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COMPLICATIONS OF UNSAFE ABORTION: CASE REPORTS AND THE NEED FOR CURRICULUM REVIEW IN NIGERIA

AV Umoh, AJ Umoiyoho
Department of Obstetrics and Gynaecology, University of Uyo Teaching Hospital, Uyo, Nigeria.

ABSTRACT
Unsafe abortion remains a major reproductive health problem in Nigeria. These are 2 case reports of unsafe abortion, one performed by a patent medicine dealer where a false passage was created in the substance of the cervix to evacuate the uterus using a cannula. A piece of the cannula was left in situ for five years leading to chronic infection and infertility. The second case was performed by a medical practitioner for a second trimester abortion. He deliberately created a false passage in the substance of the cervix to evacuate the uterus leading to severe haemorrhage. We conclude that there is a need to review and improve the training of medical practitioners in termination of pregnancies to avoid unsafe abortion.

Keywords: unsafe abortion, cervical injury. *(Accepted 12 May 2008)*

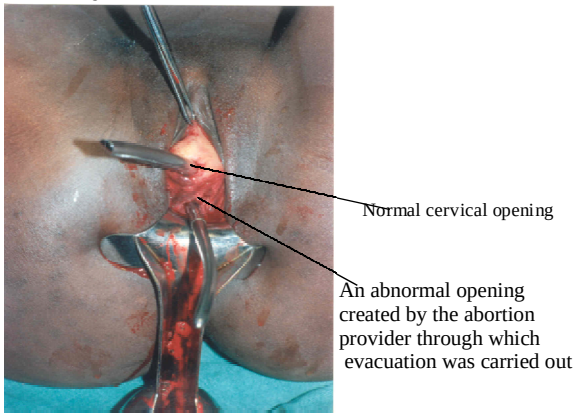
INTRODUCTION
Unsafe abortion is defined as one performed either by persons lacking necessary skills or in an environment lacking minimal medical standards or both[1]. Unsafe abortion is a major contributor to maternal mortality and morbidity especially in the developing world [1-5]. In Nigeria many abortions are performed annually despite the restrictive nature of the abortion laws in the country [6,7]. These are done both by quacks as well as by medical personnel especially in private medical establishments. In fact many studies have shown that medical personnel perform a significant number of the abortions in those reports [4-9]. In a recent study, six in 10 induced abortions were carried out in hospitals and clinics most of them privately owned facilities[6]. Despite this, abortion complications persist prompting greater concerns for the reproductive wellbeing of our women. The study also revealed that 25% of these women experienced serious complications [6]. It has been acknowledged that, because of the restrictive nature of abortion laws in the country, the teaching of the procedure is deficient such that many qualified medical practitioners may actually not have a good grasp of the procedure. They are consequently lacking in the necessary skill for its performance and may contribute to unsafe abortion [6,10,11]. The following case reports show different aspects of the problem of unsafe abortion.

CASE REPORTS
Case 1: Miss E. J. J. a 21 year old Para $0+^{2}$ woman presented on 18th August 2002 at Immanuel Hospital, Eket with a four-day history of bleeding per vaginum following a termination of a 16 week pregnancy at a private hospital. Bleeding was severe and there was associated dizziness. She did not have abdominal pain, fever or urinary symptoms. Her menses were regular and she had no history of menorrhagia. She had had two previous terminations of pregnancy at 8 and 12 weeks gestation without complications. Examination revealed a markedly pale young girl but who was neither febrile nor jaundiced. The pulse rate was 116 beats per minute and of small volume. Her blood pressure was 90/50mmHg. The abdomen was not distended but there was mild suprapubic tenderness. There was bleeding per vaginum and some clot was evacuated from the vagina. The cervical os was closed but there was a defect in the posterior part of the cervix from where blood was oozing (Picture 1). This was found to be a transverse incision wound about one centimeter from the cervical os posteriorly and two centimeters in length. It was continuous with the uterine cavity which was empty. The uterus was 12 weeks size, there was no adnexal mass and the Pouch of Douglas was empty. A diagnosis of cervical injury and haemorrhage following a termination of pregnancy was made. An ultrasound scan confirmed an empty uterine cavity and her Haemoglobin was 7.6gm/dl. She was transfused with two units of blood, commenced on appropriate antibiotics and the cervical wound sutured. She was discharged two days later after appropriate contraceptive counseling but was lost to follow-up. When the doctor who did the termination of pregnancy was contacted he accepted deliberately making the incision into the cervix from where he evacuated the products of conception rather than going through the cervical os in order to avoid causing cervical incompetence in terminating the mid-trimester pregnancy.

