

# Safe Abortions: Are They a Reality yet? A Case Series

Manvika Chandel<sup>1</sup>, Indra Bhati<sup>2</sup>, Balakrishna<sup>3</sup>

## ABSTRACT

**Objectives:** Annually, 210 million women conceive globally and 3 in 10 resort to abortion with an estimated 45% unsafe abortions, majority being from the developing world. This case series highlights the issues of unintended pregnancies resulting from loopholes in family planning knowledge, accessibility, and provision and failure, leading to women seeking abortions from unauthorized providers and settings endangering their lives, along with increasing the financial, social, and psychological burden on women, their families, and on health systems.

**Materials and methods:** Three case reports on unsafe abortion resulting into life-threatening complications, referred from peripheral centers are discussed. The data retrieved is a detailed discussion highlighting the reason for unintended pregnancy, execution of unsafe abortion at periphery by untrained providers, its complications, and the management provided at our tertiary center in Jodhpur.

**Results:** All the women were from rural areas, uneducated, and multiparous. None ever used any contraception. All had unwanted conceptions, and illegally procured medical termination of pregnancy (MTP) pills. One had rupture of the previous scar (from the previous two cesarean sections). The other two underwent dilatation and curettage at peripheral center by untrained staff, resulting in uterine and intestinal perforation. All underwent urgent laparotomies and admitted to intensive care unit for further management. One had bowel resection, anastomosis, and ileostomy. Two of the women required support from other medical specialties. All were discharged in healthy condition.

**Conclusion:** A collective effort to strengthen family planning system, intensive training of health providers along with educating masses about the importance of contraception should be given utmost importance to save maternal mortality and morbidity due to unsafe abortions.

**Keywords:** Family planning, Illegal abortion, Safe abortion, Unmet needs of contraception, Unsafe abortion, Unskilled health workers.

*Journal of South Asian Federation of Obstetrics and Gynaecology* (2021): 10.5005/jp-journals-10006-2099

## INTRODUCTION

World Health Organization defines “unsafe abortion” as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both.<sup>1</sup> It is alarming to see the global burden of unsafe abortion that is around 45%<sup>2</sup> of all abortions and the principal stress, that is, 97%<sup>2</sup> is borne by the developing countries (around 7 million). Each year, 4.7–13.2%<sup>3</sup> of maternal deaths is attributed to unsafe abortion. The factors which contribute toward making the abortions unsafe in developing countries are as follows: First, here, people have minimal and difficult access to safe abortion services due to rural and poor socioeconomic status and other social, religious, and policy constraints. Second, legal obstacles to the provision of safe abortion, superadded with untrained staff at the peripheral centers, overloading of quacks and unauthorized medicine distribution services. India, one of the developing countries and despite legalizing abortion around 50 years ago<sup>4</sup> along with provision in all government-run clinics free of cost, facilitation of safe abortion is still a challenge nationwide. The risks of unsafe abortion are posed across the lifespan of women from adolescents to elderly females. In India, problem is predominant in multiparous females who lack contraceptive vigilance exposing themselves to be left surprised by a pregnancy. The embarrassment makes them endure unsafe abortions. The repercussions of unsafe abortion are detrimental; women may experience a range of harms that affect their quality of life and well-being, with some women undergo complications from a range of minor to life-threatening in terms of hemorrhage, infection, injury to the genital tract and internal organs, and even death.

<sup>1,2</sup>Department of Obstetrics and Gynaecology, Dr Sampurnanand Medical College, Jodhpur, Rajasthan, India

<sup>3</sup>Department of Radiodiagnosis, Dr Sampurnanand Medical College, Jodhpur, Rajasthan, India

**Corresponding Author:** Manvika Chandel, Department of Obstetrics and Gynaecology, Dr Sampurnanand Medical College, Jodhpur, Rajasthan, India; Phone: +91 09950207179, e-mail drmanvika@gmail.com

**How to cite this article:** Chandel M, Bhati I, Balakrishna. Safe Abortions: Are They a Reality yet? A Case Series. *J South Asian Feder Obst Gynae* 2021;x(x):xx–xx.

**Source of support:** Nil

**Conflict of interest:** None

## MATERIALS AND METHODS

This is a case series of three cases having life-threatening complications as a consequence of unsafe abortions performed by untrained staff under substandard conditions at peripheral centers.

All the cases were referred from peripheral centers and admitted to our center, Umaid Hospital, Dr SN Medical College, Jodhpur, Rajasthan, India.

