

How Safe Are Abortion Practices in India?-A Case Series

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Abstract: Medical termination of pregnancy is an apparently safe and uncomplicated procedure if done with full aseptic precautions and under the guidance of skilled and trained personnel. But even today with such advancement in medical field, we still encounter cases referred from peripheries and rural set-up with life threatening complications following suction evacuation done for termination of pregnancy. Here we are reporting 3 such cases of complications following MTP. One patient came with omentum protruding through os into vagina. Her per-operative findings showed uterine perforation with omentum entering that hole. Another patient presented in emergency with acute abdomen, her per-operative findings showed uterine perforation with bowel perforation. Both the patients were managed and discharged in healthy condition. The third patient presented with abnormal uterine bleeding. She had a history of an abortion 3 years back not known to her family, conducted by an untrained dai. On hysteroscopy retained bony and cartilaginous fetal parts were seen impacted in the endometrial wall.

Keywords: unsafe abortions, uterine perforation, bowel perforation

I. Introduction

WHO quotes "unsafe abortion as a procedure for terminating an unintended pregnancy either by an untrained personnel or in an environment that does not conform to the minimum medical standards or both." WHO reports that in developed regions, nearly all abortions (92%) are safe, whereas in developing countries more than half (55%) are unsafe (1). The WHO estimates that worldwide 210 million women become pregnant each year and about two third of them or approximately 133 million deliver live infants. The remaining one third of pregnancies, about 78 million end in miscarriage, still births or induced abortion(2).

Case 1: A 32 year female P₄₊₁L₄ was admitted in the department of obstetrics and gynecology, Era's Lucknow medical college with complaint of something coming out of vagina and pain in abdomen for 3 days. She had undergone dilatation and curettage 3 days back in some private hospital after an amenorrhea of 2 months. After D&C she had complaint of some mass coming out of vagina and pain in abdomen. On examination patient was conscious and well oriented to time, place and person. She was afebrile with pulse rate of 100/mt., respiratory rate 19/mt. and B.P 120/70 mm of Hg. Per abdominal examination revealed tenderness, bowel sounds were present. On per speculum examination, omentum was seen coming through os (fig 1). On per vaginal examination, uterus was anteverted, normal in size and bilateral fornices were clear and non tender and omentum was felt coming through os. After all preliminary preparation the patient was immediately taken for laparotomy. Upon laparotomy hemoperitoneum was present, 200 ml of blood was drained out and a perforation (2x2 cms)(fig 2) was found on fundus of uterus and part of omentum was seen entering through the fundus of uterus. Omentum was clamped, cut and ligated at the point of entry at fundus; perforation was repaired with interrupted sutures followed by abdominal closure. She received a therapeutic course of intravenous antibiotics and two units of blood transfusion post operatively. Her post operative period was uneventful and she was discharged on her 9th post operative day in a healthy condition.

Case 2: A 35 year female P₆₊₃L₅ was admitted to obstetrics and gynecology department with complaint of pain abdomen for 4 days with history of medical termination of pregnancy (instrumentation) 4 days back in some private hospital. She also complained of 4-5 episodes of vomiting with history of non-passage of stools since 3 days. On examination patient was conscious and well oriented to time, place and person. Her pulse was 92/mt and B.P was 110/80mm of Hg. On per abdominal examination, abdominal distension was present, bowel sounds were absent and rebound tenderness was present. On per speculum examination no bleeding was present and per vaginal examination could not elicit any finding due to extreme tenderness. Her ultrasonography showed mild

amount of fluid with air echoes surrounding the uterus both anteriorly and posteriorly and possibility of uterine perforation was considered. Her x-ray abdomen erect posture showed multiple air fluid levels, suggestive of perforation. Patient was kept nil per orally with intravenous fluid supplementation along with Ryle's tube insertion. She was given 48 hrs of antibiotic coverage along with her vitals monitoring. After 48 hrs of antibiotic coverage and all preliminary investigations her exploratory laparotomy was performed. Upon exploratory laparotomy hemoperitoneum was found which was drained out, on further exploration a perforation was found on posterior surface of uterus which had sealed, another perforation was present approximately at a distance of 2 feet from duodenal-jejunum flexor, which was repaired by primary repair(fig-3) and a pelvic drain was put followed by abdominal closure in layers. Her post operative period was uneventful and she was discharged on her 12th post op day in a healthy condition.

