

Rare Case of Abortion Complication: Bilateral Abscess of the Shoulders

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Abstract

Septic abortions usually result from intrauterine maneuvers using non-sterile instruments or materials; they are much more common when abortion is illegal. We report the clinical case of a 28-year-old patient following a complicated abortion of endometritis and bilateral abscess of the shoulders, requiring surgical drainage and antibiotic therapy. The bacterium identified was *Escherichia coli*, sensitive to ceftriaxone.

Keywords

Septic Abortion, Endometritis, Shoulder Abscess, *Escherichia coli*, Niamey Prognosis, Niger

1. Introduction

Septic abortion is defined as that leading to local genital and/or locoregional or general infectious complications. This type of abortion is seen in countries with very low health coverage and often outside the health facility [1].

2. Medical Observation

We report a case (with clear consent accepted by the patient) of abortion complication in a 28-year-old woman, married, without occupation, admitted to impotence of pelvic limbs after abortion at home. The first pregnancy proceeded normally and childbirth by the child living vaginal and single layer suite. This second desired and spontaneous pregnancy was at the end of 10 weeks of amenorrhea on ultrasound. No medical or surgical antecedent was known in this patient. The symptomatology of the day of the abortion (spontaneous?) was dominated by pelvic pain accompanied by minimal and then abundant metrorrhagia and the expulsion of a part of the product of conception at home. No consulta-

tion is done that day, so no post-abortion care is given and the patient stays at home for four days. We received her on the fourth day post-abortum. She presented at admission a general state preserved with a temperature at 39.5°C, a blood pressure of 110/70 mm of mercury, intense pain to the bite type at the shoulders. The conjunctivae and mucous membranes were slightly pale, the abdomen soft, uterine fundus palpated above pubis, uterus painful on examination and presence of purulent secretions at the vulva. The speculum examination reveals the uterine origin of very fetid purulent secretions.

There were no lesions or signs of vaginal and cervical trauma. With vaginal touch the cervix was short median admitting a finger to the internal orifice and fingerstall brought franc pus. At the level of the musculoskeletal system we noted pain and tetra-paresis. The examination of other devices reveals nothing particular. In front of this table the biological assessment shows: GB = 32,200/UI (normal 4000 - 10,000/UI, HG = 8.9 g/dl), N 11 - 16 g/dl, platelets = 247,000 /l (normal 100,000 - 300,000/l), negative falcine-formation test, serology HIV negative a glycemia: 0.97 g/dl (normal 0.70 - 1.10 g/dl), ultrasound pelvic revealed the presence of an enlarged uterus containing ovular debris (incomplete abortion, bad quality picture), and concluded post-abortion endometritis. An X-ray of the right and left shoulder was performed and is without particularity. Antibiotic therapy (ceftriaxone and metronidazole) was initiated followed by uterine evacuation of remaining trophoblastic tissue.

After three days of hospitalization, the general condition was stationary. Examination of the same day revealed the presence of swelling of the right (**Figure 1**, **Figure 2**) and left (**Figure 3**, **Figure 4**) shoulder. Both shoulders had increased considerably in volume, red and painful. This is bilateral abscess of the shoulders. Anti-inflammatory and analgesic treatment was combined with the dual antibiotic therapy already in place. On the seventh day of hospitalization,



Figure 1. Right shoulder abscess drainage.



Figure 2. Right shoulder abcess drainage.



Figure 3. Left shoulder drainage Epaule Gauche.



Figure 4. Left shoulder drainage.

an incision and drainage of abscess of two shoulders was made, reducing about 1000 cc of franc pus to the right shoulder, and 500 cc of pus to the left shoulder. Installation of two drainage blades. Bacteriological examination of the pus isolates *E coli* sensitive to ceftriaxone and amikacin. Antibiotic therapy was maintained as well as the absence and administration of analgesics and then progressive rehabilitation of the pelvic and upper limbs. At the end of twenty-nine (29) days of hospitalization, due to the improvement of her general condition, the aseptis of shoulder sores and even the mobilization of limbs found again, discharge from the hospital was authorized with ambulatory antibiotherapy oral, martial treatment and dressing every other day.

3. Comments

Septic abortions usually result from abortions caused by intrauterine maneuvers using non-sterile materials or instruments; they are much more common when abortion is illegal. The most common infectious complications are: cervicitis, salpingitis, endometritis, peritonitis.

The case of this patient present is exclusively a model of non-medical illegal abortion in a country where abortion is not legal. This was done in unsanitary conditions with non-sterile objects. The materials used can introduce bacteria from the vagina and cervix into the uterine cavity, leading to post-abortion infection of the upper genital tract [2]. The terms pelvic infection of post-abortum [2] and post-abortion pelvic inflammatory disease [2] were also used to describe this condition. The risks of abortion classically reported in the literature, are age below 24 years or 70% at 17 years [3] and 69% in case of celibacy [3] or among students and students 42% [5], the nulliparity, multiple sexual partners, history of salpingitis or gonorrhoea, genital infection (gonorrhoea, chlamydia, bacterial vaginosis) not treated at the time of abortion [1].

The disadvantaged socio-professional categories 64% among uneducated women [4] and the low socio-economic level, HIV infection, multiply the risk of infection by 3 to 4 in the case of surgical abortion. Similarly, the term of pregnancy (≥ 50 days) increases the risk of infection by approximately 2 in the case of medical abortion [3]. The provoked nature of abortion is rarely acknowledged. In this case, the patient is from an underprivileged environment, seronegative to HIV, the pregnancy is aborted at 10 weeks of amenorrhoea. She developed the endometritis of the post abortum and bilateral abscesses of the shoulders. This clinical case is comparable to that in Okinawa Hospital [5], where a 43-year-old patient presented with postabortum endometritis with right shoulder abscess whereas she had no other factor such as an immune deficiency or intrauterine maneuver. However, performing an intrauterine procedure is not the only factor that can lead to the occurrence of this complication since post-abortion infections are also possible after medical abortion by unqualified health personnel [2]. Is it an initial cervico-vaginal infection that has evolved? The spread of the germ towards the shoulders could be lymphatic and we think that a cytotobacteriological

examination could be recommended before any endo-uterine gesture to prevent contamination of the genital tract or the administration of aero-anaerobic antibiotics after any endo-uterine gesture. must be systematic. For the management of our patient, bi-antibiotic therapy (ceftriaxone and metronidazole) was initiated followed by uterine evacuation of the remaining trophoblastic tissue (Figures 1-4).

Clandestine abortions are mostly incomplete, as in Kouamé series in Abidjan with 26.3% curettage and even 18.7% hysterectomy [4] Intensive antibiotic treatment is recommended in case of post abortum infection [1]. The typical antibiotic regimen includes clindamycin 900 mg IV every 8 h plus gentamicin 5 mg/kg IV 1 time/day, with or without ampicillin 2 g IV every 4 h. Otherwise, a combination of ampicillin, gentamicin and metronidazole 500 mg IV q 8 h may be prescribed.

4. Conclusion

Clandestine abortion, performed under unsanitary conditions, often leads to complications, including very serious infectious diseases that can even be life-threatening. The rapid identification of the pathogenic germ and the massive specific antibiotherapy remain the essential of the management after insurance of uterine emptiness. Prevention lies in systematic prophylactic antibiotic therapy during any intrauterine act.

Conflicts of Interest

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

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