Surgical Complications of Abortions at Periphery

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Objectives: To study the patients presented with catastrophic abdominal misadventure due to abortion performed by untrained birth attendants to get rid of unwanted fetus by un-indicated procedures in unfavorable circumstances. **Design:** Observational case series. **Place and Duration of Study**: Surgical Unit I, Sh. Zayed Hospital, Rahim Yar Khan from July, 2001 to August, 2004. **Patients and Methods:** Forty patients from different age groups presented with this killer problem. Majority was concealing it. They were resuscitated, operated and managed postoperatively. **Results:** These patients presented late, suffered financial loss, morbidity and significant mortality. **Conclusion:** Unplanned abortions are catastrophic. Education of masses in regard to birth control is mandatory.
Key words Criminal Abortions; septic abortion, intestinal trauma, uterine trauma, rectal trauma.

To get rid of the unwanted fetus is a problem to the sufferer lady. It is a social, cultural and at time thought to be a financial burden on the family to have an unwanted baby. For centuries, women have attempted to get rid of unwanted pregnancies by a variety of methods and illegal abortion has been a source of considerable morbidity and mortality. Abortion is a subject that attracts very strong opinion and there is wide spread divergence of views on the subject mainly relating to religious and cultural background. In UK Abortion Act was passed in 1967. As a result illegal abortion has virtually disappeared in UK[1].

The current abortion rate is about 9-14 per 1000. Women aged 15-45 years are sufferer that represents a life time chance of around 1 in 401. More than 36 to 53 millions abortions are conducted in the world. Out of which 26 to 31 million are legal and 10 to 22 million are clandestine. In the world, 150 000 women die due to abortion each year[2].

In USA, more than 1000 deaths were reported due to abortions in 1940. In 1988, only 20 deaths were reported; out of witch 12 were due to spontaneous, 6 legal and 2 illegal abortions respectively[2].

Patients and methods:

This is a hospital based prospective, observational study carried out at surgical unit I, Sh. Zayed hospital Rahim Yar Khan. The period of study was between July, 2001 and August, 2004.

Inclusion criteria: Only those patients who underwent abortions at periphery and were needed general surgical intervention in the form of laparotomy were included.

Exclusion criteria: All patients with septic abortions managed conservatively or managed exclusively by gynecological department were excluded from the study. Forty patients were included in this study. Age, marital status, time to reach hospital, presentations, operative findings, operative procedures and outcome were recorded.

As shown in table I the majority of patients presented were either young (25%) unmarried with illegal pregnancy or elderly (55%) whom did not afford baby due to poverty.

Marital status: 10 patients i.e., 25% were unmarried as shown in table II.

Time to reach hospital: Majority of patients belonged to Tehsil Rahim Yar Khan (80%) and a few (20%) were from Tehsil Sadiq Abad. All were with in 20 miles from the well connected site of study. But it is astonishing to note that only 5 patients reached at Sh. Zayed Hospital with in four days while rest (87.50%) took 5-7 days as shown in table III.

Presentations: It is again a matter of great concern (as shown in table IV) that only 13 patients gave prospective history of abortion and in 27 patients there was retrospective acceptance or no acceptance at all. As shown in table V, 100% has per vaginal bleeding, peritonitis and generalized sepsis. While substantial number of patients had something (on examination gut) coming out per vagina, intestinal obstruction and shock. One patient presented with urinary leakage on removal of Foley's catheter.

Operative findings: Table VI shows operative findings i.e. massive peritonitis in 100% of patients. 87.50% had uterine perforation while five had gangrenous uterus with fetus lying in the pelvis. Small intestines were perforated or gangrenous in 13 cases. Large gut sustained injury in five cases. Rectum was perforated in two patients while in third one it was shattered into pieces. Urinary fistula is a missed injury and being investigated.

Operative procedures: Table VII shows 90% patients got uterine repair while in 10% hysterectomy was the only solution. 05 patients underwent resection anastomosis while in 13 patients colostomy was performed in addition to resection anastomosis. Peritoneal toilet was done, drains placed and abdomen closed primarily or at time second look laparotomy performed. Patients were managed in the ward postoperatively.

