

## CLINICAL PROFILE OF STERILISATION WITH MEDICAL TERMINATION OF PREGNANCY IN A RURAL HOSPITAL

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Kasturba Hospital, Gandhigram, Tamil Nadu State is a rural based and rural oriented hospital. It is a Voluntary Organisation strated nearly 40 years ago. It has a bed strength of 160. It is a small general hospital with 50 beds reserved for family welfare surgery. The annual turn over is around 5000 tubectomy. Very good follow up care is given to adopters of family welfare. It is to satisfy the need of such mothers. Tube recanalisation is done in this hospital since 1973 with satisfactory results. Again to suit the needs for a number of rural mothers, the Medical Termination of Pregnancy programme was started in this hospital in November 1976. Mothers come to this hospital for family welfare services from far and near for various reasons.

### Introduction

As we all know that the majority of the population of our country is in the rural areas, this prompted the authors to do the

above study. This study has been undertaken in the Kasturba Hospital, Gandhigram, Madurai District, Tamil Nadu doing mainly rural medical service. Now-a-days sterilisation and Medical Termination of Pregnancy goes hand in hand. In our set up, 50% of patients get admitted for both which shows the awareness of the rural population about the newly introduced Medical Termination of Pregnancy Act.

In this study, an attempt has been made to analyse the different relevant facts regarding Medical Termination of Pregnancy with concurrent sterilisation in 1502 cases, admitted in this hospital from January to December 1978. Intrauterine and transcervical hypertonic saline was the only method adopted for Medical Termination of Pregnancy in this series.

### Material and Methods

The majority of the patients come under the age group of 26-30 (48%) (Third decade).

The younger age group mothers are more conscious of limiting the family size. Very low incidence was seen above the age of 35 (3.5%). The parity wise distribution of cases (Table I) shows that

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TABLE I  
Percentage Distribution of Cases by Parity

Month	I	II	III	IV	V & above
January-February	0	19.0	17.0	11.2	11.0
March-April	0.5	30.5	25.5	20.0	20.0
May-June	0	25.0	36.0	22.5	11.8
July-August	0	29.0	28.0	21.5	23.0
September-October	0.5	28.5	35.0	17.0	14.5
November-December	0	63.0	31.0	22.0	16.5

the second parity constituted the highest percentage 32.5% next comes the third parity 28.6% suggesting the growing consciousness for small families. Other parities constitute 16% each.

Distribution of cases among various religions shows the highest incidence among the Hindus 98.2%, Muslims come the next 1.4%, and Christians 0.7%.

#### Discussion

This study confined to mothers who have adopted Medical Termination of Pregnancy with concurrent sterilisation in this hospital. Majority of the mothers in this study were from the rural areas for whom we have been flexible in certain aspects. For example, pregnancy of more than 16 weeks were accepted for fear that if we reject them they are sure to resort to indigenous criminal methods of terminating an unwanted pregnancy. In this hospital, about 50% of the sterilisation adopters seek Medical Termination of

Pregnancy services also. Most of them seek the Medical Termination of Pregnancy services early in pregnancy. Only few of the mothers (Table II) come during late second trimester which again is an indication that Medical Termination of Pregnancy awareness has permeated to the village.

In the earlier days in this hospital various methods were adopted for termination of pregnancy. Due to convenience of preparation, easy administration, and early termination, minimal or practically no chance of complications like incomplete termination, excessive bleeding and infection we now adopt this two stage technique. We use hypertonic saline instillation either intra-amniotic or transcervical, except in early pregnancy where termination is done with menstrual regulator (Carman syringe).

In our hospital, usually sterilisation is done under short general anaesthesia (open drop ether). The hypertonic saline

TABLE II  
Percentage Distribution of Medical Termination of Pregnancy Acceptors  
by Duration of Pregnancy (in Weeks)

Month	Upto 8	9-12	13-16	17-18	19-20	21-24	above 24
January-February	16.7	17.6	19.3	3.7	2.5	3.0	0.5
March-April	27.0	36.0	25.0	5.0	4.0	2.5	0.5
May-June	24.0	36.0	17.0	5.5	3.0	0.7	—
July-August	27.0	27.5	29.0	6.0	7.5	2.0	—
September-October	32.5	30.5	24.0	4.0	5.0	6.0	—
November-December	28.0	27.4	15.5	6.0	5.0	4.0	1.0



