
The Horrors of Unsafe Abortion

K. Zehra Naqvi ¹

¹Consultant Obs/Gynae

Liaquat National Hospital and Medical Collage Karachi

Correspondence: Dr. K. Zehra Naqvi, Consultant Obs/Gynae, Liaquat National Hospital and Medical Collage Karachi

Email: kanizzehranaqvi@yahoo.com

Abstract

A case report of 29 years old woman is presented, who under went an unsafe abortion for unintended pregnancy resulting in uterine perforation and bowel having been was pulled out and cut and removed via the introitusa.

Key words: Unsafe abortion, Bowel injury.

Introduction

An unsafe abortion is defined as a procedure for terminating an unintended pregnancy carried out either by a person lacking the necessary skills or in an environment that does not conform to minimal medical standards or both.

According to World Health Organization (WHO), a woman dies every 8 minutes in a developing country due to complications arising from an unsafe abortion.¹ The fifth United Nations Millennium Development Goal recommends 75% reduction in maternal mortality by 2015. WHO deems unsafe abortion one of easiest preventable causes of maternal mortality and a public health issue. Data suggests that even as the overall abortion rate has declined, the proportion of unsafe abortions is on the rise, especially in the developing nations.²

Approximately 1 in 10 pregnancies end in an unsafe abortion, giving a ratio of 1 unsafe abortion to about 7 live births.³

Highest number of unsafe abortions take place in Latin America, Africa and South East Asia.¹ The main causes of death or morbidity due to unsafe abortion are haemorrhage, sepsis, genital trauma and bowel injury.

Case Report

A 29 year old patient was admitted through the Accident and Emergency department with complaints of severe abdominal pain since afternoon after evacuation of uterus for an incomplete abortion, following 10 weeks of amenorrhoea. Work up done for fever three to four weeks earlier revealed pregnancy of about 10 weeks duration. She took some abortifacient 15 days before the day of admission to abort this unintended pregnancy. She had bleeding per vaginum following that, for which she had uterine evacuation at some small clinic. After that she came home but next day she started to bleed heavily per vaginum, therefore she went back to the same place and was prescribed tablet

misoprostol twice daily. She took this tablet for 1 week but as she continued to bleed, she again visited the same clinic and second uterine evacuation was performed. After 2 or 3 days she went to the same clinic because her bleeding had not yet subsided. A third attempt on uterine evacuation was made but this time there was lots of pain which was unbearable, so the person attempting the evacuation gave her some intravenous sedation and completed her job! After returning home, the patient almost collapsed due to severe pain, so her family brought her to the hospital. On examination she was conscious, pale and in obvious discomfort, her BP was 115/77 mm Hg, pulse 99/min, temperature was 99.2°F. Abdominal examination revealed generalized tenderness and guarding all over the abdomen. Bowel sounds were absent. On vaginal examination, there was no active bleeding, vagina was hot, uterus was about 10-12 weeks size, mobile and cervical os was closed. Her blood investigation showed Hb 7gm/dl, white cell count $9.6 \times 10^9/l$, platelets were $278 \times 10^9/l$. urea, creatinine and electrolytes were all within normal limits. Ultrasound pelvis showed fluid with echoes in pelvis, an empty uterus and normal looking ovaries. Suspecting uterine/bowel injury we also asked for x-ray abdomen both erect and supine and it showed gas under the diaphragm. A clinical diagnosis of uterine perforation leading to bowel injury was made and laparotomy planned after resuscitation of patient.

At operation there was about 500-800 ml of blood in the abdominal cavity, two separate segments of small bowel were seen lying at a distance from

each other and in between mesentery was bruised and necrosed (Figure 1).

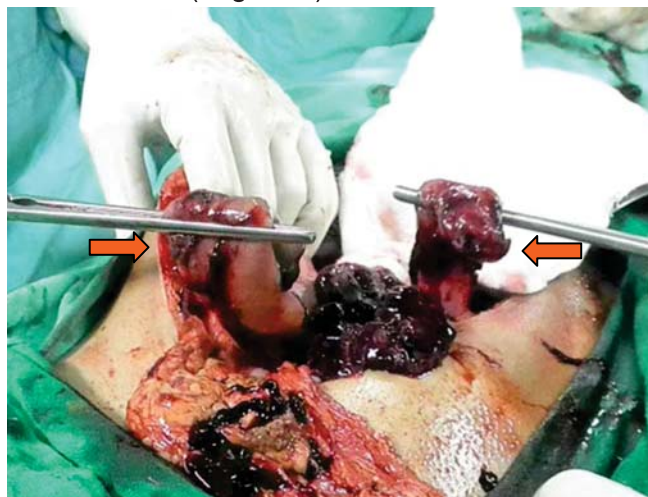


Figure 1. Cut Ends of Small Bowel

When the gut was run, we found that only about one and half feet of small bowel from duodeno-jejunal flexure and about 6 inches from ileo-caecal junction was intact, rest of the small bowel was missing completely. It transpired that while doing the evacuation the person had removed the whole of small gut except for those two small pieces. A perforation measuring approximately 2.5 cms was noticed in the anterior wall of uterus close to cervical canal.(Figure. 2)

