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Original Research

Study on self induced unsupervised medical abortion, its complications, follow up and contraceptive counselling

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ABSTRACT:

Background: Unsafe abortion is a significant cause of death. Medical Method of Abortion (MMA) is a safe effective and available method of first trimester abortion. Unsupervised use of MMA drugs has increased the risk of complications. **Objective**: To study the complications of unsupervised self induced medical abortion, follow up and contraceptive counseling. **Methods**: It is a prospective study of 100 women presenting with complications of medical abortion. It was done on the basis of questionnaire which included information from the patient and their relatives about unsupervised self administration or by quacks, proper drug intake according to guidelines, single or double drug used, prior examination and investigations, reporting time to the hospital. **Results**: Complications occur frequently when Medical abortion is attempted unsupervised e.g. bleeding from incomplete abortion, fever, sepsis, shock, ruptured ectopic etc. **Conclusion**: Health education and counseling regarding safe abortion and contraceptive practices can reduce the complications – maternal morbidity and mortality.

Key words: MMA, Unsafe Medical Abortion, Counseling.

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INTRODUCTION

Medication abortion, also known as medical abortion, non-aspiration, non-surgical abortion, refers to safe and effective methods for terminating an unwanted pregnancy through the use of a drug or combination of drugs that are administered orally, vaginally, buccally, sublingually, and/or intramuscularly. Medical abortion became an alternative method of abortion in 1970s with prostaglandin analogue. Later in the 1980s[1.] antiprogestogen mifepristone (also known as RU-486)[2] was available for medical use. Mifepristone blocks progesterone receptors in the endometrium and decidua, causing necrosis of uterine lining and detachment of implanted embryo. Misoprostol causes strong uterine contraction, cervical dilatation and expulsion of embryo.[3] Medical method of abortion is a safe, effective, affordable and alternative method to vacuum aspiration, if it is given by trained service providers particularly to population in rural and remote areas[4]. Unsafe abortion is a significant cause of maternal mortality accounting for 8% of all maternal deaths and is third largest cause of maternal morbidity in India.[5] MTP Act is legalised since 1971 in India. MMA is legalised under the amended MTP act in 2002.[6] Mifepristone – misoprostol combination is recommended up to 49 days gestation by Government of India and 63 days by WHO.[7] The schedule mentioned alone should be adhered to, along with all other provisions under the Act i.e. counselling, consent, examination, confirmation of pregnancy, and prescription by a registered medical practitioner, client card[8].

Till 2017, there was a dichotomous classification of abortion as safe and unsafe. Unsafe abortion[9] was defined by WHO as "a procedure for termination of a pregnancy done by an individual who does not have the necessary training or in an environment not conforming to minimal medical standards." However, with abortion technology

now becoming safer, this has been replaced by a three tier classification of safe, less safe, and least safe permitting description of the spectrum. Comprehensive Abortion Care (CAC)[9], a term "rooted in the belief that women must be able to access high-quality, affordable abortion care in the communities where they live and work", was first introduced in India by Ipas in 2000. The concept of CAC encompasses care through the entire period from conception to post abortion care and includes pain management.

However, ignorance, lack of access to safe abortion services, malpractices by quacks, over the counter availability of MMA drugs and current climate of hostility towards abortion has forced some women, particularly those belonging to low socio-economic group to use MMA on their own at home[10]. Numerous barriers limit access to safe abortion services including lack of information about legality and availability of services.

Ignorant women don't know the conditions where MMA is contraindicated like advanced pregnancy, pregnancy with IUCD, suspected ectopic pregnancy, bleeding disorders, prolonged steroid intake, chronic heart, liver and lung diseases. This puts them at risk of complications like,

- Incomplete abortion.
- Diarrhoea and vomiting.
- Fever and sepsis .
- Heavy and prolonged bleeding.
- Shock. / ruptured ectopic gestation
- Headache and dizziness.
- Failure of the drug may cause unwanted pregnancy (congenital anamoly).

  These complications may need surgical evacuation, blood transfusion, management of shock and laparotomy.

MATERIAL AND METHOD

This study was done during June 2015 to May 2017. Total number of 100 cases were selected from gynaecology OPD and labour room emergency of a government medical college in Bihar.

Inclusion criteria: All women attending Labour room emergency and GOPD with history of amenorrhoea of short duration and vaginal bleeding. History of self medication for MMA was confirmed and a thorough clinical examination was done.

Exclusion criteria: History of surgical evacuation, 2nd trimester vaginal bleeding, those who came with USG finding of abnormal uterine bleeding (AUB) and those who did not give consent.

From the selected cases detailed history of LMP, obstetrical history, MMA drug intake (single or double) was asked. Symptoms like vaginal bleeding, pain, fever, rigors, collapse, i.v. fluid infusion with duration were noted. The patients were admired and clinical examination was done. Investigations were done for CBC, RBS, LFT, KFT, Viral markers and abdominal USG. Admitted patients were resuscitated by fluid or blood transfusion as needed. Surgical evacuation or laparotomy was done as required.

