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A Seven Year Review of the Management of Abortion Cases in Kogi State Specialist Hospital, Lokoja, Nigeria

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Abstract: Despite restrictive abortion law in Nigeria, unsafe abortion for unintended pregnancies is on the increase and remains a serious concern to the health of women. The aim of this review is to highlight the management outcome of abortion cases in a tertiary health facility in a developing nation. The study was a retrospective review of demographic characteristics of patients, clinical presentations, diagnosis and treatment of abortion cases managed at the Kogi State Specialist Hospital, Lokoja, Nigeria between January 1, 2012 and December 31, 2018. Data collected were analysed using SPSS window version 20.0 statistical package. A total of 233 abortion cases were managed. Out of these 62 (26.6%) cases were from complications from induced abortions while 171 (73.4%) were other types of abortions. Majority of the patients were between 26 - 30 years (39.3%) of age. Majority of the induced abortion cases were done by Christian faithful 54 (60.6%) while 35 (39.3%) of the patients were Muslim. About 79 (88.7%) of the patients were married while 10 (11.3%) were single. All patients had standard abortion care services. There was no case of maternal mortality from abortion complications throughout the seven years under review. Unsafe abortion for unintended pregnancies remains a reproductive health problem among our women and improvement in access to contraception services, provision of safe abortion and post abortion care services may help reduce maternal morbidity and mortality.

Keywords: Unintended Pregnancy, Unsafe Abortion Complications, Management, Prevention, Developing Nation, Lokoja, Nigeria

1. Introduction

Despite restrictive abortion law in Nigeria, unsafe abortion for unintended pregnancies is on the increase and remains a serious concern to the health of women. Abortion is defined as extraction or expulsion of product of conception before the age of viability [1]. Abortion is broadly classified into induced, spontaneous, recurrent and tubal abortions. Induced abortion in developed countries is extremely safe. Sadly, illegal unsafe abortion remains a major contributor to maternal morbidity and mortality on global basis which is high in developing countries. The common clinical presentations are those of amenorrhea, vaginal bleeding, lower abdominal pain, fever and foul smelling vaginal discharge. Complications do increase with older age, multiparty and increasing gestational age. Complications of abortion especially induced abortion are usually categorised into those which occur immediately at the time of the procedure and those which occur subsequently. The common complications include anaemia from haemorrhage, perforation, retained products of conception and sepsis. Abdominopelvic ultrasound scan is a common diagnostic tool and surgical evacuation of the uterus is a standard treatment.

Abortion in Nigeria is governed by two laws that differ depending on geographical location. Northern Nigeria is governed by the penal code and southern Nigeria is governed by the criminal code. The only legal way to have an abortion in Nigeria is if having the child is going to put the mother's life in danger [2].

The study of long term complication of abortion is challenging and has been limited by data and the limitations of study design.

Induced abortion is one of the most commonly practiced

gynaecological procedures in the UK. Surgical abortion by vacuum aspiration or dilatation and curettage was the main method from 1990s, with introduction of vacuum aspirations and flexible catheters forming the turning point in practice by reducing volume of blood loss and perforation risk.

In the late 1980s and 1990s, some exciting new development in medical methods for terminating mid-trimester abortion with introduction of Mifepristone, one of the most significant developments in fertility control of recent years. The result has been an ever-evolving extension of patient choice and a diversification in the provision of abortion services with emphasis on safety and efficacy with widened opportunity for delivery within hospital setting. In 2009, 189,100 abortions were performed in England and wales [3] and there were 13,000 abortions in Scotland [4]. Both rates showing a decrease on previous years for the first time. Around one in three British women will have had an abortion by the age of 45 years. In the UK, over 98% of abortions are undertaken on the grounds that the pregnancy threatens the mental or physical health of the woman or her exiting children. A minority of abortions are undertaken because of the fetal abnormality, multi-fetal pregnancy reduction and selection termination for abnormality and the special legal, ethical and service issues relating to these merit separation consideration [3]. Gestational age is a major determinant of the options available for abortion and a decision is usually reached by the woman in consultation with her medical carer and pregnancy counsellors.

