

MATERNAL NEAR-MISS IN A GREAT GRANDMULTIPARA FOLLOWING UNSAFE ABORTION: A FOCUS ON THE UNCOMMON CONTRIBUTING FACTORS

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ABSTRACT

Unsafe abortion and its complications have been limited to adolescents lacking family and partner support without attention to older, married women and their peculiarities regarding unsafe abortions. Main objective of the study was to focus on uncommon contributing factors to unsafe abortion in older women. A 40year old, great grandmultipara [Para 10⁺, 8 alive] with awareness on modern contraception underwent unsafe abortion following cultural and peer pressure influences, resulting in severe morbidity [severe anaemia, perforated gangrenous uterus and septicaemia] which necessitated exploratory laparotomy and subtotal hysterectomy. Adequate puerperal care, cultural re-orientation, review of information in family planning jingles and liberalization of abortion law will assist in preventing unsafe abortions among older women.

Key words:

Maternal near-miss, unsafe abortion, great grandmultipara, contributing factors.

INTRODUCTION

Unsafe abortion is the termination of an unwanted pregnancy performed by individuals lacking the necessary skills or in an environment that does not meet the basic medical standard or both.[1] Maternal morbidity and mortality is a major public health problem. WHO estimated about 19million induced unsafe abortions are performed annually resulting in 68,000 deaths equivalent to 1 in 8 of all pregnancy-

related maternal deaths.[2] The loss of reproductive life as a result of illness and death from unsafe abortion has been integrated into the disability burden of unsafe abortion as the disability adjusted life years [DALYs]. Estimates showed that a loss of about 5 years of productive years or 14% of all DALYs lost from pregnancy related conditions resulted from unsafe abortions.[3] Annually, 5 million women are admitted to hospitals for treatment of complications of unsafe abortion in developing countries; Africa has an average of 8.8/1000 while Nigeria has 5-6/1000 admissions[4]. Nigeria practices restrictive abortion law and complications of induced abortions account for 30-40% of maternal deaths.[5] Victims of unsafe abortion have been reported to be mainly young, unmarried, students who are usually unaware of contraception with a report that mainly young [<25 years old] females in Africa [6] are in greatest need of interventions to prevent unsafe abortion.[7] The excuses for unsafe abortion include potential for disruption of education, non readiness for marriage, parental non acceptance, denial of the pregnancy by the male partner and ignorance about contraception.

Case Presentation

A 40year old married, Para 10⁺ [8 alive] woman presented with fever, abdominal pain and passage of foul smelling vaginal discharge of six days duration. The fever was of high grade, persistent with abdominal pain which was initially in the suprapubic region but progressively became generalized. There was passage of foul smelling, copious, purulent vaginal discharge; she was passing flatus, no vomiting or diarrhea and last bowel motion was 72 hours before presentation. Onset of symptoms was preceded by termination of a 13weeks pregnancy; this was initially done by the apprentice of a drug store owner in her village using metallic instruments. This was followed by severe abdominal pain; she re-presented 24 hours later and had a repeat evacuation by the drug store owner using the same instruments. She was discharged home with analgesics and haematinics; but the symptoms worsened after the second procedure necessitating her presentation at this facility. The indication for the termination of pregnancy was due to peer pressure from her friends who insisted that she should no longer have children

since her first daughter had started having children. She was a poor antenatal attendee but had all except one of her deliveries in primary health care centers and private hospitals but insisted that she was never informed about family planning after delivery. She was informed about family planning through radio jingles but her friends discouraged her with tales of possible complications. The husband was also informed about family planning from radio jingles but did not discuss with his wife because he thought the woman should initiate discussions about contraception. She was a petty trader married to a peasant farmer and the first of two wives with eight surviving children [four males and four females], her last childbirth was three years prior to presentation. The second wife also had four children.

Examination at presentation showed that she was febrile [Temp 38.4°C], pale, and anicteric with no pedal oedema. The respiratory rate was 38 cycles per minute with vesicular breath sounds. The pulse rate was 118 beats per minute, regular with full volume and blood pressure 110/60mmHg. The abdomen was full, moved with respiration with tenderness over an abdominopelvic mass compatible with a 14 week size pregnancy; the liver and spleen were not palpable. There were no demonstrable ascites and bowel sounds were reduced. Pelvic examination showed copious purulent vagina discharge, the cervix and vagina wall were grossly normal on speculum examination. Digital examination showed cervical Os to be 2cm dilated with cervical excitation tenderness, the uterus was tender and bulky, there was tenderness in the left adnexium, the pouch of Douglas was not full. The assessment was suspected uterine perforation with septicaemia following induced unsafe abortion. She was admitted; the investigations showed Packed Cell Volume of 17%, urinalysis was normal while serum electrolyte and urea showed hypokalemia. A plain abdominal radiograph [erect and supine] did not show air under the diaphragm while an abdomino-pelvic ultrasound scan showed a bulky uterus with features suggestive of retained product of conception and an echogenic mass on the posterior uterine segment extending from the cavity through the myometrial wall as well as a mixed echogenic collection in the left adnexium with internal septations suggestive of an abscess collection.

