ORIGINAL PROF-969

GYNAECOLOGICAL EMERGENCIES

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ABSTRACT... drsardarali@hotmail.com Objectives: To highlight the various gynaecological problems presenting as acute surgical abdomen and their management. Design. Prospective Study. Setting: District Headquarters Hospital Kasur. Period: Two years from January 2001 to December 2002. Materials & Methods: A total of 44 patients presenting with acute surgical abdomen but having some gynaecological problems included. The females above 12 years of age and admitted through emergency. Clinical assessment and routine laboratory investigations were performed in all the patients. More specific investigations were performed where required. All the patients were resusscitated and operative treatment; where required; was performed under general anesthesia at the earliest possible time. The surgical procedure was tailored according to the circumstances. Further management, conservative or post operative care was done in surgical ward. Results: Pelvic Inflammatory Disease (PID) which is the inflamation of upper genital tract with its complications like pelvic cellulitis and pelvic peritonitis was the most common (40.9%) emergency. The age group between 16 to 30 years was the commonest having gynaecological problems. There was a clear predilection of married than unmarried females facing these problems. Because of lack of experience and limited diagnotistic facilities erroneous diagnosis was made to some extent in almost all the cases. 55.55% of patients suffering from PID were treated successfully by conservative means. Surgical procedure was performed in all the patients (100%) suffering from ruptured ectopic pregnancy, perforated uterus and torsion of ovarian cyst and pedunculated subserosal fibroid. Wound infection and delayed wound healing were among the most common postoperative complications. Mortality occurred in ectopic pregnancy (16.66%) and PID (5.55%). Conclusion: The different gynaecological problems are commonly encountered in general surgical practice. The surgeons often fall in this un-wary trap because of (1) close resemblance of clinical features (2) less exposure to gynaecological problems (3) non availability of more sophisticated diagnostic tools in emergency. The overall sufferings of patients can be reduced to some extent by overcoming these shortcomings.

Key words: PID, Pelvic inflammatory disease: USG, Ultrasonography, Salpingooophorectomy.

INTRODUCTION

A fairly large number, up to 13% of patients admitted in surgical treatment for presumed acute appendicitis may general surgical wards for acute abdomen have some gynaecological problem[1]. The patients undergoing also have some gynaecological problem up to 9.6%[2].

The patients "having gynaecological'problems like pelvic inflammatory disease, ectopic pregnancy, uterine perforation, torsion of ovarian cyst and pedunculated subserosal fibroid, haemorrhagic functional ovarian cyst, endometriosis and degeneration of fibroid are admitted in general surgical wards because of close resemblance with general surgical diseases[3'4].

So there is little or no escape from such gynaecological problems which present fairly, regularly and commonly in the course of general surgical practice. A surgeon, therefore, must be familiar with the appropriate technique of clinical assessment and management of such cases.

Pelvic inflammatory disease is one of the most serious infections in women today. Untreated or unsuccessfully treated women may develop life threatening complications and even adequately treated are at much higher risk for potentially serious sequelae like infertility and ectopic pregnancy[5],

Ectopic pregnancy especially when ruptured is also life threatening gynaecological emergency. Because of close resemblance of clinical features superadded by hurried and inadequate or wrong history and unknown Last Menstrual Period (IMP), the erroneous diagnosis like acute appendicitis is often made. Many young girls are operated in mid cycle due to mittleschumerz for appendicitis.

Uterine perforation leading to peritonitis is a frequent complication of instrumental evacuation usually in the hands of untrained and unauthorized non medical abortionists. Ovarian or pedunculated subserosal fibroid torsion comprises of 2.7% of gynaenocologic surgical emergencies and is a well known poorly recognized and infrequently encountered clinical entity.

Functional ovarian cysts are common, frequently asymptomatic and may require no treatment. This is the 4th most common gynaecological cause of hospital admission53. The purpose of the study was to highlight the various gynaecological problems presenting as acute surgical abdomen and their management,

MATERIALS AND METHODS

This prospective study "Gynaecological Emergencies" was conducted at DHQ Hospital, Kasur over a period of two years from January 2001 to December 2002. A total of 44 patients presenting as acute surgical abdomen but having some gynaecological problem were included. All the patients were females above the 12 years of age and admitted through emergency.