In Nigeria, unsafe abortions alone accounts for about 10-14% of maternal morbidity and mortality [5-7]. It is estimated that 1.25 million induced abortions occurred in Nigeria in 2012, equivalent to 33 abortions per 1000 women aged 15-49 years. The estimated unintended pregnancy rate was 59 per 1000 women aged 15-49 years; 56% of these unintended pregnancies ended in abortion. About 212,000 women were treated for complications of unsafe abortion, representing a treatment rate of 5.6 per 1000 women of reproductive age and an additional 285,000 experienced health consequences but did not receive the treatment they needed [2]. Abortion has been a great challenge in developing countries like Nigeria due to restrictive abortion law. Quackery practices have increased maternal morbidity and mortality and thus make abortion unsafe and life threatening. Currently about 75% of global maternal deaths are due to unsafe abortion. The high incidence in Nigeria is likened to lack of adequate health care resources and infrastructure, restrictive abortion law and religion beliefs.

In Nigeria, about 40 million women are in their child-bearing ages and the country accounts for about 2.4% world population, however unsafe abortions and pregnancy related deaths in Nigeria results to about 10% of global deaths [4], this therefore suggest that incidence of unsafe abortion is high in Nigeria.

In spite of the restrictive abortion law in Nigeria the levels of unintended pregnancy and unsafe abortion continue to be high in Nigeria. Perhaps improvement in access to contraception services, provision of safe abortion and post abortion care services may help reduce maternal morbidity and mortality [1, 2]. The aim of this review is to highlight the pattern of presentation, diagnosis and treatment of abortion cases in a tertiary health facility in a developing nation.

2. Methods

The study was a seven year retrospective review of abortion cases managed at the Kogi State Specialist Hospital, Lokoja, Nigeria between January 1, 2012 and December 31, 2018. Medical records of the available case files of abortion cases managed in the hospital within the study periods were retrieved manually and data on the demographic characteristics of patients, pattern of presentation, diagnosis, treatment and outcome were collected for analysis using SPSS window version 20.0 statistical package (IBM corp. Released 2011. IBM SPSS Statistics for windows, version 20.0 Armonk, NY: IBM corp).

3. Results

In the seven years period, review of abortion cases managed between January 2012 and December 31, 2018 was carried out, 233 abortion cases were managed in Kogi State Specialist Hospital, out of these, 62 (26.6%) cases were complications from induced abortions. While 171 (73.4%) were other types of abortions. However, eighty nine case files were available for review.

Majority of the patients were between 26-30 years of age which constitute 38.2%, followed by 31-35 years which were 20 (22.4%). One patient was between 10-14 years of age which constitutes 1.1% (Table 1).

Table 1. *Age distribution of abortion cases.*

Age	Frequency	Percentage
10-14	1	1.1
15-20	5	5.6
21-25	16	17.9
26-30	34	38.2
31-35	20	22.4
36-40	12	14.6

Majority of the abortion cases were procured by Christian faithful 54 (60.6%) while 35 (39.3%) were Muslim. Nullipara, 32 (35.9%) were the leading parity followed by pramipara, 25 (28.1%). The parity distribution of the patients is shown in Figure 1.

