AN UNUSUAL SELF-INVENTED METHOD OF UNSAFE ABORTION

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INTRODUCTION

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]. About 99% of these abortions are carried out in the developing countries [3].

About 890,000 induced abortions occur in Pakistan every year [3]. Most of the unsafe abortions are conducted by dais, lady health workers and untrained personnel. The procedures adopted by these individuals have been astonishing as well as alarming. The variety of unhygienic methods used, have led to diverse complications extending from local tears to life threatening septicaemias. The main purpose of this case report is to highlight the method of unsafe abortion that was used.

CASE REPORT

A young lady aged 30 years, from low socioeconomic group, presented to the gynae outdoors with pain lower abdomen of 25 days duration. The pain had aggravated for the last five days and was accompanied by fever and occasional vomiting. However she was passing stools and there was no abdominal distension or any urinary complaint. Infact the symptoms started immediately after she underwent induced/ unsafe abortion from a dai with 10 weeks amenorrhoea. She had five previous live births by spontaneous vertex delivery and this was an unwanted pregnancy. The couple had not been practicing any contraceptive method in the past. On examination she was a toxic looking lady, dehydrated and pale, with a temperature of 99^0 F. Abdominal examination revealed marked tenderness/ guarding in the hypogastrium and both iliac fossae, especially on the left side. The digital rectal examination was normal while the vaginal examination showed a patulous os with foul smelling discharge. The rest of the examination was normal. Her haemoglobin was 8.4 g/dl, total leucocyte count was 22.8 x 109/L with 84% neutrophils and the platelet count was 350 x 109/L. Serum urea, creatinine, electrolytes and bilirubin were normal. Serum alanine aminotransferase was 60 U/L and serum alkaline phosphatase 554 U/L with negative hepatitis B surface antigen and anti hepatitis C virus antibodies. The prothrombin time was 17 sec (control 14 sec), tissue thromboplastin time with kaolin 38 sec (35 sec) and plasma fibrinogen 230 mg/dl (normal 150-350 mg/dl). Ultrasonography abdomen and pelvis showed bulky uterus alongwith about 120 ml abnormal collection of fluid (pus ?) above the uterus and pockets of fluid in the left iliac fossa. The patient was placed on injectable antibiotics cefoperazone/ sulbactum (2 gram IV 12 hourly) with metronidazole (500 mg IV 8 hourly). Blood was arranged and after intravenous fluid resuscitation, exploratory laparotomy was planned. The abdomen was opened through lower midline incision and dense adhesions were encountered. The small gut was found plastered to the uterus and pelvic organs. By gentle sharp dissection the adhesions were separated and a long tube was found perforating through the fundus of the uterus with thick pus around it (Figure 1). The pus was also extending into the left paracolic gutter. It was evacuated and the tube removed. The small opening in the uterine fundus was not closed. The gut continuity was confirmed followed by thorough

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peritoneal lavage and tubal ligation. A drain (28 Fr Foley catheter) was placed in the pelvis and the wound was closed. However the skin was left open and was subjected to delayed primary closure. The post operative recovery was smooth and the injectable antibiotics were continued for five days followed by oral ciprofloxacin for five more days. The tube was opened and was found to be about 30 cm long portion of intravenous set which had been made rigid by a broom stick (jharoo ka tinka) (Fig. 2).

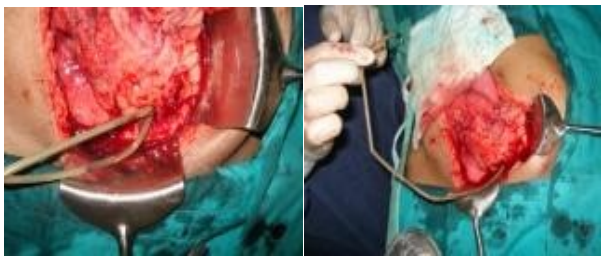

Figure 1: The tube being extruded out of the perforation site

Figure 2: The tube containing the rigid broom stick (*jharoo ka tinka*)

DISCUSSION

Unsafe abortion is illegal in Pakistan and frequently performed in a haphazard, slipshod, secretive, illegal or deceptive manner by skilled and unskilled personnel in unhygienic conditions threatening the life and health of the women involved [4].

An estimated 19 million unsafe abortions occur worldwide each year, resulting in the death of 68,000 to 70,000 women and many other suffer chronic morbidities. Maternal deaths attributed to the unsafe abortion are found to be 4.17% to 10.5% in various studies [4 - 7]. In Pakistan nearly all these unsafe abortions are performed by untrained, back street abortionists and victims are mostly poor, malnourished and anaemic ladies belonging to the underprivileged classes of the society. There are many doctors who decline to carry out any such procedure because of their religious or personal beliefs and the danger of having been labeled as an 'abortionist'. We highlight an interesting case in which the abortion was induced by a dai in a relatively different manner. She used a long (about 30 cm) tube which was a portion of intravenous set and it was made rigid by passing a broom stick (jharoo ka tinka) into its lumen. Interestingly the tube had been passed into the uterine cavity and was left as such. Even the patient did not know about the details of the procedure adopted by the dai.

In developing countries where sepsis ranks high amongst contributors to maternal morbidity and mortality and where risks of illegal abortion are superadded by religious probations on abortion, they are done by untrained personnel in unhygienic conditions. Once the interference is done, infection starts as endometritis involving endometrium and any retained products of conception [8]. If untreated infection spreads further into myometrium and parametrium, leading to peritonitis. In situations where the uterus is perforated, the main infection also starts in the peritoneal cavity resulting in abscess formation, adhesions, intestinal obstruction and peritonitis in acute phase and late sequel like pelvic inflammatory disease, adhesions and infertility can occur. The patient may develop bacteremia and sepsis at any stage of septic abortion.

About 90% of abortions are done in the first trimester of pregnancy and 9% in the second. The procedures adopted by trained doctors include surgical (suction curettage/ vacuum aspiration, dilatation and curettage, dilatation and evacuation, hysterotomy) and

medical (misoprostol, methotrexate, mifepristone RU 486). However the variety of methods used by the untrained staff is indeed interesting. They attempt for dilatation and curettage [9]. With various instruments and modified surgical termination. The methods of mechanical intervention are in vogue, intrauterine contraceptive devices, all sorts of wooden sticks, herbal sticks [4] and old historical laminaria tents [5] are being practiced in our country. These are forcibly pushed through the cervix into the uterus thus resulting in various cervical tears and uterine lacerations.

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