## RESULTS

### Case 1

A 34-year-old female admitted to our hospital, with a history of 4-month amenorrhea, urine pregnancy test (UPT) positive with c/o pain abdomen and bleeding per vagina for the last 2 days. She was G5P2A2L2, with the previous two cesarean sections, one male

child of 13 years and the second female child of 1 year. After the last delivery, the patient had lactational amenorrhea for 6 months, after which she started menstruating irregularly for around 2 months, for which she sought hormonal pills for withdrawal bleeding, from peripheral health center. However, she did not get menses after this treatment; so, after the advice from a local health worker, she got a pregnancy test done, which was positive. She, then obtained a medical termination kit from a local chemist without a medical prescription. After the intake of tablets, she experienced pain abdomen and bleeding per vagina for which she consulted district government hospital from where she was referred to Jodhpur, Rajasthan, India. In our center, on examination, patient had BP, 100/56 mm Hg; pulse, 110/min; shock index, 1.1; SpO<sub>2</sub>, 99%; respiratory rate, 28/min.

Per abdominal examination revealed uterus of 20-week size with tender abdomen. On per vaginal examination, bleeding was present. An urgent ultrasound was suggestive of an IUD of 19.4 week with rupture of uterus from the previous scar site and gross hemoperitoneum. An urgent laparotomy was planned. Intraoperative findings were as follows: After opening the abdomen, gross hemoperitoneum was seen. Around 2 L of blood was suctioned out. Fetus and placenta with membranes were lying in the peritoneal cavity which were extracted out. **Figure 1** depicts an IUD of 19 weeks extracted out from the abdominal cavity after opening the abdomen. **Figure 2** depicts 2 L of hemoperitoneum suctioned out.

Rupture of the uterus was seen at the entire previous scar site with a 2-cm extension in the downward direction on the left lower end. Same repaired. Sterilization (bilateral tubectomy) was done by modified Pomeroy method. She was discharged on day 7 in a healthy condition.

## Case 2

A 32-year-old, P3A1L3 female was admitted in our hospital on 12 June 2021. She conceived for the fourth time, which was an unintended pregnancy and due to completion of family, illegally consumed MTP pills. She gave h/o aborting at home, following which she bled for which she approached nearby health center, where she was subjected to dilatation and curettage by the staff (ANM) on 11 June 2021. Subsequently, her general condition deteriorated and she c/o pain abdomen and vomiting and was referred to a private hospital nearby. In the private hospital, the

female was given symptomatic treatment. Her USG was suggestive of uterine perforation (the lower uterine segment showing hyperechoic line joining endometrial cavity with peritoneal cavity indicating full thickness uterine perforation). She was further referred to our tertiary center. On admission, her blood pressure (BP) was 96/44 mm Hg, pulse was 150/min, shock index was 1.5, and SpO<sub>2</sub> was 98%. The female was immediately shifted to operation theatre (OT). The intraoperative findings were as described as follows: After opening of abdomen, hemoperitoneum admixed with foul smelling particulate matter of 400 mL was suctioned out. A rent of 5 cm 3 cm was present over anterior surface of uterine body which was repaired. Ileal perforation (40-cm proximal to ileocecal junction) was present from which fecal matter was popping out and was addressed by the surgeon. Stoma was created and ileostomy done. **Figure 3** depicts rent over anterior surface of uterus due to dilatation and curettage. **Figure 4** depicts particulate matter popping through ileal perforation caused due to dilatation and curettage. **Figure 5** depicts ileal perforation secondary to dilatation and curettage.

Posterior wall of uterus, bilateral fallopian tubes, and ovaries were visualized and found intact and normal; 1 blood transfusion (BT) and 4 fresh frozen plasma (FFP) given.

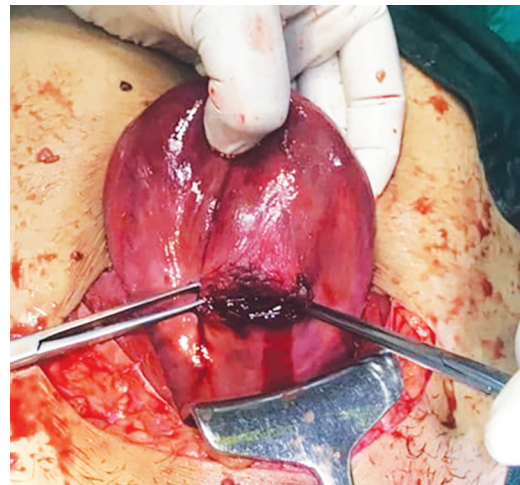
Postoperatively, the patient was shifted to gynecology intensive care unit (GICU), intubated, and on vasopressor support. On day 2,



**Fig. 2:** Two liters of hemoperitoneum suctioned out



**Fig. 1:** An IUD of 19 weeks extracted out from the abdominal cavity after opening the abdomen



**Fig. 3:** Rent over anterior surface of uterus due to dilatation and curettage



the patient was extubated and nor adrenaline was tapered down by day 4. Consequently, kidney function started deranging in the form of escalating blood urea levels and decreasing urine output, for which she was referred to nephrology department. By day 5, oral feeding was started in the form of liquid diet and progressed to semi-solid diet. The patient was discharged after 15 days with an advice to attend surgery department after 2 months for closure of ileostomy loop.

