Complications and Management of Septic Abortions: A Five Year Study

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Summary

A total of 46 patients of septic abortions admitted over the last five years with septic abortion were studied. The termination of pregnancy was done by untrained persons in 39.68% cases. Most of the terminations were performed at home or private hospital. The presenting symptoms were fever (82.60%), pain in abdomen, abnormal vaginal discharge.

The complications were renal failure (13.04%), sepsis (17.38%), shock (19.56%), generalised peritonitis (13.47%), coagulation failure (4.34%) and faecal fistula (6.52). Surgical treatment was refused by 15.65% cases. The maternal mortality was seen in 4 patients (8.69%). Medical termination of pregnancy should be performed in recognised centres only for which education of masses is important. Early surgical intervention in cases of septic abortion can lower the morbidity and mortality.

Introduction

Although septic abortion has become an uncommon problem in developed countries and where legal abortion is allowed, it continues to be a major problem in third word countries and where abortion is not yet legalized. Despite India being one of the first few countries to legalize abortion through MTP Act of 1971, it is unfortunate that we still see cases of septic abortion here. The most common cause is termination done by an untrained person like traditional birth attendant (Dai) or some other quacks who charge very little money and are available in the vicinity of the victim. Patients find it expensive to go to authorized private centres and inconvenient to go to Government hospitals. However, once a complication has developed then they are almost always referred to Government hospitals as no one else would accept such a moribund patient.

Material and Methods

We are presenting a retrospective study done over previous five years period in Lok Nayak Hospital on 46 women admitted with us with septic abortion. Most of the patients were admitted to us only after sepsis had ensued with termination done outside by some quack or trained person. Data was collected from the files of patients admitted with septic abortion in our hospital.

Results

A total of 46 women admitted with septic abortion in Gynaecology ward of Lok Nayak Hospital over previous five years were analysed for various parameters. Age of patients ranged from [illegible] to 42 years with mean being 27.5 years. Parity ranged from

to 5 with mean being 3.0. A total of 89.13% were married while 10.86% were unmarried. Period of gestation at the time of termination ranges from 6 weeks to 12 weeks in 54.34% cases and more than 12 weeks in 45.66% cases. Mode of termination was by instrumentation in majority of cases (82.60%).

Untrained persons performed termination on 69.59% cases while 30.41% terminations were performed by doctors who were not fully trained for MTP. The indication of termination of pregnancy was unwanted pregnancy in all the cases (10.86% were unmarried).

The presenting findings of patients are shown in Table I. Fever was the commonest finding (82.80%) followed by abdominal and pelvic pain (69.59%). Pelvic pain was seen in (41.38%) cases while generalised peritonitis was seen in (43.47%) cases.

Table I : Showing Presenting Complaints of patients of Septic Abortions

S. No.	Characteristic	No. of Patients	Percentage
1	Fever	38	82.60
2	Pain in abdomen	32	69.59
3	Pelvic peritonitis	19	41.38
4	Generalised peritonitis	20	43.47

The complications are shown in Table II. There was renal failure in 6(13.04%), septicemia in 8(17.38%) shock in 9(19.56%), genralised peritonitis in 20(43.47%), coagulation failure in 2(4.34%) and taecal fistula in 3(6.52%) cases.

Table II Showing Complications in Patients of Septic Abortion

S. No.	Characteristic	No. of Patients	Percentage
1	Renal Failure	6	13.04
2	Septicaemia	8	17.38
3	Septic shock	9	19.56
4	Generalised peritonitis	20	43.47
5	Coagulation failure	20	4.34
6	Faecal fistula	3	6.52

Out of total 46 patients, 42(91.31%) recovered while surgical treatment was carried out in 21(45.65%) cases. The hospital stay ranged from 7 days to 105 days with mean being 22.5 days. The various types of surgical treatments are shown in Table III. Unfortunately inspite of best efforts, 4 patients died with a maternal mortality of 8.69%. The cause of maternal mortality was septicaemic shock in 2 cases, generalised peritonitis in 1 case and renal failure in 1 case.

Table III – Showing types of surgical treatment in 21 patients.

