

Short Reports

Retrospective study of 600 consecutive admissions with abortions at Kamuzu Central Hospital

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Introduction and Methods

Abortion is the main cause of hospitalisation in the gynaecology ward at Kamuzu Central Hospital. We studied retrospectively the files of 600 consecutive cases admitted with the diagnosis of abortion from 1st January 1990 to 10th May 1990. This represented 45% of all admissions to the gynaecology ward during that period.

Results

Of the 600 cases, 428 (71%) were first trimester abortions and 172 (29%) were second trimester abortions. There were 510 cases (85%) of incomplete abortion and 192 of these (38%) were septic on admission. Complete abortion was diagnosed in 90 patients, and 4 had signs of post abortal infection.

168 (28%) patients were clinically felt to require blood transfusion and 38 were actually transfused. The Figure shows the distribution of the cases according to gravidity.

There were 33 cases of *obviously* induced abortion. 30 patients were found with a stick (usually a cassava stalk) in the cervix, vagina or uterus, and 3 acknowledged having taken "home" medication by mouth. Of these patients, 24 were still at school and experiencing their first pregnancy, and 9 were married multiparous women.

Six women underwent major surgery and three of these patients died later on the ward. All six had a diagnosis of induced abortion and their case histories are detailed below.

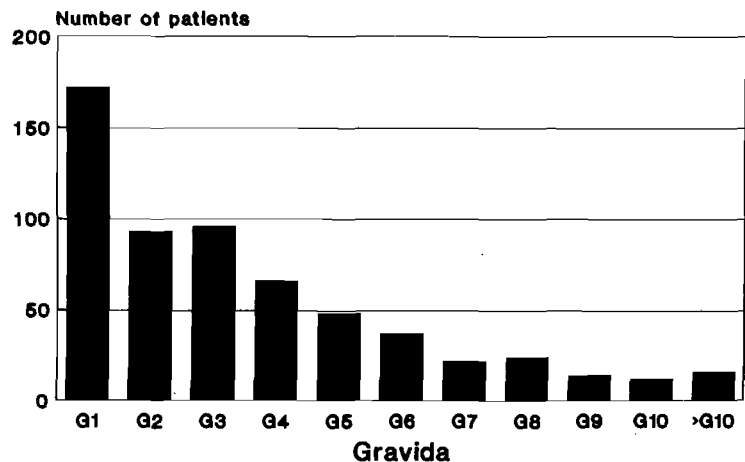
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Patient 1 - a 24 year old Para 4 with all children living (youngest 5 months old). She was an educated woman who attended a traditional healer for an abortion, which was induced with sticks. She was admitted with generalised peritonitis and underwent a laparotomy. There was a perforation of the left cornu of the uterus, which had become necrotic. A subtotal hysterectomy with bilateral salpingo-oophorectomy was performed. She died 4 weeks later.

Patient 2 - a 20 year old primigravida, who was still attending school. An abortion was induced by

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a traditional healer with sticks. She was septic on admission and underwent an evacuation, with antibiotic cover. However she developed peritonitis and a laparotomy and drainage was performed. She died 3 weeks later.

Patient 3 - a 20 year old primigravida, who was still attending school. An abortion was induced by a traditional healer with sticks. She was admitted with a pelvic abscess and at laparotomy was found to have a necrotic, perforated uterus.

Subtotal hysterectomy was performed. She died 19 days later.

Patient 4 - a 22 year old primigravida student. An abortion was induced with sticks by a traditional

healer. She was septic on admission and underwent evacuation of the uterus with antibiotic cover. She developed generalised peritonitis and at laparotomy the uterus was found to be perforated and necrotic. A total abdominal hysterectomy with left salpingo-oophorectomy was performed. She did well postoperatively.

Patient 5 - a 22 year old primigravida, who was following training in her chosen profession. She had an abortion induced with a stick and was admitted with peritonitis. She underwent laparotomy and drainage of pus. Her postoperative course was stormy, and complicated by a burst abdomen. She was found to be HIV reactive. She was discharged 4 months after admission.

Patient 6 - a 20 year old primigravid schoolgirl. An abortion was induced with a stick. She was admitted with peritonitis and at laparotomy was found to have a perforated uterus and a haematoma in the right broad ligament. Total abdominal hysterectomy with right salpingo-oophorectomy was performed. She recovered well and was discharged 2 weeks later.

Apart from these 6 patients, all other women with induced abortion did well after evacuation and antibiotics.

Discussion

It has been estimated that up to 20% of recognised pregnancies end in spontaneous abortion¹, and this usually occurs in the first trimester. The uterus is not efficient at emptying its contents in early pregnancy, so that abortion is often complicated by retained products. These provide a nidus for infection, which will spread to involve the fallopian tubes and if not rapidly controlled will lead to pelvic abscess, generalised peritonitis and septicaemia. Retained products also prevent haemostasis, and the blood lost during abortion can be life threatening.

These facts are borne out by our study in which over a third of the cases of incomplete abortion were septic, and 28% of the admissions were anaemic enough to warrant transfusion. The fact that less than a quarter of these anaemic women actually received blood reflects the problems inherent in our blood bank. The rest were discharged on iron and folic acid treatment.

The definitive treatment of incomplete abortion is evacuation of the uterus. Sometimes this can be done digitally when the patient is first admitted, gentleness and explanation being all that is required to gain the patient's cooperation. Bleeding will immediately cease, and the patient can often be allowed home the same day. However the majority of women will require some form of analge-

sia/anaesthesia to remove the retained products, and this should be done within 24 hours of admission.

Induced abortion was diagnosed in 33 patients, 5.5% of the total. However it is impossible to know the true incidence as interference is not readily admitted to. In countries which have legalised abortion, the apparent clinical incidence of early spontaneous abortion has declined. It would appear that many so called "miscarriages" prior to legalised abortion were actually the result of surreptitious attempts at induced abortion¹.

Induced abortion has been used by women of all cultures and religions since time immemorial, to rid themselves of unwanted pregnancy. However it is a major cause of maternal mortality, morbidity and profound misery which is now completely avoidable. When modern methods of contraception are made easily available, and backed up by legalised, safe abortion, induced abortion becomes a thing of the past.

This country has an admirable network of family spacing clinics. Unfortunately there is a reluctance to making these services available to unmarried women. The AIDS crisis has brought to the fore the risks of promiscuous relationships and has rightly made the condom freely available, even to students. It is equally important that in the context of health education, the risks of unwanted pregnancy and the evils of induced abortion are discussed. Women are now playing an increasingly important role in the development of this country. They may well be in their late teens by the time they complete Form 4 and they are no longer "school girls", but adults, and should be encouraged to be in complete control of their fertility.

Our analysis by parity suggests that abortion occurs more commonly in first pregnancies. However this appears to reflect the percentage of first pregnancies in the general population. A subsequent analysis of 600 consecutive deliveries in our hospital showed that there was a similar parity distribution to that of the abortions shown in the Figure. Unfortunately we were unable to look at the age distribution of our patients as this data was invariably not recorded in the notes.

In this study we were looking at the immediate complications associated with abortion. We should not forget the long term risks of ectopic pregnancy, which may be life threatening, and subsequent infertility. Both of these problems are associated with past episodes of genital tract infection.

Reference

1. Laferla JJ. Spontaneous Abortion. *Clinics in Obstetrics and Gynaecology*, March 1984.