TABLE III  
Injection Abortion Interval (Parity Wise)

Size of the uterus (in weeks)	Time taken for expulsion/Injection abortion interval in hours parity wise				Average
	II	III	IV	V and above	
12	21	48	33	22	31
14	38	24	35	36	33
16	17	32	33	25	26
18	27	29	18	26	25
20 and above	24	28	26	23	25
Average	26	32	29	26	

is instilled at the rate of 10 ml. per week of pregnancy. It is instilled intra-amniotically if the pregnancy is more than 14 weeks and through the cervical route if the pregnancy is 12 weeks or less. The injection abortion interval was 20 to 30 hours on an average. After the spontaneous expulsion of the foetus, which is usually entire and complete, the uterine cavity is curetted as a routine to exclude the possibility of retained products. If the pregnancy is less than 10 weeks instrumental evacuation is done when the os is open.

Among the 1502 cases, spontaneous termination occurred in 315 cases (21.5%) we did not encounter any complications. Four hundred and eighty-three (30.7%) patients had undergone instrumental evacuation without dilatation. Four hundred and fifty-seven (28.3%) required dilatation due to non-ripening of the cervix.

If there was no response to saline for 48 hours the same or slightly less amount of hypertonic saline was introduced once again, 12 (4%) patients. Usually spontaneous termination occurred within 24 hours of second induction. We tried also injection syntocinon instead of second instillation for acceleration and spontaneous termination which also gave satisfactory response. We had more cases in the early

pregnancy (9-16 weeks) 75% totally. We have seen that the injection was abortion interval less in the second para (Table V) which went up in the third para and

TABLE IV  
Causes for Rejection

Causes for Rejection	No. of cases
Anaemia	38
Pelvic infection	29
Advanced pregnancy	37
Prolapse uterus	11
Hear disease.	4

came down in fourth and fifth parity. Similarly, more advanced the pregnancy earlier the expulsion, which was noticed specially in pregnancy around 20 weeks and more. As far as our study is concerned we have not made out any significant difference between intra-amniotic and transcervical saline.

Suderstorm and Hyden (1977) report. They have reported 1000 cases of mid-trimester out patient saline abortions without major complications or fatality. We also had the same expeperience during surgery. We encountered certain pathological conditions in 20 cases. Ovarian cyst (non-specific and non-malignant) in 17 cases, Tubercles in 9 cases, and hydro-

salpinx in 4 cases. These patients were given treatment accordingly.

The complications we experienced were mainly injury to the neighbouring organs. Among them, injury to the ovary occurred in 7 cases, injury to the parametrium in 2 cases, injury to bladder in 1 case, and injury to intestine in 1 case. They were tackled immediately by appropriate surgical procedures. As far as saline complications are concerned, we had only hyperpyrexia in 5 cases. Luckily we did not have the dreaded complications like coagulation failure, hypernatraemia, septicaemia etc. Similarly, in medical termination of pregnancy also we had excessive bleeding in 3 cases and perforation in 1 case.

Though we get plenty of cases we follow certain criteria to accept the case for sterilisation with medical termination of pregnancy. If the patient is not fit for surgery, we reject them. Among the causes for rejection (Table VI) anaemia and advanced pregnancy constitute the highest percentage, next comes pelvic infection as given in Table VI. We do not leave the patient as such; we treat the anaemia and pelvic infection with appro-

priate, haematinics and antibiotics and take her up for surgery. Similarly, patients with cardiac complications were treated first and then taken up for surgery, after informing the patient and her husband about the cardiac condition. For such mothers, surgery was done under sedation and local analgesia. Hypertonic glucose was used in few cardiac patients. Very few mothers with cardiac complications were rejected.

#### Summary

One thousand, five hundred and two cases of sterilisation with concurrent medical termination of pregnancy done in a rural set up is discussed. Various aspects of medical termination of pregnancy, like the technique of termination, injection/abortion interval in relation to parity and size of the uterus, complications met during surgery and after saline instillation are mentioned.

#### References

1. Suderstorm, R. M. and Heyden, G. E.: *Advances in Planned Parenthood*. 12: 98, 1977.