Clinical history and assessment including per rectal and pelvic/vaginal examinations were carried out in all these cases except unmarried females where per vaginal examination was omitted.

In all the cases laboratory investigations like blood complete examination, urine analysis, blood sugar, blood urea, serum electrolytes (Na+, K+) and blood grouping were carried out. Plain X-Ray of abdomen and chest, ECG, pregnancy test, bacteriological assessment and culdocentesis were also performed

where required. Regarding management, all the patients were resuscitated preoperatively and operated upon (where required) the earliest possible under general anesthesia. The surgical procedure was tailored according to the pathology.

Further management, operated or non operated / conservative was performed out in surgical ward. Specific investigations like USG of abdomen in non operated cases were also carried out in support of final diagnosis.

A complete record of all the patients on a proforma for the same purpose was maintained from the admission till discharge from the hospital including detailed clinical course during the hospital stay and follow up till one year.

RESULTS

Table-l. Percentage of various gynaecological emergencies (n=44)

Diseases	Cases	%age
Pelvic Inflammatory Disease	18	40.90
Ectopic Pregnancy	6	13.63
Utrine Perforation	8	18.18
Adnexal Torsion	3	6.81
Ruptured functional ovarian cyst	9	20.45

PID was the most common (40.90%) emergency followed by ruptured functional ovarian cyst (20.45%) and uterine
perforation (18.8%) while adnexal torsion was the least common (6.81%).

Table-ll. Incidence of gynaecological emergencies in various age groups(n=44)

Disease	12 to 15 years		16 to 30 years		31 to 45 years		More than 45 yrs	
	Cases	%age	Cases	%age	Cases	%age	Cases	%age
Pelvic inflammatory disease (18)	-	-	12	66.66	5	27.77	1	5.55
Ectopic Pregnancy (6)	-	-	4	66.66	2	33.33	-	-
Utrine perforation (8)	-	-	3	37.55	5	62.45	-	-
Adnexal Torsion (3)	-	-	-	-	2	66.66	1	33.33
Rupture ovarian cyst (9)	-	-	6	66.66	3	33.33	-	-

The age group between 16 to 30 years was the commonest having gynaecological problems i.e. 66.66% in each of the PID, ectopic pregnancy and ruptured ovarian cyst. The age group below 15 years and above 45 years were least involved.

Table-Ill. Incidence of each disease in married & unmarried females (n=44)

Disease	Married		Unmarried	
	No. of cases	%age	No. of cases	%age
Pelvic Inflammatory disease (18)	14	77.77%	4	22.22
Ectopic Pregnancy (6)	5	83.33	1	16.66
Uterine Perforation (8)	7	87.50	1	12.50
Ednexal Torsion (3)	2	66.66	1	33.33
Ruptured Functional ovarian cyst (9)	5	55.55	4	44.44

Table-IV. Incorrect / erroneous diagnosis (n=44)

Disease	Correct diagnosis		Incorrect/Erroneous diagnosis			Average
	No.	%age	Diagnosis	Total No.	%age	
Pelvic Inflammatory disease (18)	14	77.77	Acute Appendicitis (1) Perforated Appendix (3)	4	22.22	24.49
Ectopic pregnancy (6)	4	66.66	Acute Appendicitis (2)	2	33.33	
Perforated Uterus (8)	7	87.5	Typhoid Perforation (1)	1	12.5	
Ednexal Torsion (3)	-	-	Ectopic Pregnancy (1) Acute Appendicitis (2)	3	100	
Ruptured functional ovarian cyst (9)	5	55.55	Acute Appendicitis (1) Ectopic pregnancy (3)	4	44.44	

There was a clear predilection of married than unmarried females in all the gynaecological problems except ruptured functional ovarine cyst with the narrow margin. Because of lack of experience and limited diagnostic facilities erroneous diagnosis was made to some extant in almost all the cases. The maximum

being in Adnexal Torsion (100%) and Ruptured functional ovarian cyst (44.44%). Minimum in uterine perforation (12.5%).

