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Short Communication

The retained fetal skull: An obstetrician's night mare

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ABSTRACT

In the growing era where safe abortion practices are advocated, we still encounter the complications of illegal abortions. We present a case of 40-year-old P3L3A1 referred to our tertiary care center with history of massive bleeding following illegal second trimester abortion and USG revealing the retained fetal skull. The retained fetal skull was removed but there was torrential hemorrhage on attempting to remove the placental mass. Balloon tamponade and hemostatic agents failed leading to laparotomy and discovery of placenta accrete syndrome which eventually lead to hysterectomy, Intensive ICU care and admission, massive blood transfusion and ultimately contributing to maternal near miss situation.

1. Introduction

Safe abortion practices are advocated and encouraged. Second trimester abortion has been a topic full of dilemmas and controversies and could result in disastrous outcomes. With this case report we present a case of 40 year old previous three LSCS referred in view of massive hemorrhage following second trimester illegal abortion and USG revealing the retained fetal skull. With this case report we will bring out the hazards and complications associated with illegal abortion. The importance of provision of safe abortion for all under MTP act needs to be stressed in this era to avoid preventable maternal morbidity and mortality. The role of USG in diagnosing the retained products of conception and the dreaded associated complication of placenta accrete syndrome needs to be kept in mind when performing second trimester abortion specially in cases of previous LSCS. The employment of MRI and CT in cases of doubtful situations needs to be emphasized.

2. Case Report

A 40-year-old P3L3 with history of 4-month amenorrhea was referred to our tertiary care center with history of torrential hemorrhage following second trimester abortion. Obstetric history: All three were LSCS and last child birth was 11 years ago. No history of ligation in the past was illicted. Her previous cycles were regular and last menstrual date was not known. At the time of arrival-patient was conscious, oriented, severely pale. Her vitals-Pulse-120/min, BP-120/70, sp02: 99%, chest: clear. Fundal height was 16 weeks and os was patulous with slight bleeding on per vaginal examination. Ultrasonography revealed: uterus was bulky with heterogenous area in lower segment: suggesting the fetal skull of 17 weeks and 6 days. Placenta was present in the lower segment. After the initial resuscitation with two units of blood the fetal skull was removed under general anesthesia. There was torrential hemorrhage on attempting to remove the placenta. Hemostatic agents and balloon tamponade failed resulting in exploratory laparotomy after informed consent. Intraop: uterus was 10 weeks, flabby and placenta was found to be adherent to the lower segment of uterus: Placenta

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accrete syndrome. Total hysterectomy was done followed by bilateral internal artery ligation. Intra-op, patient was intubated. 4 units of PRBC, FFP and platelets were arranged and infused. Inotrope support given to maintain the vitals. Despite the mentioned measures bleeding continued from the vault henceforth 2 packs of the large sized mops were left in situ. Intraperitoneal drain was inserted and abdomen was closed in single mass closure. Patient was extubated and ionotropic support tapered and stopped the next post op day. Her post op Hb was still 7 gm/dl and prothrombin time was deranged suggesting DIC. Patient was additionally transfused 2 units of FFP and PRBC. The packs were removed after 48 hours of the initial surgery under general anesthesia and no oozing was found from the vault. Rectus sheath was closed and the skin was left open for healing as the wound was found to be infected. Her post op recovery was good and secondary suturing was done on day 10. Histopathology of the uterus sample confirmed placenta accrete.

3. Discussion

Unsafe Second trimester abortion can result in disastrous outcomes and account for 8% of maternal deaths worldwide.[1] Complications resulting from unsafe second trimester abortion range from excessive blood loss, uterine perforation, injury to adjacent organs, pelvic infection, aspiration of visceral organs and retained products of conception.[2] Jasmina et al. have reported the retained fetal skull in the left iliac fossa after perforating the uterine wall.[3] The patient presents with history of excessive blood loss and ultrasound is the first line of investigation following such evacuations. The sensitivity of detecting retained fetal skull by USG is good but CT and MRI have an additional advantage of detecting the site of perforation.[4] The present case presented with history of excessive bleeding and USG suggesting the retained fetal skull. There was torrential hemorrhage on attempting to remove placenta uncontrolled by hemostatic agents and uterine tamponade, hence the decision for laparotomy and finally the discovery of placenta accrete syndrome. Only few cases have been reported where placenta accrete has been found in first and second trimester. Rash Baum et al. have noted 0.04% incidence of placenta accrete encountered during dilation and evacuation. Placenta accrete has been reported more than placenta percreta.[5] Nearly all the cases reported resulted in hysterectomy with massive blood transfusion and intensive ICU care. Pressure packing, internal artery ligation are additional measures to prevent excessive blood loss. Pressure packing and relaparotomy to remove such packs after 24 hrs of r correction of blood coagulation profile has been attempted with successful outcomes.[6,7]

4. Conclusion

The decision of second trimester should be taken with utmost caution and attempted only after ruling out placental abnormalities specially in patients with history of previous caesarean section. The need for blood and blood related products should be ensured before commencing this procedure. Furthermore, the need to do ligation after successive caesareans are the good practice points to prevent unwanted pregnancies and prevent such disastrous outcomes following illegal second trimester abortion.

5. Abbreviations

USG: ultrasound, CT: computed tomography, MRI: Magnetic resonance imaging.

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7. Conflict of Interest

None.

References

1. Say L. Global causes of maternal death: a WHO a systematic analysis. *Lancet Glob Health*. 2014;2(6):323–33.
2. Chauhan N. Iatrogenic uterine perforation with abdominal extrusion of fetal parts. A rare radiological diagnosis. *J Radiol Case Rep*. 2013;7(1):41–7.
3. Begum J. Unusual complication of surgical abortion with pelvic extrusion of fetal head: A case report. *J Clinn Diag Res*. 2015;9(11):11–12.
4. Gakhal M. Levy Sonographic diagnosis of extruded fetal parts from uterine perforation in the retroperitoneal pelvis after termination of intrauterine pregnancy that were occult on magnetic resonance imaging. *J Ultra Med*. 2009;28:1723–7.
5. Rashbaum W. Placenta Accreta Encountered During Dilation and Evacuation in the Second Trimester. *Obstet Gynecol*. 1995;85(5):701–3. doi:10.1016/0029-7844(95)00050-2.
6. Gupta N, Gupta A, Green M, Kang HS, Blankstein J. Placenta percreta at 17 weeks with consecutive hysterectomy: a case report and review of the literature. *Case Rep Obstet Gynecol*. 2012;2012. doi:10.1155/2012/734834.
7. Ahuja M. Focused abdominal compression as a means of controlling post-partum hemorrhage. A case report. *Ind J of Obst and Gynecol*. 2018;5(2):287–89.

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