SURGICAL TERMINATION OF PREGNANCY

Surgical Abortion, In-Clinic Abortion

The termination of pregnancy by removing a fetus or embryo before it can survive outside the uterus that is performed by surgery.

△ Risk factor  ♀ Female

About Surgical termination of pregnancy

Surgical abortion is the ending of pregnancy by surgical removing a fetus or embryo before it can survive outside the uterus. Up to 15 weeks’ gestation, suction-aspiration or vacuum aspiration is the most common surgical methods of induced abortion. First-trimester procedures can generally be performed using local anesthesia, while second-trimester methods may require deep sedation or general anesthesia.

Some women favour medical abortion (using drugs) because they perceive it to be more natural. Other women prefer surgical abortion because of the comfort and finality of the procedure being completed in a single clinic visit, their preference for anesthesia or their desire not to see the fetus.

While a single first-trimester abortion carried no more mental health risk than carrying a pregnancy to term, abortion could not be proven safe in other cases as far as mental health was concerned. Women who terminate a pregnancy because of abnormalities discovered through fetal screenings have a similar risk of negative mental health outcomes as women who miscarry a wanted pregnancy or experience a stillbirth or the death of a newborn. However, “the differing patterns of psychological experiences observed among women who terminate an unplanned pregnancy versus those who terminate a planned and wanted pregnancy highlight the importance of taking pregnancy intendedness and wantedness (an individual’s orientation to the possibility of becoming pregnant) into account when seeking to understand psychological reactions to abortion.

The type of surgical abortion procedure used is based on the woman’s stage of pregnancy.

First Trimester Surgical Abortion — (8 to 12 Weeks)

If the pregnancy is more than eight weeks gestation, the preferred method is a vacuum aspiration (Pic. 1). In this procedure, forceps are inserted into the vagina. A local anesthetic is inserted into the cervix. The cervix is then carefully dilated. A thin tube is passed through the cervix and into the uterus. A tube is attached and used to suction the tissue out of the uterus. A curette is then used to ensure the complete removal of pregnancy tissues.

Second trimester surgical abortion — (12 to 24 weeks)

This process is more complicated and hospitalisation is usually required for a day or two. Medicine is inserted into the vagina to induce natural expulsion of the pregnancy. After the foetus and placenta are aborted, the womb is cleared by vacuum aspiration as above.

Third trimester surgical abortion

Abortion is not allowed if a pregnancy has progressed beyond 24 weeks. Most doctors would not initiate abortion beyond 23 weeks, so an earlier decision is best. The only exception to this rule is a severe or lethal foetal abnormality. Even in this case, special approval would have to be sought from the authorities before the procedure can be done.
Symptoms

Common side effects of the procedure include:

- bleeding, including blood clots
- cramping
- nausea and vomiting
- sweating
- feeling faint
- back pain
- abdominal pain

Associated diseases

- Asherman’s syndrome – uterine adhesions
- menstrual cycle disorders
- pelvic inflammatory disease (PID)
- endometriosis
- fallopian tube blockage

Complications

Abortion is one of the safest surgical procedures for women, if it takes place within the first trimester and is done by a trained professional. The risk of death associated with abortion is low and the risk of major complications is less than 1 percent. In fact, giving birth is more dangerous than an abortion. However, problems are more likely if an abortion is carried out later in a pregnancy.

The medical risks associated with abortions are:

- haemorrhage (excessive bleeding) – occurs in about one in every 1,000 abortions
- damage to the cervix (the entrance of the womb) – occurs in no more than 10 in every 1,000 abortions
- damage to the womb – occurs in up to four in every 1,000 abortions during surgical abortion, and less than one in 1,000 medical abortions carried out at 12-24 weeks

Bacteria (germs) from the vagina or cervix may enter the uterus and cause an infection. Antibiotics may clear up such an infection. In rare cases, a repeat suction, hospitalization or surgery may be needed. Infection rates are less than 1 percent for suction curettage, 1.5 percent for D&E, and 5 percent for labor induction.

Additionally, surgical abortion appears to be associated with an increased risk of spontaneous preterm birth in comparison with medical termination of pregnancy.

Newer, better-designed studies consistently showed no association between induced and spontaneous abortions and breast cancer risk.

While maternal mortality seldom results from safe abortions, unsafe abortions result in 70,000 deaths and 5 million disabilities per year. Complications of unsafe abortion account for approximately an eighth of maternal mortalities worldwide, though this varies by region.

Risk factors

- unintended pregnancy
- threatened the life or health of the woman
- threatened healthy fetal development
- genetically defective fetus development
- ectopic pregnancy
- societal pressure

Prevention

The first line prevention for surgical abortion is preventing unwanted pregnancy. Pregnant women should seek medical assistance and not self-medicate or turn to folk remedies (e.g. eating pineapple) in order to terminate a pregnancy.
How it can affect fertility

Especially in women after multiple surgical abortions, there is a higher risk of damage to cervix or uterus in the process because any instrument is inserted inside the uterus can potentially cause scarring in these areas, especially when it’s done multiple times. However, surgical removal of the scar tissue can usually solve the problem and restore fertility.

Having multiple abortions can result in a higher risk that the placenta will implant abnormally in future pregnancies. Since it doesn’t affect fertility it is an obstetrical complication of abortions.

An increased risk of premature delivery was found following multiple surgical, but not first trimester, medical IAs. While this could reflect the effect of repeated surgical trauma to the cervix, this needs further exploration in future studies with long-term periods of follow-up.

Prognosis

Having an abortion will not usually affect woman’s chances of becoming pregnant and having normal pregnancies in future. Additionally, there is no scientific evidence to support the idea that having an abortion is any more dangerous to a woman’s long-term mental health than delivering and parenting a child she did not intend to have or placing a baby for adoption. Studies demonstrate that the predominant feeling following abortion is one of relief and diminution of stress.

Although it is very uncommon, women undergoing abortion after 25 weeks gestation sometimes give birth to a fetus that may survive briefly (occurring 0 to 13% or 0 to 50%, depending on the method and gestation). Longer term survival is possible after 22 weeks.

If medical staff observes signs of life, they may be required to provide care: emergency medical care if the child has a good chance of survival and palliative care if not. Induced fetal demise before termination of pregnancy after 20–21 weeks gestation is recommended to avoid this.

Find more about related issues

Diagnoses

Asherman’s syndrome
A medical condition, where the walls of the uterus stick to one another due to bands of scar tissue.
Learn more at: www.fertilitypedia.org/therapy/diag/asherman-s-syndrome

Menstrual cycle disorders
An abnormal condition in a woman’s menstrual cycle.
Learn more at: www.fertilitypedia.org/therapy/diag/menstrual-cycle-disorders

Gallery
Pic. 1: Vacuum-aspiration
Fig. I: The vagina is held open by a speculum in order for a tube (called a vacurette), which is attached to a suction pump, to be inserted through the patient’s cervix. Fig. II: The products of conception are then evacuated through the vacurette.

FIGURE I

Sources

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