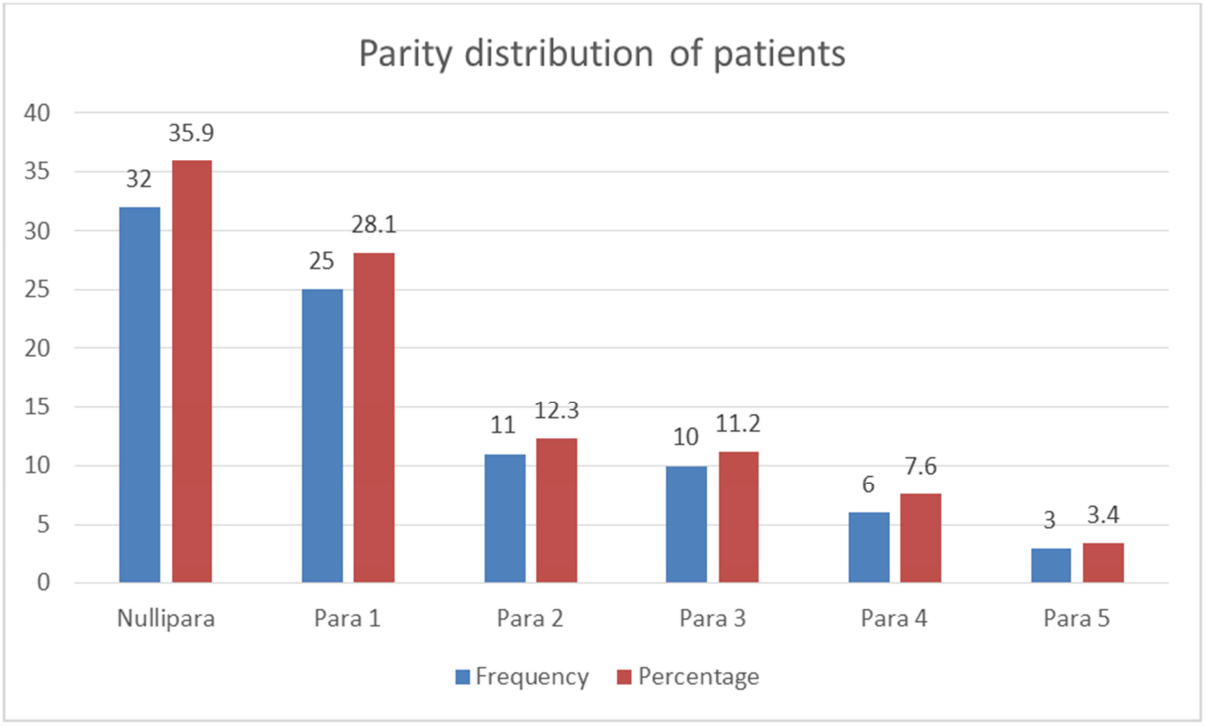

Figure 1. *Bar chart of parity distribution of patients.*

About 79 (88.7%) of the patients were formally married while 10 (11.3%) were single. The occupational status of the patients is captured in Figure 2. Housewife were the majority accounting for 22 (24.7%), followed by students 15 (16.8%) and applicants accounted for 11 (12.3%).

