# Demographic and Clinical Profile of Patients with Complicated Unsafe Abortion

AALIA TAYYBA, GUL-E-RAANA

## ABSTRACT

**Aim:** To describe the demographic and clinical profile of patients admitted as a result of complicated unsafe abortion.

**Design:** A case series

**Place and duration of study:** The study was carried out in the Department of Obstetrics and Gynaecology, Sir Ganga Ram, Lahore from August, 2008 to September, 2011.

**Methods:** Patients admitted with completed unsafe abortion were evaluated regarding age, parity, marital and educational status, indication for abortion, method used, qualification of abortion providers, contraceptive usage, complications and death rate in abortion seekers.

**Results:** Fifty-nine patients were admitted with complicated unsafe abortion. The mean age was 29 years, 95% were married and multi-parous, 40% had secondary and higher education, 85% approached unqualified abortion providers who used instrumentation in more than 40% of cases for termination of pregnancy resulting in visceral trauma. More than 50% were using contraception and 5% died due to postabortion complications.

**Conclusion:** Unsafe abortion is a major health problem. The associated morbidity is much higher than mortality. This study focus on the need of post abortion care and easy accessibility to contraception to improve quality of health.

**Keywords:** Abortion, unsafe, clinical profile

## INTRODUCTION

According to WHO, unsafe abortion is a procedure to terminate an unintended pregnancy undertaken either by individuals lacking the necessary skills or in an environment that does not meet basic medical standards or both[1,2].

It is difficult to establish exact incidence of unsafe abortion due to its controversy in terms of personal emotions, religious and cultural attitudes and ethical considerations. An estimated 19 million unsafe abortions occur worldwide, each year, resulting in the deaths of 68,000 to 70,000 women and many others suffer chronic morbidities. Many are permanent, like infertility, fistula and psychological sequel which are difficult to quantify[3,4].

Unsafe abortion is a preventable cause of maternal mortality and yet remains a significant cause in developing countries. Important causes of death after unsafe abortion are hemorrhage and infection[5,6].

The rate of unsafe abortion is much higher in countries with limited access to contraception and restrictive abortion laws and complications from such abortions account for most hospital admissions in gynecology wards. These complications are incomplete abortion, uterine trauma, abdominal visceral injury, infection, shock, anemia, DIC, and

thromboembolism. Complicated unsafe abortions have substantial detrimental consequences for society negatively affecting women, their families, public health system and economy[7].

There is also substantial evidence that unsafe abortion contributes to an increased risk of HIV, hepatitis B and C viruses along with other infections[8].

Induced abortion is illegal in Pakistan and is frequently performed in a haphazard, slipshod, illegal, secretive or deceptive manner by skilled and unskilled personnel under unhygienic conditions using crude instrumentation with due consequences for life and health of women involved[9].

The reasons for seeking abortions are poverty, overwhelming personal responsibilities, lack of contraceptive facilities, contraceptive failure and extramarital pregnancy[6].

Both medical and surgical methods are used for termination of pregnancy. In general, the earlier the abortion, the safer it is. Mortality and morbidity associated with the procedure increase with the duration of pregnancy at the time of termination[10,11].

The aim of this study was to describe the demographic and clinical profile of patients admitted as a result of complications of unsafe abortion.

## PATIENTS AND METHODS

This was an observational case series conducted at the Departmental of Obstetrics and Gynaecology

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*Dept. of Obs.& Gynae, Sir Ganga Ram, Lahore*
*Correspondence to Dr. Aalia Tayyaba Email: draalia1994@gmail.com*

Unit-II, Sir Ganga Ram Hospital, Lahore, from August, 2008 to September, 2011.

All the patients who were admitted with complicated unsafe abortion were included in the study. For data collection, a questionnaire was developed which contained both open and close ended questions. All the women were interviewed after taking informed verbal consent about age, marital status, parity, educational status, gestational age at which pregnancy was induced, indication for abortion, qualification of abortion provider, method used for termination of pregnancy, attitude towards contraception and complication with which they presented to hospital. For assessment of complications history was taken regarding vaginal bleeding, abdominal / pelvic pain, urinary / bowel complaints and fever. General physical, systemic and pelvic examinations were performed for making diagnosis of a specific complication. Relevant investigations like blood complete examination, urine examination, blood cultures, serum fibrinogen and fibrinogen degradation products, high vaginal swabs for culture and sensitivity, and ultrasonography of pelvis were performed.

Data was analyzed by using SPSS version-10. Descriptive statistics in terms of percentages were determined and chi-square test was applied to compare the frequency of complicated unsafe abortion between contraceptive user (Group I) and non-contraceptive user (Group-2) groups at p-value < 0.05 level of significance. Relationship between educational status and contraceptive use was also determined.

## RESULTS

During the study period, 468 women were admitted with abortion related complaints. Fifty-nine women out of 468 gave history of unsafe abortion comprising 12.6% of total abortions and showing the annual hospitalization rate of 14/100.

The age of patients ranged between showed that 3(5.08%) were unmarried while 56(94.9%) were married. The educational status of women was grouped in 3 categories i.e. illiterate, having primary education and secondary or higher education. Women with secondary or higher education presented more with complications 22(37.28%) compared to women with primary education 19(32.2%) or illiterate 18(30.57%). Fourteen (23.7%) pregnancies were terminated at a gestational age of 6 weeks or less, 21 (35.5%) between 6-8 weeks, 13(22.09%) between 9-12 weeks, 9(15.2%) between 13-20 weeks and only 2(3.38%) were terminated after 20 weeks of gestation.

With respect to their own reasons for abortion 24 (40.6%) were having financial problems, 18 (30.57%) were working women and an additional child would mean a time away from work and thus money, 11 (18.6%) were related to contraceptive failure. Three (5.08%) stated that they were sick and weak and 3 (5.08%) were unmarried who were ashamed of disclosing pregnancy.