She was resuscitated with three units of whole blood and potassium infusion to correct the hypokalemia. She was counseled for an exploratory

laparotomy and reviewed by the anaesthetist. Surgery was done under general anaesthesia and showed a perforation on the posterior wall of the uterine body measuring 5cm in diameter and walled off by the omentum [fig. 1]; the uterus was gangrenous including the left adnexium with 500ml of purulent material between the uterus, omentum and left adnexium, the right adnexium was normal and there were no bowel perforations. A subtotal hysterectomy with left salpingo-oophorectomy was performed with a pelvic drain left in situ. She had two units of blood transfused intra-operatively. The sample of the pus was taken for microscopy, culture and sensitivity and it showed growth of acinobacter sensitive to Imipenem and Ampicillin/Sulbactam.

Post operation, she continued her antibiotics and analgesics, the wound inspection showed purulent discharge with slough on the floor; the skin sutures were removed and she was commenced on twice daily wound dressing with to honey. The abdominal drain and nasogastric tube were removed on the fourth day post surgery and graded oral intake commenced which she tolerated. She improved significantly and was counseled on the findings at surgery, the procedure done and the implications on her reproductive capability. She was discharged home on the thirteenth day post operation. She was clinically stable on follow up visit two weeks after discharge from the hospital.

DISCUSSIONS

A case of maternal near-miss following unsafe abortion in a 40 year old great grandmultipara who was aware of contraception but was afraid to use it; she eventually got pregnant and was influenced by peer-pressure to procure an unsafe abortion due to cultural beliefs. This resulted in uterine perforation and gangrenous uterus necessitating and exploratory laparotomy and subtotal hysterectomy with post operation wound infection. The contributing factors in this case were inadequate puerperal counseling, inadequate information about contraception, cultural and peer pressure influences and the continuing activities of quacks.

Maternal near-miss refers to a woman who nearly died but survived a complication that occurred during pregnancy, childbirth or within 42 days of termination of the pregnancy[8] it is also referred to as severe acute maternal morbidity [SAMM]. It can result from various causes including complications of unsafe abortion as in Mrs. A.S.

Adequate puerperal care is an important component of postpartum care and consists of perineal care, breast care, contraception, diet, adequate rest and exercise.[9] Mrs. A.S did not receive contraception counseling despite having nine of her ten deliveries in health facilities; this showed the inadequacy of puerperal care. The effectiveness of the electronic media in creating awareness about contraception was demonstrated in the case presented; however, the content of the jingles need to be reviewed. The use of contraception has been reported to be limited by considerable misinformation especially on the side effects.[10] Although Mrs. A.S was aware of contraception; the perceived complications from her friends misled her to assume that no method was safe. Before now, peer pressure as a catalyst in unsafe abortion has been limited to adolescents; the case presented opens up cultural norms as another area of consideration. Among the Yoruba tribe to which Mrs. A.S belong, it is culturally regarded as a shameful act for a woman to have more children once her daughter has started bearing children; this coupled with the pressure from her age groups compelled her to seek pregnancy termination. This shows how some women may anchor strongly to traditional myths and cultural expectations regarding family, sexuality and fertility.[11] Unsafe abortion has been almost exclusively limited to adolescents; but the case presented showed that older women deserve similar attention as they can suffer similar severe complications seen in younger women. In a study among Scandinavian women, it was reported that although the rates of abortion in the 40-44 year old was relatively smaller, the literature has not focused on them; but there is potential for considerable improvements when attention is given.[11] The case of Mrs. A.S was similar to reports of Fawole et al in a study on complications of unsafe abortions in this centre which showed sepsis as the commonest complication in 92.7%, abscess collections in 64.9% and visceral injuries in 28.2% of women following unsafe abortions[12]. In addition, the ever increasing cases of quacks in Nigeria and other developing countries performing medical procedures of which uterine evacuation is one of the commonest calls for a strategic approach by the medical associations as well as other regulatory agencies in these countries. This provides another opportunity for the call for a review of the abortion law in such countries; although the result from nations where abortion has been liberalized vary, it is likely to provide the opportunity for skilled physicians to use their skill

thereby preventing the attendant morbidities and mortality.

We recommend the use of checklist to ensure adequate puerperal care before discharges after delivery, cultural re-orientation, review of information in family planning jingles to address their safety and a review of abortion law in the prevention of unsafe abortions among older women.

Figure 1:

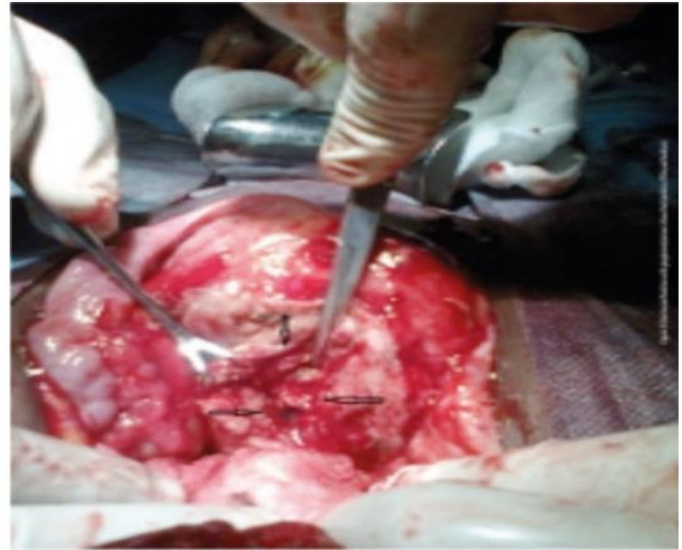


Figure 1: Showing perforation on the posterior wall of the uterus (arrows show the borders of perforation)

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