CASE REPORT

The Unending Tragedy- Maternal Near Miss with Intra-Uterine Fetal Death due to Domestic Violence in Pregnancy - A Case Report

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Abstract

Domestic violence, pregnancy, intra-uterine fetal death, near miss, unending tragedy

1 | INTRODUCTION

Domestic violence, also known as intimate partner violence, has been defined by the World Health Organization as any behavior within an intimate relationship by an intimate partner that causes physical, psychological or sexual harm to those in the relationship[1] and knows no cultural, socio-economical, ethnic or religious bounderies[2].

Although women can also be violent in their relationship with men, intimate male partners are the most common perpetrators of violence against women[1]. Domestic violence is a global public health problems[3] and pregnancy presents a period of particular vulnerability[4] with the prevalence of intimate partner violence reported to be higher than many common obstetric complications[5]. The overall prevalence of domestic violence during pregnancy in developed countries is estimated to be about 13.3 percent while that of the less developed countries was reported to be about 27.7 percent[6]. Martin –de-Las Heras et al found a domestic violence in pregnancy prevalence of 21% in their Cohort in Spain and found that psychological IPV was associated with urinary tract infection, vaginal infection and spontaneous preterm labour while physical IPV was associated with antenatal hospitalization[7]. Other studies

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had also associated domestic violence in pregnancy with miscarriages, low birth weight and prenatal deaths\[8][9\]. In Nigeria, the Nigeria Depographic and Health Survey of 2013 got a prevalence of domestic violence in pregnancy to be 5 percent[[10]].

Though domestic violence has been recognized as a global public health problem, pregnancy confers a very big risk on it in terms of both maternal and fetal complications including mortality of the mother, the fetus or both. Domestic violence that a non pregnant woman can stand, albeit psychological and physically bruised, can cause death of the woman and or her baby or both of them if the same woman was to be pregnant. Despite the fact that domestic violence has been acknowledged to have serious adverse consequences in pregnant women, everybody including the world health bodies, policy makers, health practitioners including obstetricians seem to treat it with levity that undermines its devastation while the carnage it causes go on unabated.

We present a case of domestic violence that nearly claimed the life of the woman who suffered near miss and led to intrauterine death of the 4.3kg female fetus at term. [11]

2 | THE CASE

Mrs. A. M. is a 30 year old G3P2\+0 A2 farmer and petty trader who presented at our obstetric Accident and Emergency unit ,on Wednesday 4th November 2019, brought in with the ambulance of a peripheral mission hospital with ongoing unit of blood and normal saline in shock and semiconscious state. She was accompanied by the husband who gave a history of her wife complaining of weakness and dizziness of 2 days duration and fainting attack a few hours before presentation to the hospital. (When eventually the woman, who kept saying that her husband really beat her up, got better and fully regained consciousness she gave a history of having misunderstanding with her husband over his having extramarital affairs which led to the man thoroughly beating her up including punching her on the abdomen. The husband completely ignored her complaint of increasing weakness and dizziness until she fainted. It was then she was rushed to the hospital).

She was rushed to the mission hospital where the health workers seeing her critical state started resuscitation with normal saline and blood and brought her to our facility immediately with their ambulance. Her husband admitted that they quarreled and had a minor skirmish and he pushed her and she landed on the bed with her buttocks. Patient has had 2 previous deliveries. In the first one, she gave birth to a life male baby at a health center who cried immediately after birth and is alive and well. The second pregnancy was carried to term and she gave birth to a life female baby through an emergency caesarean section due to obstructed labour.

Examination revealed a semiconscious young woman who was drowsy and in shock. She was afebrile to touch, anicteric but markedly pale with no putting pedal edema. The pulse rate was 120 beats per minute and thread. Her blood pressure was 90mm systolic with no diastolic pressure heard and she had cold clammy extremities. The abdomen was gravidly enlarged with generalized tenderness. She had a midline umbilical incision that extended to the left of the umbilicus. There were no uterine contractions felt. The symphysis-fundal height was 43cm and there was a singleton fetus in longitudinal lie, cephalic presenting with the presenting part five-fiths palpable per abdomen. The fetus was in right occipito-anterior position. The fetal heart was not heard. Vaginal examination revealed a normal vulva and vagina with the cervix tubuler and the cervical os closed.

