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Unsafe Abortion – An Existing Problem Decades after Legalization

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Abstract: *Background:-Unsafe abortions (defined by the World Health Organization, as those performed by unskilled individuals with hazardous equipment, or in unsanitary facilities) carry a high risk of maternal mortality and morbidity. An estimated 19 million unsafe abortions occur worldwide each year, resulting in deaths of about 67,900 women[1]. Even in countries like India where the abortion is legalized, often inadequate and inaccessible health systems, religious, social and ethical implications predispose to unsafe abortions and late referrals of complications. Women may self induce abortion in ways that are dangerous or seek clandestine from inadequately trained health personnel out of fear of disclosure of their sexual activity or pregnancy especially in the age group of 14 to 19 years. Here in this case stigma contributed to life threatening complications of abortion in a teenage girl.*

Case: *This case of uterine perforation and omental injury was one such mishap of unsafe abortion which remained undiagnosed and asymptomatic for seven days since the instrumentation as the fetus itself sealed the perforation. An unmarried teenage girl of five months amenorrhea presented to the emergency gynaec department with complaints of bleeding per vagina, high grade fever and lower abdominal pain with history of attempted instrumentation for termination of pregnancy five days ago. Ultrasound revealed collapsed fetus of 18 weeks gestation with no evidence of defect in the uterus or free fluid in the pelvis. Patient was managed as a case of criminal abortion, repeat ultrasound revealed retained products of conception with no free fluid or collection in the pelvis with no obvious defect in the uterus and x-ray abdomen was normal. Patient shifted to operation theater for examination and evacuation in the double set up with a diagnosis of complicated induced abortion. Per speculum examination revealed omental prolapse through the cervical os. Immediately the procedure was stopped and emergency exploratory laparatomy was done with the assistance of general surgeon as the perforation was very close to the bladder. A perforation (figure-1) of 3 to 4 cm on the right lateral wall of the uterus close to the cervix with omental prolapse was noticed and successfully managed.*

Keywords*: Unsafe abortion; Stigma in Abortion; Criminal abortion; Complicated induced abortion; omental prolapse, exploratory laparotomy; Uterine perforation; Termination of pregnancy; abortion legalization.*

- **Key Messages:**
- High degree of clinical suspicion is required in patients with history of instrumentation. Anticipation, Vigilance and Surgical preparedness in such situations is needed.
- The defect in the uterus may not always be identifiable on ultrasound and may not always show signs of free fluid in the pelvis.
- Without skilled providers, adequate facilities and easy access, the promise of safe legal abortion remains unfulfilled.
- Social stigma is a major hurdle in making abortion safe.
- A more integrated approach of brining awareness to the general public, involving local people and re-educating the healthcare providers is the need of the hour.
- Post-abortion counseling, education and family planning services should be offered promptly so as to avoid repeat abortions.

I. Introduction

With the Medical termination of pregnancy act, abortion has been legalized in India since 1971. The law is quite liberal so as to reduce illegal abortions and maternal mortality. This case of criminal abortion in the present scenario is a reminder of the existing burden, a silent tragic. It is estimated that globally unsafe abortions are responsible for 67,900 maternal deaths annually, accounting for 13 percent of total maternal mortality. Unsafe abortion, a procedure characterized by the lack of inadequacy of skills of the provider, hazardous techniques and unsanitary facilities – a definition formulated by WHO technical working group in 1992[3], with the aim of directing the focus to the safety of the abortion procedure, rather than the legality. While the abortion is legal in most countries, stigma is a recognized contributor to the maternal morbidity and mortality. Women may self induce abortion in ways that are dangerous or seek clandestine from inadequately trained health

personnel or out of fear of disclosure of their sexual activity or pregnancy or abortion if they present to safe licensed facility.

II. Case Report

A Seventeen year old unmarried primi gravida presented to the emergency gynaec department with complaints of bleeding per vaginum, high grade fever and lower abdominal pain since five days, with history of five months amenorrhea and usage of over the counter abortificient drugs, followed by attempted instrumental evacuation by local dai, of with there was no documentation available. Ultrasound report, done earlier one month ago showed evidence of fetus of 18 weeks gestation, crumpled, in breech presentation with no cardiac activity, implying a missed abortion. At the time of presentation her vitals were; temp-101^{o}F, pulse rate 106/mt, Blood pressure 110/60 mm hg, respiratory rate 26/mt. Her general condition was febrile with moderate pallor. Systemic examination normal with mild tachycardia. Abdominal examination revealed soft abdomen without any signs of peritoneal irritation. Uterus was 16 to 18 weeks size and was tender. On per speculum examination, anterior lip of cervix was ragged with mild bleeding through the os, false passage noticed in the anterior lip of cervix, not beyond 1 cm. On pelvic examination cervix was patulous and fetal parts felt through the os, uterus was 16 to 18 weeks size, mid position and tender, fornices were free.

Investigation:

Routine laboratory investigations were significant for mild anemia of 8.2 gms and elevated total lencocyte count of 15,000 cells/cmm with neutrophilia Ultrasound done revealed mass in the endometrial cavity with collapsed skull bones and no evidence of uterine defect or free fluid in pelvis. Erect X-ray abdomen was normal. High vaginal swab and blood sample sent for culture and sensitivity.

