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A discussion on “Serosal prolapse through vagina: A rare presentation of uterine perforation following a surgical abortion”

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Introduction

We read with great attention and interest the case report by Gill et al. [1] aimed to present a unique and the first case of serosal stripping of the small bowel after unrecognized uterine perforation from the dilation & curettage (D&C) for a missed miscarriage. It is an issue of utmost importance for several reasons. First, it is an extremely rare event partly due to improved education and techniques of D&C partly due to underreporting, especially in the undeveloped world. Unfortunately, there are several shortcomings in the case report by Gill et at. First, this is not the first case of this pathophysiologic mechanism. It was published previously and can be found in the review on the subject by Augustin et al. [2]. In the other article by Augustin et al. [3], this pathophysiologic mechanism is described in detail, as the highest degree of small bowel obstruction, along with other degrees of intestinal obstruction as a result of uterine perforation from D&C. This article was published after Gill et al. (although present for a long time as the ‘article in press’); therefore, the authors were probably unaware of it. The most commonly used term for this pathophysiologic process is small bowel ‘degloving injury’. Other terms used are ‘serosal stripping’ or ‘serosal rip-off’. These last two terms are commonly used with the active, intentional processes while a degloving injury is always unintentional and passive, mostly traumatic event. From our point of view the sentence in Gill et al. [1] ‘’This ripped off serosa was seen protruding through the perforation into the uterus” is wrongly presented. When the uterine perforation opening is small, and the operator performs D&C, the serosal detachment is the result of an inadvertent pulling of the small bowel mistaken for the umbilical cord [4]. Therefore, from the published cases, detached serosa is not found in the vagina, but the intraperitoneal cavity, and small bowel with the remaining layers but without serosa is prolapsing [3]. Authors do not have a picture of serosa protruding through the vagina; therefore, we do not have a confirmation of that statement.

Some data in the medical history, essential for this pathology, are missing and include the duration of pregnancy until D&C and the use of uterotonics. Both these variables have their potential impact on the degree of this dreadful complication. Also, there is no mention of perioperative care, especially antibiotic use after the operation with small bowel resection, and final pathology report of the small bowel. Another issue is that authors claim that the most common perforation site is uterine fundus putting the reference at number 12. This reference does not even mention the location of perforation sites. Also, this reference is not a review of the literature. The review of the locations of uterine perforation from D&C can also be found in the article by Augustin et al. [3].

References

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