Case 3: A 32 year old P₃+L₃ patient presented in OPD with irregular bleeding per vaginum for 6 to 7 years. Last delivery was 10 years back and there was no history of any abortion in the past. On persistent questioning she revealed a history of abortion not known to her family, and may have been done at an advanced gestational age by some untrained person so the products may have been retained. Now the patient was presenting with abnormal uterine bleeding. On per speculum examination slight bleeding was present. On per vaginal examination a polyp of about 2x2 cms felt through os. Her USG finding showed space occupying lesion in posterior myometrium. The hysteroscopic findings showed retained bony elements, therefore she had off and on history of pelvic inflammatory disease and irregular uterine bleeding(fig 4).The products were removed under hysteroscopic guidance and the material curetted out were sent for histopathological examination. The patient was discharged in a healthy condition.

II. Discussion

Unsafe abortion is one of the highly neglected problems of healthcare in developing countries. In India it accounts for 41.9% of maternal deaths (3). During surgical abortion, perforation of the uterus can occur or there may be damage to cervix, which can predispose to the risk of pre term labor in subsequent pregnancies (cervical incompetence) (4). There is also an increased risk of injury to infected tissue and spreading of the infection. The incidence of upper genital tract infection associated with first trimester abortion is about 1 in 200 cases and the incidence of complication after a first trimester D&C is 1.7%. Uterine perforation may occur more frequently than previously expected. Kaali et al found that uterine perforation occurred in 14/706 first trimester elective abortions (1.98%), of which 12 were recognized only by laparoscopy immediately after abortion (5). All were successfully treated with conservative management. Many cases of perforation can accompany intestinal injuries, which require surgery. In case 1, the omentum was seen coming out through os into the vagina. There was a uterine perforation through which omentum had entered the uterus. Although this complication is known among the obstetricians, few cases have been reported. Thus, its nature and clinical characteristics have not yet been well established. In case 2, there was uterine perforation along with intestinal injury and perforation. On laparotomy although the uterine wound was sealed but the intestinal perforation had to be repaired. Third case was an example of a neglected and suspicious abortion presenting as abnormal uterine bleeding. Previous report identified some risk factors of uterine perforation, the training level of caregivers, advanced maternal age, greater parity, retro verted uterus and history of prior abortion or cesarean section(6). Only a small percentage of women with perforation suffer omental and bowel prolapse and injury. Although the training level of the caregivers may also be a risk factor for such injuries, it is not known whether intestinal prolapse is caused by chance or some other risk factor.

III. Conclusion

A "safe" abortion is "safe" only after its completion. We must make efforts to reduce the incidence of "unsafe" abortion regardless of the level of medical services available. Appropriate training and the use of ultrasound may reduce the number of "unsafe" abortions but we must also bear in mind that we cannot eliminate adverse events; ultimately, there is no "routine" D&C.

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Figure 1-Omentum seen coming out through vagina