Treatment:

Patient managed as a case of criminal abortion with nil by mouth, intravenous fluids, intravenous broad spectrum antibiotics and 200 micrograms oral misoprostol, in an attempt to hasten the expulsion of uterine contents. Within few hours' incomplete expulsion of products occurred. Repeat ultrasound revealed retained products of conception with no free fluid or collection in the pelvis with no obvious defect in the uterus and x ray abdomen was normal. Patient managed conservatively with intravenous fluids, intravenous broad-spectrum antibiotics and tab Misoprostol 100 micrograms 6th hourly by vaginal route for 24 hours. But the temperature not reverted to back and pain abdomen not releaved. Hence the patient shifted to operation theatre for examination and evacuation under double setup with a diagnosis of complicate induced abortion. Per speculum examination revealed omental prolapse through the cervix. Immediately the procedure was stopped and emergency exploratory laparatomy was done with the assistance of general surgeon as the perforation was very close to the bladder. The perforation was identified on the lateral wall of the uterus close to the cervix on right side, sealed by necrotic omentum. Omental adhesions were released, uterovesical fold of peritoneum opened, bladder pushed down. Perforation of 3 to 4 cm size was identified and sutured in two layers with no.1chromic catgut. Perfect haemostasis was secured, necrosed omentum excised and ligated, small bowel and sigmoid colon were explored and were found normal. Tubes and ovaries were edematous with no signs of infected tissue. Peritoneal lavage was done and abdomen closed after verifying mops and instruments.

Post operative period was uneventful and the patient was discharged after two weeks, because of continuous bladder drainage for two weeks as the perforation lied very close to the bladder. Thorough counseling was done regarding future obstetric carrier, child bearing and risk of uterine rupture in future pregnancy. Further followup after 4 weeks was uneventful.

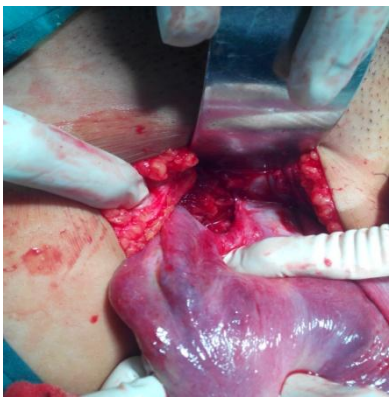

Figure-1

III. Discussion

An unsafe abortion remains a preventable burden in many under resourced countries including India. The W.H.O assembly in 1967, the program of action of the international conference on population and development and the world conference on women in Beijing in 1995, all reiterated the extent of serious health consequences of unsafe abortion for women and need for individual countries to take action[4].

According to world health organization, every eight minutes a woman dies of complications arising from unsafe abortions. Basic principles of management of a case of criminal abortions are to control sepsis, to remove source of infection, to give supportive therapy to bring back normal homeostatic and cellular mechanism and finally to assess response to treatment. Indications of surgery are injury to uterus, suspected bowel injuries, presence of foreign body in uterus or in abdomen and unresponsive peritonitis suggestive of collection of pus. In this case injury to uterus i.e., perforation of uterus occurred which was sealed by the fetus itself later followed by the omental prolapse after expulsion of the fetus.

Incidence of uterine perforation varies from 0.4 to 15/1000 abortions, as reported by various studies[12]. Uterine perforation is most likely to occur during first and second trimester procedures and with sharp curette. Perforation should be suspected if uterine bleeding is brisk and bright red or when intra uterine instruments pass farther than expected or lack a discernible endpoint. The most common location for perforation is the utero cervical junction, the weakest area in the uterine muscle. The patient may present either during or immediately following the procedure with moderate to brisk uterine bleeding. If uterine atony, cervical laceration and retained products have been ruled out as potential etiological factors or if a uterine defect is palpated on bimanual examination, the patient must undergo laparoscopy or laparotomy[6]. Adequate cervical preparation, using misoprostol alone or in combination with osmotic dilators at least 1.5 hours prior to mechanical dilation, will minimize the risk of uterine perforation[5, 9]. Ultrasound observations beginning at the time of dilation throughout the period of uterine evacuation is also advisable, particularly during second trimester procedures. The patient here was an unmarried primigravida who wanted to self terminate the unintended pregnancy owing to social stigma. Following the intake of over the counter unprescribed drugs, she developed vaginal bleeding and was taken to local dai for evacuation, which resulted in life threatening complications. In various studies 55-57% of abortions were carried out by untrained and unqualified peaple[8]. These Unqualified abortion providers are easily accessible to the clients in countries such as India. Illiteracy, unawareness about the available health facilities, hesitations and myths about contraception use, over the counter availability of the drugs for medical abortion and easy accessibility to untrained abortion providers lead to very high mortality and morbidity in India. Although uterine perforation is a well known complication of unsafe abortion, a delayed presentation is itself an unusual event which was detected and treated sooner by us, thereby preventing the occurrence of dreadful complication of bowel ischacmia[13] and obstruction.

IV. Conclusion

In spite of legalization of abortion in India in 1971, most of the abortions are done by untrained personnel[10]. Factors inhibiting the use of safe abortion and hence being a hurdle in achieving the desired maternal health are, lack of privacy, confidentiality, poor access and discouraging attitudes of healthcare providers[11]. Therefore legalization of abortion was a necessary but insufficient step towards improving women's health. While high degree of clinical suspicion is required in patients with history of instrumentation. Anticipation, vigilance and surgical preparedness in such conditions is needed. The defect in uterus may not always be identifiable on ultrasound and may not always show signs of free fluid in pelvis. Regardless of the legal status of abortion, all women should have access to treatment for abortion related complications, post abortion counseling, education and family planning schemes.

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