A Review Of The Complications From Unsafe Abortions in Ilorin, Nigeria

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Abstract

This is a retrospective evaluation of the 220 patients that presented at the University of Ilorin Teaching Hospital (U.I.T.H.) with complications from unsafe abortions between 1st January 1986 and 31st December 1999. History of previous induced abortion was found in 80.5% of patients while only 6.8% had previous contraceptive use. Sepsis 204 (92.7%) with abscess formation in 64.9%, visceral injuries 62(28.2%) with haemoperitoneum in 25.9% and maternal mortality was recorded in 26.4% of the series. Findings are comparable with previous studies from this centre between 1981 and 1985 and with reports from other parts of the world. The need for behavioural change within the society and the re-training of physicians in post-abortal care is emphasized.

Keywords: Unsafe abortions, Complications, maternal mortality.

Introduction

Unsafe abortion- is, induced abortions that take place outside the formal health care system and, performed by unskilled providers under unsanitary conditions or both, and has continued to be a growing health problem all over the world, particularly in developing countries[1]. In settings where access to abortion is highly restricted and desire to regulate fertility is low, deaths due to abortions is a major contributor to maternal mortality [2]. In Africa particularly, the picture is of increasing hospital admissions for abortion complications and a distressingly high rate of maternal morbidity and morality due to abortion [3,4]. Reports [5,6,7] on women hospitalized for abortion complications have shown them to cross all age groups, marital status and occupation. Reasons for procuring abortions are also quite familiar especially in the urban areas with the desire not to interrupt education/career as the main factor in the unmarried women while nursing mothers with babies of very tender age is the major reason in married women [8]. The problems associated with unsafe abortions have been the infections, visceral injuries, haemorrhage, social and psychological consequences in survivors and mortality in the rest [2,4,5].

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This paper is a retrospective evaluation of the varieties of complications from unsafe abortion admitted at the Department of Obstetrics and Gynaecology, University of Ilorin Teaching Hospital (UITH) Ilorin, Nigeria. This is a main referral centre that services about six states. Demography, pattern of presentation and associated problems identified on further assessment of these admitted patients will be reviewed and discussed. The purpose of the paper is to highlight the persisting health problem of complications from unsafe abortion in our environment. Also it is hoped that the findings in this study will be of assistance to physicians in centers that may have to care for these women.

Materials and Methods

From 1st January 1986 to December 31st 1999, all patients with complication from unsafe abortion that presented in the hospital were reviewed. All data in this study were obtained from the Medical Records department, the Gynaecological Wards and the Operating theatre. Most patients did not have referrals as initial attempted terminations were performed by medical personnel that did not want to reveal their identities or "quacks" who had no fixed address or by the patients themselves. There were 241 patients that presented during the study period, out of this, 220 had complete records. Patients age, parity, occupation, marital status were retrieved from the case notes. The symptomatologies at presentation were recorded. General physical assessment including bimanual examination of pelvis in the ward or under anaesthesia in the theatre was carried out in all patients and findings recorded. Exploratory laparotomy was performed when indicated and findings also noted. Hospital stay period was also recorded for the patients. Data is presented with numbers, percentages and tables.

Results

During the time interval from January 1986 to December 1999, there were 11,862 Gynaecological admissions at the department of Obstetrics ad Gynaecology, University of Ilorin Teaching Hospital (UITH). Amongst these women, 241 (2.93%) presented during the period with complications following unsafe abortions but only 220 (1.8%) had com-

Table 1: Age distribution

Age (years)	No of cases	Gestational age at termination weeks (%)			
		< 8	9-12	13-16	17-20
< 15	5(2.3)	3(1.3)	1(0.4)	-	1(0.4)
16-20	58(26.4)	23(10.5)	8(3.6)	19(8.6)	8(3.6)
21-25	64(29.1)	33(15.0)	16(7.3)	7(3.2)	8(3.6)
26-30	47(21.4)	15(6.8)	12(5.5)	4(1.8)	16(7.3)
31-35	32(14.5)	11(.5.0)	15(6.8)	2(0.9)	4(1.8)
36-40	6(2.7)	4(1.8)	2(0.9)	-	-
41-45	3(1.3)	3(1.3)	-	-	5(2.3)
46-50	5(2.3)	-	-	-	-
Total	220(100)	92(41.7)	54(24.5)	32(14.5)	42(19.0)