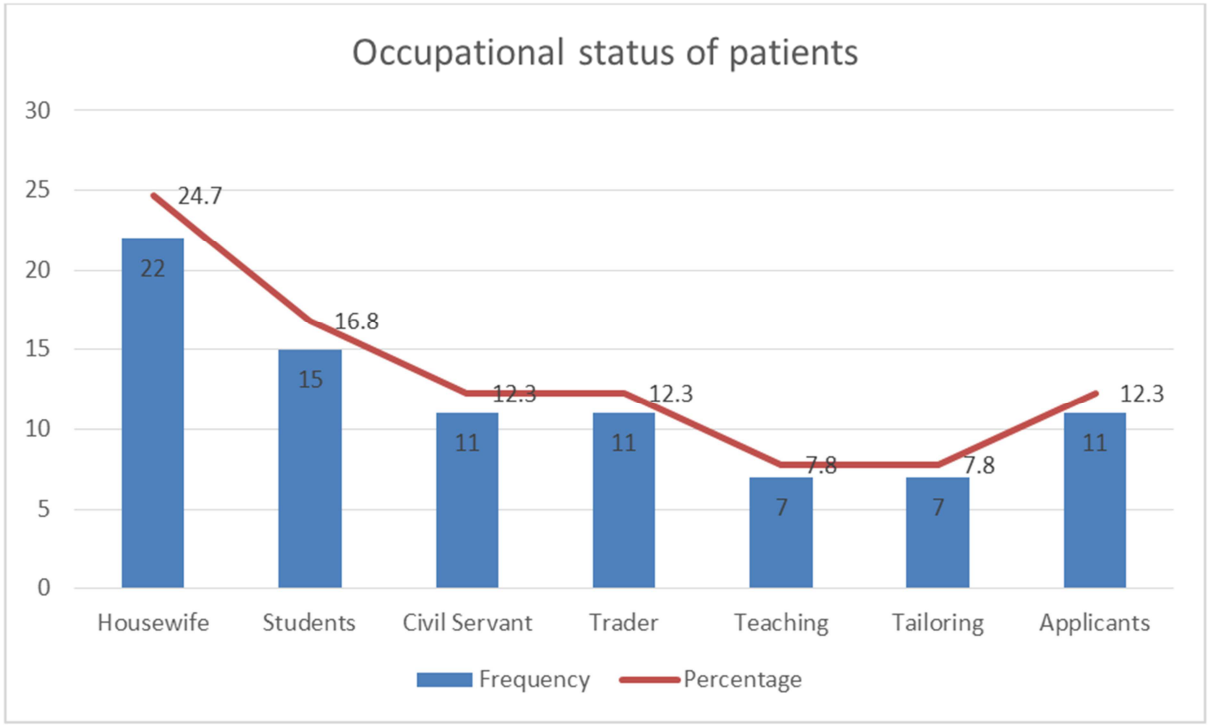

Figure 2. *Combo chart of occupational status of patients.*

There was poor data collection on the educational status of the patients. In 70 (78.7) of the cases educational status of the patients were not captured. Out of the nineteen captured, 18 (20.2%) had tertiary education while 1 (1.1%) had primary education (Figure 3).

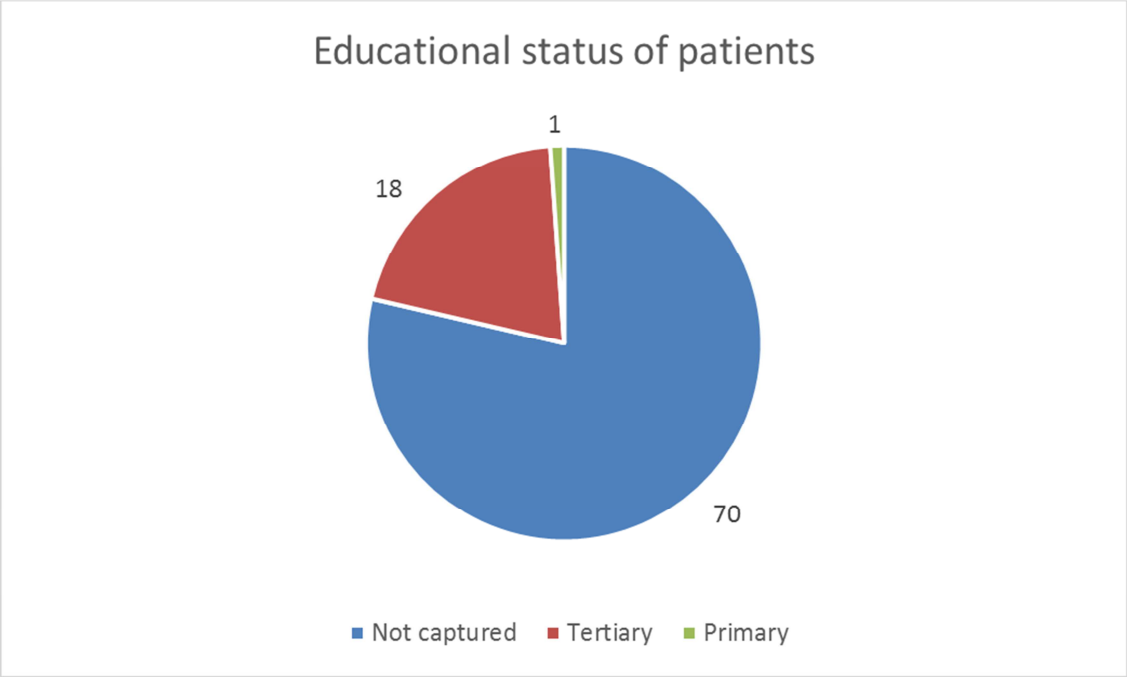

Figure 3. *Pie chart of educational status of patients.*

Majority of the abortions occurred in the second trimester 49 (55.1%) while 37 (41.6%) occurred in the first trimester. Only 3 (3.3%) of them were not known.