### Case 3

A 25-year-old female, P4A1L4, was referred from peripheral hospital on a/c/o D&C at periphery following self-ingestion of MTP pills with perforation of the uterus was admitted on 2 March 2021. With a h/o 2-month amenorrhea and bleeding PV for last 1 day. On admission, her general condition was poor with cold and clammy extremities, BP, 70/40 mm Hg; pulse, 156/min; and shock index, 2.2. On per abdomen examination, there was tense and tender abdomen with guarding and rigidity. On prevaginal examination of admitted tip of finger, uterus bulky and bilateral fornices were full and tender. She was directly taken to OT from emergency ward. Intraoperatively, moderate pyoperitoneum with Greyish green serohemorrhagic fluid, approximately 700 mL, suctioned out. Rent of 2 cm × 2 cm on fundus of uterus seen. Hemostatic sutures were taken. About

3 cm × 1 cm jejunal perforation was suspected which was addressed by the surgeon. Figure 6 depicts colostomy bag attached post laparotomy and bowel repair. Figure 7 depicts uterine perforation due to dilatation and curettage. Figure 8 depicts jejunal perforation as a complication of dilatation and curettage.



Fig. 6: Colostomy bag attached post laparotomy and bowel repair

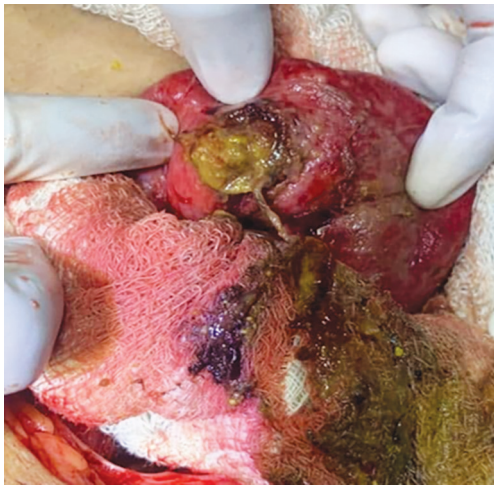


Fig. 4: Particulate matter popping through ileal perforation caused due to dilatation and curettage

