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Management of Complications of Induced Abortion at the Gynaecology-Obstetrics Clinic of the Sylvanus Olympio University Hospital (Lome-Togo)

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Abstract

Introduction: The objective of this study is to describe the management of complications of induced abortion in the Gynaecology-Obstetrics clinic of the Sylvanus Olympio University Hospital. **Methods:** This is a descriptive cross-sectional study of patients admitted to the gynaecology-obstetrics clinic of the CHU-SO in Lomé between 1 August 2017 and 31 July 2022 (5 years) for complications of induced abortion. The records of patients who presented complications related to induced abortion during our study period were included. Our sample was exhaustive and included patients who met our inclusion criteria. **Results:** We recorded 20.2% complications of induced abortion. Drugs were used in 52.9% of patients. Toxic substances were used in 14.4% of cases. Foreign bodies were used in 7.1% of cases. The average time to onset of complications was 09 days. Haemorrhagic complications occurred in 88.6% of patients. Infectious complications were dominated by endometritis (22.9%). Uterine perforation was recorded in 07% of cases. Surgical treatment was given in 52.8% of cases, including hysterotomy in 7.1%. The average time to surgery was 11 hours 48 minutes. Contraception was used in 52.9% of cases. The case fatality rate was 8.6%. **Conclusion:** With all of this complications, induced abortion is a major factor in morbidity and mortality in women of childbearing age, compromising the obstetrical future of patients. A legal framework is needed in our country to avoid the sometimes fatal complications of induced abortion.

Keywords

Care, Induced Abortion, Death, Togo

1. Introduction

Approximately 73 million induced abortions are performed each year worldwide [1], and 13% of deaths in pregnancy are due to unsafe abortion [2]. In countries where abortion is legal, complications are rare. Most of these deaths occur in countries where abortion is highly restricted or illegal. In developing regions, 220 women die for every 100,000 unsafe abortions [3]. One third of all unsafe abortions were carried out in the most dangerous conditions, *i.e.* by people with inadequate training in this field and using dangerous and invasive methods [4]. In Togo in 2018, according to DHIS2 data, 8933 cases of abortion were recorded, of which 1700 were voluntary terminations of pregnancy [5], and abortion-related complications accounted for 16.9% of maternal deaths [6]. The components common to all aspects of reproductive health include family planning (FP) and post-abortion care (PAC). Despite the availability of these measures, we are still witnessing an upsurge in the number of cases of induced abortion in gynaecology and obstetrics clinics, not to mention the complications that can sometimes result in death. The way in which complications of abortion are managed has evolved, helping to reduce maternal mortality due to abortion. From digital curage and curettage under local anaesthetic or sedation, we have moved on to manual intra-uterine aspiration under local anaesthetic or even simple medical treatment: this has improved the quality of care and services. The length of hospitalisation has been reduced from a few days to a few hours, making it possible to provide outpatient care [7]. Studies on abortion and its complications [8]-[11] have been carried out in Togo, but not specifically on induced abortion and its complications. In order to take stock of the cases of complications of induced abortion received and their management at the gynaecology-obstetrics clinic of the Sylvanus Olympio University Hospital Center (CHU-SO) in Lome, we initiated this study, the general aim of which is to describe the management of complications of induced abortion at the gynaecology-obstetrics clinic of the CHU-SO in Lome.

2. Methods

This is a descriptive cross-sectional study conducted among patients received at the Gynaecology-Obstetrics clinic of the CHU-SO of Lome between 1st August 2017 and 31 July 2022 (5 years) for complications of induced abortion. The records of patients who presented complications related to induced abortion during our study period were included. Our sampling was exhaustive and concerned patients who met our inclusion criteria. The variables studied were epidemiological, clinical and therapeutic. The data were processed and analysed using Excel and Epi info version 7.2 software. The results were considered

significant for a p value < 0.05. Patients' anonymity was preserved. An agreement of the ethical committee and an authorization N˚1078/2022/MSHPAUS/CHU-SO/DIR/DRH/SERV.PERS. of the Direction of the CHU-SO were also obtained.

Operational definitions

- Foreign body: This refers to the stem of a manioc plant or other local plants or a metal object that can be introduced into the uterus.
- Toxic substances: These are cocktails based on potash and lemon, potash and "Guinness", or bleach solution.

3. Results

3.1. Frequency

We recorded 347 cases of abortion, including 70 complications of induced abortion. This represented 20.2% of all abortion cases.

3.2. Socio-Demographic Characteristics

The average age of the women was 23.06 ± 5.87 years, with extremes of 15 and 42 years. Single women accounted for 60%. They had secondary education in 54.3% of cases and were retailers in 21.4% of cases.

