

Abnormal Uterine Bleeding due to Retention of Fetal Bones after Abortion: A Case Report

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Abstract

Background: Retention of fetal bones is a rare cause of abnormal uterine bleeding. Others may present as subfertility, chronic pelvic pain, abnormal vaginal discharge, menometrorrhagia, dysmenorrhea and spontaneous expulsion of bony fragments. Incidence is 0.26% among patients undergoing hysteroscopy. **Aim:** To document a pattern of presentation of retained fetal bone and its management. **Case Presentation:** Our patient is an 18-year old who presented with vaginal bleeding of four weeks duration and managed for abnormal uterine bleeding due to retained fetal bone following second trimester abortion. **Conclusion:** The use of transvaginal ultrasound in making diagnosis of retained fetal bone is effective. Treatment by removal of bones through evacuation by dilatation and curettage or hysteroscopy brings about resolution of symptoms. Use of pelvic ultrasonography to confirm complete evacuation of the uterus after abortion especially second trimester abortion could aid in early diagnosis and management of incomplete abortion.

Keywords

Abnormal Uterine Bleeding, Retained Fetal Bones, Abortion, Transvaginal Ultrasound, Dilatation and Curettage, Hysteroscopy

1. Introduction

The restrictive abortion law in Nigeria has not halted or even reduced the rate at which women seek abortion in the country, instead it has forced many to seek abortion services surreptitiously from unqualified practitioners resulting in high rate of maternal morbidity and mortality [1]. It can result in immediate compli-

cations like hemorrhage, uterine perforation, cervical injury and at times late complications like infections, bleeding, menstrual abnormalities and uterine syn-echia to mention a few [2].

Fetal bones are rarely found within the uterine cavity. They have been reported to follow majorly retained bone fragments, however, some cases are suspected to be due to metaplasia of mature endometrial stromal cells following chronic inflammation or trauma [3]. Second trimester abortion can be done through dilatation and curettage or by medical means. The most common cause of retained fetal bones is complication of unsafe abortion [4].

Abnormal uterine bleeding has a variety of causes as per FIGO (International Federation of Obstetrics and Gynaecology) [5] [6]. Intrauterine fetal bone retention is a rare cause as the incidence in our environment with highly restrictive abortion laws is 0.26% among patients undergoing hysteroscopy [3]. Transvaginal ultrasonography aids in the diagnosis of abnormal uterine bleeding due to retention of fetal bones, as well as Hysteroscopy [3] [6] [7] [8]. So we present a case of an 18-year old lady with abnormal uterine bleeding due to retention of fetal bones following second trimester abortion.

2. Case Report

An 18-year old female P0 + 1 presented to our gynecology clinic with chief complaint of vaginal bleeding for 4 weeks. The bleeding was scanty and associated with intermittent lower abdominal pain. There was no complaint of fever, lethargy, dizziness or abnormal vaginal discharge. Six weeks prior to the current hospital visit, she presented with amenorrhea of 16 weeks and 3 days requesting for termination of pregnancy which was turned down according to country and hospital policy. She proceeded to have an unsafe abortion. She attained menarche at 12 years of age and menstruation has been relatively regular. The first sexual intercourse was at 16 years of age and she denied history of multiple sexual partners. Her past medical and surgical history was not significant.

On examination, her general condition and vital signs were stable. Abdominal examination was not remarkable. Bimanual examination showed a slightly bulky, anteverted uterus and free adnexa. Examining finger slightly stained with blood. Speculum examination showed healthy looking cervix and vagina, no active vaginal bleeding. Pregnancy test was negative and packed cell volume was within normal. Transvaginal ultrasound showed endometrium of 6.27 mm thick, calcified foci measuring 2.8×2.0 cm in widest diameter are seen tracking down towards the cervix, normal ovaries and no fluid in pouch of Douglas.

After due counselling on options of management, removal of bony fragments was done via dilatation and curettage and extraction with forceps under saddle block. Our patient could not afford the cost of hysteroscopy and she was not willing to disclose what had happened to her parents nor ask for their assistance. Gross examination of the specimen revealed seven (7) fetal skeletal fragments filling the lower uterine segment. Estimated blood loss was minimal.

She was well postoperatively and discharged on oral antibiotics same day. The patient remained normal in subsequent follow-up visits, bleeding had stopped and had a normal menstrual cycle.

3. Discussion

Incidence of retained intrauterine fetal bone is rare with few cases reported in Nigeria [3] [7]. Most cases reported followed second trimester surgical abortion [6] [7] [8]. Unsafe abortion is one of the major health problems in low resource countries with restrictive abortion laws [1] [3] [8].

Retained fetal bone present in a number of ways such as subfertility, chronic pelvic pain, vaginal discharge, menometrorrhagia, dysmenorrhea, spontaneous expulsion of bony fragments as well as abnormal uterine bleeding [2] [3] [4] [6] [7] [8] [9] [10]. Retention of fetal bone as a cause of abnormal uterine bleeding is rare [3] [8]. Abortion is usually a safe procedure especially when carried out by an expert but it is not without its own complications. When abortion is done in the second trimester or if the fetus was removed by destructive means, some part of the fetus may be left unintentionally in the uterine cavity [2] [8]. In our case, abnormal uterine bleeding occurred after unsafe abortion. Retained fetal bone after surgical management of missed abortion has also been reported [6] [8].

Mechanism of abnormal uterine bleeding could be due to chronic endometritis or altered prostaglandin levels. The menstrual blood volume and prostaglandin F2 concentration before and after removal of retained fetal bone were measured in women with menorrhagia and infertility and it was found that their menstrual blood volume and prostaglandin concentration reduced by 50% after evacuation of the fetal bones [6] [10]. In our case, abnormal uterine bleeding occurred after surgical abortion which may have been caused by the retained fetal bones through similar mechanism.

Adequate history and examination is paramount to comb down on the differentials of abnormal uterine bleeding. Transvaginal ultrasound is effective in making diagnosis of retained fetal bone. Deeply impacted bones that might be missed at hysteroscopy are rarely missed at ultrasonography [8]. However, hysteroscopy is gold standard as it is both diagnostic and therapeutic [2] [4] [6].

Treatment of retained fetal bones is by removal through evacuation either by dilatation and curettage or hysteroscopy [3] [6] [7] [8]. Our patient had fetal bones removed by dilatation and curettage due to financial constraints. Complete resolution of symptoms follows after complete removal of fetal bones.

4. Conclusions

Retention of fetal bones is a rare cause of abnormal uterine bleeding and every gynecologist should have a high index of suspicion when evaluating patients with previous history of second trimester abortion. The role of transvaginal ultrasound in making diagnosis is indispensable. Treatment by removal of fetal

bones brings about resolution of symptoms.

The time to review restrictive abortion laws is now. Our patient was an eighteen-year-old who had unplanned pregnancy and desired for termination of pregnancy. She was young, in school and not prepared for the pregnancy. She had not much knowledge of contraceptive methods nor ready for what it takes to carry a pregnancy and care for a newborn. The question is, at what point did we fail her?

Use of pelvic ultrasonography to confirm complete evacuation of the uterus after abortion especially second trimester abortion could aid in early diagnosis and management of incomplete abortion thereby preventing this ruinous complication of abortion as seen in our patient.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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