The types of abortion managed are shown in Figure 4. Majority 58 (65.1%) of cases were induced abortions, followed by missed, incomplete and threatened abortion 11 (12.3%), 9 (10.1%) and 9 (10.1%) cases respectively.

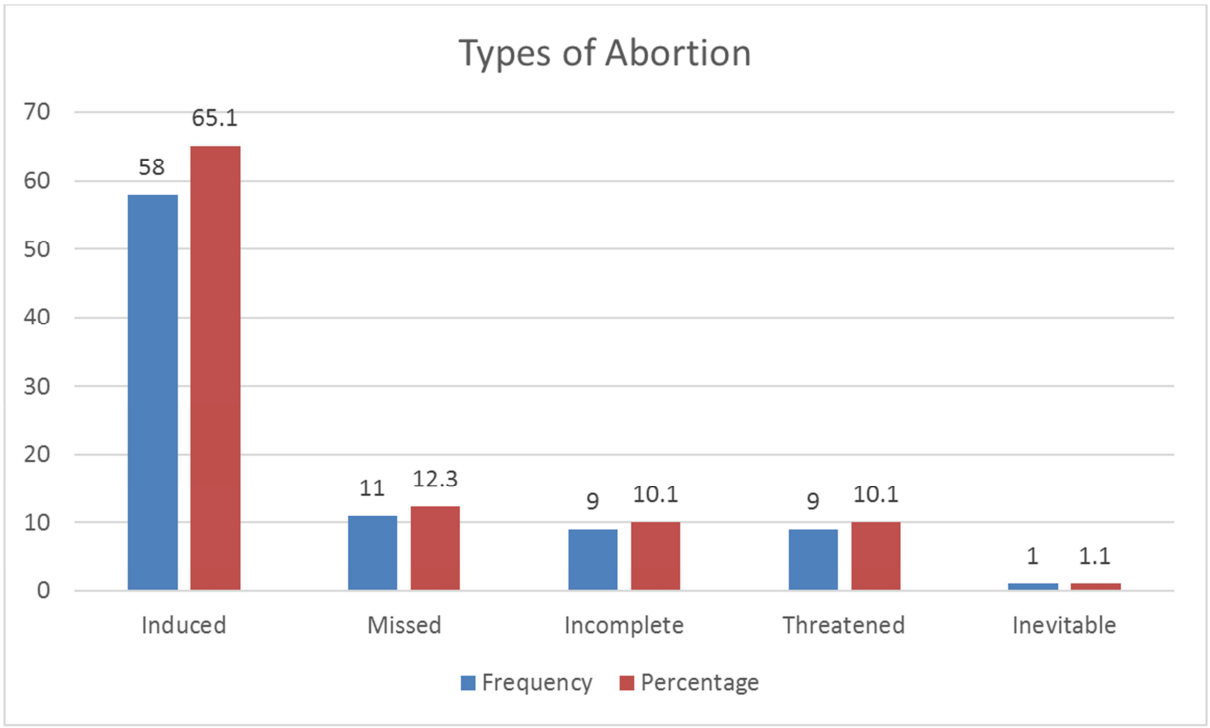

Figure 4. *Bar chart of types of abortions.*

During the period of review, we had four maternal mortality cases. Two were from postpartum haemorrhage, one caused by puerperal sepsis and one due to sickle cell crises in pregnancy. There was no case of maternal mortality from abortion complications managed within the review period. However, there was one case of near-miss event due to post abortion sepsis from induced abortion in a 24 year old nullipara. Common presentations were those of amenorrhea,

vaginal bleeding, lower abdominal pain, fever, foul smelling vaginal discharge and anaemia. Abdominopelvic ultrasound scan was the common tool for diagnosis and surgical evacuation of the uterus was the common mode of treatment. Common complications were anaemia, retained products of conception and sepsis. Post abortion care services included support and contraception. Medical record keeping was poor in both completeness and quality.

4. Discussion

In the review of abortion cases in Kogi State Specialist Hospital, Lokoja, Nigeria over seven years period between 2012 and 2018, 233 abortion cases were managed but only 89 case files were available for review due to poor record keeping and change from paper record to ICT record system. Despite the poor record keeping observed, out of 233 cases of abortion, 62/233 (26.6%) were complications from induced abortion while 171/233 (73.4%) were other types of abortions. This is not surprising as 76,000 induced abortions are performed annually in Nigeria [8]. However, 89 case files were available for review.