3.3. Age of Terminated Pregnancy

The mean age of the terminated pregnancies was 12.8 ± 5.1 SA with extremes of 5 SA and 28 SA. Fifty-one point forty-two percent of patients had pregnancies between 10 and 14 SA (Table 1).

Table 1. Distribution of patients by age of pregnancy.

	Number	Percentage
<10 SA	19	27.1
[10 - 14[	36	51.4
≥	12	17.1
Unknown	3	4.3
Total	70	100.0

3.4. Reasons for Abortion

Fear of parents and studies were the main reasons for abortion in 35.7% and 31.4% of patients respectively (Table 2).

Table 2. Breakdown of patients by reason for abortion.

	Number	Percentage
Parents	25	35.7
Studies	22	31.4

Continued

Professional reasons	8	11.4
Close pregnancy	7	10
Infidelity of the father	6	8.6
Lack of financial means	5	7.1
Refusal of sire	4	5.7
Contraception failure	3	4.3
Sexual assault	1	1.4

3.5. Provide a Qualification

Paramedics had performed the abortion for 48.5% of patients. (Table 3).

Table 3. Distribution of patients according to abortion provider.

	Number	Percentage
Paramedics	34	48.5
Herself	31	44.3
Traditherapists	3	4.3
Doctor	2	2.9
Total	70	100.0

3.6. Procedure Used for Abortion

Medications were used by 52.9% of patients; curettage in 24.3%; followed by manual intrauterine aspiration in 14.4% of cases and toxic substances in 14.4% of cases. Foreign bodies were used for abortion in 7.1% of cases.

3.7. Complications of Abortion

- Time to onset of complications

The average time to onset of complications was 9 days, with extremes of 24 hours and 2 months. In 63% of cases, complications appeared within 07 days post-abortion, in 23% of cases within 14 days, and 14% of patients presented complications after 02 weeks.

- Types of complications

Haemorrhagic complications were found in 62 patients (88.5%), infectious complications in 38.6%, traumatic complications in 11.4% and intoxication complications in 4.3% (Table 4).

Table 4. Distribution of patients according to complications.

	Number	Percentage
Haemorrhagic complications		
Retention of placental debris	54	77.1

Continued

Uterine perforation	7	10
Déchirures cervicales	1	1.4
Infectious complications		
Endometritis	16	22.9
Pelviperitonitis	07	10
Acute generalised peritonitis	03	4.3
Sepsis	01	1.4
Traumatic complications		
uterine perforation	07	10
cervical tear	01	1.4
Poisoning complications		
Ingestion of toxic substances	03	4.3

3.8. Management

Patients were managed with a surgical component and a non-surgical component.

The debris collected after manual intrauterine aspiration (MVA) was all sent to pathology.

- Non-surgical care

All patients had received antibiotic therapy. Uterotonics were used in 61.4% of patients (Table 5).

Table 5. Distribution of patients according to medical treatment.

	Number	Percentage
Antibiotics	70	100.0
Fluids	66	94.3
Antianemics	63	90.0
Utero-tonics	43	61.4
Contraceptive method	37	52.9
Transfusion	27	38.6
Digital curage	20	28.6
Anti-D immunoglobulin	1	1.4
Oxygen therapy	1	1.4

3.9. Surgical Management

Thirty-seven patients underwent surgical treatment (52.8%), 40% of whom underwent MVA. The mean time to surgery was 11 hours 48 minutes, with extremes of 1 hour 30 minutes and 4 days (Table 6).

Table 6. Distribution of patients according to surgical method.

	Number	Percentage
Manual intrauterine suction	28	40.0
Hysterography	5	7.1
Exploratory laparotomy + wash + drainage	2	2.9
Hysterectomy + wash + drainage	1	1.4
Trachealography	1	1.4

3.10. Elements Found during Exploration

Retained placental, trophoblastic or ovarian debris was found in 28 patients (40%), followed by uterine perforation in 05 patients (7.1%). One patient presented with ischaemic necrosis of the uterus accompanied by pus and cervical tearing.

3.11. Outcome of Treatment

Outcomes were favourable in 64 patients and 06 patients died (8.6%). Sepsis was the most likely cause of death in 4 (5.7%) patients, followed by anaemia and substance intoxication in 1.4% of cases. Of the 6 patients, one had undergone hysterectomy and the other five were admitted in shock and had been resuscitated unsuccessfully. Acute renal failure occurred in 2 patients and liver failure in one.

