TERMINATION OF PREGNANCY

Dr. Nabila Kamil

Termination of pregnancy

Termination of pregnancy: is a decision taken by doctor due to abnormal pregnancy or its complication to ↓the risk in future to the mother.

1st trimester until 12 week: termination usually by surgical evacuation. (D&C) especially in cases of missed abortion, in complete abortion or if mother can`t continue her

pregnancy either due to **renal disease** end stage renal disease or heart disease specially. Grade ш and IV or fetus with multiple congenital abnormalities.

After full history and physical examination or incase of early pregnancy fetal infection transmitted from the mother in case of **Rubella Infection**. Before termination full investigation done like

1. RH., Blood group.
2. Hb, PCV as baseline IX and preparation of blood especially in cases of missed abortion to avoid complication if occur specially DIC.
3. Investigation done related to the cause like R.B.S, VDRL, and Toxoplasma test.

D&C Dilatation & Curettage: evacuation done under GA after full preparation of the patient with empty bladder put the patient in lithotomic position size of uterus<12 weeks. If cervix closes done dilatation by special dilator start from smaller one then evacuate uterus by sponging & curette.

Complication:

1. Bleeding if it severs may end with DIC especially in missed and septic abortion.
2. In complete evacuation.
3. Infection → sepsis → infertility in future due to tubal adhesion.

4. Uterine perforation and injury to adjacent organs especially to bowel in cases of missed & septic abortion.
5. Excessive curettage ended with intra uterine adhesion calls Asher man Syndrome.

6. Failure of the procedure: failure of dilatation especially in patient with pin point CX or excessive tightness specially in prime gravid
7. Post curettage pain.
8. Psychological upset due to fetal loss.

- Second trimester: between 12-24 weeks.

Indication:

1) Multiple fetal malformations.
2) Fetal death.
3) Early rupture membrane with chorioaminonitis.
4) Complicated medical disorders that mother cannot continue the pregnancy due to the risk on her life.

There are 2 options for this:

A. Medical T.: use of potent

1. Prostaglandin (PGF 2α) given vaginally 1mg as vaginal pessory 3 hr. only for five doses. Induce active contractions and provokes miscarriage.

2. Mife pristone 200 mg orally (24-36)hr. before the PGA administration may significantly shortens the induction delivery interval.
3. Oxytocin (pitocin): induce uterine contraction like in normal labour by good titration in dilated fluid.

Risk of Oxytocin in general:

- Hyper stimulation of uterus due to excessive uterine contraction may be rupture uterus.
- Fetal hypoxia & distress.
- Hyperosmolar syndrome due to osmotic swelling of R.B.C leading to jaundice (water intoxication) in fetus.

B. **Surgical treatment:** here it's more hazards proportionate to the gestational age because the fetal parts are bigger and the risk of tearing the cervix or damaging the uterus is greater.

So the cervix should be prepared with P/G for softening and dilatation of the cervix or by dilapin (absorbs moisture and swells up over (8-12) hr. under u/s guide. Oxytocin (syntocinoun is used to ensure the uterus is contracted after delivery.

Termination from 24 weeks until onset of labour:

- This called elective termination of pregnancy by induction of labour.

Indication of induction:

A. Maternal causes

1. PET
2. D.M
3. Prolong pregnancy.

4. Rh. In compliably.
5. Infection.
6. Auto immune disease.
7. APH
8. Malignancy
9. PROM

B. Fetal

1. IU.D
2. Congenital abnormality
3. Unstable lie
4. IU.G.R
5. Fetal infection (sepsis).

Methods of induction:

1. Surgical method (artificial rupture of membrane).
2. Medical methods (PG & Oxytocin).
3. Mechanical.

2. SURGICAL(AMINOTOMY) complication:

1. Fetal injury.
2. Maternal injury.
3. Cord prolapsed
4. Accidental hemorrhage
5. Infection.
6. Amniotic fluid embolism.
7. Feta distress.

2. Medical method:

Oxytocin: by increasing the rate of Oxytocin infection at interval of (15-20 mint). Infusion commenced at 1mu/mint and doubled every 20 mint.

- PG.
- Rout → oral, I.V, gel, pessary extra amniotic for ↑cervical softening and ripening especially vaginally.
  PGE2→↑uterine sensitivity to Oxytocin.
- Mife pristone.

- Used for softening and dilating the pregnant CX. Prior to surgical evacuation and produce complete abortion in 85% of cases if used up to 7weeks amenorrhea. Its anti progesterone.

3. Mechanical: By dilating cervix by using folly catheter.
4. Inter course & nipple stimulation→ release of Oxytocin

CI of induction:

- CPD.
- Placenta previa. (Grade III &IV).
- Fetal distress.
- Sever IU.GR (end stage) cannot tolerate induction).
- Previous scar
- Multiple pregnancies.

- Assessment of patient suitable for induction, by Abd examination for size of baby and engagement. Bishop score > 4. Exclude any element of pelvic contraction like flat sacrum, palpable promontory of sacrum, narrow subpupic arch, and prominent Ischia spine.

CI of induction:

1. Fetal distress.
2. ↑ C/S rate.
3. PPH.
4. Rupture uterus.
5. Maternal distress.
6. ↑ Rate of assisted delivery.
7. ↑ Risk of infection.

- Other method termination by caesarean section (C.S)

1. Elective C/S done at appropriate time for both patient and surgeon.
2. Emergency C/S not appropriate time.

Classical C/S upper segment indication:

1) Preterm delivery with poorly formed lower segment.
2) Premature rupture of membrane, poor lower segment with transverse lie with Bach inferior
3) Large cervical fibroid

4) Sever adhesion in lower segment.
5) Post mortem C.S.
6) Placenta previa with large vessels in lower segment

Lower segment:

I. Lower transverse
II. Lower vertical

lower transverse: commonly used due to less dissection of the bladder and less blood loss with ↓incidence of rupture uterus in subsequent pregnancy.

- lower vertical incision (De lee`s incision) when there's poorly formed lower segment.

C of C/S:

1. C of anesthesia like failure of intubation, difficult intubation, Mendelssohn syndrome

2. Bleeding.
3. Injury to adjuster organs like bladder, bowel ureter.
4. Infection.
5. PPH
6. Thromboembolism.
7. Wound infection.

Indication of C/S

- In labour:
  - Fetal or maternal distress.
  - Obstructive labour.
  - Cord prop lapse.

- Not in labour:
  - Fulminate PET
  - Previous successful repair for vesico vaginal fistula or prolapse.
  - Previous IU.GR.
  - Premature breech.

*hysteretomy→ mini C/S >24 week <36 weeks