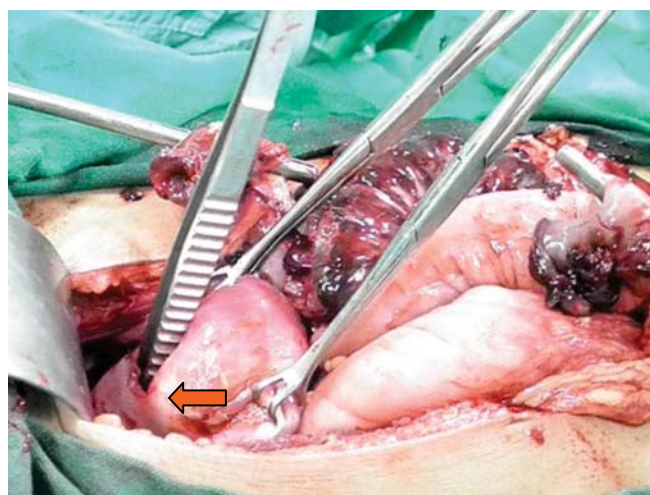


Figure 2. Perforation in Anterior Wall of Uterus

After resecting the nonviable portion of intestines an end to end anastomosis was performed. Primary repair of uterine perforation was done. Abdominal cavity washed and closed leaving a drain behind. Post operatively she was kept in high dependency unit. The patient received three units of packed red cells, broad spectrum antibiotics and intravenous fluids. She responded well to the treatment, and on third post operative day the intra-abdomen drain was removed. She was discharged on tenth post operative day with an advice to take low residue diet.

Discussion

Uterine perforation and bowel injuries are the major complications of unsafe abortion. The reason for these complications is that most abortions are done by untrained personals i.e. Dais and LHVs in very unhygienic conditions.^{4,5} **The same happened with this unfortunate lady.** The person doing the evacuation did not recognise that she had perforated the uterus and what she was pulling out was intestines and as a result this patient ended up with only one and half to two feet of small intestine.

These unqualified abortion providers are easily accessible to the clients in countries such as Pakistan. Complications due to unsafe abortion account for an estimated 13% of maternal deaths world over or 70,000 deaths per year.⁷

In various studies, about 55%-77% of abortions were carried out by untrained and unqualified persons^{4,5,6} In another study done at Khyber medical collage and hospital the incidence of gut injury after induced abortion was about 42%.⁶

Unsafe abortion is a significant problem both medical and social world wide. In developing countries most

unsafe abortions are carried out by untrained persons resulting in high morbidity and mortality.⁸

Conclusion

To reduce the morbidity and mortality associated with unsafe abortions, intensive dissemination of information and commitment at all levels is required, as is the use of various contraceptive methods to be promoted. Regular training courses for traditional birth attendants, nurses and doctors under the supervision of expert obstetricians is recommended.

References

1. Unsafe abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2003. 5th ed. Geneva: World Health Organization; 2007. World Health Organization.
2. Sedgh G, Henshaw S, Singh S, et al. Induced Abortion: rates and trends worldwide. *Lancet*. 2007; 370: 1338-1345.
3. Unsafe abortion: Global and regional estimates of incidence of unsafe abortion and associated mortality in 2000. 4th ed. Geneva: World Health Organization; 2004. WHO.
4. Jain V, Saha SC, Bagga R, Gopalan S. Unsafe abortion a neglected tragedy. Review from tertiary care hospital in India. *J Obstet Gynaecol* 2004; 30: 197-201.
5. Bhattacharya S, Mukherjee G, Mistri P, Pati S. Safe abortion-still a neglected scenario: A study of septic abortions in a tertiary hospital of rural India. *Online J Health Allied Sc*. 2010; 9: 7.
6. Najib JM, Siddiqui MI, Afirdi B. A review of septic induced abortion cases in one year in Khyber

- teaching hospital Peshawar. J. Ayub Med Coll Abbotabad 2004; 16(3):59-62.
7. Singh S, Wulf D, Hussain R, Sedgh G, New York: Guttmacher Institute; 2009. Abortion Worldwide. A decade of Uneven Progress.
 8. Gupta S, Chauhan H, Goel G, Mishra S. An unusual complication of unsafe abortion. J Family Community Med. 2011 Sep- Dec; 18 (3): 165-167.
-

Please explore the current (2009-2012) obstetric/gynaecology or other pertinent literature, of interest or importance, either published or electronic and send its **Extracts in your own words** (200-300); with its complete reference i.e the Author(s) name(s), Title of the article, Journal or other source, year of publication, pages and the website, if applicable; for publication in JSOGP at jsogp.articles@gmail.com. Your name (along with your designation and the institution you work in), should be sent, as a **Contributor**. You may refer to this "topic", in the already published issues of JSOGP. your contribution will be appreciated and it will help in inculcating the Educative Search of literature.