

## A REVIEW OF SEPTIC ABORTIONS

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### SUMMARY

A review of septic abortion is made as it was found to be an important cause of maternal death. Mostly untrained personnel were found to be involved. Surgical intervention was done in 73.3% of cases. Mortality was to the tune of 13.3% and morbidity was also quite high. Eradication of illiteracy and correcting the defect in existing health care system require immediate implementation to prevent such an avoidable gigantic problem.

### INTRODUCTION

There are more maternal deaths in India in one day than deaths in one month in all developed countries (Harison-1989). Septic abortion is an important cause of maternal death. Thus it becomes important to study these cases so that appropriate action can be taken for the prevention of such high morbidity & mortality.

### MATERIAL AND METHOD

The material was from the prospective study of septic abortion cases admitted at Pt. B.D. Sharma Medical College & Hospital, Rohtak and concerned period July, 93 to

June, 94. During this period, 177 patients of spontaneous abortion were admitted in one unit out of which 15 patients were of septic abortion giving incidence of 9%.

### DISCUSSION

The trends in septic abortion have been highlighted. In most of the cases injury has been inflicted by untrained doctors or dais. Surgical experience of the physician is an important factor in decreasing the mortality & morbidity. In a study (JAMA 1992) performance of abortion by a resident rather than by an attending physician was found to be a powerful risk factor for uterine perforation (relative risk 5.5). Advancement of gestational age and in-

## OBSERVATION

Sl. No.	Age years	Parity	Rural / Urban	Procedure done outside	Qualified/ Unqualified Personnel	Complication	Outcome	Hospital stay
1.	35	P2	Rural	Sp. abortion at 5 mths. intervention	-	Pelvic peritonitis	Improved on conservative treatment	12 days
2.	24	P2	Rural	D & C Following continuous bleeding P/V after delivery 4 mths. back	BAMS	Ut perforation + Gut perforation (whole of small gut was gangrenous)	Laparotomy Jejunioileal anastomosis Repair of uterine perforation Expired next day.	2 days
3.	28	P2	Rural	Vag. swab instilled by Dai for MTP at 2 mths. gestation Fever and bleeding D & C done at C.H.C.	Dai MBBS	Ut perforation + Small gut perforation	Resection Anastomosis of gut + subtotal Hysterectomy Improved	15 days
4.	40	P2	Rural	MTP (D&C) at 10 + weeks	MBBS	Ut perforation + small perforation in small gut	Repair of Ut perforation + Gut perforation. Abd. wound gaped restitching done subtotal intestinal obstruction Cured with conservative treatment.	42 days
5.	24	P2	Rural	D & C after SP abortion	Untrained	Ut perforation + Gut perforation,	Repair of Ut perforation resection anastomosis of small gut Cured	28 days

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6.	22	P0	Urban	MTP (D & C)	BAMS	Pt. in shock Ut perforation	Laparotomy Repair of Ut perforation, drainage of pus, Pelvic abscess Cured-Colpotomy	34 days
7.	23	P2	Urban	MTP (D & C) 8 mths. gest.	BAMS	Ut perforation	Laparotomy perforation stitched Cured	12 days
8.	28	P3	Urban	16 weeks (for MTP) Emcredil I/M Prostodin	MBBS	Rupture uterus	Laparotomy Subtotal Hysterectomy  Cured	10 days
9.	36	P3	Rural	MTP (D & C) at 2 mths. gest.	MBBS	Ut perforation with uremia	Died within 12 hrs. of admission Unoperated	12 hours
10.	20	P2	Rural	Spont abortion	—	Endometritis	Antibiotics D & C Cured	6 days
11.	30	P3	Urban	MTP (D & C) at 8 weeks	Untrained	Endometritis	Antibiotics Cured	7 days
12.	25	P1	Urban	MTP for 6 wks. Amenorrhea	BAMS	Endometritis	Cured with conservative Rx.	6 days

Sl. No.	Age years	Parity	Rural / Urban	Procedure done outside	Qualified/ Unqualified Personnel	Complication	Outcome	Hospital stay
13.	26	P2	Rural	D & C following incomplete abortion at 26 weeks	BAMS	Pelvic peritonitis	Colpotomy Cured	30 days
14.	26	P3	Rural	MTP at 5 mths. gest.	Untrained	Pelvic peritonitis	Laparotomy and drainage of pus Cured	7 days
15.	18	P0	Rural	D & C for bleeding after 35 days Amenorrhoea	Dai	Peritonitis	Laparotomy and drainage of pus Cured	17 days

creasing parity also increases risk of perforation.

In the present study, there was death in 2 cases (13.3%). Though Hira et al (1992), found a mortality of 6.2% in his series.

Surgical intervention was undertaken in 11 (73.3%) cases, Laparotomy was performed in 9 cases (60%) while one patient expired within 12 hrs. of admission. She could not be taken for laparotomy as she was brought to hospital in uremia and shock. It was found that early surgical intervention gave better result as compared to previously advocated role of protracted conservative treatment.

Injury to gut was present in 4 cases (26.7%). Kreles (1986) in a study of intestinal surgical in gynaecological operations found that 9% of injury occurred during dilatation & curettage in D & C. In this review, the current opinion is that gynaecological residents should learn to perform the principles of repair of intestinal laceration. Grade I sepsis was present in 3 cases. This could have been avoided had the patients availed of the facilities of trained doctors. Most of the patients were of rural background. Thus eradication of illiteracy and correcting the defect in existing health care system appears to go along with in preventing these complications.

### CONCLUSIONS

From this study we conclude that such premature loss of life can be prevented by creating awareness in women to go to a trained person for M.T.P. Training in the Family Planning Clinic is also essential for all residency and universal basic teaching should be given highest priority.

**REFERENCE**

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