



## Results for Pregnancy after Uterine Cavity Perforation

Elad Leron\*

Department of Obstetrics and Gynecology, Soroka University Medical Center, Ben-Gurion University of the Negev, Beer Sheva 8410101, Israel

### INTRODUCTION

After holes were looked at, there were two deliveries. 51 women were identified as having uterine perforation following gynaecological operations, including the installation of an intrauterine device (IUD), during the study period. At the time of diagnosis, the average patient age was. The majority of patients both had perforation after IUD insertion and during surgical operations. Several of the patients who were multiparous or grand-multiparous experienced pelvic abscesses after the IUD was inserted [1]. 50 patients in total had 71 births after uterine perforation. Fetal abnormalities caused intrauterine foetal death in one patient. One patient had a ruptured uterus. There were no additional significant obstetric issues reported. Negative obstetric outcomes may be linked to uterine perforation.

### DESCRIPTION

Any type of uterine manipulation has the potential to result in complications, one of which is the perforation of the uterus. Perforations can occur anywhere from 0.1 to 5% of the time, depending on the process and the performer's level of ability. Although these figures are modest, it is believed that the prevalence of perforations is actually much higher because many perforations go unnoticed or go unreported. Usually, the injury happens when the cervix is dilated or an operating device is introduced. The uterine fundus, uterine anterior wall, and cervix are common sites for uterine perforation. Various risk factors, such as the following, have been discovered for perforation during uterine procedures: a late diagnosis of a stenotic or scarred cervix e complication or intraabdominal organ injury [2,3].

At Soroka University Medical Center (SUMC), a retrospective cohort research was carried out on patients who received care between 1996 and 2018. All patients who were treated at our

hospital and went on to birth after receiving a uterine perforation diagnosis were included. The patient's electronic medical records were used to gather information about the patient's demographics, general health state, perforation management data, and surgical reports. From the computerised obstetric database of the Obstetrics and Gynecology department, pregnancy, delivery, and perinatal outcomes were gathered. After perforations were added, there could be up to two deliveries. Patients without sufficient data were not included in the analysis. Due to the retrospective study's design, informed consent was not sought Soroka University's Institutional Review Board waived it [4].

51 women were identified during the study period with a diagnosis of uterine perforation and subsequent delivery. At the time of diagnosis, the average patient age was. The vast majority of the patients were either multiparous or grand multiparous. The demographic traits are displayed in 76.5% of the patients had their intrauterine device (IUD) inserted in outpatient clinics, which was the most frequent operation that resulted in a perforation. The remaining patients mostly developed dilatation and curettage-related perforations during surgical operations. In 86.4% of the cases, an anteverted uterus was discovered. The parametria experienced injury the most frequently. Five patients, who were referred for a laparoscopy because of a lost IUD, had capsulated pelvic abscesses, according to the diagnosis. The abscess had no symptoms [5].

A retrospective cohort analysis was carried out by us in a tertiary referral hospital. We located patients who experienced pregnancies after uterine perforation. Our patients were primarily multiparous, which is known to increase the risk of perforation. Contrary to earlier studies that claimed a retroverted uterus was a substantial risk factor for perforation, the majority of the participants in our study had an anteverted uterus [6]. Uterine hyperanteversion in these patients may be one explanation, but sadly, these data were not accessible

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**Corresponding author:** Elad Leron, Department of Obstetrics and Gynecology, Soroka University Medical Center, Ben-Gurion University of the Negev, Beer Sheva 8410101, Israel; E-mail: leron.elad@yahoo.ir

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[7]. Our population's prevalence of post-partum haemorrhage correlated with that noted in earlier studies. In our study group, we discovered more abnormal placental diseases. Four patients had manualysis after birth, whereas adherent placentas complicate 1-3% of deliveries in the general population.

## CONCLUSION

One patient experienced uterine rupture, which manifested as non-laboring abdominal pain. A dramatic and uncommon consequence that generally happens following a caesarean section is uterine rupture. The likelihood of uterine rupture following caesarean delivery is estimated, in contrast to the likelihood of uterine rupture in a uterus without scarring. The rupture of an unscarred uterus was associated with higher rates of maternal and foetal mortality, probably as a result of the unanticipated nature of this condition. In those circumstances, an undiagnosed uterine perforation from a prior uterine operation may be a risk factor for uterine rupture. Additionally, a possible cause for uterine rupture following prior perforation may be linked to aberrant and disorganised uterine activity as a result of the disruption of the circuit of healthy muscle fibres.

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