Table-V. Management of patients (n=44)

Disease	Treatment /Plan				Procedure for gynaecological pathology
	Operated	%age	Conservative	%age	
Pelvic Inflammatory disease (18)	8	44.44	10	55.55	Peritoneal Lavage
Ectopic pregnancy (6)	6	100	-	-	Salpingooophorectomy
Perforated Uterus (8)	8	100	-	-	Uterine Repair & Peritoneal Lavage (6) Hystrectomy (1)
Adnexal Torsion (3)	3	100	-	-	The erroneous pathology treated
Ruptured functional ovarian cyst (9)	6	66.66	3	33.33	Blood mopping & haemostasis

The conservative treatment was opted in PID (55.55%) and ruptured functional ovarian cyst (33.33%), while 100% of patients with ectopic pregnancy, perforated uterus and adnexal torsion were operated upon. The surgical procedure was tailored according to the gynaecological pathology and erroneous diagnosis.

Table-VI. Post operative morbidity (n=31)

Disease	Morbidity					
	Wound infection	Delayed wound healing	Stitch sinus	Adhesive bowel disease	Total	%age
Pelvic inflammatory disease (8)	2	2	2	1	7	87.5
Ectopic pregnancy (6)	-	-	1	-	1	16.6
Perforated Uterus (8)	3	3	-	1	7	87.5
Adnexal Torsion (3)	-	-	-	-	-	-
Ruptured functional ovarian cyst (6)	1	1	1	-	3	50

The 87.5 of the patients with PID and Uterine Perforation had some minor post operative complications like wound infection, delayed wound healing, stitch sinus and adhesive bowel disease. There were two mortalities one in each PID and ectopic pregnancy.

DISCUSSION

About 40.9% of females presenting as acute surgical abdomen because of some gynaecological problem were found to have PID which remained the most frequent cause in this study is comparable with other studies5 67B, The maximally involved age group of 16 to 30 years is comparable with other studies where 16 to 25 years of age is the cqmmonest sufferer1'6'7. About 77,70% of married womert had this disease in this study. It is slightly less than another study where 85% of sexually active females of reproductive age are involved5. This is because of social values regarding sex in our society. In spite of non availability of more sophisticated diagnostic tools like USG and Laparoscopy in emergency in our set up the incidence of making incorrect / erroneous diagnosis 24.49% (on an average) is comparable with another study where the rate was 25.5%[9,10,11]. The surgical procedure of laparotomy in PID in 44.44% of patients who does not respond to conservative treatment or presented with advanced peritonitis is recommended in other studies[12'13]. Conservative treatment of PID patients and surgical intervention where (1) disease is advanced (2) poor response to conservative treatment (3) uncertainty about the diagnosis is a recommended protocol[12'13].

Salpingooophorectomy / salpingectomy in cases of ectopic pregnancy are well practiced surgical procedure in other studies[14'15'16]. Repair of uterus and hysterectomy in Uterine perforations is also performed in other studies[17]. The conservative treatment and surgical intervention when deemed necessary in ruptured functional ovarian cyst was also done in another study[3]. The morbidity in the form of wound infection, delayed wound healing and adhesive bowel disease in 87.5% in PID and uterine perforation is higher than other studies[18'19'20] because of (1) delayed patient presentation (2) poor operating conditions (3) less effective anti microbial therapy in our set up. The slightly higher mortality rate in this study as compared to another study[21] is also because of less perfect treatment facilities in our set up.

CONCLUSION

The different gynaecological problems are fairly commonly and regularly encountered in general surgical practice. The rate of making erroneous diagnosis and maltreatment is high because of (1) close resemblance of clinical features and difficulties in differential diagnosis (2) less exposure of general surgeons to gynaecological problems (3) non availability of certain diagnostic facilities in emergency. The sufferings of the patients in terms of morbidity, mortality and economy can be reduced to some extent by improving these shortcomings.

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