Table 2: Presentation of unsafe abortion

Complaints	No of Cases
Abdominal/Pelvic pain	143(65.0)
Abdominal distension	106(48.2)
Fever	122(55.4)
Palor	111(50.5)
Vaginal bleeding	113(51.4)
Vaginal discharge	51(23.2)
Vomiting	46(20.9)
Constipation	30(13.6)
Diarrhoea	29(13.2)
Nausea	8(3.6)
Tenesmus	7(3.2)

plete hospital records and these were evaluated. The patients' age ranged from 14 years through 48 years with mean of 25.1 ± 6.1 years (Table 1). The gestational ages of pregnancies at induced abortion admitted to by the patients ranged between 5 and 20 weeks. The mean gestational age at termination of pregnancy was 6.4 ± 11.6 weeks. All age groups were represented at all gestational age of induced abortion. The number of single women equaled he number of married women at 109. Of the unmarried women, 52 (47.7%) had one or two previous parous experiences. Majorities were traders 70(31.8%) followed by students 57 (25.9%) and apprentices to vocational job 25(11.4%). One hundred and seventy four (79.1%) patients had induced abortion prior to the index one. On the other hand only 15 (6.8%) women agreed to previous contraceptive use. The presenting complaints are listed in Table 2. Abdominal

Table 3: Findings at Surgical Evaluation

Findings	No of Cases
Retained products	81(36.8)
Adhesion formations	108(49.1)
Visceral lacerations	
Uterus	48(21.8)
Cervix	6(2.7)
Vagina	4(1.8)
Intestines	4(1.8)
Abscesses	
Pouch of Douglas (POD) only	70(31.8)
POD + Right Adnexum	18(8.2)
POD + left adnexum	8(3.6)
Pelvic + abdominal extensions	47(2.14)

pain correlated well clinically with abdominal tenderness and guarding but no masses were detected at initial examination on presentation. Gastrointestinal disturbances occurred in both patients with visceral injuries as well as those patients with intra-abdominal/pelvic abscesses. Tenesmus occurred in patients with pelvic pain. The time interval from induced abortion procedure to the time of presentation at our hospital for treatment varied from one day to three months, with mean of 12.04±17.15 days. Various degrees of vaginal bleeding and abdominal distension caused early presentations of many patients to the hospital. The late presentations were in patients that had self-medicated on haematinics, analgesics and antibiotics until symptoms became unbearable or exaggerated.

Table 3 shows the findings at examination under anaesthesia and at laparotomy. Histological confirmation of decidual and membranous inflammatory changes was made only in 52 (23.6%) women as not all the specimen arrived at the laboratory. Sixtyfour (29.1%) endo-cervical swab cultures yielded mixed growth of coliforms sensitive to Ampicillin, Gentamycin, Ceftriaxone, Clavulanate-potentiated-amoxycillin, Cefuroxime, Sultamicillin and Clindamycin while there was no growth of bacteria in the rest. Blood cultures were growing mixed contaminants with some recording no growth at all. The small bowel was protruding into the vagina through a large vaginal laceration in one patient. At Laparotomy 108 (49.1%), adhesions-exudative and fibrinous, were present between the pelvic organs, the bowels and the anterior abdominal wall. Injuries to the uterus ranged from perforations to outright lacerations positioned posteriorly 29 (15.2%), lateral 10 (4.5%), fundal 7 (3.2%) and anteriorly 2 (0.9%). Lacera-