Majority of the patients were between 26-30 years of age which accounted for 34/89 (38.2%). This falls within the reproductive age group of 15-49 years. This is higher than 32.5% found in Abakaliki in Nigeria [9]. One (1.1%) patient was between 10-14 years of age which is unusual findings as this age does not fall within the routine reproductive age group of 15-49 years.

Most induced abortion cases were procured by Christian faithful accounting for 54/89 (60.6%) while 35/89 (39.3) were Muslim. This findings shows that abortion especially induced abortions abound in both major religions despite the restricted abortion law in Nigeria. Numerous religious traditions have taken a stance on abortion but few are absolute [10].

Nulliparous patients formed the majority of the patients as seen in Figure 1 where 32/89 (35.9%), followed by primiparous which was 25/89 (28.0%) while para 5 were 3 in number accounting for 3.3%. Majority of the patients were formally married 79/89 (88.7%) while 10 (11.3%) were single. These findings did not agree with 32.5% in other studies [11, 12]. Moreover, this is a retrospective study of all types of abortion under the years of review and not just pure induced abortion.

Majority of the patients captured in this study had no occupation other than housewife which constitute 22/89 (24.7%), followed by students of 15/89 (16.8%) and applicant 11/89 (12.3%). This finding did not agree with study done in Lagos and Tanzania where students were the majority [13, 14] as seen in Figure 2.

There was poor record keeping on the educational status of the patients. 70/89 of the patient educational status was not captured. Out of 19 captured, 18/19 (94.7%) had tertiary education while 1/19 (5.2%) had primary education. This is not surprising as most tertiary students will not want to retain unintended pregnancy for fear of interruption of their studies.

Majority of the abortion took place in the second trimester 49/89 (55.1%) while 37/89 (41.6%) took place in the first trimester. Second trimester abortions carry relatively more risk and account for a greater proportion of complications than first trimester abortion even in the best of hands. This figure is higher than the 10-15% globally and still higher than 19.2% in the study done in Ethiopia [15].

Induced abortion were 58/89 (65.1%), followed by missed abortion and incomplete abortion which were 11/89 (12.3%) and 9/89 (10.1%) respectively. These findings are not different as induced abortion is one of the most commonly practiced gynaecological procedures in both developed and developing countries. Common presentations were history of amenorrhea, vaginal bleeding, lower abdominal pain, fever and foul smelling vaginal discharge. The common complications were anaemia, sepsis and retained products of conception. There was nothing unusual about these findings and are in keeping with literatures.

Abdominopelvic ultrasound was the main tool for diagnosis of incomplete abortion and evacuation of the retained products of conception is the common mode of treatment. The main stay of post abortion care were supports and contraception.

During the period under review, there were four maternal mortality cases. Two were caused by primary postpartum haemorrhage, one was caused by puerperal sepsis and one was from sickle cell crises in pregnancy. There was no case of maternal mortality due to abortion complication, rather one near-miss event due to post abortal sepsis from induced abortion.

In conclusion, induced abortion rate of 73.4% found in this study is high and remains a practice among married women in 88.7% of cases and christians in 60.6% of patients. Agreed, levels of unintended pregnancy and unsafe abortion continue to be high in Nigeria. Improvement in access to contraception services, provision of safe abortion and post abortion care services may help reduce maternal morbidity and mortality.

5. Limitations of the Study

1. The small sample size of patients in the current study cannot be considered representative of the women in Nigeria.
2. The study is retrospective in nature and lack of exhaustive registers in the gynaecological unit limit the data available, therefore the findings are not representative enough and there may be need for a prospective study for adequate capture of abortion data in the center.
3. This is an institutional study, quality of care given may be suboptimal, though in this study no maternal mortality was recorded. Data on post abortion morbidity were not available. Introduction of institutional abortion register may be an asset for future study.
4. Majority of the case files could not be retrieved due to poor record keeping of the system. This might not

repeat its self as the current data keeping is computerised.

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