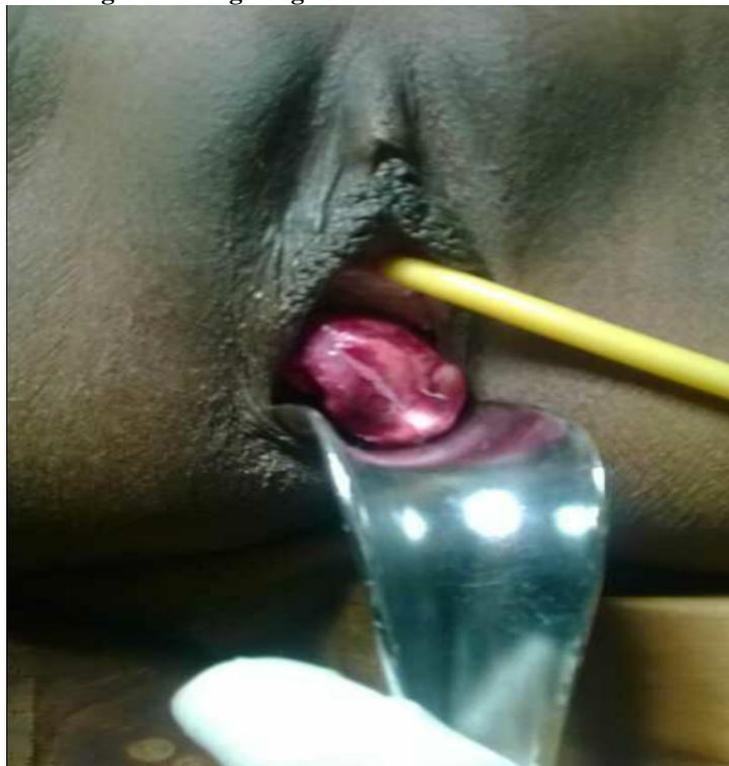


Figure 2-Perforation in fundus of uterus

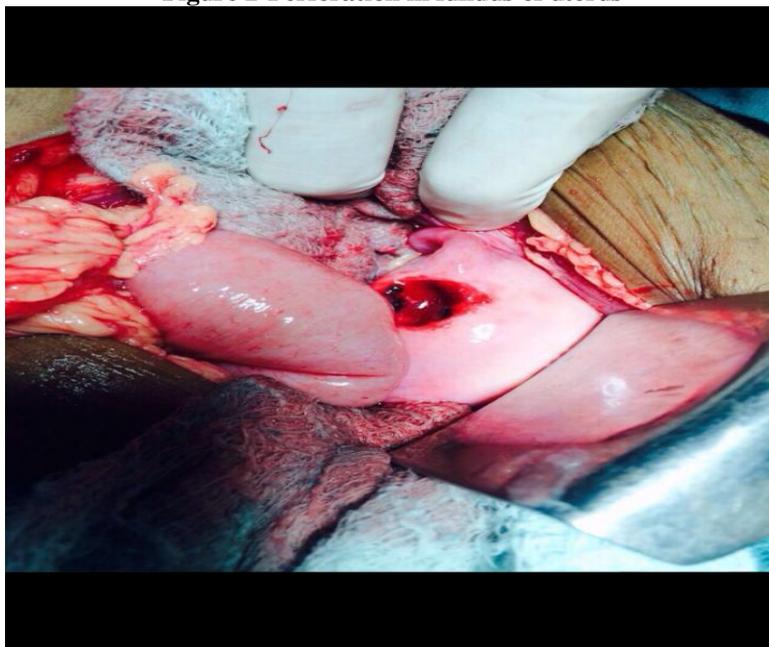


Figure 3-Bowel perforation repaired

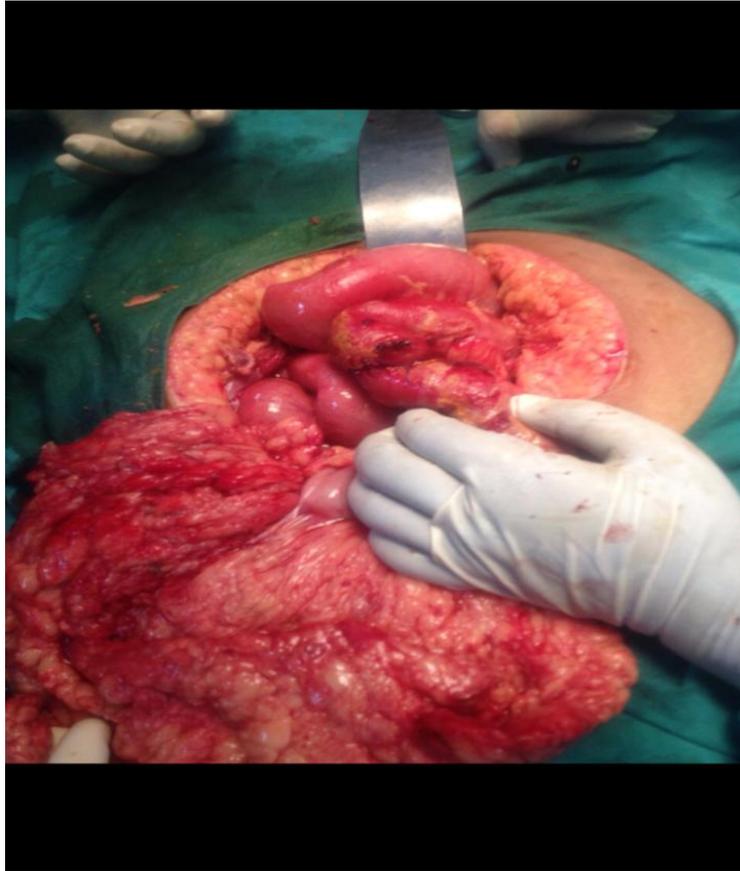


Figure 4-Hysteroscopy showing retained bony and cartilaginous elements impacted in endometrial wall