RESULTS

A total of 100 patients were studied. 7 cases were < 21 years of age, 26 cases were 21 to 25 years, 38 cases were of 26 to 30 years, 11 cases were of 31 to 35 years and 7 cases were of > 35 years of age was observed in this study.

Table 1: showing age distribution

Age Group	No. of Cases	Percentage
<21 years	9	9%
21 to 25 years	28	28%
26 to 30 years	43	43%
31 to 35 years	12	12%
>35 years	8	8%

Out of 100 patients 10 were nulli para, 15 were para 1, 21 were para 2, 37 were para 3 and 17 were more than para 3.

Table 2: Showing parity

Age Group	No. of Cases	Percentage
Nulli para	10	10%
Para 1	15	15%
Para 2	21	21%
Para 3	37	37%
Para >3	17	17%

91 cases presented with vaginal bleeding, 3 cases presented with features of shock, 4 cases presented with severe abdominal pain with features of shock, 2 cases presented with foul smelling vaginal discharge in the present study.

Table 3: Showing primary presenting symptoms

Primary Presenting Symptoms	Number of cases
Vaginal bleeding	91
Features of Shock	03
Pain abdomen with shock	04
Foul smelling discharge	02

78 cases reported 3 days after drug intake, another 9 cases reported on 4 to 7 days, 11 cases reported after 7 days and 2 cases reported after >15 days.

Table 4: Showing primary Reporting time to hospital after drug intake

Reporting time in days	Number of cases
03 days	78
3 to 7 days	09
> 7 days	11
>15 days	02

All patients were treated with Parenteral fluid, proper antibiotics and other medications as required. Blood transfusion was given in 19 cases. Surgical management

in the form of suction evacuation was done in 73 cases. Dilatation and curettage was done in 23 cases. Laparotomy for ruptured ectopic gestation was done in all 4 cases included in the study. Cases who presented with shock and sepsis were treated accordingly.

Contraceptive counselling was done in all patients during their hospital stay. Most of the patients accepted contraceptives in the hospital itself in the form of OC pill, IUCD, DMPA injection, CHHAYA and condoms.. Tubal ligation was accepted by 16 cases.

DISCUSSION

International Institute for Population Sciences (IIPS), Mumbai and Population Council, New Delhi conducted the first study in India to estimate the incidence of abortion. The results from this study were published in Lancet Global Health journal in December 2017 in the form of a paper titled 'The incidence of abortion and unintended pregnancy in India, 2015[11]. According to HMIS reports, the total number of abortions that took place in India in 2016-17 was 970436, in 2015-16 was 901781, in 2014-15 was 901839, and in 2013-14 was 790587. Ten women reportedly die due to unsafe abortions every day in India. The data, which is dynamic in nature, can be accessed on the Health Management Information System (HMIS) portal. This study estimates that 15.6 million abortions took place in India in 2015. 3.4 million (22%) of these took place in health facilities, 11.5 million (73%) were done through medical methods outside facilities, and 5% are expected to have been done through other methods. The study further found the abortion rate at 47 abortions per 1000 women aged 15-49 years.

Unsafe abortion is an important and preventable cause of maternal morbidity and mortality in India. Government of India has taken various steps to reduce the incidence of unsafe abortions. Still in rural and remote areas of Bihar several women opt for unsafe abortion due to ignorance, lack of knowledge of legality and availability of abortion services, guilt, shame and many other reasons and put themselves in danger. Inadequate knowledge about the medication and the procedure was seen among them as most have used misoprostol alone or at advanced gestational age or taken inadequate dose. Unsupervised MMA may cause complications ranging from trivial to life threatening, like shock, sepsis and ruptured ectopic gestation. A multi-centric report by Duggal R[12] suggests that even after legalization of abortion, only 1/6th obtain it from registered and certified doctors. A study by Bhutta has shown maternal mortality 9 % among women who presented with unsafe abortions; however, most women presented after surgical abortion and had severe complications such as bowel injury or septicaemia[12]. In the present study, there was no mortality. It is far less with medication abortion as compared to septic or surgical abortion, and this is a major advantage of MMA.

One must be certain about the decision before taking any medication to begin a medical abortion. If decided to continue the pregnancy after beginning to take the medications used in medical abortion, the foetus will be at risk of significant birth defects. Medical abortion hasn't been shown to affect future pregnancies unless complications develop. MMA should not be attempted if the pregnancy is of more than nine weeks. It is also not attempted when a high risk of uterine rupture, for example, several surgical scars that could rupture or an intrauterine device (IUD) is present.

CONCLUSION

MMA under medical supervision is an effective, safe and affordable method of early pregnancy termination. By following the guidelines laid in CAC, maternal mortality and morbidity associated with unsafe abortion can be reduced.

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