THE REPORT OF 150 CASES OF MEDICAL TERMINATION OF PREGNANCY

by

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and

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Introduction

The report of 150 cases of medical termination of pregnancy (M.T.P.), done since 1st April 1972, is presented here. The figure represents combined experience of senior and junior medical staff of the Department of Gynaecology and Obstetrics at L.T.M.G. Hospital, Sion.

The prospective study is carried out for these cases and they are followed up after 2 weeks to 1 month after discharge from the hospital. The purpose of evaluating these cases is to know the exact physical and emotional risks involved with M.T.P. It is too early to come to any definite conclusion but still effort is made to evaluate these cases so that knowledge of difficulties and complications involved in M.T.P. can help the physician to come to a responsible decision after balancing the benefits of the therapy with its disadvantages.

This is more true in presence of existing law as nearly all abortion laws all over the world, permits a physician to undertake abortion within certain framework. They are not obligatory. The doctor has most important role in interpreting the law and must always endeavour to help the woman or couple to make the decision that is most likely to be in the interest of her health and the health of her family.

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Material and Methods

With above background in mind, 150 cases of M.T.P. done at L.T.M.G. Hospital, Sion, since 1st April 1972 are analysed here. These cases were followed up meticulously throughout preoperative and postoperative stay in the hospital as well as 2 to 4 weeks after discharge. The results are as follows:

TABLE I

Age

Age (in Yrs.)	No. of cases	Percentage
15-20	25	16.6%
20-30	86	57.2%
30 and above	39	26%

TABLE II

Religion

Religion	No. of cases	Percentage
Hindu	117	78%
Muslims	9	6%
Christians	24	16%

This table shows number of women of different religions coming for the request of M.T.P. The figures for Hindu and

Christian broadly corresponds with percentage of these women coming to our hospital for deliveries. The percentage of muslim women coming for normal delivery to our hospital is 25 per cent as against 6 per cent coming for the request of M.T.P.

TABLE III
Education

Education	No. of cases	Percentage
Illiterate	52	34.8%
Upto S.S.C.	94	62.6%
Graduate	4	2.6%

This table shows that almost 35% of women were illiterate. This is a good indication, that even these women are aware of the present Law and the facilities available for them in general hospitals.

TABLE IV
Marital Status

Marital Status	No. of cases	Percentage
Married	120	80%
Unmarried	27	18%
Divorced/Widow	3	2%

This table shows that 80 per cent of women came forward to get their pregnancy terminated were married, as against 20 per cent of unmarried or divorcees and widows. This shows that present law also serves another purpose to some extent i.e. of family planning, because high percentage of these women are also eligible for contraceptive advice. Twenty-seven unmarried girls came to general hospital shows that in absence of present law, these are the cases who were likly to use self-induction or would have gone to quakes for termination merely adding up in the mortality and morbidity of septic abortion.

TABLE V
Total Family Income per Month

Total Income	No. of cases	Percentage
Upto Rs. 300/-	112	74.6%
Rs. 301 to 500/-	22	14.6%
Rs. 500/- and above	8	5.4%

Table V shows around 75 per cent of cases are from low socio-economical group. These patients must be getting exploited by quakes before implementation of this law. Now they can take advantage of facilities of general hospitals.

TABLE VI
Residence

Residence	No. of cases	Percentage
Bombay	111	74%
Out of Bombay	21	14%
Address incorrect	18	12%

50 per cent of the cases staying in slums.

This important Table of residential status of these women shows that 74 per cent of women were residing in Bombay. Out of them 50 per cent were residing in slums and these cases came forward for contraceptive advice only because they felt that we have helped them for their problem of unwanted pregnancies.

Similarly, this Table shows that 14 per cent of women came from distant places outside greater Bombay, indicating need for facilities of M.T.P. at district hospitals.

Twelve per cent of women gave incorrect address or have changed address within a month of discharge. All these add up in difficulties to follow-up of these cases.

TABLE VII

Gravida

Gravida	No. of cases	Percent-age
1st	46	30.6%
2nd	13	8.6%
3rd	26	17.4%
4th and above	65	43.4%

This Table shows that 46 patients were terminated for their first pregnancy. Out of these, 28 girls were unmarried or widows. Demaining, though married, could not afford even one child in their present economical conditions and had given contraceptive failure as reason to get termination done. Exactly how many were really married is difficult to know at times.