tions on the bowels were all on small bowels. One patient had a necrotic portion of the ileum and another had the whole of the terminal ileum gangrenous. Bowel serosa abrasions/tears however inadvertently occurred in 16 (7.3%) patients at exploration of peritoneal cavity adhesions and other definitive procedures. Haemoperitoneum in the pelvis and abdomen was found in 57 (25.9%) patients in association with visceral injuries. The volume of significant blood drained ranged from 250ml to 1500ml (mean 470 ± 620ml). Free and loculated purulent material (abscesses) was found in he pelvis and abdomen in 143 (64.9%) patients. Abscess in the adnexa were in association with tubo-ovarian complexes. Abdominal extensions of the abscess were found in such sites as the subphrenic spaces and the paracolic pouches. The volumes of purulent material drained from cavities ranged from 100ml to 2400ml with mean of 718.3 ± 821.9ml. The shortest hospital stay recorded for these women was six hours the patient presented in septic shock and she died during resuscitation. Majority (61%) of the patients left hospital within two weeks of admission with mean of 12.3 ± 7.3 days. There were a total of 58 maternal deaths from unsafe abortion during the study period. This was 26.3% (263.4 per 1000 unsafe abortions) of all the cases with complete records and a case fatality ratio of 1 in 3.8. Mortality was recorded across the ages and in all parous groups. Postmortem was not carried out on any of the dead patients but clinically the probable causes of death diagnosed were septicaemia 31 (53.4%), hypovolaemia 9 (15.5%), renal failure 6 (10.3%), the rest were unknown causes 12 (20.7%).

Discussion

The prevalence of induced abortion in this environment can not be determined because it is illegal but clandestinely performed and it is only those with resultant complications of morbidity an mortality that come to the limelight [3]. In this study, it constituted 1.8% of all gynaecological admissions. The spectra of the age and the marital status groups in this study are similar to what had been reported over the years [6,8,9]. Also these women have always demonstrated low usage of modern contraceptive methods [6]. The large presence of previous parous experiences in the unmarried women shows that premarital sexual intercourse is practiced much in the community probably because of increasing urbanization that broke down cultural barriers and predisposed to increased sexuality [8]. This needs to be studied further so that effective intervention strategies for positive behavioural change will be mounted. Sepsis is the commonest associated complication of induced abortion World-wide [1,6,10]. The present study revealed a total infection rate of 92.7% and it was the commonest associated complication in the series. This rate is higher than the previous report from this centre in 1986 shortly after the hospital was upgraded from a general hospital to a tertiary referral centre and also when compared studies from other parts of the world [7,8,10,11]. The reason for this cannot be ascertained. The causative organs recovered on culture from specimen that were taken from the patients showed sensitivity pattern to agents ranging from first line through second to third line antimicrobial agents. It is possible that morbidity from sepsis could have been reduced much below this present rate even first line antimicrobial agents had been administered in correct and adequate doses right from the time of induced abortion. Injuries to the reproductive organs and the intestines reported in these women were comparable to report from other parts of the world [5,12,13]. Faulty technique and the use of traumatic instruments by the abortionists, who are either poorly trained or not trained at all, have been responsible for injuries in induced abortion. [14]. This is also applicable to the abortionists mentioned by the patients in this study, as most of them did not give referral letters and were of no fixed addresses. Trauma to the viscus resulting in haemorrhage is also a well-recognized complication of unsafe abortions [7,14,15]. The risk of haemorrhage increased with gestational age of pregnancy at induced abortion as 4 in 10 cases at 8 weeks and below and 8 in 10 cases at greater than 16 weeks. The morbidity from excess blood loss in our environment of inadequate of blood screening and banking facilities with associated complications of blood transfusion itself especially HIV infection presents a gloomy picture for these group of patients. Mortality from unsafe abortion was high, contributing 19.4% of all maternal mortality cases in the hospital at this period [17].Other workers have reported similar high rates.[6,14] The high rate can be ascribed to a combination of late presentations and severe morbidity in the patients and limited facilities on the ground [18].

In conclusion, unsafe abortion still results in needless wastage of scarce health resources and avoidable human suffering with very high risk of mortality. Appropriate education on human sexuality has to be carried out in schools focusing on students and in the market and open spaces focusing on traders and apprentices. Medical personnel will have to be trained in effective post-abortion care for these women to reduce its attendant morbidity and mortality. Facilities to care for these women need to be improved and made available. Also contraceptive services must be accessible and made provider friendly to the adolescent, young, unmarried and married women.

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