Only 9(15.2%) abortions were induced by doctors, 26(61%) by lady health visitors and 24(40.6%) by Dais. Methods used for termination of pregnancy were dilatation and curettage in 28(47.45%) cases, herbal sticks in 21(35.59%) and medication in 10(16.94%) cases.

Out of 59 abortion seekers, 32(54.2%) were using contraception before conceiving and 27(45.8%) were not using contraception. The literate status of women was directly related to contraceptive use. Women having even minimal education were using some kind of contraception as compared to illiterate women (p-value <0.001, Table I).

The commonest complication was incomplete abortion 24(41%), visceral trauma in 19(32.2%), septicemia in 9(15%), pelvic inflammatory disease in 6(10.1%) and one (1.6%) patient had cardiac failure due to anemia. Three (5.08%) out of 59 patients died in spite of treatment. Causes were hemorrhagic shock, septic shock, renal failure, septicaemia and DIC.

Table I: Education status of abortion seekers between contraceptive users (Group I) and non-contraceptive users (Group-II)

| Educational status | Group I | Group II | n | P value |
|---|---|---|---|---|
| Illiterate | 2 | 16 | 18(30.5%) | < 0.001 |
| Primary | 11 | 8 | 19(32.20%) | NS |
| Secondary+ higher | 19 | 3 | 22(37.28%) | < 0.001 |

Level of significance for P-value is < 0.05

Table: Complications in unsafe abortion

| Complications | n |
|---|---|
| Incomplete abortion | 24(41%) |
| **Trauma** | **19(32.2%)** |
| -Uterine Perforation | 5(8.47%) |
| -Uterine perforation with bowl trauma | 8(13.5%) |
| -Uterine perforation with urinary tract injury | 2(3.38%) |
| -Cervical tear | 2(3.38%) |
| -Vaginal tear | 1(1.6%) |
| -Vesico vaginal fistula | 1(1.6%) |
| Septicemia | 9(15.1%) |
| Pelvic inflammatory disease | 6(10.1%) |
| Anemia and cardiac failure | 1(1.6%) |
| Total | 59(100%) |

## DISCUSSION

Unsafe abortion is an important public health problem and occurs practically in every society. The frequency and annual hospitalization rate from unsafe abortion varies globally depending upon contraception services, abortion laws, cultural and religious attitudes. The frequency of unsafe abortion is 12.6% of abortion related admissions in this study which is higher than that reported by Rana et al. and is 6% of total abortions[12]. The annual hospitalization rate from unsafe abortion was 14/1000 in this study which is double than that estimated by Singh. It is more than the reported 4-7/1000 in Pakistan, Nigeria and Philippines but comparable to 15/1000 in Egypt and Uganda[1].

All major studies in developing countries have shown that 43-95% of unsafe abortions are in young unmarried girls. [11, 13]This was also noticed in a study from the USA. But presently, 94.9% women were married which is similar to that reported in other studies carried out in Pakistan and Turkey.

The mean age in years is 29.14 years and the mean parity was 4, this is similar to other studies in which most women were in their third decade of life and multi-parous. Many women want to postpone the birth of child but do not use contraception either due to non-availability of services or lack of awareness. About 45.8% of women were not using any contraceptive measure before conceiving index pregnancy in this study. The situation is more disappointing in other developing countries, 66-85% in Nigeria, 70% in Turkey, and 60% in another Pakistani study[1,11,13].

No significant association was observed between the women's educational level and having an induced abortion in this data. This is similar to the observation by Grimes and Benson in Turkey but differs with Goyaux who observed that education level is lower in women who had induced abortion in African countries. Another important finding in this study was significant association of contraception use with educational status.

Unsafe abortion is a preventable cause of maternal mortality, and accounts for 13% of maternal mortalities in developing countries. Only 5.06% of deaths occurred in this series which is lower than that reported in other developing countries and ranges 9-13% in India, Bangladesh, Nepal, Sri Lanka, Nigeria and Pakistan. The maternal mortality in this study is probably underestimated due to limitation of available data and evidence which was collected only from patients presenting in hospital.

Morbidity due to complications of unsafe abortion is less reliable as many postabortion complications like anemia, genitourinary infections,

risk of infertility and psychological disturbances are not reported by patients. The common complications encountered in this study were incomplete abortion (41%), visceral trauma (32%) and sepsis (15%). The results correlates with those reported by Tayyab and Noor Jehan from Pakistan and Goyaux from Africa, which showed that major presentations after abortion are hemorrhage and sepsis. The complication noted only in Bangladesh is that 55% of women develop tetanus infection after induced abortion.

Unfortunately, hospital-based studies like this one, alone cannot asses the exact extent of morbidity and morality related to unsafe abortion in a county like Pakistan where private facilities treat a large number of women for post-abortion complications, therefore, for actual estimation, research in public and private sector is required.

Future research is definitely required and opinion surveys are suggested for asking about support for the legality of abortion and the use of misoprostol in termination of pregnancy.

Public health program should be launched on primary, secondary and tertiary prevention which can reduce unsafe abortion related diseases and deaths. Primary prevention includes promotion of contraceptive use by women (and men) at risk of unwanted pregnancy; secondary prevention involves the liberalization of abortion laws and access to safe abortion care in the country. In contrast, tertiary prevention includes the integration and institutionalization of post-abortion care. Efforts to address these problems will contribute both in reducing maternal mortality and achieving health developing goals.

## CONCLUSION

Unsafe abortion constitutes a major threat to the health and lives of women. This study highlights the need for post-abortion care to minimize morbidity and mortality till the legal abortion services are available and there should be easy accessibility to contraceptives to improve the quality of health.

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