S.No.	Operation	No. of cases	Percentage
1.	Evacuation	6	28.5
2.	Colpotomy	5	23.8
3.	Laparotomy with Drainage of Pus	6	28.5
4.	Laparotomy with Hysterectomy	4	19.04

Discussion

In spite of legalisation of abortion by MTP Act of 1971, illegal abortions continue to occur in India. The main reason probably is early availability of quacks in the vicinity of patients. They charge very less and are easily affordable. So the women can avoid expensive MTP in authorised private health centres or at the long queues in Government hospitals but it come at a great cost which can jeopardise the health of woman seriously and can even be fatal. The sequelae may even render many women permanently sterile.

The renal failure continues to occur as important sequelae of septic abortion and was seen in 4 cases in our study. Zewdu (1994) from Ethiopia and Ferreyra et al (1994) from Argentina also found septic abortion to be the leading cause of renal failure in their studies. Singh and Mishra (1999) found renal failure in 4.8% of septic abortion cases.

Similarly septic shock which was seen in 19.56% of our patients, although uncommon but is a very serious complication and can cause up to 50% maternal deaths (Figueroa Damian and Arredondo Garicia 1993). Maternal mortality was 8.69% in the present study which was comparable to 6.2% by Hira Lal (1992), and 12.5% by Sinha and Mishra (1999).

Any bacteria including gram positive, gram negative or anaerobes can be involved in the aetiopathogenesis of septic abortion. Even tetanus and gas gangrene have been reported in the patients of septic abortion (Lauveau et al 1993, Dylewski et al 1989). Even endocarditis has been reported after septic abortion in Indian patients. (Grover et al 1991). Pedal gangrene has been reported as a complication of septic abortion (Mathur et al 1998).

The antibiotics usually given in India are penicillins (or ampicillin) to cover gram positive bacteria, gentamycin to cover gram negative bacteria and metronidazole to cover anaerobes but they should be prescribed by intravenous route and culture sensitivity

report and local bacteriological spectrum should be given a consideration. Ciprofloxacin, monotherapy or clindamycin alone or in continuation with gentamycin has been tried with good results. (Thadepalla et al 1991, Zambrano 1991).

Surgery in the form of evacuation, colpotomy or laparotomy should be performed in these cases to improve the outcome and surgery should be done early rather than late for better outcome. (Rivlin and Hunt 1986, Singhal et al 1982). Surgical intervention in the form of laparotomy or colpotomy was required in 92.3% and 73.3% cases in two Indian studies (Sinha et al 1999, Meenakshi et al 1995)

To conclude, inspite of legalisation of abortion in India, septic abortion continues to be a major problem. Safe MTP should be made more popular and easily accessible to the pregnant ladies to avoid the sequelae of septic abortion.

References

1. Dylewski J, Wiesenteld H, Latour A: Rev Infect Dis 11(3): 470, 1989.
2. Fauveau V, Mamdani M, steinglass R, Koblinsky M Int J Gynecol Obstet 40(1): 3, 1993.
3. Figueroa-Damian R, Arredondo-Garcia H: Ginecol Obstet Mex 61: 337, 1993.
4. Firmat J, Zucchini A, Martin R, Aguirre C: Ren Fail 16(1): 91, 1994.
5. Grover A, Anandi S, Varma J: Int J Cardiol 33(1 83.88, 1991.
6. Hira Lal: J Obst Gyn Ind 42: 288, 1992.
7. Mathur v, Mathur RK, Singh S, Jain G: J Obst Gyn Ind 48: 88, 1998.
8. Meenakshi, Sirohiwal D, Sharma d, Gulati N: J Obst Gyn Ind 45: 186, 1995.
9. Rivlin ME, Hunt JA: Obstet Gynecol 1986; 632, 67(5), 1986.
10. Singhal PC, Kher VK, Dhall GI: Int J Gynecol Obstet 20(3): 189, 1982.
11. Sinha HH, Mishra MG: J Obst Gyn Ind 49: 50, 1999.
12. Thadepalla H, Mathai D Scojji R: Obstet Gynecol 78(4): 696, 1991.
13. Zambrano D: Clin Ther 13(1): 58, 1991
14. Zewdu W: Ethiop Med J 32(2): 79, 1994