine contents associated with broad-spectrum antibiotic therapy. This can normally be done through suction curettage or a blunt curette, however, if patients do not respond promptly to uterine emptying and intravenous antibiotics, aggressive surgical intervention, including hysterectomy, may be required to save lives, while delay can be fatal.

CONFLICT OF INTEREST

We declare for all due purposes that there is no conflict of interest in this case report.



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