TABLE VIII

The Period of Gestation

Gestation Period	No. of cases	Percent-age
0-12 weeks	103	68.6%
12-20 weeks	41	27.4%
20 weeks and above	6	4%

This Table shows around 28 per cent of patients came after 12 weeks of gestation for termination. We all know the risk of termination increases after 12 weeks of gestation and this should be explained to patients so they come early to hospital.

TABLE IX

Indications

Indications	No. of cases	Percent-age
Social	31	20.6%
Socio-economic	111	74%
Medical	8	5.4%

The first two groups of indications overlap each other; 74 per cent of cases who came for socio-economical reasons were eligible for sterilization.

TABLE X

Method of Induction

Method of induction	No. of patients	Percent-age
D & C or Suction evacuation	100	66.6%
Intra-amniotic saline	42	28%
Hysterotomy	5	3.4%
Oxytocics	3	2%

This Table shows that in most of the cases, either suction evacuation or intra-amniotic saline injection was used. There is hardly any need for hysterotomy these days for induction. Oxytocics were used for 3 cases where the os was open, and history of laminaria tents introduction outside was probably tried. These cases aborted with pitocin drip.

TABLE XI

Complications

Complications	No. of cases	Percent-age
During operation	5	3.3%
Post-operative	28	18.7%
Nil	117	78%

This Table shows that 78 per cent of women had no complications of any severity. Out of 28 cases who had post-operative and post-discharge complications are as follows:

Twelve cases required readmission for various reasons:

(i) Three cases continued pregnancy, two of them requiring hypertonic saline injection for termination. One case refused admission and has been lost to follows-up.

(ii) Four cases came back as incomplete abortions requiring surgical treat-

ment: 2-following hypertonic saline, 2-following suction evacuation. Blunt currette check is very important after suction evacuation and some cases of hypertonic saline if there is doubt about complete evacuation.

(iii) One case came with secondary haemorrhage through vaginal sterilization incision requiring packing and blood transfusion.

(iv) Three cases were admitted for sepsis with history of foul vaginal discharge requiring antibiotics and rest. One of them had developed bilateral tubo-ovarian masses.

'Sepsis' in fact is an important cause of mortality and morbidity of criminal abortion. In M.T.P. this must be by all means avoided. Preoperative treatment of purulent vaginal discharge or gonorrhoea and good hygeinic precautions after discharge are important factors.

(v) One case had psychological paresis of both the legs during post-operative period. Complete investigations and treatment was given to this patient.

(vi) Five cases had complications during operations.

(1) Primary haemorrhage over 500 cc of blood requiring blood transfusion in two cases.

(2) Cervical trauma, requiring suturing in 2 cases.

(3) One case had perforation of the uterus requiring exploratory laparotomy and suturing.

Remaining 16 cases had minor complaints like, spotting, pain in the abdomen or backache, where clinical examination did not reveal any abnormal findings.

TABLE XII

Hospital Stay

Duration of Stay	No. of cases	Percentage
1 to 5 days	97	64.6%
1 Week	45	30%
More than 2 weeks	8	5.4%

This Table shows that around 65 per cent of cases were discharged within 5 days of admission. Those who had to stay in the hospital for more than 2 weeks, were cases done for medical complications. Most of the cases of D & C or vacuum aspiration were discharged next day of operation.

TABLE XIII

Contraceptive Advice

Vaginal Sterilisation	Abd. Sterilisation	IUCD	Vasectomy	Other	Nil
68	5	17	2	2	56

Permanent method of contraception like tubectomy or vasectomy was undertaken in 70 cases. Fifty-six cases did not follow contraceptive advice after discharge from the hospital which was found on follow-up. It is very important that these patients should follow contraception for spacing, otherwise they will come back for another termination of pregnancy. I.U.D. insertion immediately after M.T.P., is the best type of contraceptive device for our hospital class of patients. Careful double blind study done on large series of patients at Chille have shown that I.U.D. insertion immediately after abortion does not increase risk of infection or expulsion.

Similarly, very few cases came for

M.T.P. had real contraceptive failure. Most of the cases had either neglected contraception or had no clear idea of contraceptive method they were using. Meticulous family planning advice must be given to all patients coming for M.T.P.