4. Discussion

Limitations of the study: The sociocultural stigma surrounding abortion. Indeed, voluntary termination of pregnancy is not permitted in the country. As a result, there is a shortage of cases. The only patients we received were those who had complications, and some of these would probably have died from abortion complications before arriving at the CHUSO, the national referral center or would have been cared for in other health facilities. But this study will have had the merit of highlighting the various complications of abortion, and will open the way to multicentre studies.

Induced abortions accounted for 20.2% of all abortions received at the Gynaecology-Obstetrics clinic at the CHU SO. This result is almost similar to that reported by Diallo *et al.* [12] in Guinea Conakry in 2016, which was 17.2%. This non-negligible frequency of induced abortion in our series could be explained by various reasons, including patients' lack of knowledge or prejudice about contraceptive methods, the fact that voluntary interruption of pregnancy is not legalised in Togo, and above all fear of reprisals and rejection by parents (fear of parents: 35.7%) or society (pregnancy outside marriage is considered a sin or a family dishonour). The mean age of the patients was 23.06 ± 5.87 years, with extremes of 15 and 42 years. Essie *et al.* [13] in 2020 in Brazzaville reported an average age of 25 ±6.6 years. Young women are more prone to induced abortion. This may be due to their high fertility rate, and also to a lack of sex education, sex

being a taboo subject in our society. Most of the time, we hesitate to talk about it within the family. It's true that school curricula now include sex education, but we don't think that's enough. Haemorrhagic complications were in first place, with retained placental debris (68.6%). Laghzaoui [14] in Morocco reported trophoblastic retention (91.3%). Misoprostol is often used, and is a source of incomplete abortion and haemorrhage [15]. In addition, abortions in developing countries are carried out under dangerous conditions [2]. In Togo, MVA is available in most health facilities, mainly to treat haemorrhagic complications of incomplete abortion and thus prevent women dying as a result of abortion. Contraceptive products are also available free of charge to prevent unwanted pregnancies. Infectious complications were dominated by endometritis (22.9%), followed by pelviperitonitis in 10% of cases. Uterine perforation was recorded in 10% of cases. Diallo *et al.* [12] reported 25% of cases of endometritis. Also, endo-uterine manoeuvres performed in septic conditions are most at risk of infectious complications. According to the WHO, restrictions do not reduce recourse to abortion, but probably increase the number of women seeking abortions by illegal and unsafe means, in the worst safety conditions, by incompetent people using dangerous and invasive methods [16]. In our case, toxic substances (potash and lemon, potash and 'Guinness', or bleach solution) and foreign bodies (cassava stems or other) were used in 14.3% and 7.1% of cases respectively. MVA was performed in 40% of patients and laparotomy in 11.4%. These results are similar to those of Diallo *et al.* [16] who reported 48.21% of cases of MVA compared with 10.71% of cases of laparotomy. In fact, endo uterine manoeuvres are more likely to cause traumatic lesions, if the technique is not properly applied, which may then require laparotomy to repair them. In 7.1% of cases, patients underwent hysterorrhaphy; hysterectomy was performed in 1.4% of patients. The case fatality rate in our study was 8.6%. Mukendi *et al.* [17] in the DRC in 2024 reported a hysterectomy rate of 12.5% and a hysterorrhaphy rate of 6.25%. Nationally, abortion-related deaths accounted for 16.9% of maternal deaths [6]. This lethality may be linked to delays in patient management. It has to be recognised that abortion, because of its stigmatising nature in our environment, patients after the act, whether by personal techniques (ranging from toxic products to manioc stems), or by the intervention of unqualified personnel, in an unsafe environment, would not have quickly decided to consult a doctor as soon as the first signs of complications appeared, thus causing a delay in treatment and hence the worsening of complications and then the death of some patients. In addition, socio-economic status (most of our patients were street vendors, and therefore on low incomes) could be blamed for this delay in treatment, since relatively young patients who are still financially dependent on their parents would not have been able to afford medical care without the support of a parent or guardian, who would often point an accusing finger at the perpetrators of this act, which in some conditions is considered a sin or an abominable crime [18]. In addition, the socio-cultural context (voluntary interruption of pregnancy is not permitted and the act of abortion is considered a criminal offence punishable by imprisonment [19]) is

also frowned upon by those around her.

5. Conclusion

Although illegal, induced abortion is still practised in Togo. This highlights the unmet need for contraception. With all the complications it causes, it constitutes a major factor in morbidity and mortality among women of reproductive age, compromising the obstetric future of patients. It therefore remains a real public health problem. The acquisition of a legal framework in our country is therefore necessary to avoid the sometimes fatal complications of abortion.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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