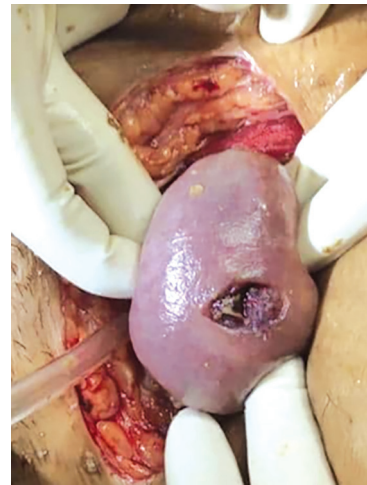


Fig. 7: Uterine perforation due to dilatation and curettage

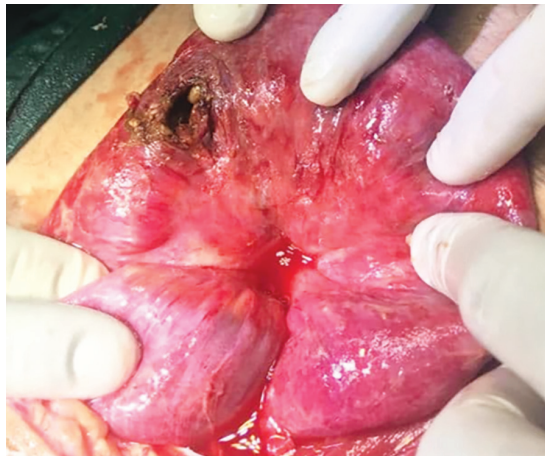


Fig. 5: Ileal perforation secondary to dilatation and curettage

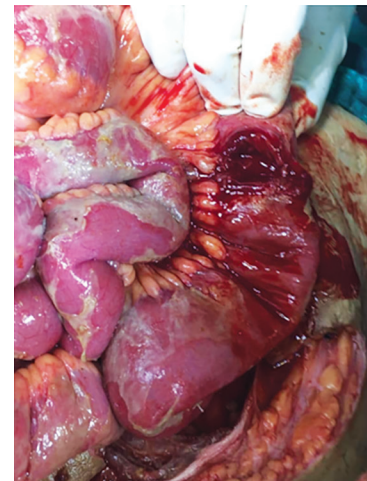


Fig. 8: Jejunal perforation as a complication of dilatation and curettage

Intraoperative 2 BT and 6 FFP given. Postoperatively, the patient was shifted to GICU and was intubated. The patient was extubated on postoperative day 2 and then kept under observation and on day 6, she developed abdominal distention and obstruction for which she was transferred to surgery department on 9 March 2021; from where she was discharged on 17 March 2021. in healthy condition.

## DISCUSSION

Termination of pregnancy outside health facilities, without a prescription account for majority of all abortions in India, among which 67% undergo highly unsafe procedure with a high risk of complications.<sup>5</sup> The prime reason for the complications is the performance of abortions by highly untrained, unauthorized staff under grossly unhygienic conditions.<sup>6</sup> Globally, the reported incidence of uterine perforation varies from 0.4 to 15 per 1,000 abortion.<sup>7</sup> Bowel perforation is a rare but severe complication of D&C.<sup>8</sup> The ileum and sigmoid colon are more vulnerable to injury due to their close relationship to the posterior surface of the uterus. The patients with uterine perforation following surgical abortion may present with vaginal discharge, pain, abdominal cramps or fever. Bowel injury secondary to uterine perforation can lead to adhesions, partial, or complete obstruction leading to abdominal pain with/without distension, vomiting, and diarrhea or absence of flatus or stool. Unsafe abortion being the fourth leading cause of maternal mortality, if left untreated, it may end in peritonitis, septic shock. and even death.<sup>9</sup>

## CONCLUSION

From preventive medicine standpoint, the strategies at three different levels will help reduce the frequency and severity of complications from unsafe abortion. The primary prevention includes the following: Percolation of knowledge regarding contraceptives in the common masses, promoting awareness regarding reproductive and sexual health in women, intensive training of the health providers, and checking the unauthorized

availability of MTP pills and abortifacients, when induced abortion is legal. Secondary prevention includes a prompt evacuation of incomplete abortion, medical and surgical management of induced abortions in alignment with the WHO guidelines with prompt empirical antibiotic therapy. Tertiary prevention includes improving thorough management skills of the faculty for life-threatening complications.

## ORCID

Manvika Chandel  <https://orcid.org/0000-0003-4348-5936>

## REFERENCES

1. World Health Organization. Safe abortion: technical and policy guidance for health system. 2003, p.12. [https://apps.who.int/iris/bitstream/handle/10665/173586/WHO\\_RHR\\_15.04\\_eng.pdf](https://apps.who.int/iris/bitstream/handle/10665/173586/WHO_RHR_15.04_eng.pdf).
2. Ganatra B, Gerts C, Rossier C, et al. Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. *Lancet* 2017;390(10110):2372–2381. DOI: 10.1016/S0140-6736(17)31794-4.
3. Say L, Chou D, Gemmill A, et al. Global causes of maternal death: a WHO systematic analysis. *Lancet Glob Health* 2014; 2(6):e323–e33. DOI: 10.1016/S2214-109X(14)70227-X.
4. Ministry of Health and Family Welfare, Government of India. MTP Act 1971. Available at: [main.mohfw.gov.in](http://main.mohfw.gov.in).
5. Yokoe R, Rowe R, Choudhury SS, et al. Unsafe abortion and abortion-related death among 1.8 million women in India. *BMJ Glob Health* 2019;4(3):e001491. DOI: 10.1136/bmjgh-2019-001491.
6. Bhattacharya S, Mukherjee G, Mistri P, et al. Safe abortion—still a neglected scenario: a study of septic abortions in a tertiary hospital of rural India. *Online J Health Allied Sci* 2010;9(2):7.
7. Alam I, Perin Z, Haque M. Intestinal perforation as a complication of induce abortion: a case report and review of literature. *Faridpur Med Coll J* 2012;7:46–49.
8. Ngowe N, Atangana R, Eyenga V, et al. Intestinal infarctus following dilatation and uterine curettage. *Case Rep Gastroenterol* 2008;2:125–127. DOI: 10.1159/000104976.
9. Khan KS, Wojdayla D, Say L, et al. WHO analysis of causes of maternal death: a systemic review. *Lancet* 2006; 367: 1066–1074.