Discussion

Induced abortion is a global problem of epidemic proportion and deaths from illegal, unskilled abortions play a considerable role in the maternal mortality pattern of many countries. Most abortions, in country like India, which is rapidly undergoing urbanization and some degree of economic development take place as a result of couples desire to space or limit their families in certain social or economic situation. Many, but not all, induced abortions can be eliminated by use of contraception or sterilization. Some or the other kind of contraceptive method must be implemented on every couple desiring M.T.P. The present statistic shows very poor response to contraceptive advice after M.T.P., especially when it is done for spacing. IUD insertion immediately after termination would be the best solution for this. On demographic prediction, each sterilization prevents 1.5 live births as against 0.5 by IUCD and 0.15 by conventional contraceptives.

It is of primary importance that all engaged in the difficult problem of termination recognise that their role is one of service and that it is their role to provide sympathetic, safe, expeditious and economical pregnancy counselling services without morally biased. By extension of medical indications and recognisation of eugenic and humanitarian indications, frequency of illegal and self-induced abortions have not disappeared, even in countries where abortion on request has been available for more than a decade. This stubborn survival of practices detrimental to health probably reflects at least in part dissatisfaction with the manner in which the official abortion services are organised, especially as regards protection and privacy. In addition to providing her facilities of abortion and family planning advice, the opportunity for sympathetic discussion of her problems must be done which will provide her with emotional support. It has now been appreciated that it is important to adopt a sympathetic attitude towards these patients. If this is observed she is likely to come through the experience with no long term emotional scars as against if the professional personnel caring for the woman adopt a puritan attitude, she is likely to feel some degree of guilt afterwards.

The termination of pregnancy is neither safe nor simple as to advocate 'Abortion on demand'. Serious complications are well known after M.T.P. Whether liberal or conservative views are held on M.T.P. due to political, social or educational background, the fact remains that doctor has some responsibility for what follows, both to the patients aborted and to the society as a whole. The many delayed complications, physical as well as emotional, should not be neglected and therefore complete long term follow-up of patients is obligatory.

The abortion law as it exists in India to-day should be publicised widely for the benefit of the medical profession and the lay public. It is very important that women desiring M.T.P. come to physicians in early weeks of gestation for safer induction.

No out-patient termination of pregnancy should be advocated at least till such time we have better hospital facili-

ties, and enough trained personnel to avoid complications detrimental to the health of the woman. Sepsis which is the cause of death in illegal abortion must by all means be prevented in M.T.P. The majority of women coming for the request of M.T.P. in India are from low-socioeconomic, semi-educated and younger age group. These are cases, residing in poor hygeinic conditions like slums and who cannot take adequate rest and medicines at home. These are the cases who already have poor physical health and handicaps like anaemia, mal-nutrition, etc. All this adds to the complications of M.T.P., especially if it is done as an outdoor procedure.

Summary and Conclusions

One hundred and fifty cases of M.T.P. from L.T.M.G. Hospital are studied. Following conclusions are apparent from this study.

(1) The abortion law as it exists in India today should be publicised widely for the benefit of the medical profession and lay public, so that women in need will be guided to come to proper hospitals and get skilled medical help. This will reduce the morbidity of criminal abortions. But, at the same time public should not be misled into believing that induction of abortion is a minor procedure and this can be used as mere extension of contraception.

(2) Every couple coming forward for the request of induction must be advised contraceptive method, as far as possible sterilization, for eligible couples. I.U.D. insertion postoperative is thought to be the best method for our type of patients.

(3) OPD termination of pregnancy should be avoided, at least for such time, till enough competent trained staff and good OPD facilities for operation are available. It must be remembered that our hospital cases are from low socio-economic class who are already anaemic, malnourished and are staying in poor hygeinic conditions. These are the cases more prone to develop postoperative infection and are reluctant to follow medical advice. They need hospitalization and postoperative rest, haematinics and antibiotics.

(4) To reduce the number of septic and self induced abortions, protection and privacy should be given to cases coming for M.T.P. Counselling is needed for these patients. The opportunity given to them for sympathetic discussions of their problems, and sympathetic attitude of professional people treating them is of high importance to get over social problems and psychological sequelae of M.T.P.

(5) Last but not the least, prospective study and meticulous long term follow-up of these patients is needed in our country to know the exact risk, either physical or psychological, and early as well as late sequelae of M.T.P.

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