Necessary investigations –full blood count, serum electrolytes, urea and creatinine, urinalysis etc were carried out and 4 units of blood were grouped and cross matched for her. An abdominal ultrasound done revealed a cephalic presenting fetus with no limb body movement and no fetal heat activity. Consult was sent to the theatre and Anesthetist. An assessment of intrauterine fetal death secondary to? Uterine rupture in a multipara in shock was made.

We commenced resuscitation, transfused her with two units of blood, normal saline and took her to the theater. Intra-operatively we found moderate adhesions in the peritoneal cavity, a haemo-peritoneum of about 3 liters with blood clots. There was a gravidly enlarged uterus that had a rent about 10cm in the
upper segment around the antero-medial aspect of the insertion of the right round ligament with the placenta bulging out and filling the rent. There was also another thumb-sized contusion at the mid portion of the uterus. We evacuated the haemo-peritonium, extended the rent and delivered the 4.3kg fresh stillborn female baby and placenta cleaned out the uterus and closed it in two layers. Peritoneal lavage was done with warm normal saline.

The patient was placed on antibiotics and analgesics and was further transfused with 2 more units of blood. She developed abdominal distension which was managed conservatively. She did well and was discharged home on the 10th day with counseling of the patient and the husband.

3 | DISCUSSION

Domestic violence in pregnancy is a great danger to the pregnant woman and her unborn baby and may lead to the death of one or both as in the present case where the baby suffered intra-uterine fetal death and the mother nearly lost her life. This case is being reported so that we all can really know that the complication of DV in pregnancy is really grave and that the problem is ongoing.

Furthermore, the gravity of DV in pregnancy may not be fully exposed by many of the studies most of which are questionnaire based studies issued carried out mainly on antenatal and postnatal women who would have survived any violence they may have suffered in pregnancy. Report of deaths of either the mother, fetus or both are rare in most of these studies hence the need to highlight this gruesome dimension of the problem. If Mrs A.M. had died before reaching the hospital, nobody may have got to know what or who killed her and that it would have been a death due to domestic violence in pregnancy as the living male partner will do all in his power to absolve himself from the partners’ death as our patients husband tried to do.

No partner would intentionally go to commit murder by willingly going out to kill his partner but that is what happens eventually in some instances of domestic violence in pregnancy. Anger, alcohol use by the male partner[11] or the used of other recreational drugs had been noted to be some of the triggers of DV in pregnancy.

Domestic violence is not only more prevalent in pregnancy but has more devastating consequences such as death as can be seen in this case. All hands must therefore be on deck not only to create awareness about it but to reduce it to the barest minimum. Obstetricians must be in the vanguard to galvanize support for this fight and place the problem in the front burner of public opinion. As a starting point medical screening for domestic violence in pregnancy and identifying victims and treating them should be made mandatory in all maternity units.

4 | CONFLICT OF INTEREST

There is no conflict of interest

5 | AUTHOR CONTRIBUTION

- Dr Anozie OB contributed significantly in management of the patient, conception and write up of case.
- Dr Ukaegbe CI contributed significantly in management of the patient, conception of the paper
- Otti K - Contributed significantly in management, research and writing of case
- Obarezi Henry contributed significantly in management, research and analysis
- Ogbuinya Oliver Contributed significantly in management design and research
- Marcel Onwudiwe CS - contributed significantly in management, research and writing.
- Asogwa SU, - Contributed in management, research and writing of case
- Akaeze JO - Contributed significantly in management and research.
- Ewah RL - The anaesthetist. He contributed significantly in the management and conceptualizing of the paper.
REFERENCES