Outcome: Nature of morbidity suffered by 87.50% of patients is obvious from the above study. Five patients i.e. 12.50% lost their lives too as shown in table IIIV.

Table I Age distribution of patients

Age (in years)	n=	%age
15-25	10	25
26-35	8	20
36-45	22	55

Table II Marital status

Marital status	n=	%age
Unmarried	10	25
Married	30	75

Table III Time to reach hospital

Days	N=	%age
0-4	5	12.50
Day 5	18	45
Day 6	10	25
Day 7	7	17.50

Table IV Diagnosis

Diagnosis on	n=	%age
History of abortion	10	25
Laparotomy	27	67.50

Table V Presentation of patients

Presentation	n=	%age
P/V Bleed	40	100
Something out of vagina (intestine)	5	12.50
Intestinal obstruction	13	32.50
Sepsis	40	100
Peritonitis	40	100
Shock	8	20
Urine in drain on removal of foley's catheter	1	2.50

Table VI Operative findings

Findings	n=	%age
Severe peritonitis	40	100
Perforated uterus without gangrene	35	87.50
Gangrenous uterus	5	12.50
Fetus outside uterus	5	12.50
Gangrenous/perforated small gut	13	32.50
Perforated large gut	5	12.50
Rectal injury	3	7.50
Urinary bladder injury	1	2.50

Table VII Operative procedures

Procedure	n=	%age
Peritoneal toilet	40	100
Urine repair	35	87.50
Hysterectomy	5	12.50
Resection and anastomosis of small gut	5	12.50
Resection and ileostomy	8	20
Rectal/large gut repair & colostomy	8	20

Table VIII Prognosis

Parameter	n=	%age
Severe morbidity	35	87.50
Mortality	5	12.50

Discussion:

In unnatural deaths male to female ratio is 87%:13%[3]. Though in spontaneous abortions case fatality rate is only 0.7/100 000 abortions[4], in induced abortions death to case ratio is 2.4% where all abortions were conducted by indigenous birth attendants[5]. In this observational study maternal mortality is 12.25%, on the other hand 25.8% of 21 000 pregnancy related deaths in Bangladesh were due to the complications of induced abortions. Majority were clandestine abortions[6].

Data for the whole Pakistan was not available but maternal mortality ratio during pregnancy was 560/100 000 live births in Balochistan. Direct obstetric deaths were 99%[7]. By the legalization of abortion morbidity and mortality have disappeared in the western world while in the third world it still prevails. In a study of 92 cases of septic abortions deaths of 09 patients occurred, 16 cases were operated for tubo-ovarian abscesses; including pus drainage, salpingectomy, salpingo-ophrectomy, and uterine rent repairs, one case of burst abdomen and three fecal fistulas[6].

There is change in cervical swab culture from one to other pathogenic organism by just insertion of Foley's catheter even in the best setting. Organisms like B. hemolytic streptococcus group B, Candida Albicans, Candida Glabrata and Gardenella Vaginalis appear[8]. Septic illegal abortion is a serious infection of the uterus and its appendages6 and is full of complications. Repeated spontaneous abortions are associated with ectopic pregnancy, hydatidiform moles, preterm births, spontaneous abortions, retained placenta[9], vesico-vaginal fistula[10] leading to reproductive failure[11]. Hemiplegia is on record too[6].

Even suicide rate is higher with induced abortion especially in unmarried and low socioeconomic status patients[12].

Conclusion:

In addition to loss of fetus, induced septic abortion is a proven major detrimental factor for the maternal mortality and morbity[6].

Improved introduction of safe, acceptable means of fertility regulations may save many mothers lives3 and save them from major physical and psychological trauma. Regardless of personal feelings about interrupting pregnancy, health professionals have duty to know the medical facts about the regulations. Health professionals are not required to perform abortions, but they have the duty to help the patients' asses' pregnancy risks and to make appropriate referra[12].

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