Correspondences: Dr A V Umoh
E mail:avumo@yahoo.com

Case 2: Mrs. I. P. presented on 1st of June 2004 to the Gynaecological Outpatient clinic of University of Uyo Teaching Hospital with a five-year history of inability to get pregnant. However, the immediate reason for her presentation was because recently her husband had been having a piercing sensation on deep penetration during sexual intercourse. There was associated dyspareunia. She was Para 1+[1] and had been delivered of a live male infant 6 years earlier at home by a traditional birth attendant (TBA). The child was alive and well. About 6 months after the delivery, she became pregnant again but decided to terminate the pregnancy at 8 weeks gestation because it was too early for her to carry another pregnancy. She subsequently went to a patent medicine dealer where she procured the abortion. She had some bleeding but this later stopped on medication. Her menstrual periods had been regular but in the past two years she had been experiencing severe dysmenorrhoea and copious malodorous vaginal discharge. She was a trader and the only wife of her husband who was a welder. Examination revealed a young woman in apparent good health. The significant findings were on vaginal examination. She had a copious yellowish vaginal discharge. The cervical os appeared normal but on the lower lip of the cervix was a small dark mass protruding, for about 0.5cm, out of it. It was hard, sharp at the edge but did not bleed on touch. There was cervical motion tenderness. A further probe with a pair of forceps showed it to be a foreign body and a gentle pull yielded 5cm long tip of a 6mm size Karman's cannula. There was no bleeding after removal. The foreign body and a sample of high vaginal swab were sent for microscopy, culture and sensitivity. Both cultures yielded streptococcus species. She was treated on appropriate antibiotics while awaiting results of investigations for the evaluation of infertility. She was however lost to follow up.

Picture 1: **Picture Showing an Abnormal Opening Posterior to the Cervix Which Was Deliberately Created By the Abortion Provider.**



DISCUSSION

Improperly performed induced abortions are fraught with problems which include haemorrhage, sepsis, genital tract injuries, injuries to the intestines and other intraperitoneal structures and death on the short term and infertility, uterine synechiae, cervical incompetence and psychosexual problems in the long term [1-5]. The management of a second trimester abortion is even more difficult and must be handled with extreme care by experienced providers where absolutely necessary [1]. Medical induction is the method of choice in such circumstances [1]. The use of dilation and curettage at this time is to be discouraged [10]. To make an incision into the substance of the uterus at this time i.e. hysterotomy all in a bid to avoid the risk of cervical incompetence in the future is in our view an absurd reasoning and the height of incompetence. This exposes the woman to the risk of haemorrhage as seen in this case and death had intervention not occurred. Moreover, in trying to avoid cervical incompetence the patient is left to the risk of uterine rupture in the future [12]. All it exposes is incompetence by the practitioner. There is no doubt that this practitioner is a quack and a danger to the society. The patent medicine dealer obviously could neither use the very simple MVA kit nor identify the cervix. The cervical injury so caused led to haemorrhage while the foreign body predisposed her to chronic infection. With the chronic infection by the foreign body it would have been interesting to see what the state of the tubes would be as this in itself could contribute to the problem of infertility. The problem of management of second trimester termination of pregnancy by trained practitioners had earlier been highlighted in a case report by Oye-Adeniran et al [10]. The reports presented here further emphasize the problem and underlies the need for a review of the medical curriculum as has been advocated by many workers [6,11,13]. To all intents and purposes both the patent medicine dealer and the medical practitioner were unskilled and therefore providers of unsafe abortion. The review must include some form of training on the procedure of abortion. This may be hands-on or simulated especially in a legally restrictive society such as ours in order to impart the requisite skill to trained medical practitioners to be able to provide safe abortion and post-abortion care where necessary. The possession of the skill is one thing, its use by any practitioner is entirely another. This would ensure that the practitioner moves beyond the level of the quack and so assure the safety and trust of his patient.

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